

Louisiana State University  
Health New Orleans



Department of  
Vascular Surgery  
2014 – 2015  
House Officer Manual

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## House Officer List

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### LSUHSC Department of Surgery 2014-2015

**Fifth Years:**

Adel Barkat  
Amit Chawla  
Thomas Cook  
R. Scott Daugherty  
Robyn Deranger Daugherty  
Fabienne Gray  
James "Buddy" Leithead  
April Mendoza  
Joshua Sibille

**Fourth Years:**

Lindsey Beakley  
Katie Hanisee  
Michael Hall  
Imtiaz Khan  
Seeyuen Lee  
Catherine McGee  
Cianna Pender  
Carrie Spangler

**Third Years:**

Jarret Brashear  
Christopher Cullom  
Thomas Delahoussaye  
Nathan Hite  
Wajeeh Irfan  
Rahal Kahanda  
Patrick McLaren  
William Steinhardt

**Second Years:**

Robert Amato  
Maxine Miller  
Willard Mosier  
Lindsey Richard  
Jesse Sulzer  
Ryan White  
Andrew Gruezeke (p)

**First Years:**

Elyse Bevier-Rawls  
Edwin Manley  
Ngan Nguyen  
Benjamin Robichaux

Jack Torres  
Adele Williams  
Bethany Zimmerman  
Danielle Cobb (p)  
Gina Corsaletti (p)  
Luke Cvitanovic (p)

Aimee Hymel (P)  
Allyson Jarvis (p)  
Crystal Leach (p)  
Nisha Loganantharaj (p)  
Naoki Murai (p)  
Salah Mohamed (p)  
Daniel Rittenberg (p)  
Sarah Travers (p)

**Research:**

Jessica Zagory (will return as  
a PGY 4 in '16)  
Erika Lindholm (will return  
as a PGY 5 in '15)

**Trauma Critical Care****Fellow:**

Margaret Moore  
Rosemarie Robledo

**Vascular Fellow:**

Taylor Gwin  
Chiranjiv Virk

**Vascular-Integrated****Residents:**

**Third years:**  
Estela Brooke  
Gregory Ellison

**Second years:**

Lucy Kupersmith  
Laurel Hastings

**First Years:**

Melanie Sabbagh  
Samuel Victoria

**Plastic Surgery Residents:****Eighth Years:**

James Mayo  
Christopher Sanders

**Seventh Years:**

Daniel Womac

**Fifth Years:**

Mark Stalder  
Michael Tarakji  
John Guste

**Plastic Surgery Residents-  
Integrated:****Second Years:**

Jonathan Lam  
Haiqiao "Tommy" Jiao

**First Years:**

Patrick Emelife  
Radbeh Torabi

**Rotators**

Kamran Dastoury (OMFS)  
Justin Hastings (OMFS)  
Joe Mayes (OMFS)  
Peter Park (OMFS)  
Shahrouz Zarrabi (OMFS)

Thomas Lucak (Ortho)

Jack McKay (Ortho)  
Neuyen Mclean (Ortho)  
Vikas Patel (Ortho)

Lindsay Lasseigne (NS)

Mathieu Forgues (ENT)  
Elizabeth Gardner (ENT)  
Victoria Givens (ENT)  
Anne Kane (ENT)

## Departmental Policies

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### *Residency Selection Policy*

Graduates of all LCME schools in the United States and Canada are invited to submit applications through the Electronic Resident Application System (ERAS). Additionally applications are also accepted from Foreign Medical Graduates meeting the ECFMG criteria and submitted through ERAS. The Department of Surgery does not support Visas. If a foreign medical graduate matches with our program, they must be registered and certified through the Educational Commission for Foreign Medical Graduates before beginning their residency training. All applicants must also meet the requirements for licensure through the Louisiana State Board of Medical Examiners – either an intern card, which will eventually lead to an unrestricted license or a Graduate Education Training Permit (GETP) given to foreign medical graduates.

Submitted applications are then reviewed by the Coordinator, Program Director and other faculty. Criteria for interview involve an academic score based on the USMLE Step 1 and 2, School Transcripts, Letters of Recommendation, Dean's Letter, Curriculum Vitae, and the ERAS application.

Interviews take place in November, December, and January. Applicants are interviewed by the interview committee (Approximately 6 faculty) with interviews approximately 20 minutes long. All applicants with meet with the Program Director. There is also an informal interview with the chairman and 3–6 applicants. A ranking meeting is held at the completion of each interview day and based on both objective and subjective information, a draft ranking list is developed.

At the completion of the interview process, faculty, chief residents, the program director, and the chairman meet and based on the applicants interviewed and

their advocates among the faculty, a final ranking list is prepared and then submitted to the National Resident Match Program (NRMP).

### ***Resident Promotion Policy***

Evaluations by faculty, peers, and students. An assessment of academic performance (e.g. ABSITE scores, reading assignment participation, mock oral exam performance, etc.) play a determining role in resident promotion. At the end of each evaluation form the faculty member is asked if they think that the resident should be promoted to the next level. There is a check box for promotion or remediation in which the faculty member has a chance to respond with their opinion. Each resident is discussed by faculty and chief residents four times a year during the Resident Evaluation Meeting and decisions are made for promotion of each into the next level. **Residents must pass USMLE Step 3 in order to advance to the PGY 3 level.**

### ***Resident Dismissal Policy***

The Department of Surgery adheres to the Institutional Policy of non-renewal of agreement of appointment which ensures that the resident receive notification of non-renewal of appointment *no later than four months* prior to the end of the resident's current agreement of appointment. If the primary reason for the non-renewal occurs within the four months prior to the end of the agreement of appointment, the institution must ensure that the program provide their residents with as much written notice of the intent not to renew as the circumstances will reasonably allow, prior to the end of the agreement of appointment. Residents must be allowed to implement the institution's grievance procedures when they have received a written notice of intent not to renew their agreements of appointment.

### ***Professionalism and Learning Environment***

The Department of Surgery wishes to ensure:

1. Patients receive safe, quality care in the teaching setting of today.
2. Graduating residents provide safe, high quality patient care in the unsupervised practice of surgery in the future.

3. Residents learn professionalism and altruism along with clinical medicine in a humanistic, quality learning environment.

Important aspects of the learning environment include:

1. Professionalism including accepting responsibility for patient safety
2. Alertness management
3. Proper supervision
4. Effective transitions of care
5. Clinical responsibilities
6. Communication / teamwork

Residents must take personal responsibility for and faculty must model behaviors that promote:

1. Assurance for fitness of duty
2. Assurance of the safety and welfare of patients entrusted in their care
3. Management of their time before, during, and after clinical assignments
4. Recognition of impairment (e.g. illness or fatigue ) in self and peers
5. Honest and accurate reporting of duty hours, patient outcomes, and clinical experience data

The institution further supports an environment of safety and professionalism by:

1. Providing and monitoring a standard Transitions Policy as defined on page 10.
2. Providing and monitoring a standard policy for Duty Hours as defined on page 25.
3. Providing and monitoring a standard Supervision Policy as defined on page 13.
4. Providing and monitoring a standard master scheduling policy and process in New Innovations.
5. Adopting and institution wide policy that all residents and faculty must inform patients of their role in the patient's care.

6. Providing and monitoring a policy on Alertness Management and Fatigue Mitigation that includes:
  - a. On line modules for faculty and residents on signs of fatigue.
  - b. Fatigue mitigation, and alertness management including pocket cards, back up call schedules, and promotion of strategic napping.
7. Assurance of available and adequate sleeping quarters when needed.
8. Requiring that programs define what situations or conditions require communication with the attending physician.

### **Process for Implementing Professionalism Policy**

Our program assures implementation of the Professionalism Policy by the following:

1. Core Modules for residents on Professionalism, Duty Hours, Fatigue Recognition and Mitigation, Alertness Management, and Substance Abuse and Impairment.
2. Required LSBME Orientation.
3. Institutional Fitness for Duty and Drug Free Workplace policies.
4. Institutional Duty Hours Policy reflecting the ACGME Duty Hour.
5. Language added specifically to the Policy and Procedure Manual, the House Officer manual and the Resident Contract regarding Duty Hours Policies and the responsibility for and consequences of not reporting Duty Hours accurately.
6. Orientation presentations on Professionalism, Transitions, Fatigue Recognition and Mitigation, and Alertness Management.

### **Monitoring Implementation of the Policy on Professionalism**

The program and institution will monitor implementation and effectiveness of the Professionalism Policy by the following:

1. Evaluation of residents and faculty including:
  - a. Observation of the resident in the patient care setting.
  - b. Evaluation of the residents' ability to communicate and interact with other members of the health care team by faculty, nurses, patients where applicable, and other members of the team.
  - c. Monthly and semi-annual competency based evaluation of the residents.
  - d. By the institution in Annual Reviews of Programs and Internal Reviews.
  - e. By successful completion of modules for faculty and residents on Professionalism, Impairment, Duty Hours, Fatigue Recognition and Mitigation, Alertness Management, and others.
  - f. Program and Institutional monitoring of duty hours and procedure logging as well as duty hour violations in New Innovations.

### ***Grievance Procedures, Sexual Harassment, Equal Opportunity, and Drug Free Workplace***

The department follows the Louisiana State University's GME Handbook regarding the above noted topics. The department strives to create a professional work environment, regardless of gender and ethnicity. If questions arise regarding sexual harassment please feel free to contact Dr. John Hunt (jhunt2@lsuhsc.edu) or Dr. Jen Mooney (jmoone@lsuhsc.edu) If questions crop up regarding possible racial discrimination, please feel free to contract Dr. John Hunt ([jhunt2@lsuhsc.edu](mailto:jhunt2@lsuhsc.edu)).

## ***Policy on Effective Transitions***

Effective transitions are facilitated by:

1. Provision of complete and accurate rotational schedules in New Innovations
2. Backup plan where a resident is unable to complete their duties.
3. The ability of any residents to be able to freely and without fear of retribution report their inability to carry out their responsibilities due to fatigue or other causes.

## **Policy and Process**

Residents receive educational material on Transitions in Orientation and as a Core Module.

In any instance where care of a patient is transferred to another member of the health care team an adequate transition must be used. Although transitions may require additional reporting the minimum standard for transitions must include the following information:

1. Demographics
  - a. Name, Age, Medical Record Number
  - b. Unit/room number
  - c. Attending physician – Phone numbers of covering physician
2. History and Problem List
  - a. Primary diagnoses
  - b. Chronic problems (pertinent to this admission/shift)
3. Current condition/status
4. System based
  - a. Pertinent Medications and Treatments



5. Pertinent lab data
6. To do list: Check x-ray, labs, wean treatments, etc. – rationale
7. Contingency Planning – What may go wrong and what to do
8. Code status/family situations

Rotation faculty will periodically observe resident transitions, on their services. Their assessment of how effectively a resident performs a transition will become a part of your evaluation for the rotation.

