LSU

Policies and Procedures
Division of Plastic Surgery
Resident Handbook
2015-2016

Chapter 1:
Mission, Goals and Objectives

Mission

Our mission is to provide a supportive environment for the study of Plastic and Reconstructive Surgery. Our philosophy is based on the concept that the study of this field is a lifelong project which is best begun by study of the core curriculum and a varied surgical responsibility. We hope to nurture scientific curiosity, inventiveness and the best academic, ethical and clinical growth of both our trainees and faculty.

General Policies of the Division of Plastic Surgery

Policy on Professionalism and Learning Environment

In keeping with the Common Program Requirements effective 7/1/2011 our Plastic Surgery Program wishes to ensure that:

1. Patients receive safe, quality care in an academic environment.
2. Graduating residents will be able to provide safe, high quality patient care in their unsupervised practice of medicine after graduation.
3. Residents learn professionalism and altruism along with clinical medicine in a humanistic, quality learning environment.

To that end we recognize that patient safety, quality care, and an excellent learning environment are about much more than duty hours. Therefore, we promote policies that address all aspects of the learning environment. These include:

1. Professionalism; including accepting responsibility for patient safety
2. Avoidance of fatigue which may jeopardize judgment
3. Appropriate supervision of resident activities
4. Clear documentation of 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 in this manual, pp. 4-5.
2. Providing and monitoring a standard policy for Duty Hours as defined in this manual, p.6.
3. Providing and monitoring a standard Supervision Policy as defined in this manual, pp. 7-10.
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

The programs and institution will assure effective implementation of the Professionalism Policy by the following:

1. Program presentations of this and other policies at program and departmental meetings.
2. Core Modules for faculty and residents on Professionalism, Duty Hours, Fatigue Recognition and Mitigation, Alertness Management, and Substance Abuse and Impairment.
3. Required LSBME Orientation.
4. Institutional Fitness for Duty and Drug Free Workplace policies.
5. Institutional Duty Hours Policy which adopts in to the ACGME Duty Hours Language.
6. 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.
7. Comprehensive Moonlighting Policy incorporating the new ACGME requirements.
8. 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. Daily rounding and 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. End of rotation and semi-annual competency based evaluation of the residents.
    d. By the institution and it's GME activities.
    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.

Policy on Effective Transitions

The transitions policy is created in recognition that multiple studies have shown that transitions of care create the most risk or medical errors (ACGME teleconference July 14, 2010.) In addition to the below specific policies, promotion of patient safety is further ensured by:

1. Provision of complete and accurate rotational schedules in New Innovations.
2. Presence of a back up call schedule for those cases 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 clinical responsibilities due to fatigue or other causes.

Process for Effective Transitions

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 than in this policy a minimum standard for transitions must include the following information:

1. Demographics
    a. Name*
    b. Age
    c. Hospital *

    d. Unit/room number*
    e. Allergies
    f. Attending physician – Phone numbers of covering physician as published in resident's manual.*
2. History and Problem List *
    a. Primary diagnosis(es)
    b. Surgical Procedures performed or anticipated*
3. Current condition/status*
4. System based (details will depend on the patient's stability, ICU status, etc)
    a. Pertinent Medications and Treatments
    b. Oral and IV medications
    c. IV fluids
    d. Blood products
    e. Oxygen
    f. Respiratory therapy interventions
5. Pertinent lab data
6. To do list: (Postoperative Rounds, wound check, dressing changes, discharges, scheduling for surgery)*
7. Contingency Planning – What may go wrong and what to do
8. **ANTICIPATE** what will happen to your patient. Ex:
    a. "This patient had a lot of oozing during surgery, be sure you check to see that they do not have a hematoma."
9. Code status/family situations if patient is critical
10. Difficult family or psychosocial situations as appropriate

This information must be transferred by the resident who is responsible for the patient to the resident assuming responsibility IN WRITTEN FORM. The written form required is via LSU Web Mail, which is encrypted. A copy of the E-mail will be sent to the faculty member covering the service and the Resident Coordinator, who will keep copies of the correspondence on file.

When plastic surgery residents are rotating on services which are **not plastic surgery**, they are expected to conform to the transition policies of the service itself (ie: general surgery, ICU, etc.) When they are on services with plastic surgery attendings, this transition policy will be in effect.

A more abbreviated sign-out is acceptable for transitions of care for weekend or holidays, as long as the patient is stable. The items above with asterisks must be transmitted. Services which are not covered by another resident (Baton Rouge) and whose patients are the responsibility of the private faculty should be certain that the attending physician is aware that the resident is free of responsibility. Services that have no inpatients and services where residents have no primary patient care responsibilities (aesthetic) are not required to submit information. Children's, West Jefferson, Academic Medical Center (UH), VA, and Baptist are always required.

Faculty on each rotation must ensure that these transitions are adequate.

The process and effectiveness of each program's system is monitored by the ACGME in the form of reports and surveys which are required annually. Furthermore the institution monitors supervision through a series of questions in the Annual Resident Survey. This information is accumulated in an accreditation data system (WebADS). Residents will answer annual surveys regarding the educational environment.

This information is found on pocket cards delivered to each house officer. The process by which this information is distributed is via Core Modules and Orientation presentations to residents and via a Compliance Module for faculty. In addition this information is presented in program/departmental meetings.

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. While plastic surgery residents do not have the demands of long hours of duty and almost never take call in the hospital, they are nonetheless subject to fatigue. Fatigue can not only reduce efficiency, but can lead to errors in patient care.

Alertness management and fatigue mitigation strategies are outlined on the pocket cards distributed 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
    f. Feeling drowsy and sleepy when driving
2. SLEEP STRATEGIES FOR HOUSESTAFF

A. On Duty Residents

1. Don't start Call w/a SLEEP DEFICIT – GET 7-9 hours of sleep. You are given a minimum of 12 hours off between duty hours during the first 3 years. You are expected to schedule your time off effectively and get needed sleep. Some rotations during the senior year are taxing. In the event that you are on duty more than 16 hours, you must discuss the situation with your attending. Back up call is scheduled.
2. Avoid Heavy Meals / exercise w/in 3 hours of sleep
3. Avoid Stimulants to keep you up
4. Avoid ETOH to help you sleep

B. ON Call Residents

1. Tell Chief/PD/Faculty, if too sleepy to work! A list of backup faculty is in New Innovations. *NEVER feel that you should not call if you perceive a problem!*
2. When on call at home, remember that rest is important. Do not over-schedule yourself while on call and render yourself too tired to respond.
3. BEST Circadian Window for naps is 2PM-5PM & 2AM- 5AM
4. AVOID Heavy Meals
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 although this should rarely be a problem.
2. Full Recovery from Sleep Deficit takes 2 nights
3. Take 20 min. nap or cup of coffee 30 min before driving. If you are concerned about driving safely, take a cab home. The department will reimburse you for travel expenses. Alternatively call the faculty on backup call and they will assist you. NEVER drive if you are extremely fatigued.

In addition the programs will employ back up call schedules as needed in the event a resident can't complete an assigned duty period. This backup call schedule is published in New Innovations. Plastic Surgery backup call is posted on the monthly schedule for those residents on plastic surgery rotation.

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 the chief residents, faculty, 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), the annual ACGME Resident Survey and the Internal Review process. Residents are responsible for entering data in New Innovations consistently and contemporaneously.

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 must be supervised in such a way that they assume progressive responsibility as they progress in their educational program. This is a critical and evolving maturation process. Progressive responsibility is determined in a number of ways including:

1. On each service or rotation, the attending or supervising faculty determine what level of surgical autonomy each resident may have to ensure growth of the resident and patient safety. Residents just beginning the program will naturally require more supervision and have less responsibility than those ending their training.
2. The Program Director and Chief Residents assess each resident's level of competence in frequent personal observation. The progress of each resident is documented in end-of-rotation evaluations and a semi-annual review of each resident.
3. Where applicable progressive responsibility is based on specific milestones

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.

Integrated Residents

1. PGY-1 residents
    i. PGY-1 residents in plastic surgery will rotate on services that will build a foundation of surgical competence. These rotations will provide the resident with experience in basic surgical treatment and techniques.
    ii. GPY-1 residents will spend the first month of each rotation in direct supervision of the educational director or their designee. As the rotation progresses the residents will assume more responsibility in evaluating new patients, caring for postoperative patients, dressing changes, counseling patients and families.
    iii. PGY-1 residents will initially act as assistants in surgery. Once they have assisted on a procedure and are felt to have adequate knowledge of the anatomy involved and the techniques required, they may be allowed to perform part of the procedure. As they progress they may perform the entire procedure in less complex situations under direct supervision of the faculty or the chief residents.
    iv. PGY-1 residents will initially round with the faculty on patients on the service (depending on the condition) daily. As they gain experience they may attend to less complex patient care in the hospital with supervision immediately available.
    v. PGY-1 residents do not take call
    vi. PGY-1 may attend plastic surgery conference and other activities when their other duties permit.

2. PGY-2 residents
    i. PGY-2 residents will rotate on services which provide additional areas of surgical interest and on services where, at the PGY-2 level, they have more progressive surgical responsibly.
    ii. PGY-2 Residents will see patients in the clinics, normally with either direct or immediately available supervision. They will round on patients and will have greater responsibility for daily patient care. They will be supervised by senior residents and faculty.
    iii. PGY-2 residents should be able to perform relatively straightforward procedures with either direct supervision or supervision immediately available. All rotations require that the faculty be physically present or immediately available in the hospital operating area for residents to be rendering surgical care to patients.
    iv. Second year residents are allowed to take call. Virtually all call is taken at home. They begin to progressively handle emergency call with supervision by senior residents. They may perform minor procedures in the Emergency Room

3. PGY-3 residents

i. PGY-3 residents continue to advance in progressive responsibility. Rotations in general surgery will provide a much higher level of progressive responsibility and residents are to perform, under supervision, relatively straightforward general surgery cases.

ii. PGY-3 residents begin Plastic Surgery rotations. They will be either on rotations with senior residents or only with faculty. They will be given progressive responsibility as they move through the rotation

iii. PGY-3 residents learn to evaluate new plastic surgery patients.

v. PGY-3 residents work in the clinics under the supervision of faculty or senior residents. They begin to learn administrative responsibilities such as booking cases, management of schedules and office management.

vi. PGY-3 residents start working with faculty on academic projects

vii. All residents will take the annual ASPS In-Service exam and must score above a 30th percentile.

4. PGY-4 Integrated Residents- PGY 5 Independent Residents

viii. PGY-4 residents begin a period of more intense exposure to plastic surgery

ix. PGY-4 residents must attend all division conferences, workshops and labs

x. PGY-4 residents work with the faculty on academic projects

xi. PGY-4 residents may attend regional or national meetings at department expense if they have presentations at the meeting.

xii. PGY-4 residents are expected to have developed a significant level of competence in basic plastic surgery.

xiii. PGY-4 residents take the annual in-service examination. They are expected to perform at least at the 30th percentile.

xiv. PGY-4 residents begin to take call for plastic surgery services from home.

5. PGY-5 Integrated Residents- PGY 6 Independent Residents

i. PGY-5 residents rotate on specific plastic surgery rotations which are immersion experience.

ii. PGY-5 residents attend all conferences, workshops and labs

iii. PGY-5 residents are expected to complete at least one academic investigation which is suitable for publication or presentation.

iv. PGY-5 residents will obtain a level of surgical competence which allows them to perform most procedures expected in non-aesthetic practice.

v. PGY-5 residents will supervise lower level plastic surgery residents.

vi. PGY-5 residents will become competent to diagnose and treat straightforward congenial plastic surgery problems

vii. PGY-5 residents will become competent to diagnose and treat straightforward problems with the hand and upper extremity.

viii. PGY 5 Integrated and All Independent residents will take the annual ASPS

In-Service exam and must score above a 30th percentile.

6. PGY-6 Integrated Residents- PGY-7 Independent Residents
   i. PGY-6 residents assume responsibilities of chief resident
   ii. PGY-6 residents will achieve a level of surgical competence which allows them to independently perform complex procedures required of plastic surgeons.
   iii. PGY-6 residents will supervise junior residents on all services
   iv. PGY-6 residents will run the plastic surgery clinics at the Academic Medical Center.
   v. PGY-6 residents will become competent to perform aesthetic surgical procedures and to evaluate and care for aesthetic patients.
   vi. PGY-6 residents will produce at least one paper which is presentable or potentially publishable.
   vii. PGY 6 Integrated and All Independent residents will take the annual ASPS In-Service exam and must score above a 30th percentile.

The expected components of supervision include (Integrated Residents):

1. Defining educational objectives. These are to be discussed at the beginning of each rotation.
2. The faculty assessing the skill level of the resident by direct observation.
3. The faculty 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.

Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

Inpatient Services Major Procedures

PGY	*Direct by Faculty*	*Direct by senior residents*	*Indirect but immediately available - faculty*	*Indirect but immediately available - residents*	*Indirect available*	*Oversight*
1	**X**	**x**				
2	**X**	**X**				**Depends on complexity**
3	**X**	**X**	**X**			**Depends on complexity**
4	**X**	**X**	**X**			**Depends on complexity**
5	**X**	**X**	**X**	**x**		**Depends on complexity**
6	**X**		**X**			**Depends on complexity**

Inpatient Non-major Procedures

PGY	*Direct by Faculty*	*Direct by senior residents*	*Indirect but immediately available - faculty*	*Indirect but immediately available - residents*	*Indirect available*	*Oversight*
1	**X**	**X**				
2	**X**	**X**	**X**			
3	**X**	**X**	**X**	**X**		
4	**X**	**X**	**X**	**X**		
5	**X**	**X**		**X**		
6	**X**		**X**			

Ambulatory Settings (clinics)

PGY	*Direct by Faculty*	*Direct by senior residents*	*Indirect but immediately available - faculty*	*Indirect but immediately available - residents*	*Indirect available*	*Oversight*
1	**X**	**X**	**X**			**Faculty attend all clinics**
2	**X**	**X**	**X**	**X**		
3	**X**	**X**	**X**	**X**		
4	**X**	**X**				
5	**X**	**X**	**X**	**X**		
6	**X**		**X**			

Consult Services

PGY	*Direct by Faculty*	*Direct by senior residents*	*Indirect but immediately available - faculty*	*Indirect but immediately available - residents*	*Indirect available*	*Oversight*
1	**X**	**X**				**Dependent on complexity**
2	**X**	**X**				
3	**X**	**X**	**X**			
4	**X**	**X**	**X**	**X**		
5	**X**	**X**	**X**	**X**		
6	**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 Internal 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.

Independent Residents

1. First year residents will spend the first month of each rotation in direct supervision of the educational director or their designee. As the rotation progresses the residents will assume more responsibility in evaluating new patients, caring for postoperative patients, dressing changes, counseling patients and families.

2. First year residents will initially act as assistants in surgery. Once they have assisted on a procedure and are felt to have adequate knowledge of the anatomy involved and the techniques required, they may be allowed to perform part of the procedure. As they progress they may perform the entire procedure under direct supervision of the faculty or the chief residents.

3. First year residents will initially round with the faculty on patients on the service (depending on the condition) daily. As they gain experience they may attend to patient care in the hospital with supervision immediately available.

4. First year residents will be monitored closely when taking call, either by the chief resident or the faculty. They are to report all contacts to the faculty on call for advice at all times other than routine medication issues.

5. First year residents are expected to attend the microsurgical laboratory prior to working under the microscope. They will attend the annual cadaver dissection course and begin dissecting flaps at that point.

5. Second year residents will see patients in the clinics, normally with either direct or immediately available supervision. They may schedule cases and plan the surgical care with the approval of the faculty. They may supervise junior residents in the clinics and while on hospital rounds.

6. Second year residents should be able to perform relatively straightforward procedures with supervision immediately available. Complicated or technically difficult procedures require direct supervision. All rotations require that the faculty be physically present in the hospital operating area for residents to be rendering surgical care to patients.

7. Second year residents are able to progressively handle emergency call with supervision by telephone. They may perform minor procedures in the Emergency Room with supervision by telephone.

The expected components of supervision include:

1. Defining educational objectives. These are to be discussed at the beginning of each rotation.
2. The faculty assessing the skill level of the resident by direct observation.
3. The faculty 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.

Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

Inpatient Services Major procedures

PGY	*Direct by Faculty*	*Direct by senior residents*	*Indirect but immediately available - faculty*	*Indirect but immediately available - residents*	*Indirect available*	*Oversight*
6	**X**					
7	**X**	**X**				**Dependent on complexity**
8	**X**		**X**			**Depends on level of case**

Inpatient Non-major procedures

PGY	*Direct by Faculty*	*Direct by senior residents*	*Indirect but immediately available - faculty*	*Indirect but immediately available - residents*	*Indirect available*	*Oversight*
6			**X**			
7		**X**				
8			**X**			

Ambulatory Settings (clinics)

PGY	*Direct by Faculty*	*Direct by senior residents*	*Indirect but immediately available - faculty*	*Indirect but immediately available - residents*	*Indirect available*	*Oversight*
6	**X**	**X**				**Faculty attend all clinics**
7		**X**				
8			**X**			

Consult Services

PGY	*Direct by Faculty*	*Direct by senior residents*	*Indirect but immediately available - faculty*	*Indirect but immediately available - residents*	*Indirect available*	*Oversight*
6	**X**		**X**			**Dependent on complexity**
7		**X**				
8					**X**	

Policy on Mandatory Notification of Faculty (on plastic surgery rotations)

Policy and Process

In certain cases faculty 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.

Condition- Integrated	**PGY 4**	**PGY5**	**PGY 6**
Care of complex patient not in the OR	X	X	
Unplanned transfer to ICU	X	X	X
DNR or other end of life decision			
Emergency surgery	X	X	X
Acute drastic change in course	X	X	X
Unanticipated invasive or diagnostic procedure	X		
Private patient calling after hours or on the weekend with a problem	X	X	X

Condition- Independent	PGY 5	PGY6	PGY 7
Care of complex patient not in the OR	X	X	
Unplanned transfer to ICU	X	X	X
DNR or other end of life decision			
Emergency surgery	X	X	X
Acute drastic change in course	X	X	X
Unanticipated invasive or diagnostic procedure	X		
Private patient calling after hours or on the weekend with a problem	X	X	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.

Duty Hour Policies

Plastic Surgery residents must report their duty hours weekly in New Innovations. These reports will be monitored by the Division of Plastic Surgery. If you think that you have a situation which may violate the Duty Hours policies, you are to call the Program Director as soon as practical. If you have a concern about the schedules, the work time rules or policies may be adversely affected, you should notify the program coordinator and a faculty member will meet with you.

Policy on Residents Staying Longer than 24+4

Policy and Process

1. PGY 1 residents' duty periods may be no longer than 16 hours and there are **no exceptions allowed**.
2. Upper level residents are not allowed to stay longer than 24 hours with 4 hours for transitions.
3. In those rare and extenuating cases where a resident absolutely must remain after 24+4 the resident must contact the Program Director for a specific exemption. If that is permitted verbally then the resident must communicate by email with the Program Director telling:
    - the patient identifying information for which they are remaining
    - the specific reason they must remain longer than 24+4
    - assurance that **all** other patient care matters have been assigned to other members of the team,

4. Assurance that the resident will not be involved in any other matter than that for which the exemption is allowed
5. Assurance that the resident will notify the program director when they are complete and leaving.

In the event that the Program Director does not hear from the resident in a reasonable time (8 hours), the Program Director or designee will locate the resident in person and assess the need for any further attendance by the resident. Residents caught in violation of this policy or who abuse this rare privilege will be subject to disciplinary action for unprofessional behavior.

It is extremely unlikely that Plastic Surgery residents would ever stay more than 24 hours in the hospital. In the event that this would occur, the resident must notify the faculty of the situation and the faculty will decide how to deal with the situation. The program director will be notified as described above. Senior residents who spend 24 hours will be relieved of duty for a minimum period of 8 hours for sleep. **All divisional rules are subject to the institutional work hour rules as described below.**

How Monitored:
The program director will directly monitor each of these cases. It is anticipated these requests will be infrequent at most. The Program Director will collect and review the written requests on a regular basis on each case and all cases in aggregate. The institution will monitor numbers and types of exceptions of this during annual reviews of programs and Internal Reviews.

INSTITUTIONAL POLICY ON DUTY HOURS AND WORK ENVIRONMENT

(Passed June 11, 2003; Revised Nov 20, 2008; Feb 17, 2011)– GMEC)

The institution through GMEC supports the spirit and letter of the ACGME Duty Hour Requirements as set forth in the Common Program Requirements and related documents July 1, 2003 and subsequent modifications. Though learning occurs in part through clinical service, the training programs are primarily educational. As such, work requirements including patient care, educational activities, administrative duties, and moonlighting should not prevent adequate rest. The institution supports the physical and emotional well-being of the resident as a necessity for professional and personal development and to guarantee patient safety. The institution will develop and implement policies and procedures through GMEC to assure the specific ACGME policies relating to duty hours are successfully implemented and monitored. These policies may be 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 and time returning to the hospital while on home call.

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.

Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.

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

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 [as defined by the Review Committee] 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 [as defined by the Review Committee] 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 [as defined by the Review Committee] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

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

Maximum Frequency of In-House Night Float

Residents must not be scheduled for more than six consecutive nights of night float. [The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

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.

At-home call must not be as frequent or taxing as to preclude rest or reasonable personal time for each resident.

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.

The institution as well as each program is required to monitor and document compliance with these requirements for all trainees. This policy applies to every site where trainees rotate.

POLICY ON MOONLIGHTING

Professional activity outside of the scope of the House Officer Program, which includes volunteer work or service in a clinical setting, or employment that is not required by the House Officer Program (moonlighting) shall not jeopardize any training program of the University, compromise the value of the House Officer's education experience, or interfere in any way with the responsibilities, duties and assignments of the House Officer Program. **It is within the sole discretion of each Department Head and/or Program Director to determine whether outside activities interfere with the responsibilities, duties and assignments of the House Officer Program. Any Moonlighting by Plastic Surgery resident must be approved in advance by the Program Director if he is convinced that the Moonlighting will have no impact on the educational experience or cause the resident to be unfit for resuming his duties.**

House Officers must not be required to moonlight. Before engaging in activity outside the scope of the House Officer Program, House Officers must receive the written approval of the Department Head and/or Program Director of the nature, duration and location of the outside activity. (Revised 4/2001) All moonlighting activities must be tracked in New Innovations Software Program. PGY1's may not moonlight. All internal and external moonlighting must be counted in the 80 hour maximum weekly

hour limit. Resident must not schedule moonlighting that will cause the 80 hour maximum. Residents who schedule moonlighting activities resulting in violation of the 80 hour work rule will be subject to disciplinary action including but not limited to loss of moonlighting privileges. (Revised 2/17/2011) The house officers' performance will be monitored for the effect of these moonlighting activities upon performance and that adverse effects may lead to withdrawal of permission to continue. All documentation will be kept in the house officer's program file. (Revised 7/1/2005)

House Officers, while engaged in professional activities outside the scope of the House Officer Program, are **not provided professional liability coverage** under LSA-R.S. 40:1299.39 et seq., unless the professional services are performed at a public charity health care facility. A House Officer providing services outside the scope of the House Officer Program shall warrant to University that the House Officer is and will remain insured during the term of any outside professional activities, either (1) insured against claims of professional liability under one or more policies of insurance with indemnity limits of not less than $500,000 per occurrence and $1,000,000 in the aggregate annually; or (2) duly qualified and enrolled as a health care provider with the Louisiana Patient's Compensation Fund pursuant to the Louisiana Medical Malpractice Act, LSA-R.S. 40:1299.41 et seq. or (3) that the House Officer is provided such coverage by the person or entity who has engaged the House Officer to provide the outside professional services.

House Officers shall not provide outside professional activities to any other state agency (e.g., Department of Health and Hospitals, Department of Public Safety and Corrections, Office of Mental Health, etc.) by means of a contract directly between the House Officer and the other state agency. Should a House Officer desire to provide outside professional services to another state agency, the contract must be between the LSU School of Medicine in New Orleans and the other state agency for the House Officer's services, and the House Officer will receive additional compensation through the LSU payroll system. House Officers should speak with the Departmental Business Administrator of the House Officer Program to arrange such a contract.

House Officers may not moonlight at any site without a full and unrestricted license. Occasional exceptions may be granted by the LSBME only after a specific request by a program and are largely limited to moonlighting which is in the same institution as the program, is under the supervision of program faculty and similar to activity the trainee might have in the program. In addition, residents on J-1 visas may not moonlight (revised 1/2008).
The LA State Board and the DEA will independently investigate and prosecute individual residents if they so desire regarding the following:

- To moonlight all house officers must be fully licensed and have their own malpractice and DEA number.
- Moonlighting in pain and weight loss clinics is not allowed by the LSBME.
- Pre-signing prescriptions is illegal.
- Using MCLNO prescriptions outside MCLNO is prohibited – your "MCLNO" number is site specific.
- Don't ever sign anything saying you saw a patient if you didn't see the patient.

- All narcotics prescriptions must be put in the patient's name and address plus the date Don't "let the nurse do it".
- House officers are held accountable for things all things signed - read the fine print.
- Follow accepted practice guidelines for everything especially weight loss and pain patients.
- All house officers should be cognizant of Medicare fraud and abuse guidelines.

