INTRODUCTION

This compilation of materials is designed to assist the Plastic Surgery Resident in successfully completing the educational experience with a minimum of confusion.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequently Called Numbers</td>
<td>4</td>
</tr>
<tr>
<td>Faculty &amp; Residents</td>
<td>6</td>
</tr>
<tr>
<td>Weekly Conference Schedule</td>
<td>7</td>
</tr>
<tr>
<td>Teaching/Administrative Conference</td>
<td>8</td>
</tr>
<tr>
<td>General Policies</td>
<td>9</td>
</tr>
<tr>
<td>TDC Service Coverage</td>
<td>11</td>
</tr>
<tr>
<td>Travel Guidelines</td>
<td>12</td>
</tr>
<tr>
<td>Administrative Chief Resident Duties</td>
<td>14</td>
</tr>
<tr>
<td>Clinic Policies</td>
<td>15</td>
</tr>
<tr>
<td>Admission Procedure</td>
<td>16</td>
</tr>
<tr>
<td>Patient Photographs</td>
<td>17</td>
</tr>
<tr>
<td>Medical Photography</td>
<td>18</td>
</tr>
<tr>
<td>Operating Room</td>
<td>20</td>
</tr>
<tr>
<td>Dictating Instructions</td>
<td>21</td>
</tr>
<tr>
<td>Resident Operative Logs</td>
<td>23</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>24</td>
</tr>
<tr>
<td>Evaluations</td>
<td>25</td>
</tr>
<tr>
<td>Clinical Competency Committee</td>
<td>26</td>
</tr>
<tr>
<td>General Competencies</td>
<td>27</td>
</tr>
<tr>
<td>In-Service Exam</td>
<td>31</td>
</tr>
<tr>
<td>PSQI</td>
<td>32</td>
</tr>
<tr>
<td>Study Materials</td>
<td>33</td>
</tr>
<tr>
<td>Plastic Surgery Journals</td>
<td>34</td>
</tr>
<tr>
<td>ABPS</td>
<td>36</td>
</tr>
<tr>
<td>ASPS</td>
<td>37</td>
</tr>
<tr>
<td>Block Diagram</td>
<td>38</td>
</tr>
<tr>
<td>Competency Based Goals &amp; Objectives/</td>
<td></td>
</tr>
<tr>
<td>Overall Goals of the Plastic Surgery Residency Program</td>
<td>39</td>
</tr>
<tr>
<td>Core Conference Schedule – PGY-1/PGY-2</td>
<td>40</td>
</tr>
<tr>
<td>Conference Schedule</td>
<td>41</td>
</tr>
<tr>
<td>Professional Meetings to Attend</td>
<td>43</td>
</tr>
<tr>
<td>Supervision Guidelines</td>
<td>44</td>
</tr>
<tr>
<td>Duty Hours and Call</td>
<td>45</td>
</tr>
<tr>
<td>Transfer/Handoff Protocol</td>
<td>48</td>
</tr>
<tr>
<td>Sleep Deprivation</td>
<td>49</td>
</tr>
<tr>
<td>Advancement Policy</td>
<td>50</td>
</tr>
</tbody>
</table>
UTMB, PLASTIC SURGERY CONTACT INFORMATION
301 UNIVERSITY BOULEVARD GALVESTON, TX 77555-0724

COORDINATORS:
Lanette Patton  772-8119
Erica Ruiz  772-0531
Cheryl Kernan  772-8128
Office Fax  772-1872

JSH:
Operator  2-1011
BIC  72170
OR Charge Nurse  75010
Day Surgery  24448
O.R. Posting  23266
O.R. Front Desk  21245
Dianne Apffel  28450
Kristi Elliott NP  2-0668

UHC:
Clinic  772-7472
Janie Copado  772-0149/ Fax 27201
Derm Mohs  772-7431

VL:
Clinic  832-505-1800
OR  832-505-1300
PACU  832-505-1312, 1313
Breast Health Clinic  51731
Melinda Cruz  51804
Clinic RN  51809
Posting  51305, 51347
Phyllis Jennings  51314

TDC:
Bryan Hicks  772-6188
TDC Precert  747-8624
Sharon Hicks  772-6132

SHRINERS:
Linda Bias  713-793-3776
Anna (HOU)  713-793-3988
HOU Nursing St.  713-793-3772
Galveston Main  770-6600
GAL Clinic  409-770-6515, 6873
Theresa Pickett  770-6781
PACU  770-6792
Cadaver Skin  643-0289

**SJMC:**
713-757-1000, 713-757-7537
Yuliya Litvak  (713)756-5148

**SUPPORT STAFF:**
Kenny (Kwok Lee)  772-5649
Steve Schuenke  772-0303
Eileen Figueroa  772-6686

**DICTATION:**
UTMB (409)747-0000, (877)367-9237
SHC-HOU (713)-793-3937
SHC-GAL (409)770-6665
SJMC (713)757-7499

**MISC:**
OT Department 23060
Dianne pager 175935
ER Radiology Room 7-2804
Film Library 21110
Surgical Pathology 22853
CT 3D recon 2-4229
FACULTY & RESIDENTS

FACULTY
Linda G. Phillips, M.D.
Ludwik Branski, M.D.
Steven J. Blackwell, M.D.
Eric L. Cole, M.D.
Kevin DJ Murphy, M.D. MCh
Robert L. McCauley, M.D.
William Norbury, M.D.
Karen L. Powers, M.D.

St. Joseph Medical Center:
Ben E. Cohen, M.D.
Donald R. Collins, M.D
Ernest D. Cronin, M.D.
Brian K. Smith, M.D.
Leopoldo Lapuerta, M.D.

Bay Area Community:
Jan Garcia, M.D.
Mark S. Barlow, M.D.
Clayton Moliver, M.D.

RESIDENTS
Kristen Aliano, M.D.
Danielle Andry, M.D.
Olga Bachilo, M.D.
Chris Bates, M.D.
Andrew Berry, M.D.
Stefanos Boukovalas, M.D.
Chase Castillo, M.D.
Nick Howland, M.D.
Shana Kalaria, M.D.
Shelby Lies, M.D.
Mariela Lopez, M.D.
Jillian McLaughlin, M.D.
Elise Mecham, M.D.
Stephanie Nemir, M.D.
Cecelia Nguyen, M.D.
Jared Potts, M.D.
Surjit Rai, M.D.
Phillip Rozak, M.D.
Erick Sanchez, M.D.
Blake Sparks, M.D.
Nandi Wijay, M.D.
Ben Yarbrough, M.D.
WEEKLY CONFERENCE SCHEDULE

**Monday**
4:30 p.m.-6:00pm  Planning & Outcomes Reading Club
Or 5:00 p.m.  Varied Conferences

**Wednesday**
1\textsuperscript{st} Wednesday of each month:
7:00 a.m.  ENT/OMFS/PRS Face Conference
8:00 a.m.  Surgery Grand Rounds

2\textsuperscript{nd} Wednesday of each month:  (Plastic Surgery Library)
7:00 a.m.  Educational Conference (2 hrs.)

3\textsuperscript{rd} Wednesday of each month:  (Plastic Surgery Library)
7:00 a.m.  Plastics Surgical Quality Improvement Conference / OPlogs / Unknowns

4\textsuperscript{th} Wednesday of each month:  (Plastic Surgery Library)
7:00 a.m.  Educational Conference

**Thursday**
2\textsuperscript{nd} or 4\textsuperscript{th} Thursday of each month
5:00 p.m.  BAJC Journal Club
6:30 p.m  Houston Society of Plastic Surgeons
(monthly)

*Residents on non-Plastic Surgery services attend those rotation-specific conferences.*
TEACHING AND ADMINISTRATIVE CONFERENCE

Conference will start promptly at 7:00 a.m. on the designated Wednesdays. Please be prompt to allow for assembly and announcements. The resident should prepare and distribute a list of annotated references pertinent to the topic.

On the third Wednesday of each month, the conference will cover the morbidity and mortality for the preceding month. Each case is to be concisely presented and analyzed by the resident, after which it will be discussed by the Faculty members. The patient list should be ready one week in advance, pictures, and pertinent lab and X-ray data obtained. Attending staff should be contacted one week prior to the conference to discuss the patients involved.

In preparation for conference, be sure to discuss the subject being presented with the appropriate attending at least one week prior to the presentation.

Competency conferences are 3-4 times a year.

Oral Exams and casebook exams are given to all residents yearly.