### ***Policy on Alertness Management / Fatigue Mitigation Strategies***

#### **Policy and Process**

Residents and faculty are educated about alertness management and fatigue mitigation strategies via on line modules and in departmental conferences. Alertness management and fatigue mitigation strategies are outlined on the pocket cards distributed, by the institution, to all residents and contain the following suggestions:

1. Warning Signs
  - a. Falling asleep at Conference/Rounds
  - b. Restless, Irritable w/ Staff, Colleagues, Family
  - c. Rechecking your work constantly
  - d. Difficulty Focusing on Care of the Patient
  - e. Feeling Like you Just Don't Care
2. SLEEP STRATEGIES FOR HOUSESTAFF
  - a. Pre/On-Call Residents
    1. Tell Chief/ Faculty, if too sleepy to work! Sleep prior to call & avoid ETOH
    2. Nap whenever you can > 30 min or < 2°
    3. BEST Circadian Window 2PM-5PM & 2AM- 5AM
    4. AVOID Heavy Meal

5. Strategic Consumption of Coffee (t ½ 3–7 hours)
  6. Know your own alertness/Sleep Pattern!
- c. Post–Call Residents
1. Lowest Alertness 6AM –11AM after being up all night
  2. Full Recovery from Sleep Deficit takes 2 nights
  3. Never drive while drowsy. 20 min. nap/Cup Coffee 30 min before driving.

### **How Monitored:**

The institution and program monitor successful completion of the on line modules. Residents are encouraged to discuss any issues related to fatigue and alertness with supervisory residents, chief residents, and the program administration. Supervisory residents will monitor lower level residents during any in house call periods for signs of fatigue. Adequate facilities for sleep during day and night periods are available at all rotation sights and residents are required to notify Chief Residents and program administration if those facilities are not available as needed or properly maintained. At all transition periods supervisory residents and faculty will monitor lower level residents for signs of fatigue during the hand off. The institution will monitor implementation of this indirectly via monitoring of duty hours violations in New Innovations, the Annual Resident Survey (administered by the institution to all residents and as part of the annual review of programs) and the Internal Review process.

### **Supervision and Progressive Responsibility Policy**

#### **Policy and Process:**

Several of the essential elements of supervision are contained in the Policy of Professionalism detailed elsewhere in this document. The specific policies for supervision are as follows.

## **Faculty Responsibilities for Supervision and Graded Responsibility:**

Residents in the General Surgery Program must be supervised in such a way that they assume progressive responsibility as they progress in their educational program. Progressive responsibility is determined in a number of ways including:

1. GME faculty on each service determine what level of autonomy each resident may have that ensures growth of the resident and patient safety.
2. The Program Director and Chief Residents assess each residents' level of competence in frequent personal observation and semi-annual review of each resident.
3. Rotation specific progressive responsibility may be based on specific metrics such as participation in simulation labs, faculty observation of a given procedure, etc.

The expected components of supervision include:

1. Defining educational objectives.
2. The faculty or senior resident observing/assessing the skill level of the resident by direct observation.
3. The faculty or senior resident defines the course of progressive responsibility allowed starting with close supervision and progressing to independence as the skill is mastered.
4. Documentation of supervision by the involved supervising faculty must be customized to the settings based on guidelines for best practice and regulations from the ACGME, JACHO and other regulatory bodies. Documentation should generally include but not be limited to:
  - a. progress notes in the chart written by or signed by the faculty
  - b. addendum to resident's notes where needed
  - c. counter-signature of notes by faculty

- d. a medical record entry indicating the name of the supervisory faculty.
- 5. In addition to close observation, faculty are encouraged to give frequent formative feedback and required to give formal summative written feedback that is competency based and includes evaluation of both professionalism and effectiveness of transitions.

**The levels of supervision are defined as follows:**

- **Direct Supervision by Faculty** – faculty is physically present with the resident being supervised.
- **Direct Supervision by Senior Resident** – same as above but resident is supervisor.
- **Indirect with Direct Supervision IMMEDIATELY Available – Faculty** – the supervising physician is physically present within the hospital or other site of patient care and is **immediately** available to provide Direct Supervision.
- **Indirect with Direct Supervision IMMEDIATELY Available – Resident** – same but supervisor is resident.
- **Indirect 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.
- **Oversight** – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

**Program Supervision Requirements:** The program has delineated a set of minimal supervision requirements by the type of care rendered. This may be augmented by any given attending or institution which the residents rotate through and are listed below:

**Inpatient Services**

<i>PGY</i>	<i>Direct by Faculty</i>	<i>Direct by senior residents</i>	<i>Indirect but immediately available – faculty</i>	<i>Indirect but immediately available – residents</i>	<i>Indirect available</i>	<i>Oversight</i>
I	x	x	X			
II	x	X	X	X	X	X
III	x	X	X	x	X	X
IV	x	X	X	x	X	X
V	x	X	x	x	X	X

**Intensive Care Units**

<i>PGY</i>	<i>Direct by Faculty</i>	<i>Direct by senior residents</i>	<i>Indirect but immediately available – faculty</i>	<i>Indirect but immediately available – residents</i>	<i>Indirect available</i>	<i>Oversight</i>
I	x	X	x			
II	X	X	X	X		
III	X	X	X	X	X	X
IV	X	X	X	X	X	X
V	X	x	X	x	X	X

### Ambulatory Settings

<u>PGY</u>	<u>Direct by Faculty</u>	<u>Direct by senior residents</u>	<u>Indirect but immediately available – faculty</u>	<u>Indirect but immediately available – residents</u>	<u>Indirect available</u>	<u>Oversight</u>
I		X			X	X
II		X			X	X
III					X	X
IV					X	X
V					X	X

### Consult Services

<u>PGY</u>	<u>Direct by Faculty</u>	<u>Direct by senior residents</u>	<u>Indirect but immediately available – faculty</u>	<u>Indirect but immediately available – residents</u>	<u>Indirect available</u>	<u>Oversight</u>
I	x	X	x	X		
II	X	X	X	X	X	
III	X	X	X	X	X	x
IV	X	X	X	X	X	X
V	X	x	X	x	x	X

**Operating Rooms:**

<i>PGY</i>	<i>Direct by Faculty</i>	<i>Direct by senior residents</i>	<i>Indirect but immediately available – faculty</i>	<i>Indirect but immediately available – residents</i>	<i>Indirect available</i>	<i>Oversight</i>
I	X					
II	X	X				
III	X	X				
IV	X	X	X			
V	x		x			

**Procedure Rotations**

<i>PGY</i>	<i>Direct by Faculty</i>	<i>Direct by senior residents</i>	<i>Indirect but immediately available – faculty</i>	<i>Indirect but immediately available – residents</i>	<i>Indirect available</i>	<i>Oversight</i>
I	X	X				
II	X	x				
III	X	X	X			
IV	X	X	X			
V	X	X	x			

**PGY 1 residents may not be unsupervised by either faculty or more senior residents in the hospital setting.**

**How Monitored:**

The institution will monitor implementation of the policies through Annual Review of Programs and Special Focused Program Reviews. Furthermore the institution monitors supervision through a series of questions in the Annual Resident Survey. The program will monitor this through feedback from residents and monitoring by Chief Residents and Program Directors. Supervision will be added to the annual review of programs.

***Policy on Mandatory Notification of Faculty***

**Policy and Process**

In certain cases faculty or a senior resident must be notified of a change in patient status or condition. The table below outlines those instances in which faculty must be called by PGY level.

<b>Condition</b>	<b>PGY 1</b>	<b>PGY2</b>	<b>PGY 3 and above</b>
Care of complex patient	x	x	
Transfer to ICU	x	x	x
DNR or other end of life decision	x	x	x
Emergency surgery	x	x	x
Acute drastic change in course	x	x	x
Unanticipated invasive or diagnostic procedure	x	x	x
Reintubation	x	x	x
Blood transfusion – non-urgent	x	x	
Routine admission	x	x	
Hypotension requiring pressors	x	x	x
Sustained tachycardia	x	x	x
Routine consultation	x	x	
Fever	x		



## **How monitored**

Chief Residents, faculty, and programs will monitor by checking for proper implementation on daily rounds, morning reports, and other venues as well as solicitation of reports from faculty on lack of appropriate use of the policy.

### ***Policy on Continuity of Care (Resident unable to perform duties)***

Residents may be unable to perform duties for a variety of reasons ranging from sleep deprivation to emergency family leave. The rotation faculty supervisor is best suited to deal with these occasions. The faculty supervisor may reassign resident duties within the rotation, ranging from operating room coverage to on-call duty to maintain adequate resident coverage. This reassignment must still comply with the duty hours regulations. The faculty supervisor may request additional resident coverage from the program director to meet long absences or insufficient resident coverage for other reasons.

## **Administrative Information**

### ***Rotation Schedules***

Resident rotation schedules are prepared by the Chief Resident, Program Director and Chairman with input from the faculty and resident staff. The full five year curriculum has been created to ensure equivalent experience and provide full access to all segments of our program for all our residents. Included in the experience are mandatory rotations on General Surgery, Pediatric Surgery, Transplant Surgery, Cardiac Surgery, Plastic Surgery, Laparoscopic Surgery, Trauma Surgery, Vascular Surgery, Hepatobiliary Surgery, and the SICU. The staff has made every effort to provide residents with as many of their requests as possible, but obviously this is not always possible. After assignments are distributed, **NO CHANGES SHOULD BE MADE WITHOUT APPROVAL FROM THE PROGRAM DIRECTOR.**

### ***Advisors/Mentors***

Each first year resident is assigned a faculty advisor. As a resident progresses through the program and their career path becomes clearer they may choose a mentor more in line with their interests. The mentor will then replace the assigned advisor and assume their duties. It is expected that each resident will declare a mentor by the end of their third year.

A copy of the staff evaluations and a summary of peer and student evaluations will be maintained in the resident's permanent file. Residents are encouraged to contact their advisors/mentors throughout the year for personal and academic counseling. Advisors/mentors are responsible for giving the advisee his/her ABSITE score. It is the resident's responsibility to arrange his/her twice yearly conferences with his/her advisor. Resident's may review their permanent records at any time upon giving the residency coordinator one week notice.

### ***Research Laboratory***

Selected residents will be assigned to the research laboratory after the third year. The usual laboratory rotation is for 1–2 years. Residents who think they might be interested in such a rotation should discuss this possibility with his/her advisor/mentor and the Program Director well in advance of the development of the schedule during their second year. Consideration is given based on a resident's academic and clinical performance and planned research projects.

### ***Moonlighting***

The following guidelines have been set forth by the Department with regard to a resident's work hours outside their regularly assigned clinical and research duties:

1. No moonlighting is allowed for residents on clinical rotations.
2. Residents may moonlight under the following circumstances:
  - a. Research elective
  - b. Vacation

3. Research residents should not allow their moonlighting to interfere with ongoing research projects. Under no circumstance is moonlighting permitted during the work week (Monday–Friday, 8:00 a.m.–5:00 p.m.).
4. Failure to comply with these guidelines will be grounds for probation. Repeated offense will result in dismissal from the program.
5. Please refer to the Liability Insurance Section of the GME Policy and Procedures Manual. Moonlighting is NOT covered by your LSU malpractice insurance.

## **Evaluations – Faculty and Resident**

***Resident Evaluation by Faculty*** – All residents are evaluated at the end of each rotation by the staff members they worked under. The goals & objectives and evaluation forms are rotation and level specific (see attached sample form section) and should be reviewed by the resident before starting the rotation. This evaluation becomes part of the permanent file and will be used at periodic evaluation sessions (every three months) by the Department as a means of determining strengths, weaknesses, problems and promotions. These evaluations plus the ABSITE examination (a yearly in-training examination administered in late January of each year by the American Board of Surgery), plus comments from the staff are the basis for renewal of contracts and promotions as well as recommendation to sit for the qualifying examination of the American Board of Surgery (ABS).