Goals and Objectives of the Plastic Surgery Program
Independent and Integrated Programs

Patient Care: The goals of the Division of Plastic Surgery will be:

1. To produce graduates that possess sufficient clinical skills, sound judgment and comprehensive, high quality care skills to be able to practice independently and without supervision.
2. To provide rotations in basic surgical specialties that will develop good surgical techniques (During the PGY 1 to PGY 3 years for Integrated Residents)
3. To provide rotations that allows the resident to become competent in management of surgical patients, complications and preoperative and postoperative care
4. To provide rotations that allows the resident to become familiar with the management of patients in associated disciplines.
5. Compassionate and considerate of patient's feelings.
6. Knowledgeable of appropriate plans of treatment based on faculty experience and best practices contained in the literature.
7. Allowed to have graduated responsibility in the program beginning with the noncomplex to the most complex procedures. At the time of finishing the program, the resident should be capable of performing complex procedures in a way that the program feels adequate to independent practice of plastic surgery.
8. These educational goals are achieved through
    i. Focused experiences in which they are able to learn to care for patients under direct guidance of the faculty. This takes place in scheduled and structured educational experiences in hospitals and clinics.
    ii. Residents work one-on-one with faculty in all plastic surgery rotations
    iii. Residents are allowed and supported in progressive responsibility as the rotations become increasingly complex.
9. Evaluated for achievement of learning goals. Multiple evaluation instruments will be used, including focused evaluation by educational directors, presentations at conferences, mock oral board examinations, ASPS In-Service training examination, and other instruments.

Medical Knowledge: The goals of the Division of Plastic Surgery will be:

1. Knowledge of the core curriculum is essential to effective treatment of plastic surgical problems. Residents are exposed to these principles in:
    i. Weekly core curriculum conferences
    ii. Weekly case presentation conferences
    iii. Monthly Journal Club
    iv. Annual Cadaver dissection course
    v. Annual microsurgery laboratory
    vi. Annual facial trauma laboratory
    vii. Visiting Professor presentations
2. The program emphasizes the value of continuing lifelong education.

3. Evaluation of educational outcomes will be by performance at conferences, weekly quizzes, mock "Oral Boards" and the In-service Training Examination. The semiannual evaluations will also include conference participation and laboratory experiences.

Practice Based Learning and Improvement:

1. Residents should be able to access information through readily available online sites, our regional medical library as well as selected readings and other assigned texts. They are expected to apply this knowledge to treatment of their patients, and, hopefully to continue lifetime study. Residents are encouraged to keep a "journal" and should add each day something that they have learned.
2. The modalities used to fulfill these educational goals are:
    i. Monthly M&M conferences
    ii. Weekly case presentation conferences which evaluate operative outcomes on the various rotations.
    iii. Focused experiences with faculty on individual rotations allow residents to see preoperative and postoperative conditions on a large variety of patients.
    iv. Biannual research conferences, during which resident projects are discussed and eventually graded.
    v. Residents are given responsibility to teach junior residents and medical students on many rotations.
    vi. Residents will rotate on other services to understand the treatment of patients whom they are likely to contact later as plastic surgeons and to learn to work with other specialties for the best outcome of the patient
3. The resident will learn to reflect on the treatment plans that they propose, the surgical procedures performed, and outcomes of their patients. They will discuss all three parameters with the faculty and as the question "How could it be done better?"

4. They should become familiar with the concept of evidence based medicine, the reference resources available to support clinical decision making and the application of these modalities to improving quality of care for their patients.
5. The program will instill a foundation for problem solving and independent thinking that will last a professional lifetime.
6. Residents also will be evaluated on their ability to determine the validity of articles in the literature during the journal club.
7. Evaluation of the educational goals will be made during the semi-annual evaluation report, which will include focused evaluation by the educational directors. Residents are asked to add a self-reflective note based on the evaluation to be included in their portfolio. Residents are also evaluated by the junior residents and medical students.

Interpersonal and Communication skills:

1. Residents will learn to communicate with patients, faculty and other team members so as to best treat their patients.

2. This goal is achieved by:
   i. Residents will present patients competently during patient presentation
   ii. Residents are taught Interpersonal and Communication skills during their one-on-one rotations with the faculty in the clinics and hospitals. They will learn to communicate effectively and compassionately with patients.
   iii. Residents will write clear and cogent notes on the rotations to document their plans and so that other team members know what they are thinking.
   iv. Residents at University Hospital will learn to be team leaders and demonstrate this leadership by efficiently and effectively managing the service. Residents will demonstrate teamwork by co-managing patients and providing uninterrupted care for patients on weekends and holidays.

3. Evaluation of the Educational Goals:

4. Residents receive evaluations by the educational director of each rotation and the end of that rotation. Their ability to communicate clearly, to work with others, to engage in adequate handoffs for patients is part of the evaluation.
   During the semiannual evaluation, residents are evaluated by 360 degree evaluations, peer evaluations and evaluation by the faculty. Communications and interpersonal relationship issues are discussed with the residents and suggestions are made for improvement. Medical records are monitored by the individual faculty who are responsible individuality for the patient's medical records.

Professionalism:

1. The goal is for residents learn professionalism, both in appearance and in the way that they deal with patients and other members of the health care team.
    i. Residents must be at all times act professionally. On their clinical rotations they are expected to maintain a professional appearance, to behave in a compassionate, respectful and ethical manner.
    ii. While on these rotations they learn by exemplary behavior and attitudes of the faculty.
    ii. At University hospital they must interrelate with the health care team. They must relate to their peers professionally and act responsibly. They must do whatever it takes to support patient care, even if it is inconvenient or distasteful to them.

2. The socio-economic characteristics of our patients vary widely. Residents must relate to patients of all socio-economic and intelligent levels. The patients at University Hospital are frequently indigent and have few resources or education. Patients on the Aesthetic rotation are financially secure and educated. The must be sensitive to the feelings of all patients and treat all patients with respect and a level of concern similar to that which they wish to receive themselves.

3. During our clinical rotations, they work alongside of the faculty. Residents learn to treat all coworkers with respect and dignity even if stressed by other coworker's actions. Rotations outside of plastic surgery will be good learning experiences

4. Evaluation: Residents are graded on professionalism at the end of each rotation and during the semi-annual evaluations. This is augmented by 360 degree evaluations, evaluation by faculty and peers.

Any activities which are not standard will be discussed with the resident and residents are requested to reflect on the result of nonprofessional behavior on them and their ability to build a practice.

System Based Practice:

1. Residents will experience caring for patients in today's complex multifaceted healthcare system.
    i. Many rotations have a strong multidisciplinary approach to problems
        a. The craniofacial clinic at Children's Hospital is a multidisciplinary clinic with teamwork as a critical component
        b. The hand rotation interfaces with therapists on a daily basis.
        c. University Hospital, Our Lady of the Lake and the West Bank rotation are experiences facilities with diverse socio-economic patient bases.

d. On the more general rotations in hospital settings, residents interface with social network agencies and become familiar with levels of care.
e. On many rotations, residents will learn how to employ CPT coding and how to do ethical billing. They will be exposed to practice dynamics and how to run an office.

2. Evaluation of the educational process: Residents will be evaluated during the semiannual evaluation on their ability to function in diverse levels of care. They will attend CPT and coding courses. Residents will be critiqued on their input during Patient Safety parts of the M&M conferences and will be required to differentiate between systemic problems or individual performance problems.

3. Scholarly Activities: Residents will be expected to participate in all conferences and laboratories. They will attend at least one national or regional meeting. They are expected to engage with a faculty member in a research project. This project should produce one manuscript for possible publication or abstracts for presentation at regional/national meetings. They will attend all visiting professor lectures and will be expected to present unusual cases to the visiting professor. Residents should be knowledgeable about the IRB process and understand the implications thereof on their research projects.

Goals and Objectives by Year.

Independent:

The vast majority of our residents have historically completed training in a prerequisite residency which resulted in ability to perform complex surgery independently. Our goal therefore is to train these competent surgeons in the special techniques required to treat patients with plastic surgery problems.

First Year:

The goal for the first year is to begin to expose residents to the expansive core curriculum in plastic surgery. Most of our residents have a general surgery background, but we have also trained orthopedists, otolaryngologists and oral surgeons. Each pre-requisite training program already has established special knowledge of some of the areas that we teach, but have little exposure to others.

We also provide an anatomy laboratory (4 weeks) to familiarize the residents with areas that might not have been included in their prerequisite training. We provide a microsurgical laboratory to begin exposure to microsurgery. We have a facial trauma course in the spring to introduce them to Craniomaxillofacial injuries.

The first year residents must learn some of the techniques that are required to perform complex procedures. They are exposed to gentle handling of tissues, meticulous homeostasis, good preoperative planning and other technical skills.

The first year residents begin rotations in ancillary specialties, primarily anesthesiology and dermatology. This enables them to focus on outpatient anesthesia, patient selection and safety of patients undergoing anesthesia in an outpatient setting. Dermatology is important for the identification of skin lesions and the treatment of benign and malignant skin lesions.

The first year residents begin by assisting the faculty on their clinical rotations. When the faculty feels that they are capable, they begin performing simple and then moderately complex procedures. The first year rotations are experiences in general hospital plastic surgery, (West Jefferson and Our Lady of the Lake) which provide opportunities to do consultations, workup, surgery and follow up on general hospital based patients.. We also provide a hand rotation at this level so that residents can gain experience in the diagnosis and treatment of hand problems.

Second Year:

The goal for the second year is to increase their knowledge of the core curriculum by repeating some of the core and adding additional parts not covered during the first year. They are also responsible for helping organize the presentations for core curriculum.

They participated in the anatomy labs and the microsurgery courses as a team with the first year residents. The second year residents are expected to help with the instruction of the first year residents. The second year residents will be introduced to aesthetic surgery and begin to learn about these patients and their specific problems

The second year residents also have ancillary rotations in Oral Surgery, Orthopedics, and Ophthalmology. During these rotations they are expected to learn surgery of the mandible, occlusion, and orthognathic techniques. Orthopedics will provide opportunities to deal with trauma patients and bone healing. Ophthalmology will be helpful in learning preoperative issues with orbital surgery and how to deal with topical problems in the eye.

The second year residents will begin more developed progressive responsibility. They will begin rotations at University Hospital to be involved in more complex cases. They will begin to improve their microsurgery skills and will be involved in teaching junior residents and medical students, after they have been judged capable by the faculty.

Third Year:

The final year residents will be the Chief residents. They will help to administer the program and run the service at University Hospital. They will attend all core curriculum conferences, undergoing mock oral board examinations and assume a “junior faculty” role in conferences.

They will undertake to teach the junior residents, and act as proctors in the anatomy lab and the microsurgery laboratory. They will be expected to finalize their work on papers which they have begun during their first two years. They will be expected to have the skills necessary for the independent practice of plastic surgery upon graduation. They will be exposed to complex craniofacial surgery, and complex head and neck reconstructive surgery. They will be expected to develop skills in aesthetic surgery and become capable of independent practice in aesthetic surgery.

Integrated:

Residents will have completed medical school and will have had varied exposure to clinical practice. It is our goal to begin at that entry level and progress through a training program that will produce surgeons who are able to operate independently.

PGY-1 Year

The goal for the PGY-1 year is to introduce the resident to clinical practice in both surgical and specialty practice. Residents will rotate through general surgery where they will learn to evaluate the surgical patient, perform history and physical examinations, assist in surgery and begin to care for surgical patients on the floor. They will rotate through Emergency Medicine, learning to evaluate and treat patients who present with both acute medical and surgical problems. They will learn how an emergency room operates and how to prioritize care. They will perform closure of lacerations and learn basic resuscitation. They will rotate through Orthopedics and learn to evaluate patients with musculoskeletal injuries. They will learn basic splinting and cast application. They will assist in the repair of fractures. They will rotate through the ICU and learn management of critical care patients, including use of ventilator support and fluid management. They will rotate through the trauma service and learn complex resuscitation and assist in emergent surgery. They will rotate through the dermatology service to become exposed to the diagnosis of skin lesions.

PGY-2 Year

The goal for the PGY-2 year is to continue to attain progressive responsibility in general surgery. Tissue dissection and avoidance of complication are goals, as well as progressive responsibility for care on the floor. They will learn to place central lines, chest tube, tracheostomy and other invasive procedures. They will rotate through Neurosurgery to learn how to evaluate patients with neurosurgical injures, frequently associated with craniofacial trauma. They will learn to evaluate burn patients and their resuscitation on the burn service as well as complex nutritional problems. They will rotate on the vascular service to be exposed to vasculopathies and vascular surgical repair. They will learn the evaluation of patients for anesthesia on that service and learn basic anesthesia drugs and techniques. They will have two months of introductory plastic surgery in this year to begin to understand the plastic surgery patient and to assist on plastic surgical procedures.

PGPY-3 Year

This is the final year prior to starting formal plastic surgery rotations. They will rotate on the head and neck service for exposure to patients with head and neck cancer and the surgery for ablation in order to appreciate the reconstructive demands in these patients. They will rotate on a transplant service to learn to appreciate the process of evaluation, matching and avoidance of rejection. They will have upper level general surgical experience, performing more complex procedures and managing complex patients on the floor and in the clinics. They will have additional months of basic plastic surgery and attend conferences while on that service.

PGY-4 Year

This year begins to focus on plastic surgery. Hand and upper extremity surgery rotation takes place during this year. Basic and complex hand problems are treated in a setting with hand surgeons who have a CAQ in hand surgery. Residents will learn hand anatomy and physical diagnosis of hand problems. They will first assist, then perform parts of hand procedures. During their next years, they will assume greater responsibility for hand trauma, especially at the Academic Medical Center. They will rotate on an oral surgical service to be introduced to lower facial trauma, application of splints and intermaxillofacial fixation and other oral surgical skills. They will be exposed to ophthalmology and learn to examine the eye and to understand the possible complications which may occur after eyelid surgery.
They will begin research activity with one of the faculty. They will have advanced rotations in plastic surgery and begin to perform plastic surgical procedures and care for complex plastic patients in the clinics and wards. They will take plastic surgery call and attend all conferences and laboratories that the division holds.

PGY-5 Year

This year contains rotations that are specific and immersion experiences. There is a three month experience in cleft lip and palate and congenital malformations at the Children's Hospital. A rotation specific to breast reconstruction will be available and the residents will rotate to Our Lady of the Lake in Baton Rouge for a very varied experience in general plastic surgery and surgery of the hand. The residents will be exposed to craniomaxillofacial surgery in adults and will start to assume senior responsibility at the Academic Medical Center and the Veteran's Association Hospital. They will continue their research activities and should produce at least one paper or presentation during this year. PGY-5 residents will attend all conferences and laboratories that the division sponsors.

PGY-6 Year.

This year will be six months of exposure in aesthetic surgery. Residents will work with faculty both in the private setting and in a clinic setting. Residents will perform their own surgery on clinic patients under supervision of the faculty. They will learn injectable procedures and resurfacing. They will be exposed to lipo-injection and will be shown office management and ethical aesthetic surgery. All procedures will be in fully licensed facilities with MD anesthesia. The will also assume the role of chief resident on the plastic surgery service and assist with management of the service. They will teach junior residents and medical school.

They will run the service at the Academic Medical Center. They should have another paper produced during this year.

Chapter 2:

Organization, Faculty and Institutions

Organization

Plastic and Reconstructive Surgery is a division of the Department of Surgery of the Louisiana State University School of Medicine in New Orleans. The resident is part of a high quality, fully accredited state university which espouses the institutional requirements of the Accreditation Council for Graduate Medical Education (ACGME).

Faculty

Robert Batson, M.D., F.A.C.S.
Chairman
Department of Surgery

Charles L. Dupin, M.D., F.A.C.S.*#
Division Chief and Program Director
Plastic and Reconstructive Surgery

Oren Tessler, MD*#
Academic Faculty
Chief of Plastic Surgery, Academic Medical Center
Educational Director Academic Medical Center

Hugo St. Hilaire, D.D.S., M.D.*#
Academic Faculty
Chief of Cranio-maxillofacial Surgery
Co-director of Craniofacial Malformation Clinic, Children's Hospital

David Jansen, MD
Clinical Faculty
Program Director Tulane School of Medicine

Abigail Chaffin, MD
Clinical Facilty

Tulane University School of Medicine faculty

Kamran Khoobehi, M.D., F.A.C.S.*#
Clinical Faculty
Chief of Aesthetics Surgery
Educational Director, Aesthetic Surgery Rotation

Erick George, MD*#
Educational Director, Hand and Upper Extremity Surgery

Hamid Masshia, MD *#
Director of Aesthetic Clinic

Kelly Babineaux, M.D.
Chief of Hand Surgery (Plastic)
Academic Medical Center

Taylor Theunissen, M.D.*#
Clinical Faculty
Educational Director of Baton Rouge Rotation

Rick Ahmad, M.D., F.A.C.S.
Clinical Faculty
Baton Rouge Rotation

Robert Allen, M.D., F.A.C.S.
Division Chief Emeritus
Plastic and Reconstructive Surgery

Jonathan Boraski, M.D., F.A.C.S.
Clinical Faculty
West Jefferson Medical Center

John Lindsay, M.D., F.A.C.S.
Clinical Faculty
Hand Surgery

Michael Moses, M.D., F.A.C.S.
Chief of Plastic Surgery
Children's Hospital
Co director of Craniofacial Clinic, Children's Hospital

Michael Hanemann, M.D.
Clinical Faculty
Baton Rouge Rotation

Charles Gruenwald, M.D.
Clinical Faculty
Baton Rouge Rotation

**Educational directors*
 # Core faculty

Sponsoring Institutions

Louisiana State University is the major educational institution in Louisiana. Medical training is based in two campuses, one in New Orleans and one in Shreveport, Louisiana. The New Orleans campus is called the Louisiana State University Health Sciences Center. It includes a four year medical school and postgraduate training programs in virtually all specialties and administers University campus of the Medical Center of Louisiana. It also has a Nursing School and an Allied Health Professional school.

University Medical Center New Orleans (UMCNO) Opened August 1, 2015 On Tulane Avenue in New Orleans. The new state of the art Privately owned and operated 450 bed University Medical Center is the only Level 1 Trauma Hospital in the city.

Participating Institutions (descriptions)

Children's Hospital - is a large, well equipped non-profit hospital treating all levels of childhood illnesses, including craniofacial anomalies and pediatric plastic surgery. It includes one of the largest craniofacial clinics in the South. It has 201 beds and over 380 pediatricians and pediatric specialists. The hospital admits over 7,000 inpatient and 170,000 outpatient visits each year. The hospital services the entire state of Louisiana and Gulf Coast region.

West Jefferson Medical Center - is a large, (licensed for 450 beds) fully equipped non-profit state hospital on the West Bank. This hospital provides a large, varied experience in both elective plastic surgery and trauma.

Houma Outpatient Surgical Facility - is a licensed and fully accredited outpatient surgical facility. It is utilized as the primary outpatient facility for the Division and is where many aesthetic cases are performed under the supervision of MD anesthesiologists.

Our Lady of the Lake - in Baton Rouge. OLOLRMC is the dominant institution in health care in the Greater Baton Rouge area and the largest private medical center in Louisiana, with 763 licensed beds. In a given year, OLOLRMC treats approximately 25,000 patients in the hospital, and services about 350,000 persons through outpatient locations. It has a complement of almost 900 physicians and 3,000 staff members. The Lake also operates two nursing homes, has an affiliated cancer facility adjacent to the main hospital, and operates a number of outpatient services on its campus as well as in outlying locations. According to the most recent survey data 82,775 patients visited the hospital's emergency room; a total of 34,016 patients were admitted. Its physicians performed 10,214 inpatient and 7,019 outpatient surgeries.

East Jefferson General Hospital - serves as the primary site for the dedicated hand rotation. The hospital provides funding for this rotation and the hand faculty uses it as their primary hospital.

Ochsner Medical Center-Baptist - is a specialty hospital in uptown New Orleans. LSU has an active breast reconstruction program at this hospital. It has 43 inpatient beds (mostly for post-operative patients, 6 operating rooms and a surgical ICU. It is utilized by academic and clinical faculty for elective cases.

Ochsner Medical Center-Westbank - is a 250 bed hospital in Jefferson parish on the west bank of the river. It is occasionally utilized by clinical and academic faculty for elective cases.

Touro Infirmary - is a large hospital in Orleans Parrish utilized by academic and clinical faculty for general plastic surgery cases.

Baton Rouge General Hospital- located in Baton Rouge, Louisiana it has a burn unit through which residents rotate.

All facilities are administered by LSUHSC or have a participation agreement with the University.

Chapter 3:
Rotations, Clinical Curriculum

All resident rotations in any participating facility will be governed by the rules discussed in this manual and the LSU House Staff Manual. The Plastic Surgery Independent program at LSU is currently a three year program whereas the integrated program at LSU is a 6-year program.

The following is the projected rotation schedule for each academic year and the Goal and Objectives that correspond to each rotation.. There may be some changes in the schedule due to circumstances beyond control of the division of plastic surgery.

Independent:

Third Year- 1												
Block	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**
Site	1	1	1	8	8	8	1	1	1	8	8	8
	UMCNO	UMCNO	UMCNO	HOS	HOS	HOS	UMCNO	UMCNO	UMCNO	HOS	HOS	HOS
Rotation Name	AVR	AVR	AVR	Aesthetics	Aesthetics	Aesthetics	AVR	AVR	AVR	Aesthetics	Aesthetics	Aesthetics

Third Year- 2												
Block	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**
Site	8	8	8	1	1	1	8	8	8	1	1	1
	HOS	HOS	HOS	UMCNO	UMCNO	UMCNO	HOS	HOS	HOS	UMCNO	UMCNO	UMCNO
Rotation Name	Aesthetics	Aesthetics	Aesthetics	AVR	AVR	AVR	Aesthetics	Aesthetics	Aesthetics	AVR	AVR	AVR

Second Year- 1												
Block	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**
Site	5	5	5	2	2	2	4	4	4	1	1	1
	Touro	Touro	Touro	Childrens	Childrens	Childrens	Ochsner	Ochsner	Ochsner	UMCNO	UMCNO	UMCNO
Rotation Name	Breast	Breast	Breast	CONG	CONG	CONG	CMF	CMF	CMF	Plastics	Plastics	Plastics

Second Year-2												
Block	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**
Site	2	2	2	5	5	5	1	1	1	4	4	4
	Childrens	Childrens	Childrens	Touro	Touro	Touro	UMCNO	UMCNO	UMCNO	Ochsner	Ochsner	Ochsner
Rotation Name	CONG	CONG	CONG	Breast	Breast	Breast	Plastics	Plastics	Plastics	CMF	CMF	CMF

First Year -1												
Block	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**
Site	1	1	1	7	7	7	6	6	6	3	3	3
	UMCNO	UMCNO	UMCNO	OLOL	OLOL	OLOL	WJ	WJ	WJ	EJ	EJ	EJ
Rotation Name	Plastics	Plastics	Plastics	Plastics	Plastics	Plastics	Plastics	Plastics	Plastics	Hand	Hand	Hand

Rotations:	Sites:
Aesthetics	1. University Medical Center New Orleans- UMCNO
Advances Reconstruction- AVR	2. Childrens Hospital New Orleans- Childrens
Breast	3. East Jefferson General Hospital- EJ
Congenital and Cleft- CONG	4. Ochsner
Craniomaxillofacial- CMF	5. Touro Infirmary
Hand	6. West Jefferson Medical Center- WJ
Plastic Surgery	7. Our Lady of the Lake- Baton Rouge- OLOL
	8. Houma Outpatient Surgery Center- HOS

Goals and Objectives of the Independent Residency Rotations:

Aesthetic Surgery:

Rotation Goals:

Aesthetic surgery is a critical component in plastic surgery. The plastic surgeon has an enormous amount of competition for these cases, and the number of non plastic surgeons in the market is increasing. Plastic surgeons must be well trained in aesthetic surgery in order to be successful in this competitive marketplace. This rotation is an intensive immersion in aesthetic surgery, both in the private and clinic sector. Residents will attend private clinic and surgery and will also attend their own senior resident aesthetic surgery clinic. At the end of the rotation, the resident will demonstrate that he/she has developed the necessary knowledge and surgical skills to evaluate and treat patients with aesthetic problems.

Objectives of the Rotation:

A. Patient Care

During the rotation, the resident will be required to:

1. Demonstrate caring and respectful behavior towards aesthetic patients
2. Demonstrate the ability to interview and listen to aesthetic patients
3. Demonstrate a satisfactory level of competency in the following general categories of aesthetic surgery:
    a. Facial plastic surgery
        i. Rhytidectomy
        ii. Eyelid and brow surgery
        iii. Rhinoplasty
        iv. Otoplasty
        v. Skin resurfacing
        vi. Fat injection/fillers
    b. Breast aesthetic surgery
        i. Breast hypoplasia
        ii. Breast ptosis
        iii. Macromastia and gynecomastia
    c. Trunk aesthetic surgery
        i. Abdominoplasty
        ii. Liposuction
        iii. Surgery after weight loss

2. Medical Knowledge

During this rotation, the resident should:

1. Understand the concepts of beauty and aesthetic principles
2. Recognize the effects of aging, photo-damage, lipodystrophy and other causes of aesthetic deformity

3. Demonstrate adequate knowledge of facial anatomy:
    a. Anatomy of the eyelids, muscles, fascia, cartilage support and function of components
    b. Principles of ptosis of the eyelids, blepharochalasis, and brow ptosis
    c. Anatomy of the facial muscles, facial nerve and fascia and their relationship to the facelift
    d. Bony and cartilaginous structures of the nose and airway
4. Be familiar with aesthetic problems of the breast, include ptosis, tubular breast and asymmetry
5. Be familiar with aesthetic and functional issues of the abdominal wall

3. Interpersonal and Communication Skills

During the rotation, the resident will be expected to:

1. Relate professionally with aesthetic patients and listen to their problems and concerns
2. Obtain an informed consent and discuss the patient's risks and expectations prior to surgery

4. Professionalism

During the rotation, the resident must:

1. Practice punctuality, demonstrate a professional demeanor and reliably perform his/her duties
2. Be sensitive to the special needs of the aesthetic patient and respect his/her privacy and confidentiality
3. Dress appropriately

5. Practice Based Learning and Improvement

During the rotation, the resident should:

1. Demonstrate that he/she can compare the preoperative condition and postoperative results in a critical manner
2. Identify complications and formulate a plan to correct them and prevent them in the future
3. Develop knowledge of the aesthetic literature and apply the information to specific cases
4. Use digital photography to document the patient's course

6. Systems Based Practice

During the rotation, the resident must:

1. Demonstrate an understanding of ethical billing for aesthetic surgery
2. Understand the use of appropriate consultation, i.e. ophthalmic consultation prior to blepharoplasty
3. Demonstrate that he/she is cognizant of safety concerns in aesthetic surgery:
    a. Volume of liposuction
    b. Causes of post-blepharoplasty blindness and problems with lid position
    c. Dry eye syndrome and its prevention

d. Injuries to the facial nerve
e. Hematoma in aesthetic surgery
f. Pulmonary embolism and its prevention
g, Evaluation of cancer prior to breast surgery
h. Evaluation of nutritional status prior to surgery for massive weight loss

This rotation includes aesthetic surgery of the head and neck, trunk and extremities and the breast. All clinic cases scheduled by the residents at the outpatient facility must fulfill the certification requirement. In order to be certified as competent to perform any aesthetic case, the resident must have observed/assisted a staff member in performing that type of case and demonstrate adequate knowledge about techniques, complications and follow-up to ensure that he/she can perform the surgery. Residents must have supervision at the time of surgery. The resident serves as Administrative Resident for the program during this rotation and schedules conferences, cadaver dissections and monthly journal club meetings. The Administrative Resident also makes up the call schedule.