Divisional Retreats are 3-4 times/year.
GENERAL POLICIES

1. Plastic Surgery Residents will be expected to maintain a professional appearance and demeanor in their contacts with patients and other health care professionals. You are our main PR agent! COURTESY WITH NURSES, ATTENDANTS AND OTHER SUPPORT STAFF PAYS DIVIDENDS TO ALL OF US.

2. It is important to gain and maintain good rapport with patients. A frequent criticism is that we talk too much about patients and too little with them. Remember that you may not need to see or talk to each patient each day, but the patient needs to see and talk to you each day. This includes children.

3. It is essential that residents be available and in contact with the residency coordinator in the division office. Use the pager system effectively, keep the coordinator informed where you can be reached. Check mailboxes at least once per day.

4. Promptness is essential in the operating room, on rounds, in clinics, and at conferences.

5. Operative notes and discharge summaries should be dictated the day of surgery and/or discharge. Delinquent dictations are reason for withdrawal of OR privileges until caught up. Zero tolerance exists for delinquencies.

6. Consultations should be seen the day they are requested, and in all cases within 24 hours. Contact appropriate Attending to see and write or sign note.

7. Patients are admitted under service of attending responsible for case and Attending is immediately notified of admission, and the case is discussed.

8. A Plastic Surgery Resident will write a succinct admitting note on all patients.

9. Each resident is entitled to vacation. In general, no more than two weeks are to be taken at once. NO VACATIONS WILL BE GRANTED DURING THE MONTHS OF JUNE AND JULY. All vacation leave requests must have approval signatures from appropriate Faculty Attending and the residents providing coverage prior to submitting to Dr. Phillips for final approval. Accrued vacation time not taken by graduation will be reimbursed by the Hospital. Preference is given to meetings over vacation when the schedule is arranged. Six days are allotted for job interviews during residency – the months of June & July should be avoided. Meetings are given preference to vacation. All approved vacations must be placed on the resident calendar. Requests for away time of any kind require both KRONOS and paper sign off.

10. Each Resident must keep a running record of their operative experience for annual report to the Residency Review Committee. Keep this up to date. The PSOL must be submitted monthly for review with Dr. Phillips.

11. Residents are allowed to attend meetings at which they are presenting. Prior to submitting papers/posters/abstracts to meetings the following must be done: Complete and submit the Presentation Proposal form to Dr. Phillips for approval to submit. After her approval of the proposal form, submit manuscript to Dr. Phillips NO LESS than 2 weeks prior to departure for meeting. Failure to abide by this rule will result in cancellation of meeting attendance by that resident and result in future restrictions for resident to submit presentations.
12. All outside hospital consults should be signed by the faculty and placed in the department’s Billing mailbox the day they are seen.

13. All emergency admissions require notification of the involved resident service by the next A.M.

14. 2nd call starts at 17:00h on weekdays and is all day/night on weekends. From 7:00 – 16:59h the Service Chief of the 1st call will provide back-up.

15. The Chief Resident ensures that the O.R. schedule is called in to Operating Room Posting Office @ 23266 as soon as the decision is made to operate. Planning requests for equipment, implants, pain pump, etc. are made at the same time. Add all cases to the Plastic Surgery OR webpage. Send a meeting request to the faculty surgeon so the case posts to their calendar.

16. Each resident must have a research project and a QI project.
TO: All Faculty and Residents

RE: Coverage of TDC Service during Chief Residents out of campus rotation

I. Friday's clinic will be covered under the direction of the Administrative Chief Resident.

II. Emergency Room admissions and hospitalized patients will be followed by the On-call Faculty's Service. All admissions should be brought to the attention of the Chief Resident on call and the following morning, to the Admitting faculty's service.

III. Elective cases will be included in the elective schedule for the Administrative Chief Resident's service.

IV. A complete log of all cases to be scheduled for admission with their diagnosis, procedure, date of admission and tentative surgery will be kept by Senior Residents.

V. Discharges will be done as in John Sealy Hospital; by the operating resident or resident following patient, not by the intern, except if intern is the primary surgeon of the case.

VI. All elective cases are to be presented to the specific faculty, with adequate documentation, consents, photos, and plan of treatment.

VII. In the event of a back-log of elective cases, those accumulated will have priority in their treatment the following month, according to the next available operating room time; regardless of the diagnosis and degree of difficulty.

VIII. Any clinics to be canceled must be cleared by Dr. Phillips. The TDC-J Clinic requires written notification AT LEAST TWO WEEKS IN ADVANCE.
GUIDELINES FOR PLASTIC SURGERY HOUSE STAFF

Plastic Surgery House Staff are encouraged to present at academic/professional meetings in the field of Plastic and Reconstructive Surgery and Wound Healing Research. There are, however, guidelines that must be followed depending upon the source of funds for reimbursement.

There are two sources of funding from which travel is reimbursed – Division funds and Shriners Burns Institute grant funds. Residents/Fellows are asked to complete the appropriate travel authorization forms for the appropriate funding agency at least one month prior to travel. There are a number of offices that these forms must pass through before travel is approved. This is especially true for the Shriners Burns Institute, as any travel must be approved by the Local Board of Governors prior to travel, and the Board meets only once each month. The residency coordinator is available to assist you with the proper completion of your travel and reimbursement forms. Plane reservations are to be booked through Marchi Travel for domestic flights and Anthony travel for international flights.

It is necessary that you discuss your intent to submit a presentation with Dr. Phillips prior to it being submitted to any association or society.

Prior to submitting papers/posters/abstracts to meetings the following must be done:
Complete and submit the Presentation Proposal form to Dr. Phillips for approval to submit. After her approval of the proposal form, submit manuscript to Dr. Phillips NO LESS than 2 weeks prior to departure for meeting. Failure to abide by this rule will result in cancellation of meeting attendance by that resident and result in future restrictions for resident to submit presentations.

Some internal guidelines to remember are:

1. All travel forms must have documentation attached; i.e., meeting flyer with registration form. This must include the name of the meeting, dates for the meeting, and where the meeting is being held. If you are presenting, a copy of your presentation (i.e. abstract) and a copy of your letter of acceptance is required.

2. Original receipts and invoices are required for all reimbursements, as well as the original canceled airline ticket.

3. Meal per diem is $30 per day.

4. No rental cars will be reimbursed.

5. All flights must be at the lowest possible airfare. Marchi Travel is the default. If you find a lower fare on the Web, you MUST get it approved.

6. Take advantage of early registration. Do not wait until the last minute and expect the Division to pay for late registration – the Division WILL NOT PAY FOR LATE FEES.
GUIDELINES FOR PLASTIC SURGERY HOUSE STAFF

7. Once you have completed all of your travel forms, do not change your travel plans at the last minute. The University requires that any changes in travel dates (i.e. your travel authorization indicates that you will travel 7/1 through 7/15, and you change your plans at the last minute to 6/30 through 7/14 be resubmitted on a superseding travel authorization). This will only delay your travel reimbursement.

8. When possible, residents are encouraged to share rooms to reduce costs.

9. Be aware that travel aboard has specific requirements and the paperwork must be submitted as soon as the decision to travel abroad is made.

**DO NOT TRAVEL WITHOUT PRIOR APPROVAL**
Complete a Leave Request Form and Travel Authorization Form
Obtain the signatures of your back-up coverage residents, your attending faculty and then submit your leave request form to the Administration Chief Resident
Chief Resident submits signed form to Residency Coordinator for completion of process; upon Program Director’s signature, travel authorization form is then submitted to department chairman for travel approval; approved form is copied and given to traveling resident.

**BE SURE THAT YOU HAVE COMPLETED PRIOR TRAVEL AUTHORIZATION FORMS ACCORDING TO THE ABOVE GUIDELINES**

**WHEN IN DOUBT, GET A RECEIPT**

Again, the residency coordinator is available to assist you with the proper forms and travel process. Please provide her with proper documentation and information regarding your travel in advance.
ADMINISTRATIVE CHIEF RESIDENT

This appointment is to administratively supervise the professional aspects of patient care.

1. Assures that the following assignments are carried out: House officer coverage of clinics, in-patients, and O.R. schedule.

2. Sees or arranges to follow all JSH consultation patients, notifies attending and visits patients with them.

3.Contacts Residents and Attendings on other services regarding all consultations.

4. Maintains call roster for resident coverage.

5. Maintains conference schedule and assigns topics.

6. **Keeps Attending staff informed** of all incidents, complications, and unhappy patients.

