INTRODUCTION:

Core Value: University of Miami Leonard M. Miller School of Medicine Division of Plastic, Reconstructive and Aesthetic Surgery will provide the highest quality cost-effective patient centric care, train and educate the most outstanding residents and medical students, as well as serve as an exemplary role model for our local, regional and national plastic surgery communities.

Educational Goals and Objectives for the University of Miami/Jackson Memorial Hospital, Division of Plastic Surgery are outlined within in the Residents Reference Guide. This is presented to the residents upon matriculation. It is fully discussed during the orientation session held each July. The goal of our educational program is to guarantee the completion of training of each plastic surgery resident and to ensure each has developed an ethical, professional and educational sound foundation for their future independent practice of their chosen specialty.

Mission of the University of Miami/Jackson Memorial Hospital, Division of Plastic, Reconstructive and Aesthetic Surgery is to enable our residents to acquire satisfactory clinical skills and a sound basic fund of Didactic knowledge. This will then enable them to independently practice their chosen specialty of Plastic Surgery. This is primarily achieved through the progressive process of increasing the resident’s responsibility and continued self-evaluation based on the faculty’s direct assessment of the individual resident’s level of achievement in their education, ability, judgment, and clinical experience. Each patient is to be treated with dignity and respect.

DEFINITION OF TRAINING:

Graduate Medical Education is defined as the professionalism by which clinical and competent didactic experience are provided to residents; thereby, enabling them to acquire those necessary clinical and technical skills, knowledge base, practice based learning and improvement and systems based practice, interpersonal skills, communication techniques, professionalism, as well as moral and ethical behavior which are necessary to provide quality patient care. Purpose of a Residency Teaching Program is to provide an organized and integrated educational program providing both satisfactory guidance and supervision to their residents. This facilitates the development of their individual professional and personal development, while simultaneously insuring safe, appropriate and cost effective patient centric care. UM Division of Plastic, Aesthetic and Reconstructive Surgery will foster a spirit of inquiry and collaboration and provide an optimal clinical and didactic learning environment for residents and medical students.
Plastic Surgery Residency is an essential dimension in the transformation of a physician with the independent practitioner. It is physically, emotionally and intellectually demanding and requires longitudinally-concentrated effort on the part of the resident.

Plastic Surgery is the surgical specialty that encompasses resection, repair, replacement and reconstruction of acquired and congenital defects of form and function of the skin and their underlying anatomic systems. This includes the craniofacial region, upper aerodigestive tract, the trunk, breast, perineum and upper and lower extremities. Our specialty also involves the cosmetic improvement of undesirable form. Plastic Surgery residency program at the University of Miami/Jackson Memorial Hospital is a fully accredited three year independent training program with its primary objective, the education and training of physicians in the broad scope of plastic and reconstructive surgery in order to develop independent plastic surgeons of high moral and ethical caliber. A variety of educational formats and clinical experience will be employed to achieve these goals and fulfill our mission. We are currently transitioning to a 3 year independent program. We will continually measure, monitor and continuously strive to improve the quality of our service.

SCOPE OF TRAINING:

1. All pre-requisite training must be taken within programs accredited by the ACGME, Royal College of Surgeons (Canada), or the American Dental Association. Proof of having completed this pre-requisite training must be submitted and approved by the American Board of Plastic Surgery. This approval must be submitted in writing to the Program Director prior to the commencement of matriculation into the Residency Program. This will become part of the resident’s permanent file. This necessary paperwork must be accomplished prior to the actual matriculation into the UM Plastic Surgery Program or admission to the American Board of Plastic Surgery Examination.

2. The present independent Plastic Surgery curriculum in plastic surgery at UM/JMH is three years.

3. The program is approved by the RRC for a total of 9 residents (3 per year for 3 years)

PRE-REQUISITE TRAINING REQUIREMENTS:

(A-1) **Undergraduate Medical Education:**

Graduation from an U.S. accredited or Canadian Medical School or graduation from a foreign Medical School, Foreign Medical Graduates, or those currently listed to practice medicine in a state are acceptable Board Requirements.

(B-1) **Graduate Education in Plastic Surgery:**

All pre-requisite training must have been satisfactorily completed in a program approved by the Residency Review Committee (“RRC”) for Surgery and accredited in the U.S. by the ACGME or in Canada by the RCPS for full training. All general surgery training must be successfully completed prior to commencing the Plastic Surgery Residency. The Program Director in General surgery must provide written verification of completion of training. Each individual record is evaluated and must be approved by the American Board of Plastic Surgery in writing prior to entering the UM/JMH Plastic Surgery Residency Program. This must be included in the resident’s permanent academic file.

OR:

C. Completion of an accredited program in Orthopedic Surgery. Satisfactory completion must be verified in writing by the Program Director

OR:

(D) Certification by the American Board of Otolaryngology – although plastic surgery training may be started immediately following satisfactory completion of the Otolaryngology Residency Program. The certifying examination by the American Board of Plastic Surgery can only be completed after certification by the American Board of Otolaryngology. A letter by the Program Director verifying successful completion of training is mandatory.
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OR:
Completion of Neurosurgery;

OR:
Ophthalmology;

OR:
Oral and Maxillofacial Surgery with a minimum of 2 years of progressive clinical training in general surgery.

Plastic surgery training may not be less than two years at the same institution with the final year at a Chief resident level. Training may be completed in either the U.S. or Canada that have received approval by the Residency Review Committee and accredited by the ACGME.

INSTITUTIONAL ORGANIZATION:

A. The sponsoring organization with primary responsibility for the entire Plastic Surgery Education Program is Jackson Health Systems. Jackson Health Systems maintains an annual Operating Agreement (AOA) with the University of Miami Leonard M. Miller School of Medicine for the staffing of Clinical Faculty. They provide attending coverage and supervision for JMH residents. Plastic Surgery is a Division within the UM/JMH Department of Surgery. Resident's salaries and benefits are paid for and arranged through the Housestaff Office at JMH. Plastic Surgery Administrative offices are located with the UM/JMH Department of Surgery area, the 4th floor of the Clinical Research Building (CRB). Specifics related to benefits such as salaries, vacation, educational leave, and healthcare can be obtained from the JMH Housestaff Office which is located at Institute 5th Floor. These are in accordance with the CIR Union agreement and JMH. Copies of this agreement can be readily obtained from the JMH Housestaff Office located on the 9th Floor of the Clinical Research Building, can contact Nilda Gonzalez at (305) 243-9637. The Division also maintains offices and a resident multimedia library in the central building of Jackson Memorial Hospital East Tower 3019.

B. Participating Affiliate Institutions in the Plastic Surgery Residency Program:

University of Miami Hospital
Miami Children’s Hospital
Miami Veteran’s Affairs Medical Center

C. Chief and Program Director of the UM/JMH Division of Plastic Surgery is Dr. Seth Thaller, who is directly responsible to the Chairman of the Department of Surgery Dr. Alan Livingstone. Chief of Plastic Surgery oversees and is directly responsible for educational program of the Division. Program Director seeks significant input from the Educational Advisory Committee, which is comprised, of full time faculty and representatives of the Voluntary Faculty of each affiliate teaching hospital in order to fulfill this important teaching responsibility. A second resource for guidance is the GMEC office located on the 9th floor of the Clinical Research Building.

D. Appointment of Residents:

At the present time, the Plastic Surgery Resident Review Committee (RRC) permits Jackson Health Systems to appoint a total of 9 residents into the UM/JMH Plastic Surgery Program. This consists of 3 residents per year for 3 years. Applications which are received for the Independent Plastic Surgery Program through the San Francisco Central Application Service are then reviewed by the Residency Selection Committee comprised of the full time and representative voluntary faculty members appointed by the Division Chief. Applicants are then chosen by the Committee to proceed through the interview process. After completion of all interviews the Committee then meets and preferentially ranks the candidates. This list is then submitted to the Plastic Surgery San Francisco Central Application Service. Selected residents are given a one-year contract by Jackson Health Systems. This is renewed by JMH each year after successfully completing the plastic surgery program requirements for the 6 core competencies as evaluated by the faculty. At the completion of the Residency Program, the Chief of Service is required by the American Board of Plastic Surgery to
corroborate the resident’s successful completion of the plastic surgery residency program in order to become eligible to take the Board Examination in Plastic Surgery.

E. Institutional Requirements:

These are consistent with the Essentials written in The Graduate Medical Education Directory 2003-2004 located on pages 13-16. Significant institutional responsibilities involved in Resident Education include:

Assurance of an educational environment in which residents may raise and resolve issues without fear of intimidation or retaliation. This includes the following:

1. Provision of an organizational system for residents to communicate and exchange information on their working environment and their educational programs. This may be accomplished through a resident organization or other forums in which to address resident issues.
2. A process by which individual residents can address concerns in a confidential and protected manner.
3. Establishment and implementation of fair institutional policies and procedures for academic or other disciplinary actions taken against residents.
4. Establishment and implementation of fair institutional policies and procedures for adjudication of resident complaints and grievances related to actions that could result in dismissal, non renewal of a resident’s contract, or other actions that could significantly threaten a resident’s intended career development.
5. Both Doctors A. Livingstone, Chairman of the Department and Thomas Salerno, Vice Chairman, have an open door policy and an additional resource to voice concerns.
6. Each resident has an assigned mentor who can serve as a role of advocate and pathway to discuss any concerns in a non-threatening environment.
7. An ombudsman will be selected

HISTORY OF THE PLASTIC SURGERY PROGRAM AT THE UNIVERSITY OF MIAMI/JACKSON MEMORIAL HOSPITAL:

In 1963, Dr. W. Dean Warren, the Chairperson of the Department of Surgery, commenced a formal search to choose a Program Director to head the newly formed University of Miami Division of Plastic Surgery. Dr. Gil Snyder, who had completed his Plastic Surgery training at John Hopkins eventually, accepted the position. Prior to Dr. Snyder’s arrival to the University of Miami, Plastic Surgery training at Jackson Memorial Hospital was conducted with the collaboration of the private practices of Drs. Clifford Snyder, Clinical Assistant Professor of Surgery, and Dr. D. Ralph Millard. However, with formal organization of the Plastic Surgery Division in 1964, Dr. G. Snyder was assigned a general surgery resident and intern to help with the clinical activities of the Plastic Surgery program. Dr. Snyder also was assisted by other members of the Miami Dade Plastic Surgery community including Drs. Thomas Baker, Howard Gordon, Thomas Zaydon, Sr., Clifford Snyder, Phil George and D. Ralph Millard. They provided invaluable help in the education of residents and medical students. As the program became more active in its second year, Dr. Peter Stokley was appointed the first resident following completion of the general surgery program at Emory University. Approximately 6 months later, the second resident, Dr. Gassan Khalil, entered the program. On July 1, 1967, Dr. D. Ralph Millard assumed the position of Program Director, which he held until 1995. During that period, Dr. Millard made many significant contributions to the field of Plastic Surgery, especially in the areas of Cleft Lip/Palate, Nasal reconstruction and Aesthetic Surgery. In 1991, Dr. Robert Hunsaker at Dr. Millard’s request assumed responsibility for day-to-day administrative needs of the Division. In 1994, Dr. Joseph Moylan became the new Chair of the Department of Surgery and made a strong commitment to developing a full-time academic program in Plastic Surgery.

In 1995 Dr. Thaller assumed the full-time position as Professor and Chief. Within the year; two additional full-time faculty joined the division. Dr. Paul Liu and Dr. Helen Tadjalli, who both eventually joined the full-time faculty at other institutions. Dr. William Scott McDonald joined in February of 1999 and left for private practice in 2005. Dr. Milton Armstrong joined the University of Miami in July of 1999 from Ohio State University and left on August 2009 to be the Chief of Plastic Surgery as Medical University of South Carolina. Dr. Zubin Panthaki arrived after his Plastic Surgery Training at McGill University and reconstructive
microsurgery fellowship at the Buncke Clinic in September of 2001. The division has continued to grow with the addition of Dr. Lawrence Iteld in 2005 following a fellowship at MD Anderson. In 2006, with Dr. John Oeltjen following completion of his plastic surgery residency at Baylor College of Medicine, Dr. Iteld left for private practice opportunity in Chicago. On June 1, 2010, Dr. Christopher Salgado joined us as Associate Professor from University Hospitals Cleveland in Cleveland, Ohio. We have now hired 3 additional new faculty. Dr. Wrood Kassira completed both her general surgery and plastic surgery at the University of Miami/Jackson Memorial Hospital and an Aesthetic Fellowship at New York Eye & Ear Infirmary. Dr. Kassira will assume a role of directing the JMH Resident Aesthetic Staff Clinic. Dr. Haaris Mir completed a Hand Fellowship at University of Louisville and a Burn Fellowship at the University of Indiana. He completed his Plastic Surgery residency as well at the University of Indiana. He will develop a significant role in both our Plastic Surgery Residency and Hand Fellowship. He will work closely with our Burn service to enhance our residents’ clinical experience in this area. Dr. Morad Askari completed his Plastic Surgery Residency at USC and a Hand Fellowship at the Mayo Clinic. He will also retain a significant position in both our JMH Hand and Plastic Surgery Program. The Division of Plastic Surgery possesses potential to maintain a tremendous future at the University of Miami/Jackson Memorial Hospital. Clinical material available for teaching of residents remains unsurpassed in both its quantity and quality. Resident clinics at both JMH and the affiliated institutions are extremely active and provide a vast variety of teaching material in all clinical fields of plastic surgery including reconstruction, reconstructive microsurgery, aesthetic, replantation, congenital deformities, chronic wounds cleft lip/palate, craniofacial trauma, acute and rehabilitation burn care and surgery of the upper/lower extremities. This clinical experience is augmented by further exposure to the private practices of our outstanding voluntary faculty at our affiliate institutions.

We have developed a superb full time faculty with expertise in hand surgery, reconstructive microvascular surgery, craniofacial, cleft lip/palate, pediatric plastic surgery, and reconstructive breast surgery and general plastic and reconstructive surgery as well as all aspects of cosmetic surgery. In addition, we have been able to develop excellent working relationships with our colleagues in oral and maxillofacial surgery, otolaryngology, neurosurgery, ophthalmology and orthopedics. These colleagues also provide excellent clinical expertise and serve as excellent educational resources. This enables us to share in an additional pool of patients and provides our division with a unique clinical perspective. We are also fortunate to have an outstanding Voluntary Faculty, many of whom are well-known contributors to the field of plastic surgery. These factors have allowed us to develop an excellent, well-rounded teaching program utilizing all the resources available both within our institution and our surrounding community. The entire faculty remains committed to providing an optimal educational environment to our residents and providing continued excellence in patient centric care.

**FACULTY RESPONSIBILITIES:**

The ultimate goal of our Division is the providing quality patient care and the educational success of each resident. These missions are closely linked.

The Program Director is responsible for the overall quality of the Residency Program and ensuring that the program is in compliance with the policies of the appropriate certifying organizations and JHS. These include:

A) Familiarity with all current guidelines adopted by the ACGME. These requirements must be maintained for continued RRC approval of the residency program. The Program Director must promptly notify the Executive Secretary of the Residency Review Committee in writing of any change in the Program that may significantly alter the resident’s educational experience.

B) Developing and maintaining written guidelines specifically delineating supervisory responsibilities of the faculty and attending staff in each hospital or facility utilized by the training program.

C) See that the educational environment, the volume and variety of the patient population and concept of progressive surgical procedures is performed and followed at all affiliated facilities.

D) Responsible for annual collection, compilation and retention of the number and types of plastic surgery procedures performed at all facilities by the residents. (PSOL’S)

E) Ensure compilation of comprehensive record and number and type of surgical procedure in which the resident was either surgeon or assistant. These records must be maintained and verified by the Program Director.
F) Must verify documentation and credentials of each resident.

G) Responsible for regular evaluation of individual residents and the overall teaching program.

H) Advise, verify, and document all resident applicants of prerequisite training for the American Board of Plastic Surgery.

I) Ensure that the Plastic Surgery residents are supervised by the teaching staff so each individual resident may develop progressively increasing clinical responsibility based on their level of basic plastic surgery knowledge, talents, judgment, experience, and technical abilities.

J) Follow Jackson Health System Policies.

K) Recruit and maintain highly focused, qualified and dedicated faculty and staff.

L) Advanced material and surgical knowledge through original clinical and laboratory research.

M) Measure, monitor and continuously strive to improve the quality of services provided last year through its faculty and staff.

Faculty should serve as clinician educators who provide an appropriate level of supervision consistent with the resident needs. This will enable each individual to acquire those necessary technical skills, clinical experience, and basic fund of knowledge that allow each one to eventually independently practice their specialty of plastic surgery. It is important to remember and emphasize: teaching is a cooperative ongoing task, closely linking resident and faculty centered on working relationships that facilitate overall achievement, learning and continued self assessment and improvement and fully develop successful completion of the six core competencies.

FACULTY SHOULD:

a) Possess qualifications that contribute to the comprehensive training program and education of residents and students, including high moral and ethical standards and should demonstrate an appropriate commitment in time and energy to fulfill their required teaching assignments.

b) Evidence of scholarly activities among the Plastic Surgery faculty. Such evidence should include a high order of teaching skills, participation in clinical and/or basic research, involvement in plastic surgery and/or other scientific organizations and their meetings, and publications in refereed journals, monographs and books.

c) Faculty members are responsible for the level of care provided to each patient and must, therefore, be familiar with the individual patients they are assigned responsibility for.

d) To fulfill their clinical responsibility requires some level of personal involvement with that patient, i.e. pre-op notes and post-op follow-up and routine in-hospital rounds.

e) All residents must function under the direct close supervision of a faculty member. Therefore, a responsible faculty member must be readily available to the resident in person, telephone, or any other method of accessible telecommunications device as is appropriate. This is dependent on the resident’s level of clinical expertise, experience, and level of training, judgment and competence, and needs of the specific clinical situation.

f) Foster a spirit of a inquiry and collaboration.