Pediatric Plastic Surgery and Craniofacial Surgery

Rotation Goals

Residents will attend a large craniofacial clinic and surgery at the Children's Hospital. They will see the team approach to congenital deformities of the head and neck and also will see adult craniofacial surgery as well. At the end of the rotation, the resident should demonstrate understanding of special plastic surgical problems and that he/she has reasonable experience and capabilities to care for these children.

Rotation Objectives

A. Patient Care

The resident should:

1. Exhibit a caring and respectful attitude towards patients and their families.
2. Obtain sufficient historical data and perform an adequate physical examination to formulate a treatment plan.
3. Be able to work with a multidisciplinary team
4. Have adequate operative exposure and appropriate technical skills in the following general pediatric plastic surgery categories: Knowledge of techniques of cleft lip and palate surgery including:
    a. Unilateral Cleft Lip Repair
    b. Bilateral Cleft Lip Repair
    c. Palatoplasty
    d. Pharyngeal Flaps

e. Cleft Lip Nose Repair
f. Revision of Cleft

5. Have operative experience with:
    a. Synostosis, simple and complex
    b. Crouzon's, Apert's and other syndromes associated with craniosynostosis.
    c. Treacher Collins, Pierre Robin, Microsomia and other clefts and dysplasias.
6. Has had satisfactory technical experience with ear deformity:
    a. Microtia
    b. Developmental deformities
    c. Acquired deformities
5. Postoperative care for children, including pain control, fluid and electrolyte balance, wound care and antibiotic therapy

6. Be familiar with and have operative experience with acquired deformities and trauma, such as:
    a. Pediatric facial fractures
        i. Upper 1/3 face
        ii. Lower 1/3 of face
        iii. Complex lacerations of the face
    b. Acute and chronic tissue defects

2. Medical Knowledge

The resident must demonstrate understanding of:

1. Etiology, embryology and anatomy of congenital abnormalities seen in children, including:
    a. Cleft lip and palate and velopharyngeal incompetence
    b. Speech disorders related to cleft lip and palate
    c. Understanding the deformities in the craniofacial skeleton
    d. Genetic factors involving craniofacial anomalies.
    e. Neural tube disorders
2. Understanding the classification of facial fractures in children and how their treatment is different than in adults.

3. Interpersonal and Communication Skills

The resident should:

1. Communicate well with the patient's parents and relatives
2. Be able to obtain informed consents to parents regarding risks and expectations prior to surgery
3. Communicate effectively with health care professionals, including office staff, nurses and OR personnel

4. Professionalism

The resident must demonstrate:

1. A professional, punctual and reliable demeanor when performing his/her duties
2. Superb attendance in clinics and surgery
3. Sensitivity to a diverse population

5. Practice Based Learning and Improvement

The resident must:

1. Demonstrate the ability to properly compare the preoperative condition and postoperative results in a critical manner
2. Be able to identify complications, formulate a management plan and prevent them in the future
3. Demonstrate the use of library and online resources and apply the information from these sources to cases
4. Use digital photography to document the course of his/her patient

6. Systems Based Practice

The resident is expected to be:

1. Aware of the risk of child abuse
2. Able to appropriate consultations from other members of the pediatric team and other staff, if needed
3. Cognizant of pediatric safety concerns, such as the following:
    a. Maintaining a normal core temperature in surgery
    b. Avoidance of excess blood loss in infants
    c. Eye protection during facial trauma surgery
    d. Airway and postoperative edema
    e. Prevention of equinus deformity in extremity trauma
    f. Prevention of decubitus ulcer

Hand and Upper Extremity Rotation

Rotation Goals:

At the end of the rotation the resident should demonstrate that he/she is familiar with both traumatic and elective surgery of the hand and upper extremity. He/she should be able to treat peripheral nerve problems and arthritic diseases of the hand and be capable of performing reconstructive procedures, such as tendon transfers.

Rotation Objectives:

A. Patient Care

By the end of the rotation, the resident should be able to:

1. Obtain the patient's medical history and perform physical examination of the upper extremity to formulate a diagnostic and therapeutic plan.
2. Apply splints and casts and understand their indication.
3. Manage post-operative care and participate in rehabilitation of the hand as a member of the medical team.
4. Make accurate diagnoses and formulate a surgical plan for hand pathology:
    a. Surgery of traumatic injuries including primary and secondary reconstruction of tendons and nerves
    b. Surgery of entrapment neuropathies and tendon transfers following nerve injury
    c. Surgery following amputation, including flaps, replantation surgery and soft tissue coverage
    d. Treatment of fingertip injuries
    e. Diagnosis and establishment of treatment plan for arthritis of the hand
    f. Diagnose and treat infections of the hand and upper extremity
    g. Exhibit familiarity with and have operative experience with fractures of the upper extremity
    h. Pediatric hand fractures
    i. Acute fractures and dislocations of the hand and wrist joints

B. Medical Knowledge

By the end of the rotation, the resident will have:

1. Adequate knowledge of the anatomy and physiology of the tendons, nerves, ligaments and joints of the upper extremity
2. Competence in utilizing radiographic examination of the hand and upper extremity for accurate diagnosis
3. Knowledge of electro diagnostic studies and the ability to use them for adequate diagnosis
4. Ability to diagnose and treat benign and malignant tumors of the soft tissue of the hand
5. Developed knowledge of tumors arising in the bone, and their diagnosis and treatment
6. Knowledge of the diagnosis and treatment of inflammatory and proliferative diseases of the hand, including Dupuytren's contracture, joint contracture and arthritis

C. Interpersonal and Communication Skills

During the rotation, the resident is expected to:

1. Communicate well with the patient and his/her family
2. Obtaining informed patient consent and discuss the patient's risks and expectations
3. Communicate effectively with office staff, nurses and OR personnel

D. Professionalism

The resident must demonstrate:

1. Professional demeanor, punctuality and reliability in regard to the performance of his/her duties
2. Responsibility for clinic and surgery when called upon
3. Sensitivity to the patient's right to privacy and confidentiality

E. Practice Based Learning and Improvement

The resident must be able to:

1. Compare a patient's preoperative condition and postoperative results in a critical manner
2. Identify complications and formulate a plan to handle them and prevent them in the future
3. Use the library and online resources to access literature and apply that literature to his/her cases

F**. Systems Based Practice**

By the end of the rotation, the resident is expected to be:

1. Aware of malingering and dystrophic conditions and be able to differentiate them
2. An active participant in hand therapy management
3. Cognizant of hand surgery safety issues such as the following:
    i. Proper use of tourniquet time and pressure
    ii. Avoidance of injuries from improperly applied casts and splints
    iii. Importance of magnification and operating in a bloodless field
    iv. Importance of periods of immobilization to prevent stiffness

Ochsner Baptist:

Rotation Goals:

The resident will attend microsurgical cases done at Ochsner Baptist as well as craniofacial cases done at the Ochsner Main Campus. They should also be competent to perform other types of breast surgery, including reconstruction and aesthetic breast surgery. At the end of the rotation the resident should be familiar with all flaps performed for breast reconstruction and should be able to outline a plan for craniofacial reconstruction including virtual planning procedures and multiple flap procedures.

Goals and Objectives of the rotation:

A. Patient Care: During the rotation, the resident is expected to:

1. Demonstrate caring and respectful behavior toward breast patients
2. Demonstrate that they can obtain a coherent history of breast cancer risks and genetic causes of breast cancer.
3. Demonstrate a satisfactory level of competency treating patients in these general categories of breast surgery
    a. Cosmetic Breast Surgery:
        1. Mastopexy
        2. Breast Reduction

3. Congenital Breast Deformity (eg Poland's Syndrome)
4. Tubular Breast Deformity
5. Augmentation Mastopexy
6. Implantation surgery

b. Reconstructive Breast Surgery:
   1. Autogenous Reconstruction (Immediate/Delayed)
      a. DIEP flap
      b. Gluteal Artery Perforator flaps, Inferior and Superior
      c. SIEA flap
      d. Thoracodorsal flap
      e. Local Perforator flaps
   1. Implant reconstruction
   2. Expander reconstruction

c. Other procedures:
   1. Nipple areola reconstruction
   2. Liposuction for symmetry
   3. Reduction for symmetry

B. Medical Knowledge: During this rotation, the resident should:

1. Understand current treatments of breast disease.
2. Recognize the deformities resulting from mastectomy, failed reconstruction and radiation. .
3. Demonstrate adequate knowledge of breast and chest wall anatomy:
4. Recognize congenital and acquired non-oncologic breast disease
5. Understand the timing of reconstruction, chemotherapy, and radiation therapy.

C. Interpersonal and Communication Skills: During the rotation the resident must

a. Be able to relate professionally with breast patients, and is a good listener.
b. Be able to inform patients about risks and expectations prior to surgery

4. Professionalism: During the rotation the resident must:

a. Demonstrate punctuality, professional demeanor and reliable performance of his duties.
b. The resident should be attentive to the special needs of breast cancer patients, respect their privacy and confidentiality.
c. Dress appropriately

5. **Practice Based Learning and Improvement**: During the rotation, the resident should:

a. Demonstrate that he/she can compare the preoperative condition and postoperative results in breast reconstruction in a critical manner.
b. Been able to identify complications, is able to formulate a plan to deal with them and prevent them in the future.

c. Develop knowledge of the breast surgery literature and can apply information form the literature to specific cases.
d. Become knowledgeable to use of digital photography to document the patient's course.

6. Systems Based Practice: During the rotation, the resident should:

a. Demonstrate an understanding of ethical use of CPT coding for breast surgery.

b. Understand the need for multidisciplinary teamwork, for example pathology surgery oncology radiation therapy.
c. Demonstrate that he/she is cognizant of breast surgery safety:
    i. Etiology of nipple necrosis.
    ii. Prevention of pulmonary embolism in lengthy cases.
    iii. Fluid balance management during lengthy cases.
    iv. Hematoma in breast surgery
    v. Postoperative flap monitoring.
    vi. Prevention of hernia or abdominal weakness.
    vii. Evaluation of causes of increased morbidity in reconstructive surgery.

Position of patient in long cases to prevent neuropathy

Our Lady of the Lake:

Rotation Goals

This rotation in Baton Rouge is based at Our Lady of the Lake. At the end of the rotation, the resident should demonstrate the ability to care for patients in both in and outpatient settings. The resident should be able to use plastic surgery principles to solve a variety of problems including extremity trauma, complex wounds, facial fractures, oncologic reconstruction, facial deformities, breast deformities, etc.

Rotation Objectives

A. Patient Care

During the rotation, the resident must:

1. Exhibit compassion and respect to all patients
2. Obtain sufficient historical data and perform a physical examination adequate to formulate a treatment plan
3. Demonstrate ability to work with a multidisciplinary team
4. Demonstrate ability to manage postoperative complications in adults, including infections, nutrition and wound healing problems
5. Exhibit operative exposure and appropriate technical skills in general plastic surgery
6. Obtain knowledge of techniques for plastic surgery problems including:

a. Extremity trauma
b. Facial trauma
c. Hand trauma
d. Delayed wound healing
e. Chest and abdominal reconstruction
f. Macromastia
g. Oncologic reconstruction after resection of breast, head and neck, and skin cancers
h. Body contouring after massive weight loss

7. Demonstrate adequate knowledge experience in skin grafts, local flaps, free flap tissue transfer and complex wound closure

2. Medical Knowledge

During the rotation, the resident should:

1. Demonstrate adequate knowledge of head and neck, hand, trunk and extremity anatomy
2. Demonstrate sufficient knowledge of wound healing
3. Have an adequate fund of knowledge to treat problems such as difficult wounds, extremity trauma, hand trauma, facial trauma and oncologic problems

3. Interpersonal and Communication Skills

During the rotation, the resident must demonstrate:

1. Appropriate communication skills with the patient and his/her family
2. Ability to obtain an informed consent and discuss the patient's risks and expectations prior to surgery
3. Ability to communicate well with colleagues, office staff, nurses and OR personnel
4. Leadership qualities while running a busy plastic surgery service

4. Professionalism

During the rotation, the resident must demonstrate:

1. Punctuality, a professional demeanor and reliable performance of all duties
2. Superb clinic and surgery attendance when scheduled
3. Professional dress and grooming
4. Respect to all healthcare professionals, including staff, faculty, fellows, residents, nurses, office staff, etc.
5. Respect of patient privacy and confidentiality

5. Practice Based Learning and Improvement

During the rotation, the resident should have:

1. Surgical knowledge to compare treatment approaches suggested in professional literature
2. Surgical knowledge to identify complications and formulate a plan to correct them, as well as prevent them in the future

3. Ability to use digital photography to document the patient's course

6. Systems Based Practice

During the rotation, the resident must demonstrate understanding of:

1. General plastic surgery principles
2. Teamwork with other members of the treatment team.

Touro Infirmary:

Rotation Goals:

Touro is a large community hospital in downtown New Orleans. Residents during this rotation will be exposed to two educational experiences. One is general plastic surgery as practiced in a community hospital setting. Residents will work with a young well trained plastic surgeon and will be involved with referrals from the hospital as well as the community. At the end of the rotation they will have gained considerable experience in community based plastic surgery.

The second experience will be in high quality microsurgery of the breast. The educational director is a highly innovative micro surgeon and performs state of the art inventive procedures for microsurgical reconstruction of the breast. Upon completing the rotation, residents should be capable of innovative thinking and performing cutting edge microsurgery.

Rotation Objectives:

A. Patient Care

1. Residents will learn how to deal with patients in a private practice community based setting.
2. They will answer consults in the hospital and emergency room. They will assess the patient's problem, initiate a workup and form a plan of care.
3. They will perform surgery of mild complexity and assist in complex reconstructive cases.
4. They will round on patients, assess their progress and write orders which are necessary for ongoing treatment
5. It is expected that the resident will have experience in breast surgery (reconstructive and aesthetic, skin lesions (benign and malignant), facial aesthetic surgery and surgery of complex wounds.

B. Medical Knowledge

1. Residents are expected to produce a paper of publishable quality during this rotation
2. Residents will have prepared for this rotation by reading the Selected Readings in Plastic Surgery which deal with comprehensive topics.
    a. Melanotic and non melanotic skin cancers
    b. Breast reduction and mastopexy

c. Mastectomy and breast reduction
d. Trunk reconstruction
e. Lower extremity reconstruction

3. Residents will learn about ethical coding and ethical practice promotions on this rotation.

C. Practice Based Improvement

1. While on this service, residents will attend all private clinics to observe the results of surgery that the resident has participate in.
2. The resident will attend all conferences, including M&M, at which all complications arising on the service will be presented.
3. The resident will teach medical students who are at Touro during this rotation

D. Professionalism

1. The resident will understand the role of the plastic surgeon in the community hospital setting. He will answer consults promptly both in the ER and on the floors.
2. The resident will respect the confidentiality in this private patient rotation.
3. The resident will learn the importance of cordiality and availability in a successful private practice setting.

E. Interpersonal Relationship and Communication

1. Resident will communicate patient care issues promptly to the educational director
2. Resident will write clear and concise notes on patients on the service
3. The resident will cordially work with the nursing staff to ensure that patients are well cared for. In the private setting relationship with the staff nurses can be critical.
4. The resident will work in the educational director's private office and observe how his staff supports his practice.

F. System based care

1. The resident will utilize support systems in place to ensure that patients have appropriate care after discharge.
2. Patients will be carefully instructed in post discharge wound management, postoperative appointments and any restriction in activities
3. Even in the private setting, many patients are treated by a team. The resident will learn to coordinate care, to follow up results and to ensure that the care is seamless.

West Jefferson Medical Center

Rotation Goals:

Residents will begin their training in this rotation or at OLOL. They will be introduced to the evaluation of plastic surgery patients. They will answer consults in the hospital and emergency room under the supervision of the faculty. They will operate with the faculty, first as assistant, and then as their skills improve, they will be more involved in performing the procedures. They will see the patients before and after surgery in the faculty clinic. They will also work with the office staff on matters of coding and billing.

Resident Responsibilities

Residents are expected to attend the clinic twice a week. They will examine new patients, evaluate and form a care plan to present to faculty. They will see postoperative patients, compare preoperative and postoperative results and discuss with faculty how the result could be improved. Complications arising on the West Bank rotation should be presented in Morbidity, Mortality and Patient Safety Conference. Residents are also expected to make rounds daily during the week with the faculty and to answer consults. Residents call is addressed in the section on Call Responsibilities. First year residents will in the beginning of the rotation assist faculty in most cases. They will progress in surgical responsibility and by the end of the rotation should be able to perform simple to mid-level plastic surgery cases.

Senior residents rotating on the service should be able to take advantage of progressive responsibility and perform with supervision of the faculty the more complex procedures.

Rotation Objectives and educational outcomes

1. Patient Care

The resident must:

A. Be able to evaluate plastic surgical trauma patients and make a plan of care.
B. Be able manage acute burns and understand the principles of burn reconstruction.
C. Be able to evaluate tissue deficiencies and develop plans for reconstruction
D. Demonstrate knowledge of diagnosis and treatment of benign and malignant skin lesions
E. Evaluate and treat lower extremity trauma and reconstruction
F. Perform the following surgical procedures:
    1. Skin grafts and flaps
    2. Composite, cartilage and bone grafting
    3. Excision of skin tumors and aesthetic based reconstruction
    4. Repair of hand trauma, tendons, nerves, fractures and soft tissue defects
    5. Breast surgery
    6. Decubitis surgery
    7. Perform nerve blocks in the hand, head and neck
    8. Exposure to free transfer for extremity and breast reconstruction

9. Reduction mammoplasty
10. facial trauma and fractures

2. Medical Knowledge

The resident must:

A. Demonstrate basic knowledge of head, neck and hand anatomy
B. Demonstrate knowledge of wound healing, both normal and abnormal
C. Be able to obtain data from the literature, use of online resources and provide published documentation of treatment plans
D. Demonstrate competence in the evaluation of radiographs for facial trauma, as well as diagnosing the type

3. Practice Based Learning and Improvement

During the rotation, the resident should:

A. Demonstrate that he/she can compare the preoperative condition and postoperative results in a critical manner
B. Identify complications, formulate a plan to address them and prevent them in the future
C. Show familiarity with the literature and apply information from the literature to his/her case
D. Use digital photography to document the patient's course

4. Interpersonal and Communication Skills

At the completion of the rotation, the resident should demonstrate:

A. Effective communication skills with other health care professionals in both the office and hospital settings
B. Ability to obtain proper informed consent, including risks

5. Professionalism

During the rotation, the resident must show:

A. Punctuality, a professional demeanor and reliable performance of his/her duties
B. Sensitivity to the special needs of patients, respect their privacy keep their medical information confidential
C. Appropriate dress and appearance
D. Appropriate response to calls from the emergency room as well as patient exchanges

6. Systems Based Practice

During the rotation, the resident should:

A. Act as an advocate for his/her patients
B. Utilize levels of care (acute care, outpatient, long term acute care, nursing homes, home health care and durable equipment)
C. Understand the relation between the plastic surgeon in the hospital and his/her colleagues

D. Understand some of the rudiments of practice management, including billing, ICD-9 codes and CPT codes
E. Understand hospital safety issues:
    1. Use of the information technology system
    2. Writing legible orders and prescriptions
    3. Awareness of airway problems in facial trauma
    4. Awareness of airway and multiple trauma problems in burn patients

Evaluation of achievement of educational goals:

A. At the end of the rotation, the educational director will provide a written evaluation of the residents' ability to meet the goals of the rotation. (see evaluation instrument)
B. The educational director will attest to the operative skills commiserate with the level of training.
C. A 360 degree evaluation will be obtained for the semiannual evaluation.
D. The resident's participation in conferences and oral and written quizzes will tract their progress with the core curriculum and will be part of the semiannual evaluations.

University Medical Center at New Orleans (UMCNO)

Rotation Goals

At the end of the rotation, the resident should demonstrate the ability to care for plastic surgery patients in both the inpatient and outpatient setting. Plastic surgery principles will be applied to solve a variety of problems, including extremity trauma, complex wounds, facial fractures, oncologic reconstruction, facial deformities, breast deformities, etc.

Rotation Objectives

1. Patient Care

During the rotation, the resident must:
A. Exhibit compassion and respect to all plastic surgery patients
B. Obtain sufficient historical data and perform physical examination to formulate a treatment plan
C. Demonstrate ability to work with a multidisciplinary team
D. Demonstrate ability to manage postoperative complications in adults, including infections, nutrition and wound healing problems
E. Gain operative exposure and appropriate technical skills in general plastic surgery
F. Obtain technical knowledge of plastic surgery problems including:
    1. Extremity trauma
    2. Facial trauma
    3. Hand trauma
    4. Delayed wound healing
    5. Macromastia
    6. Oncologic reconstruction

7. Gain operative experience with skin grafts, local flaps, free tissue transfer, complex wound closure

2. Medical Knowledge

During the rotation, the resident should:

A. Demonstrate adequate knowledge of head and neck, hand, trunk and extremity anatomy
B. Demonstrate sufficient knowledge of wound healing
C. Access an adequate fund of knowledge to treat difficult wounds such as extremity trauma, hand trauma, facial trauma and oncologic problems

3. Interpersonal and Communication Skills

During the rotation, the resident must demonstrate:

A. Appropriate communication skills with the patients and their families
B. Ability to discuss risks and expectations with the patient prior to surgery
C. Ability to communicate with colleagues on other services, office staff, nurses and OR personnel
D. Leadership qualities when running a busy plastic surgery service

4. Professionalism

During the rotation, the resident must demonstrate:

A. Punctuality, a professional demeanor and reliable performance of all duties
B. Superb attendance at clinic and procedures to which he/she is assigned
C. Appropriate dress and grooming
D. Respect to all healthcare workers (i.e. faculty, staff, residents and fellows)
E. Respect of the patient's right to privacy and confidentiality

5. Practice Based Learning and Improvement

During this rotation, the resident should have:

A. Surgical knowledge to compare treatment approaches suggested in the literature
B. Surgical knowledge to identify complications and formulate a plan to identify problems and correct them in the future
C. Ability to use digital photography to document his/her patient's course

6. Systems Based Practice

During the rotation, the resident must demonstrate an understanding of:

A. General plastic surgery principles
B. Teamwork with other divisions on a multidisciplinary service (emergency medicine, orthopedics, medicine, ENT, neurosurgery, trauma, etc.)

Resident Responsibilities

Residents on this rotation are expected to be at the maximum progressive responsibility. They Will round daily during the week on all patients on the service, see consults in the hospital and emergency room and scrub on all procedures done on the service. They are also expected to

act as a team leader on this service, coordinating care for patients and interfacing with other services. They are also expected to teach the medical students and junior rotating residents the principles of plastic surgery. They attend the University Clinic and see all new patients in the clinic. They will formulate a plan of care and schedule the patients. They will see all post operative patients and present them to the faculty to discuss the outcome and opportunities for improvement. All preoperative patients of educational value are to be presented in Grand Rounds conference and all complications are to be presented at M&M. Residents are however always under direct supervision of the faculty in the operating room, hospital and clinics.

University Hospital plastic call includes hand and facial trauma. We now take hand call one day in four and facial trauma call every other day. Normally there is an intern or junior resident on first call. They do not, however, have the training necessary to manage anything other than the most straightforward laceration. The plastic surgery resident is expected to see any ER consult of any significance. During the daytime, the consult should be discussed by the faculty member on call for that day. At night, if there is a case that needs to go to the OR It is mandatory to call the faculty and get instructions from them. If there is any concern at any time it is always best to speak with the faculty. If the problem is not urgent, the faculty member should be contacted the following morning so that he can see the patient.
If the resident becomes overwhelmed or fatigued, they also must call the faculty assigned.

Many complex cases are now being done by the University faculty at Ochsner Baptist. The University resident, unless he has operative responsibilities at University will avail themselves of the opportunity to scrub on those cases. The resident will be notified by the faculty about these cases. The university resident will also be expected to round on those patients during the week.