7. Supervises in-patient records – sees that progress notes, dictation, etc. are done promptly.

8. Maintains log of all complications and infections. Chiefs submit all cases performed and ensuing complications on monthly basis by the 5th of each month.

9. PSQI dictations are due by the 5th of next calendar month. A list of all cases performed during that month is to be submitted. These are to be turned in to the residency coordinator.

10. Assures everyone is notified if Grand Rounds or other conferences are cancelled.


12. Assures conference evaluations and attendance/sign-in roster are available for each conference and submits to the residency coordinator at end of conference.
CLINIC POLICIES

1. Clinics start at 8:00 a.m.

2. All appropriate residents must be present. If residents are unavailable, the Chief Resident must obtain help.

3. TDC clinic (Fridays at 8:00 a.m.) is resident controlled. All available residents are expected to assist the TDC resident.

4. Do not post a case in the schedule book until the case has been discussed with and cleared by a Senior Resident and Attending staff. This includes clearance for the day the case is scheduled.

5. Photos of elective cases pre and post-operative must be taken.

6. Paperwork: H&P, orders, consent, dictation must be completed by the end of each clinic. This must not impede the steady flow of patients.

7. Residents are expected not to wear scrubs. Professional dress is expected, including shirt and tie for men, appropriate dress for women and white coats.

8. Clinic notes must be completed in EPIC the same day.
ADMISSIONS

Adults:
1. Call extension 22711 (8:00 a.m. – 4:30 p.m.)
   Speak to Administrative Coordinator
2. Day Surgery: Extension 24359
3. ER Admissions: Extension 26896, 26895 (8:00 a.m. - 4:30 p.m.)
4. TDC Managed Care: Extension 7200

Pediatrics:
   Call extension 23554 (8:00 a.m. – 4:00 p.m.)
   Speak to Pediatric Admitting Coordinator
   
   After 4:00 p.m. speak to Pediatric Nursing Coordinator

To schedule admissions, you must have:

NAME
UH NUMBER
DIAGNOSIS/DATE OF ONSET/SIGNS AND SYMPTOMS
DATE OF ADMISSION
LENGTH OF STAY
STAFF FOR THE DAY & CHIEF RESIDENT FOR THAT STAFF
TRANSFERRING DOCTOR AND HOSPITAL

Fill out predetermination or quote sheet slip and give to Ashley or Janie to give to Posting Office
(from Plastic Surgery Clinic – Elective Admissions).

Notify Chief Resident and Attending physician of all ER admissions and consults at the time of admission.

Clear all elective admissions from clinic with Senior Resident present (usually Chief Resident) and Attending staff.

Notify Chief Resident in charge of TDC about any TDC admissions during the night.

All admissions must have H&P, admit note and orders, and consent if needed. Order bedside supplies if needed. Complete admission packets and give to nursing staff to fax to DSU and Pre-determination office.
PHOTOGRAPHS

1. Residents are responsible for taking photographs of all cases. Pre-operative photos should be made before the patient goes to the operating room, except in emergencies. All burns should be documented with photos. Read the hand-out on clinical photography carefully.

2. Intra-Operative photos are very valuable. Take them in all cases. Also, be sure to take photos of interesting x-rays.

3. Complications should be recorded with photos. This requires great diplomacy with patients!

4. Follow-up photos must be made in the clinic. The resident must take a camera to each clinic.

5. The resident will make temporary MIRROR files from the memory chip. Remember: Pictures you take belong to the patient’s Attending staff and are needed for records and medical/legal purposes.

6. The resident must remember to print pictures from the MIRROR files ten days prior to the presentation at conferences, especially PSQI, to ensure that pictures are available for the conference.
MEDICAL PHOTOGRAPHY

We have converted to digital photography. Do not purchase 35mm cameras. We suggest digital cameras.

Here are some practical suggestions for physicians using medical photography in their practice:

- Avoid auto-focus cameras and lenses. If you are using macro lenses, reproduction ratios are strongly recommended to achieve consistent results.

Accurate photographs are a basic part of a patient’s history and physical examination. The photograph of a surface defect or contour problem serves as a document in the same fashion as an x-ray or an electrocardiogram. It is now requested by insurance companies, courts, and by other physicians who participate in the care of the patient. The photograph also serves as a means of measuring the success or failure of the operative procedure and the postoperative period, and the photograph is the major record by which a surgeon can demonstrate a clinical research project. The photograph, in essence, is the major record presented for a manuscript. Photographic presentations of clinical problems are very much the domain of the surgeon whether he is in a private practice and is talking to hospital staff or in a teaching capacity. The quality of photographs presented by plastic surgeons at regional and national meetings and in manuscripts presented to journals is appalling considering that these individuals are purporting to be skilled and aesthetic.

CAMERAS

THE DIVISION HAS GONE TO A DIGITIZED FORMAT.
DO NOT PURCHASE LIGHT REFLEX CAMERAS.

CLINICAL PHOTOGRAPHY

The basic purpose of clinical photography is to document the status of the patient in a fashion which is reproducible. The document should be simple without distractions and should clearly illustrate the object involved. For example, a patient undergoing a rhinoplasty should have a photograph of the entire face as well as profiles and a chin up view. These photographs should be reproduced in the post-operative period exactly. This means the same angles, the same lighting and exposure, and ideally the same background. The magnification or reproduction ratio will be standardized in using a macro lens by taking all photographs of the face with a 1:10 reproduction ratio. This will also assure the lighting will be the same since the distance between the light source and the subject will be standardized. The angles of photography are important. The camera lens should be at a right angle to the plane of the subject and should be in the mid-portion of the subject. If the photograph is taken with the chin down at one time and the chin up at another time, the nose will appear longer in the chin down photograph and shorter in the chin up photograph than is actually the case. Many plastic surgeons present such photographs as documentation of changes post-operatively. They are not attempting to misrepresent the case, but have not been aware of these factors in making the documents.
Backgrounds should be plain and non-reflective. Each individual may use his own taste as to the color of background, but the most neutral color is generally a medium to dark blue. Black backgrounds are preferred by some individuals, but this appears to me to be very stark and has the only advantage that there are no shadows on the black background. White backgrounds tend to avoid contrast between the skin and the background, and are not pleasing to the eye. When in the clinic, use the blue curtain (UHC) or wall (VL) as background. Distracting things in the background such as the surgeon’s library tend to focus attention on the current journals and books rather than on the subject matter. Jewelry again distracts the viewer who might be paying more attention to the type of jewelry the individual is wearing than the object intended. Misguided efforts to respect the patients modestly, such as half removed clothing are actually more suggestive than totally nude. Full body photographs can be taken with the bikini underwear if the genital area is not a necessary part of the photograph.

Photographs of hands should not be placed flat on a background because positions of fingers will be disguised if pressed against a wall or table.

The primary purpose of this system is to present standardization and the details of simplifying the photographs, and avoiding misleading lighting or angle situations requires a minimal but basic attention to detail and practice.

### SUGGESTED PHOTOGRAPHIC CATEGORIES

1. Breast  
2. Burns: Electrical and thermal-chemical; x-ray dermitis and ulceration  
3. Cancer-skin  
4. Cleft lip and cleft palate  
5. Congenital deformities  
6. Cosmetic: face and body  
7. Ear reconstruction  
8. Facial Palsy  
9. Flaps and grafts  
10. G-U  
11. Hand reconstruction  
12. Head and neck  
13. Hemangioma  
14. Lymphedema  
15. Nevi and benign skin lesions  
16. Sarcoma  
17. Skin diseases and epidermolysis bullosa  
18. Transsexual  
19. Trauma  
20. Ulcers  
21. Wounds, scars, and keloids
OPERATING ROOM

STARTING TIMES:
   Monday, Tuesday, Thursday, Friday – 7:15 a.m.
   Wednesday – 9:00 a.m.

To post an ER case you must call:
   Anesthesiology (Anesthesiologist: 747-5003/ Charge Nurse: 747-5010
   After Hours Call: Sr. Resident Anesthesia @ Pager 00777

To post an elective case:
   Complete the hospital-specific posting packet and submit to clinic staff.

Enter JSH and VL cases into EPIC.

H&P must be updated in EPIC the day of Surgery; faculty must attest prior to roll back to the OR.

**Do not post a case without clearing with the Chief Resident and Attending Staff.**
DICTATING INSTRUCTIONS

Dictation will not record unless all 15 digits are entered into the touch tone telephone prior to dictating.