***Faculty Evaluation by Residents*** – Just as the faculty have an opportunity to evaluate house officers, house officers are provided the opportunity to evaluate individual staff members with whom they have worked. An evaluation of the rotation should be completed on all rotations. These evaluation forms will be completed via New Innovations upon the completion of the rotation. Residents are encouraged to be completely honest in their assessments; at no time will faculty members see the completed evaluation forms.

All staff members receive a typed, anonymous cumulative report of their evaluations at the end of the year. The staff members cannot trace information

back to the individual residents. The Chairman also receives a copy of each faculty member's cumulative evaluation report.

***Peer Evaluations*** – Residents complete evaluations of the peers on their service at the completion of each rotation. These evaluations are confidential and part of each resident's record. All residents evaluate their fellow residents as well as attending staff on their services at the end of each rotation.

***Rotation Evaluations*** – Residents will evaluate their rotation experience upon completion of the rotation. These evaluations are confidential and will be utilized by the Program Evaluation Committee as an assessment tool and as a basis for program development and change.

***Annual Program Evaluations*** – All residents will complete a comprehensive program evaluation in May or June of each year. The results of this evaluation will be synthesized and reviewed by the Program Evaluation Committee (PEC) to determine program strengths and weaknesses and as a basis for program development and change.

***General Surgery Milestones*** – Milestones are knowledge, skills, attitudes, and other attributes for each of the ACGME competencies organized in a developmental framework from less to more advanced. They are descriptors and targets for resident performance as a resident moves from entry into residency through graduation. There will be two reporting periods – November/December and April/May. For each reporting period, review and reporting will involve selecting the level of milestones that best describes a residents current performance level in relation to milestones, using evidence from multi-source feedback, tests, and record reviews. For a complete breakdown of the ACGME Milestones, click on the link: [Surgery-General Milestones](#).

### **Statement on Oversight and Liaison**

The Program Director maintains contact with faculty members placed in positions of supervision and oversight of residency training. Faculty members are encouraged to discuss resident issues with the Program Director in personal interviews and at the monthly faculty meetings. The Program Director also

meets with the faculty members four times a year during the resident evaluation meetings. At this time any aspect of the training program is open for discussion.

## **Six General Competencies**

Moving towards a competency based education; the ACGME has implemented the requirement of six general competencies into the curriculum of all accredited programs. These competencies will be used as an evaluation tool for faculty evaluating residents on each rotation, the definition of each is outlined on the below:

1. **Patient Care** – Compassionate, appropriate and effective for treatment and prevention of disease.
2. **Medical Knowledge** – About established and evolving sciences and their application to patient care.
3. **Interpersonal and Communication Skills** – Effective information exchange and cooperative “learning”.
4. **Professionalism** – Commitment to professional responsibilities, ethical principles and sensitivity to diverse patient populations.
5. **Practice-Based Learning and Improvement** – Investigate and evaluate practice patterns and improve patient care.
6. **Systems-Based Practice** – Demonstrate an awareness of and responsiveness to the larger context and system of health care.

## **Dress Code**

As medical professionals, your appearance says a lot about who you are. Patients, families, and staff expect physicians to be dressed in a professional manner. Whenever possible, residents should appear at conferences, clinics, and rounds in appropriate attire. Wearing scrubs is acceptable for residents who are on trauma call or who are going in and out of the operating room. Please remember that wearing scrubs outside of the hospital is **unacceptable**. Particular dress requirements may be service specific and will be elaborated at the beginning of the rotation by the service chiefs.

## **Vacation:**

LSU Plastic Surgery residents are entitled to three weeks of paid vacation during the first year and 4 weeks during the second year. Residents should realize that a total of eight weeks of vacation is a lot of time away from an intensive residency. Relaxation is important, but residents are urged to follow these guidelines.

Vacation, interviews, travel, moving and education leave are all part of vacation. Vacation can be taken during the University rotation but not the hand rotation. The vacation time should be limited to one week plus two weekends (9 days) and may not be taken consecutively. A week of “holiday vacation” is granted which is part of the annual leave.

Vacations should be spaced once every fourth month for the first year residents and once every three months for the second year residents. All vacation requests must be approved in advance by Dr. Dupin and the educational director of the rotation. Once approval has been received, you must notify the Residency Coordinator of your intended days. The residency coordinator will keep a vacation calendar. **Only one resident is allowed out-of-town at any time** on a first-come first-serve basis in relation to approval by Dr. Dupin and notification given to the residency coordinator. Each

resident should have at least one month prior approval from Dr. Dupin. The residency coordinator should be notified at least one month in advance for scheduling purposes. Vacations are not allowed during the month of June for the first and second year residents. Senior residents are advised that the program completion date is the last day of June. Senior residents are strongly encouraged to use their 4<sup>th</sup> week of vacation for the last week of June. Alternatives will be given to residents with fellowship commitments the last week of June.

### **Educational Leave**

LSU Plastic Surgery residents may take up to one week of educational leave per year to attend meetings, courses or seminars with the approval of Dr. Dupin and Dr. Frey. Each resident may receive funds from the Department of Surgery (if available) to help defray the costs of approved meetings and courses. **If residents expect funding for the trip, all travel arrangements must be arranged in advance through the department of surgery well in advance of travel. The department has a person who is responsible for travel and residents must contact them to obtain guidelines for state travel, or he/she may not be reimbursed.** Ordinarily, 1<sup>st</sup> year residents attend the semi-annual maxillofacial course. Senior residents should attend the senior resident conference. Other courses may be attended, without division funding, at the discretion of the Division Chief.

Residents are encouraged to present research papers at national and local meetings. Costs incurred for these meetings will be paid by the department pending fund availability. Arrangements for reimbursement must be made prior to the trip or the resident may not be reimbursed.

### **Time Off**

Each resident is encouraged to take two weekends off per month or at least 4 full days (24 hours) without any clinical duties over a four-week period.

Residents must make mutually acceptable arrangements with another resident to turn over their beeper and patient list. The Chief Administrative Resident must approve of all weekend coverage arrangements. Residents are required to give detailed sign out lists by email, including patient details, clinically important facts and a note about what is to be done to the patient during weekend call coverage and vacation time.

## **Payroll**

Payroll is automatically deposited on a semi-monthly basis. It is **mandatory** that you sign up for direct deposit, since you are assigned to out of town rotations. Electronic paycheck stubs can be accessed online.

## **Insurance Coverage**

Please see the GME House Officer Manual on Policies and Procedures for information on health, life, and malpractice insurance as well as disability coverage.



## INSTITUTIONAL/PROGRAM POLICY ON DUTY HOURS

The program and institution supports the spirit and letter of the ACGME Duty Hour Requirements. Though learning occurs in part through clinical service, the training programs are primarily educational. As such, work requirements including patient care, educational activities, and administrative duties should not prevent adequate rest. The program and institution has developed policies and procedures to assure the specific ACGME policies relating to duty hours are successfully implemented and monitored. They are summarized as:

### Maximum House 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.

### Mandatory Time Free of Duty

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.

### Maximum Duty Period Length

Duty periods of PGY-1 residents must not exceed 16 hours in duration.  
No exceptions

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

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, for no longer than an additional four hours.

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

Under those circumstances, the resident must:

Appropriately hand over the care of all other patients to the team responsible for their continuing care; and,

Document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

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

#### Minimum Time Off between Scheduled Duty Periods

PGY-1 resident should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.

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.

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. 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. This will be monitored by the program director.

#### Maximum Frequency of In-House Night Float

Residents must not be scheduled for more than six consecutive nights of night float.

#### 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).

#### At-Home Call

Time spent in the hospital by residents on at-home call must count towards the 80-hours 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 on-day-in-seven free of duty, when averaged over four weeks.

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".

Residents are required to log all duty hours in New Innovations Software Program or its replacement program. Those who fail to log duty hours or log erroneous duty hours are subject to disciplinary action. This applies to every site where trainees rotate.

**\*\*Duty Hours will be monitored through New Innovations and should be completed by the end of each week. If a resident is more than 2 weeks behind in completing their duty hours, Dr. Daniel Frey will send out a notice detailing that the resident has 48 hours to update his duty hours. If the Duty Hours are not completed in that time, vacation time will be assigned so the resident can complete them.**

## **Duty hour Types Set up in New Innovations**

At home call – not called in – to be used when at home during home call. Any hours logged on this duty type do NOT count towards the 80 hour week.

At home call – called in – to be used when called in to work during at home call. Any hours logged on this duty type DO count towards the 80 hour work week.

Call – to be used when doing overnight call.

Clinic – to be used when doing clinical duties.

Conference – to be used when attending conferences, journal clubs, didactics, and other educational events.

Continuity Clinic – to be used when working at a continuity clinic.

Night Float – to be used when working night float rotation or shift.

Post Call – to be used after a 24 hour overnight call to complete paperwork and patient transition activities.

Shift – Regular working hours that do not fit any of the other duty hour types.

Vacation/Leave – Vacation, sick leave, educational leave. Days scheduled as Vacation/Leave are not counted as days off for day off requirements.

## **Computers and Libraries**

Computers and medical libraries are available to residents at all hospitals. User ID's and passwords are assigned by Computer Services after completing paperwork given to you during GME intern orientation. **All residents are given an email account through LSU and are required to check it daily. This is the primary way in which information concerning the residency program will be distributed.**

## **Resident Responsibilities**

It has been said that in order to be a successful physician, one must display three vital characteristics: *availability*, *affability*, and just plain *ability*. (Dr. R.J. Lousteau, 1987). In the department of Surgery, these essential qualities will be expected of every resident, without exception.

*Availability.* Our department has proudly observed a long tradition of service, and here at LSU we have a reputation of being ready and willing to provide that service to anyone in need. Thus, we make it a policy to be available at all times, and to answer all calls promptly. The persons listed in the call schedules must regard their on-call days and nights as serious responsibilities that are not to be taken lightly. If at any time a resident is unable to fulfill the demands of being on call, he or she must immediately notify the other resident members of the team so that alternative coverage may be arranged.

It is the resident's responsibility to be sure that beepers and telephones are in working order and that the hospital operators, emergency rooms, and ward know how to reach him/her at all times. Furthermore, it is the responsibility of all residents to be "geographically positioned" in the community so that responses to hospital calls can be made within a reasonable time. Remember that in a real emergency, someone's life may depend on how far away you are. As a general rule, residents on call should be reachable by beeper and telephone within five minutes, and when taking calls from outside of the hospital, must be able to get to the hospital within 15 to 20 minutes.

*Affability.* Our policy toward consultations, whether from primary care physicians, emergency rooms or other services, is to be courteous and “glad to be of assistance”. Remember that few other medical professions have any in-depth training in surgery, and no matter how simple or how complex the patient’s problem may be you are being called to provide help in solving it. We will therefore project a pleasant, outgoing attitude in answering all calls for help from other services. Your demeanor is a reflection of your Department!

*Ability.* Every resident in our program will be expected to perform at the very highest level he or she is capable of attaining. By virtue of your acceptance into this training program, you have demonstrated the basic skills necessary to become a fine surgeon. While the Department will provide an excellent foundation for developing those skills, each resident will be expected to devote the time and energy necessary to hone them finely through a combination of didactic study, clinical observation, and one-on-one contact with faculty.