Integrated:

RESIDENT	JULY	AUGUST	SEPTEMBER	October	November	December	January	February	March	April	May	June
HO- 1A	Trauma (1) UMCNO	Trauma (1) UMCNO	Plastics (1) UMCNO	Plastics (1) UMCNO	Ortho (1) UMCNO	Ortho (1) UMCNO	GS (7) Childrens	GS (1) UMCNO	GS (1) UMCNO	EM (1) UMCNO	EM (1) UMCNO	Derm (1) UMCNO
HO- 1B	Ortho (1) UMCNO	Ortho (1) UMCNO	Trauma (1) UMCNO	Trauma (1) UMCNO	EM (1) UMCNO	EM (1) UMCNO	Plastics (1) UMCNO	Plastics (1) UMCNO	Derm (1) UMCNO	GS (7) Childrens	GS (1) UMCNO	GS (1) UMCNO
HO- 2A	NS (1) UMCNO	NS (1) UMCNO	ICU (1) UMCNO	ICU (1) UMCNO	GS (5) BRG	BU (6) BRG-B	VS (12) WJ	VS (12) WJ	Plastics (1) UMCNO	Plastics (1) UMCNO	Anes (12) WJ	OP (1) UMCNO
HO- 2B	VS (12) WJ	VS (12) WJ	OP (1) UMCNO	Anes (12) WJ	NS (1) UMCNO	NS (1) UMCNO	ICU (1) UMCNO	ICU (1) UMCNO	BU (6) BRG-B	GS (5) BRG	Plastics (1) UMCNO	Plastics (1) UMCNO
HO- 3A	Anes (12) WJ	Hand (1) UMCNO	Hand (1) UMCNO	GS (1) UMCNO	GS (7) Childrens	GS (1) UMCNO	OS (1) UMCNO	OS (1) UMCNO	Plastics (1) UMCNO	TP-GS (11) Tulane	Plastics (1) UMCNO	Plastics (1) UMCNO
HO- 3B	GS (7) Childrens	GS (1) UMCNO	GS (1) UMCNO	Anes (12) WJ	TP-GS (11) Tulane	Plastics (1) UMCNO	Plastics (1) UMCNO	Plastics (1) UMCNO	OS (1) UMCNO	OS (1) UMCNO	Hand (1) UMCNO	Hand (1) UMCNO
HO- 4A	HAND (8) EJ	HAND (8) EJ	HAND (8) EJ	Plastic (4) TOURO	Plastic (4) TOURO	Plastic (4) TOURO	Plastic (9) OLOL	Plastic (9) OLOL	Plastic (9) OLOL	Plastic (4) TOURO	Plastic (4) TOURO	Plastic (4) TOURO
HO- 4B	Plastic (4) TOURO	Plastic (4) TOURO	Plastic (4) TOURO	HAND (8) EJ	HAND (8) EJ	HAND (8) EJ	Plastic (4) TOURO	Plastic (4) TOURO	Plastic (4) TOURO	Plastic (9) OLOL	Plastic (9) OLOL	Plastic (9) OLOL
HO- 5A	CONG (7) Chldrens	CONG (7) Chldrens	CONG (7) Chldrens	BR (3) BAPTIST	BR (3) BAPTIST	BR (3) BAPTIST	Plastics (1) UMCNO	Plastics (1) UMCNO	Plastics (1) UMCNO	CMF (3) BAPTIST	CMF (3) BAPTIST	CMF (3) BAPTIST
HO- 5B	BR (3) BAPTIST	BR (3) BAPTIST	BR (3) BAPTIST	CONG (7) Chldrens	CONG (7) Chldrens	CONG (7) Chldrens	CMF (3) BAPTIST	CMF (3) BAPTIST	CMF (3) BAPTIST	Plastics (1) UMCNO	Plastics (1) UMCNO	Plastics (1) UMCNO
HO- 6A	AS (2) HOS	AS (2) HOS	AS (2) HOS	AVR (1) UMCNO	AVR (1) UMCNO	AVR (1) UMCNO	AS (2) HOS	AS (2) HOS	AS (2) HOS	AVR (1) UMCNO	AVR (1) UMCNO	AVR (1) UMCNO
HO- 6B	AVR (1) UMCNO	AVR (1) UMCNO	AVR (1) UMCNO	AS (2) HOS	AS (2) HOS	AS (2) HOS	AVR (1) UMCNO	AVR (1) UMCNO	AVR (1) UMCNO	AS (2) HOS	AS (2) HOS	AS (2) HOS

LEGEND:

ANES= Anesthesia
AS= Aesthetic Surgery
AVR= Advanced Reconstruction
Plastic= Basic Platstic
BR= Breast
BU= Burn Unit
CMF= Craniomaxillofacial, Microsurgery
CONG= Congenital and Cleft
Derm= Dermatology
EM- Emergency Medicine
GS= General Surgery
HAND= Hand Surgery
ICU= Critical Care
NS= Neurosurgery
OP- Ophthalmology
ORTHO= Orthopedic Surgery
OS- Oral Surgery
TP= Transplant
TRAUMA= Trauma Surgery
VS= Vascular Surgery

ROTATION SITES:

1 UMCNO- University Medical Center New
2 HOS= Houma Outpatient
3 Baptist= Ochsner Baptist
4 TOURO= Touro Infirmary
5 BRG-B- Baton Rouge Genern Burn Center
6 BRG= Baton Rouge General
7 Childrens= Children's Hospital
8 EJ= East Jefferson
9 OLOL= Our Lady of the Lake
10 VA= Veteran's Administration
11 Tulane- Tulane Medical Center
12 WJ- West Jefferson Medial Center

* Please note: The VA rotation is expected to be completed during the PGY-3 year.
Upon Opening, the VA will replace the 2 Hand rotations at UMCNO and 1 Plastics Rotation at UMCNO

Goals and Objectives of the Integrated Residency Rotations:

Goals & Objectives at UMCNO
Plastic Surgery
PGY-1

Rotation Goals

At the end of the rotation, the resident should be able to perform routine inpatient care for plastic surgery patients. They are introduced to plastic surgery principles to be applied to solve a variety of problems, including emergency room consults, lacerations, minor hand trauma and other simple problems. They will learn to write orders and start to understand evaluation of patient's problems.

Rotation Objectives

A. Patient Care

During the rotation, the resident must:

1. Perform a satisfactory history and physical examination
2. Learn to decide what laboratory and radiological tests are necessary.
3. Learn to write orders for inpatient plastic surgery patients
4. Manage postoperative complications with close supervision in adults, including infections, nutrition and wound healing problems
5. Gain operative exposure and appropriate technical skills in general plastic surgery
6. Obtain technical knowledge of plastic surgery problems including:
    a. Suture technique
    b. Principles of bone fixation
    c. Evaluation of radiological studies in fractures of the head and neck and hand.
    d. basics of wound healing
    e. Make rounds on patients with the senior residents
    f. Understand the admission, transfer and discharge planning for inpatients
    g. Gain operative experience with skin grafts, local flaps,, complex wound closure

B. Medical Knowledge

During the rotation, the resident should:

1. Begin to acquire knowledge of head and neck, hand, trunk and extremity anatomy
2. Learn the commonly used medication for plastic surgery patients
3. Begin to understand the core plastic surgery knowledge.
4. Begin to understand the basic surgical principles of tissue handling and avoidance of injury to normal tissue.

C. Interpersonal and Communication Skills

During the rotation, the resident must demonstrate:

1. The ability to communicate with the patients and their families
2. Learn to discuss risks and expectations with the patient prior to surgery
3. Ability to communicate with colleagues on other services, office staff, nurses and OR personnel
4. Learn to write cogent notes in the medical record.

D. Professionalism

During the rotation, the resident must demonstrate:

1. Punctuality, a professional demeanor and reliable performance of all duties
2. Consistent attendance at clinic and procedures to which he/she is assigned
3. Appropriate dress and grooming
4. Respect to all healthcare workers (i.e. faculty, staff, residents and fellows)
5. Respect of the patient's right to privacy and confidentiality

E**. Practice Based Learning and Improvement**

During this rotation, the resident should have:

1. Attend all laboratories as well prepared as possible
2. Attend conferences, do the required readings and participate in the conferences
3. Ability to use digital photography for photo documentation.

F. Systems Based Practice

During the rotation, the resident must demonstrate a good level of understanding of:

1. Basic plastic surgery principles
2. Teamwork with other divisions on a multidisciplinary service (emergency)
3. Become familiar with and use computerized medical information systems.

Goals and Objectives at UMCNO:
Plastic Surgery
PGY 2

Goals of the rotation: Residents in the PGY-3 & PGY-4 rotation will be assigned to the University Medical Center for a Plastic Surgery Service. Additionally they will be assigned to a critical care rotation in which they will manage seriously ill patients. They will rotate as PGY-2 residents on general surgery, vascular surgery and neurosurgery as well as dermatology.

Specifically the UMC rotation will be a rotation designed to improve their skills in basic tissue dissection, understanding of surgical anatomy and working in a clinic service. These residents will be exposed to a large experience in skin tumors, lower and upper extremity surgery and surgery of the trunk as well as a high volume of adult craniomaxillofacial trauma. As a PGY-2 resident this service will allow for a good deal of progressive responsibility and the resident will be able to perform most straightforward cases with the faculty assisting him.

Rotation Objectives:

A. Patient Care

1. Residents will learn:
    a. To do specific evaluations on more complicated patients
    b. To work out a plan of care for the patients based on their diagnosis
    c. To order laboratory tests and radiological examination to support the diagnosis
    d. To schedule the patients for surgery and be certain that the patients is ready to go to the operating room.
    e. To assist in complex procedures
    f. To perform all or parts of relatively straightforward and simple procedures
        i. skin grafts and simple flaps
        ii. Treat hand injuries both operatively and non-operatively
        iii. Application of splints and casts
        iv. Placement of lines, catheters, chest tubes
        v. Management of ventilators and life support
        vi. Learn to work in the plastic surgery clinics
    g. To perform follow up care on his patients through discharge.
    h. To be aware of complications and take steps to prevent or correct them
    i. Learn the proper use of peri-operative antibiotics and pain management.

B. Medical Knowledge:

1. The resident should
    a. Demonstrate an investigatory and analytic thinking approach to clinical situations, learn about treatment plans
    b. Apply basic and clinically supportive sciences to clinical situations
    c. Know and apply knowledge to the perioperative management of the surgical patient
    d. Demonstrate knowledge of the anatomy relevant to moderately complicated surgical procedures
    e. Become certified in ALS
    f. Understand the various protocols for resuscitation.

C. Interpersonal and Communication Skills

1. Working in a Hospital requires specific interpersonal skills; residents will learn:
    a. To work effectively in an institution in which the resident's initiative is important
    b. To deal with work rules in a way that patient care is optimized
    c. To be an advocate for the patient
2. Residents will learn to employ the Information Technology System
3. Residents will write clear and concise notes on patients in clinic and on the floor
4. Transition of care is critical to allow for coordinated care of patients when the resident is not on duty. Residents will use the LSU transition process

D. Professionalism

1. The resident will be punctual and will be at clinic prior to the time the clinics begin. will attend Plastic Surgery Clinic)
2. Professional dress and grooming is expected
3. Residents will respect the privacy of the patients and guard their data
4. All consults in the hospital will be answered promptly. The PGY-2 resident will inform the senior resident of all new consults or admissions.

E. Practice Based Learning and Improvement

1. Residents will attend M&M conferences and all other plastic surgery conferences that the rotation services will allow.
2. The rotation will be lengthy enough for residents to be able to follow their patients through a continuum of care so that they can see how patients do.
3. The Residents will photo-document a case within the rules of the institution and will guard the confidentiality of the photos.

F. System Based Practice

1. Residents will learn:
    a. How the inter-hospital referral system works and how to accept and transfer patients.
    b. To access the various parts of the system in the care of VA patients.
        i. Physical therapy and occupational therapy
        ii. Home health services
        iii. Participate in discharge planning.

Goals and Objectives at UMCNO:
Plastic Surgery
PGY-3

Goals of the rotation: Residents in the PGY3 year will rotate through the Veteran's Administration Hospital. They will be responsible for administering a plastic surgical service under close supervision. There will be no higher level plastic surgery residents on this service. This will be a rotation designed to improve their skills in tissue dissection, understanding of surgical anatomy and beginning to develop skills in complex plastic surgical problems. These residents will be exposed to skin tumors, lower and upper extremity surgery and surgery of the trunk.

Rotation Objectives:

A. Patient Care

1. Residents will
    a. Admit and work up all patients admitted to the VA service
    b. Submit a plan of care to the faculty
    c. Be certain that the patient has completed all of the required workup prior to surgery

d. Perform all surgery with the faculty performing as much of the case as their preparation and abilities allow.

e. Be responsible for postoperative care, including prophylaxis against DVT, pressure sores and other problems

f. Run the VA Plastic Surgery clinic with the faculty

e. Answer consults to the plastic surgery service in the hospital

B. Medical Knowledge:

1. The resident must be competent to diagnose most problems presented to them in the clinic or on the wards. They will have had several rotations prior to this specific rotation during which they experienced a variety of plastic surgery problems.

2. The resident must know the surgical anatomy of the procedures that he is likely to encounter.

a. Surgical anatomy of the hand and upper extremities
b. Surgical anatomy of the trunk and breasts
c. Surgical anatomy of the lower extremities
d. Basic microsurgical skills
e. Anatomy and planning of flaps and grafts
f. Treatment and diagnosis of skin malignancies

C. Interpersonal and Communication Skills

1. Working in a VA Hospital requires specific interpersonal skills; residents will learn:
   a. To work effectively in an institution which is bureaucratic.
   b. To deal with work rules in a way that patient care is optimized
   c. To be an advocate for the patient
2. Residents will learn to employ the Information Technology System
3. Residents will write clear and concise notes on patients in clinic and on the floor
4. Transition of care is critical to allow for coordinated care of patients when the resident is not on duty. Residents will use the LSU transition process

D. Professionalism

1. The resident will be punctual and will be at clinic prior to the time the clinics begin.
2. Professional dress and grooming is expected
3. Residents will respect the privacy of the patients and guard their data
4. All consults in the hospital will be answered promptly. The PGY-3 resident will inform the staff of all new consults or admissions.

E. Practice Based Learning and Improvement

1. Residents will attend all conferences
2. The rotation will be lengthy enough for residents to be able to follow their patients through a continuum of care so that they can see how patients progress.
3. The Residents will photo-document a case within the rules of the institution and will guard the confidentiality of the photos.

F. System Based Practice

1. Residents will learn:
    a. How the inter-hospital referral system works and how to accept and transfer patients.
    b. To access the various parts of the system in the care of VA patients.
        i. Physical therapy and occupational therapy
        ii. Home health services
        iii. Discharge planning

Goals and Objectives for Plastic Surgery PGY-4:

The PGY four year builds on the experience gained by the earlier years. The rotations are at Our Lady of the Lake and Touro Hospital

Goals of the rotation: Residents in the PGY-4 rotation will be assigned to the Touro and Our Lady of the Lake hospital for a Plastic Surgery Service.
This will be a rotation designed to improve their skills in tissue dissection, gaining competence of surgical anatomy and working in a clinic service. PGY-4 resident on this service will allow for a good deal of progressive responsibility and the resident will be able to perform most of the cases with the faculty assisting him.

Rotation Objectives:

A. Patient Care

1. Residents will
    a. Admit and work up all patients admitted to the service
    b. Submit a plan of care to the faculty
    c. Be certain that the patient has completed all of the required workup prior to surgery
    d. Perform all surgery with the faculty and do as much as their skills allow.
    e. Be responsible for postoperative care, including prophylaxis against DVT, pressure sores and other problems
    f. Run the Plastic Surgery clinic with the faculty
    e. Answer consults to the plastic surgery service in the hospital

B. Medical Knowledge:

1. The resident must be competent to diagnose most problems presented to them in the clinic or on the wards. They will have had several rotations prior to this specific rotation during which they experienced a variety of plastic surgery problems and should be increasing familiar with them.
2. The resident must know the detailed surgical anatomy of the procedures that he is likely to encounter.
    a. Surgical anatomy of the hand and upper extremities
    b. Surgical anatomy of the head and neck
    c. Surgical anatomy of the trunk and breasts
    d. Surgical anatomy of the lower extremities
    e. Basic microsurgical skills
    f. Anatomy and planning of flaps and grafts

g. Treatment and diagnosis of skin malignancies

C. Interpersonal and Communication Skills

1. Working in a General Medical Hospital requires specific interpersonal skills; residents will learn:
    a. To work effectively in an institution which is heavily bureaucratic.
    b. To deal with work rules in a way that patient care is optimized
    c. To be an advocate for the patient
2. Residents will learn to employ the Information Technology System
3. Residents will write clear and concise notes on patients in clinic and on the floor
4. Transition of care is critical to allow for coordinated care of patients when the resident is not on duty. Residents will use the LSU transition process

D. Professionalism

1. The resident will be punctual and will be at clinic prior to the time the clinics begin. (PGY-4 will attend Plastic Surgery Clinic)
2. Professional dress and grooming is expected
3. Residents will respect the privacy of the patients and guard their data
4. All consults in the hospital will be answered promptly. The PGY-4 resident will inform the staff of all new consults or admissions.

E. Practice Based Learning and Improvement

1. Residents will attend all teaching conferences
2. The rotation will be lengthy enough for residents to be able to follow their patients through a continuum of care so that they can see how patients do.
3. The Residents will photo-document a case within the rules of the institution and will guard the confidentiality of the photos.

F. System Based Practice

1. Residents will learn:
    a. How the inter-hospital referral system works and how to accept and transfer patients.
    b. To access the various parts of the system in the care of VA patients.
        i. Physical therapy and occupational therapy
        ii. Home health services
        iii. Discharge planning

Interim LSU Public Hospital Rotation: Goals and Objectives
Plastic Surgery PGY-5

Rotation Goals

The PGY-5 year is completely plastic surgery rotations. The residents will rotate at the Children's Hospital for three months each. They will rotate at the Ochsner Baptist Hospital for 6 months and at University Medical Center for three months. The Children's rotation is craniofacial, cleft lip and palate and pediatric plastic surgery. The educational director is a fellowship trained craniofacial surgeon. The Ochsner Baptist rotation is primarily for breast reconstruction and cranio-maxillofacial (adult) trauma. While at the University Medical Center, the residents are junior residents preparing for their senior rotation the following year.

Rotation Objectives

A. Patient Care

During the rotation, the resident must:

1. Learn to evaluate pediatric patients for cleft lip and craniofacial surgery
2. Learn the appropriate procedures for cranio-synostosis, both syndromic and non-syndromic.
3. Learn to prescribe medications in the pediatric population
4. Learn the appropriate treatment for pediatric facial fractures
5. Be able to perform microvascular anastomosis and harvest free flaps with increasing level of responsibility
6. Improve technical performance in increasingly difficult cases.
7. Understand and learn how to plan and execute major maxillofacial reconstruction
8. Develop skills in breast reconstruction, including autologous and non-autologous reconstruction

B. Medical Knowledge

During the rotation, the resident should:

1. Demonstrate adequate knowledge of the genetics of cranio-facial anomalies
2. Demonstrate sufficient of surgical options in craniomaxillofacial reconstruction
3. Be aware of the current literature dealing with cleft lip, craniofacial anomalies and cranio-maxillofacial reconstruction.
4. Develop knowledge of vascular anomalies and the treatment.

C. Interpersonal and Communication Skills

During the rotation, the resident must demonstrate:

1. Appropriate communication skills with the patients and their parents
2. Ability to discuss risks and expectations with the patient prior to surgery
3. Ability to communicate with colleagues on other services, office staff, nurses and OR personnel
4. Leadership qualities when running a a craniofacial team

D. Professionalism

During the rotation, the resident must demonstrate:

1. Punctuality, a professional demeanor and reliable performance of all duties
2. Attend all clinic and procedures to which he/she is assigned
3. Appropriate dress and grooming
4. Respect to all healthcare workers (i.e. faculty, staff, residents and fellows)
5. Respect of the patient's right to privacy and confidentiality

E**. Practice Based Learning and Improvement**

During this rotation, the resident should have:

1. Surgical knowledge to compare treatment approaches suggested in the literature
2. Surgical knowledge to identify complications and formulate a plan to identify problems and correct them in the future
3. Ability to use digital photography to document his/her patient's course

F. Systems Based Practice

During the rotation, the resident must demonstrate an understanding of:

1. Become familiar with the various electronic medical records at these hospitals
2. Teamwork with other divisions on a multidisciplinary service such as the cleft palate team.

Advanced Reconstruction at UMCNO
Goals and Objectives
PGY-6

Rotation Goals

At the end of the rotation, the resident is expected to demonstrate a level of competence which will enable them to practice without supervision.

Rotation Objectives

A. Patient Care

During the rotation, the resident must:

1. Be able to independently examine patients, identify problems and undertake plan of care development.
2. Order diagnostic tests in a clear and economical way.
3. be able to schedule cases and arrange for insurance approval prior to each case
4. Demonstrate ability provide leadership in a multidisciplinary team
5. Demonstrate ability to recognize and manage postoperative complications in adults, including infections, nutrition and wound healing problems
6. Perform entre procedures with minimal assistance

7. Be competent to operate successfully on all of the following categories:
    a. Extremity trauma
    b. Facial trauma
    c. Hand trauma
    d. Delayed wound healing
    e. Macromastia
    f. Oncologic reconstruction of the breast and head and neck
    g. Free tissue transfers

B. Medical Knowledge

During the rotation, the resident should:

1. Be able to show a clear understanding of the core curriculum which they have been exposed to for 6 years.
2. Demonstrate adequate knowledge of the literature
3. Have sound judgement and a commitment to lifetime learning

C. Interpersonal and Communication Skills

During the rotation, the resident must demonstrate:

1. Appropriate communication skills with the patients and their families
2. Ability to and understanding of informed consent.
3. Ability to communicate with colleagues on other services, office staff, nurses and OR personnel
4. Leadership qualities when running a busy plastic surgery service

D. Professionalism

During the rotation, the resident must demonstrate:

1. Punctuality, a professional demeanor as an example to the junior residents
2. Superb attendance at clinic and procedures to which he/she is assigned
3. Appropriate dress and grooming
4. Respect to all healthcare workers (i.e. faculty, staff, residents and fellows)
5. Respect of the patient's right to privacy and confidentiality

E**. Practice Based Learning and Improvement**

During this rotation, the resident should have:

1. Surgical knowledge to compare treatment approaches suggested in the literature
2. Surgical knowledge to identify complications and formulate a plan to identify problems and correct them in the future
3. Ability to use digital photography to document his/her patient's course
4. be committed to lifetime learning

F. Systems Based Practice

During the rotation, the resident must demonstrate an understanding of:

1. General plastic surgery principles
2. Teamwork with other divisions on a multidisciplinary service (emergency)
3. Ability to manage patients both in the hospital and to utilize alternative levels of care.

Trauma at UMCNO
Goals and Objectives
PGY-1

Rotation Goals:

Plastic Surgeons frequently are called upon to treat patient with multisystem trauma. This rotation should equip the resident with experience to be able to evaluate and treat patients admitted to a level one trauma unit. This would enable them to be competent to evaluate and treat these patients facial and extremity trauma.

Rotational Objectives:

A. Patient Care

1. Initial evaluation of trauma patients
    a. Neurological injuries of the brain
        i. Focused examination of cranial nerves
        ii. Focus examination of spinal and peripheral nerves
        iii. Evaluation of corneal and pupil reflexes
        iv. Evaluation of respiratory drive and ability to swallow
    b. Injury to the craniofacial skeleton
        i. Evaluation of extra-ocular motion function
        ii. Evaluation of injury to lids, cornea, globe
        iii. Physical examination of intra and extra oral skeletal stability
        iv. Interpretation of radiological examinations in craniofacial trauma
    c. Injury to the airway
        i. Evaluation of obstruction of the upper airway
        ii. Emergent intubation and airway control
        iii. Tracheotomy
    d. Chest and lung trauma
        i. Evaluation of chest wall motion
        ii. Auscultation and percussion
        iii. Interpretation of radiological examination of the chest
        iv. Treatment of hemo-pneumo-thorax
            1. Insertion of chest tube
            2. Management and removal of chest tube
    e. Injuries of the abdomen
        i. Physical examination of the abdomen in non-penetrating trauma
        ii. Evaluation of penetrating trauma
        iii. Emergency Laporotomy
        iv. Interpretation of radiological examination of the abdomen

f. Injuries of the upper and lower extremities
    i. Examination of range of motion of the extremities
    ii. Examination of neuro-circulatory condition of the extremities
    iii. Diagnosis and treatment of Compartment syndromes
        1. Fasciotomy of the upper and lower extremity
    iv. Evaluation of radiological examinations of the extremities

g. Management of penetrating and non penetrating injuries to the neck
h. Burns
    v. Emergency Burn treatment
        1. Airway management in acute burns
        2. Fluid resuscitation in acute burns.
        3. Escharotomy
        4. Evaluation of electrical burns and fasciotomy

i. Envenomation treatment

B. Medical Knowledge

1. The resident will know the function of the cranial and spinal nerves
2. The anatomy of the facial bones and mandible will be studied
3. The resident will become familiar with the anatomy of the neck and upper respiratory system and the recommended management of injuries to these structures.
4. The resident will attend conferences dealing the bowel, liver, kidney and spleen and the best practices for dealing with the injuries.
5. The resident will study the vascular and neuroantatomy of the upper and lower extremities and the recommended methods of treatment of injuries to these structures.
6. The resident will study the pathophysiology of thermal and electrical burns. He will understand burn resuscitation and management of fluids and electrolytes. He will be familiar with the avoidance of burn wound sepsis.
7. The resident will know about bites and envenomation toxins and their recommended treatment.