Operative Report                  Discharge Summary                  Priority Reports
EXT. 22660                        EXT. 26605                        EXT. 26608

TO DICTATE (after beep):

1. **RESIDENTS:** Enter four (4) digit ID#
   Enter four (4) digit attending ID#
2. **ATTENDING:** Enter four (4) digit ID#
   Enter four (4) digit ID# again
   *If the ID# is less than four (4) digits, place zeros (0) at the FRONT to make it six digits.

1. Enter six (6) digit patient UH# (do not enter alpha-character).
   *If UH# is less than six (6) digits, place zeros (0) at the FRONT to make it six digits.

3. 1 = operative report
   2 = discharge summary
   3 = clinical summary
   4 = clinical operative report

You will hear a soft ready tone.

Begin dictation. **Recorder stops and starts with your voice.** (You will be disconnected after 4 minutes if you have not resumed speaking or used button 4 to pause).

TO PAUSE: Push four (4). (You will be disconnected if you are in pause for over 15 minutes).

TO RESTART: Push two (2), then resume dictation after pause, rewind, or listen.

TO REWIND AND PLAYBACK: Push three (3), will rewind 10-15 words and begin automatic playback.

TO EDIT:
1. Push eight (8) for rewinding
2. Push four (4) to stop at place for edit
3. Push one (1) to listen to dictation
   -or-
4. Push two (2) to dictate on previous dictation

FAST FORWARD: Push seven (7)
MULTIPLE DICTATIONS: This must be used for more than one dictation.

1. Push five (5) between reports, your four (4) digit attending ID# is automatically reentered
2. Residents: Enter four (4) digit attending ID#
3. Attending: Enter four (4) digit attending ID# again
4. Enter patient UH#
5. Enter one (1) digit report number (see above)
6. Push two (2) to resume dictation

FOR ASSISTANCE/INSTRUCTIONS:
Push 0 (intercom), or call extension 21675 or 21840

TO CLEAR ID#: 
If an error is noticed before entering all 15 numbers, push * to clear all numbers. Numbers can only be cleared prior to the last ID digit being entered.

TONES SIGNALS:
Low/Continuous = Dictate
Low/Intermittent = One minute left on tape
High/Intermittent = Wait to dictate – tape changing
High/Continuous = Stop dictation – tape full

**TO ASSURE ACCURATE TRANSCRIPTION OF YOUR REPORT, THE FOLLOWING INFORMATION IS REQUIRED AT THE BEGINNING OF EACH DICTATION:**

1. Identify yourself
2. Identify your department/service
3. Identify the type of report
4. Identify the attending physician
5. Identify the patient – Name and UH#, please spell patient’s name
6. Give age, sex, and race of the patient
7. If you are dictating a discharge summary, give admission and discharge dates
8. If you are dictating an operative report, give the date of surgery, name of surgeon, and name of assistant (s)
9. If a copy of the report is to be sent to the referring physician, give the name and address of that physician
10. Identify the date of dictation

FOR ASSISTANCE, PLEASE CALL EXT. 21675 OR 21840
Go to Medical Records at least weekly. When leaving, you must designate an “alternate” who will sign off charts for you.
The Residency Review Committee for Plastic Surgery requires that each resident keep a detailed record of operative experience. The maintenance and accuracy of this record are the responsibility of the individual resident. In addition, copies of operative notes must be kept for all cases in which the resident is listed as responsible surgeon. **You will need this to obtain hospital privileges when you leave the residency.**

The Residency Review Committee uses a computerized program for the compilation of the resident’s operative experience. We now have the PDA version, downloading to the Internet. You MUST use this system!

The residents will download and print their PSOL monthly to allow review for deficiencies.

Chief residents will NOT be allowed to leave before reviewing their final PSOL with Dr. Phillips.
EMERGENCY ROOM

1. The resident On Call that day covers ER from 5:00 p.m. to 7:00 a.m.; from 7:00 a.m. to 5:00 p.m. in the ER is covered by residents assigned to JSH-Staff Team; Shriners resident and research resident are exempt from daytime calls unless coverage is requested by the Chief Resident. Weekend Call is Saturday 8:00 a.m. – Sunday 8:00 a.m., and Sunday 8:00 a.m. – Monday 7:00 a.m.

2. Prompt response to all ER Call is absolutely mandatory at all times.

3. Inform Chief Resident of all admissions at the time of admission and ER consults. Inform Attending Staff of all patients (admissions and/or outpatients) seen in the Emergency Room.

4. **Photographs** must be taken of all ER consultations and admissions as part of the H&P or consult.

5. Patients are admitted to the staff physician On Call unless they are established patients of a different staff physician.

6. Emergency Room paperwork is all on EPIC.

7. The resident On Call is responsible for all of the following regarding ER admissions: H&P, admit orders, admit note, pertinent lab and X-rays, photos, operative consents (obtain consents before pre-medication), posting of ER cases in OR, discussion of operative plan with patient and Chief Resident and staff. ER patients should only be sent to the clinic of the Attending staff accepting the patient for treatment.

8. If you believe a consult is not appropriate to Plastic Surgery, you MUST discuss this with your faculty before refusing.
EVALUATION AND FEEDBACK

Four times per year each resident will make a patient presentation that addresses the ACGME competencies. In addition, the Faculty will evaluate each resident after completion of the rotation. Evaluation will include assessment of knowledge, clinical ability, problem solving, operating skills, and attitude based on the ACGME competencies.

Twice yearly, Dr. Phillips will meet privately with each resident to discuss the evaluation and progress in training. These conferences are intended to be constructive and helpful, rather than occasions for criticism and “chewing out”. The resident should not approach them with a defensive or negative attitude. At the same time, the resident will have an opportunity for comments and critique of his experience during the rotation, but should not use this as simply an opportunity for griping.

The In-Service Exam is mandatory for all residents. If a resident achieves a percentile of 90 or greater on either exam, they will be allowed to choose a book purchased for them.

Mock Orals:
In June, all residents will take part in oral examinations conducted by the community faculty. The residents are to prepare a case for presentation and examination. All residents (PGY1-through PGY-6) are also tested on unknowns.

Failure to perform well on standardized exams (Surgery Board Exam failure, or <30 percentile on the In-Service Exam), or an inability to demonstrate sufficient progress in the operating room (in terms of PSOL numbers and operative independence) may lead to failure to progress in the residency.

The following pages contain a copy of the areas of evaluation and expectations, and a copy of the evaluation form.

Residents are required to complete faculty and programmatic evaluations via the electronic New Innovations system in order to maintain anonymity.

The Division holds a quarterly review. Attendance is mandatory for all residents and faculty. Residents are to meet with the Administrative Chief prior to the review and ask the Chief to present anonymously any concerns the resident does not want to discuss.
CLINICAL COMPETENCY COMMITTEE

The Clinical Competency Committee (CCC) is appointed by the Program Director and includes all faculty members of the Education Program Committee. The duties of the Clinical Competency Committee includes:

a. Review all training evaluations of resident performance.

b. Preparation of the semiannual report of all residents' Milestones progress.

c. Uses the RRC Plastic Surgery Clinical Milestones.

d. Recommendations on resident progress including promotion, remediation and dismissal.

The Education Program Committee consists of the core faculty (Drs. Phillips, Powers, Cole, Zhang, and Murphy). The Clinical Competency Committee includes the Education Program Committee members plus faculty from the major participating training sites: SHC-Galveston (Dr. McCauley); SHC-Houston (Dr. Cole); MD Anderson (Drs. Hanasono, Garvey); and St. Joseph's Hospital (Dr. Ernest Cronin).
Assessment of General Competencies in Plastic Surgery

The ACGME has endorsed general competencies for residents in the areas of:

- Patient care
- Medical knowledge
- Practice-based learning and improvement
- Interpersonal and communication skills
- Professionalism
- Systems-based practice

These competencies will be evaluated, in part, via presentation of index cases appropriate for the resident level, four times per year. This project will result in the development of a portfolio for each resident that demonstrates their surgical maturation from the PGY-3 to PGY-5 level.

Competency Presentation:

15 minutes will be allotted for each presentation; therefore, they must be concise and well organized. The resident should be familiar with the full description of the ACGME competencies in order to demonstrate how the case has fulfilled aspects of the 6 categories.