The three factors mentioned above are the foundations of professionalism. Implicit, of course, in this concept of professionalism are the qualities of personal integrity, responsibility, and honesty. It should go without saying that these qualities will be expected from each and every resident at all times. By embracing these ideals, we all strive to provide the best of care for our patients as well as the spirit of cooperation and concern for our colleagues.

As residents progress through the program they will be expected to grow emotionally, technically and intellectually. Individual responsibilities will increase yearly in a graduated fashion. Every resident should recognize that he/she is part of the LSU General Surgery Program for an entire year. Those residents taking one or two years of general surgery prior to a surgical specialty residency are still considered part of our department and are expected to meet all the requirements of our department. All problems experienced while part of the Department of Surgery will be resolved within the Department of Surgery.

## Medical Licensure

Every resident is required to hold a Louisiana medical license. A copy must be provided to the Department upon initial receipt and upon renewal each year. All interns must be registered to take **USMLE Step 3** by **September 30<sup>th</sup>**. Interns should plan to apply for permanent licensure before the end of postgraduate year one, as soon as the USMLE Step 3 is completed. Once you have passed you must notify your coordinator and submit a copy of your scores to the department. If you cannot obtain a license by the start of postgraduate year 2 you must renew your Intern Card and provide the Department with a copy. You must obtain a full Louisiana Medical license at your postgraduate year 2 to be promoted to the postgraduate year 3. All US graduates must have a permanent Louisiana medical license to begin post graduate year 3. This is a state licensure requirement. If you do not have a license, you cannot continue in the residency.

Specific licensure information should be obtained directly from the Louisiana State Board of Medical Examiners. [www.lsbme.louisiana.gov](http://www.lsbme.louisiana.gov) or you can call them at 504.568.6820

## Research Project

Each categorical resident will be required to complete one research project and manuscript suitable for publication in a major national journal. The manuscript should be submitted to the Program Director and the project presented at one of the end of year resident research meetings. Whether the paper is of acceptable quality will be determined by the Program Director and Faculty the paper was written with. **This requirement should be completed by the end of fourth year and final graduation will be dependent upon fulfilling this requirement.** Case reviews are not permitted for presentation. Start early. It is suggested that interns have their project chosen by the middle of their first year.

Residents should not submit papers, abstracts or any other materials to any meeting, journal or society unless it has been reviewed by the staff. Residents may request reimbursement for expenses incurred while presenting a paper at

a major meeting within the 48 contiguous states. Reimbursement will fall within state guidelines if adequate advance notice is given and the trip has been approved.

## **Meetings**

The Department of Surgery will fund meetings in which the resident has had an abstract/paper accepted for presentation as either an oral or poster format. Prior to submitting the paper, the appropriate staff should verify that the paper is in an appropriate format and approve submission. Once the paper is accepted, the resident needs to comply with all state travel guidelines in effect at the time. In addition, appropriate work hour rules and time off from clinical duties regulations must be followed. Deviation from the accepted guidelines can result in non-reimbursement of travel expenses.

## **Faculty Expectations of Residents**

1. The Chief Resident speak for all residents in the program and is responsible for the overall management of resident activities within the program. The Chief Resident will be the resident to whom the Chairman will communicate all problems within the program.
2. The teaching chief resident is responsible for coordinating the resident conferences. In addition, the teaching resident works with faculty to coordinate the basic and clinical science conferences. Assignments for resident conferences should be made sufficiently in advance so that those presenting properly prepare. The teaching chiefs are also responsible for coordinating the presentations at the Rives conference.
3. The senior level residents (PGY V & PGY IV) are responsible for the running of their service and the authority to maintain discipline. The senior resident on each service will be expected to make daily rounds on the entire service so that he/she may be aware of any problems or complications that occur and communicate with the attending staff on a regular basis.
4. Senior residents should remember that the staff attendings hold the chief resident on each service responsible for complications, deaths, clinical



decisions, and any other incidents that occur on the service under his/her direction.

5. Residents need to recognize the hierarchy of the training program. Junior residents report to senior residents who report to attending staff.
6. When a resident is planning to do an operation, he/she needs to know the details of the H&P on the patient, have a plan for the operation, and communicate with the attending regarding the conduct of operation. If the resident is unprepared, the attending staff may choose not to allow him/her to perform the operation.
7. After performing an operation on a patient, the resident needs to take ownership of the patient and stay involved in the decision-making and care regarding the patient.
8. Each resident should be prepared to present his/her cases at the appropriate conference (e.g. M&M, pre-operative conference, and grand rounds).
9. Senior residents are expected to pay full attention to their clinical responsibilities, which include supervising junior residents in the operating room, making rounds with junior residents regularly, being knowledgeable about all patients on the service, seeing postoperative patients in the morning before going to the operating room, and being available at all times to provide care to patients on the service.
10. Residents must arrange for adequate coverage if they aren't available (interviews, vacation, etc.). Key Attending staff on the service (or Chief of Service) must also be notified.

### **American Board of Surgery In-Training Examination**

On the last Saturday of January each year, the American Board of Surgery In-Training Examination (ABSITE) is administered. The examination consists of approximately 225 questions covering both basic and clinical sciences. All residents, regardless of the hospital to which they are assigned at the time of the examination, will take the examination simultaneously.

The ABSITE is extremely important. It gives both you and the department an idea of your strengths and weaknesses. It also gives you experience in taking

exams administered by the American Board of Surgery. The Department gives serious consideration to your scores on the ABSITE when considering individuals for promotion in the program.

Residents scoring **below the 30<sup>th</sup> percentile\*** will be required to participate in academic remediation program. Failure to actively attempt to improve his/her in-service score over a two-year period, regardless of the percentile correct, may result in dismissal. Residents should develop and maintain a daily study routine to ensure the highest possible score.

\* Any resident may participate in the remediation program despite previous scores, however this is **required** for those who previously scored below the 30<sup>th</sup> percentile.

## **Medical Records**

Residents are responsible for dictating and signing medical records on all patients they are responsible for. Operative notes must be dictated immediately after the operation. Admission history, physical exams, consults and discharge summaries should also be dictated immediately so they appear in the patient's chart in a timely manner. It is the resident's responsibility to visit medical records weekly and sign off on all notes. If you do not sign off on notes in a timely manner you will be placed on the delinquent list, which will ultimately lead to a suspension of privileges without pay. It is extremely important that residents complete all dictations prior to changing rotations, especially when going out of town on rotation. If your dictations are not complete you will be required to return and complete them. Timely completion of medical records is a cornerstone of professionalism. Your performance in this area will be considered in your advancing through the program.

## **Dictating Notes for Medical Records**

The operative report is one of the most important pieces of information in a patient's medical record. The text of the report should be organized, clear and carefully dictated. The operative report is a legal document therefore, it is imperative that the report is so accurate that someone reading the report in the future will know exactly what happened in the operating room. You should read the report after transcription to check for errors; draw a single line through any

errors and insert the corrected text above the errors. Make sure you initial any corrections.

A basic format should be followed when dictating operative reports. Some modifications can be made depending on the surgeon's preference, but the following information must be included:

**YOUR NAME**

**PATIENT NAME** – First and last name; spell any names which may confuse the transcriber

**MEDICAL RECORD NUMBER** – The eight digit number following the patient's school designation

(T for Tulane or L for LSU)

**DATE OF OPERATION** – month, day, year

**PRE-OPERATIVE DIAGNOSIS** – The actual or presumed diagnosis which prompts the surgery. Multiple diagnoses may be included. Terms such as “breast mass” or “colonic neoplasm” should be used for tumors with indeterminate pathology. Be as specific as possible.

**POST OPERATIVE DIAGNOSIS** – Be as specific as possible. Multiple diagnoses can and should be listed if appropriate. Terms such as “rectal neoplasm” or “adrenal mass” should be used if the diagnosis is dependent on a final pathology report.

**PROCEDURE** – List all procedures performed and be sure the list coincides with the “Report of Operation” (see below). Accuracy and clarity are extremely important here.

**ATTENDING SURGEON** – All operations are supervised by an attending surgeon on the LSU faculty. His/her name must appear in the report for legal reasons; it is necessary to obtain reimbursement for our patients from third party payers. A senior or chief resident may not be listed as the attending surgeon; a senior or chief may be listed as a first assistant or teaching assistant.

**RESIDENT** – usually the physician that dictated the report. You may list the first assistant or teaching assistant here. For legal and reimbursement reasons, the distinction between “attending surgeon” and resident must be clear.

**ANESTHESIA** –You only need note the type used (general, spinal, monitored, etc.); you need not detail each drug utilized.

**ESTIMATED BLOOD LOSS** – Confer with the anesthesiologist and examine suction containers, lap sponges, etc. to get an idea of the amount of blood loss for the case.

**SPECIMENS** – List any specimen that was sent to Pathology or Microbiology, as well as the source of the specimen (e.g. “hepatic nodule”, “intra–abdominal abscess”, “product of left modified radical mastectomy”, etc.) Be specific and use anatomical terms.

**INTRA–OPERATIVE FINDINGS** – A short paragraph which summarizes pathologic findings and any sequela of the pathologic process. Procedural and technical details will be included in the “Report of Operation” and should not be included here. Some surgeons do not create a separate section for intra–operative findings and instead include them in the “Report of Operation”. That is completely acceptable.

**INDICATION FOR PROCEDURE** – This should be a short paragraph that includes and pertinent history, physical findings, diagnostic studies or identifiable problem that led to the surgery. Do not repeat the admission H&P. Most surgeons restate that the patient and been informed of the risks, benefits and therapeutic alternatives and has given consent.

**REPORT OF OPERATION** – This is the body of the report and should be descriptive, detailed and accurate. Descriptions should be illustrative and clear; the credibility of the report suffers from a surgeon’s editorializing. Describing the appendix as “the biggest I’ve ever seen” is not quite as clear as a description as “six centimeters long with an erythematous tip”. It is important to be objective.

**ECONOMY OF WORDS** – The amount of detail included in the report does not have to be painful. For instance, it is simpler and more direct to indicate that “the abdomen was entered through a midline incision” instead of saying “a number 10 scalpel was used to make an incision in the skin in the patient’s abdomen, going from a starting point about halfway between the umbilicus and the pubic symphysis, followed by the Bovie electrocautery, which was set on 30/30.

**ACCURACY** – Do not say the small bowel spontaneously erupted if you made an enterotomy while opening the abdomen. Always be honest.

**SIGNING OFF** – Include the statement “(Attending surgeon) was present for (the key portion or the entire operation)”.

**INPATIENT DISCHARGE SUMMARY**

ADMISSION DATE:

DISCHARGE/TRANSFER DATE:

ATTENDING?RESIDENT:

DIAGNOSIS:

COMORBIDITIES:

OPERATIONS/PROCEDURES:

DISCHARGE/TRANSFER MEDICATIONS:

ALLERGIES/SENSITIVITIES:

CONDITION OF PATIENT AT DISCHARGE/TRANSFER:

BRIEF SUMMARY OF HISTORY & PHYSICAL:

BRIEF HOSPITAL COURSE:

SIGNIFICANT EVENTS:

PERTINENT CLINICAL FINDINGS/LABS:

RESPONSE TO TREATMENT:

COMPLICATIONS:

DISCHARGED TO:

TEST RESULTS AT TIME OF DISCHARGE:

DISCHARGE PLAN/INSTRUCTIONS:

HOME CARE SERVICES:

FOLLOW UP:

## Surgical Case Logs

The following are requirements posted by the American Board of Surgery:

- All residents (categorical, designated preliminary, and non-designated preliminary) must enter their operative experience concurrently during each year of the residency in the ACGME case log system.
- 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 procedure, and
  - direction of the postoperative care.
- When justified by experience (completion of the required minimum in the particular defined category) a PGY 4 or 5 resident may act as 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 (SJ) performing the case will also be credited as surgeon for these cases.