C. Interpersonal and Communication Skills

1. In the trauma setting, communication between team members is critical and the resident will learn to communicate with team members, patients and families.
2. The resident will be sensitive to patients who are unable to communicate in English. He will be aware of the resources for interpreters and how to use them to communicate with his patients.
3. The resident will write cogent and informative notes
4. The resident will answer pages promptly
5. The resident will adhere to sound transition policies

D. Professionalism

1. Courtesy and professional conduct will occur when answering consults to the ER.
2. The resident will be immediately available as per trauma protocol
3. Communication with the family will be achieved even with difficult or hostile families

4. The resident will become aware of fatigue, its recognition and the proper response to it. The resident will be provided with a faculty member to contact if fatigue is an issue.

E. Practice Based Improvement

1. The resident will become familiar with trauma protocols and best practices
2. The resident will participate in all trauma conferences and rounds
3. The resident will participate in Morbidity and Mortality conference and present any patients that he has cared for.
4. The resident will complete any required readings as assigned to him during the rotation

F. System Wide Care

1. The resident will understand the continuum of care from the Emergency Medical Services to the Emergency Department, consultation and assumption of care of the patient.
2. The resident will understand the necessity of teamwork in trauma care. He will be especially exposed to working with a large number of surgeons, consultants, therapists and others who are involved in the trauma care program.

3. The resident will undertake to teach medical students who are on the service and incorporate them in the care of his patients

Orthopedics: Goals and Objectives
PGY-1

Rotation Goals: Plastic Surgeons are frequently involved in treatment of fractures, especially in the hand and the head and neck. It is important to be familiar with fracture healing, reduction and internal fixation. It is also important to be able to apply properly fitting splints and casts. Additionally Plastic Surgeons frequently work as a team with orthopedics in lower extremity trauma.

Rotation Objectives:

A. Patient Care

1. The plastic surgery resident will learn to take a focused history of orthopedic patients
2. Examination of patients with extremity trauma will be learned.
3. The plastic surgery resident will learn about principles of open reduction and internal fixation of fractures.
4. The resident will learn to apply casts and splints to the upper and lower extremity.
5. The resident will become familiar with radiography in the diagnosis of fractures and major orthopedic trauma

B. Medical Knowledge

1. The resident will understand the principles of bone healing
2. The resident will become familiar with the anatomy of the upper and lower extremities
3. The resident will understand how to apply internal and external fixation devices.
4. The resident will understand the classification of tibial fractures
5. The resident will learn about dislocation and reduction.

C. Interpersonal and Communication Skills

1. The plastic surgery resident will understand the syntax and language of bony anatomy, injury and repair and will be better able to communicate with orthopedic colleagues.

2. The resident will attend clinics and learn to work with a communicate with cast therapists, occupational and physical therapists.
3. The residents will understand the critical nature of radiographs when dealing with all extremity trauma and disease.
4. The resident will write clear and concise notes on patients on the service

D. Professionalism

1. The resident will lean to deal compassionately with patients with orthopedic injuries
2. Patient who have language problems will be given special attention and the use of interpreters will be critical.
3. The resident will learn the value of adequate documentation with transition

E. Practice Based Improvement

1. The resident will complete the assigned readings during the course of the rotation
2. The resident will attend clinics and follow the patients with whom he has been involved to determine what their outcomes are.
3. The resident will understand the protocols for orthopedic trauma and best practices

Emergency Medicine: Goals and Objectives
Plastic Surgery PGY-1

Rotation Goals: Plastic surgeons in many institutions serve the emergency room patients. They should understand how an emergency unit operates and how patients are triaged. They should manage simple injuries and be able to evaluate patients presenting to the emergency room. At the end of the rotation, the resident should be able to triage patients, evaluate patients with trauma or medical conditions, understand basic medications used in the emergency room and perform surgical procedures commonly done in the emergency unit.

Rotation Objectives:

A. **Patient Care**

1. Evaluation of the acutely traumatized patient
    a. Airway management
        i. Evaluation of patency of airway
        ii. Intubation
        iii. Primary Ventilator management
        iv. Integrity of chest wall and diagnosis of pneumothorax
    b. Control of bleeding
        i. Use of direct pressure
        ii. ER procedures to reduce hemorrhage
        iii. Diagnosis of acute abdominal injuries
    c. Maintaining Circulation
        i. Insertion of peripheral and central lines
        ii. Understanding resuscitation with crystalloids
        iii. Monitoring of urine output

        iv. Insertion of urinary catheters
2. Diagnosis of the acute abdomen in non trauma patients
    a. Physical Examination of the abdomen
    b. Evaluation of ancillary lab and radiological examination
3. Diagnosis and treatment of sepsis
    a. Understanding the signs and symptoms of sepsis
    b. Understanding the process of determining the source of the sepsis
    c. Initiating effective treatment
4. Diagnosis and treatment of Neurological injuries and diseases
    a. Application of the Glasgow coma scale in acute injuries
    b. Performing a neurological examination
    c. Understanding radiologic examinations
5. Suturing techniques in the ER
    a. Evaluation and cleaning of the wound
    b. Determining if deep structures are involved
    c. Simple skin repair techniques
    d. When to obtain consultation
6. Evaluation and treatment of hand injuries
    a. Learning examination of the hand
        i. Tendon and muscle
        ii. Nerves
        iii. Diagnosing fractures of the hand and wrist
        iv. Interpreting radiological examination of the hands

7. Evaluation and treatment of facial injuries
    a. Evaluation for facial fractures
    b. Evaluation for involvement of deeper structure injuries
    c. Evaluation for soft tissue injuries to the peri-orbital structures
8. Understanding and treating allergic reaction
9. Evaluation of patients who have acute respiratory distress
    a. Understanding monitors and blood gasses
    b. Determining when ventilator support is indicated
    c. Becoming familiar with commonly used respiratory drugs and therapy
    d. Interpretation of radiological evaluations
10. Evaluation of patients with chest pain and arrhythmias
    a. Conducting a code
        i. ACLS guidelines
        ii. Medications used during codes
        iii. Use of Defibrillators and anti arrhythmic drugs
    b. Evaluating chest pain

i. Interpreting the EKG in the ER
ii. Understanding Blood Gasses and their implication in cardio-respiratory disease.

c. Understanding common cardiac medications

B. Medical Knowledge

1. The anatomy and physiology of the upper airway, trachea and lungs
2. The anatomy of the hand, including nerves, bones and tendons
3. The physical and radiological anatomy of the face, including facial bones
4. The doses, indication and contra-indication of commonly used drugs in the emergency room
5. Knowledge of the central and peripheral nervous system, how anatomy can reveal the site of dysfunction.

C. Interpersonal and Communication Skills

1. The resident will become sensitive to patients who have no ability to communicate in English
2. The resident will understand how to use interpreters
3. The resident will learn to compassionately communicate with families
4. The resident will learn effective transition of care when patients leave his care.

D. Professionalism

1. Work as a team member with other physicians, nurses and other persons on the team
2. Deal with disruptive or hostile patients
3. Work constructively with family members
4. Place the patient's needs first and foremost.

E. Practice Based Improvement

1. The resident will be exposed to emergency room protocols
2. The resident will attend group meetings and PI meetings held by ER personnel during the rotation.
3. The resident will be present when consultants see patients and learn how to improve primary care of the patient.
    a. They will become aware of any errors made in initial diagnosis
    b. They will be exposed to a higher level of training and experience

F. System Based Practice

1. Emergency Medical Services protocol
2. How the ER physicians triage patients
3. How to use consultants effectively
4. Seamless care from the street to the ICU or surgery

Goals and Objectives for General Surgery at UMCNO
Plastic Surgery
PGY-1

Rotation Goals:

Residents starting as PGY1 residents will need to have progressive responsibility in surgical skills through the PGY-3 level. These skills include: care of surgical patients, medical knowledge of the anatomy and pharmacology of surgical care, dissecting techniques and avoidance of untoward events. These basic skills will be required as they transition into the full plastic surgery curriculum. Following their general surgery rotations the residents will be expected to have sound judgment in the care of surgical patients and will the operative skills that will be sufficient for them to transition to the technical demands of plastic surgery.

Rotation Objectives:

A. Patient Care

1. Residents should be able to do comprehensive history and physical examination on new patients in the hospital and clinics.
2. They should be able to formulate a workup, with necessary supporting laboratory and radiologic studies.
3. By the PGY-2 level they should be able to formulate a treatment plan which is appropriate to the diagnosis.
4. They should be able to write appropriate orders for treatment protocols
    a. Antibiotics
    b. DVT prophylaxis
    c. Pain management
    d. Respiratory treatments
    e. Cardiovascular disease
    f. Diabetes
    g. Diet and nutrition
    h. Coagulation and hyper coagulation
5. Procedures:
    a. Central line placement (PGY-1)
    b. Wound care, VAC dressings (PGY-1)
    c. Simple and complex wound repair (PGY-1 and PGY-2)
    d. Handle soft tissue atraumatically (PGY-1)
    e. Chest tube placement (PGY-2)
    f. Hernia, appendectomy, minor surgery procedures (PGY-2)
    g. Scrub and assist on major abdominal and chest procedures
6. Residents should be competent to run a code

B. Medical Knowledge

1. Residents should know the dosage, indications and contraindications of commonly prescribed medications. (PGY 1 and 2)
    a. Pain medication
    b. Antibiotics
    c. Diabetic medications
    d. Medications for treatment of respiratory insufficiency
    e. Major types of cardiovascular treatment
        i. hypertension
        ii. cardiac insufficiency
        iii. Cardiovascular disease
        iv. Anti-hypertensives
    f. Drugs used in resuscitation
    g. Drugs used in codes
    h. Drugs used in wound healing
    i. Anticoagulants
2. Residents should develop knowledge of surgical anatomy
    a. abdomen and viscera
    b. chest, lungs and heart
3. Demonstrate investigatory and analytic thinking approach to clinical situations
4. Know and apply basic science in the treatment of surgical patients

C. Interpersonal and Communication Skills:

1. Relationships with patients are critical. Residents will develop a sound, ethical and therapeutic relationship with their patients.
2. Post-discharge planning will be thorough and made clear to patients
3. Residents will become good listeners and use listening skills to acquire pertinent information in order to make therapeutic decisions.
4. Residents will write clear notes which state the problems are the plans
5. Residents will respond promptly to pages from everyone on the team.

D. Professionalism:

1. They will demonstrate respect, compassion and integrity to meet the needs of their patients.
2. They will be accountable; will attempt to use resources wisely.
3. They will maintain confidentiality and guard their patient's privacy
4. They will have clear transitions of care.
5. They will demonstrate sensitivity and responsiveness to patient's culture, age, gender and disability.
6. They will be sensitive to language problems and use interpreters as needed.
7. The resident will be aware of fatigue steps to take when fatigue is recognized.

E. Practice Based Learning and improvement

1. The resident will begin to use systematic methodology for analyzing patient outcomes.
2. The resident will access information from the literature frequently to select best practices management for his patients.
3. The residents will participate in medical education for medical students on the rotation.

F. Systems-Based Practice

1. The resident should demonstrate the ability to enlist other members in the spectrum of patient support when caring for his patients. This includes social service, therapists, durable medical equipment, home health services and others.
2. The resident will consult other physicians when the patient requires input.
3. The resident will understand that surgical practice is not isolated and that it is part of a large system of health care.

Dermatology Rotation: Goals and Objectives
Plastic Surgery PGY-1

Rotation Goals:

Plastic surgeons treat patients with cutaneous lesions on a regular basis. There is very little in the prerequisite training programs that prepare them for the diagnosis and treatment of surface lesions and conditions of the skin. Residents should be able to diagnose straightforward skin lesions and differentiate benign and malignant lesions. They should understand the use of cryotherapy and electro-desiccation and curettage.

Rotation Objectives:

A. Patient Care

1. Recognition and outpatient therapy of benign lesions and lesions of uncertain behavior
    a. Topical medications
    b. Shaving, biopsy techniques
    c. The use of lasers
2. The procedures utilized for malignant lesions
    a. Appropriate use of biopsy vs. excision
    b. Electrodessication and curettage.
    c. Cryotherapy
    d. Excision and closure techniques used in dermatology
    e. The MOH principle in malignant cutaneous disease.
3. The physical examination of dermatologic lesions and how to differentiate between benign and malignant disease.

B. Medical Knowledge

1. To be familiar with the physical characteristics supporting diagnosis by physical examination of the lesion.
2. Understand lesions of unknown behavior and premalignant lesions.
3. The resident will be exposed to and learn to clinical course of the most common malignancies.
4. The resident will be exposed to the more common familial syndromes which result in malignant change later in life.

C. Communication and Interpersonal Skills

a. Learn how the dermatologist is able to see patients efficiently and in high volume
b. Learn how the dermatologist gives patients advice about the avoidance of risks for skin cancer

D. Professionalism

a. Attending clinics as scheduled
b. Professional appearance while in the clinics
c. Respecting the privacy and protecting the integrity of patient records.

E. System Wide Health Care

a. Understand prevention of skin lesions by actinic damage
b. Counseling patients in sunscreens and sun protection
c. Understanding the relationship between dermatology and plastic surgery and how patients can benefit from that relationship.

Neurosurgery rotation: Goals and Objectives
PGY2

Rotation Goals: Plastic Surgeons are frequently called upon to treat patients with Craniomaxillofacial trauma. They normally do so in concert with neurosurgeons, so experience on a neurosurgical service should provide insight into how the neurosurgeons treat head trauma. The rotation will take place at MCLANO, which is a level one trauma center. They should leave the rotation with the ability to classify neurosurgical trauma, the emergency procedures required and the issues that may complicate repair of facial fractures.

Rotation Objectives:

A. Patient Care

1. Residents will learn how to evaluate patients with head trauma
2. They will become familiar with the coma and head trauma classification
3. They will understand how to determine if surgical intervention is needed
4. They will learn how to monitor patients with severe head trauma
5. They will be exposed to surgery required for treatment of head trauma

B. Medical Knowledge

1. They will become familiar with the anatomy of the skull
2. They will learn how to interpret radiologic examinations of the skull

3. They will learn about spinal fluid leak, subdural and epidural hematomas and their treatment.

C. Interpersonal and Communication Skills

1. They will be a part of the neurosurgical team
2. They will learn to write cogent notes which document the care of their patients on neurosurgery.
3. They will learn how cooperation between the neurosurgery and plastic surgery services benefit patient progress.
4. They will communicate changes in the patients neurological status to senior residents promptly and accurately.

D. Professionalism

1. They will answer all pages promptly
2. They will be sensitive to patient special needs, especially language problems and family support.
3. They will be careful to relay information about the patient only to those who are eligible to receive it.

E. Practice Based Learning and Improvement

1. They will be exposed to best practices in head trauma management
2. They will attend neurosurgery conferences while on the service

F. System Based Care

1. They will learn how neurosurgery integrates into a level one trauma center
2. They will learn about the team management of these patients between neurosurgery, ophthalmology, and plastic surgery.
3. They will work with social workers and physical therapist to learn how they can be helpful in treatment of these complex patients.

Critical Care at UMCNO
Goals and Objectives
PGY-2

Rotation Goals:

Plastic Surgeons frequently are called upon to treat patient with multisystem trauma in the critical care setting. This rotation should equip the resident with experience to be able to evaluate and treat patients admitted to a level one trauma unit.

Rotational Objectives:

B. Patient Care

2. Initial evaluation of trauma patients admitted to the critical care area
    a. Review admitting order to ensure appropriateness
    b. Appropriately apply the principles of Basic Cardiac Life Support (BLS), Advanced Cardiac Life Support (ACLS) and Advanced Trauma Life Support (ATLS) to the critically ill and injured surgical critical care patient
    c. Actively direct the resuscitation of patients in shock
    d. Neurological injuries of the brain
        i. Focused evaluation of cranial nerves

ii. Focus examination of spinal and peripheral nerves
iii. Evaluation of corneal and pupil reflexes for evident of ocular trauma
iv. Evaluation of respiratory drive and ability to swallow

e. Injury to the craniofacial skeleton
i. Evaluation of injury to lids, cornea, globe
ii. Physical examination of intra and extra oral skeletal stability
iii. Interpretation of radiological examinations in craniofacial trauma

f. Injury to the airway
i. Evaluation of adequacy of the upper airway
ii. Emergent intubation and airway control
iii. Tracheotomy

g. Chest and lung trauma
i. Evaluation of chest wall motion
ii. Auscultation and percussion
iii. Interpretation of radiological examination of the chest
iv. Treatment of hemo-pneumo-thorax
1. Insertion of chest tube
2. Management and removal of chest tube

h. Injuries of the abdomen
i. Physical examination of the abdomen in non-penetrating trauma
ii. Emergency Laporotomy
iii. Interpretation of radiological examination of the abdomen
iv. Management of tracheal support

i. Injuries of the upper and lower extremities
i. Examination of range of motion of the extremities
ii. Examination of neuro-circulatory condition of the extremities
iii. Diagnosis and treatment of Compartment syndromes
1. Fasciotomy of the upper and lower extremity
iv. Evaluation of radiological examinations of the extremities

j. Management of penetrating and non penetrating injuries to the neck

k. Burns
v. Emergency Burn treatment
1. Airway management in acute burns
2. Fluid resuscitation in acute burns.
3. Escharotomy
4. Evaluation of electrical burns and fasciotomy

l. Envenomation treatment

m. Master common Critical Care procedures, including:
1. Arterial and venipuncture
2. Insertion of central venous line
3. Tube thoracostomy
4. Placement of pulmonary artery catheter with appropriate interpretation of the catheter readings

5. Intubation

B. Medical Knowledge

1. The resident will know the function of the cranial and spinal nerves
2. The anatomy of the facial bones and mandible will be studied
3. The resident will become familiar with the anatomy of the neck and upper respiratory system and the recommended management of injuries to these structures.
4. The resident will read about injuries to the bowel, liver, kidney and spleen and the best practices for dealing with the injuries.
5. The resident will study the vascular and neuroantatomy of the upper and lower extremities and the recommended methods of treatment of injuries to these structures.
6. The resident will study the pathophysiology of thermal and electrical burns. He will understand burn resuscitation and management of fluids and electrolytes. He will be familiar with the avoidance of burn wound sepsis.
7. The resident will know about bites and envenomation toxins and their recommended treatment.

C. Interpersonal and Communication Skills

1. In the trauma setting, communication between team members is critical and the resident will learn to communicate with team members, patients and families.
2. The resident will be sensitive to patients who are unable to communicate in English. He will be aware of the resources for interpreters and how to use them to communicate with his patients.
3. The resident will write cogent and informative notes
4. The resident will answer pages promptly
5. The resident will adhere to sound transition policies

D. Professionalism

1. Courtesy and professional conduct will occur when answering consults to the ER.
2. The resident will be immediately available as per trauma protocol
3. Communication with the family will be achieved even with difficult or hostile families
4. The resident will become aware of fatigue, its recognition and the proper response to it.

E. Practice Based Improvement

1. The resident will become familiar with trauma protocols and best practices
2. The resident will participate in all trauma conferences and rounds
3. The resident will participate in Morbidity and Mortality conference and present any patients that he has cared for.
4. The resident will complete any required readings as assigned to him during the rotation

F. System Wide Care

1. The resident will understand the continuum of care from the Emergency Medical Services to the Emergency Department, consultation and assumption of care of the patient.
2. The resident will understand the necessity of teamwork in trauma care. He will be especially exposed to working with a large number of surgeons, consultants, therapists and others who are involved in the trauma care program.

3. The resident will undertake to teach medical students who are on the service and incorporate them in the care of his patients.

Goals and Objectives for General Surgery
Plastic Surgery PGY2

Rotation Goals:

Residents starting as PGY1 residents will need to have progressive responsibility in surgical skills through the PGY-3 level. These skills include: care of surgical patients, medical knowledge of the anatomy and pharmacology of surgical care, dissecting techniques and avoidance of untoward events. These basic skills will be required as they transition into the full plastic surgery curriculum. Following their general surgery rotations the residents will be expected to have sound judgment in the care of surgical patients and will the operative skills that will be sufficient for them to transition to the technical demands of plastic surgery.

Rotation Objectives:

A. Patient Care

1. Residents should be able to do comprehensive history and physical examination on new patients in the hospital and clinics.
2. They should be able to formulate a workup, with necessary supporting laboratory and radiologic studies.
3. By the PGY-2 level they should be able to formulate a treatment plan which is appropriate to the diagnosis.
4. They should be able to write appropriate orders for treatment protocols
    a. Antibiotics
    b. DVT prophylaxis
    c. Pain management
    d. Respiratory treatments
    e. Cardiovascular disease
    f. Diabetes
    g. Diet and nutrition
    h. Coagulation and hyper coagulation
5. Procedures:
    a. Central line placement (PGY-1)
    b. Wound care, VAC dressings (PGY-1)
    c. Simple and complex wound repair (PGY-1 and PGY-2)
    d. Handle soft tissue atraumatically (PGY-1)
    e. Chest tube placement (PGY-2)

f. Hernia, appendectomy, minor surgery procedures (PGY-2)
g. Scrub and assist on major abdominal and chest procedures

6. Residents should be competent to run a code.

B. Medical Knowledge

1. Residents should know the dosage, indications and contraindications of commonly prescribed medications. (PGY 1 and 2)
    a. Pain medication
    b. Antibiotics
    c. Diabetic medications
    d. Medications for treatment of respiratory insufficiency
    e. Major types of cardiovascular treatment
        i. hypertension
        ii. cardiac insufficiency
        iii. Cardiovascular disease
        iv. Anti-hypertensives
    f. Drugs used in resuscitation
    g. Drugs used in codes
    h. Drugs used in wound healing
    i. Anticoagulants
2. Residents should develop knowledge of surgical anatomy
    a. abdomen and viscera
    b. chest, lungs and heart
3. Demonstrate investigatory and analytic thinking approach to clinical situations
4. Know and apply basic science in the treatment of surgical patients

C. Interpersonal and Communication Skills:

1. Relationships with patients are critical. Residents will develop a sound, ethical and therapeutic relationship with their patients.
2. Post-discharge planning will be thorough and made clear to patients
3. Residents will become good listeners and use listening skills to acquire pertinent information in order to make therapeutic decisions.
4. Residents will write clear notes which state the problems are the plans
5. Residents will respond promptly to pages from everyone on the team.

D. Professionalism:

1. They will demonstrate respect, compassion and integrity to meet the needs of their patients.
2. They will be accountable; will attempt to use resources wisely.
3. They will maintain confidentiality and guard their patient's privacy
4. They will have clear transitions of care.

5. They will demonstrate sensitivity and responsiveness to patient's culture, age, gender and disability.
6. They will be sensitive to language problems and use interpreters as needed.
7. The resident will be aware of fatigue steps to take when fatigue is recognized.

E. Practice Based Learning and improvement

1. The resident will begin to use systematic methodology for analyzing patient outcomes.
2. The resident will access information from the literature frequently to select best practices management for his patients.
3. The residents will participate in medical education for medical students on the rotation.

F. Systems-Based Practice

1. The resident should demonstrate the ability to enlist other members in the spectrum of patient support when caring for his patients. This includes social service, therapists, durable medical equipment, home health services and others.
2. The resident will consult other physicians when the patient requires input.
3. The resident will understand that surgical practice is not isolated and that it is part of a large system of health care.

d. PA catheter use and interpretation
e. Medications used in the ICU Setting

Burn Rotation: Goals and Objectives
Plastic Surgery PGY 2

Rotation Goals:

The care of the burn victim will benefit plastic surgery residents because it gives them the opportunity to learn a great deal about thermal injuries, electrical injuries and chemical injuries. With the global expansion of terrorism, it is quite likely that these types of injuries will, unfortunately, be seen in the community. Studying burn wounds allows the resident to understand injury and wound healing. While many may not treat large acute burns in their practices, they will likely see smaller burns and deformities that can occur after healing. They will get experience in a number of procedures which have applicability beyond acute burn care.

Rotation Objectives:

A. Patient Care

1. Residents will
    a. be able to evaluate burn victims for ABC of trauma
    b. be able to evaluate the percentage burn
    c. determine if escharotomy is necessary
    d. determine if intubation is necessary
2. Initiation of therapy by resuscitation
    a. Crystalloid resuscitation will be planned and initiated
    b. Patients will be monitored for adequacy of resuscitation

c. Addition of albumin or blood will be done as required

3. Initiation of burn wound sepsis prophylaxis
4. Initiation of DVT prophylaxis
5. Use of splints in burns of the hand and feet
6. Burn care procedures
    a. intubation
    b. bronchoscopy
    c. escharotomy
    d. tangential excision
    e. debridement
    f. application of homograft or acellular dermal matrix
    g. split thickness skin grafting
    h. fasciotomy
7. Diagnose and treat chemical burns
8 Diagnose and treat electrical injuries
9, Learn to take steps to prevent post burn deformity.

B. Medical Knowledge

1. Residents will know the pathophysioloy of thermal burns and how to determine thickness. They will know the "rule of nines" for adults and children.
2. Airway burns and ARDS are not uncommon in burn patients with inhalation injuries. Residents must understand the pathophysioloy of inhalation injury and its treatment.
3. Prevention of sepsis is important in burns. Residents will learn about topical antimicrobials, antibiotics, burn wound incision and treatment of burn wound sepsis
4. Residents will know the Parkland Formula for resuscitation and how to manage it.
5. Residents will know the difference between electrical, thermal and chemical burns
6. Specific therapy for common chemical burns will be learned
7. Effect of electrical burns on the heart, skin and muscle will be learned

C. Interpersonal and Communication Skills

1. Burns wounds are tremendously hard on families. Residents will learn to deal with the families in a patient and compassionate manner.
2. Residents will maintain cogent and up to date notes on their patients when on the service.
3. Residents will communicate frequently with other team members, especially burn wound therapists, from whom they can learn a great deal.