It is suggested that by utilizing the following outline, at least five of the six categories will be addressed:

- Pre-operative evaluation and planning
- Analysis of options
- Planning sheet
- Intra-operative management
- Post-operative care
- Post-discharge care
- Evaluation of outcome; aesthetics, function, impact on patient’s quality of life
- Coding

Resource use analysis: charge to patient, post-operative (monetary or otherwise), how was case covered. Examples of cases appropriate for resident level are:

<table>
<thead>
<tr>
<th>PGY-1</th>
<th>PGY-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z-plasty</td>
<td>Nailbed repair</td>
</tr>
<tr>
<td>Skin graft</td>
<td>Local random flap</td>
</tr>
<tr>
<td>Excision of skin malignancy</td>
<td>Nasal Fracture reduction</td>
</tr>
<tr>
<td>Extensor tendon repair</td>
<td>ORIF hand fracture</td>
</tr>
<tr>
<td>Revision amputation</td>
<td>Liposuction</td>
</tr>
<tr>
<td>Laceration repair</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PGY-3</th>
<th>PGY-4</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER face or hand</td>
<td>TE/ Implant</td>
</tr>
<tr>
<td>Trauma cases</td>
<td>Flexor tendon repair</td>
</tr>
<tr>
<td>ORIF mandible</td>
<td>Pressure ulcer coverage</td>
</tr>
<tr>
<td>MMF</td>
<td>Liposuction</td>
</tr>
<tr>
<td>Liposuction</td>
<td>Burn Reconstruction</td>
</tr>
<tr>
<td>Breast reduction</td>
<td>Harvest iliac crest bone graft</td>
</tr>
</tbody>
</table>

Breast reduction
Abdominoplasty
### Assessment of General Competencies in Plastic Surgery  
*Continued*

<table>
<thead>
<tr>
<th>PGY-5</th>
<th>PGY-6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominoplasty</td>
<td>Cleft lip repair</td>
</tr>
<tr>
<td>Breast reduction</td>
<td>Cleft palate repair</td>
</tr>
<tr>
<td>Mandible fracture</td>
<td>Autologous breast reconstruction</td>
</tr>
<tr>
<td>Dupuytren’s</td>
<td>Face lift</td>
</tr>
<tr>
<td>Hand fracture/ reduction fixation</td>
<td>Rhinoplasty</td>
</tr>
<tr>
<td>Breast augmentation</td>
<td>Blepharoplasty</td>
</tr>
<tr>
<td>Breast reconstruction with flap</td>
<td>Free tissue transfer</td>
</tr>
<tr>
<td>LE reconstruction</td>
<td>Complex facial trauma</td>
</tr>
<tr>
<td>Fat grafting</td>
<td>Craniofacial procedure</td>
</tr>
<tr>
<td>Mastopexy</td>
<td>Brachial plexus repair</td>
</tr>
</tbody>
</table>
GENERAL COMPETENCY RATING SHEET

Patient Care:
(1) (2) (3) (4) (5)
Novice Advanced Beginner Competent for Resident Level Proficient Expert

Medical Knowledge:
(1) (2) (3) (4) (5)
Novice Advanced Beginner Competent for Resident Level Proficient Expert

Practice-Based Learning and Improvement:
(1) (2) (3) (4) (5)
Novice Advanced Beginner Competent for Resident Level Proficient Expert

Interpersonal and Communication Skills:
(1) (2) (3) (4) (5)
Novice Advanced Beginner Competent for Resident Level Proficient Expert

Professionalism:
(1) (2) (3) (4) (5)
Novice Advanced Beginner Competent for Resident Level Proficient Expert

Systems-Based Practice:
(1) (2) (3) (4) (5)
Novice Advanced Beginner Competent for Resident Level Proficient Expert

Comments:
QUARTERLY EVALUATION OF PLASTIC SURGERY RESIDENTS

1. **Knowledge:**
   General knowledge of medical information (Surgery Board Exam)
   Broad knowledge of plastic surgery
   Knowledge of literature related to development of plastic surgery
   Knowledge of current literature including controversial areas
   Timing learning about current clinical procedures
   Attitude and initiative toward self-improvement and learning
   In-Service Exam scores >30 percentile

2. **Clinical Ability:**
   Ability to establish rapport and maintain 2-way communication with patients
   Quality of work-ups – thoroughness and pertinence
   Quality of records – progress notes, operative notes, summaries, etc.
   Ability to perform/use basic clinical techniques
   Quality of pre- and post-op management; number of operative cases
   Development of clinical judgment
   Thoroughness of preparations for surgery, conference, etc.
   Attention to detail

3. **Problem Solving:**
   Inventiveness and innovation
   Analytic (& diagnostic) skills
   Application to visualize technical steps and pitfalls in proposed solutions
   Consideration and planning of alternatives

4. **Operating Skills**

1. **Attitudes:**
   Realistic appraisal and awareness of own strengths and weaknesses
   Professionalism as physician, appearance and demeanor
   Readiness to accept instruction/correction
   Effectiveness of 2-way communication with juniors, seniors, peers, ancillary personnel, leadership
   Promptness, attentiveness, perseverance, initiative, ambition
PLASTIC SURGERY IN-SERVICE EXAMINATION

Each year the Plastic Surgery Education Foundation offers an In-Service Examination. The test is administered in March, and may be taken by residents, fellows, and practicing surgeons. The participant receives a score in relation to the entire group taking the exam and one relation to his/her peer group. Therefore, it is an excellent means of evaluating your current educational level.

The examination also provides a break-down of scores in specific “content areas”. The participant can thus identify his/her own areas of relative strength and weakness, as a guide to future study. The participant also receives a statement of all his/her incorrect answers and a syllabus, which provides a detailed discussion of each question. Most participants find the In-Service exam to be an excellent educational exercise and self-assessment tool.

It is expected that each resident will perform satisfactorily (50th percentile or above) on the In-Service examination. Failure to do so can result in a resident being placed on probationary status.

Achievement of 90th percentile wins the award of a book of the resident’s choice.
Plastic Surgical Quality Improvement Conference:
Faculty and residents, with the assistance of other involved medical specialties, review their treatment and management of actual patient cases. Specific focus is placed on outcomes resulting in death or morbidity. This monthly review explores issues related to risk management, quality assurance, ethics, medical knowledge and technical competency. This conference affords those presenting cases an opportunity to develop and practice communication techniques and teaching skills. The resident with the faculty member, develops a case summary prior to presentation. It also allows faculty to give feedback and positive criticism to help the resident improve patient care. Faculty are always available to support the resident in the presentation. A critical review of the literature routinely takes place.

In order to standardize these reports, we will do so in an H&P format:

1. Patient initials
2. Operation and date: PICTURES!
3. Complication and date: PICTURES!
4. Brief summary of H&P; hospital course including operation and complication; describe therapy rendered
5. Follow-up: PICTURES!
The Division of Plastic Surgery has a large collection of books, sound/slide programs, and reprints available for your use. They are also needed by others. They should be used in the library. In the event that it becomes necessary to remove anything from the library, they must be signed out by leaving a note card with the Plastic Surgery residency coordinator that includes the name of the reference, the borrower and the date borrowed. No materials will be removed from the library for more than 48 hours. It is important to adhere to this policy, as there are occasions when a particular book is needed immediately. Therefore, the whereabouts of the book is imperative. In the event that adherence to this policy becomes a problem (i.e. books are not being checked out or returned in a timely fashion), no materials will be removed from the library under any circumstances.

More recent books, which have web access, can be viewed at http://www.expertconsultbook.com

Username: utmbprs@gmail.com
PLASTIC SURGERY JOURNALS

A number of journals deal entirely or predominantly with Plastic Surgery topics. Most of these offer discounts to residents who wish to purchase subscriptions. The following is a partial list of these journals, with subscription information when available.

PLASTIC SURGERY NEWS
3580 Hythe Court
Columbus, Ohio 43220
(NOTE-PSN is an informative publication of the ASPRS. It contains reports of Society activities and meetings, descriptions of government actions, classified ads, etc. Residents can receive PSN at substantial savings if they become members of the ASPRS Resident Affiliate Group).