The following information is required for each case entered on the ACGME site:

Resident

Attending

Institution

Resident's role

*Surgeon Chief (SC)* – Residents in their chief year (PG5)

*Surgeon Junior (SJ)* – Residents in years 1–4 (PG1 – PG4)

*Teaching Assistant (TA)* – A PG 4 or 5 who has completed the minimum in the particular defined category

*First Assistant (FA)* – A resident other than SC, SJ, or TA assisting in the case

Rotation

Patient type – adult or pediatric

Procedure date

Case ID (patient’s hospital number)

If the patient was involved in trauma it must be indicated

CPT Code (More than one CPT code may be entered. However only one may be marked for credit)

There is an outcome section (not required) where you may enter anything you wish to note about the case.

The Residency Review Committee (RRC) and the American Board of Surgery require that all residents participate in a minimum number of operative cases in certain “defined categories”. Please refer to the following pages for the minimum numbers and for the procedures that count in each defined category. There are no exceptions to these minimum numbers. Residents must continue to record cases even after finishing the minimum numbers.

Please contact your coordinator, Katie Bowen, at 504-568-4760 if you have any problems logging into the ACGME case log system

**Your ACGME case log will be monitored weekly by the Program Director and Assistant Program Directors.**

## **Program Requirements**

- **All our chief residents will be required to have a minimum of 200 cases as Surgeon Chief and 50 cases as teaching assistant.**
- **Total Major Case Requirements by finishing year: 1050 Major Cases**

The chief resident should involve himself/herself in the operative management of cases and document this activity for future reference. Chief residents should not give all their cases to those residents below them but should share cases appropriately.

American Board of Surgery requirements specify that you must identify and list those patients, particularly trauma cases, who are followed on the service but do not require operations.

Your role as the surgeon or assistant should be clearly identified in your own list. Each resident should keep a copy of his/her operative dictations. In addition, each resident should keep a book of cases in which they were involved. The computer system will act as a check and balance for each residents log book. We will attempt to track the operative experience for every resident and hospital in the program, but the ultimate responsibility falls with each individual resident.

Take note: PGY-4's and 5's must have a record of experience with non-operative trauma and ICU/critical care. To graduate you must have 30 cases in the management of non-operative trauma and 30 cases in Critical Care. It is also essential that you record all cases you scrub on while on the Transplant service, even if you scrub in as First Assistant; you must have experience in transplant cases in order to complete your residency and sit for the American Board of Surgery.



## ***Surgery RRC Defined Categories & Minimal Requirements***

The numbers listed are the minimum requirements you must meet for each category during your five years of training. A lesser amount will not be accepted. You must maintain complete records of all the cases in which you participate. **Continue recording cases even after you've reached the required minimum. You will be held to these as well as the Program case requirements**

### **SKIN AND SOFT TISSUES AND BREAST – 25**

All procedures except:  
Biopsy (breast)  
Other major

### **HEAD AND NECK – 24**

All procedures except:  
Tracheostomy on other major

Plus:

Carotid endarterectomy (Vascular)  
Vertebral endarterectomy (Vascular)  
Thyroidectomy (Endocrine)  
Parathyroidectomy (Endocrine)  
Repair of brachial cleft anomalies (Pediatric)  
Repair of cleft lip/cleft palate (Plastic)  
Reduction and stabilization of  
maxifacial (Trauma)  
Repair of carotid (Trauma)

### **ALIMENTARY TRACT – 72**

All procedures except: Other major  
Gastrostomy  
Appendectomy  
All Ano-rectal

### **ABDOMEN - 65**

All procedures except: All other major  
Exploratory laparotomy exclusive  
of trauma  
All hernia

### **BASIC LAPAROSCOPIC PROCEDURES – 60**

Appendectomy, Cholecystectomy,  
Diagnostic Laparoscopy, etc.

### **COMPLEX LAPAROSCOPIC PROCEDURE – 25**

### **LIVER (ABDOMEN) – 4**

All procedures except: Other Major  
Plus: Repair & Drainage of hepatic laceration  
(Trauma)

### **PLASTIC – 5**

All other procedures except:

Other Major

### **PANCREAS (ABDOMEN) – 3**

All other procedures except: Other Major  
Plus: Pancreatic endocrine proc. (Endocr)  
Drainage of pancreatic injury (Trauma)  
Resection of pancreatic injury (Trauma)

### **VASCULAR – 44**

All procedures except: Other Major  
All Miscellaneous Vascular  
Shunt (Vascular Access)  
Fistula (Vascular Access)  
Insertion of peritoneo-venous or indwelling  
venous catheter (Vascular Access)  
All amputations

Plus: Repair of Thoracic aorta (Trauma)  
Repair of carotid (Trauma)  
Repair of abdominal aorta (Trauma)  
Repair of peripheral vessels (Trauma)  
Repair of other major vascular injuries  
(Trauma)

### **ENDOCRINE – 8**

All procedures except: Other Major

### **THORACIC – 15**

All procedures except: Other Major

### **PEDIATRIC – 20**

All other procedures except: Other Major

### **TRAUMA – 10**

All procedures except: Other Major  
Repair of tendon or nerve  
Exploratory laparotomy  
Closed reduction of fracture  
Debridement and suture of major wound  
Burn debridement and/or grafting  
Plus: Replantation (Hand)

### **NON-OPERATIVE TRAUMA – 20**

### **ENDOSCOPY – 85**

All procedures except:  
Sigmoidoscopy, rigid or flexible  
Other endoscopy

### **TOTAL MAJOR OPERATIONS:**

## Conferences

All conferences meet year round and are rarely cancelled. Residents are expected to attend all conferences and arrive on time (attendance is kept and reported to the RRC). Rounds are not to be made during conferences. Attendance at less than 80% of teaching conferences and 80% of M&M conferences will be regarded as inadequate and will be grounds for dismissal.

- Residents rotating at Kenner, West Jefferson, Touro, and Children's Hospital should attend, at minimum, the weekly M&M and Grand Rounds conference.
- Residents rotating out of town are excused from conferences in New Orleans but should attend regularly scheduled conferences at OLOL and UMC.

### ***Morbidity and Mortality Conference***

The LSU General Surgery Morbidity and Mortality Conference (M&M) is held every Thursday and the time will depend on which rotation you are on. All complications that occur on all patients on the general surgery services the preceding week (Sunday 7:00 a.m.–Sunday 6:59 a.m.) will be presented. **All complications should be submitted to the Chief Resident on service in the appropriate M&M reporting form no later than noon on Tuesday for presentation at the conference that week** (see form at end of section). Presentations are given by residents to the department heads, faculty and other residents. All complications from the previous week are presented and a healthy and positive dialogue is encouraged, with emphasis on how to avoid future complications. Participation in discussion is encouraged by all.

For M&M Conference, the following applies:

- The resident associated with the care of the patient will present the patient.

- The presentation should be researched, concise and rehearsed. Residents presenting at conferences should know the patient's history, physical examination, laboratory data and hospital course.
- All pertinent studies are expected to be available for viewing. Patient confidentiality should be protected and all identifying information should be blacked out.
- Residents should be prepared to answer questions from staff members about the case.
- Resident assignments for each conference will be circulated in advance. Attendings should be notified if their case is being presented.
- Complications should be classified as one of the following at the end of the presentation:
  - 'Error in diagnosis'
  - 'Error in Judgment',
  - 'Error in Technique', or
  - 'Disease Progression'
- A literature review and discussion pertinent to the complication is expected

When holiday's or other activities interfere with the conference schedule, all complications for the interrupted week will be presented at the next available conference date, along with the presentations scheduled for that date.

If the Associated Resident rotates to an out-of-town hospital, the Chief Resident of that service will be responsible for presenting that particular complication. Minutes will be recorded for each presentation and will include results, conclusions, recommendations, corrective action and follow-up and re-assessment when appropriate.

Attire for M&M is encouraged to be professional for all presenters. Scrubs are acceptable only for residents on trauma call.

### ***Grand Rounds***

Grand rounds consist of a 45 minute presentation by an invited guest, faculty member, or residents. The information presented can be cutting edge research or evidence based clinical discussions designed to stimulate interest in the area presented. The content will reflect the “Topic of the Month” as outlined in the curriculum. The conference will be organized by the faculty of the month.

### ***Pre-Op Conference***

Residents will present the operative cases scheduled for the next two weeks. Pertinent history, x-rays, labs, etc. should be available. Discussion is directed to the differential diagnosis, treatment plan, surgical intervention and emphasis on outcomes and the surgical literature.

### ***Basic Science Conference***

The basic science curriculum follows the topic of the month format and consists of lectures in the basic science related to the topic of the month. The conference is done 1–2 times per month depending on the basic science content of the particular topic of the month. Both faculty and residents can be presenters.

### ***Surgical Skills***

A surgical skills lab that will cover surgical, laparoscopic, and team training skills is held bi-weekly under the direction of Dr. John Paige. As space is limited, residents should make every effort to attend their assigned sessions.

### ***Cohn Rives Conference***

The Cohn–Rives Society, as its members refer to it, is the official alumni organization of the New Orleans LSU Department of Surgery. The Cohn–Rives Society was also established to promote the advancement of knowledge,

practice and teaching of surgery. Every spring the Society holds an annual conference in which all residents are expected to participate.

### ***Claude C. Craighead MD Lectureship Conference***

Calude C. Craighead MD Lectureship Conference is geared towards providing a better understanding and information regarding Cardiothoracic Surgery in the New Orleans area. It is held in the spring replacing Ground Rounds. Residents in New Orleans are required to attend, but out of town residents are not.

## **Academic Outline 2014-2015**

### **New Orleans**

	<b>Week 1</b>	<b>Week 2</b>	<b>Week 3</b>	<b>Week 4/5</b>
<b>7-8 am</b>	M&M	M&M	M&M	M&M
<b>8-9 am</b>	Faculty Grand rounds	Faculty Grand rounds	Faculty Grand rounds	Faculty Grand rounds
<b>9-11 am</b>	Case Conference	Basic Science/SCORE	Mock Orals/Skills Lab	ABSITE Review/JM Questioning
<b>11-12 pm</b>				Journal Club

### **Baton Rouge**

	<b>Week 1</b>	<b>Week 2</b>	<b>Week 3</b>	<b>Week 4/5</b>
<b>1-2 pm</b>	Case Conference	Case Conference	Case Conference	Case Conference
<b>2-3 pm</b>	Resident Basic Science Review	Surgical Jeopardy (ABSITE Q and A)	Resident Basic Science Review	Surgical Jeopardy (ABSITE Q and A)
<b>3-4 pm</b>	M&M	M&M	M&M	M&M
<b>4-5 pm</b>		Skills Lab		
<b>7-9 pm</b>			Journal Club	

### **Lafayette**

	<b>Week 1</b>	<b>Week 2</b>	<b>Week 3</b>	<b>Week 4/5</b>
<b>7-8 am</b>	Case Conference	Case Conference	Case Conference	Case Conference
<b>8-9 am</b>	M&M	M&M	M&M	M&M
<b>9-10 am</b>	Pre-Op Conference	Pre-Op Conference	Pre-Op Conference	Pre-Op Conference
<b>10-11 am</b>	Resident Basic Science Review	Surgical Jeopardy (ABSITE Q and A)	Resident Basic Science Review	Surgical Jeopardy (ABSITE Q and A)
<b>7-9 pm</b>		Journal Club		

## **PROGRAM EDUCATIONAL GOALS**

### **LSU GENERAL SURGERY RESIDENCY**

The primary goal of the vascular surgery residency at the Louisiana State University School of Medicine is to produce, at the completion of the five year program, physicians who will successfully complete the Qualifying and Certifying Examinations of the American Board of Surgery and who will function as practitioners of surgery at the high level of performance expected of a board certified specialist. The surgical residency program encompasses education in the basic sciences, cognitive, affective and technical skills, and development of clinical knowledge, surgical judgment, and maturity.