D. Professionalism

1. Dealing with burn wound victims and their families requires the ultimate professionalism.
    a. families are frequently extremely distraught and frightened
    b. patients can have a horrible appearance and be difficult for residents to face
    c. families and patients require an unbelievable amount of psychological support.
2. Residents will assist in teaching medical students who may be on the rotation.

E. Practice Based Learning and Improvement

1. The common burn protocol and best practices will be learned

2. Residents will attend all conferences and clinics on the service to see the outcomes of patients in the units.

3. Residents will review the selected readings on acute burns prior to starting the rotation.

F. System Based Practice Objectives

1. In no other area of surgery is so much done to patients by members of a team. Residents must appreciate the contributions made by other team members
    a. burn wound therapists
    b. inhalation therapists
    c. social workers
    d. occupational and physical therapy
2. There is likewise a tremendous amount to be learned about burn care from the dedicated team members and residents must humble themselves to learn from them.

Anesthesia Rotation: Goals and objectives
Plastic Surgery PGY-2

Plastic surgery is now largely performed either as outpatient or 23 hours stay. Additionally many surgeons have operating rooms in their office which raises important patient safety issues. In order to learn the important working relationship between outpatient plastic surgery and outpatient anesthesia; a rotation in the anesthesia department was established. Residents should be able to administer conscious sedation, intubate patients, induce anesthesia and recover patients in the outpatient surgery unit.

Rotation Goals:

The anesthesia rotation will provide an educational experience to plastic surgery residents which will provide increased safety for patients undergoing plastic surgery procedures

Rotation Objectives: Residents will learn:

A. Patient Care

1. Residents will learn accepted and safe anesthesia techniques
    a. Induction medications and the choice of airway management
    b. Intubation and LMA placement
    c. Monitoring vital signs (Blood Pressure, C02, P02 etc.)
    d. Types of inhalant anesthetics and intravenous anesthetics and how they are used
    e. Maintenance of blood pressure and intravascular volume
    f. The principles of administering outpatient anesthesia
    g. Postoperative nausea and its prevention
    h. Conscious sedation and Monitored Anesthesia Care
    i. Medical Knowledge Prophylaxis for DVT

B. Medical knowledge

1. Residents will be exposed to the classification of anesthetic risks and how these risks apply to the selection of patients to be done in the outpatient setting.
2. Residents will know the most commonly used inhalant and intravenous agents, their indications and risks of use.
3. Residents will know the common agents used for conscious sedation and the appropriate levels of sedation and how to monitor and maintain them.
4. Residents will become familiar with the anesthesia and monitoring equipment used in the operating room.

C. Interpersonal and Communication skills

1. Communication between the anesthesiology staff and the patients are important to avoid patient safety issues. Patients must be counseled about the safety of continuing home medications before and after anesthesia.
2. The importance of communication between the anesthesia staff and the physician is very important. Among these issues are:
    a. What type of patients are optimal candidates for:
        i. Monitored Anesthesia
        ii. LMA airway management
        iii. Intubation, including route of intubation
    b. What position is best and will avoid problems with airway management and nerve injury?
    c. Importance of communication during procedures between the anesthesia staff and the surgeon so that the surgeon is aware of problems arising during the procedure.
    d. Importance of conferring about preoperative morbidity:
        i. Pulmonary problems including COPD and Sleep Apnea
        ii. Hypertension control
        iii. Chronic use of steroids
        iv. Diabetes
        v. Previous history of difficulty with anesthesia or familial history.

D. Professionalism

1. Residents will learn the issues of the team members who are providing anesthesia services to their patients.
2. Residents will become aware of the issues of anesthesia consents and how to best alert patients to the risks of anesthesia while maintaining patient confidence.

E. Practice Based Learning and Improvement

1. Residents will be exposed to how anesthesia measures outcomes.
2. Residents will be exposed to the issues around planned discharge from the outpatient setting:
    a. Prolonged emergence from anesthetic medications
    b. Problems with prolonged Postoperative Nausea
    c. Concerns about doing suboptimal patients in the outpatient settings

F. Systems Based Practice

1. Residents will be exposed to the continuum of care from outpatient admission to discharge.
2. The importance of avoiding complications from the anesthesia which will require hospital admission.
3. Necessity of good working understanding between surgeon and anesthesia staff about the appropriateness of selecting outpatient setting for complicated patients or procedures.

Ophthalmology Rotation: Goals and Objectives

PGY-2

Rotation Goals: Plastic Surgeons frequently perform peri-orbital procedures. It is important that the surgeon understand how to examine the eye, and what to look for when approaching a patient with orbital trauma, or in preparation for blepharoplasty. The plastic surgeon should be aware of potential complications and the need for consultation. They should be able to describe problems to the ophthalmologist so that communication is adequate.
They should understand the importance of preoperative evaluations, and how to perform rudimentary tests to rule out complicating problems.

Rotation Objectives:

A. Patient Care

1. Residents will learn to take a focused history of the visual system
2. Examination of the eye will become familiar to the resident
    a. evaluation of lid position, ptosis
    b. evaluation of the cornea and anterior chamber
    c. examination of the retina
    d. evaluation of lubrication of the eye
    e. evaluation of extra-occular motion
3. Resident will understand the more common examinations performed by ophthalmologists
    a. use of the slit lamp
    b. measurement of lubrication and tearing
    c. measurement of visual fields
    d. measurement of tension
4. Residents will be introduced to lid reconstruction
    a. upper lid reconstruction

b. lower lid reconstruction

5. Resident will understand treatment of ocular emergencies.

B. Medical Knowledge

1. Resident will become familiar with the anatomy of the orbit
    a. eyelid anatomy
    b. anatomy of the globe
    c. anatomy of the extraoccular muscles.
    d. common medications used in ophthalmology
2. Resident will be exposed to conditions complicating blepharoplasty
    a. diagnosis of ptosis, types of ptosis and repairs
    b. dry eye syndrome
    c. chemosis
    d. orbital hematoma and blindness

C. Interpersonal relationship and communication

1. Resident will become familiar with the terms that ophthalmologists use in describing injuries and disease of the eye.
2. Residents will understand the practice of the ophthalmologist and the patients that is seen in the clinic and how to communicate with these patients.
3. Residents will understand the importance of clear and concise notes.

D. Professionalism

1. Patient confidentiality is very important and residents will learn to be very cautious about discussing patients in public
2. The plastic surgery resident will be courteous to the ophthalmologists with whom they are experiencing the rotation.

E. Practice Based Improvement

1. Resident will be assigned readings from the literature at the beginning of the rotation
2. Residents will attend clinics so that they can see the results of surgery on patients that they have encountered.
3. Residents will gain a store of knowledge that will assist them in eyelid surgery.

F. System Based Practice

1. The resident will understand the relationship between the ophthalmologist and the plastic surgeon, especially the importance of preoperative workup
2.The resident will understand the need for consultation when problems occur following blepharoplasty

Goals and Objectives of Vascular Surgery Rotation
Plastic Surgery PGY-2

Rotation Goals:

Because plastic surgeons frequently are involved in extremity trauma, it is important for them to know the vascular anatomy of the extremities and how to access vessels for later training in microsurgery. Additionally residents must be familiar with vascular disease and vascular repair. At the end of the rotation the resident will have a working knowledge of the vascular anatomy of the upper and lower extremity and neck. They will have learned to handle tissue gently and have experienced vessel repair and vein grafting.

Rotation Objectives:

A. Patient Care

1. Residents should be able to perform a competent physical examination of the vascular system.
2. Residents should be able to perform vascular access including central lines
3. Residents will learn how to approach the vessels in the extremities and head and neck which will prepare them for access in microsurgery.
4. Residents will learn basic arterial repair techniques, including end to end and end to side.
5. Residents will learn the principles of vein grafting, including harvest, flow issues and anastamosis
6. Residents will learn how to evaluate the swollen limb. They will learn to differentiate between venous and arterial skin necrosis. They will become familiar with compressive dressings.
7. Residents will understand vascular injuries, their diagnosis and treatment

B. Medical Knowledge

1. Residents will learn:
    a. the vascular anatomy of the upper and lower extremity and neck
    b. hypercoagulability, coagulation and medications used in treatment of clotting disorders.
    c. venous disease and its relationship to edema and ulceration.
    d. diabetes and neurovascular pathology in the lower extremity.

C. Interpersonal and Communication Skills

1. Residents will
    a. be able to communicate to patients the reasons for their vascular problems and what they need to do in order to help solve their problem.
    b. write legible and concise notes when they see patients in the hospital or clinics.
    c. be courteous and helpful when relating to other residents, faculty and patients.
    d. Provide information to patients in a timely fashion
2. Communication about risk factors should be part of communication with families and patients.

D. Professionalism

1. Demonstrate respect, compassion, and integrity to meet the needs of the patients and society
2. Demonstrate accountability to patients, society, and the medical profession
3. Maintain the confidentiality of patient information and provide informed consent
4. Understand and provide sound, ethical business practices
5. Demonstrate sensitivity and responsiveness to patient's culture, age, gender and disabilities
6. Maintain a professional demeanor in difficult or sensitive patient encounters

E. Practice-Based Learning and Improvement

1. Understand the use of systematic methodology for practice analysis and perform practice-based improvement.
2. Locate, appraise, and assimilate evidence from scientific studies related to patient health problems. Residents will attend vascular surgery conferences.
3. Participate in or facilitate the learning of students who are on the vascular surgery rotation and other health care professionals.

F. Systems-Based Practice

1. Demonstrate the ability to effectively call on system resources to provide optimal patient care. This includes providers of durable medical equipment, orthotics and mobility devices
2. Many medical conditions including diabetes and obesity have serious impact on vascular disease. Residents should understand the interrelationships between their practice and the larger system of the center and the health care system as a whole.
3. Understand continuum of care issues specific to injured patients.

Interim LSU Public Hospital Hand Rotation: Goals and Objectives
PGY-3

Rotation Goals:

At the end of the rotation the resident should demonstrate that he/she is familiar with both traumatic and elective surgery of the hand and upper extremity. He/she should be able to treat peripheral nerve problems and arthritic diseases of the hand and be capable of performing reconstructive procedures, such as tendon transfers. Residents attend hand clinics with the faculty.

Rotation Objectives:

1. Patient Care

By the end of the rotation, the resident should be able to:

A. Obtain the patient's medical history and perform physical examination of the upper extremity to formulate a diagnostic and therapeutic plan.
B. Apply splints and casts and understand their indication.

C. Manage post-operative care and participate in rehabilitation of the hand as a member of the medical team.
D. Make accurate diagnoses and formulate a surgical plan for hand pathology:
    1. Surgery of traumatic injuries including primary and secondary reconstruction of tendons and nerves
    2. Surgery of entrapment neuropathies and tendon transfers following nerve injury
    3. Surgery following amputation, including flaps, replantation surgery and soft tissue coverage
    4. Treatment of fingertip injuries
    5. Diagnosis and establishment of treatment plan for arthritis of the hand
    6. Diagnose and treat infections of the hand and upper extremity
    7. Exhibit familiarity with and have operative experience with fractures of the upper extremity
    8. Pediatric hand fractures
    9. Acute fractures and dislocations of the hand and wrist joints

2. Medical Knowledge

By the end of the rotation, the resident will have:

A. Adequate knowledge of the anatomy and physiology of the tendons, nerves, ligaments and joints of the upper extremity
B. Competence in utilizing radiographic examination of the hand and upper extremity for accurate diagnosis
C. Knowledge of electro diagnostic studies and the ability to use them for adequate diagnosis
D. Ability to diagnose and treat benign and malignant tumors of the soft tissue of the hand
E. Developed knowledge of tumors arising in the bone, and their diagnosis and treatment
F. Knowledge of the diagnosis and treatment of inflammatory and proliferative diseases of the hand, including Dupuytren's contracture, joint contracture and arthritis

3. Interpersonal and Communication Skills

During the rotation, the resident is expected to:

A. Communicate well with the patient and his/her family
B. Obtain informed patient consent and discuss the patient's risks and expectations prior to surgery
C. Communicate effectively with office staff, nurses and OR personnel

4. Professionalism

The resident must demonstrate:

A. A professional demeanor, punctuality and reliability in regard to the performance of his/her duties

B. Responsibility for clinic and surgery when called upon
C. Sensitivity to the patient's right to privacy and confidentiality

5. Practice Based Learning and Improvement

The resident must be able to:

A. Compare a patient's preoperative condition and postoperative results in a critical manner
B. Identify complications and formulate a plan to handle them and prevent them in the future
C. Use the library and online resources to access literature and apply that literature to his/her cases

6. Systems Based Practice

By the end of the rotation, the resident is expected to be:

A. Aware of malingering and dystrophic conditions and be able to differentiate them
B. An active participant in hand therapy management
C. Cognizant of hand surgery safety issues such as the following:
    1. Proper use of tourniquet time and pressure
    2. Avoidance of injuries from improperly applied casts and splints
    3. Importance of magnification and operating in a bloodless field
    4. Importance of periods of immobilization to prevent stiffness

Resident Responsibilities

Residents on this rotation will work closely with the faculty. They will attend his private hand clinics. They be able to form a treatment plan for the patients. They will also see postoperative patients and compare the preoperative result with the treatment plan, including radiography. The resident will operate with the faculty on their private service. If there are hand cases in the hospital, the resident will round on them daily. Residents will take call for the faculty during this two month rotation, but will be completely free from call one day in seven. This rotation is a first year rotation and the resident will assist at the beginning of the rotation. As the resident's knowledge and operative skills increase, they will also increase their operative responsibility. Residents will also learn to work as a team with therapists and others on the hand team.

Hand and Upper Extremity Faculty-Supervision and Responsibilities

Dr. Hal Stokes is the supervising faculty for the Hand and Upper Extremity rotation. is. The rotation is an intensive immersive experience and residents on this rotation will work full time with the hand faculty in the operating room and office with one-on-one supervision.

Teaching: Provide both didactic and clinical instruction in surgery of the upper hand and extremity.

Supervision: All surgery done on the service and all clinics.

Formal Education: Responsible for core curriculum related education for hand surgery.

GOALS AND OBJECTIVES FOR TRANSPLANT SURGERY ROTATION

(HO 3 or HO 4)

Medical Knowledge Objectives for HO 3 or 4:

1. Resident will participate in the following critical learning experiences:
    a. Management of patients with end-stage liver and renal disease
    b. Management of diabetic patients
    c. Dialysis access
    d. Organ transplantation
    e. Immunosuppression

2. Residents are expected to:
    a. Understand the impact of diabetes, renal failure, liver disease on patient evaluation and management, with specific attention to impact on surgical decision making and post-operative care.
    b. Formulate comprehensive management plans for patients with lesions of the liver, bile ducts, and pancreas
    c. Effectively interact with a multidisciplinary team to provide quality patient care

3. Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social behavioral sciences, as well as the application of this knowledge to patient care by:
    a. Understanding the pathophysiology, immunology, and indications for transplantation.
    b. Understanding the criteria for brain death and the indications and contraindications for organ procurement from all types of donors
    c. The ability to describe procedures used for provision of dialysis

4. Residents must be able to discuss the indications for and results of kidney, pancreas, liver, and intestinal transplantation.

Patient Care Objectives for HO 3 or 4:

1. Residents must be able to perform the following procedures:
    a. Dialysis Access Surgery
    b. Abdominal Organ Harvest
    c. Laparoscopic Donor Nephrectomy
    d. Kidney Transplant

2. Residents should participate and assist in orthotopic liver transplant.

Interpersonal and Communication Skills Objectives for HO 3 or HO 4:

1) Create and sustain a therapeutic and ethically sound relationship with patients
2) Use effective listening skills and elicit and provide information using effective communication skills applicable to a broad range of socio-economic and cultural backgrounds.
3) Work effectively with others as the leader of the team and as a member of the broader hospital community
4) Pass on important patient information to his /her faculty in a timely manner
5) Respond appropriately and in a timely manner to pages, consults and requests for attention
6) Maintain accurate and up to date medical records.

Professionalism Objectives for HO 3 or HO 4:

1) Demonstrate respect, compassion, and integrity to meet the needs of the patients and society
2) Demonstrate accountability to patients, society, and the medical profession
3) Maintain the confidentiality of patient information and provide informed consent
4) Understand and provide sound, ethical business practices
5) Demonstrate sensitivity and responsiveness to patient's culture, age, gender and disabilities
6) Maintain a professional demeanor in difficult or sensitive patient encounters

Practice-Based Learning and Improvement Objectives for HO 3 or HO 4:

1) Use systematic methodology for practice analysis and perform practice-based improvement.
2) Locate, appraise, and assimilate evidence from scientific studies related to patient health problems.
3) Participate in or facilitate the learning of students and other health care professionals.

Systems-Based Practice Objectives for HO 3 or HO 4:

1) Demonstrate the ability to effectively call on system resources to provide optimal patient care
2) Understand the interrelationships between their practice and the larger system of the health care system as a whole.
3) Understand continuum of care issues specific to injured patients

General Surgery at UMCNO
Goals and Objectives
PGY3

Rotation Goals:

Residents starting as PGY1 residents will need to have progressive responsibility in surgical skills through the PGY-3 level. These skills include: care of surgical patients, medical knowledge of the anatomy and pharmacology of surgical care, dissecting techniques and avoidance of untoward events. These basic skills will be required as they transition into the full plastic surgery curriculum. Following their general surgery rotations the residents will be expected to have sound judgment in the care of surgical patients and will the operative skills that will be sufficient for them to transition to the technical demands of plastic surgery.

Rotation Objectives:

A. Patient Care

1. The resident should be able to:
    a. Obtain accurate historical information from patients with complex surgical problems.
    b. Perform physical examinations on patient with complex surgical diseases or injuries.
    c. Make appropriate diagnostic and therapeutic decisions based on the information that he has derived.
    d. Take charge of the patient's care in the preoperative and postoperative period. They should examine their patients frequently and note important changes in the patient's condition
    e. Manage surgical patients with complicating medical problems

i. Diabetic patients
ii. Patients with cardiac deficiencies
iii. Malnourished patients.
iv. Chronic lung disease
v. Endocrine disease.

f. Perform procedures appropriate to the PGY-3 level of training:

i. Laparotomy
ii. Laparoscopic cholecystectomy and common duct exploration
iii. Mastectomy and axillary dissection
iv. Anatomic resection and gastrointestinal anastomosis (gastric resection, small bowel resection, and colon resection)
v. Thyroid and parathyroid surgery
vi. EGD and colonoscopy

2. Demonstrate appropriate knowledge and skills managing patients in the intensive care unit (with supervision)
3. Triage and manage acutely injured patients including:
i. Resuscitation
ii. Interpretation of blood gases
iii. Mechanical ventilation modes and uses
iv. PA catheter use and interpretation
v. Medications used in the ICU Setting

B. Medical Knowledge

1. Demonstrate an investigatory and analytic thinking approach to clinical situations in which they encounter complex surgical problems.
2. Apply basic and clinically supportive sciences appropriate to the PGY-3 level of training. Have a competent knowledge of abdominal and thoracic anatomy and physiology.
3. Understand the pharmacology and interactions of commonly used drugs in the intensive care unit
4. Be able to competently manage the ventilator support for complex patients.
5. Understand the anatomy and physiology relevant to thyroid and parathyroid surgery
6. Understand the pathophysioloy of commonly encountered surgical problems
   a. abnormal conditions of the thyroid gland and treatment
   b. The pathophysioloy of chest diseases and chest trauma.
   c. Disease of the abdominal organs and conditions arising from trauma to the abdominal contents.
   d. Understand the anatomy and function of the abdominal wall and chest.

C. Interpersonal and Communication Skills:

1. Relationships with patients are critical. Residents will develop a sound, ethical and therapeutic relationship with their patients.
2. Post-discharge planning will be thorough and made clear to patients

3. Residents will become good listeners and use listening skills to acquire pertinent information in order to make therapeutic decisions.
4. Residents will write clear notes which state the problems are the plans
5. Residents will respond promptly to pages from everyone on the team.

D. Professionalism:

1. They will demonstrate respect, compassion and integrity to meet the needs of their patients.
2. They will be accountable; will attempt to use resources wisely.
3. They will maintain confidentiality and guard their patient's privacy
4. They will have clear transitions of care.
5. They will demonstrate sensitivity and responsiveness to patient's culture, age, gender and disability.
6. They will be sensitive to language problems and use interpreters as needed.
7. The resident will be aware of fatigue steps to take when fatigue is recognized.

E. Practice Based Learning and improvement

1. The resident will begin to use systematic methodology for analyzing patient outcomes. As they progress they will come to understand how to interpret articles published in the literature.
2. The resident will access information from the literature frequently to select best practices management for his patients.
3. They will begin a lifelong learning process for their surgical careers.
4. The residents will participate in medical education for medical students on the rotation.

F. Systems-Based Practice

1. The resident should demonstrate the ability to enlist other members in the spectrum of patient support when caring for his patients. This includes social service, therapists, durable medical equipment, home health services and others.
2. The resident will consult other physicians when the patient requires a different level of knowledge.
3. The resident will understand that surgical practice is not isolated and that it is part of a large system of health care.

Anesthesia Rotation: Goals and objectives
Plastic Surgery PGY-3

Plastic surgery is now largely performed either as outpatient or 23 hours stay. Additionally many surgeons have operating rooms in their office which raises important patient safety issues. In order to learn the important working relationship between outpatient plastic surgery and outpatient anesthesia; a rotation in the anesthesia department was established. Residents should be able to administer conscious sedation, intubate patients, induce anesthesia and recover patients in the outpatient surgery unit.

Rotation Goals:

The anesthesia rotation will provide an educational experience to plastic surgery residents which will provide increased safety for patients undergoing plastic surgery procedures

Rotation Objectives: Residents will learn:

G. Patient Care

2. Residents will learn accepted and safe anesthesia techniques
    a. Induction medications and the choice of airway management
    b. Intubation and LMA placement
    c. Monitoring vital signs (Blood Pressure, C02, P02 etc.)
    d. Types of inhalant anesthetics and intravenous anesthetics and how they are used
    e. Maintenance of blood pressure and intravascular volume
    f. The principles of administering outpatient anesthesia
    g. Postoperative nausea and its prevention
    h. Conscious sedation and Monitored Anesthesia Care
    i. Medical Knowledge Prophylaxis for DVT

H. Medical knowledge

1. Residents will be exposed to the classification of anesthetic risks and how these risks apply to the selection of patients to be done in the outpatient setting.
2. Residents will know the most commonly used inhalant and intravenous agents, their indications and risks of use.
3. Residents will know the common agents used for conscious sedation and the appropriate levels of sedation and how to monitor and maintain them.
4. Residents will become familiar with the anesthesia and monitoring equipment used in the operating room.

I. Interpersonal and Communication skills

3. Communication between the anesthesiology staff and the patients are important to avoid patient safety issues. Patients must be counseled about the safety of continuing home medications before and after anesthesia.
4. The importance of communication between the anesthesia staff and the physician is very important. Among these issues are:
    a. What type of patients are optimal candidates for:
        i. Monitored Anesthesia
        ii. LMA airway management
        iii. Intubation, including route of intubation
    b. What position is best and will avoid problems with airway management and nerve injury?
    c. Importance of communication during procedures between the anesthesia staff and the surgeon so that the surgeon is aware of problems arising during the procedure.
    d. Importance of conferring about preoperative morbidity:
        i. Pulmonary problems including COPD and Sleep Apnea
        ii. Hypertension control
        iii. Chronic use of steroids
        iv. Diabetes
        v. Previous history of difficulty with anesthesia or familial history.

J. Professionalism

3. Residents will learn the issues of the team members who are providing anesthesia services to their patients.
4. Residents will become aware of the issues of anesthesia consents and how to best alert patients to the risks of anesthesia while maintaining patient confidence.

K. Practice Based Learning and Improvement

3. Residents will be exposed to how anesthesia measures outcomes.
4. Residents will be exposed to the issues around planned discharge from the outpatient setting:
    a. Prolonged emergence from anesthetic medications
    b. Problems with prolonged Postoperative Nausea
    c. Concerns about doing suboptimal patients in the outpatient settings

L. Systems Based Practice

4. Residents will be exposed to the continuum of care from outpatient admission to discharge.
5. The importance of avoiding complications from the anesthesia which will require hospital admission.

6. Necessity of good working understanding between surgeon and anesthesia staff about the appropriateness of selecting outpatient setting for complicated patients or procedures.

Oral Surgery: Goals and Objectives
PGY-3

Rotation Goals:

Although our residents are exposed to major craniofacial reconstruction and trauma in their later years of residency, we feel that a rotation in oral surgery will be of great benefit to our residents. We also hope that the experience will inspire the residents to continue activities in maxillofacial surgery following graduation. The rotation will be with the Department of Oral and Maxillofacial surgery at LSU. During this rotation the residents will gain experience in the treatment of mandibular and maxillary fractures. They will learn to treat patients with simple and complex fractures, in the OR and the clinic. At the end of the rotation they should be well prepared to start training in complex craniomaxillofacial surgery.

Rotation Objectives:

A. Patient Care

1. Residents will learn to evaluate and diagnose fractures of the maxilla and mandible.
2. Residents will use radiographs, including cat scans and Panorex to document the fractures
3. Airway issues and neurosurgical issues involving maxillofacial fractures will be learned
4. Occlusion and malocclusion will be studied in detail
5. Residents will learn procedures involved in oral surgery
    a. Interdental wiring
    b. Application of splints and other forms of occlusion stabilization
    c. Application of fixation devices including plates and screws
    d. Surgical approaches to fractures of the mandible and maxilla
    e. Procedures on the mandible for malocclusion and excursion
    f. Osteotomies of the facial bones
6. Residents will be exposed to orthognathic procedures and the diagnosis of occlusion, including cephalometrics and modeling.
7. Residents will learn the basic principles in evaluation and management of tempromandibular joint disorders

B. Medical Knowledge

1. Residents will learn the anatomy of the maxillofacial area
2. Residents will learn the principles of occlusion and malocclusion
3. Residents will be familiar with the principles of rigid and semi rigid fixation of maxillofacial fractures
4. The function of the tempromandibular joint and the muscles of mastication will be learned.