FACULTY SUPERVISION:

It is the University of Miami Leonard M. Miller School of Medicine policy to supervise house staff in a fashion consistent with the applicable educational goals of the plastic surgery residency program and appropriate needs of each patient. Faculty must be able to assess the resident’s clinical competency in accordance with the programs requirements and standards of professionalism and to encourage fair, efficient and equitable solutions for problems that arise out of the individual needs of residents. Chief Residents in the JMH Plastic Surgery Program are delegated a high level of responsibility and authority for appropriate independent activity in an atmosphere where consultation, collaboration and advice are immediately available from the supervisory faculty. Due to the extensive quantity of cases on each service, the resident may be permitted to act as an
independent surgeon during each year depending on their individual progression and maturity. However, no surgery may be performed at any institution without adequate attending supervision, input or approval. Supervision refers specifically to which faculty member is responsible for the operation in order to enhance each resident’s knowledge and clinical experience. This simultaneously ensures that adequate levels of quality of care are delivered to each patient by our service. The education of a Plastic Surgery resident to become an independent practitioner is bases on clinical experience. This can only be successfully achieved in the context of the health care delivery system and an optional clinical and didactic learning experience. Developing the skills, knowledge and attitude lending to proficiency in all dominions of clinical competency requires the resident to assume personal responsibility for the care of individual patients. Therefore, the essential learning activity is the continual interaction with patients under the guidance and supervision of faculty members who give value, context and meaning to those clinical activities. As residents continue to gain experience and are able to demonstrate their growth in their capacity to care for their patients, they will be permitted exercise those skills with greater independence. This concept of graded and progressive responsibility is a keystone to American Graduate Education.

The goals of attending supervision within graduate medical education involve:

a. Assuring the provisions of safe and effective care to individual patients.

b. Assure each resident an opportunity to develop skills, knowledge and professional attitudes required for inter-independent practice.

c. Establishing a foundation for continued and lifelong professional growth and maturity.

Each patient has a readily identified appropriately credentialed attending that is ultimately responsible and available to residents, faculty and patients.

Residents will be supervised by an attending faculty in a manner consistent with ACGME program requirements. This level of faculty control and supervision is assessed by the faculty member’s observation, consultation, direction, and guidance. It also requires the simultaneous impression of knowledge, clinical skills, professionalism and attitudes developed through the experience of that faculty with the resident. This must be accomplished in an atmosphere that assures that the level of patient care is delivered in a timely and effective manner. Supervision may be provided to our resident staff in a number of different formats such as person-to-person contact with the housestaff in the presence or absence of the patient, or through consultation via the telephone on other acceptable telecommunication modes in appropriate circumstances. Identified faculty supervisor will provide a written evaluation of each resident’s performance during the period under the faculty’s direct supervision. Whenever the faculty’s personal presence is required, the faculty member must be available to the resident within a reasonable time interval. Attendings must write an admitting note after examining the medical record and meet the patient within 24 hours of admission. Progress notes on in-patients must be written by an attending at least 3 times per week. Every operative case must have a pre-op note by the responsible named attending surgeon regarding their participation in the surgical procedure. Attending must also sign date and time the resident’s pre-op history and physical examination and consent form before a patient is brought into the operating room. Attending responsible for the surgical case should actively participate in the pre-op, intra-op and post-op management of the case. Attending physicians must complete a pre-operative note detailing significant findings and a proposed plan. Attending physicians must also confirm their presence and level of participation in the OR by documentation in the computer care system located in each OR at Jackson Memorial Hospital/University of Miami. This is confirmed by the nursing and anesthesia staff. There always will be available attending supervision in the clinic, as per attending assignments. Therefore, each resident clinic at JMH will be supervised by a responsible named faculty member whose sole responsibility is to provide needed guidance and supervision for that specific clinic. A sign-in book is located in the ACC-West 4th floor clinic, documenting each attendings attendance and availability. All cases seen for emergency surgery are discussed with the chief resident and on call faculty and a decision is made by the attending as to the level of supervision necessary. Attendings must also be available at all times for resident consultation as needed in the clinics and operating rooms. Continuity of care is provided on each rotation. As residents rotate back on to individual services as senior residents, they can often follow patients they managed during their 1st year. In summary, the faculty will be involved in the care of patient’s assigned to them on the patient’s need and the gradual level of responsibility of the resident. It is imperative for the resident to develop an appreciation of their clinical limitation. This will form an extremely significant impression for the faculty’s assessment for promotion of the resident: residents must never practice beyond their level of training.
LEVELS OF SUPERVISION

Supervision will be provided through a variety of methods. Some clinical situations will require the physical presence of supervising faculty. In other instances, the supervising physician can be an advanced resident of fellow. Other aspects can require immediate availability either in the institution of by means of telephonic and or other electronic modalities. In some instances, supervision may even take the form of post-hoc review of resident-delivered care or feedback as to appropriate care.

- **Direct Supervision** – physically present
- **Indirect Supervision** – Immediately available
- **Oversight** – Availability to provide review after actual care provided

Faculty supervision will be sufficient direction at each institution to enable the involved attending to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.

THE EDUCATIONAL PROGRAM

**Goals:** Our primary mission for the UM/JMH Plastic Surgery Program is to provide each individual resident with a broad based clinical experience and the development of a basic fund of knowledge thus enabling him to independently practice plastic and reconstructive surgery in either a private practice or academic environment. Curriculum is centered on residents rotating through distinct educational experiences with progressive graded surgical responsibility under the guidance of the attending staff. It is expected that at the successful completion of the program, each resident should be able to pass appropriate specialty oral and written board examinations.

ASSIGNED ROTATIONS

**Year 1:**
- JMH/UMH: 9 months
- Hand/Micro: 2 months
- MCH: 1 month - case by case assignment by Program Director
- Dr. Stuzin’s Office: per Program Director

**Year 2:**
- VAH/Possible Laser/Possible private office: 4 months – Alternate Tuesdays with Dr. Stuzin’s office
- Hand/Micro: 1 month
- JMH/UMH: 4 months (administrative chief responsibility)
- Elective Hand Rotation: 1 month
- MCH/Dr. James Stuzin’s office/: 1 month
- Elective Cosmetic Surgery Rotation: 1 month - case by case assigned by Program Director
- Vacation: 1 month

**Year 3:**
To be determined

**Clinical Components:**

Knowledge of surgical design, surgical diagnosis, embryology, surgical anatomy, artistic conceptualization, surgical physiology and pharmacology, wound healing, surgical pathology and microbiology, adjunctive oncological therapy, biomechanics, rehabilitation and surgical instrumentation are fundamental to clinical practice of the specialty of plastic surgery. Judgment and technical capability for achieving satisfactory surgical results are mandatory qualities for developing a competent independent plastic surgeon.

The UM/JMH Division of Plastic Surgery is directed towards providing the foundation leading to the development of different areas of clinical expertise at each hospital site. However, the primary goal of the program remains the development of a superior level of patient care through graded supervision by the faculty. Residents need to be totally cognizant of their limitations and must never attempt to provide clinical care or accept personal responsibility for clinical services or procedures for which they are not completely trained or confident of accomplishing. As part of their professional development each resident must clearly recognize their abilities and not practice outside of their level of training. Each resident is personally responsible for
communicating to the faculty significant issues as they relate to patient care. Such communication must be documented in the appropriate medical records. Failure for the resident to perform within these guidelines of graduated levels of responsibilities or satisfactorily communicate significant patient care issues to a responsible faculty member may result in an immediate warning or even a more severe sanction.

1. Specific training should be provided in the following areas of competency:
   (a) Basic science as it applies to the general practice of Plastic Surgery - Medical knowledge.
   (b) Basic technical skills to independently practice Plastic Surgery - Interpersonal skills and communication.
   (c) Exhibit ethical attitudes and behavior consistent with excellent patient care - Patient care.
   (d) Investigation and evaluation of their own patient care, appraisal, and assimilation of scientific evidence and improvements in patient care - Practice based learning and improvement.
   (e) Commitment to carrying out professional responsibilities adherence to ethical principals and sensitivity to a diverse patient population - Professionalism.
   (f) An awareness is manifested by actions and responsiveness to a larger context and system of healthcare and edibility to effectively call on system resources to provide care of optimal value - Systems Based Practice.

2) Areas within the specialty of Plastic and Reconstructive Surgery include:
   a) Congenital defects of the head and neck including cleft lip/palate, other craniofacial, and dental-facial anomalies
   b) Neoplasms of the head and neck, including the oropharynx, and training in appropriate diagnostic endoscopy procedures
   c) Craniofacial trauma; basic dental anatomy and terminology
   d) Aesthetic surgery of the head, neck, trunk and extremities
   e) Plastic surgery of the breast: reconstructive and aesthetic
   f) Surgery of the hand/upper extremities
   g) Plastic surgery of the lower extremities
   h) Plastic surgery of congenital and acquired defects of the trunk and genitalia
   i) Burn management, resuscitation, early surgical management and reconstruction
   j) Microneurovascular surgical techniques applicable to plastic surgery
   k) Reconstruction by tissue transfer including various flaps and grafts
   l) Surgery of benign and malignant lesions of the skin and soft tissues

3. Outpatient Experience: There must be a well-organized and well-supervised outpatient clinic. This clinic must operate in relationship to outpatient services employed within the JMH educational program.

   a) Residents must have an opportunity to see patients, establish provisional diagnosis and initiate preliminary treatment plans with appropriate faculty supervision and guidance;
   b) An opportunity for follow-up care must be provided so that the results of surgical care may be evaluated by the responsible resident with appropriate faculty supervision.
   c) All these activities must be under an appropriate level of faculty supervision. In the cases where residents participate in pre and postoperative care in a private office, the Program Director must ensure that residents function with an appropriate degree of responsibility with adequate supervision. A daily diary or log to document the resident’s attendance and educational experience for the private office cosmetic rotation.
   d) Satisfactory experience should be provided in office practice procedures and management
   e) There must be an adequate quantity and breadth of surgical experience for each resident
   f) Experience in all 12 categories of surgical experience is most important and must not be limited by excessive nonclinical activities or service demands.
   g) There must be equivalent and equal distribution of categories and number of cases among the residents
   h) Resident experience in patient management should be characterized by graded and progressive responsibility
   i) The Chief Plastic Surgery Resident may be expected to serve as an intermediate supervisor or teaching assistant when documented prior experience makes it appropriate. However, they must always have supervision readily available from faculty or staff.
Didactic Components:

The scope of plastic surgery is sufficiently broad so that a well-organized, comprehensive and effective educational curriculum is necessary to ensure that each resident experiences sufficient training in all the various areas of our specialty. Pertinent related basic science applications must also be covered. The written curriculum should reflect careful planning of all years of the program with evidence that the cyclical presentation of core specialty knowledge is being supplemented by the addition of current information including practice management, ethics and medico-legal topics as related to the practice of plastic surgery.

Conferences should be organized by the faculty and held in an educational environment to allow discussion of topics selected to broaden knowledge in the wide field of plastic surgery and to critically evaluate current information.

There should be regular documented attendance of plastic surgery conference by both residents and faculty. These mandatory conferences include: Indications Conference, Grand Rounds, Didactics Conference, Plastic Surgery and Hand Journal Clubs, Quarterly Research Meeting Conference and Mock Oral Examinations. Attendance is documented by a sign in sheet. Conferences are presented by both residents and faculty. Faculty will serve as advisors for resident presentations. Visiting faculty from other institutions are frequently invited. Residents on affiliated service rotations such as hand and microsurgery, Miami Children’s Hospital, Burn and VAH may attend conferences located within that institution if they do not interfere with required core curriculum conferences at UM. Absences must be discussed with the Program Director sufficiently in advance and appropriately signed off. A summary of the assigned Journal Club article should be forwarded to the Program Director the day prior to the assigned date of the Journal Club. This summary must cover the analysis so the article incorporating the six core competencies. At Journal Club, the format should follow the title, authors and a critical analysis of the article including level of evidence, how it changed your practice. It should NOT be a general summary of the article.

Periodic review of Morbidity and Mortality experience of the service must be documented. This will occur with the completion of each 2 month rotation, the administrative chief resident (JMH) will be responsible for organizing and assigning presentations. This must be accomplished with the active participation of the involved supervisory faculty member. Each resident presentation should include a discussion of the case through a description or each of the six competencies as they relate to that particular case. Residents will be expected to present appropriate cases from each of our affiliate hospital. The resident should provide photo documentation and be able to discuss a relevant clinical description of what occurred as well as answer pertinent questions regarding management. Participation in and presentation of educational material at conferences is expected of each individual resident. Level of resident participation in these conferences will serve as a significant part of the assessment of the resident’s educational performance and their synthesis of a basic fund of knowledge.

Resident Policies:
1) In hospital responsibilities: clinical rotations
2) On call
3) Mentor system
4) Annual vacation time/travel time
5) Duty hours – MUST BE LOGGED ON NEW INNOVATIONS WEEKLY
6) Moonlighting
7) Evaluations & assessment of residents

Residency training in plastic surgery is a full-time responsibility; activities outside the educational program must not interfere with the resident’s performance in the educational process as determined by the program director. Also, this must not interfere with the resident’s opportunities for rest, relaxation and the faculty study. Moonlighting activities are NOT permitted. In addition, residents are NOT to participate at any other unassigned clinical site without prior approval from the Program Direction.

In addition, residents are required to engage in other scholarly activities such as participation in ongoing clinical and/or basic science research projects with appropriate faculty; preparation of manuscripts for publication or presentation in scientific meetings, maintenance of patient records such as written charts, photographs and copies of x-rays, as well as fulfilling basic responsibilities such as completing medical records, dictations and PSOL reports in a timely manner. Also, each resident must be present at their assigned rotation unless excused by the Program Director. Lastly, each resident is required to be present at their clinical and didactic assignment
on time. Repeated tardiness will result in loss of vacation days or further actions. These are an integral part the Professionalism Core Competencies.

EVALUATION

The ACGME now requires that the faculty provide evidence of suitable resident learning in all six competencies. These are considered most meaningful to physician practice using dependable measurement tools (competency focused evaluation tools) that can assess the effectiveness of individual resident education in the six requisite skills. These should define the specific knowledge, expertise and attitudes required to supply adequate educational experiences as needed for the individual resident to demonstrate in the context of a physician practice. Requirements clearly mirror the ever-changing public expectations and perceptions of physician. Basically our patients expect competence, kindness, and professional responsibility. Art of medicine can and should undergo continued assessment that provides evidence that learning has occurred. Whatever is measured can be improved; therefore we will direct our energies toward documented accountability. At the successful completion of the residency program the resident’s acquired skills and clinical experience will enable him/her to practice their field of plastic surgery competently and independently. This shift in plastic surgical education that had emphasized “traditional” time-based mentoring has necessitated an ever evolving change in how learning concepts apply to a plastic surgical education, now focusing on educational outcomes.

Competence includes:
(a) Cognitive function-acquiring and using knowledge to solve real life problems. It depends on habits of mind including critical curiosity
(b) An integrative function-using biomedical and psychosocial data in clinical reasoning; it is not only what you know but also how you use it and acquire new knowledge
(c) A relational function-communicating effectively with patients and colleagues
(d) An effective/moral function-the emotional awareness, willingness, and patience to use these skills judiciously and humanely

Studies have demonstrated that information describing physician competence complements additional information acquired form other sources and may even improve moral and performance. These assessments drive learning by sustained observing and testing. This notion of evaluation expresses “value” by communicating a moral tone for the entire institution. Residency training is more about gaining situation specific judgment and skills rather than learning basic principles. Assessments will include global evaluations, focused observational assessments; patient and professional associate assessments of residents, and the development of portfolios that will supplement classic cognitive examinations. These will be formulated as an open process due to the size of the program representing a small enterprise.

The term TOOLBOX has been employed as a description of assessment (defined as the process of collecting, synthesizing, and interpreting information to aid decision-making.) The results of an assessment should allow faculty inferences about what learners know, believe, and what they can do. Residents will have ample learning opportunities during their 3 year residency period.

<table>
<thead>
<tr>
<th>Competency</th>
<th>Opportunities for assessment</th>
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<tbody>
<tr>
<td>Patient Care</td>
<td>Clinical teaching&lt;br&gt;OSCE’s&lt;br&gt;Clinical Experience&lt;br&gt;Performance Feedback&lt;br&gt;Operating Room Preparation &amp; Performance&lt;br&gt;Divisional conferences, lectures, discussions&lt;br&gt;Clinic notes and evaluation&lt;br&gt;360° Evaluation&lt;br&gt;M &amp; M Conferences</td>
</tr>
<tr>
<td>Medical Knowledge</td>
<td>Clinical teaching&lt;br&gt;OSCE’s&lt;br&gt;M &amp; M Conferences&lt;br&gt;Clinical experience: Rounds, clinic, OR&lt;br&gt;Performance feedback&lt;br&gt;Weekly quizzes, In-service exams, Mock oral exams, Didactic sessions, Indications conferences, Journal Club</td>
</tr>
</tbody>
</table>
## ASSESSMENT INSTRUMENTS INCLUDE:

(a) **Multivariate/360 degree evaluation**: these consist of instrument tools or surveys completed by multiple people in a person’s sphere of influence: i.e. superiors, peers, subordinates, patients, families and nursing staff in clinics, wards and operating rooms; generally this is accomplished via a survey gathering data on an individual’s performance using rating skills. This technique can provide formative feedback on such significant areas as interpersonal relations, communication skills, professional behaviors, and some aspects of patient care and systems based practice. Studies in industry indicate that a 360-degree assessment improves morals and overall work performance. This is designed to be a formative evaluation of the resident. Evaluations will be distributed to various members of our Plastic Surgery team, collected and the data shared with residents in a confidential manner.

(b) **Oral Examinations**: assess clinical decision-making and the application or use of basic plastic surgery medical knowledge with actual patients; scores are determined by pre-defined rules. This area will be further assessed by performance at didactic sessions, journal club, indications conference, and various clinical settings.

(c) **Written Examination**: better for assessing recall or medical knowledge. This will be supplemented by scores on weekly quizzes during the didactic sessions, performance at didactic and indications conferences, and in-service examinations.

(d) **Checklists**: consist of essential or specific behaviors or steps that make up a more complex competency. These will be evaluated by reviewing clinical performance and observations by attending in the staff clinic.

(e) **M & M and Indications Conference Presentation**: Each resident will be expected to follow the recommended format. Assessment of the resident performance will play a significant aspect of the resident’s evaluation for progression and graduation.

(f) **Global rating**: a rater judges general categories of abilities (e.g.: patient care skills, medical knowledge, interpersonal and communication skills) rather than specific skills, tasks, or behaviors; these are usually completed retrospectively and are based on general impressions obtained over a period of time using multiple sources of information. Evaluation forms will be used and completed by the faculty at the completion of each two-month rotation. The results will be discussed confidentially with the resident during the bi-monthly discussion of PSOL’S.