During the first post graduate year the resident has a wide exposure to surgery in various hospital and ambulatory settings, building on the knowledge gained in medical school of anatomy, physiology and pathology. The majority of this year is spent in the area of general surgery including trauma, oncologic surgery, critical care, cardiothoracic, vascular and general surgery. Skills learned during this year include the placement of central lines and their monitoring, chest tube placement, tracheal intubation, basic surgical skills, surgical assisting, anesthesia (regional and general), and the assessment and management of clinical problems.

The second post graduate year consists of rotations in general, pediatric, and vascular surgery. Also, during this year, residents participate in the educative process of the interns and medical students. The residents initiate treatment, make diagnoses and decisions with direct supervision. Medical and surgical skills continue as well those cognitive and affective skills necessary for exemplary patient management.

The third post graduate year is spent in general, cardiothoracic, vascular and oncologic surgical rotations. Operating skills and experiences in the operating theater increase during this year. The third year resident also takes an active role in the teaching process by giving presentations in surgery and specialty conferences, as well as morbidity and mortality conference.

The fourth year resident can function as the chief resident on some of the specialty services. Technical skills are further enhanced by acting as primary

surgeon on most operative cases. Cognitive and affective skills are developed by presentations at grand rounds, and other surgical conferences as well as the teaching resident on various operative cases. The fourth year resident rotates through a wide variety of surgical specialties including pediatric surgery, oncologic surgery, hepatobiliary, transplant, trauma, and general surgery.

The fifth post graduate year is spent as chief on various general and vascular services. Two administrative chief residents are each assigned for a six month period and have responsibilities for all resident administrative tasks in the program including call schedules, rotation schedules and serves as the chief of one of the major surgical services. Two other administrative teaching resident are designated, each for a six month period and they are responsible for all aspects of teaching within the program by scheduling and monitoring surgical conferences such as grand rounds and basic clinical science conferences. Each chief is also available as liaison between hospital, faculty, departmental personnel and the residents.

At the completion of the vascular surgery residency program the resident will be able to manage surgical disorders based on knowledge of basic and clinical sciences, demonstrate competency in those surgical techniques required of the qualified surgeon, use critical thinking when making effective decisions for patient and family management, make sound ethical and legal judgments, collaborate effectively with colleagues and other health professionals, teach and share knowledge with colleagues, residents, students and other health care providers, be responsible for teaching patients and families of all age groups in accord with their health care needs, value continuing education as a lifelong process which facilitates personal and professional growth, conduct and evaluate independent research, demonstrate leadership in and management of complex programs and organizations, provide cost-effective care to surgical patients and families within the community and respect the religious needs of patients and their families and provide surgical care in accord with those needs.

## **GOALS AND OBJECTIVES FOR VASCULAR SURGERY**

### Knowledge-Based Objectives for HO 1, 2 or 3:

1. Describe arterial and venous anatomy
2. Understand risk factors for atherosclerosis
3. Understand risk factors for chronic venous insufficiency
4. Recognize signs and symptoms of acute and chronic arterial disease
5. Recognize signs and symptoms of acute thromboembolic disease
6. Differential diagnosis of a swollen extremity
7. Signs and symptoms of venous insufficiency
8. Signs and symptoms of lymphedema

### Performance-Based Objectives for HO 1, 2 or 3:

1. Perform a focused history and physical for the vascular system.
2. Wound management: wet to dry dressings etc.
4. Obtain ankle brachial index (ABI)
6. Placement of central venous lines (femoral, jugular, subclavian)
7. Appropriate care of an ischemic limb
9. digital amputation

### Knowledge-Based Objectives for HO 4 or HO 5:

1. Understand the natural history of medically treated or untreated vascular disease:
  - carotid artery stenosis
  - abdominal aortic aneurysm
  - femoral artery occlusive disease
2. Summarize principles for preoperative assessment and postoperative care of patients undergoing major vascular surgical procedures
3. Describe the indications for:
  - balloon angioplasty
  - arterial stent placement
  - inferior cava filter placement



4. Describe the indications for operative intervention:

- claudication
- rest pain
- abdominal aortic aneurysm
- TIA and stroke
- asymptomatic carotid stenosis
- varicose veins
- venous stasis ulcer

Performance-Based Objectives for HO 4 or HO 5:

1. Perform:

- carotid endarterectomy
- repair of aortic aneurysm
- aortic reconstruction for occlusive disease
- femoral distal bypass
- extra-anatomic reconstruction

**Evaluation Scale:**

- 1 Major Deficiency
- 2 Minor Deficiency
- 3 Expected Performance
- 4 Exceeds Expectations

**LSU Health Sciences Center  
Department of Surgery  
Vascular Surgery HO 1,2, 3 Evaluation Form**

**Name of Resident:** \_\_\_\_\_ **PGY Level:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Clinical Competencies to be Assessed:**

1. **Patient Care** – compassionate, appropriate and effective for treatment and prevention of disease
2. **Medical Knowledge** – about established and evolving sciences and their application to patient care
3. **Interpersonal & Communication Skills** – effective information exchange and cooperative “learning”
4. **Professionalism** – commitment to professional responsibilities, ethical principles & sensitivity to diverse patient populations
5. **Practice-Based Learning & Improvement** – investigate and evaluate practice patterns and improve patient care
6. **Systems-Based Practice** – demonstrate an awareness of and responsiveness to the larger context and system of health care

**I. Patient Care:**

**Rating: 1 2 3 4**

1. Does the resident communicate effectively and demonstrate caring and respectful behaviors to patients and families
2. Does the resident gather essential/pertinent and accurate information during history-taking?
3. Does the resident make appropriate diagnostic and therapeutic decisions based on patient information and preferences?
4. Does the resident perform a complete vascular exam?
5. Does the resident demonstrate appropriate understanding of the management of wounds in vascular patients?
6. Does the resident identify acute limb-threatening emergencies in the clinical setting?

**II. Medical Knowledge**

**Rating: 1 2 3 4**

1. Does the resident demonstrate an investigatory and analytic thinking approach to clinical situations?
2. Does the resident know and apply basic and clinically supportive sciences appropriate to their level of training?
3. Does the resident understand the pathophysiology and clinical course of acute and chronic arterial and venous disease?

**III. Interpersonal and Communication Skills**

**Rating: 1 2 3 4**

1. Does the resident create and sustain a therapeutic and ethically sound relationship with patients?
2. Does the resident use effective listening skills and elicit and provide information using effective communication skills?
3. Does the resident work effectively with others as a member (or leader) of a health care team?
4. Does the resident pass on important patient information to his seniors in a timely manner?
5. Does the resident respond in a timely manner to pages and requests for attention?

**IV. Professionalism**

**Rating: 1 2 3 4**

1. Does the resident demonstrate respect, compassion, and integrity to meet the needs of the patients and society?
2. Does the resident demonstrate accountability to patients, society, and the medical profession?
3. Does the resident maintain the confidentiality of patient information and provide informed consent?
4. Does the resident understand and provide sound, ethical business practices?
5. Does the resident demonstrate sensitivity and responsiveness to patients culture, age, gender and



**LSU Health Sciences Center  
Department of Surgery  
Vascular Surgery HO 4,5 Evaluation Form**

**Evaluation Scale:**

- 1 Major Deficiency
- 2 Minor Deficiency
- 3 Expected Performance
- 4 Exceeds Expectations

**Name of Resident:** \_\_\_\_\_ **PGY Level:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Clinical Competencies to be Assessed:**

1. **Patient Care** – compassionate, appropriate and effective for treatment and prevention of disease
2. **Medical Knowledge** – about established and evolving sciences and their application to patient care
3. **Interpersonal & Communication Skills** – effective information exchange and cooperative “learning”
4. **Professionalism** – commitment to professional responsibilities, ethical principles & sensitivity to diverse patient populations
5. **Practice-Based Learning & Improvement** – investigate and evaluate practice patterns and improve patient care
6. **Systems-Based Practice** – demonstrate an awareness of and responsiveness to the larger context and system of health care

**I. Patient Care:**

**Rating: 1 2 3 4**

1. Does the resident gather essential/pertinent and accurate information during history-taking?
2. Does the resident make appropriate diagnostic and therapeutic decisions based on patient information and preferences?
3. Does the resident demonstrate appropriate use of consultants and senior level residents in the management of critically ill and injured patients?
4. Does the resident perform procedures appropriate to his/her level of training on this service?
  - ✓ Carotid endarterectomy
  - ✓ Abdominal aortic aneurysm resection/repair
  - ✓ Fem-distal bypass

**II. Medical Knowledge**

**Rating: 1 2 3 4**

1. Does the resident demonstrate an investigatory and analytic thinking approach to clinical situations?
2. Does the resident know and apply basic and clinically supportive sciences appropriate to their level of training?
3. Does the resident understand the natural history of treated and untreated vascular disease (carotid, aortic aneurysm, iliac/femoral occlusive disease) and offer management alternatives for each?

**III. Interpersonal and Communication Skills**

**Rating: 1 2 3 4**

1. Does the resident create and sustain a therapeutic and ethically sound relationship with patients?
2. Does the resident use effective listening skills and elicit and provide information using effective communication skills?
3. Does the resident work effectively with others as a member (or leader) of a health care team?
4. Does the resident pass on important patient information to his seniors in a timely manner?
5. Does the resident respond in a timely manner to pages and requests for attention?

**IV. Professionalism**

**Rating: 1 2 3 4**

1. Does the resident demonstrate respect, compassion, and integrity to meet the needs of the patients and society?
2. Does the resident demonstrate accountability to patients, society, and the medical profession?
3. Does the resident maintain the confidentiality of patient information and provide informed consent?
4. Does the resident understand and provide sound, ethical business practices?
5. Does the resident demonstrate sensitivity and responsiveness to patients culture, age, gender and

disabilities?

6. Does the resident maintain a professional demeanor in difficult or sensitive patient encounters?

**V. Practice-Based Learning and Improvement**

**Rating: 1 2 3 4**

1. Does the resident use systematic methodology for practice analysis and perform practice-based improvement?
2. Does the resident locate, appraise, and assimilate evidence from scientific studies related to patient health problems?
3. Does the resident participate in or facilitate the learning of students and other health care professionals?

**VI. Systems-Based Practice**

**Rating: 1 2 3 4**

1. Does the resident demonstrate the ability to effectively call on system resources to provide care that is of optimal value?
2. Does the resident understand the interrelationships between their practice and the larger system of health care?
3. Does the resident understand continuum of care issues specific to injured patients, i.e. follow-up, discharge, rehabilitation needs?