5. Residents will learn the classification of maxillofacial injuries and be familiar with the surgical repair of each.

C. Interpersonal and Communication Skills

1. In order to be able to communicate in a helpful manner, residents are expected to become familiar with terms that oral surgeons use to communicate.
2. Residents will write cogent and concise notes on patients on their service
3. Residents will work in the oral surgery clinics and will show interest and eagerness to participate in care in the clinics.

D. Professionalism

1. Residents will act professionally at all times while on the service and approach the oral surgery residents and faculty with respect and due consideration for their skills
2. Residents will assume call responsibility while on the service and will be prompt to answer calls.
3. Residents will treat oral surgery patients in a compassionate and helpful manner. They will explain the importance of postoperative dental care and diet.

E. Practice Based Improvement

1. Residents will read the Selected Readings in Plastic Surgery discussing craniomaxillofacial trauma prior to beginning the rotation.
2. Residents will attend all clinics to follow patients that they were involved with in the hospital service and clinics.
3. Residents will maintain a log of procedures done while on the service and discuss these cases with the program director.

F. System Based Practice

1. Residents will learn to work with both oral surgery staff and other team members in the oral surgery clinic. Teams may consist of hygienists, prosthodontists, pediatric dentists and others.
2. Residents will learn the importance of oral surgery specialists in the continuum of care for patients with maxillofacial problems

Hand and Upper Extremity Rotation
PGY 4

Rotation Goals:

At the end of the rotation the resident should demonstrate that he/she is familiar with both traumatic and elective surgery of the hand and upper extremity. He/she should be able to treat peripheral nerve problems and arthritic diseases of the hand and be capable of performing reconstructive procedures, such as tendon transfers.

Rotation Objectives:

A. Patient Care

By the end of the rotation, the resident should be able to:

1. Obtain the patient's medical history and perform physical examination of the upper extremity to formulate a diagnostic and therapeutic plan.
2. Apply splints and casts and understand their indication.
3. Manage post-operative care and participate in rehabilitation of the hand as a member of the medical team.
4. Make accurate diagnoses and formulate a surgical plan for hand pathology:
    a. Surgery of traumatic injuries including primary and secondary reconstruction of tendons and nerves
    b. Surgery of entrapment neuropathies and tendon transfers following nerve injury
    c. Surgery following amputation, including flaps, replantation surgery and soft tissue coverage
    d. Treatment of fingertip injuries
    e. Diagnosis and establishment of treatment plan for arthritis of the hand
    f. Diagnose and treat infections of the hand and upper extremity
    g. Exhibit familiarity with and have operative experience with fractures of the upper extremity
    h. Pediatric hand fractures
    i. Acute fractures and dislocations of the hand and wrist joints

B. Medical Knowledge

By the end of the rotation, the resident will have:

1. Adequate knowledge of the anatomy and physiology of the tendons, nerves, ligaments and joints of the upper extremity
2. Competence in utilizing radiographic examination of the hand and upper extremity for accurate diagnosis
3. Knowledge of electro diagnostic studies and the ability to use them for adequate diagnosis
4. Ability to diagnose and treat benign and malignant tumors of the soft tissue of the hand
5. Developed knowledge of tumors arising in the bone, and their diagnosis and treatment
6. Knowledge of the diagnosis and treatment of inflammatory and proliferative diseases of the hand, including Dupuytren's contracture, joint contracture and arthritis

C. Interpersonal and Communication Skills

During the rotation, the resident is expected to:

1. Communicate well with the patient and his/her family

2. Obtaining informed patient consent and discuss the patient's risks and expectations
3. Communicate effectively with office staff, nurses and OR personnel

D. Professionalism

The resident must demonstrate:

1. Professional demeanor, punctuality and reliability in regard to the performance of his/her duties
2. Responsibility for clinic and surgery when called upon
3. Sensitivity to the patient's right to privacy and confidentiality

E. Practice Based Learning and Improvement

The resident must be able to:

1. Compare a patient's preoperative condition and postoperative results in a critical manner
2. Identify complications and formulate a plan to handle them and prevent them in the future
3. Use the library and online resources to access literature and apply that literature to his/her cases

F**. Systems Based Practice**

By the end of the rotation, the resident is expected to be:

1. Aware of malingering and dystrophic conditions and be able to differentiate them
2. An active participant in hand therapy management
3. Cognizant of hand surgery safety issues such as the following:
    i. Proper use of tourniquet time and pressure
    ii. Avoidance of injuries from improperly applied casts and splints
    iii. Importance of magnification and operating in a bloodless field
    iii. Importance of periods of immobilization to prevent stiffness

Congenital and Cleft Lip Pediatric Plastic Surgery
Children's Hospital New Orleans
PGY 5

Rotation Goals

Residents will attend a large craniofacial clinic and surgery at the Children's Hospital. They will see the team approach to congenital deformities of the head and neck and also will see adult craniofacial surgery as well. At the end of the rotation, the resident should demonstrate understanding of special plastic surgical problems and that he/she has reasonable experience and capabilities to care for these children.

Rotation Objectives

A. Patient Care

The resident should:

1. Learn surgical skills and patient management specific to infants, children and young adults
2. Obtain sufficient historical data from parents and children and perform an adequate physical examination to formulate a treatment plan.
3. Learn to ode drugs in appropriate dosage ranges and give appropriate fluid measurements
4. Have adequate operative exposure and appropriate technical skills in the following general pediatric plastic surgery categories: Knowledge of techniques of cleft lip and palate surgery including:
    a. Unilateral Cleft Lip Repair
    b. Bilateral Cleft Lip Repair
    c. Palatoplasty
    d. Pharyngeal Flaps
    e. Cleft Lip Nose Repair
    f. Revision of Cleft
5. Have operative experience with:
    a. Synostosis, simple and complex
    b. Crouzon's, Apert's and other syndromes associated with craniosynostosis.
    c. Treacher Collins, Pierre Robin, Microsomia and other clefts and dysplasias.
6. Has had satisfactory technical experience with ear deformity:
    a. Microtia
    b. Developmental deformities
    c. Acquired deformities
7. Postoperative care for children, including pain control, fluid and electrolyte balance, wound care and antibiotic therapy
8. Be familiar with and have operative experience with acquired deformities and trauma, such as:
    a. Pediatric facial fractures
        i. Upper 1/3 face
        ii. Lower 1/3 of face
        iii. Complex lacerations of the face
    b. Acute and chronic tissue defects

2. Medical Knowledge

The resident must demonstrate understanding of:

1. Etiology, embryology and anatomy of congenital abnormalities seen in children, including:

a. Cleft lip and palate and velopharyngeal incompetence
b. Speech disorders related to cleft lip and palate
c. Understanding the syndromes of craniofacial anomalies
d. Genetic factors involving craniofacial anomalies.
e. Neural tube disorders

2. Understanding the classification of facial fractures in children and how their treatment is different than in adults.
3. Understand the clarifications and treatment of vascular anomalies

3. Interpersonal and Communication Skills

The resident should:

1. Communicate well with the patient's parents and relatives
2. Be able to obtain informed consents to parents regarding risks and expectations prior to surgery
3. Communicate effectively with health care professionals, including office staff, nurses and OR personnel
4. Learn to work with a multidisciplinary team in the clinics

4. Professionalism

The resident must demonstrate:

1. A professional, punctual and reliable demeanor when performing his/her duties
2. Constant attendance in clinics and surgery
3. Sensitivity to a diverse population; many of whom do not speak English

5. Practice Based Learning and Improvement

The resident must:

1. Demonstrate the ability to properly compare the preoperative condition and postoperative results in a critical manner
2. Be able to identify complications, formulate a management plan and prevent them in the future
3. Demonstrate the use of library and online resources and apply the information from these sources to cases
4. Use digital photography to document the course of his/her patient

6. Systems Based Practice

The resident is expected to be:

1. Aware of the risk of child abuse
2. Able to appropriate consultations from other members of the pediatric team and other staff, if needed
3. Cognizant of pediatric safety concerns, such as the following:
    a. Maintaining a normal core temperature in surgery
    b. Avoidance of excess blood loss in infants
    c. Eye protection during facial trauma surgery
    d. Airway and postoperative edema
    e. Prevention of equinus deformity in extremity trauma
    f. Prevention of decubitus ulcer

Ochsner Baptist: Goals and Objectives
Plastic Surgery Resident PGY-5

Rotation Goals:

The resident will attend microsurgical cases done at Ochsner Baptist as well as craniofacial cases done at the Ochsner Main Campus. They should also be competent to perform other types of breast surgery, including reconstruction and aesthetic breast surgery. At the end of the rotation the resident should be familiar with all flaps performed for breast reconstruction and should be able to outline a plan for craniofacial reconstruction including virtual planning procedures and multiple flap procedures.

Goals and Objectives of the rotation:

A. Patient Care: During the rotation, the resident is expected to:

4. Demonstrate caring and respectful behavior toward breast patients
5. Demonstrate that they can obtain a coherent history of breast cancer risks and genetic causes of breast cancer.
6. Demonstrate a satisfactory level of competency treating patients in these general categories of breast surgery

b. Cosmetic Breast Surgery:

7. Mastopexy
8. Breast Reduction
9. Congenital Breast Deformity (eg Poland's Syndrome)
10. Tubular Breast Deformity
11. Augmentation Mastopexy
12. Implantation surgery

d. Reconstructive Breast Surgery:

2. Autogenous Reconstruction (Immediate/Delayed)
    f. DIEP flap
    g. Gluteal Artery Perforator flaps, Inferior and Superior
    h. SIEA flap
    i. Thoracodorsal flap
    j. Local Perforator flaps
3. Implant reconstruction
4. Expander reconstruction

e. Other procedures:

4. Nipple areola reconstruction
5. Liposuction for symmetry
6. Reduction for symmetry

B. Medical Knowledge: During this rotation, the resident should:

6. Understand current treatments of breast disease.

7. Recognize the deformities resulting from mastectomy, failed reconstruction and radiation. .
8. Demonstrate adequate knowledge of breast and chest wall anatomy:
9. Recognize congenital and acquired non-oncologic breast disease
10. Understand the timing of reconstruction, chemotherapy, and radiation therapy.

C. Interpersonal and Communication Skills: During the rotation the resident must

c. Be able to relate professionally with breast patients, and is a good listener.
d. Be able to inform patients about risks and expectations prior to surgery

D. Professionalism: During the rotation the resident must:

d. Demonstrate punctuality, professional demeanor and reliable performance of his duties.

e. The resident should be attentive to the special needs of breast cancer patients, respect their privacy and confidentiality.
f. Dress appropriately

E. **Practice Based Learning and Improvement**: During the rotation, the resident should:

e. Demonstrate that he/she can compare the preoperative condition and postoperative results in breast reconstruction in a critical manner.
f. Been able to identify complications, is able to formulate a plan to deal with them and prevent them in the future.
g. Develop knowledge of the breast surgery literature and can apply information form the literature to specific cases.
h. Become knowledgeable to use of digital photography to document the patient's course.

F. Systems Based Practice: During the rotation, the resident should:

d. Demonstrate an understanding of ethical use of CPT coding for breast surgery.

e. Understand the need for multidisciplinary teamwork, for example pathology surgery oncology radiation therapy.
f. Demonstrate that he/she is cognizant of breast surgery safety:
    viii. Etiology of nipple necrosis.
    ix. Prevention of pulmonary embolism in lengthy cases.
    x. Fluid balance management during lengthy cases.
    xi. Hematoma in breast surgery
    xii. Postoperative flap monitoring.
    xiii. Prevention of hernia or abdominal weakness.
    xiv. Evaluation of causes of increased morbidity in reconstructive surgery.
    Position of patient in long cases to prevent neuropathy.

Goals and Objectives
Craniomaxillofacial Surgery
PGY-5

Rotation Goals: The goals of the Ochsner Main Campus part of the Ochsner rotation are to gain experience in major craniofacial and microsurgical surgery. The resident will participate in the craniofacial clinic and assist in complex surgery done at Ochsner Main Campus

Rotation Objectives:

A. Patient Care
   1. Resident will gain experience in the diagnosis of craniofacial anomalies
   2. Resident will understand the principles of
      a. Craniosyostosis: syndromic and non-syndromic
      b. Distraction Onsteogenesis
      c. Craniofacial Advancement
      d. Orbital dystopia
      e. Mandibulomaxillary advancement and recession

B. Medical Knowledge
   1. Resident will learn the causes of craniosynostosis
   2. Residents will become familiar with craniofacial syndromes associated with craniosynostosis
   3. Residents will learn cranial anatomy, especially in children
   4. Residents will learn principles of occlusion and mal-occlusion

C. Professionalism
   1. Residents will act professionally at all times
   2. Residents will interact in a constructive manner with patients and their families
   3. Residents will answer pages promptly and see patients in clinic as scheduled

D. Interpersonal relationship and Communication
   1. Residents will write cogent and consistent notes, both in clinic and on the floors
   2. Residents will learn teamwork and will seek to learn what other team members can teach them.
   3. Residents will learn and use the Epic IT system used at Ochsner

E. Practice based improvement
   1. Residents will attend all clinics and have the opportunity to follow patients postoperatively
   2. Residents will learn best practices in craniofacial surgery
   3. Residents will learn patient safety in lengthy procedures on young children

F. System Based Care
   1. Residents will attend a multispecialty clinic as scheduled at Ochsner Main Campus
   2. Residents will learn to interact with neurosurgeons, therapists, oral surgeons, speech therapists and otolaryngologist who work in the clinic

Aesthetic Surgery: Goals and Objectives
PGY-6

Rotation Goals:

Aesthetic surgery is a critical component in plastic surgery. The plastic surgeon has an enormous amount of competition for these cases, and the number of non-plastic surgeons in the market is increasing. Plastic surgeons must be well trained in aesthetic surgery in order to be successful in this competitive marketplace. This rotation is an intensive immersion in aesthetic surgery, both in the private and clinic sector. Residents will attend private clinic and surgery and will also attend their own senior resident aesthetic surgery clinic. At the end of the rotation, the resident will demonstrate that he/she has developed the necessary knowledge and surgical skills to evaluate and treat patients with aesthetic problems.

Objectives of the Rotation:

A. Patient Care

During the rotation, the resident will be required to:

1. Demonstrate caring and respectful behavior towards aesthetic patients
2. Demonstrate the ability to interview and listen to aesthetic patients
3. Demonstrate a satisfactory level of competency in the following general categories of aesthetic surgery:
    a. Facial plastic surgery
        i. Rhytidectomy
        ii. Eyelid and brow surgery
        iii. Rhinoplasty
        iv. Otoplasty
        v. Skin resurfacing
        vi. Fat injection/fillers
    b. Breast aesthetic surgery
        i. Breast hypoplasia
        ii. Breast ptosis
        iii. Macromastia and gynecomastia
    c. Trunk aesthetic surgery
        i. Abdominoplasty
        ii. Liposuction
        iii. Surgery after weight loss

2. Medical Knowledge

During this rotation, the resident should:

1. Understand the concepts of beauty and aesthetic principles
2. Recognize the effects of aging, photo-damage, lipodystrophy and other causes of aesthetic deformity

3. Demonstrate adequate knowledge of facial anatomy:
    a. Anatomy of the eyelids, muscles, fascia, cartilage support and function of components
    b. Principles of ptosis of the eyelids, blepharochalasis, and brow ptosis
    c. Anatomy of the facial muscles, facial nerve and fascia and their relationship to the facelift
    d. Bony and cartilaginous structures of the nose and airway
4. Be familiar with aesthetic problems of the breast, include ptosis, tubular breast and asymmetry
5. Be familiar with aesthetic and functional issues of the abdominal wall

3. Interpersonal and Communication Skills

During the rotation, the resident will be expected to:

1. Relate professionally with aesthetic patients and listen to their problems and concerns
2. Obtain an informed consent and discuss the patient's risks and expectations prior to surgery

4. Professionalism

During the rotation, the resident must:

1. Practice punctuality, demonstrate a professional demeanor and reliably perform his/her duties
2. Be sensitive to the special needs of the aesthetic patient and respect his/her privacy and confidentiality
3. Dress appropriately

5. Practice Based Learning and Improvement

During the rotation, the resident should:

1. Demonstrate that he/she can compare the preoperative condition and postoperative results in a critical manner
2. Identify complications and formulate a plan to correct them and prevent them in the future
3. Develop knowledge of the aesthetic literature and apply the information to specific cases
4. Use digital photography to document the patient's course

6. Systems Based Practice

During the rotation, the resident must:

1. Demonstrate an understanding of ethical billing for aesthetic surgery
2. Understand the use of appropriate consultation, i.e. ophthalmic consultation prior to blepharoplasty
3. Demonstrate that he/she is cognizant of safety concerns in aesthetic surgery:
    a. Volume of liposuction
    b. Causes of post-blepharoplasty blindness and problems with lid position

c. Dry eye syndrome and its prevention
d. Injuries to the facial nerve
e. Hematoma in aesthetic surgery
f. Pulmonary embolism and its prevention
g, Evaluation of cancer prior to breast surgery
h. Evaluation of nutritional status prior to surgery for massive weight loss

This rotation includes aesthetic surgery of the head and neck, trunk and extremities and the breast. All clinic cases scheduled by the residents at the outpatient facility must fulfill the certification requirement. In order to be certified as competent to perform any aesthetic case, the resident must have observed/assisted a staff member in performing that type of case and demonstrate adequate knowledge about techniques, complications and follow-up to ensure that he/she can perform the surgery. Residents must have supervision at the time of surgery.

The resident serves as Administrative Resident for the program during this rotation and schedules conferences, cadaver dissections and monthly journal club meetings. The Administrative Resident also makes up the call schedule

Chapter 4:
Didactic Curriculum

Mastering the core knowledge in plastic surgery is exceedingly challenging. The anatomic footprint of the specialty is extensive and the technical details overwhelming. Nonetheless it can be done, if an orderly and consistent effort is undertaken.

Our core curriculum is divided into approximately 30 topics. Additionally we have one conference per month to review the current literature (Journal Club) and one conference devoted to Morbidity and Mortality and Patient Safety. We also will have workshops in Anatomy, plating techniques and art.

A schedule will be arranged at the beginning of the year and we will try to adhere to it.

The weekly conferences include take place on Friday morning from 7:00am until 10:00am.The first hour and a half will be devoted to a core curriculum lecture. The remaining time will be spend n case presentations, M&M and Patient Safety, reading discussions and the "unknowns" that will be sent out weekly.

All conferences will be telecast to Baton Rouge.

The workshops include

1. Cadaver Dissection which will take place in the Fall after the General Surgery boards. One session will be upper extremity, one head and neck and on trunk and lower extremity.
2. A plating course will be given in the fall; usually during September or October.
3. A microsurgery lab will be given in the fall
4. A course on drawing, sculpture or photography will be given in the spring
5. Workshops in Injectables and fillers will be given throughout the year.

Organization of the conferences:

Core Curriculum Conference

Assigned readings will be schedule for each core curriculum conference. A team of resident and faculty will be assigned to each topic. It is expected that the resident will contact the faculty and arrange the format for the presentation. Hopefully both the resident and faculty member will present the material. It is mandatory that the residents complete the assigned reading prior to conference. The presentation should be approximately 45 minutes in length.

Medical Knowledge: Each topic is designed to be an overview of established and recommended care. Topics are chosen to cover the core curriculum over a 12 month period; therefore each topic is covered twice during the two year residency. Repetition has been

shown to be an effective way of establishing knowledge. Resident In-service and Board Scores support this method.

Case Presentation Conference
The resident at ILH must present at least one interesting preoperative case. All other services should prepare one case to be presented. Residents must contact the Program Coordinator and send a list of potential cases, which will be chosen at the conference. These cases will be used as "unknowns" for a mock oral practice. Each case should be accompanied by at least one seminal article from the literature. Presentations should be about 10 minutes in length.

Patient Care: *Preoperative Conference will be attended by residents from both programs, faculty from the LSU and Tulane programs, medical students and rotating residents from both programs. Residents will present primarily preoperative patients from various services. Residents must present cases with photo-documentation and all relative studies. Other residents are called upon to discuss the patient and to formulate a plan of care. The residents presenting the case must then present their approach and risk benefit issues of each approach are presented. This weekly exercise is similar to what the residents will see during their oral board examinations. Every effort is made to make this a patient based experience. Occasionally certain cases are required to be presented postoperatively as well.*

Morbidity and Mortality Conference.
Every service must collect all significant complications and the LSU residents will transmit the "clean" data to the Program Coordinator, who will then archive it in an encrypted site. The data should contain the patient's initials, diagnosis, and procedure, date of surgery, resident, faculty and untoward event. This is an ACGME requirement and must be fulfilled. This should be done by the Wednesday prior to M&M.

Practice Based Learning and Improvement: *Although PBLI is a primarily a goal of our clinics, this conference is directly related to practice based learning and improvement. This exercise is primarily to investigate the care of patients who have had an adverse event. Adverse events may include failed reconstructive efforts, pulmonary emboli, patient injury, infections and other events which negatively impact patient care. We attempt to differentiate between systemic problems and individual practice issues. We have discussed, for example, the prophylaxis of pulmonary emboli in the postoperative setting. Risk factors and recommendations from the literature were presented, and recommendations for prophylaxis reviewed. We have changed our prophylactic protocol as a result, and have become increasingly aware of risk factors. The PDSA cycle of each case is reviewed and evaluated. Was there a fault in planning? Were the goals achievable or realistic? What was the course of events? What did not work? How can we prevent such an event in the future?*

The case to be presented will be chosen by the faculty and the format will be organized not only to report the complication but to attempt to determine the root cause of the problem and suggestions about prevention.

Journal Club
Residents will be assigned articles to read and evaluate. They will present the article and discuss why the article is or is not valid. All residents should attend this conference which is at night and should not interfere with duties.

Practice Based Learning and Improvement: *Lifetime learning directly effects improvement in patient care by the process of assimilation of scientific evidence and to use that evidence to improve patient outcomes. Journal Club is an exercise that directly impacts this effort. It directly addresses the access to, assimilation and implementation changes to improve the quality of practice. It is important however to critically assess new ideas to be sure that they really are going to lead to improvement in outcomes.*

Interpersonal and Communication Skills: *Residents learn about how papers are written and how they are used to communicate information. They learn how a paper is well written and supported by good clinical and statistical data.*

Professionalism: *They are made aware of conflict of interest issues and bias in publication. System Based Medicine: Many articles deal with cost awareness and risk benefit analysis. Some articles deal with identifying systemic errors in patient treatment and suggest systemic solutions.*

Preparation for written Boards
At least twice per month a series of questions will be sent out to be taken at home in a timed manner. The tests will be discussed prior to the core curriculum lecture on Friday and a key will be sent out.

Preparation for the Oral Boards
Each Friday the cases presented will be used as unknowns.
An annual "mock oral" will be scheduled in the spring.

On Line Webinars and other activities

The Dean of Graduate Medical Education has a series of required Webinars for Residents. These teaching activities are required for all residents training in the institution. This information is provided in the resident orientation at the beginning of each year. Current topics include:

Competencies Overview
Recognizing Signs of Fatigue
Impaired Physicians
Professionalism – Part I1
Professionalism – Part II
Medical Error – Part I1
Medical Error – Part II
Breaking Bad News
Patient Safety
Interpretation of Diagnostic Screening Tests
How to Read a Clinical Trial
Intro to Evidence Based Medicine2
Study Design 1
Study Design 2
Risk Management and Quality Assurance
Introduction to Biostatistics
EMTALA

The web site address is:
http://www.medschool.lsuhsc.edu/medical_education/graduate/core_curriculum.asp

CPT coding workshop
Because accurate coding and billing are an important part of system wide practice and professionalism, we send our residents to a CPT coding workshop. Although faculty members will address coding after surgical procedures, residents will have more basic course, provided by the division through the American College of Surgeons. This is an effort to have another activity to support System Based Practice, as accurate coding is important in professional practice.

Annual Resident Survey
Each spring, the RRC requires residents in plastic surgery to complete an annual survey. This survey is very important for the continued accreditation of the program. The survey is completed on line. It is very important for residents to understand what the questions are really asking. This data, along with other data is reviewed yearly by the RRC to determine if the program remains accredited. Residents will be notified when the survey is open.

This forum will be held annually, and is based on the competency of Professionalism, to provide a system through which residents are able to raise and resolve issues without fear of intimidation or retaliation.

Resident Scholarly Activities

Required Research: *Program accreditation is based on accumulated data which is housed in the WebADS section of the ACGME website. Documentation must be submitted of all papers, presentations, posters or lectures presented by the faculty and residents.*

Each resident is required to write a paper suitable for publication. Topics can include basic research, clinical studies, retrospective or prospective reviews or worthwhile case studies. Topics must be approved by Drs. Tessler, Lau, Dupin, Khoobehi, Masshia or St. Hilaire within the first six months of residency. Frequently, these projects result in a paper for publication or presentation at the Senior Resident's Conference or a regional or national meeting. Completion of the paper is required for faculty recommendation to take the board exam.