(g) **Objective Structured Clinical Examination (OSCE)**: standardized patient encounter stations; these provide a standardized means to assess the resident’s capacity to satisfactorily complete a physical examination, history taking skills, communication skills with patients, family members, breadth and depth of knowledge, ability to summarize and document findings, ability to make a differential diagnosis, or plan treatment based on patient notes and encounter; this provides a direct measurement.
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in a standardized manner of patient-doctor relationship. To achieve this goal, each resident will go through a number of stations with patients demonstrating typical plastic surgery clinical problems. They will be asked to interview and examine these patients and then develop a comprehensive management plan. These sessions will be videotaped and then evaluated by full-time and voluntary faculty. The resident’s skills will be assessed by the faculty and then reviewed with the individual resident.

(h) Procedure, operative, case logs, and medical records: these serve to document each medical encounter by medical condition, surgical operation, or procedures. This is useful for determining the scope of patient care experience. It is important to acknowledge: NUMBERS DO NOT INDICATE COMPETENCE.

(i) Patient surveys: surveys will be employed to assess satisfaction with hospital, clinic, or office visits; they will assess the overall satisfaction with resident physician care e.g.: amount of time spent, patient’s impression of the overall quality of care, overall impression of the house staff physician’s competency courtesy, empathy, and communication skills.

(j) Portfolios: collection of products prepared by the resident that provides evidence of learning and achievement related to a learning plan; this can take on a variety of forms of information including: Statements about what has been learned, applications, remaining learning needs and how they can be met; log of procedures performed; summary of treatment plans; literature searches; practice based improvement such as a variety of teaching experiences, and individualized studies or research.

(k) Record review: can provide information regarding clinical decision-making, follow-through in patient management and preventive health services, and appropriate use of clinical facilities and resources.

(l) Journal Club – Each resident will be expected to put together and hand in a 1-2 paragraph of their assigned articles describing the relationship to practice based practice and practice based learning and improvement. M & M – a similar 1-2 paragraph summary regarding the case presentation.

RESIDENTS ARE EXPECTED TO DEMONSTRATE COMPETENCIES IN THE FOLLOWING AREAS:

1. PATIENT CARE: residents must be able to provide patient care that is considered compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. (i.e. beneficial, prudent and therapeutically parsimonious. Therefore, treatment is expected to be rendered with both effective communication and a caring respectful affect.

Residents will be expected to:

(a) Develop and implement a patient care plan-Oral examinations Indications Conference

Standardized patient assessments.

ASSESSMENT TOOLS:

These can be sent in unannounced; can be perform ratings immediately after a visit reviewing a videotape of the encounter.

(b) Develop satisfactory technical ability demonstrating that they can competently perform all medical and invasive procedures considered essential for the area of practice e.g.: index procedures.

(c) Apply information technology to optimize patient care decisions and patient education.

(d) Appropriate evaluate and interpret diagnostic studies

(e) Communicate effectively and demonstrate caring respectful behaviors when interacting with patients and their families; counsel and educate patients and their families Standardized patient assessments Arctic Sun Simulated 360-degree assessments

PSOL’S

Journal Club

Oral Exam

Indications

Conference

Peer

assessments

assessments
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patient management exercise

(f) Gather essential and accurate information about their patients
(g) Provide health care services aimed at preventing health problems or maintaining health
(h) Work with health care professionals, including those from other disciplines to provide patient focused care:

2. MEDICAL KNOWLEDGE: residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognitive sciences and the application of knowledge to patient care.

(a) Know current medical information – can tap into the trainees thinking process; evaluate their ability to use medical literature to exercise good clinical judgment. Assessments will include assignments that approximate real practice situations

    Oral Examinations
    Indications
    Conference Didactic sessions
    Weekly quiz
    In-service examinations

Portfolios: these may include videotapes of technical procedures and other real life practice data that will inform the trainee and faculty advisor about the trainees’ accomplishments and weaknesses. These lend credibility to assessment programs by allowing trainees to demonstrate what they can actually do and are capable of doing.

(b) Critically evaluate scientific information

    Oral Examination
    Indications
    Conference
    Journal Club
    Discussions
    Didactic Sessions

3. INTERPERSONAL SKILLS AND COMMUNICATION: residents in training must be able to demonstrate their interpersonal and communication skills that result in effective information exchange and teaming with patients, their families, and other health care professionals

(a) Communicate with other health care professionals
    360-degree surveys
(b) Counsel and educate patients and families
    OSCE
    PSOL record
(c) Maintain appropriate records documenting Practice activities and outcomes
    Medical records deficiency
    Quality assurance report
    360-degree survey
(d) Function as a team player

4. PRACTICE BASED LEARNING AND IMPROVEMENT: this incorporates investigation and evaluation of the individual residents own patient care, appraisal and assimilation of scientific evidence, and improvements in-patient care

(a) Commitment to practice
    Lifelong learning
    Research project
    Oral examination
    Indications conference
(b) Analyze personal practice outcomes
    PSOL log
5. PROFESSIONALISM: residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse population. Residents will be expected to conduct themselves in a professional, collaborative manner while providing services to patients and the public. They must treat others with respect, courtesy and dignity through teamwork and conduct themselves in a professional manner.

a) Maintain high standards of ethical behavior
b) Demonstrate continuity of care
c) Sensitivity to age, gender, cultural differences
   In an atmosphere of mutual respect
d) Demonstrate honesty, dependability
e) Concepts of virtues are highlighted including
   the need for self-effacing and respectful of persons
   while displaying compassion and integrity.
f) Residents must demonstrate a commitment to ethical principle
   including informed consent and replraisal, confidentiality and
   aspects of business ethics
g) Arrive at their assignment on time
   h) Be at assigned rotations unless previously signed off by the Program Director

6. SYSTEMS BASED PRACTICE: residents must demonstrate an awareness as manifested by their actions a responsiveness to a larger context and system of health care and how they have an impact on that system and vice versa and the ability to effectively call on system resources to provide care that is of optimal value. The resident will be expected to develop an appreciation of how healthcare costs may be controlled while continuing the delivery of quality healthcare. The resident must develop a delicate balance between serving the patient’s needs and fully understanding of how to work within our current healthcare system for the benefit of patient and system.

a) Practice cost-effective care and resource allocation
   Without compromising quality
b) Know how different practice systems operate to deliver care
   Indications Conference
   360 degree survey
   Indications Conference
   c) Understand how they’re patient care and other professional
   Practices affect other health care professionals, Indications conference
   360 degree survey
   Oral examination
   The health care organization, and the larger society
   And how these elements of the system affect their own practice
d) Advocate for quality patient care and assist patients in dealing
   with system complexities
   360 degree survey
   Conference
   Oral Exam
   f) Know how to partner with health care managers and health care
   providers to assess, coordinate, and improve health care and
   know how these activities can affect system performance
   360 degree survey
   Indications Conference Oral Exam

Overall assessment of each resident will be performed via a global performance rating, focused observation and evaluation. 360° assessments and structured case discussions such as on ward rounds, the operating room and conferences. All six general competencies can be covered and evaluated thoroughly through those activities by faculty and associate colleagues. These evaluations will be employed to provide a resident with both oral and written feedback, through individual resident’s learning, maturity, and progress as well as aid the faculty in addressing the programs overall educational effectiveness and make appropriate changes as indicated. These
will be collected every 2 months at the completion of each clinical rotation and will serve as significant parameters in the overall evaluation of the resident.

Each resident will have 2 formal “mock” oral examinations per year that will assess the 6 aforementioned competencies. These will help track the individual’s learning, growth, and progress and will be of significant importance in the overall evaluation of the resident. The standardized in-service examination is given once per year and the scores are particularly well served to objectively track the resident’s competency with patient care and medical knowledge. It will also be of moderate importance in the overall evaluation of the resident’s progress. Review of the PSOL’s (Plastic Surgery Operative Log) is done at the completion of each 2 month clinical rotation. It will be directed towards assessment of practice based learning and improvement and possesses a high importance in the overall resident evaluation. Review of patient outcomes will be assessed during conferences such as M & M and indications, clinics and rounds. This assessment will be done multiple times during a clinical rotation and will be of significant importance in the resident’s overall assessment.

Residents must be able to function safely without supervision at the time of completion of their three-year residency at UM/Jackson Memorial Hospital.

Residents spend their first year at a junior level and progressively rise to a more senior level with increasing independent responsibility in their third year where they serve as a Chief Resident. At the completion of each rotation, residents will be evaluated by the service attending and appropriate faculty who are directly responsible for the resident’s supervision and training. Resident will then meet with the Program Director and a faculty member and/or representative from the Educational Advisory Committee for an in-depth discussion of his/her progress, including strengths and weaknesses while serving on that rotation. Knowledge and progress of each resident, including personality characteristics and ethics, interpersonal relationships, communication and professional skills must be evaluated by the Program Director in consultation with the teaching staff and Educational Advisory Committee in a semi-annual written review. Residents must sign this evaluation to indicate to the Program Director that he/she has satisfactorily reviewed the evaluation. Semi-annual review will accomplish the following:

1. Identify and document deficiencies as well as develop an enhancement plan if necessary to correct these deficiencies prior to completion of the residency program.
2. Evaluations will be communicated to the individual resident in a confidential conference with the Program Director and another faculty member, with a discussion of any recommended necessary remedial steps. Review and comments should be signed by the Program Director, involved faculty, and the resident with the Program Director and be maintained on file for at least five years following the resident’s completion of the program.
3. All educational programs and resident activities will be discussed with the Educational Advisory Committee who will provide significant input to the Program Director regarding the initial progress and eventual graduation of each individual resident.
4. At the completion of the 3 year residency program, each senior resident will have a terminal interview to discuss the resident’s educational experience and encourage constructive criticism of the residency program. The Program Director will also place in the resident’s file a note regarding the resident’s clinical competency ethics/professionalism and basic fund of knowledge to independently practice the specialty of Plastic Surgery.

Faculty Evaluation:

Program Director and the resident staff evaluate all faculty members at least annually. There will be preservation of the confidentiality of this process allowing for the positive and constructive development of the teaching program. Residents are required to complete faculty evaluations after each rotation. These can be accomplished anonymously on line through New Innovations. The Program Director uses these to evaluate the faculty annually and counsel them as needed. The residents and fellow also have the GME Hotline (1-855-GME-2050) available 24 hours a day, 7 days a week as a means to report any concerns or issues about the Plastic Surgery training program. Faculty, our institution or work environment. All messages are monitored daily and are handled in an anonymous and confidential manner unless otherwise instructed.

Internal Evaluation: Within the program, we will have at least one internal evaluation of the educational, research and clinical aspects of our program. The entire division (faculty, resident, administrative support and research staff) will meet annually for an overall evaluation of the program in terms of clinical experience,
research, educational productivity and review the goals and objectives of the program. This is supplemented by monthly division meetings. All full-time faculty, administrators, staff and the Plastic Surgery Director meet monthly to discuss more acute divisional challenges.

**Guidelines for Advancement of Residents** – first year through second year: First year residents will be expected to satisfactorily complete each clinical rotation and exhibit the satisfactory development of graded clinical responsibilities as demonstrated by their faculty evaluations and assessments. Residents, who have poor or unsatisfactory evaluations by the faculty rotations for significant deficiencies in clinical or technical skills, basic fund of knowledge, or interpersonal relationships or communication skills for two service rotations will be given an immediate warning or placed on academic probation. Residents are expected to pass both Mock Oral Examinations, achieve a score of >50% on the In-Service Exam, have all medical records up to date, complete their annual research project, maintain PSOL data and a level of >50%, have satisfactory 360 generations, satisfactory completion of elective modules, pass the OSCE’s and demonstrate a satisfactory progression through the 6 competencies as evaluated by the “tool box”.

The criteria to have the warning removed from the residents’ academic record include:

a) Attendance at >90% of the Division’s mandatory conferences.
b) Significant improvement in evaluations by the faculty especially in areas cited.
c) Satisfactory completion of an enhancement educational program initiated by the faculty.
d) Improvement of performance in all educational activities such as Indications and Didactic Conferences, Mock Oral Exam’s, OSCE’s and In-Service Exams, and 360 evaluations.

**Reasons for failure of Re-appointment** – The Educational Advisory Committee of the division will periodically meet with the objective to provide constructive feedback to the residents regarding their development of clinical skills and basic fund of knowledge in the field of plastic surgery. The committee shall advise the program director regarding the competence of individual resident’s performance and make recommendations regarding advancement.

a) Continued unsatisfactory clinical and didactic performance as determined by faculty evaluation, assessment of educational sessions including mock oral exams and in service examination scores, OSCE’s, attendance at educational sessions, and satisfactory completion of general regulations and the six core competencies.
b) 2 warnings per academic year.
c) Failure to correct probationary status.
d) Failure to comply with conducts as embodied in the “Principle of Medical Ethics”.
e) Resident resignation or dismissal.
f) Jackson Health System maintains a zero tolerance approach towards intimidating, disruptive and illegal behaviors that may contribute to a work environment impacting staff safety, quality of patient care or criminal behaviors. Jackson Health System employees are accountable for their behavior.
g) Disruptive behavior - controversy and disruptive behavior is defined as behavior that has negative impact on workplace environment.
   a. Overly negative attitude
   b. Inappropriate comments
   c. Unprofessional behavior in patient care
   d. Deliberate violations of organizational policies
   e. Profane or disrespectful languages
   f. Sexual harassment
   g. Discerning behavior
   h. Outbursts of anger
   i. Deliberate disregard of established policy
   j. Insubordination, rude, antagonistic or offensive conduct towards supervisors, co-workers or public.
h) Tardiness is defined as arriving at the work location after the scheduled starting time. Excessive tardiness is defined as reporting for duty at least twice in a pay period. Tardiness that follows a set pattern also may constitute excessive tardiness and failure to uphold policy.
i) Dress Policy – Every employee of Jackson Health System is expected to come to work appropriately dressed.
Each resident will be expected to be satisfactorily prepared to perform the surgical procedures as demonstrated in their pre-op assessment and operative plan. This is to be accomplished with satisfactory photo documentation and a stepwise written discussion of their operative plan. Each resident is expected to have demonstrated an adequate quantity of surgical procedures to ensure satisfactory clinical experience in the wide range of plastic surgery procedures as determined by the faculty. If the resident has a surgical experience of 25% or less, an immediate warning will be assessed. All medical records and PSOL’s must be completed in a timely manner. Resident attendance is mandatory at all Didactic Conferences, Journal Clubs, Research Conferences, Interdisciplinary Conference, Gross Anatomy, Indication Conferences, M & M, and Grand Rounds. If a resident has more than 10% unexcused absences or tardiness for these mandatory conferences, they will be given an immediate warning. Each resident must satisfactorily demonstrate a synthesis of basic plastic surgery knowledge during rounds, conferences and didactic sessions at completion of Division’s educational program as assessed by the Plastic Surgery Faculty. Residents are freely permitted to review records of their own performance and files.

In-Service Examination scores, performance on the two Mock Oral examinations and participation in the overall educational program will help determine whether a resident has achieved an adequate level of a basic fund of knowledge in Plastic Surgery. In-Service Exam: This multiple-choice examination has been developed by the Plastic Surgery Educational Foundation and is graded by the National Board of Medical Examiners. Results are compared with all residents at similar levels of training. It is generally given in the spring. Results will allow the resident to evaluate his strength and weaknesses in each area of specialization. Residents are expected to achieve a minimal score of 50% or be placed on an enhancement program. To correct this, the program director will organize a series of tutorials with members of our faculty. During these individual sessions, the resident will be given appropriate reading assignments and then satisfactorily complete an examination that will ensure that the resident has achieved a satisfactorily level of a basic fund of knowledge. First Mock Oral Exam will consist of cases presented to the resident by the faculty and in the second, the resident will prepare a number of cases determined by the faculty in accordance with the ABPS guidelines for the oral exam. This booklet will be given to the resident at orientation. Examiners will be from the full-time and voluntary faculty members. Each resident will be given an assessment of their performance on the Mock Oral exams by the Program Director. These results will help the faculty in determining the level of which a resident has synthesized a basic fund of knowledge and the resident’s ability to analyze their basic fund of knowledge into clinical performance.

Corrective Action: 1. Residents may be required to complete corrective action secondary to unsatisfactory academic performance and/or misconduct including but not excluding: basic fund of knowledge, technical skills, interpersonal relationships, professionalism, job achievement, or violation of applicable policies or procedures (job performance).

2. At the recommendation of the Educational Advisory Committee to proceed with an adverse action due to unsatisfactory job performance, the resident may be requested to attend a conference for the purpose of discussion and counseling regarding the faculty’s concern prior to the imposition of any corrective measures or disciplinary action. Goal of such a meeting is to encourage communication regarding specific areas of concern and development of corrective actions.

Graduation: to be signed-off by the Program director, the senior resident should have demonstrated competence and responsibility in plastic surgery in the following areas: patient care, medical knowledge and cognitive skills, interpersonal and communication skills, practice based learning, professionalism and ethical behavior, and system based practice. These parameters will be evaluated through faculty evaluations, examinations, performances in conferences and the operating room, clinics & wards. In addition, the resident should have developed into a competent and responsible plastic surgeon with high moral and ethical character capable of functioning as an independent plastic surgeon. Each clinical rotation must be satisfactorily completed as exemplified by the faculty evaluations and observations. A broad based operative experience as demonstrated by the PSOL data is also required. This will be demonstrated by achieving a level of performing a minimal number of required index cases at the 50%. A chief resident will have demonstrated a satisfactory basic fund of knowledge within the field of plastic surgery as exemplified by their participation in all Didactic sessions, performance during indications conference pre-operative and clinical preparations, scores on the In-Service exam, and results on the two Mock Oral exams and OSCE’s. Any recognized educational deficiencies must have corrected by appropriate remedial steps as previously determined and outlined by the Program Director and the Educational Advisory Committee. All required divisional and institutional paperwork must be completed in a timely manner. Educational Advisory Committee will consist of members appointed by the Program Director from the full-time faculty and senior Voluntary Faculty who will help to evaluate the
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Educational progress of our residents on a semi-annual basis. During these meetings, the members will assess resident’s areas of concern; progress related to their training including issues involving interpersonal relations, duty hours and on-call schedules and vacation time; and focus primarily on the assessment of the resident in gaining satisfactory competence in the areas of medical knowledge, patient care, practice based and system based learning. In addition, this committee will concentrate on constantly improving the overall educational experience of the entire division. This committee will meet semi-annually to review each resident and also provide input to the Division Chief for Promotion and Graduation of each resident.