**Recommendation: \_\_\_Promotion to next PGY level \_\_\_Remediation**

**Comments:**

**Name of Evaluator:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

## Guidelines for Giving Effective Presentations

- Remember that the hallmark of a good presentation is **communication**. Basic rules of public speaking always apply. Obviously, you have to know your subject matter. But just knowing your subject matter does not make you a good speaker, we have all had the experience of sitting through lectures from “experts” who clearly knew their subjects inside and out but couldn’t communicate it. Remember to speak **to the audience**, not to the projection screen; speak up and speak clearly; whenever possible, include clinical cases or examples to make the subject matter more interesting and relevant to the listeners. When appropriate, invite participation by asking residents and staff for their input or interpretation. In other words, **communicate**.
- One of the goals of this residency program is to turn out physicians who are capable of, and comfortable with, giving excellent medical presentations. This skill will enable you to speak more clearly not only to audiences, but to colleagues, co-workers, and patients alike. Because communication is so important to good medical care, your will be expected to give frequent presentations throughout your residency. You may be asked to give presentation at local, regional, or national meetings. If you are uncomfortable with speaking before audiences, you should read **Osgood on Speaking**, a very short, concise and excellent resource book by Charles Osgood.
- Whenever you give a presentation, do your best to see that the area in which you will give your talk is as neat and orderly as possible. If you want to make a good impression you shouldn’t let the physical environment distract your audience. This includes making sure that the computer and projector works, that the shades come down (so your computer presentation can be seen well), that the screen is there, that you have some kind of pointer if you need one etc.
- When presenting x-rays, CT scans, MRI scans and the like, use an overhead projector if possible. This magnifies the image, and allows as many people as possible to see and focus on what you are trying to show. Have your x-rays in correct orientation and order.

## ***Guidelines for Making Visual Aids for Presentations***

One of the most frequent complaints about medical educational presentations is that many speakers use power point slides that are difficult to read or that are too complicated or “busy”. The following guidelines come from expert speakers and educators who know how to get a point across without confusing an audience. You want your presentation to communicate effectively as possible. Following the recommendations below will help you to accomplish this goal.

### ***Guidelines for Legible Power Point Slides***

- All word slides should **have no more than 7 lines** (including title) and each line should be **no longer than 27 characters** (including spaces).
- Each slide should be devoted to **one single concept**.
- Keep each slide **simple** and in **outline form**.
- Do **not** put all text in capitals—it’s less readable that way.
- Be certain to break down complicated concepts into a **series** of simple slides.
- One **key** word is often more effective than a sentence.
- If you are using graphs, charts, or other non-verbal material, consider splitting the material into two or more graphs, or put complicated graphic material **in your handout** rather than a slide.
- Avoid using complicated tables as slides.
- Avoid using distracting backgrounds or colors that contrast poorly in slides.
- Make sure you **spell check** everything correctly in your slides. There’s nothing quite like a spelling error in a medical presentation to make people doubt whether you really know what you’re talking about!

## ***Guidelines for Preparation of Posters for Presentation at Meetings***

The usual standard poster board surface area is four feet high and eight feet wide (4x8). Your presentation must be limited to this area. Boards will be provided and set up by staff at most meetings. You are responsible for affixing your posters to the board and removing them.

Prepare for the top of your poster space, a label indicating the title of the abstract and the authors. The lettering for this section should not be less than one inch. A copy of your abstract, in large typescript should be posted.

Bear in mind that your illustrations will be viewed from distances of three feet or more. All lettering should be at least 3/8" high, preferably in bold font. Charts, drawings, and illustrations might well be similar to those used in making slides. Keep everything as simple as possible; avoid "arty" or ornate presentation. Captions should be brief and labels few and clear. It is helpful to viewers if the sequence to be followed in studying your material is indicated by numbers, letters, or arrows. Do not mount illustrations on heavy board as it may be difficult to keep in position on the poster board.

Your poster should be self-explanatory so that you are free to supplement and discuss particular points raised by inquiry. The poster session offers a more intimate forum for informal discussion than the power point presentation, but this becomes difficult if you are obliged to devote most of your time to merely explaining your poster to a succession of visitors. You may find it useful to have on hand a tablet of sketch paper and suitable drawing materials, but please do not write or paint on your poster boards.

Bring push pins, double-stick tape, or similar fasteners, with you to the meeting.



## ***Guidelines for Preparation of Abstracts***

**Introduction:** The introduction should be 2 or 3 brief sentences and contain the following elements:

The reason the study was inaugurated

What the object of the study was (what could be gained)

**Methods:** A description of the methods necessary to evaluate the study must be included (i.e., retrospective chart review, prospective trial, etc.) Detailed descriptions of laboratory techniques should not be included (i.e., measurements were made of calcium, phosphate and creatinine). Methods of specimen collections, etc. should be indicated. Where the paper is to describe a study based on a laboratory technique (i.e., leukocyte adherence in advanced malignancy), the technique should be described sufficiently to be understood by workers in the field. *Methods* should occupy a brief portion of the abstract.

**Results:** This should occupy one-half to two-thirds of the abstract. Specific data necessary to evaluate the abstract should be included along with p values and significance should be indicated whenever possible. If there is doubt that additional data would enhance the abstract, include them. Statements to the effect: "...data will be discussed at the presentation" or "results of the study will be presented:", etc. are sometimes ground for refusal of the abstract.

**Conclusions:** The conclusion should be no more than 2 or 3 lines indicating the significance of the results in terms of what was originally deigned.

### ***Remember the four basic questions that should be answered by any abstract:***

- What did you do the study?
- How was it done?
- What did you find?
- What is the importance of your findings?

### ***Some Reasons Why Abstracts are Turned Down:***

- Previously reported study
- Paper presented or published elsewhere
- Too little data
- Inadequate control
- Methods of study not indicated
- Insignificant study
- Abstract did not conform to requirements (i.e., too long over the 1 page box)
- Poorly written presentation
- Conclusion is questionable in relationship to data presented

## ***Submission of Manuscripts and Abstracts***

All residents are both encouraged and expected to write articles for publication in journals and to make presentations to Surgery meetings. Any such contributions to the scientific literature by resident must, however, be submitted for approval by a full-time faculty member and the Chairman PRIOR to submission of the final manuscript to any journal. The name of the journal to which the manuscript is being submitted must be indicated. This must be done whether the resident is the sole author or has co-authors.

Residents who plan to present papers or posters at scientific meetings must submit the final abstract to the Chairman and Residency Director PRIOR to submission for presentation. The abstract must be accompanied by the appropriate "Abstract Submission Approval" form, a copy of which is available from the Residency Coordinator. Abstracts cannot be submitted without such prior departmental approval.

These policies are in no way intended to discourage resident submission of abstracts and papers. Rather, they are intended to ensure that all scientific contributions from resident have had the benefits of review by individuals who have had experience with the process, thereby enhancing the likelihood of acceptance by journals and meetings.

## New Innovations

New Innovations is a web based system that will be used to track schedules, conference attendance, evaluations and duty hours.

### INSTRUCTIONS TO ACCESS WEB RP FROM OFF CAMPUS SITES

These are the simple procedures the attendings and residents need to follow when using WebRP.

Always use the URL [www.new-innov.com](http://www.new-innov.com) to access NI.

You can log on to WebRP directly from the GME home page as well. [http://www.medschool.lsuhschool.edu/medical\\_education/graduate/](http://www.medschool.lsuhschool.edu/medical_education/graduate/). Click on “House Officer Resources.”

If you have any questions or problems, contact Katie or the GME office directly:

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## LSU Surgery Infection Control

### 1. General Infection Control Principles

#### a. Standard Precautions

- i. Are to be applied to the care of all patients regardless of their diagnosis or presumed infection status. ALL patients are potentially infectious.
- ii. Use personal protective equipment (gloves, masks, face shields, eye protection, gown) to prevent contact with blood, all body fluids, secretions, excretions (except sweat), regardless of whether they contain visible blood, and to prevent contact with nonintact skin, and mucous membranes when caring for all patients.
- iii. Handle used patient care equipment soiled with blood, body fluids, secretions, and excretions in a manner that prevents exposures to health care workers, other patients, and the environment. Ensure that reusable equipment is not used for the care of another patient until it has been appropriately cleaned and reprocessed. Single-use items are to be properly discarded.
- iv. **Hand Hygiene** is a critical component of Standard Precautions
  1. Remove all jewelry
  2. Soap and water - Wash hands with soap and water vigorously for at least 15 seconds. Dry hands and turn faucet off with paper towel
  3. Waterless alcohol-based (62% alcohol) antiseptic - use for routine decontamination if hands are not visibly soiled. Apply product to palm, rub hands together, covering all surfaces until hands are dry. Do not rinse.
  4. Must use soap and water to perform hand hygiene after caring for patients with *Clostridium difficile*. Waterless alcohol-based hand cleaners do not kill the spores of *C. difficile*.
  5. Must use soap and water when hands are visibly dirty or contaminated with blood, body fluids, or excretions. Do not use alcohol-based hand rub in this instance.
  6. Perform hand hygiene:
    - a. Before and after patient contact regardless of whether gloves are worn

- b. Before and after glove use
  - c. Before donning sterile gloves for procedures such as central line placement
  - d. Before other procedures such as urinary catheter insertion and peripheral vascular catheter placement
  - e. During patient care when moving from a contaminated body site to a clean body site on the same patient
  - f. Before eating and after using the restroom – use soap and water
- v. **Respiratory Hygiene/Cough Etiquette** –Place a surgical mask on patients that are undiagnosed with a cough, particularly those with fever, until evaluated. Patients, visitors, and health care workers are to cover the nose and mouth when coughing or sneezing. Use tissues to contain respiratory secretions and dispose of them in the nearest waste receptacle after use. Perform hand hygiene after having contact with respiratory secretions and contaminated objects.
- b. **Transmission Based Precautions** – are used **in addition to** Standard Precautions and are designed for patients documented or suspected to be infected with highly transmissible or epidemiologically important pathogens.
- i. **Airborne Precautions** – are used for microorganisms transmitted by airborne droplet nuclei 5µm or smaller. Airborne Infection Isolation Room has special air handling including negative air pressure and/or HEPA filtration. The patient is to be kept in the room with the door closed, and transport of the patient out of the room should be limited. Healthcare workers, and visitors need to wear N-95 masks to enter the room, and patients should wear surgical masks if transport out of the room is medically necessary. Susceptible persons should not enter the room of a patient with known or suspected measles or varicella. Diseases requiring Airborne Precautions include:
    - Tuberculosis
    - Measles (Rubeola)
 Contact Precautions **ALSO** Required for:
    - Varicella (chickenpox), or multi-dermatomal zoster
    - SARS ( + eye protection)
    - Variola (smallpox), Monkeypox

Viral Hemorrhagic Fever (Ebola, Lassa, Marburg)

- ii. **Droplet Precautions** – are used for microorganisms transmitted by respiratory droplets generated during coughing, sneezing, talking or during procedures such as suctioning or bronchoscopy. The patient is placed in a private room with no special air handling required. Health care workers and visitors wear surgical masks to enter the room. The patient wears a surgical mask when transport out of the room is medically necessary. Droplet Precautions are used for diseases such as:

*Neisseria meningitidis*  
invasive *Hemophilus influenzae* type b  
drug-resistant pneumococcus  
Diphtheria (pharyngeal)  
Mycoplasma pneumonia  
Pertussis  
Pneumonic plague  
Streptococcal pharyngitis, pneumonia, scarlet fever  
in young children  
Rubella  
Adenovirus  
Influenza  
Mumps  
Parvovirus B19

- iii. **Contact Precautions** - are used for diseases spread by contact with intact skin or surfaces. Place the patient in a private room, or cohort patients with the same microorganism. Wear gloves when entering the room. Change gloves after contact with infective material, and perform hand hygiene. Wear a gown when entering the room if you anticipate that your clothing will have substantial contact with the patient or environmental surfaces, or if the patient is incontinent, or has drainage from a wound or ostomy site not contained by a dressing. Wear gloves and a gown when entering the room of a patient with vancomycin-resistant enterococci (VRE). Diseases requiring Contact Precautions include:

Multi-drug resistant bacteria (e.g., VRE, VRSA, MRSA, ESBL)  
*Clostridium difficile*  
patient with diarrhea and fecal incontinence due to: E. coli 0157:H7, Hepatitis A, Shigella, Rotavirus

Respiratory syncytial virus  
Parainfluenza  
Enterovirus  
Diphtheria (cutaneous)  
Herpes simplex  
Zoster – single dermatome, normal host, covered  
by dressing  
Impetigo, furunculosis  
Wound infections, cellulitis  
Lice, scabies  
Conjunctivitis  
Viral Hemorrhagic Fever (Ebola, Lassa, Marburg) -  
Airborne Precautions also required

## 2. Infection Control in the Operating Room

- a. Evaluate your OR attire, equipment, and techniques for exposure risk reduction.
- b. If you anticipate fluids soaking through your gown (strike through), either double gown or wear a plastic apron; report defective surgical gowns.
- c. Double glove for orthopedic surgery or use orthopedic gloves.
- d. Do not allow surgery to start until all those in the OR are wearing goggles and have all hair on their heads and faces covered. It is important to be consistent.
- e. Reduce airborne risk of exposure by carefully handling power equipment and pulsating lavage systems.
- f. When possible, utilize autologous blood transfusions and a cell saver.
- g. Avoid palpating for a needle in a blind cavity. Remember HIV, HBV, and HCV have a two-way transmission.
- h. Use staple and safe suturing techniques whenever possible. Avoid risk of sticking hands that are retracting for you. Avoid having two people suture at the same time. Use no-touch instrument tying when possible. Cut needles off before tying sutures.
- i. **OR Safe Zone** – Sharps are never to be passed hand-to-hand. Announce when you are passing a sharp; make arrangements with the surgical technicians and colleagues as to how sharps will be handled (e.g. pass sharps to a safe, neutral station such as an intermediate tray rather than directly to an assistant). Keep needles lying flat on the mayo stand rather than loaded in the needle holder. Cover protruding ends of wire or pins with a protector.
- j. Remove shoe covers and mask before leaving the OR; put on a clean lab coat.

### 3. Infection Control for Surgery Patients

- a. At the bedside, secure long neckties and hair to prevent them from contaminating the patient, or from becoming contaminated.
- b. Carefully remove Penrose drains, or other devices that may splatter body fluids into your face or onto another team member. A solution is to hold a gauze pad over the wound during drain removal and wear protective face wear.
- c. Postoperative incision care – protect with a sterile dressing for 24 – 48 hours postoperatively an incision that has been closed primarily. Perform hand hygiene before and after dressing change, or any contact with the surgical site. Use sterile technique for dressing change. Unresolved issues include whether incisions closed primarily need to be covered beyond 48 hours, and when the appropriate time to shower or bathe with an uncovered incision.
- d. Throw old dressings in the trash. Be careful not to throw them in linen bags or sharps containers. Do not allow them to fall on the floor.
- e. Dressings and other contaminated disposables from infected wounds are to be placed in Red Bags. Red Bag waste is incinerated. Waste contaminated with a substance for which the patient is on Isolation Precautions needs to be discarded in a Red Bag. For example, a wound dressing from a patient on Contact Precautions for MRSA (or other resistant organism such as VRE, or multi-resistant gram negative rods) in the wound is discarded in a red bag. Red Bag waste also includes bulk blood and live birth placentas.

### 4. Sharps Safety

- a. Do not recap needles. If you must recap a needle, use a single-handed technique.
- b. The sharps user is responsible for sharps disposal. Always dispose of sharps properly – in a sharps container. Do not wrap needles, pins, wires, or other sharps in dressings. Do not leave sharps in bedding or linen. Do not discard sharps in trash cans.
- c. Familiarize yourself with safety devices before use. Do not remove or circumvent the safety device.

### 5. Infection Surveillance

- a. Culture wounds suspected of being infected. Culture expressed pus from freshly cleaned wounds; cultures of wound surfaces and drains give meaningless information and can lead to unnecessary antibiotic usage and organism resistance.





- a. Perform hand hygiene before and after catheter placement. The use of gloves does not obviate the need for hand hygiene.
- b. Wear sterile gloves for the insertion of arterial and central catheters.
- c. Selection of catheter insertion site - weigh the risk and benefits of placing a device at a recommended site to reduce infectious complications against the risk for mechanical complications (e.g., pneumothorax, subclavian artery puncture, subclavian vein laceration, subclavian vein stenosis, hemothorax, thrombosis, air embolism, and catheter misplacement)
  - i. Use a subclavian site (rather than a jugular or a femoral site) in adult patients to minimize infection risk for nontunneled CVC placement.
- d. Maximal sterile barrier precautions during catheter insertion. - Use aseptic technique including the use of a cap, mask, sterile gown, sterile gloves, and a large sterile sheet, for the insertion of CVCs (including PICCS) or guidewire exchange.
- e. Disinfect clean skin with an appropriate antiseptic before catheter insertion and during dressing changes. A **2% chlorhexidine based preparation is preferred**, but tincture of iodine, an iodophor, or 70% alcohol can be used.
- f. Allow the antiseptic to remain on the insertion site and to air dry before catheter insertion. Allow povidone iodine to remain on the skin for at least 2 minutes, or longer if it is not yet dry before insertion
- g. See reference for full recommendations: CDC. Guidelines for the Prevention of Intravascular Catheter-Related Infections. Morbidity and Mortality Weekly Report 2002;51(RR-10):1-32.

## 9. Blood and Body Fluid Exposures

- a. Immediately after an exposure - **WASH** exposure site with soap and water; mucous membranes should be flushed with water
- b. **REPORT** the incident by filling out incident report and notifying Charge Nurse/ Administrator on the Unit to facilitate blood draw on source patient. The patient will be tested for hepatitis B, hepatitis C, and HIV. The incident report must be filed in order to test the source patient for HIV. (A separate report is to be filed with LSU. This should be done **after** the assessment for postexposure prophylaxis. See Chancellor's Memorandum 25.)
- c. **GO** to designated area in the facility for evaluation of exposure and need for postexposure prophylaxis (usually Occupational Health, or the Emergency Department).
- d. Follow current guidelines for postexposure prophylaxis - CDC Guidelines for Management of Occupational Exposures to HBV,

HCV, HIV and Recommendations for Postexposure Prophylaxis  
MMWR 2001;50(No. RR-11). HIV Postexposure prophylaxis:

- i. 4-week regimen of two drugs for most HIV exposures (such as zidovudine and lamivudine)
- ii. addition of a third drug (such as indinavir, or nelfinavir) to the basic regimen for exposures that pose an increased risk for HIV transmission, or resistant virus known or suspected in the source patient
  1. choose best antiviral regimen against source patient's virus - may need Infectious Diseases consult.
- iii. Special Circumstances - when consultation with local experts +/- National Clinicians' PEP Hotline (888) 448-4911 is advised
  1. delayed exposure report
  2. unknown source
  3. pregnancy in the exposed person
  4. resistance of the source virus to antiretrovirals
  5. toxicity of the postexposure regimen
- iv. HIV postexposure prophylaxis should be initiated as soon as possible
- v. Do NOT test needles/sharps for HIV - reliability and interpretation of HIV test in this situation is unknown and testing might be hazardous to the person handling the sharp instrument.
- vi. Hepatitis B postexposure prophylaxis includes assessment of the need for Hepatitis B Immune Globulin, and Hepatitis B vaccine depending on the source patient and healthcare worker Hepatitis B status.
- vii. There is no immediate postexposure prophylaxis for exposures to Hepatitis C sources. The healthcare worker is to be followed for signs of seroconversion, and assessed for the need for treatment at that time.
- viii. The guidelines can be found on the web:  
<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5011a1.htm>

#### 10. Bloodborne Infections in Healthcare Workers

- a. All clinical staff should know their HIV/HBV/HCV status and to report their status, if positive, to LSU, and the hospitals where they practice.
- b. See Chancellor's Memorandum 25
- c. Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During

Exposure-Prone Invasive Procedures. MMWR July 12,1991 / 40 (RR-08); 4-5

11. Healthcare Worker Health Maintenance

- a. Hepatitis B Vaccine series should be completed for health care workers at risk for occupational exposure to patient blood and other potentially infectious materials.
- b. Annual tuberculin skin test is required.
- c. Rubella (German Measles) immunity proven by titer or documentation of 2 injections of MMR is needed.
- d. Measles (Rubeola) immunity proven by titer or documentation of 2 injections of MMR.
- e. Reduce cutaneous exposure with a program of hand and other skin care to promote rapid healing of small cuts, abrasions, and eruptions such as acne; CDC recommends against patient contact when a healthcare worker has exudative lesions on his/her hands (see Guideline for Prevention of Surgical Site Infection).

References:

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CDC. Guideline for Hand Hygiene in Health-Care Settings. Morbidity and Mortality Weekly Report 2002;51(RR-16):1-45.

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Mangram AJ, Horan TC, Pearson ML, Silver LC, Jarvis WR, The Hospital Infection Control Practices Advisory Committee. Guideline for Prevention of Surgical Site Infection, 1999. Infection Control and Hospital Epidemiology 1999;20:247 - 280. [http://www.cdc.gov/ncidod/hip/SSI/SSI\\_guideline.htm](http://www.cdc.gov/ncidod/hip/SSI/SSI_guideline.htm)

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CDC. Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures. MMWR 1991;40(No. RR-8):1-9.

<http://www.cdc.gov/mmwr/preview/mmwrhtml/00014845.htm>

## DEPARTMENTAL HOUSE OFFICER MANUAL ATTESTATION

I hereby certify that I have received the mandatory 2014-2015 Department of Surgery House Officer Manual. I understand that I will be accountable for conducting duties in the workplace in accordance with the information contained in this manual. I understand that additional information is available through the LSUHSC Department of Surgery website [http://www.medschool.lsuhs.edu/surgery/residency\\_general.aspx](http://www.medschool.lsuhs.edu/surgery/residency_general.aspx); LSUHSC Human Resources website <http://www.lsuhs.edu/no/administration/hrm>; LSUHSC GME website [http://www.medschool.lsuhs.edu/medical\\_education/graduate](http://www.medschool.lsuhs.edu/medical_education/graduate); LSU Bylaws and Regulations, LSU System Polices, LSUHSC Policies and GME Polices

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Signature

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Date

Please return completed form to  
Callie Pearson, Vascular Surgery Coordinator  
1542 Tulane Ave. Room 734  
New Orleans, LA 70112  
504.568.4633 (fax)