**PLASTIC AND RECONSTRUCTIVE SURGERY**
Williams & Wilkins
428 East Preston Street
Baltimore, Maryland 21202
(NOTE-Members of the ASORS Resident Affiliate Group receive a substantial discount)

**ANNALS OF PLASTIC SURGERY**
Little, Brown & Co.
34 Beacon Street
Boston, Massachusetts 02105

BRITISH JOURNAL OF PLASTIC SURGERY
P.O. Box 11318
Birmingham, Alabama 35202

CLINICS IN PLASTIC SURGERY
W.B. Saunders Co.
West Washington Square
Philadelphia, Pennsylvania 19105

BURNS
John E. Wright & Sons, Ltd.
632-825 Bath Road
Bristol BS45NU
England

JOURNAL OF BURN CARE & REHABILITATION
P.O. Box 416
Spring Lake, NJ 0776

MICROSURGERY
Alan R. Lisse, Inc.
150 Fifth Avenue
New York, NY 10011
CLEFT PALATE JOURNAL
American Cleft Palate Association
331 Salk Hall
University of Pittsburgh
Pittsburgh, Pennsylvania 15261

JOURNAL OF TRAUMA
Williams & Wilkins
428 East Preston Street
Baltimore, Maryland 21202

AESTHETIC PLASTIC SURGERY
Springer-Verlag New York, Inc.
44 Hatz Way
Secaucus, New Jersey 07094

FACIAL PLASTIC SURGERY
Thieme-Stratton Inc.
381 Park Avenue South
New York, New York 10016

EXCEPTRA MEDICA PLASTIC SURGERY
Excerpta Medica, Inc.
P.O. Box 3085
Princeton, New Jersey 0854

TECHINQUES IN HAND & UPPER EXTREMITY SURGERY
Wolters Kluwer/ Lippincott Williams & Wilkins
P.O. Box 1600
Hagerstown MD, 21741-1600

THE JOURNAL OF HAND SURGERY
325 Corporate Drive
Mahwah, NJ 07430
Requirements for Certification

The American Board of Plastic Surgery will contact you to complete a “Tracking Form” which should be submitted as a PGY-1.

The American Board of Plastic Surgery will contact you during your senior year of residency. Follow all deadlines as listed. At this time, an Application for Examination and Certification form will be provided. The Board also issues a “Booklet of Information” which is extremely useful in assembling the appropriate supporting letters and co-documents, and in preparing cases for the Board examination. This booklet is updated frequently, so the resident would be well advised to utilize the most recent edition while assembling materials for Certification.

Applications, booklets and additional information may be obtained by writing:

The American Board of Plastic Surgery, Inc.
Seven Penn Center, Suite 400
1635 Market Street
Philadelphia, Pennsylvania 19103-2204
(215) 587-9322

You must complete the application form and return it to the office of the Board as soon as possible. Applications for admission to the upcoming Qualifying (written) Examination, to be given in the Fall of the following year, must be received during the Spring of the Chief Resident year. The application must be completed accurately and signed by you. A standard form will be provided by the Board to Program Directors for completion at the end of the residency. This form shall require two signatures by the Program Director, one affirming that the trainee has completed the program, and a second indicating that the training is recommended for admission to the examinations for certification. If the Program Director elects not to sign either statement, he or she shall state in writing on the form the reasons and basis why he or she makes such decision.

It is your responsibility to obtain letters of recommendation as requested in the application. If you have completed training in more than one program in plastic surgery, the director of each program must verify completion of that program and recommend you for examination. Additionally, the Board may require favorable evaluations and recommendations from other surgeons.
MEMBERSHIP

We encourage all plastic surgery residents to become candidate members of ASPS. Following is the website:

http://www.plasticsurgery.org

It is also helpful to obtain resident membership (at a reduced rate) in:

American College of Surgeons
American Society of Aesthetic Plastic Surgeons
American Association of Hand Surgeons
American Society of Maxillofacial Surgeons
American Burns Association
<table>
<thead>
<tr>
<th>Year</th>
<th>PGY-1</th>
<th>PGY-2</th>
<th>PGY-3</th>
<th>PGY-4</th>
<th>PGY-5</th>
<th>PGY-6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>General Surgery</td>
<td>Trauma/GS Night Float</td>
<td>Vascular</td>
<td>Acute Burn Care</td>
<td>Pediatric Surgery</td>
<td>Urology</td>
</tr>
<tr>
<td></td>
<td>1 Month</td>
<td>1 Month</td>
<td>1 Month</td>
<td>1 Month</td>
<td>1 Month</td>
<td>1 Month</td>
</tr>
<tr>
<td></td>
<td>General Surgery</td>
<td>SICU</td>
<td>SICU</td>
<td>Trauma Day/ GS Night Float</td>
<td>Acute Burn Care</td>
<td>Orthopaedics-Hand Surgery</td>
</tr>
<tr>
<td></td>
<td>1 Month</td>
<td>1 Month</td>
<td>1 Month</td>
<td>1 Month</td>
<td>1 Month</td>
<td>1 Month</td>
</tr>
<tr>
<td></td>
<td>1 Month</td>
<td>1 Month</td>
<td>1 Month</td>
<td>1 Month</td>
<td>1 Month</td>
<td>1 Month</td>
</tr>
<tr>
<td></td>
<td>SHC-Galveston</td>
<td>SHC-Galveston</td>
<td>SHC-Galveston</td>
<td>1 Month</td>
<td>1 Month</td>
<td>1 Month</td>
</tr>
<tr>
<td></td>
<td>1 Month</td>
<td>1 Month</td>
<td>1 Month</td>
<td>1 Month</td>
<td>1 Month</td>
<td>1 Month</td>
</tr>
<tr>
<td></td>
<td>1 Month</td>
<td>1 Month</td>
<td>1 Month</td>
<td>1 Month</td>
<td>1 Month</td>
<td>1 Month</td>
</tr>
</tbody>
</table>
Overall Goal for the Plastic Surgery Residency Program

The ultimate goal of the plastic surgery residency program at UTMB Galveston is to provide a scholarly educational environment with all the resources required to allow residents to develop into competent plastic surgeons with a broad base of knowledge, able to safely treat patients independently without supervision. Based on ACGME competencies, the residency will provide:

1) Residents will have clinical **patient care** experiences in all aspects of plastic surgery (congenital defects of the head and neck; neoplasms of the head and neck; craniomaxillofacial trauma; aesthetics surgery; all aspects of breast surgery; hand and upper extremity; lower extremity; trunk; burn care, acute and reconstructive; microsurgical and other tissue transfer techniques; benign and malignant lesions of skin and soft tissues) and closely allied disciplines (anesthesiology; emergency medicine/trauma; cardiovascular, general, neurologic, urologic, orthopedic, vascular, and pediatric surgery; otolaryngology; critical care; dermatology; oral and maxillofacial surgery and occuloplastic surgery). Residents will develop experience in practice management such as coding, advertising, and ethical issues. 2) Their medical **knowledge** will increase through the experiences as well as structured didactic sessions and scholarly projects. 3) They will learn to review their own patient care to develop the life-long habit of practice based learning and improvement. 4) They will be evaluated and coached to develop and constantly improve their **interpersonal and communication skills**. 5) The environment will foster and, if necessary, remediate their life-long commitment to professionalism. 6) In the context of the various practice venues and with the different faculty of the program, they will learn effective practice that is system-based.

In this manner, we intend to graduate plastic surgeons able to not only perform competently, but to excel in fellowships, private, or academic practice.

**Competency Based Goals & Objectives:**
Can be found at Q:\PLASTIC SURGERY CURRICULUM- Competency based G&O
<table>
<thead>
<tr>
<th>Conference Type (Basic Science, Journal Club, Pathology, etc)</th>
<th>Required</th>
<th>Frequency</th>
<th>Individual(s) or Department Responsible for Conducting Conference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grand Rounds</td>
<td>Y</td>
<td>Monthly</td>
<td>Rotates among surgical division</td>
</tr>
<tr>
<td>SCORE Conference</td>
<td>Y</td>
<td>Weekly</td>
<td>Resident &amp; Faculty</td>
</tr>
<tr>
<td>Chairman’s Conference</td>
<td>Y</td>
<td>Weekly</td>
<td>Resident &amp; Faculty</td>
</tr>
<tr>
<td>Chairman’s Rounds</td>
<td>Y</td>
<td>Weekly</td>
<td>Resident &amp; Faculty</td>
</tr>
<tr>
<td>In addition, on specific rotations:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anesthesiology Didactic, lectures</td>
<td>Y</td>
<td>Daily</td>
<td>Faculty assigned</td>
</tr>
<tr>
<td>Pediatric Surgery Case Conference</td>
<td>Y</td>
<td>2 times per month</td>
<td>Resident with faculty</td>
</tr>
<tr>
<td>Pediatric Surgery Pathology</td>
<td>Y</td>
<td>Monthly</td>
<td>Dr. Hal Hawkins</td>
</tr>
<tr>
<td>Pediatric Surgery Journal Club</td>
<td>Y</td>
<td>Monthly</td>
<td>Resident</td>
</tr>
<tr>
<td>Vascular Interventional Radiology</td>
<td>Y</td>
<td>Weekly</td>
<td>Faculty</td>
</tr>
</tbody>
</table>
## CONFERENCE SCHEDULE