Unique experiences provided during the residency program should provide each resident a wide variety of educational opportunities to fulfill Board qualifications in the field of plastic surgery and to provide teaching in the field of plastic surgery to medical students and other specialists and post graduate practicing physicians.

In summary, plastic surgery residents will be evaluated and demonstrate satisfactorily competence in the following areas:

1. Plastic surgery residents are able to demonstrate at the completion of their residency they are accomplished surgeons as demonstrated by faculty evaluations to solve clinical problems.
2. Each resident has been able to demonstrate a satisfactory level of educational knowledge and comprehension and cognitive skills, as demonstrated by their satisfactory performance on their In-Service Exams, Mock Oral Exams, OSCE’s, Didactic Sessions, Grand Rounds, Journal Clubs and Indication Conference.
3. They can show basic skills in research and formulate a research plan by completion of their required yearly research project.
4. That they have been evaluated by the faculty and staff to have shown that they are ethical and moral physicians and provide effective system based practice.
5. Demonstrate a satisfactory level of clinical experience through their PSOL data and performance in the operating room and demonstration of pre-operative preparation. This will permit the faculty to assess their clinical and technical abilities
6. Have completed all required paperwork in a timely manner.
7. Demonstrate satisfactory patient care by showing they can apply their medical knowledge to solving clinical problems and results of patient satisfaction surveys and other 360° evaluations.
8. Demonstrate a satisfactory level of interpersonal and communicative skills and can function as a team member.
9. Demonstrate a satisfactory level of technical and clinical skills.
10. Demonstrate satisfactory development of professionalism and interpersonal communication.

Grievances: As per the Graduate Medical Education Program Agreement (see attachment No. 1 Personnel Relations and Disciplinary Action).

RESIDENT ROTATIONS

Resident rotations are directed towards providing teaching, adequate supervision and graded responsibility leading on to an optimum surgical educational experience so that the individual may attain a satisfactory level of achievement in the 6 required areas of competency. Should residents need to have cross coverage for educational purposes or vacations, they should arrange this among themselves with other residents (preferably at the same level of training). Each resident must obtain appropriate documentation, which must be appropriately signed off; this includes prior approval from the Program Director, and a signature on the risk management form from the covering resident agreeing to provide appropriate and complete clinical coverage. This paperwork, which is obtained from the Plastic Surgery Administrator, must be completed and signed by the Program Director at least 2 weeks prior to the requested date of vacation. Vacation requests will be made in July for the entire year and should follow recommendations as outlined in this Guide. We will make every attempt to grant vacation requests; however, they will only be permitted if they do not significantly interfere with the requirements of the division’s overall responsibilities to education and patient care. To attend an educational meeting, each resident will have to utilize their vacation time. There will be no scheduled cross coverage. All rotations will be eight weeks in duration except for the JMH junior residents. We will have a general surgery first year resident rotating on a monthly basis. First year general surgery resident is an integral part of our service and he/she should be able to become proficient in the basic tenets of plastic surgery, including basic suturing techniques, wound healing, wound management, and a complete maxillofacial evaluation. This resident will help by performing admission history and physicals, ward coverage, clinic coverage and emergency room coverage. Their maximum on-call coverage should be no more than one night in
three and they are to have a minimum of one full weekend free without any clinical responsibilities. They will not have clinical responsibilities exceeding 14 straight hours. They cannot perform any procedure, especially in the ER without approved plastic surgery resident direct supervision. Following their on-call they must be permitted to leave in order to have 10 hours of down time. Over a four week period, they must average a total of 80 hours per week, consistent with both ACGME requirements and agreement with the CIR. Their night call responsibilities will be assigned through the Chief Resident at Jackson Memorial Hospital. At the end of their rotation, they will be expected to present a short presentation to the group on a subject of their choice in consultation with the Program Director and/or Chief resident. Dr. Oeltjen will be the direct supervisor of these participants.

Education and training of medical students who rotate on the plastic surgery service remain one of our primary responsibilities as members of the University of Miami Medical School. They should be able to learn and develop basic suturing techniques, become familiar with basic flap design and physiology, normal and abnormal wound healing, and management of basic reconstructive problems, as well as to perform both a basic head and neck and hand examination. They will also be able to help with admission H&P’s ward and assist in the operating room. They should have an educational experience exposing them to the full breadth of plastic surgery. In addition, rotating residents and medical students are to meet with the Program Director at least once a week during their rotation for didactic sessions detailing the basic plastic surgery curriculum. Foreign medical students cannot perform any form of hands-on patient care including H & P’s. These individuals will be required to present a short topic to our team during their last Didactic session.

**Graded Levels of Responsibility**

An integral aspect of graduate medical evaluation is the granting each individual resident graded progressive clinical responsibility for the management of patients. Determination of this resident’s capacity to provide independent patient care or function in a teaching capacity will be based on the documented evaluation by the faculty of the resident’s clinical experience, judgment, knowledge and technical skills. In the final analysis; however, it is the decision of that involved faculty member to determine which activities the resident will be allowed to perform within the context of the assigned levels of responsibility. Overriding consideration of each faculty member will always be the safe and effective care of the patient which is the personal responsibility of each and every faculty member.

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RESIDENT ROTATIONS: 1st year requirements:

One of the Junior Residents on the Jackson Memorial Hospital service will be assigned to the Burn Service for a period of 2 weeks. Plastic Surgery resident should assume the position of the chief resident overseeing and coordinating the care of patients under the guidance of the full-time Burn Faculty. Plastic Surgery resident is responsible for day to day management as well as overall planning of each patient’s care. In addition, the Plastic Surgery resident may serve as a resident supervisor for general surgery residents, interns, and medical students who rotate on the burn service. Plastic Surgery resident will be expected to take sufficient burn call to permit satisfactory participation in acute burn resuscitation. Resident on this service will be expected to attend all clinical activities of the service under the direction of doctors Pizano, & Schultz. This will afford the resident the opportunity to evaluate the long-term effects of thermal injury and participate in various phases of burn rehabilitation. In addition, the resident should participate in weekly Burn Rounds in order to gain a comprehensive understanding of the interdisciplinary approach to burn rehabilitation. To insure adequate clinical experience with the management of acute resuscitation of burn patients, the third year general surgery resident will page the assigned plastic surgery resident upon a patient’s admission to JMH. Plastic Surgery resident is expected to respond immediately and be present and actively participate in the resuscitation. Plastic Surgery resident is also required to attend all Burn Clinics, Tuesday rounds and all Operative cases during their Burn Service rotations. In the event the Plastic surgery resident does not obtain satisfactory clinical experience, the Program Director may decide in consultation with Doctor Pizano to appropriately modify the individual’s rotation to ensure adequate experience in the care of burn patients.

1) BURN SERVICE:

A. Medical Knowledge:

GOALS:
1. To train residents to obtain a comprehensive understanding of the evaluation and management of patients that have sustained burn injuries. Including zones of coagulation, stasis, and hyperemia
2. Utilize the Rule of Nines and more detailed body surface area charts and various techniques of fluid resuscitation
3. Discuss the parameters between major, moderate, and severe burns.
4. The plastic surgery resident will become thoroughly familiar with available techniques and principles involved in the critical care of the acutely burned patient including pathophysiology, principles of burn resuscitation, and techniques of burn wound repair and reconstruction
5. Describe the pathophysiologic changes unique to chemical, acid, alkali, chemotherapy extravasations, and hydrofluoric acid burns

OBJECTIVES:
1. Discuss the various resuscitation techniques for major burns.
2. Discuss the three zones of the burn wound
3. Discuss the management of inhalation injuries
4. Discuss the management and resuscitation of electrical burns
5. Describe the indications for fasciotomies, escharotomies, and tangential excisions
6. Discuss the indications and management options for burn scar contractures
7. Describe the pathology and management options for thermal, chemical, electrical, inhalation injuries
8. Describe in detail the principles of burn shock, immunologic alterations, and bacteriology of burn wounds

B. Patient Care:

GOALS: Plastic Surgery residents should provide patient care to the patient that has sustained a burn injury that is compassionate, and effective in the management of the burn patient.
OBJECTIVES:
1. Evaluate the appearance of the burn wound in relation to depth, bacteriologic conditions, healing potential, and requirement for either surgical or non-surgical intervention.
2. Perform debridement of the burn wound and preparation of bed for skin grafting
3. Perform tangential excision, split thickness, and full thickness skin grafting
4. Utilize appropriate skin substitutes and know their individual indications
5. Utilize splinting and pressure garments
6. Perform and know indications, options and timing for post-burn contracture releases and other reconstructions
7. Participate in the acute resuscitation and overall management of the acutely injured burn patient.
8. manage patients that have sustained electrical burns and chemical burns
9. Be able to perform and know indications and timing for fasciotomies and escharotomies.

C. Practice Based Learning and Improvement:

GOAL: The plastic surgery resident will be able to investigate and evaluate their own individual patient care practices, appraise and assimilate scientific evidence, and improve their own patient care practices.

OBJECTIVES:
1. The resident should be able to employ information technology for the preparation of surgical cases in which they are participating and bring to the operating room appropriate knowledge of current treatment modalities related to patient care and the scientific evidence for that care.
2. Routinely analyzes the effectiveness of own practices in caring for burn patients
3. Improves own practices in the care of burn patients by integrating appropriately gathered data and feedback
4. Educates medical students and rotating residents as well as other associated health care professionals in the practices of burn surgery and reconstruction
5. The resident is able to function independently with graduated advancement and appropriate faculty supervision
6. Employs library and internet resources to perform research and literature searches
7. Understands the principles of clinical research and the application of biostatistics

D. Interpersonal and Communication Skills

GOALS: The plastic surgery resident should be able to demonstrate appropriate interpersonal and communication skills that result in the transferal of effective information exchange and teaming with patients, their families, and professional associates.

OBJECTIVES:
1. Educates patients and their families in postoperative and rehabilitative strategies
2. Demonstrates compassion for patients and their relatives when afflicted by burn trauma
3. Is able to provide satisfactory counseling and informed consent
4. Listens appropriately to the needs of patients and families
5. Is able to assimilate data and related information provided by other members of the burn team
6. Charts and documents necessary medical information related to the burn patient.

E. System Based Practice:

GOALS: The plastic surgery resident should be able to demonstrate an awareness of and responsiveness to the larger context and system of health care and the capacity to effectively call on system resources to provide optimal patient care.

OBJECTIVES:
1. Coordinate all facets of burn care rehabilitation by coordinating: physical therapy, occupational therapy, primary care physicians, social workers, and nutritionists
2. Demonstrates an appreciation for cost effective burn care
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3. Advocates for the burn patient within the overall health care system
4. makes appropriate referrals for the burn patient
5. facilitates time transfer from the burn unit, discharge, and outpatient management

F. Professionalism:

GOAL: The plastic surgery resident will demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. The plastic surgery resident must always present himself/herself in all clinical settings in a respectful, professional, honest and congenial manner.

OBJECTIVES:
1. Develops an appreciation of the unique stresses encountered by patients and families of burn victims
2. Exhibits an unselfish regard for the welfare of burn victims
3. Demonstrates a commitment to medical ethics
4. Respects and works appropriately with other professionals comprising the team
5. Is reliable, punctual, and accountable for own actions in the operating room
6. Maintains patient confidentiality

2) 1st YEAR ROTATION ON THE JMH HAND SERVICE

This rotation will serve to introduce the first year Plastic Surgery resident to the basic anatomy of the upper extremity, the comprehensive evaluation of the acutely traumatized upper extremity, and become familiar with options for the management of acute upper extremity injuries, as well as learn elective hand surgery and reconstruction. This rotation is under the direct supervision of Dr. Patrick Owens, Chief of the Hand Service. Residents are expected to attend all hand clinics, wards and assigned surgical cases. If vacation time is to be planned during this rotation office must be notified far in advance (July 1st) since permission will be granted on a first-come, first-served basis. Suggested preparatory readings include the following: Surgical Anatomy of the Hand published by CIBA; the Hand published by the Hand Society, the Burkholter Handout on Hand Infections, Dr. Stephan Ariyan’s Handbook and Graham Lister’s Book on Hand Examinations, and Operative Hand Surgery by David Green. The Resident will be rotating under the direct supervision of Dr. Morad Askari and Dr. Morad Askari who has a joint appointment in both the Department of Orthopedics and Division of Plastic Surgery. Additional full-time faculty will be active and significantly participate on this service. There is a large volume of blunt and penetrating trauma as well as infectious problems admitted through the Jackson Memorial Hospital Emergency Room. When on this service, the Plastic Surgery Resident is expected to serve as a full member of the service and participate in all available educational and surgical activities. The goal of the service is to expose the resident to functional hand anatomy and physiology as well as independently manage acute and elective upper extremity surgical procedures through increasing graded responsibility. Some suggestions for reading include: Hand Diagnosis and Infection by Graham Lister and the five selected reading summaries and Hand and Operative Surgery by Greene. Plastic Surgery Residents are expected to take equal number of emergency call assignments. Vacations are on a first come, first served basis on this service so requests should be sent in as soon as possible, with the Orthopedic Educational Office in July. The Plastic Surgery Resident is expected to still fill out all required paperwork in the Plastic Surgery Administrative office prior to leaving on vacation.

HAND AND MICROSURGERY

A. Medical Knowledge

GOALS:
1. The resident will achieve a detailed working knowledge of the anatomy, physiology, and embryology of the upper extremity and be able to employ this basic fund of knowledge to provide the comprehensive management of the hand, arm, and brachial plexus and be thoroughly familiar with the techniques for physical examination of the hand.
2. The resident will achieve a familiarity with the full spectrum of congenital abnormalities involving the upper extremity and be able to perform a comprehensive diagnostic evaluation and surgical management of these problems.
3. The plastic surgery resident will comprehend the principles of diagnosis and treatment options for upper extremities neoplasms and be able to perform a comprehensive management of a wide variety of such lesions.

4. The plastic surgery resident will fully comprehend the basic principles and diagnosis and management options of the upper extremity that has sustained acute traumatic injuries and perform a comprehensive evaluation and provide management of all related injuries to the hand and upper extremity.

5. The plastic surgery resident will achieve a satisfactory level of knowledge of the aesthetic and functional problems involving the hand and upper extremity. The resident will also understand the basic principles of rehabilitation.

6. The plastic surgery resident will comprehend the basic principles and techniques involving the hand and upper extremity reconstruction and apply these to the variety of congenital and acquired clinical problems.

7. Describe the principles and techniques for regional anesthesia including digital block, wrist block. Discuss the common agents for administration including: mode of action, duration of action, dosage toxicity, antidotes.

OBJECTIVES:

1. Describe in detail the anatomy and physiology of the muscles, nerves, tendons, ligaments, bones, and nerves of the hand, upper extremity, and brachial plexus

2. Identify in detail the anatomy of the vascular tree of the upper extremity including their relationship to surrounding structures

3. Identify in detail the anatomy of the nerves and their branches within the upper extremity as well as their relationship to surrounding structures

4. Draw and identify the anatomy of the brachial plexus

5. Demonstrate a detailed knowledge of the radiographic anatomy of the bony structures of the hand and upper extremity

6. Utilize the full compliment of radiologic studies including plain films, CT scans, MRI, MRA, and angiography to evaluate clinical situations within the upper extremity

7. Identify the principles of electrical studies and describe the techniques for electrical studies necessary in the examination of the upper extremities

8. describe the principles of upper extremity biomechanics

9. Describe the classification system for congenital hand anomalies including: failure of formation; failure of differentiation; duplication; overgrowth; undergrowth; congenital bands; generalized musculoskeletal anomalies

10. describe the embryologic development and theories regarding the etiology of congenital hand anomalies

11. Describe the surgical options, timing reconstruction of congenital hand anomalies.

12. Describe the management principles and techniques for upper extremity tumors

13. describe the etiologic factors, epidemiology, and modalities for treatment of tumors involving the upper extremity

14. Describe the clinical manifestations of both soft and hard tissue tumors of the upper extremity

15. Describe reconstructive options for restoration of form and function following surgical extirpation of upper extremity tumors including: vascular, nerve, benign deep soft tissue, malignant deep soft tissue, and primary bone tumors.

16. Provide the indications and options for adjunctive therapy in upper extremity such as radiation therapy and chemotherapy.

17. Describe the principles and application of diagnostic techniques for evaluation of the acutely injured hand and upper extremity

18. Describe the techniques, timing, indications, and contra-indications for operative management of the acutely traumatized upper extremity

19. Describe in detail the various options for soft tissue coverage of the hand and upper extremity including: skin grafts, biologic dressings, local flaps, regional flaps, and free tissue transfers.

20. List the surgical and medical management options for nerve compression and entrapment syndromes involving the upper extremity

21. Draw the pathologic anatomy and physiology of Dupuytren’s Contracture

22. Describe the basic pathophysiology of rheumatoid and non-specific arthritis of the upper extremity

23. describe non-surgical and surgical management options and timing and indications of rheumatoid arthritis

24. Describe the common circulatory disorders involving the upper extremity including: thrombosis, aneurysms, embolic phenomenon, A-V fistula, vasospastic disease, and scleroderma
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25. Describe the diagnosis and management options for pain syndromes including reflex sympathetic dystrophy
26. Describe the various tendon transfers including indications, and timing

B. Patient Care

OBJECTIVES: The plastic surgery resident will provide compassionate, appropriate, and effective patient care when treating hand problems.

OBJECTIVES:

1. Perform the clinical techniques for physical examination of the hand and upper extremity
2. Perform the surgical techniques, describe indications, and timing needed to manage congenital and acquired hand problems
3. Perform postoperative care and rehabilitation of patients with congenital and acquired hand problems
4. Apply casts and splints for preoperative and postoperative hand problems
5. Utilize appropriate diagnostic techniques for congenital and acquired hand problems

C. Practice Based Learning and Improvement:

GOALS: The plastic surgery resident will be able to investigate and evaluate their own patient care practices, appraise and assimilate scientific evidence, and improve patient care practices.

OBJECTIVES:

1. Use information technology to prepare for their surgical cases so that they can demonstrate satisfactory knowledge of current treatment options of care and scientific evidence for that management option.
2. Routinely analyzes the effectiveness of own practices in caring for hand patients
3. Improves own practices in the care of patients by integrating appropriately gathered data and feedback
4. Educates medical students, rotating residents, and associated health care professionals in the practices of hand surgery
5. Functions independently with graduated advancement and appropriate faculty supervision.

D. Interpersonal and Communication Skills:

GOALS: The plastic surgery resident will demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, families, and professional associates.

OBJECTIVES:

1. The plastic surgery resident will educate patients families in postoperative and rehabilitative therapies for hand patients
2. The resident will demonstrate compassion for patients and families with both congenital and acquired hand problems
3. Provides satisfactory counseling and informed consent
4. Listens to patients and their families
5. Assimilates data and information provided by hand therapists and other related professionals that comprise the health care team
6. Provides satisfactory and accurate documentation

E. System Based Practice:

GOALS: The plastic surgery resident will demonstrate an awareness of and responsiveness to the larger context and system pf health care and the capacity to effectively call on systems resources to provide optimal cost effective care.

OBJECTIVES:

1. Coordinates all aspects of hand and upper extremity postoperative care and rehabilitation including splinting, prosthesis, physical and occupational therapies, and sensory re-education.
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2. Direct and partner with associated related hand specialists such as physical and occupations therapy and prosthetic and orthotic specialists
3. Demonstrate cost effective hand care
4. Advocates for hand patients within the health care system
5. Understand the basics of Workman’s Compensation
6. Appropriately refers hand to patients to other related practitioners and agencies
7. Facilitates timely discharge of hand patients

F. Professionalism:
GOAL: the plastic surgery resident will demonstrate a commitment to carrying out professional responsibilities such as adherence to ethical principles, and sensitivity to a diverse patient population. The plastic surgery resident must always present himself/herself in all clinical settings in a respectful, professional, honest and congenial manner.

OBJECTIVES:

1. Develops a sensitivity to the unique stresses experienced by families and patients under going care of congenital and acquired hand problems
2. Exhibits an unselfish regard for the welfare and well-being of hand patients
3. Demonstrates a firm adherence to a code of moral and ethical values
4. Is respectful to hand patients and their families
5. respects and appropriately integrates other members of the hand care team
6. Provides timely hand consultations when requested
7. Demonstrates sensitivity to the individual patient’s profession, life goals, and cultural background as they apply to hand surgery
8. Is reliable, punctual, and accountable for own actions on the floor, operating room and hand clinic.

3) 1st YEAR ROTATION AT JACKSON MEMORIAL HOSPITAL/UNIVERSITY OF MIAMI HOSPITAL

JACKSON MEMORIAL HOSPITAL/UNIVERSITY OF MIAMI HOSPITAL

A. Medical Knowledge

GOALS:

1. The plastic surgery resident will demonstrate a comprehensive knowledge of the physiology and biochemistry of wound healing. The resident also must be able to manage complex wounds using a variety of available medical and surgical modalities to obtain normal wound healing with maximum aesthetic benefit.
2. The plastic surgery resident should be able to demonstrate a basic fund of knowledge in the design and physiology of both flaps and grafts and be thoroughly familiar with the surgery involving all types of flaps and grafts and will be able to effectively employ these in the practice of plastic surgery
3. The plastic surgery resident will be able to demonstrate a thorough working knowledge of the basic principles of microsurgery, develop basic microsurgical techniques including microneural and Microvascular anastomosis.
4. The plastic surgery resident will be able to demonstrate a comprehensive working knowledge of both the biology. And physiology of various implant materials including bone, cartilage, and various alloplastic materials.
5. The plastic surgery resident will be able to demonstrate a thorough working knowledge of a variety of special plastic surgery techniques including liposuction, tissue expansion, various lasers, dermabrasion, chemical peels, and recognize appropriate indications and contra-indications.
6. The plastic surgery resident will be able to demonstrate a comprehensive understanding of the medicolegal and psychiatric aspects of plastic surgery, as well as regularly obtain a satisfactory informed consent and perform a basic psychological evaluation when indicated.
7. The resident will demonstrate the indications, principles, and techniques and complications and prevention of local, regional, and general anesthesia.
The plastic surgery resident will be able to demonstrate a thorough working knowledge of the basic principles of immunology and tissue transplant techniques necessary for the management of common plastic surgery procedures.

The plastic surgery resident will be able to demonstrate a thorough working knowledge of agents administered in the surgical practice including antibiotics, anti-inflammatory agents and effectively employ such agents in a wide variety of clinical settings.

The plastic surgery resident will be able to demonstrate a thorough knowledge of patient evaluation, ICD-9 and CPT terminology and operating room management.

Identify and describe facial bone anatomy and associated structures

The plastic surgery resident will demonstrate a comprehensive knowledge of the anatomy, physiology and embryology of the trunk and breast and be able to apply this basic fund of knowledge to the comprehensive management of a variety of problems involving these anatomic regions.

The plastic surgery resident will be thoroughly familiar with mechanisms of traumatic injuries to the head and neck, comprehend the diagnostic techniques and therapeutic options for this and related problems and perform operative management of traumatic injuries involving the head and neck.

The plastic surgery resident will demonstrate knowledge of the biologic behavior, histology, physiology, and management principles of both benign and malignant processes involving the breast, and be able to complete a comprehensive medical and surgical management of these problems.

The plastic surgery resident will obtain a comprehensive working knowledge of the anatomy, physiology, embryology of the lower extremities, and use this information in the management of a variety of surgical problems of the leg.

The plastic surgery resident will obtain the basic principles for the management of trauma related problems involving the lower extremity and carry out surgical options necessary for the management of related problems.

The plastic surgery resident should be able to be thoroughly conversant with aesthetic surgery of the trunk and breast and be able to independently undertake comprehensive surgical management of clinical problems within this anatomic region.

The plastic surgery resident should be familiar with aesthetic diagnosis of the head and neck region and fully comprehend basic principles and available surgical techniques for management of problems.

B. OBJECTIVES:

1. Discuss the medical and legal perspectives of the contractual agreement between and physician and patient.
2. Describe informed consent and implied guarantee
3. Describe the medical record as a legal document
4. Discuss the legal and ethical methods of severing patient/physician relationship
5. Describe various malpractice process
6. Describe various strategies to handle a dissatisfied patient/family
7. Describe the basic physiology and biochemistry of both normal and abnormal wound healing including common agents and processes which encourage the development of abnormal wound healing including various nutritional substances
8. Describe hypertrophic wounds, keloids, and other abnormal wound healing situations and discuss both medical and surgical methods for treatment including pharmacologic agents, dressings, and splinting techniques.
9. Describe the differences between the etiology and healing mechanisms for endochondral and membranous bone.
10. Draw and plan various modalities for scar revision including z-plasty and w-plasty
11. Discuss and draw the various lines of the relaxed skin tension and their importance in obtaining maximal aesthetic results.
12. Describe the basic science of the healing, anatomy, normal and abnormal physiology, microbiology, and immunology for soft tissue, tendons, bone, nerve, and cartilage.
13. Classify and describe delayed healing and excessive healing
14. Discuss the terminology of flap movement including advancement, rotation, and transposition.
15. Describe the various classifications of flaps including vascular supply, anatomic design.
16. Discuss normal and abnormal flap physiology including delay phenomenon and ischemia
17. Discuss the physiology of STSG, FTSG, bone grafts. Tendon grafts, nerve grafts, fascial grafts, and composite grafts
18. Discuss the difference between primary and secondary wound contracture
19. Classify and describe angiosomes and dermatomes and their clinical implications
20. Describe the technological, pharmacological, clinical techniques of monitoring flaps including:
fluorescein, capillary refill, O₂ saturation, thermal. Laser flow probes, ph etc.
21. Discuss the use of the operating room microscope and define the technical aspects of microvascular
anastomosis (artery and vein) and microneural repair.
22. Differentiate the indications, contra-indications and various techniques for performing replantation of
various amputated parts. Discuss the various techniques for monitoring.
23. List in detail the anatomy of harvesting the most commonly employed flaps including latissimus dorsi,
rectus abdominis, and radial forearm.
24. Define the term-no flow phenomenon.; review various methods for salvaging a failing free tissue
transfer
25. Define and classify the physiology of nerve injury, including axontomesis, neurontomesis,
neuropaxia, Wallerian degeneration and nerve healing.
26. Draw and define the internal anatomy and topographic anatomy and anatomic relationships of the
major peripheral nerves
27. Discuss in detail the principles of nerve repair including indications for nerve grafting, anatomy of
nerve graft donor sites, physiology, timing, indications, and physiology of primary, delayed primary,
and delayed nerve repair.
28. Discuss local wound environments and their influence on bone repair
29. Discuss the variation in the healing of vascularized and non vascularized bone grafts
30. Discuss the effects of the presence of perichondrium and scarring on cartilage graft warping; describe
cartilage memory.
31. Discuss the factors involved in choosing various implant materials and their role in specific clinical
situations for reconstruction
32. Discuss the principles of management for patients undergoing tissue expansion
33. Draw the musculature, blood supply, lymphatic drainage, and innervations of the trunk, abdominal
wall, and breast
34. Discuss the embryologic development of the chest, abdominal wall, and breast
35. Discuss the knowledge of the glandular structure and function as well as the hormonal influence on
breast development and function
36. Discuss treatment priorities with patients that have sustained head and neck injuries.
37. Discuss the mechanical and structural properties of the facial skeleton as they relate to patterns of
injury. Classify and discuss primary bone healing, mal union, delayed union, non-union, and
osteomyelitis.
38. Discuss the advantages, disadvantages, and indications and contra-indications for nonoperative
treatment of fractures, closed reduction techniques, open reduction and internal fixation, primary bone
grafting.
39. Describe the management of complications from facial fracture management
40. Describe management of related soft tissue injuries including parotid gland and duct injuries, facial
nerve injuries, lacrimal apparatus injuries,
41. Give the comprehensive principles of management for fractures: frontal sinus, naso-orbital ethmoid,
orbital, zygomatic, nasal, maxillary, mandibular, pan-facial.
42. Draw the anatomy of the breast including: location on the chest wall, underlying structures, glandular
structures, lobes, lobules, nipple and associated ducts, variations in anatomy: polymastia; vasculature,
innervations, and lymphatic drainage
43. Discuss the anatomy of the trunk, anterior, and posterior abdominal wall including: muscles forming
the abdominal wall, deep and superficial fascia of the abdominal wall, anatomy of trunk muscles as
related to flap reconstruction; fat distribution; innervations, blood supply, and lymphatic drainage, skin
and its elastic quality
44. Describe the biologic behavior, histological characteristics, and clinical manifestations of breast
malignancies.
45. Discuss the surgical options for management of post-mastectomy breast reconstruction
46. Discuss long-term options for management of patients with breast cancer
47. Discuss the etiology of Gynecomastia
48. Discuss various treatment protocols for management of breast cancer
49. Discuss the complete management of breast cancer including: pathology and biologic behavior;
available diagnostic techniques; principles of primary and secondary treatment modalities.
50. Management of the opposite breast following mastectomy
51. Discuss the use of prosthetic devices for breast reconstruction, including implants, tissue expander,
and external prosthesis.
52. Discuss the surgical aspects and timing of options for breast reconstruction and the rationale for indications between various methods.
53. Draw the vascular, neural, and osseous anatomy of the lower extremity.
54. Describe the muscular and vascular anatomy of specific flaps including fascia lata, vastus lateralis, rectis femoris, sartorious, and gracilis flaps.
55. Describe the boundaries of and vascular anatomy of specific cutaneous flaps including the lateral thigh, medial thigh, posterior thigh, and groin flaps.
56. Draw the venous anatomy of the knee including the saphenous vein
57. Describe the muscular, cutaneous, and vascular anatomy of the gastrocnemius, soleus, and tibialis muscle flaps.
58. Explain the concept of fasciocutaneous flaps and be able to design them for the lower extremity
59. Describe the cutaneous margins and vascular anatomy of foot flaps such as medial plantar, lateral plantar, V-Y plantar, and dorsalis pedis based flaps.
60. Describe the neuroanatomy of and boundaries of sensate flaps of the lower extremity
61. Explain the physiology of arterial insufficiency, venous hypertension, and diabetes as they pertain to the lower extremity.
62. Draw the detailed anatomy of the popliteal artery and its branches
63. Describe the plantar arch and fundamentals of normal foot vasculature
64. Describe lower extremity embryology, abnormal development
65. Describe the anatomy of the lower extremity as it applies to flap design including: skin flaps, muscle and skin muscle flaps. Facial and fasciocutaneous flaps, sensate flaps, osseo-cutaneous flaps.
66. Describe the biomechanics of the lower extremity including: function of specific muscles, gait, and functional consequences of utilizing specific flaps for reconstructions.
67. Describe the indications and timing for closure of soft tissue defects involving the lower extremity
68. Describe coverage techniques for soft tissue closure of the lower extremity
69. Describe the management options for infectious processes related to traumatic injuries to the lower extremity
70. Describe the pathophysiology and non-surgical and surgical options for management of traumatic, ischemic, venous stasis, hypertensive, and infectious ulcers.
71. Discuss the etiology and treatment of lymphedema
72. Describe the classification of tibial fractures and treatment modifications for injuries of varying severity
73. Understand the related orthopedic management of long-bone injuries including internal and external fixation, leg lengthening, and standard techniques for replacement of bony defects
74. Describe the indications, timing, and surgical options for replantation or revascularization of the lower extremity
75. Draw the anatomy of the breast and axilla
76. Describe the pathologic anatomy and histology of the breast as it corresponds to mammary hyperplasia and hypoplasia
77. Discuss the various surgical techniques for breast reduction and their indications and contra-indications.
78. Discuss possible complications of each of the surgical procedures and available methods of managing surgical complications.
79. Describe various surgical procedures for breast augmentation as well as the indications and contra-indications
80. Describe the various types of current available breast implants and reasons for choosing a specific type for a particular situation as well as approach, and placement.
81. Discuss the short-term and long-term consequences of augmentation mammoplasty such as capsular contraction and describe current available methods for management. Discuss various breast implants and factors involved in implant choice including surface characteristics and their effect in the formation of capsular contracture.
82. Discuss various available techniques for mastopexy and indications and contra-indications for each. Discuss breast ptosis and classification.
83. Discuss the possible complications from each of the mastopexy procedures, management options, and methods of prevention.
84. Discuss the various methods for management of aesthetic trunk deformities such as panniculectomy, belt lipectomies, and abdominoplasty as well as indications and contra-indications for these procedures.
85. Discuss potential complications for each of the procedures, surgical management, and prevention.
86. Discuss treatment modalities for congenital breast anomalies such as Poland’s Syndrome, tubular breasts, and inverted nipples.

87. Discuss the various available methods for suction assisted lipectomies as applied to aesthetic deformities of the trunk as well as management for these procedures. Describe basic principles, the common techniques, and the instrumentation. Define tumescent, standard, and ultrasonic liposuction. Discuss indications and contra-indications for SAL and discuss patient assessment.

88. Discuss the typical deformities and available surgical methods for management of massive weight loss patients. Discuss various methods of staging, potential complications and methods of prevention and correction.

89. Describe concepts of beauty and aesthetic principles of facial anatomic structures

90. Discuss the pharmacology and safe utilization of conscious sedation and commonly used agents including anecdotes. Describe patient monitoring techniques.

91. Identify the principles and available techniques for aesthetic Rhinoplasty

92. Discuss the various surgical approaches for primary and secondary Rhinoplasty

93. Describe available diagnostic and therapeutic modalities in the management of upper nasal airway obstruction such as deviated septum, turbinate hypertrophy, and nasal valve collapse.

94. Identify potential complications from surgical management of nasal deformities and airway obstruction. Discuss management options for their correction and how to avoid these problems.

95. Describe the effects of sun exposure of aging.

96. Discuss the various techniques for facial rejuvenation and ancillary procedures.

97. Discuss potential complications, management options for their correction, and how to avoid these problems.

98. Discuss the aesthetic and functional problems involving the eyelids. Define dermatochalasis and ptosis. Be able to describe their diagnosis, management options, potential complications, and avoidance.

99. Discuss the evaluation and management options for facial nerve palsy

100. Discuss the diagnostic principles, pathophysiology and surgical and medicinal options for male pattern baldness.

101. Discuss various non-surgical options for the management of facial aging such as chemical peels, fillers, re-surfacing, and skin care products.

102. Describe the use of lasers, biomechanics, physics and potential complications including management and avoidance.

C. Patient Care:

GOALS:

The plastic surgery resident will provide patient care that is compassionate, appropriate, and cost effective for the treatment of reconstructive surgery

OBJECTIVES:

1. Participate in the surgical and non-surgical management of scars, keloids, etc.
2. Perform surgical techniques for scar revisions including: z-plasty, w-plasty, etc.; participate in planning surgical incisions with respect to selection in relation to lines of skin tension, plastic surgical techniques for closure, selection of various suture material and sizes. Also participate in wound management including placement and fabrication of splints, preparation of surgical beds, and employment of biologic substitutes.
3. Participate in the surgery of grafts, flaps, including: skin, dermis, cartilage, bone, tendon, muscle, fascia, and combined tissues in relation to: grafting techniques, instruments for harvesting grafts, graft preservation techniques, donor site management, recipient bed management, special techniques, and xenografts.
4. Perform surgical procedures incorporating full spectrum of reconstructive ladder achieving graduated experience.
5. Code diagnosis by ICD-9 and procedures with CPT
6. Perform standardized photography
7. Attend Indications Conference and discuss principles for handling of surgical cases preoperative, intraoperative, and postoperative events.
8. Perform a comprehensive head and neck examination and employ appropriate diagnostic examinations
10. Perform reconstructive surgery on the trunk, breast, and abdomen with increasing independence and surgical responsibility.
11. Participate in treatment of patients with breast malignancies.
12. Participate in the surgical management of thoracic and abdominal wall reconstruction with graded independence and supervision including: reconstruction following sternal dehiscence and/or infection; reconstruction after tumor extirpation employing flaps and/or grafts; abdominal wall reconstruction including fascial defects, dehiscences, hernias.
13. Participate in the full spectrum of reconstructive surgery after breast carcinoma, including procedures on the opposite breast.
14. Participate in the long-term treatment and follow-up of patients suffering from breast cancer.
15. Evaluate and treat patients with pre-malignant disease of the breast.
16. Participate in the breast reconstruction following mastectomy including: tissue expanders, implants, flaps, nipple reconstruction, other procedures such as tattooing, management of the contralateral breast.
17. Participate in the evaluation and management of patients with post-surgical breast deformities.
18. Apply anatomic and biomedical knowledge in order to choose appropriate procedures for lower extremity reconstruction.
19. Participate in the reconstruction of vascular injuries to the lower extremity.
20. Perform a thorough assessment for patients requesting facial rejuvenation surgery.
21. Perform satisfactorily the following breast surgeries independently with graduated responsibility from preoperative evaluation, intra-operative, and postoperative follow-up the following: Breast reduction, augmentation, mastopexy.
22. Perform satisfactorily the following surgeries independently including pre-operative evaluation, procedure, and postoperative follow-up for the following aesthetic procedures: suction assisted lipectomy, panniculectomy, abdominoplasty, belt lipectomy, body lifts, brachioplasty, and thigh lifts.
23. Perform a comprehensive history and physical examination (including internal and external) and participate in surgical correction of acquired and congenital nasal deformities including: primary and secondary rhinoplasty, airway obstruction, septoplasty, SMR, spreader grafts.
24. Participate in facial aesthetic surgery including: rhytidectomy, brow lift, facial SAL, Genioplasty, chin implants.
25. Perform both open and endoscopic surgical management of patients coming for correction of the aging face. Know indications, contra-indications and management and prevention of potential complications.
26. Perform ancillary procedures involved in the management of the aging face including chemical peels, skin care, injection of available filler materials, boot, etc.
27. Evaluate the psychosocial status of the patients presenting for aesthetic surgery and determine whether the patient is an appropriate candidate. Identify patients with body dysmorphic syndrome.
28. Demonstrate the ability to handle patients complaining of unfavorable results.
29. Participate in the management of patients suffering from facial nerve paralysis including: nerve grafts, placement of gold weights, dynamic vs. static slings, free tissue transfers.

D. Practice Based Learning and Improvement:

GOALS: The plastic surgery resident will investigate and evaluate their own patient care practices, appraise and assimilate scientific evidence and improve patient care practices.

OBJECTIVES:
1. Use information technology to prepare for surgical cases, bringing to the operating room the knowledge of current modalities of care and the scientific evidence for that care.
2. Routinely analyze the effectiveness of own practices in the caring for patients with aesthetic and reconstructive problems.
3. Improve own practices in the care of patients by integrating appropriately gathered data and feedback.
4. Educate medical students and rotating residents in the practice of aesthetic and reconstructive surgery.
5. Function independently with graded advancement and appropriate faculty supervision.
6. Participate in and appreciate the value of outcome studies as they apply to reconstructive and aesthetic plastic surgery.

E. Interpersonal and Communication Skills:
GOALS: The plastic surgery resident will demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families, and professional associates.

OBJECTIVES:

1. Educate patients and families in postoperative strategies for aesthetic and reconstructive surgeries
2. Demonstrate compassion for patients and families requiring reconstructive surgery
3. Provide adequate counseling and informed consent to patients
4. Listen to patients and their families
5. Assimilate data and information provided by consultants and ancillary health care workers
6. Document medical information
7. Demonstrate an appreciation of the psychosocial aspects of reconstructive and aesthetic surgery
8. Demonstrate the capacity to handle patients with unfavorable results from aesthetic procedures

F. System Based Practice:

GOALS: The plastic surgery resident will demonstrate an awareness of and responsiveness to the larger context and system of health care and ability to effectively call on system resources to provide care that is cost effective.

OBJECTIVES:

1. Demonstrate knowledge of cost effective breast reconstruction and other breast surgeries
2. Advocate for breast cancer patients within the health care system
3. Refer breast cancer patients to the appropriate practitioners and agencies
4. Facilitate the timely discharge of patients undergoing reconstructive surgery
5. Participate in all aspects of breast cancer care, partnering with general surgeons, radiation oncologists, and other members participating in the care of patients with breast cancer and related diseases.
6. Function within the organization of specialty clinics
7. Understand local, and specialty requirements for outpatient surgical centers in the care of the aesthetic surgery patient.

G. Professionalism:

GOALS: The plastic surgery resident will demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse population. The plastic surgery resident must always present himself/herself in all clinical settings in a respectful, professional, honest and congenial manner.

OBJECTIVES:

1. Develop a sensitivity of the unique stresses placed on patients and families undergoing reconstructive and/or aesthetic surgery.
2. Exhibit an unselfish regard for welfare of patients undergoing reconstructive surgical procedures
3. Be respectful of patients and families
4. Demonstrate a firm adherence to a code of moral and ethical values
5. Respect and appropriately integrate other members of the care team
6. Provide timely and appropriate plastic surgery consultations.
7. Demonstrate sensitivity to the individual’s professional, life goals, and cultural backgrounds as they apply to the reconstructive surgery patient
8. Be reliable, punctual, and accountable for won actions in the operating room and outpatient clinic.
10. Understands the impact of psychological issues such as body dysmorphic disorder and psychological stressors in patients desiring cosmetic surgical procedures
11. Participate in the Chief resident Aesthetic Clinic adhering to strict ethical principles and professionalism specifically with respect to advertising, recruiting, educating, and training patients.
12. Appreciate the potential conflict of interest that exists in the practice of aesthetic plastic surgery with respect to the patient’s surgical needs and expectations and the surgeon’s ultimate financial rewards.
13. Honestly and accurately counsel patients regarding risks, benefits, and complications regarding cosmetic and reconstructive surgery
14. Effectively deal with unfavorable results, complications, and the dissatisfied patient
First year Plastic Surgery Resident at Jackson Memorial Hospital will become proficient in the clinical management of a wide variety of general plastic surgery problems. Adult reconstructive experience will include patients with wound healing problems, breast surgery (including aesthetic), head and neck trauma, genital and other trunk and lower extremity reconstruction. On Maxillofacial trauma nights the 1st year general surgery resident will take the initial call. Junior residents are expected to provide quick and efficient response to the needs of the emergency room and provide satisfactory pick-up to the general surgery resident. We cannot perform any procedure in the ER without direct supervision. The chief resident and on-call attending will be readily available for the clinical needs of the E.R. They are always backed up by a chief resident and a faculty physician. The range of pathology seen in the ER includes head and neck trauma, facial fractures, coverage problems of skin and associated soft tissue coverage problems, soft tissue infections, and lacerations. Admissions from the ER are made to the faculty member on call. A significant portion of this rotation will provide the first year resident with an in-depth clinical and surgical experience with close guidance and supervision from the faculty and senior residents. One junior resident is responsible for attending the Cleft and Craniofacial meeting every Tuesday morning at which time they are expected to examine, evaluate, present and develop an appropriate management plan at the interdisciplinary meeting in consultation with the faculty. In addition, the resident will perform nasendoscopy on each patient under the direct supervision of the attending. Also, on-time attendance of all residents is mandatory in the Wednesday JMH Staff clinic in the ACC West building.

4) MIAMI CHILDRENS HOSPITAL

Medical Knowledge:

GOALS: The plastic surgery resident will demonstrate knowledge of congenital disorders of the trunk, breast, and abdomen, and be able to perform a complete plastic surgery management of these clinical entities.

OBJECTIVES:

1. Discuss the normal male and female breast growth and development and comprehend the general physiologic principles of disease in which breast abnormalities may manifest
2. Discuss the physiologic consequences of congenital chest wall deformities
3. Describe the surgical options for treatment of patients with congenital chest wall deformities
4. Describe the basic principles and management options for surgical treatment of common breast anomalies including: amastia, Poland’s Syndrome, asymmetry, ectopic mammary tissue, virginal hypertrophy, and gynecomastia
5. Discuss the reconstructive options of congenital posterior trunk anomalies including: meningomyelocele, sacrococcygeal teratomas;
6. Describe the team approach to many congenital deformities
7. Recite the embryology and developmental anatomy of congenital trunk, chest, G-U, posterior trunk, and breast anomalies.
8. Describe the basic principles and various techniques of orthognathic surgery for treatment of craniofacial skeletal harmony. Be able to classify occlusion, and various methods for pre and postoperative orthodontics.
9. Describe the application of aesthetic principles to the cleft patient.
10. Explain the general principles of head and neck embryology with special attention to the development of the facial structures and occurrence of congenital anomalies involving the head and neck especially cleft lip/palate. Describe the growth and development of the craniofacial skeleton
11. Recite the diagnostic criterion and evaluation and treatment of congenital facial anomalies including: craniosynostosis, hemifacial microsomia, rare craniofacial clefting, orbital hypertelorism, Pierre-Robin sequence, craniofacial tumors, choanal atresia, nasal anomalies, ear anomalies, vascular anomalies, brachial cleft cysts, lymphatic anomalies.
12. Discuss the cephalometric landmarks and analysis in the pre surgical planning of patients with congenital head and neck anomalies.

Patient Care:
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GOALS: The plastic surgery resident will provide patient care that is compassionate, appropriate, and cost effective for treatment of pediatric plastic surgery patients.

OBJECTIVES:

1. Participate in the surgical care of common developmental breast anomalies with graded surgical independence, including amastia, Poland’s Syndrome. Asymmetry, ectopic mammary tissue, virginal hypertrophy, and Gynecomastia
2. Evaluate and surgically treat patients with Gynecomastia
3. Participate in the evaluation of children with developmental breast abnormalities and perform diagnostic studies, interact with appropriate consultants in related areas.
4. Perform perioperative care and surgery on patients with developmental breast anomalies
5. Participate in the surgical care of posterior trunk lesions such as meningomyelocele
6. Participate in the multi-specialty surgical evaluation of patients with congenital deformities of the posterior trunk.
7. Participate in the reconstruction of posterior trunk congenital defects
8. Participate in the surgical care of congenital abdominal wall deformities.
9. Perform a comprehensive internal and external examination and participate in the correction of a residual cleft lip nasal deformity
10. Obtain cephalometric measurements and analyze cephalometric data in pre surgical planning
11. Formulate a definitive short and long-term treatment plan for common congenital disorders choosing the most appropriate surgical and/or non-surgical modality.
12. Draw a reconstruction of the cleft lip and palate
13. Diagnose and formulate a treatment plan for velopharyngeal insufficiency
15. Evaluate and treat patients with head and neck vascular anomalies

Practice Based Learning and Improvement

GOALS: The plastic surgery resident will investigate and evaluate their own patient care practices, appraise and assimilate scientific evidence, and improve patient care practices.

OBJECTIVES:

1. Use information technology to prepare for surgical cases, bringing to the operating room the knowledge of current modalities of care for patients with clinical problems affecting the pediatric age group.
2. Improve the practices of the care of pediatric patients by integrating appropriately gathered data and feedback
3. Educate medical students and residents in the practices of pediatric plastic surgery.
4. Function independently with graded advancement and appropriate supervision in the evaluation and management of pediatric plastic surgery patients.
5. Participate in and appreciate the value of outcome studies as they apply to management of pediatric plastic surgery problems.

Interpersonal and Communication Skills:

GOAL: The plastic surgery resident will demonstrate interpersonal and communication skills that result in effective exchange and teaming with patients, their families, and professional associates.

OBJECTIVES:

1. Educate patients and their families in pre- and postoperative care of pediatric plastic surgery problems
2. Demonstrate compassion for pediatric plastic surgery patients and their families.
3. Provide adequate counseling and families with pediatric plastic surgery problems
4. Listen to patients and their families
5. Assimilate data and information provided by the craniofacial team and other members of the health care team.
6. Assimilate data and information provided by the team caring for pediatric plastic surgery patients.
System Based Practice

GOAL: The plastic surgery resident will demonstrate awareness and responsiveness to the larger context and system of health care and ability to effectively call on system resources to provide pediatric plastic surgery care that is of optimal value.

OBJECTIVES:

1. Function within the organization of specialty clinics such as Vascular Anomalies and Cleft and Craniofacial Clinics including the coordination of all special services in the evaluation of children
3. Understand the benefits and functionality of multidisciplinary clinics
4. Refer pediatric plastic surgery patients to appropriate practitioners and agencies
5. Facilitate the timely discharge of pediatric plastic surgery patients
6. Partner with pediatricians in the care of pediatric plastic surgery patients.

Professionalism:

GOALS: The plastic surgery resident will demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. The plastic surgery resident must always present himself/herself in all clinical settings in a respectful, professional, honest and congenial manner.

OBJECTIVES:

1. Develop a sensitivity of unique stress placed on families under care for pediatric plastic surgery problems.
2. Exhibit unselfish regard for welfare of pediatric plastic surgery patients
3. Demonstrate a firm commitment to a code of moral and ethical values
4. Be respectful of pediatric plastic surgery patients and their families
5. Respect and appropriately integrate members of the pediatric plastic surgery team
6. Provide prompt consultations when requested.
7. Demonstrate sensitivity to the individual’s profession. Life goals, and cultural background
8. Be reliable, punctual and accountable for own actions in the operating room and clinics.

During this one month rotation, the resident will be exposed to a whole range of clinical entities encountered by the pediatric plastic surgeon caring for pediatric patients. Resident will be under the close supervision of the Drs. S.A. Wolfe and Chad Perlyn, Chief of Plastic Surgery at Miami Children’s Hospital. During this rotation, the first year resident will be responsible for attending all mandatory educational conferences at UM/JMH. Resident participation will be assigned the prior week by the program director on a case by case basis to optimize clinical and educational experience.

MIAMI VETERANS ADMINISTRATION HOSPITAL

Medical Knowledge

GOALS:

1. The plastic surgery resident will demonstrate knowledge and management of clinical problems of the trunk and be able to complete surgical management including reconstruction of such disorders.
2. The plastic surgery resident will demonstrate knowledge of histology, function, and development of skin.
3. The plastic surgery resident must be able to demonstrate a comprehensive knowledge of benign and malignant lesions, recognize the morphologic and histologic features of the more commonly encountered lesions and effectively manage small and large skin tumors using a variety of treatment modalities.
OBJECTIVES:

1. Discuss the detailed knowledge of surgical aspects of pressure sore reconstruction
2. Recite the etiology and non-surgical management of pressure ulcers (including preventive measures.
3. Discuss the structure and function of the three layers of skin
4. List the clinical presentations of benign and malignant skin lesions
5. Give classifications and staging systems for malignant and pre-malignant skin lesions
6. Discuss various methods of management including excision, Moh’s chemosurgery

Patient Care

GOALS: The plastic surgery resident will provide patient care that is compassionate, appropriate, and cost effective for the treatment of reconstructive surgery.

OBJECTIVES:

1. Participate in the surgical and non-surgical management of pressure sores including: etiology, staging, prevention, patient compliance, preoperative diagnostic evaluation, pressure sore surgery utilizing local flaps, muscle flaps, myocutaneous flaps, and distant flaps, complications of surgery, and rehabilitation.

Practice Based Learning and Improvement

2. Evaluate cutaneous lesions and proceed with appropriate diagnostic steps necessary to secure definitive diagnosis
3. Formulate definitive treatment plans for particular skin lesions
4. Participate in extirpative surgery for both benign and malignant lesions

System Based Practice:

GOAL: The plastic surgery resident will demonstrate an awareness of and responsiveness to the larger context and system of health care and capacity to effectively call on system resources to provide care that is optimal.

OBJECTIVES:

1. Direct the rehabilitation of pressure sore patients following surgery by partnering with the following: physical therapy, occupational therapy, and prosthetic, orthotic, physical medicine and rehabilitation specialists.

Professionalism

GOALS: The plastic surgery resident will demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. The plastic surgery resident must always present himself/herself in all clinical settings in a respectful, professional, honest and congenial manner.

This rotation provides broad exposure to general reconstructive problems including skin cancers, neoplasms of the head and neck with the resultant reconstructive needs, sequelae of spinal cord injuries and their associated rehabilitative requirements, nasal reconstruction and aesthetic surgery. Chief Resident will have full responsibility for pre-operative evaluation and developing a surgical plan and guiding postoperative management under the supervision and guidance of the faculty. All cases must be presented at our weekly Indications Conference prior to surgery. Also, cases must have appropriate photos in the medical chart prior to surgery. Every surgical case must have an attending note on the chart prior to surgery. Plastic Surgery Resident is responsible for covering the clinic, and scheduling patients. Resident must also be available for consults from other services as well as the Sleep Apnea Laboratory, Dermatology Clinic and Spinal Rehabilitation Service and should if possible attend the Head and Neck Tumor conferences. A nurse liaison is
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an invaluable resource for the scheduling of patients and overall general assistance while rotating at the VAH. Goal of this rotation is for the Resident to function as an independent Plastic Surgeon through graded responsibility and to develop administrative and leadership skills through assisting in the organization and functioning of the Plastic surgery service at the VAH.