Research conferences will be held as needed for residents to discuss their projects. The resident must choose a faculty member for each research project. Residents will have an opportunity to share their studies at Resident Research Day, held annually each June. Residents will be required to submit their finished manuscript to the supervising faculty 2 weeks prior to the resident research day. The faculty will have one week to review with residents and help them make corrections. Final manuscripts are due to Dr. Chiu's office one week prior to the resident research day.

All graduating residents MUST submit two (2) manuscripts to a peer-reviewed journal prior to being recommended for graduation from the program. All papers accepted must be documented in the division of plastic surgery and a copy of the title, date, meeting, and presenters will be kept in order to complete the annual evaluation of the academic status of the program.

Chapter 5:
Resident Selection and Evaluation

Residency Selection Policy

In accordance with the LSU School of Medicine Residents and Fellows Policies and Procedures, the resident eligibility and selection process must conform to the guidelines of the Accreditation Council for Graduate Medical Education (ACGME) General Requirements, including the Program Requirements for Residency Education in Plastic Surgery.

Qualified applications are selected by the division chief, program director and faculty members from an applicant pool established by the National Residents Matching Program.

Each year the LSU Plastic Surgery Residency Program receives a minimum of 100 applications. The following steps are taken in the reviewing process:

1. Applicants must request and complete the written application from the National Residents Matching Program
2. Applicants must file the necessary application forms through ERAS
3. Completed applications are verified by Match and sent to the LSU Plastic Surgery Residency Program, usually in the month of December.
4. Applications are reviewed by a committee of LSU plastic surgery faculty members, which decides which applicants will be interviewed.
5. After each scheduled interview date, the committee ranks the interviewed applicants.
6. Once all interviews conclude, the committee reviews the rank list for each date and prepares a combined, final rank list that is submitted to the National Resident Matching Program.

Resident Advancement Policy

Every six months, each resident will be evaluated by

1. Their immediate supervising faculty members that make up the Clinical Competency Committee (CCC).
2. Faculty members who are actively participating with the residents during rotations or ER call
3. Non faculty staff who work with residents in the clinics (360 degree)

Residents will be evaluated for progress in the clinical competencies, including surgical knowledge and skills, intellectual capacity, work habits, personal characteristics and interpersonal relationships as they relate to rotations, clinics, conference participation and required research. The comments of each evaluator will be documented and reviewed with the residents at the time of the evaluation. Primarily, evaluations will be performed by the attending staff with whom the resident has just rotated. Residents will be informed in writing of their evaluation. The resident will sign the evaluation to indicate that it was received. Each resident will write a reflective statement about their evaluation and what they liked and did not like about the rotation just completed.

In the event of performance or behavior below the standards of the division, the residents may be first given notice of deficiencies. If these are felt to be correctable a plan of remediation may be outlined to the resident. This could include more supervision, changes in rotation or surgical responsibility, additional study or requirements for behavioral changes. The plan will be in writing and will be acknowledged by the resident. Progress will be monitored by the faculty.

In the event that the performance is well below the standards, or if the faculty is unsure that the resident can complete the training and become competent, additional adverse actions may be employed. (See below)

The division also requires residents to exhibit strong academic performance on the in-service exam, held each March. The in-service exam ensures that residents are adequately prepared for the plastic surgery board exam upon completion of training. Residents are expected to achieve a ***minimum of 30th percentile*** on both in-service examinations. Failure to do so will result in probationary status. A re-test will be administered at a later date; failure to attain a 30th percentile on the re-test will constitute grounds for dismissal. Senior residents who fail to attain a 30th percentile will not be recommended for their boards until they can demonstrate ability to pass their written boards.

For additional information on reprimand and dismissal procedures, as well as conduct warranting disciplinary action, see the "Disciplinary Actions" and "Grievances/Due Process" sections of this manual.

ACGME Clinical Competency Committee (CCC) Policy and Procedure

The members of a CCC have responsibility for: 1) determining residents' or fellows' progression on the educational Milestones; 2) making recommendations on promotion and graduation decisions; and 3) recommending remediation or disciplinary actions to the program director.

Members of the CCC can include physician faculty members and members from other health professions (i.e., inter-professional) who serve on the faculty or have extensive contact and experience with residents/fellows in patient care and other health care settings.

Chief residents who have completed core residency programs in their specialty disciplines, possess a faculty appointment from the program, and are eligible for specialty board certification may attend the CCC meetings and provide input to CCC deliberations. They cannot be members of the CCC.

Residents who do not meet all of the above criteria may not serve as CCC members or attend CCC meetings. This includes chief residents in the accredited years of the program. Their exclusion from the CCC is meant to ensure that the residents' peers are not providing promotion and graduation decisions, or involved in recommendations for remediation or disciplinary actions. However, the chair(s) of the CCC and/or program director should receive input from these residents outside the context of CCC meetings through the evaluation system.

Coordinators may attend CCC meetings to provide administrative support and help document CCC deliberations and decisions. However, coordinators may not serve as members of the CCC.

May serve as member of CCC	May attend CCC Meetings, but are not members of the CCC	Cannot serve or attend CCC Meetings
1. Program faculty members 2. Program directors 3. Other health professions (e.g. Nursing, inter-professional faculty members)	1. Chief residents who meet all of the following criteria: have completed core residency programs in their specialties; possess a faculty appointment in their program; are eligible for specialty board certification 2. Program coordinators	1. Residents and chief residents still in accredited years of their programs and have not completed initial residency education

Milestones:

The milestones are designed only for use in evaluation of resident physicians in the context of their participation in ACGME-accredited residency or fellowship programs. The milestones provide a framework for assessment of the development of the resident physician in key dimensions of the elements of physician competency in a specialty or subspecialty. They neither represent the entirety of the dimensions of the six domains of physician competency, nor are they designed to be relevant in any other context.

The CCC committee will be responsible for determining where residents fall according to the ACGME Milestone scale. 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. In the initial years of implementation, the Review Committee will examine milestone performance data for each program's residents as one element in the Next Accreditation System (NAS) to determine whether residents overall are progressing.

For each period, review and reporting will involve selecting milestone levels that best describe a resident's current performance and attributes. Milestones are arranged into numbered levels. Tracking from Level 1 to Level 5 is synonymous with moving from novice to expert. These levels do not correspond with post-graduate year of education. Please note that residents in a traditional program may start at a higher level for many of the milestones due to their previous experience within the general surgery program.

Selection of a level implies that the resident substantially demonstrates the milestones in that level, as well as those in lower levels:

Level 1: The resident demonstrates milestones expected of an incoming resident.

Level 2: The resident is advancing and demonstrates additional milestones, but is not yet performing at a mid-residency level.

Level 3: The resident continues to advance and demonstrate additional milestones, consistently including the majority of milestones targeted for residency.

Level 4: The resident has advanced so that he or she now substantially demonstrates the milestones targeted for residency. This level is designed as the graduation target.

Level 5: The resident has advanced beyond performance targets set for residency and is demonstrating "aspirational" goals which might describe the performance of someone who has been in practice for several years. It is expected that only a few exceptional residents will reach this level.

Milestones for Plastic Surgery are based on the following:

	N/A	Level 1		Level 2		Level 3		Level 4		Level 5
MEDICAL KNOWLEDGE										
A) Surgical Care	○	○	○	○	○	○	○	○	○	○
B) Wound Care	○	○	○	○	○	○	○	○	○	○
C) Tissue Transfer	○	○	○	○	○	○	○	○	○	○
D) Congenital Anomalies	○	○	○	○	○	○	○	○	○	○
E) Head and Neck	○	○	○	○	○	○	○	○	○	○
F) Maxillofacial Trauma	○	○	○	○	○	○	○	○	○	○
G) Facial Aesthetics	○	○	○	○	○	○	○	○	○	○
H) Non-Cancer Breast Surgery	○	○	○	○	○	○	○	○	○	○
I) Breast Reconstruction	○	○	○	○	○	○	○	○	○	○
J) Recnstruction of the Trunk and Peineum	○	○	○	○	○	○	○	○	○	○
K) Upper Extremity Trauma	○	○	○	○	○	○	○	○	○	○
L) Non-Trauma Hand	○	○	○	○	○	○	○	○	○	○
M) Cosmetic Trunk and Lower Extremity	○	○	○	○	○	○	○	○	○	○
N) Lower Extremity	○	○	○	○	○	○	○	○	○	○

	N/A	Level 1		Level 2		Level 3		Level 4		Level 5
PATIENT CARE:										
A) Surgical Care	○	○	○	○	○	○	○	○	○	○
B) Wound Care	○	○	○	○	○	○	○	○	○	○
C) Tissue Transfer	○	○	○	○	○	○	○	○	○	○
D) Congenital Anomalies	○	○	○	○	○	○	○	○	○	○
E) Head and Neck	○	○	○	○	○	○	○	○	○	○
F) Maxillofacial Trauma	○	○	○	○	○	○	○	○	○	○
G) Facial Aesthetics	○	○	○	○	○	○	○	○	○	○
H) Non- Cancer Breast Surgery	○	○	○	○	○	○	○	○	○	○
I) Breast Reconstruction	○	○	○	○	○	○	○	○	○	○
J) Reconstruction of the Trunk and Perineum	○	○	○	○	○	○	○	○	○	○
K) Upper Extremity Trauma	○	○	○	○	○	○	○	○	○	○
L) Non-Trauma Hand	○	○	○	○	○	○	○	○	○	○
M) Cosmetic Trunk and Lower Extremity	○	○	○	○	○	○	○	○	○	○
N) Lower Extremity	○	○	○	○	○	○	○	○	○	○

	N/A	Level 1		Level 2		Level 3		Level 4		Level 5
SYSTEM BASED PRACTICE										
A) Patient Safety	○	○	○	○	○	○	○	○	○	○
B) Resource Allocation	○	○	○	○	○	○	○	○	○	○
C) Practice Management	○	○	○	○	○	○	○	○	○	○

	N/A	Level 1		Level 2		Level 3		Level 4		Level 5
Interpersonal and Communication Skills	○	○	○	○	○	○	○	○	○	○

	N/A	Level 1		Level 2		Level 3		Level 4		Level 5
Practice-Based Learning and Improvement										
A) The ability to investigate and evaluate the care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning	○	○	○	○	○	○	○	○	○	○
B) Research and Teaching	○	○	○	○	○	○	○	○	○	○

	N/A	Level 1		Level 2		Level 3		Level 4		Level 5
Professionalism										
A) Ethics and Values	○	○	○	○	○	○	○	○	○	○
B) Personal Accountability	○	○	○	○	○	○	○	○	○	○

Please refer to the ACGME Website to view further information regarding Plastic Surgery Millstones and the evaluations process.

Plastic Surgery Operative Case Log (PSOL)

Senior residents must perform 900 total procedures prior to graduating, the number deemed necessary by the RRC for adequate surgical experience. Senior residents must also complete the entire required index procedures as determined by the RRC. Occasionally you may have difficulty in entering a procedure into the PSOL log. If this happens, contact Dr. Tessler who will assist you. This is commonly a problem in the "other" category. You should access the ACGME website www.acgme.org and review the guidelines for PSOL categories (resident-assistant etc.) Your case numbers will be reviewed at the semi-annual resident evaluation.

The resident is responsible for maintaining and reporting his/her cases monthly on the Plastic Surgery Operative Case Log (PSOL) on the ACGME website (http://www.ACGME.org). Residents are to report procedures, not cases; some cases may involve multiple procedures. Procedures should be recorded as surgeon or assistant as appropriate. Failure to maintain this data jeopardizes the resident's standing and the program itself.
Failure to perform the required total number of cases and/or index cases may result in the resident not being recommended for board examination or in an additional training requirement until the deficiency can be corrected. It is important for the resident to monitor his/her performance and discuss any problems that he/she encounters in a timely manner so the deficiency can be corrected.

Resident Duty Hours Call Schedule and Back-Up Schedule

Residents are not to exceed the 80 hour work week or any other work requirement established by the ACGME. Residents will log their hours on Residency Partner (WebRP) on a weekly basis at least for the first month of each rotation. In the event that you have questions about duty hours, or feel that you are exceeding the number of duty hours, you are to immediately contact the program director and report this fact.

After Hours and Weekend Schedule

The call schedule is arranged monthly by the Resident Coordinator with the direction of Dr's. Tessler, St. Hilaire and Dupin. Weekends and holidays should be evenly and fairly distributed among all year residents. The resident advisor should be contacted if any conflicts arise that cannot be worked out among the residents.

Residents alternate taking call from home every 3rd-4th night. There is no in-house call in the LSU Plastic Surgery Residency Program for PGY-4,5 and 6. Call begins at 5:00 pm and ends at 7:00 am, depending on the location.

Residents on services are expected to complete patient care (rounds, surgery, and clinics) before the end of their working day. Residents "on call" should not, except in extraordinary circumstances, be finishing normal daily duties for other residents.

The resident on call when there are three advanced residents in town is responsible for calls as assigned by division and will also round as assigned to cover the private rotation. Normally this will involve inpatients only at University Hospital, Ochsner Baptist and West Jefferson or Touro. There may be rare exceptions when another patient will be seen, and the resident will be notified.

There will be a "back up" resident assigned to each resident on call. The "back up" resident should be called if the primary resident cannot complete rounds by early afternoon, or if the primary resident is in surgery, or if there is an issue of fatigue

When there are four residents in town, the additional hospitals are Children's Hospital and East Jefferson. It will be exceptionally rare for East Jefferson to have inpatients (hand service). In the event that residents have problems with covering these responsibilities, they shall immediately contact the faculty on call so that the faculty may assist them. Under no circumstances may residents become so fatigued as to impact patient care.
Residents in Baton Rouge take call only there. They are on call approximately every other night but must have one day per week completely free from responsibilities and also one weekend per month free of responsibilities so that they may return to New Orleans.

When residents are taking first call on faculty members' private cases they MUST notify the faculty member of any problems. While simple orders for sleeping meds, etc. need not be reported, residents must communicate with the faculty about any situations that may arise. Residents are also expected to discuss any consultations, ER calls, etc. with the faculty member on call that day or weekend.

The resident on the hand service may also be asked to cover some call nights for that service when they are already on call for other services. The total number of call nights per resident should not exceed 10-11 nights per month. Any questions or problems with the call schedule should be addressed with the resident advisor as soon as they become apparent.

It is mandatory that all cell, beeper and home numbers are given to the department for distribution. When residents are out of town their beepers should be carried by their counterpart. Residents must give the department a means of contacting them at all times, even when on leave.

Residents MUST promptly answer their calls or pages.

A list of faculty members and residents phone numbers should be obtained from the coordinator. Try the cell phone number first, then the pager or home number.

It is **mandatory** for EACH resident to correspond by email to the resident on call for the weekends. This is important for patient care and good communication. The resident must send a list of patients to be seen on the service, their location, diagnosis, and anything that must be done for the patient on the weekend. A copy should be sent to the program director every weekend.

The residency also understands that residents need time to rest and relax. The call schedule (every third night and every third weekend/ every fourth night/every fourth weekend) is on its face not particularly demanding. There may be times when residents are fatigued or possibly overwhelmed by a particular day or evening. In the event that this occurs, the resident must contact the faculty member who is on call. In no instance should a resident attempt to work or to treat patients when they do not have their faculties. All residency programs demand a longer workweek than is commonly accepted in the workforce. This is recognized in the 80 hour workweek. It is critical for patient care that residents not work when exhausted, therefore residents must call their faculty member so that arrangements can be made to meet responsibilities.

Routine Daily Work Flow:

Residents are to be guided by the policies above in each rotation. Residents may be requested to engage with other rotations from time to time. This will most ordinarily occur when residents are out of town or when services do not have a resident assigned on that date. All requests will be made through the educational director and residents should not be directed to another service without the express permission of the primary educational director, nor should faculty members directly instruct residents away from their primary rotation.

Resident, Staff and Program Evaluation

Resident Evaluation

Faculty will evaluate residents in a comprehensive fashion. Residents will be expected to show increasing knowledge of the basic didactic material. Written evaluations will be provided by the faculty member with whom the resident has rotated. Residents will also be evaluated on conference participation, teaching skills, in-service exam scores, personality and interpersonal skills. Operative skills will be evaluated by faculty who has observed the resident in the operating room. The resident will be informed about his evaluations on a periodic basis. The resident's operative logs will be reviewed in comparison to other residents as part of the evaluation.

The evaluations will be discussed with residents on a yearly basis and more often if necessary. Residents will be able to respond to the evaluations and object to them in writing if they wish. The evaluations serve as a tool to help residents improve their performance.

Evaluation instruments will include: focused observation by supervising faculty; 360 degree evaluation by non-faculty coworkers; evaluation by peers; attendance and participation at conference and presentations; Plastic Surgery Operative Log; In-service examination scores; Performance in Mock Oral examinations; Participation in laboratories throughout the year.

Faculty/Program Evaluation

Each resident will be given the opportunity to evaluate the staff following the completion of each rotation. The evaluations are confidential and the results will be reported to the faculty without identifying the resident. Each resident will also be given the opportunity to evaluate the program as a whole.

Annual Resident Forum: In the spring of each year, the chief resident will assemble the residents and convene a Resident Forum. Faculty will not participate. He will then make a list of the issues that are brought up at the forum and deliver it to the faculty. The faculty will discuss the report and meet with the residents to try to implement improvements to the program as delineated in the report.
A written record of the forum will be maintained.

Chapter 6:
Disciplinary of Adverse Actions

It is the stated and working policy of the division of Plastic Surgery that residents have the right to work in an atmosphere free from intimidation, harassment or other impediments to learning. There certainly will be instances where, in the resident's mind, are stressful or during which unreasonable demands are being made. It may be justified, or not, depending upon circumstances. Residency is a demanding training period and there is much to learn in a relatively short time.

Nonetheless, the program wants to know if the resident(s) are concerned about the learning or work environment. The program director is responsible for this environment and is dedicated to maintaining a healthy environment for the residents.

The program director must be contacted if resident(s) have concerns about this issue. He can be contacted at any time and there will be no intimidation or retaliation for speaking with the director. As much as possible the conversation will be confidential. If the director agrees that there is a problem, he may deal with the problem with an investigation, either by himself or an appointed non-involved faculty member, and try to address the problem.

Problems of a more egregious nature will be forwarded to the Chief of Surgery and/or the Designated Institutional Officer.

Additionally we have instituted a Resident Forum, which will be held once a year. Residents are encouraged to act as a group to anonymously send a report on the program and faculty. This should be done honestly and thoughtfully and with a focus on improving the program. Residents should reflect on both the strengths and weakness of the program and the educational environment. Many instances exist when the resident's suggestions can be incorporated, or problems can be solved.

At the beginning of the training program, residents are informed about departmental policies both in writing and through the Department of Surgery. These policies include training goals, evaluation, dismissal and due process procedures. The resident acknowledges receipt, understanding and acceptance of the department guidelines and his/her duties and responsibilities by signing the house officer contract. If a resident fails to perform his/her duties according to the standards of the Division of Plastic Surgery, they will become subject to the following disciplinary actions:

Minor and/or Non-Recurring Professional or Training Infractions

Counseling, reprimand, additional work or study requirements and adjustment of training privileges may be employed to correct these issues.

Major and/or Recurring Professional or Training Infractions

Probation: A disciplinary action where the division places a trainee on notice of unsatisfactory training performance. Unsatisfactory performance may refer to academic or non-academic problems. Probation is applied for training infractions that have gone beyond, in frequency or severity, what can be handled by simple counseling and/or reprimand. The trainee on probation is allowed a defined period of time to demonstrate that he/she can remedy deficiencies under departmental monitoring. Probation implies that further deficiencies and/or failure to prove he/she has overcome the deficiencies leading to probationary status may result in dismissal of the trainee or non-renewal of his/her contract for the following year.

Non-Renewal of Contract: A disciplinary action where the division concludes that further training is not in the best interest of the parties to the contract or the resident decides to leave the program. The contract is not renewed for the subsequent year.

Residents who are subject to disciplinary actions are given due process as outlined in the Department of Surgery's House Officer Manual. The Department of Surgery's procedures supersede any process of the Division of Plastic Surgery if in conflict.

Dismissal: A disciplinary action where the division removes a resident from training because of unsatisfactory performance of the program requirements, unprofessional or disruptive conduct or when patient safety is jeopardized. Dismissal may be imposed with or without preceding probation.

Conduct Warranting Disciplinary Action

Minor disciplinary actions will be documented in the evaluation file of the resident. Written communications with trainees about major disciplinary action, such as probation, non-renewal of contract or dismissal, will be either hand delivered to the resident or sent by certified mail, with receipts retained in the resident's file. The staff of the Division of Plastic Surgery along with the Chairman of the Department of Surgery will determine those infractions which require formal termination actions.

All matters of discipline do not require formal process. Minor problems may require counseling with suggested corrective action and follow-up. Failure to correct the problems may result in further disciplinary action.

Failure to attain departmental educational standards can result in probation or dismissal from the program. Failure to perform appropriately in clinical work or inability to handle oneself in a professional manner may also be ground for dismissal.

Felony conviction, involvement in unethical or illegal circumstances, repeated substance abuse or failure to seek treatment for substance abuse are grounds for dismissal.

A resident's privileges may be summarily suspended if patient safety is jeopardized.

A resident may be dismissed for appropriate cause, with or without a probationary period, after notification of dismissal has been presented in writing and the nature of the problem or problems has been discussed with the resident.

The Dean, the Executive Associate Dean for Clinical Affairs and the Coordinator for Graduate Medical Education should be notified promptly of any intent to terminate a resident's training by dismissal or non-renewal of contract.

Grievances and Due Process

The division of Plastic Surgery adheres to the LSUHSC process for grievances and due process.

It can be found in the "LSU House Officer's Manual." A copy is available in the department or on line at http://www.medschool.lsuhsc.edu/medical_education/graduate/HouseOfficerManual.asp

Chapter 7:
Vacation, Educational Leave and Time Off

Vacation:

LSU Plastic Surgery residents receive a total of 21 days' vacation as a PGY-1 and 28 days for PGY-2 to 7. 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. 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 the Residency Coordinator. The residency coordinator will keep a vacation calendar. **Only one Chief resident is allowed out-of-town at any time**. The residency coordinator should be notified at least one month in advance for scheduling purposes. Vacations are not allowed during the month of June or July for the first and second year residents. Senior residents are advised that the program completion date is the last day of June and are strongly encouraged to use their 4th week of vacation for this time. 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.** Ordinarily, 1st 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.

Chapter 8:
Required Equipment

Beepers and Cell Phones: Each resident will be provided with a beeper. Beepers must be turned on at all times, regardless of whether a resident is on call, in case of emergencies. Additionally, all home and mobile phone numbers must be on file in the department and with answering services. Residents are also required to have a cellular telephone.

Lab Coats: A lab coat is provided to the resident free of charge by the Department of Surgery. Lab coats are to be kept fresh and clean at all times.

Camera: A digital camera with flash is mandatory. Digital photography is the primary tool employed for conferences. Photo documentation is critical in the field of plastic surgery. The camera should produce quality photos but be simple enough for others to use.

Loupes: Loupes are mandatory and should be obtained before or during the first month of residency. A 3.5 magnification with extended fields and 16 inch focal length is recommended, and they usually range in price from $1100-$1300.

Goggles: Goggles or operating glasses are required for each physician's safety in the operating room.

Specialty and Micro vascular Instruments: Specialty equipment is usually available at each institution. Please ask senior residents and Dr. Dupin about specifics.

Textbooks and Reference Material: The following are recommended textbooks. The division, if funds are available, may help you to purchase some for your personal library. They are available in the LSU regional library on campus as well.

1. Mathis (8 volume set): good reference, too long to read, but fairly inclusive. You can go online to the Saunders website http://www.saundersplasticsurgery.com for online reference but only if you have purchased the set. (they only allow two computers to log on)
2. Green's Hand Surgery: Standard text, very well written. Online access is to www.greenshandsurgery.com Username: cldupinmd@aol.com , Password: lsuplastic
3. Plastic and Reconstructive Surgery (journal) most complete journal, with good online search engine for articles. http://www.plasreconsurg.com/ PRS Login: lsuplasticsurgery Password: TIGERS
4. Selected Readings in Plastic Surgery. You are highly encouraged to subscribe to this journal. It has much of the information of a major text and is more up to date than most. You can access the material through the Tulane website: Additionally the main link into Greenspace is: https://greenspace.tulane.edu/xythoswfs/webui; Username: newsome; Password: Tulane1

5 Strauch, B. Atlas of Microvascular Surgery (second edition). Available at amazon. Extremely good reference.
6 Annals of Plastic Surgery; http://www.annalsplasticsurgery.com; Username: newso=meer; Password: Plastic

Chapter 9:
Primary Department Contact

Contact Name	Title	Office Number	Cell Number	Home Number	Pager Number
Charles Dupin MD	Program Director	504-412-1240	504-258-1119	504-282-9655	
Frank Lau, MD	Assistant Program Diector	540-412-1240	617-935-2625		
Oren Tessler, MD	Educational Director and Chief, ILH	504-899-8411	617 694 9954		
Hugo St. Hilaire MD	Educational Director Children's Hospital	504-568-4750	504-287-7704	504-835-4568	504-423-7160
Department Phone Numbers					
Callie Pearson Cpear1@lsuhsc.edu	Resident Coordinator	504-568-4748	504-609-9003		
Department of Surgery	Main Office	504-568-4750 504-568-4633 fax			

LSUHSC – Plastic Surgery
Departmental House Officer Manual 2015-2016

I hereby certify that I have received the mandatory 2014-2015 Plastic 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-NO website; http://www.lsuhsc.edu/no/Administration; http://www.medschool.lsuhsc.edu/medical_education/graduate; LSU Bylaws and Regulations, LSU System Policies, LSUHSC Policies and GME Policies.

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Print Name	Level	Department
_____	_____	_____
Signature	Date	SSN