<table>
<thead>
<tr>
<th>Conference Type (Basic Science, Journal Club, Pathology, etc)</th>
<th>Required</th>
<th>Frequency</th>
<th>Individual(s) or Department Responsible for Conducting Conference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric Cardiac Cath.</td>
<td>Y</td>
<td>Weekly</td>
<td>Faculty</td>
</tr>
<tr>
<td>Pulmonary Med./Surg. Case</td>
<td>Y</td>
<td>Weekly</td>
<td>Faculty</td>
</tr>
<tr>
<td>Didactic Thoracic Surgery</td>
<td>Y</td>
<td>Monthly</td>
<td>Faculty</td>
</tr>
<tr>
<td>Neurosurgery Case Teaching Conf.</td>
<td>Y</td>
<td>Weekly</td>
<td>Faculty</td>
</tr>
<tr>
<td>Neuropathology (Case-based)</td>
<td>Y</td>
<td>Weekly</td>
<td>Faculty</td>
</tr>
<tr>
<td>Neurosurgery/Neurology (Case-based)</td>
<td>Y</td>
<td>Weekly</td>
<td>Faculty &amp; Residents</td>
</tr>
<tr>
<td>Urology Basic Science &amp; Clinical</td>
<td>Y</td>
<td>Weekly</td>
<td>Resident</td>
</tr>
<tr>
<td>Radiology-GU Case Conf.</td>
<td>Y</td>
<td>Weekly</td>
<td>Faculty &amp; Residents</td>
</tr>
<tr>
<td>Urology M &amp; M</td>
<td>Y</td>
<td>Weekly</td>
<td>Residents</td>
</tr>
<tr>
<td>Urology Journal Club</td>
<td>Y</td>
<td>Monthly</td>
<td>Residents</td>
</tr>
<tr>
<td>Urology Pathology</td>
<td>Y</td>
<td>Monthly</td>
<td>Faculty</td>
</tr>
<tr>
<td>Urologic Pediatrics</td>
<td>Y</td>
<td>Monthly</td>
<td>Faculty</td>
</tr>
<tr>
<td>Conference Type (Basic Science, Journal Club, Pathology, etc)</td>
<td>Required</td>
<td>Frequency</td>
<td>Individual(s) or Department Responsible for Conducting Conference</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>----------</td>
<td>-----------</td>
<td>-----------------------------------------------------------------</td>
</tr>
<tr>
<td>Journal Club (PRS)</td>
<td>Y</td>
<td>2x/month</td>
<td>All Faculty -UTMB -Bay Area</td>
</tr>
<tr>
<td>Surgery Grand Rounds</td>
<td>Y</td>
<td>1x/month</td>
<td>Rotates among Surgery divisions</td>
</tr>
<tr>
<td>Combined ENT/Plastic/OMFS Maxillofacial Conference</td>
<td>Y</td>
<td>1x/month</td>
<td>Alternates between the specialties</td>
</tr>
<tr>
<td>Indications Conference (Unknowns)</td>
<td>Y</td>
<td>Monthly</td>
<td>Phillips</td>
</tr>
<tr>
<td>Workshops</td>
<td>Y</td>
<td>1-2x/month</td>
<td>Varied</td>
</tr>
<tr>
<td>Anatomy Wet-Labs</td>
<td>Y</td>
<td>Variable</td>
<td>Scheduled with Faculty</td>
</tr>
<tr>
<td>Competencies Presentations</td>
<td>Y</td>
<td>Quarterly</td>
<td>All Faculty and Residents</td>
</tr>
<tr>
<td>Oral Exams (Unknowns)</td>
<td>Y</td>
<td>3-4x/ year</td>
<td>All residents &amp; non-ABPS examiners faculty</td>
</tr>
<tr>
<td>Oral Exams Case Books</td>
<td>Y</td>
<td>1x/ year</td>
<td>PGY-6, Community faculty</td>
</tr>
<tr>
<td>Planning/Outcomes</td>
<td>Y</td>
<td>Weekly</td>
<td>All residents &amp; faculty at UTMB</td>
</tr>
<tr>
<td>Oplogs</td>
<td>Y</td>
<td>Monthly</td>
<td>All residents &amp; faculty at UTMB</td>
</tr>
<tr>
<td>PSQI</td>
<td>Y</td>
<td>Monthly</td>
<td>All residents &amp; faculty at UTMB</td>
</tr>
<tr>
<td>PGY-5’s/6’s</td>
<td>PGY-4’s</td>
<td>PGY-1’s/2’s/3’s</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>---------</td>
<td>----------------</td>
<td></td>
</tr>
<tr>
<td>Breast &amp; Body Contouring</td>
<td>Fresh Start</td>
<td>Fresh Start (PGY-3’s)</td>
<td></td>
</tr>
<tr>
<td>TSPS</td>
<td>Aesthetic Facial Recon</td>
<td>ACS, Regional</td>
<td></td>
</tr>
<tr>
<td>ASSH</td>
<td>ASRM</td>
<td>PSRC</td>
<td></td>
</tr>
<tr>
<td>AAPS</td>
<td>AAPS</td>
<td>ABA</td>
<td></td>
</tr>
<tr>
<td>AAHS, ASRM</td>
<td>PSRC</td>
<td>WHS</td>
<td></td>
</tr>
<tr>
<td>Atlanta Breast Symposium</td>
<td>ASPS</td>
<td>AAPS</td>
<td></td>
</tr>
<tr>
<td>Baker-Gordon (6’s)</td>
<td>WHS</td>
<td>TSPS</td>
<td></td>
</tr>
<tr>
<td>Dallas Rhinoplasty (6’s)</td>
<td>Multidisciplinary Symposium on Breast Disease</td>
<td>ACS, National</td>
<td></td>
</tr>
<tr>
<td>ASAP (6’s)</td>
<td>ACS</td>
<td>ASPS</td>
<td></td>
</tr>
<tr>
<td>Aesthetic Fxn through Recon</td>
<td>WHS</td>
<td>Multidisciplinary Symposium on Breast Disease</td>
<td></td>
</tr>
<tr>
<td>Hand Review Course</td>
<td>TSPS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senior Residents’ Conference</td>
<td>ASMS Basic Course</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Guidelines for Supervision of Residents

Faculty are present in-house at all times for surgical cases and in the operating room suite at minimum for all key portions of procedures. On-call faculty are immediately available by beeper or phone 24-hours daily. All faculty are present at all times during out-patient office periods assigned to them. All office and ER patients are seen by faculty.

Supervision of Residents:
In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision available.

Clinical Responsibilities:
The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services.

Teamwork:
Residents must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty.

In addition, all PGY-1 residents will be supervised for all activities until they are proven competent by a minimum of a mid level (PGY-2 or PGY-3) resident. This is in addition to the faculty supervisory responsibility. This includes all patient care, procedures, office and ER contact, use of the EMR and admissions and discharges.

For all residents who take emergency room call, faculty on call for a new patient or the establishing faculty for an existing patient, MUST be consulted. If emergency room procedures are performed, or a patient is seen, the faculty must be present for the key portion of the procedure and for the administration of care. For office visits, each patient must be seen by the faculty member. Faculty members will see the in-patient under their care or during their call on a daily basis. If there is an untoward event or complication reported by a nurse or in-patient or by a call from the patient to the resident on call, that resident must pass that information to the chief resident and then either the more junior resident or the chief resident will communicate directly with the faculty member for consultation and decision of any intervention in care. Any patient who requires transfer to the intensive care unit or an end of life decision must be discussed by the chief resident with the faculty member. It is the faculty members’ decision to discuss DNR with the patient or family members.
Resident Duty Hours and Call

The call schedule for PGY-1’s, PGY-2’s and PGY-3’s is made by the service on each rotation. On Plastic Surgery, the PGY-1 will rotate with a PGY-4, and the PGY-2 & 3 will rotate with a PGY-4 or 5. The second, third, fourth and fifth year residents alternate first call so as to assure time off and a full 24-hour period off each week. They are backed by a sixth year resident who can also assure adequate rest for the junior residents. Finally, a faculty member is always on call to back up the residents.

**RESIDENT DUTY HOURS AND THE WORKING ENVIRONMENT**

Providing residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents’ time and energies. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

**DUTY HOURS**

Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site or travel time.