2ND YEAR ROTATION:

6) Miami Children’s Hospital:

Goals:

To train Plastic Surgery Residents in the:

1) Management of common pediatric plastic surgery problems encountered in clinical practice
2) Recognition and management of acute and established brachial plexus injuries
3) Recognition and management of various craniofacial anomalies
4) Recognition and management of various congenital hand anomalies

Objectives:

At the completion of the rotation, the resident:

1) Has developed a comprehensive understanding of craniofacial anomalies and the interdisciplinary management
2) Describes the indication and timing and common elective osteotomies for reconstruction of various craniofacial anomalies
3) Fully understands and recognizes various congenital hand anomalies
4) Describes the indications, timing, and common procedures for reconstruction of congenital hand anomalies
5) Fully understands the timing and various surgical options for reconstructing pediatric plastic surgery anomalies
6) Develops communicative skills necessary in the evaluation and management of pediatric plastic surgery patients and their families
7) Understands the effect of surgery and eventual growth and development of pediatric plastic surgery patients
8) Understands the diagnostic work evaluation and various surgical procedures available for reconstruction of both acute and established brachial plexus injuries

During this rotation, the resident may participate at other institutions or offices only with the prior approval of the UM/JMH program director. The Resident will receive broad and comprehensive exposure to a wide variety of clinical problems encountered in the field of pediatric plastic surgery. The resident will have responsibility for preoperative evaluation and developing a comprehensive surgical plan including various options under supervision of both the UM/JMH full-time faculty and our Voluntary faculty at Miami Children’s Hospital. The resident will be responsible for attending all educational sessions at UM/JMH will on this rotation. To enhance our residents’ outpatient experience, the residents will be expected to attend the weekly PM craniofacial clinic on the Tuesday and Friday PM Congenital Hand Clinic, and quarterly Hand Journal Club. During this rotation, the UM/JMH resident will probably come in close contact with the Craniofacial Fellow. By prior agreement and discussions, the fellow is there to enhance the resident’s educational experience by acting as a teaching assistant on appropriate cases and “stepping aside” to allow the resident to have a more comprehensive role participation of the management of the case. The resident will be assigned to participate on a case by case basis by the University of Miami/Jackson Memorial Hospital Program Director.
7) CHIEF RESIDENT AT JACKSON MEMORIAL HOSPITAL / UNIVERSITY OF MIAMI HOSPITAL

GOALS:

To train Plastic Surgery Residents in the:

1) recognition and management of acute maxillofacial injuries
2) management of lower extremity salvage procedures
3) recognition and management of common problems in pediatric plastic surgery
4) management of early and late reconstructive problems associated with cleft lip/palate and other craniofacial anomalies
5) recognition of various reconstructive and aesthetic breast operations
6) the management of general soft tissue reconstruction options including various flaps, grafts, and free tissue transfers.
7) knowledge of various facial aesthetic procedures and body contouring surgical procedures
8) the indications and various options for free tissue transfers

OBJECTIVES:

At the completion of this rotation, the resident:

1) Has constructed a comprehensive understanding of normal and abnormal wound healing and various surgical and non-surgical management options
2) Compares and contrast flap anatomy, physiology and design
3) Describes the indications and various methods for harvesting free tissue transfers and is able to provide satisfactory postoperative monitoring and follow-up
4) Describes the interdisciplinary approach to cleft lip/palate and other craniofacial anomalies
5) Demonstrates the primary and secondary surgical options for management of cleft lip/palate and other common craniofacial anomalies
6) Can completely manage patients who have sustained maxillofacial injuries and are knowledgeable of various surgical and non-surgical options.
7) Identifies basic aesthetic principles
8) Demonstrates the surgical options for both the reconstructive and aesthetic correction of both congenital and acquired nasal deformities
9) Demonstrates the various options for facial rejuvenation surgery and how to manage the complications
10) Compares appropriate ancillary procedures for facial rejuvenation of the face
11) Demonstrates various surgical techniques, indications and contraindications for aesthetic breast surgery and breast reduction as well as the management of potential complications.
12) Fully comprehends the interdisciplinary management of post-mastectomy reconstruction as well as the various options for surgical correction; can manage the opposite breast
13) Fully understands the various surgical options and management of complications for body contouring surgery
14) Fully understands the various surgical options in problems associated with pediatric plastic surgery
15) Develops communicative skills necessary in the evaluation of Plastic Surgery patients.

During this rotation, the Chief Resident is solely responsible to Jackson Memorial Hospital and may participate at other institutions or outside offices only with the prior approval of the UM/JMH Program Director. The Chief Resident is responsible for regular attendance at the Outpatient Clinic, assigning appropriate resident coverage for all surgical cases, and night call. The ultimate goal of this rotation is for the Chief resident to obtain graded responsibility for the management of all plastic surgery patients at Jackson Memorial Hospital. The Chief Resident should assume a significant role in the teaching responsibility for senior Plastic Surgery Residents, rotating residents and medical school students on the service.

Chief Resident of the Plastic Surgery Service should run a tightly integrated service at the Jackson Memorial Hospital with full knowledge of every consult and inpatient. This includes reviewing every consult (clinic, floor, emergency call) with the Junior Residents or Interns prior to the patient being presented to an attending.
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physician. During the review and prior to presentation to an attending physician, the Chief Resident in combination with the Junior Resident and Interns should determine treatment plans and options.

Chief Resident is responsible for the directing and scheduling of patients evaluated at the Plastic Surgery Aesthetic Clinic under the direct supervision of the attending staff. Goal is for the resident to gain a thorough understanding of the basic principles of patient selection, surgical indications, problem solving and most of all, the development of excellent patient communication skills. This rotation should also provide adequate experience to acquire basic and advanced surgical skills as well as develop administrative skills through assisting in the organization of the Plastic Surgery Service and the teaching of house staff and medical students. Pediatric component centers on Cleft lip/palate, craniofacial surgery, myelomeningocele and other congenital diseases. This exposure will be supplemented with cases at Miami Children’s Hospital that are performed by the full time and Voluntary attending staff with prior approval of the UM/JMH Program Director. This Chief Resident will provide backup emergency call at Jackson Memorial Hospital. Chief resident is responsible for maintaining in weekly demographic statistics including admissions, discharges, and numbers of inpatient and outpatient surgical cases, consultations, morbidity and mortality to Ms. Teresa Shipman’s office. In addition, the Chief resident should be prepared to present any assigned cases at M&M for formal presentation and discussion. Chief resident is responsible for presenting cases quarterly at the Interdisciplinary Maxillofacial Trauma Conference as well as the weekly Indications Conference. When presenting cases at the Indications conference the resident should have adequate photo documentation to be placed in the patients’ hospital medical record. Plastic surgery resident rotating on UM/JMH for private Hand service is expected to present a minimum of one case at the weekly indications conference. The same is expected of the Miami VAH Chief Resident.

Each resident is expected to be fully prepared with a preoperative evaluation, surgical indications, various surgical options, justification for their choice of surgical procedure, and other available options for managing potential post-operative complications.

AESTHETIC ROTATION / Dr. James Stuzin’s Office

GOALS:

The plastic surgery resident is to become familiar with the diagnosis of facial aging of the head and neck and fully comprehend the available surgical options for their management.

A. Medical Knowledge

Objectives:

1. Identify the pathophysiology and physical findings associated with facial aging
2. Demonstrate the available techniques for rhytidectomy, suction assisted lipectomy, and peri-ocular rejuvenation
3. Discuss the potential complications associated with aesthetic procedures involving the head and neck and discuss method for avoidance.

B. Patient Care

Objectives:

1. Perform a complete assessment of patients presenting to the clinic seeking facial aesthetic surgery
2. Be able to describe and perform surgeries including pre operative markings with achievement of graduated operative experience including:
   a. Rhytidectomy
   b. Blepharoplasty
   c. Submental lipectomy
   d. Browlift

C. Practice Based Learning
GOAL:
The plastic surgery resident will be able to investigate and evaluate their own individual patient care practices and assimilate scientific evidence in order to improve their own patient care

OBJECTIVES:

1. Routinely analyze the effectiveness of their own practice in caring for patients undergoing aesthetic facial surgery
2. Use available information technology to prepare for their facial aesthetic cases

D. Interpersonal and Communication Skills

GOAL:
The plastic surgery resident will develop those necessary interpersonal and communication skills that will result in the effective exchange of information between patients and their families as well as other related health care associates.

OBJECTIVES:

1. Educate their patients who are seeking facial aesthetic surgery the preoperative and postoperative management
2. Learn how to counsel the dissatisfied patient

E. Systems Based Practice

GOAL:
The plastic surgery resident will demonstrate an awareness and responsiveness to the larger context and system of health care and the ability to effectively call on necessary systems resources to provide optimal patient care to those seeking facial aesthetic surgery.

OBJECTIVES:

1. Facilitate timely discharge and follow-up of outpatient facial aesthetic patients

F. Professionalism

GOAL:
The plastic surgery resident will demonstrate a commitment to carrying out the professional responsibilities, adherence to ethical principles and sensitivity to a diverse patient population

OBJECTIVE:

1. Recognize a firm adherence to a code of moral and ethical values

THE JACKSON MEMORIAL HOSPITAL SERVICE:

Jackson Memorial Hospital provides a unique but very busy environment where multiple facets of Plastic and Reconstructive Surgery are encountered. In the interest in improving the efficiency of the service, improving
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upon patient care, and improving your educational experience, expectations on how the Plastic Surgery Service will be ran at Jackson Memorial Hospital are outlined below. Although some of these may entail more “front-end” work, they should also improve the efficiency and communication in appropriate patient care.

**Service Organization:**

The Chief Resident of the Plastic Surgery Service at Jackson Memorial Hospital should run a tightly integrated service with full knowledge of every consult and inpatient. This includes:

1) All consults (clinic, floor, emergency call) should be discussed with the Chief of the Service by the Junior Residents or Interns (over the weekends, the Chief Resident on call) prior to being presented to an attending physician. A treatment plan should be determined in conjunction with the Chief Resident prior to the presentation to the attending.

2) Residents are expected to review the charts on the patient they are assigned to operate on prior to meeting the patient bedside in the PACU and be prepared for the planned treatment. The “show up and operate” mentality is not appropriate.

3) All residents are expected to be up-to-date on all in-patients on the census. This includes the Chief Resident and the Junior Resident who is not assigned to round for the week.

4) Floor consults should be discussed if not staffed by an Attending Physician within 24 hours of the consult being called. The presentation to the attending physician should be fully prepared with appropriate photos and with a treatment plan determined in conjunction with the Chief Resident prior to the presentation to the attending physician.

5) Any resident (intern, junior, or chief) who performs a majority of the surgery on a patient is expected to see that patient postoperatively. This is regardless of which resident is assigned to round that week.

6) Consideration should be given to a morning Email check-out highlighting the phone calls, consults, and admissions from the prior 24 hours on call that is forwarded to the remainder of the residents on the service and appropriate attending physicians. This would be associated with any relevant digital images.

7) Residents must be prompt for all assigned educational and clinical responsibilities. Policy for tardiness will follow Jackson Health System policy.

8) All self-pay Jackson Memorial Hospital clinic patients must have obtained financial clearance prior to scheduling. This will require that the involved resident provide necessary CPT codes.

**The Jackson Memorial Hospital Resident Cosmetic Patients:**

1) Patient is to have appropriate garments ordered prior to and available on the operative day.

2) Patient is to have prescriptions for any home medications prior to the operative day to allow them to have them ready postoperatively at home.

3) Patient is to have a follow-up appointment scheduled prior to the operative day.

4) All Cosmetic patients are expected to have clearance from a primary care physician prior to undergoing surgery. This accomplishes two goals: the patient will have another doctor to work with in case of any post operative complications (i.e. DVT requiring coumadin therapy); and, this demonstrates a level of medical responsibility of the patient.

5) All patients should be given a copy of the appropriate published American Society of Plastic Surgery Informed Consents at the time a treatment plan is determined (i.e. when the Jackson Memorial Hospital consent is signed) to allow them to review it at home prior to the surgery.

6) If the fellow who booked the patient for surgery is not going to be available, the assigned primary surgeon for the case, Junior or Chief Resident, is expected to see the patient prior to the day of surgery in clinic to become acquainted with them.

**ATTENDING PHYSICIAN STAFFING OF CASES**

Assignments of cases to specific attending physicians will be performed by the Chief of the Service in conjunction with the Chief Resident of the Service. Some of the faculty members may choose to additionally meet the patients and review the charts in a clinic at ACC West. All of the above paperwork is to be accomplished (questionnaires, consents, ASPS consents, financial clearance, medical clearance, etc.) prior to the patient arriving in the clinic. This clinic is not meant to be for the attending physician to do the missing paperwork. If the charts are incomplete, the attending physician reserves the right, to either start paging residents to complete the chart or cancel the patient’s visit which will inevitably delay their surgery.
RESIDENT ASSIGNMENTS OUTSIDE THE UNITED STATES

Although we have no formal rotations, many opportunities exist and with the approval of the Program Director, voluntary trips are often available and can be taken during vacation time.

VACATIONS

Residents are entitled to a total of 28 days of vacation per residency year. A week consists of five consecutive work days (M-F) and one Saturday and Sunday. Housestaff Officers will be notified in writing of the dates of their scheduled vacation at the time the Division’s annual schedule is made up. Residents should coordinate vacation time with appropriate responsible faculty and then cleared with the UM/JMH Chief of Plastic Surgery. These days are not cumulative. There should not be any vacation during the transition months of June, July or August without prior approval of the Program Director. Appropriate documentation must be signed off prior to taking vacation at least 2 weeks in advance of desired vacation dates. This must have a signature from the resident agreeing to cover during vacation absence. When taking vacation during the Hand Service, the Plastic Surgery Resident must contact Carmen Fuentes, Orthopedics Residency Coordinator in advance, to confirm these dates as early as possible in July to ensure requests. Attendance at medical conferences will require use of vacation time. It must be emphasized these dates are given on a first come, first served basis. The resident requesting time off must also arrange adequate coverage. It is strongly suggested that vacation time be arranged in the following manner:

**Junior Residents:**
2 weeks at Jackson Memorial Hospital
and 1 week on Hand Service and
1 week at Miami Children’s Hospital

**Chief Residents:**
1 week at Veterans Hospital
1 week at Hand Service
1 week at Miami Children’s Hospital
1 week at Jackson Memorial Hospital

EDUCATIONAL LEAVE:

Per the agreement between the CIR (Union) and JMH, educational leave, i.e. conferences are only permitted with prior approval and entirely at the discretion of the Program Director.

DRESS CODE:

The division faculty expect that residents and other house-staff will follow a professional dress code that is consistent with the specialty of plastic surgery and the JMH procedure manual (see supplement).

ON CALL:

During the first year, the resident should be on-call no more than every third night. The call schedule will include each junior resident rotating every third night. On Maxillofacial Trauma Admitting nights, all call will be from home. All residents especially the Plastic Surgery residents are expected to provide efficient and prompt response to the needs of the emergency room for the management of all facial injuries and all other related plastic surgery admissions. If there is excessive need for the junior resident, the chief resident on-call will serve as backup. In addition, a plastic surgery resident is always on call for any consultation requiring specific plastic surgery expertise. Chief Residents at the VA and JMH will alternate call from home and provide satisfactory backup to the juniors. Attending back up is always available by phone or beeper. When necessary, an attending will come to the hospital. Phone calls from home do NOT count towards the 80 hour work week-when taking call from home, only the time spent physically crossing into the threshold of the hospital itself, (not travel time) is applied towards the 80 hour work week. When noted by the attending staff that a resident demonstrates signs of fatigue due to excess work, the resident may be asked to leave to spend additional time to “relax” and obtain adequate sleep. Each resident will be asked to maintain a monthly log of
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their work week on-line. The administrator will catalogue and monitor hours spent in the hospital and allow the faculty to modify with residents to accommodate the individual needs of the residents for rest and relaxation. In addition the residents will be asked to moderate whether each rotation complies with the 80 hour work week.

For efficient communication, consideration should be given to a morning Email check-out system highlighting the phone calls, consults, and admissions from the prior 24 hours on call that is forwarded to the remainder of the fellows on the service and appropriate attending physicians. This would be associated with any relevant digital images.

ROUNDS:

Each patient on the Plastic Surgery Service must have a daily progress note by a resident. The chief resident should see the patient daily on all services and communicate regularly with the appropriate supervisory attending. On Monday at 6:45 a.m. the entire JMH Plastic Surgery Resident team will meet for breakfast in the JMH cafeteria to discuss operative assignments and responsibilities & clinical problems with the chief of plastic surgery. Any attending may request surgical rounds. On Thursday during the Didactic Sessions, the entire JMH Plastic Surgery Resident team will meet for a chart review of the upcoming week’s scheduled cases with an attending physician.

DUTY HOURS:

Resident Hours: The division is committed to complying strictly with the ACGME mandated 80 hour work week. We have closely adhered to this since the institution’s standing agreement with the resident’s union CIR. Each resident is required to complete their duty hours weekly on New Innovations. The Program Director will receive an exception report at the end of the week to review non-compliance.

The goal of the 80 hour work week is to improve the quality of life for our patients and ourselves 1 day off in 7 days. Program is dedicated to provide our residents with adequate time for rest and personal activities and encourage independent self-learning. This improvement overall resident well-being by preventing sleep deprivation and fatigue will also contribute to improvements in overall patient safety and a reduction in medical errors. It has been postulated that a minimum of 7 – 8 hours of sleep is necessary for normal mental and physical functional capabilities. Incessant interruption of sleep during on-call hours may eventually cloud judgment and result in errors. Residents and faculty will be educated to recognize signs of fatigue and sleep deprivation.

(a) While is desirable that these residents have 8 hours free of duty between scheduled duty periods, there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

(b) In unusual circumstances, residents on their own initiative may remain beyond their scheduled period of duty to continue to provide care to a surgical patient. Justifications for such extensions of duty are limited for 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 family

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

TRANSITION OF CARE:

The program must ensure that the clinical assignments minimize the number of transitions in patient care. Residents must develop skills and become competent in communicating with team members in the handover process. On Monday AM, the team meets in the JMH cafeteria to review the hospital census from the weekend to ensure satisfactory turn-over of patients. Every evening upon leaving the hospital, the chief plastic surgery resident and first year General Surgery resident have a face to face meeting to hand off to the on-call team. On weekends, to ensure continuity of care, the service always ensures that one of the services assigned residents remain on-call. Lastly, each evening and weekend day, an encrypted email is forwarded to the full-time faculty and residents reporting patient status.
MENTOR SYSTEM

Each resident will be assigned someone from either the full-time or voluntary faculty to serve as a mentor to enhance each individual’s growth and development as a Plastic Surgeon. Assignments must be confirmed with the Program Director in July. Goal of this mentoring system is for each resident to develop an ongoing relationship with an experienced faculty member in order to discuss any individual concerns, progress, and obtain appropriate advice and guidance in a casual non stressful environment. In addition, the mentor may assist in eventual practice development and career choices. It is hoped that the faculty member will then be able to provide continued support throughout the training program. In addition should any challenges arise the mentor can serve as a facilitator. Also the mentor can serve as a resource in a broad range of needs including practice location, choice of fellowship, etc. The Division Chief will make arrangements.

POLICY REGARDING SLEEPINESS AND FATIGUE IN TRAINING:

(a) Effects of sleep deprivation are cumulative
(b) Sleep deprivation is associated with significant decline in vigilance, memory, cognitive and clinical performance.
(c) As nightly sleep increases, satisfaction of residency increases, stress, sense of impairment decreases and feelings of resentment and inadequacy decrease.
(d) Increased sleep time improves learning during residency
(e) Sleep deprived residence are more likely to engage in errors and expose themselves to hazardous situations.
(f) Provide relief for residents by reducing work hours and work load
(g) Minimize risk prone situations
(h) Maintain opportunities for education
(i) Support residents’ well being with cultural support
(j) Each resident must complete the web based program on sleep deprivation
(k) Each resident must attend the Grand Rounds

In summary, work hours are continuously monitored and division policies are enforced. Residents are encouraged to report situations for work hours approaching limits so safety practices can be maintained.

EDUCATIONAL PROGRAM:

SCHEDULE OF CONFERENCES (page 26A) – all the above activities are coordinated through the office of the chief of Plastic Surgery. Conference attendance is documented (with 2 sign-in sheets) and mandatory.

RECOMMENDED TEXTS

Mathes – Reconstructive Plastic Surgery
Grabb & Smith – Plastic Surgery
Green – Operative Hand Surgery
Strauch & Yu – Atlas of Microvascular Flaps
McCraw & Arnold – Atlas of Muscle and Musculocutaneous Flaps
Cohn & Goldwyn: Unfavorable results in Plastic Surgery
Grabb’s Encyclopedia of Flaps

RECOMMENDED JOURNALS:

Plastic and Reconstructive Surgery
Annals of Plastic Surgery
Journal of Hand Surgery- English Edition
Journal of Craniofacial Surgery

OTHERS: (Required)
STUDY HABITS:

Faculty strongly recommends that each individual resident develop effective study habits early in their residency so these will continue throughout their plastic surgery career.

- prior to entering the OR, the resident should read appropriate references pertaining to anatomy, pathology or physiology associated with that surgical procedure; a written plan with photos is required in the OR to serve as a teaching guide for all staff clinic patients.
- constantly read and make notes regarding new techniques, diagnosis, operations, OR clinical terms as they are encountered
- prepare for and attend all required educational activities
- develop a user friendly index system and computerization of all performed surgical procedures
- keep up to date with the significant Plastic Surgery Literature
- prepare for the Wednesday Indications Conferences and Thursday morning didactic sessions; these conferences will serve as a significant assessment of the resident’s educational progress and access each resident’s synthesis of their basic fund of knowledge in Plastic Surgery.
- always keep in mind that the most effective learning is to read about specific patient and/or clinical problems that are encountered on a daily basis during the residency program.
- the faculty is always available to guide and direct the resident towards appropriate references and study guides.

PLASTIC SURGERY MEETINGS: actual dates, locations, and other related sessions can vary and must be confirmed through the individual sponsoring organization.

January: American Society for Reconstructive Microsurgery
   American Association for Hand Surgery
February: Baker Gordon Stuzin Symposium – Miami (Residents are invited without charge)
March: Cleveland Clinic (Ft. Lauderdale Aesthetic Symposium)
April: American Burn Association
   Plastic Surgery Research Council
   American Cleft Palate – Craniofacial Association
May: American Association for Plastic Surgeons (by invitation)
   Senior Residents Conference

September: American Society for Surgery of the Hand
October: American Society of Plastic Surgeons

December: Florida Society of Plastic Surgery
Quarterly: Miami-Dade Plastic Surgery Society

LASER EXPERIENCE:

To increase the resident’s experience on lasers, Dr. Joelly Kaufman has made her office available for our residents. Optional days are Monday afternoons at University of Miami Hospital. Residents, they may utilize this time during their week of microsurgery 2nd year residents during the VA and or elective hand and or MCH rotation. Arrangements should be confirmed with Joanne at UMH (305) 243-7210 and signed off by University of Miami Hospital/Jackson Memorial Hospital Plastic Surgery Program Director.

OTHER SUGGESTIONS:

Division is strongly committed to providing each resident with an excellent educational experience. This requires active resident cooperation and participation. Residents are strongly encouraged to purchase a digital camera with a 105-mm macro lens for photo documentation of their clinical experience and for presentations at conferences. Residents are encouraged to purchase basic plastic surgery textbooks for their home library (see list of recommended tests and journals). Residents also need to purchase surgical loupes. In addition, the
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resident library and office are available at all times with accessible key card. These books and videos can be utilized only in the library and are not for general circulation. Each Thursday at 7:00 am, we will meet in the CRB conference room following to the Didactic Session to review the charts on upcoming surgical cases and assign resident’s so they have sufficient time for preparation. All residents except that on vacation, the hand service, and with an acceptable emergency should be present. On Wednesday morning the first hour and a half of Indications Conference will be used by the Chief Residents to present their upcoming surgical cases for discussion and management suggestions. The residents on the Hand Service and Miami Children’s Hospital are expected to present cases of interest during the weekly Indications Conference. Only in extraordinary cases will the patient need to be present. However, satisfactory photo documentation is mandatory. They will be followed by Grand Rounds whose important Plastic Surgery topics will be presented by full-time voluntary and visiting faculty.

**DIDACTIC COMPONENT:**

To maximize the educational experience of Indication Conferences, residents must be thoroughly prepared to justify their management options and their indications for treatment. At this conference the resident will be presented with clinical case scenarios and actual patient care experience. Plastic Surgery residents will be expected to address patient care, medical knowledge, practice-based learning, systems-based practice and interpersonal and communication skills. This conference will also address issues dealing with medical legal issues; systems based practice, interpersonal skills and professionalism. This necessitates a thorough satisfactory pre-conference preparation. It should follow the following format: indications conference, case presentations of pertinent history and physician examination and a description and analysis of planned management. This is not a didactic lecture. Topics will follow the previously discussion scheduled. If there is sufficient time, full and voluntary faculty will present interesting cases for additional discussion. Following this, we will have formal Grand Rounds. These will take a variety of educational formats. On a number of occasions the residents will be asked to actively participate in the program. Assignments will be assigned far enough in advance to allow adequate preparation. On Thursday at 7:00 am – 8:30 am, we will have our Didactic Conference. This year Grabb & Smith and Selected Readings will serve as the foundation of conferences. These conferences are curriculum topic presentations and clinical case previous related to the assigned topic. Each resident must make arrangements to have the summaries readily available. This will be held in the CRB 4th floor conference room. This will encompass a three-year cycle to expose the residents to a complete AACPS core curriculum in the field of plastic surgery. Goal is to encourage regular reading and develop a basic fund of knowledge for their independent practice of plastic surgery. All residents including the one rotating on the hand service are required to attend unless on vacation or there is an appropriate emergency. Each resident is expected to read the assigned topic prior to the session, as questions will be asked and discussed. This will enable the faculty to assess the level of each resident’s medical knowledge. Any areas not understood should be brought up and discussed. A resident will be assigned to lead the discussion and faculty to moderate the weekly topic or present a didactic lecture summarizing the assigned topic or present an appropriate case for discussion of the assigned topic. Resident assigned to lead the discussion should prepare a 2 page hand-out summarizing those pertinent aspects of the assigned topic. Didactic sessions will play a significant role in the faculty’s assessment of the residents’ basic fund of knowledge, medical knowledge, patient care and practice-based learning. Faculty will be able to readily recognize how well the resident has synthesized the assigned topic through questions, discussion, and written weekly quizzes which will be specific to the assigned weekly topic. Learning educational modules have been developed in specific index categories. These need to be completed by each resident prior to September. Tardiness will be recorded and become a significant aspect of the professionalism evaluation.

A divisional M&M Conference will be held at the completion of each two months rotation. At that time the Chief Resident will be expected to present appropriate cases from all affiliated hospitals. Resident must prepare a 1-2 paragraph summary to be included in their portfolio describing the importance of the care in regards to practice based learning and systems based practice. On the third Wednesday evening of the month we will have our Journal Club. Residents are assigned one article to present a concise summary. The residents will also need to provide a written 1-2 paragraph summary describing the articles importance in relation to the 6 corresponding specialties systems based practice and practice based learning. This will be at a faculty members’ house or office to provide an informal and friendly educational setting. Reading assignments will be circulated in advance from either Annals of Plastic Surgery PRS on the related journals to allow satisfactory preparation by the residents. Each resident will be expected to read, digest and then succinctly summarize and discuss the article for the group. Faculty will then provide additional perspective and insight to encourage active and critical discussion. Residents will be expected to engage in a literature search on the topic to enhance their
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presentation. This conference will aid in the overall assessment of patient care, medical knowledge and practice based learning. Except for vacation and emergencies all residents are expected to attend. The Plastic Surgery Service will also present a General Surgery Morbidity and Mortality on a pre-arranged schedule. The residents are invited and encouraged to attend the quarterly meetings of the Greater Miami Plastic Surgery Society. PSOL’s data is to be completed weekly and documented on the computer on the ACGME site. Program Director will also meet with all residents on the JMH service every Monday at 6:45 a.m. in the JMH cafeteria. During this meeting, we will discuss upcoming admissions, consults, surgical assignments and clinical JMH challenges. This will enable a more efficient running of the service. This will also allow us to effectively improve the educational responsibilities of the program. Timely attendance will be a significant part of the professionalism evaluation.

WEEKLY INDICATIONS CONFERENCE:
This will precede Grand Rounds on Wednesdays. Resident presentations will follow this format:
   a. Photo documentation
   b. Short history and physical examination
   c. Reasons and justification for selected treatment plan.

MONTHLY JOURNAL CLUB:
   a. Short summary of article
   b. Define clinical relevance
   c. Summarize impact on your clinical practice

Plastic Surgery In-Service Examination is given one time per year. It is expected that the residents adequately prepare for this examination. A minimum score of 50% is expected or the resident will be placed on academic enforcement. If this is not achieved, in order to successfully complete the residency, a remedial program will be individually designed to help the resident develop a satisfactory knowledge base. This must be satisfactorily completed as demonstrated by faculty evaluation before progression or graduation.

RESEARCH:
Division firmly believes that each resident should become familiar with acceptable methods of scientific inquiry and be afforded ample opportunity to ask appropriate questions and design methodology that will enable the individual to analyze results and draw appropriate conclusions. Each resident will be expected to engage and successfully complete one research paper per year for either publication or presentation at a regional or national meeting. This can take the form of a case report, a clinical series or if time permits, a basic science research project. Final manuscripts must be submitted to the program director by April 1 of their senior year. Residents must also obtain appropriate IRB approval and closely adhere to HIPPA regulations. Entire faculty is committed to providing and sharing resources for the residents to complete this assignment. If these are accepted for presentation at reputable meeting, the division will provide adequate funding for the trip, at the discretion of the Chief of Plastic Surgery. Attendance is mandatory. Residents will be expected to discuss their research ideas and progress at a Quarterly Research Meeting. This will permit an interchange of ideas and provide additional input into each project. The resident’s performance addresses practice based learning and medical knowledge. If the resident is considering submitting a paper for presentation or publication, these plans must be discussed and prior approval obtained from the Program Director prior to submission of the project or abstract for presentation.

ORAL EXAMINATIONS:
Residents will be given two mock oral examinations per year. Specific dates will be provided far enough in advance to allow adequate preparation. The First exam (usually in January) is modeled after the morning or qualifying session (practice and theory) of the Oral Board Exam. Residents will be questioned from a book consisting of cases demonstrating standard plastic surgery diagnostic and management problems. Second session will be late May or early June and will be similar to the PM session of the Certifying Exam. Residents are to accumulate a list of cases in which they have participated and have adequate pre and postoperative photo documentation. Faculty will then select 3 cases for presentation the same way they would when they will take their formal exam. Guidelines for preparation of cases should follow the book provided by the American Board of Plastic Surgery and consistent with HIPPA regulations. Examiners will come from full time and voluntary faculty. Following the Exam sessions, we will all meet to discuss the results. For successful completion and graduation from the program, each resident is expected to demonstrate an adequate fund of knowledge and progress in their development of this knowledge as exemplified by their passing performance on these exams.
Residents will need to sign their medical charts weekly. Surgical dictations should be completed at the end of every surgical procedure. Applications for hospital privileges often request a description of the candidate’s compliance with satisfactory completion of their hospital records, clinical charts and obligations must be completed immediately at the end of the session. Prompt on-time and active attendance will be a significant aspect of professionalism evaluation. Similar requirements are expected at the Miami VA Hospital and University of Miami Hospital. Beepers and lab coats can be obtained from the JMH housestaff office. Questions regarding benefits, health care and salaries should be directed to the JMH Housestaff Office. An outline describing with these benefits is included in the packet. OSCE Exams will be given once a year in June. Generally there are four stations presenting a typical scenario encountered in the practice of Plastic Surgery. This will be video-taped and reviewed with the resident. This will be evaluating all of the required educational competencies.

AESTHETIC ROTATION:

Each resident will forward weekly to the Program Director a diary attesting the following:
   a. Where rotated and with whom
   b. What they reviewed and learned

ROLE OF THE FELLOW:

Dr. Wolfe and JMH have fellowships in various aspects of plastic surgery. Fellows generally come from other programs or countries. These individuals can significantly enhance our educational program. When they work on any case with residents, their role must always be secondary to that of the resident and can in no way interfere with our primary mission of educating and training plastic surgery residents. This policy will be strictly enforced. This arrangement has been previously agreed upon with the voluntary and full time faculty. Residents must make every attempt to notify the appropriate attending of their interest in participating in the case; thereby, permitting satisfactory pre-op preparation and discussion. On the combined JMH orthopedic hand service, there are generally 1-2 fellows. Due to the extensive quantity of cases there is usually no challenge of competitions for achieving a satisfactory clinical experience. On Call is alternated between the fellows, senior orthopedic resident of plastic surgery resident. Therefore, each individual has their own admissions and follow-up. In related cases, the fellows will take the role of teaching assistant further enhancing the resident experience. On the plastic surgery hand service the fellows, are the only individual taking call. When the plastic surgery residents begin taking call at these distinct hospitals, the fellows will switch to JMH so there will not be any potential conflict for clinical cases.

TRAVEL POLICY:

- Residents are allowed one trip per year to an educational conference and can choose from the following meetings with prior approval of the Program Director. These will be counted as vacation time.
- The American Society of Plastic Surgeons
- The American Association of Reconstructive Microsurgery
- The American Cleft Palate and Craniofacial Surgery Association
- The Plastic Surgery Educational Foundation Research Council
- The American Association of Plastic Surgery Meeting (by invitation only)
- The American Hand Society Meeting
- The American Society of Aesthetic Plastic Surgery
- The Core Curriculum Course
- The Basic Maxillofacial Course
- Senior Residents Conference

PROFESSIONAL LEAVE:

Only with the prior approval of the Chief of Service, Housestaff Officers may be granted leave with pay to take examinations or to attend educational conferences and seminars. Any request for such leave must be submitted in advance to the Chief who may grant such leave when consistent with the staffing requirements and
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educational and clinical objectives of the program. Appropriate coverage must be arranged and approved by the Program Director a minimum of 2 weeks in advance. This will require the utilization of vacation time.

Chief residents will be permitted to go to one meeting per year. Arrangements may be made only after obtaining prior approval from the Program Director and adequate cross coverage arranged. There will be a cap of $500.00 the first year, $500.00 the second year and $750 the third year. This is to be used to cover the cost of the meeting including tuition, travel, and room and board. It is expected that this will cover roundtrip coach airfare. Every resident should stay over Saturday night if this will significantly decrease the cost. When two residents are attending the same meeting, double occupancy would be expected. Maximum of $30.00 per day is allowed for food and ground transportation. First year residents will be permitted to go to one meeting per year, only after approval by the Program Director and appropriate coverage is arranged with their fellow residents. Suggested meetings include the ASMS Basic Course or the Core Plastic Surgery Course. There will be a cap of $500.00. In order to obtain reimbursement, University Policy requires all original receipts to be turned in. Also the reimbursement forms must be completely filled out prior to being submitted to the division administrator. Funds for travel can be augmented with the $1250.00/ year educational fund provided by JMH. To obtain reimbursements, the residents must return airplane boarding passes and itemized receipts, especially from the restaurants. If this is not returned within 10 business days, they may lose reimbursements.

Research projects performed at the University or Miami can be submitted for consideration for presentation or publication only with the prior authorization by the Program Director. Travel will be funded by the Division, only with the prior approval and at the discretion of the Chief of the Division. All papers and abstracts must first be approved by the Program Director and a budget detailing potential costs to the division prior to submission of the paper or abstract.

OPERATING ROOM RESPONSIBILITIES

O.R. case assignments are planned a few days in advance and assignments confirmed by the Chief Resident. Two weekly conferences are held to assure as best as humanly possible up to date placement of residents. It is up to each resident to find out what cases he/she will be involved with, and to sufficiently prepare for the case. Residents are expected to review the charts on the patient they are assigned to operate on prior to meeting the patient bedside in the PACU and be prepared for the planned treatment. “Show up and operate” mentality is not appropriate.

Information about the patient is usually available in the office chart. Preparing for a case also involves participating in the planning and arrangements for surgery (securing the necessary equipment, special bed requirements, alerting consultants, etc.), as well as learning how to mark the patient preoperatively. If the patient is having a free flap harvested from extremity, you should label the limb with a visible piece of tape with a sign saying “NO IV’s or PUNCTURE”. Residents should arrive in the OR simultaneously with the patient to assist with preparations, positioning, and reviewing equipment needs with OR staff. Waiting “to be called” is not appropriate. Pertinent reading on the anatomy and operative procedure is expected. You must bring a detailed typewritten surgical plan to the OR. Photos or schematic drawings with your planned markings and approach should be included. Plan should be a “cook book” version with the order of events to take place, and material/equipment that will be necessary. This will become part of a residents file and placed in their portfolio.

Long and complicated cases may require two residents to participate in the case. This should be planned between residents. If there are staffing difficulties, the attending involved should be notified immediately. If the second resident must handle other matters as well, he/she will still be expected to report back to the case intermittently or make arrangements for another resident to replace him/her. Also, if the primary resident is successful at getting the case started early in the day and secures appropriate assistance, then everyone can finish earlier and move on to other things.

If you are a junior resident or new to the institution, and you are not sure how to set up for a case, consult with the Chief resident who might have already participated in that kind of case. Don’t be afraid to exchange information with your peers, as this is also a good source of learning. If last minute changes occur in the OR assignments, you must sign out to the person taking your place. Signing out involves discussing physical findings and specific operative plans. New resident taking over must examine the patient. If a procedure is in progress, you will have to discuss what procedure is taking place, what parts have been completed, what remain, complications if any, and the plans for postoperative care.
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When checking the patient postoperatively, double check that your orders are being carried out and that things aren’t being missed. Any fellow (Intern, Junior, or Chief Resident) who performs a majority of a complicated operation on a patient is expected to see that patient postoperatively. This is regardless of which Junior Resident is assigned to rounding that week.

It is helpful to make cards or maintain a notebook of your cases, making notes of small details that are helpful to remember for the next time. Be aware of what else is going on. If you are between cases, and there is another room going, you might want to visit to see what is being done, how, and for what purpose. If your room is delayed, you might want to even scrub temporarily in the second room. By doing this, you will gain additional experience and the work will be expedited.

I have read this orientation packet and understand the requirements set forth.

(Print Name)___________________________________________

(Signature)_____________________________________________

(Date) ________________________________________________

Revised : 7/2012

SRT/mr