In the clinical learning environment, each patient must have identifiable, appropriately-credentialed and privileged attending physician who is ultimately responsible for that patient’s care.

**Mandatory Time Free of Duty:**

Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

**Maximum Duty Hour Period Length**

Duty periods of PGY-1 residents must not exceed 16 hours in duration. They may not take in-house call.

**Minimum time Off between Scheduled Duty Periods:**

- Intermediate-level residents should have 10 hours free of duty, and must have eight hours between scheduled duty hours. They must have at least 14 hours free of duty after 24 hours of in-house duty.

- Residents in their final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

- This preparation must occur within the context of the 80-hour, maximum duty period length and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

Residents may remain on duty beyond scheduled hours. This will occur only in specific circumstances. For a PGY-2 through PGY-6 resident, if a patient has an untoward result and must return to the operating room, or to continue to give care when the patient is in extremis such as a requirement to be transferred to the intensive care unit or if they are moribund, the resident may remain past their
scheduled duty hours for continuity of care. For a PGY-5 or PGY-6 resident, in order to attain experience with a key index case they are lacking the resident may stay beyond their scheduled duty hours. In the event that disaster status is declared, residents PGY-2 through PGY-6 (and faculty) may be designated as Essential Personnel. Those individuals will serve as a small team, remaining in the hospital, on call for the duration of the disaster, providing care to remaining in-house patients and those who present to the Emergency Room. The faculty member will make every effort to assure adequate rest is attained during the emergency period. When it is safe for other residents and faculty members to travel, they will come to relieve the Essential Personnel, who will be sent home to obtain adequate rest before returning to duty. When for any of these reasons as outlined above, the resident has stayed beyond their scheduled duty hours, they will complete a form and submit this to the faculty member who was supervisory of this patient care episode and it will then be submitted to the program director. This duty hour exception will be noted in the New Innovations log and a copy of the attached form will be entered into the resident’s file. A note will be taken of each duty hour exception for each residents and this will be trended.

ON-CALL ACTIVITIES
The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal work day when residents are required to be immediately available in the assigned institution. In-house call must occur no more frequently than every third night, averaged over a four-week period.

Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours.

No new patients may be accepted after 24 hours of continuous duty, except in outpatient continuity clinics. A new patient is defined as any patient for whom the resident has not previously provided care.

At-home call (pager call) is defined as call taken from outside the assigned institution.

Maximum frequency of In-House Night Float:
Residents must not be scheduled for more than six consecutive nights of night float.

The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a four-week period.

When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

UTMB offers 35 private sleep rooms located on the 12th floor of John Sealy Towers, for residents who are too fatigued to safely return home.

The program director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

All residents who appear to be too tired to perform their assigned duties will be sent home. If they appear too tired to safely drive, they will be sent to the call room of the duty assignment where they may rest until they are able to safely travel home.

In addition:
1) All PGY-1 residents will be sent home after 16 hours. If they should appear too tired prior to 16 hours, they may be sent home or sent to the call room to rest.
2) All PGY-2 through PGY-6 residents will be sent home after 24 hours of in-house duty. If they become too tired to safely perform their duties prior to this, they should call their chief or if they are a
chief resident they should call their faculty member for backup. The administrative chief resident along with

the faculty member will assure that any additional resident coverage is provided. The resident will be given the opportunity to go home or to remain in-house in a call room resting until they are able to safely return home. It is the responsibility of the supervising resident and faculty member to assure all residents have adequate rest and are fit for duty. If the faculty member or a more senior resident observes a resident who is appearing impaired by lack of rest, they will discuss this with the individual resident and assure that they are given relief from their duties and additional rest time.

MOONLIGHTING
Moonlighting is not permitted for any residents.
Transfer/Handoff Protocol

Transfer of patient care and handovers must occur directly between the resident who is currently on duty and the next resident who will assume duty. At minimum, this must include a face to face meeting to discuss any in-house patients. For those patients whose care is more complicated, requiring SICU support or have care that needs constant monitoring such as a free tissue transfer, the handover will include a bedside examination of the patient by the two residents involved. For more extended periods of patients transfers, such as for the weekend, the current and assuming resident staff should have rounds. Whenever possible this should include the faculty members currently caring for and about to assume care of the patients who are in-house. For less complicated patients, faculty may sign out by electronic or telephone communications.
SLEEP DEPRIVATION DURING RESIDENCY

Most on-call residents receive little enough sleep to classify as sleep-deprived. Chronic sleep deprivation and impairment in functioning subsequent to loss of REM sleep, as demonstrated by impaired memory consolidation, reaction time, and the ability to process novel and divergent information have been shown in numerous studies on medical residents. Sleep deprived residents are generally grossly inaccurate judges of their impairment level. Many studies have also indicated significant dysphoria connected with sleep deprivation, as well as high increase in number of MVAs post-call.

Some common sleep symptoms related to sleep deprivation in residents:
- Common: Fatigue, irritability, GI upset
- Occasional: Difficulty initiating or maintaining sleep. Involuntary early morning awakenings and inability to return to sleep (often associated with depression). Hallucinations associated with falling asleep or waking up.
- Rare: Sleep walking or REM behavior disorder. Latter involves acting out a dream. Former arises out of slow-wave sleep.

Addendum to Sleep Suggestions:
- If possible, have spouse or significant other manage daytime chores on post-call days. Use dark shades/curtains in bedroom, decrease amount of light exposure going home post-call (sunglasses) to protect your circadian pattern.
- Avoid hot showers/baths prior to bed (body wants a lower temperature at bedtime).
- Post-call: Disconnect your phone or set the machine to automatic answering! If you are post-call, friends and family should be informed this is a needed rest time.
- Avoid sleep agents, such as Ambien to decrease sleep latency, as they may interfere with sleep architecture and may lead to habituation, ultimately increasing sleep latency.
- Once you have set your alarm clock, turn it away from your bed. Do not “clock watch”.
- There is variability in how much sleep each of us needs. Sleep time effects GH, cortisol, a multitude of cytokines as well as wound healing and BP. Try not to compare your sleep time with colleagues (who are not always accurate in their reports).
- Pagers set to vibrate may be less intrusive than when set to beep. Beeping may sensitize you to environmental sounds while you are sleeping, unnecessarily alerting you.

Alcohol: Decreases sleep latency BUT increases sleep fragmentation.

Caffeine: Increases sleep fragmentation and sleep latency, esophageal reflux. May lead to periodic leg movements. Short-term benefit: increases alertness with 24-hours sleep deprivation, however, efficacy of caffeine rapidly declines during the second night of deprivation. Micro-sleep is then likely, maybe when you are doing surgery.

Fabulous Sleep Sites:
http://www.sleepnet.com
http://www.sleepfoundation.org
http://www.sleepinglikeababy.net
http://www.users.cloud9.net
Resident Advancement Policy

After each rotation, a resident evaluation via New Innovations is completed by the faculty. Three times yearly, faculty meet to evaluate each resident. The program director then discusses this privately with each resident.

Specific objectives to achieve yearly advancement include:

- The resident’s ability to demonstrate at the end of the educational period that he/she is an accomplished surgeon. Resident must be able to develop and execute surgical plans and non-surgical management.

- The resident’s ability to demonstrate that he/she has the proper educational information by performance on In-Service Examination to at least the 50th percentile.

- Education of those junior to them must be demonstrated.

- The resident’s ability to demonstrate the basic skills in a research laboratory and have the ability to formulate a research plan.

- Finishing year residents must administer their services competently and safely.

- Have been evaluated by the faculty and staff and have satisfied that they are ethical and moral physicians.

- Ability to present and discuss fully didactic topics as assigned.

- Completion of all paperwork (op reports, clinic notes, PSOL’s) in a timely fashion.

- The resident’s ability to complete the emergency evaluation & management and out-patient care, as well as increasing operative responsibility for each rotation as assigned, according to their level of responsibility by post-graduate year.

- Milestones

Available at Housestaff Office website
http://www.utmb.edu/gme/default.htm

Housestaff Contract
Grievance Policy
Anonymous Concern Site
Healthcare Information
I acknowledge that I have received a copy/link of the July 2015 Plastic Surgery Resident Handbook.
The following topics were reviewed:

Basis of Evaluation and Forms
Call and Duty Hour Policy
Supervision Policy
Rotation Goals and Objectives
Basis of Advancement
Length of the Residency Program
Grievance Policy
Resident Manual

Signature:                         Date: