



**Chattanooga Unit of the College of Medicine**  
Plastic and Reconstructive Surgery  
979 East Third Street, Suite C-920  
Chattanooga, TN 37403  
Tel: (423) 778-9047 Fax: (423) 778-9984

## Department of Plastic Surgery

Program Guidelines 2009-2010  
Revised February 2010

The information provided within these guidelines is just a portion of the comprehensive orientation manual provided upon entry into this 3-year independent plastic surgery residency program.

### **Administrative Information**

---

- ▶ Chairman and Professor                      Larry A. Sargent, M.D.
- ▶ Residency Coordinator                      Stacey Blanks

Address:            The Department of Plastic Surgery  
                         University of Tennessee College of Medicine Chattanooga  
                         979 East Third Street, Suite C-920  
                         Chattanooga, TN 37403

The Department of Plastic Surgery (TPSG) is located in the private offices of The Plastic Surgery Group, P.C. on the 9<sup>th</sup> floor of the Erlanger Medical Mall.

Phone: 423-778-9047

Fax: 423-778-9984

Email: [UTPlastics@thepsg.org](mailto:UTPlastics@thepsg.org)

Private Office Website: [www.refinedlooks.com](http://www.refinedlooks.com)

UT Website: [www.utcomchatt.org](http://www.utcomchatt.org)

## Department of Plastic and Reconstructive Surgery General Description of Program Goals and Objectives

The program goals and objectives are distributed to faculty and residents at the Plastic Surgery orientation each July. Residents are required to review their assigned rotation goals and objectives prior to each rotation change.

All rotation goals and objectives include General Competencies the Medicolegal and Psychiatric Aspects of Plastic Surgery.

The overall goals and objectives are:

1. To provide residents with quality instruction and experience in a wide range of plastic surgery areas, including both the functional and aesthetic management of congenital and acquired defects of the face, neck, trunk, body, and extremities.
2. To produce residents who are well trained in the broad areas of general plastic and reconstructive surgery.
3. To produce residents who exhibit continued competent skills and characteristics in the six general competencies of patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice.
4. To produce residents who identify and practice the Medicolegal and psychiatric aspects of plastic surgery practice.

The goals and objectives are to be obtained over a three-year period. Upon reaching the third year rotation the senior (chief) residents have increased responsibility in patient and operative care, as well as supervisory responsibility for junior residents, and clinical and administrative duties.

Specific Training in:

1. Congenital defects of the head and neck, including clefts of the lip and palate, auricular deformities, and craniofacial surgery.
2. Neoplasms of the head and neck, including the oropharynx and training in appropriate endoscopy.
3. Craniomaxillofacial trauma, including fractures.
4. Aesthetic (cosmetic) surgery of the head and neck, trunk, and extremities.
5. Plastic surgery of the breast.
6. Surgery of the hand and upper extremity.

7. Plastic surgery of the lower extremities.
8. Plastic surgery of the congenital and acquired defects of the trunk and genitalia.
9. Burn management, acute and reconstructive.
10. Microsurgical techniques applicable to plastic surgery.
11. Reconstruction by tissue transfer, including flaps and grafts.
12. Surgery of benign and malignant lesions of the skin and soft tissues.

Residents gain experience in:

1. Surgical design
2. Surgical diagnosis
3. Surgical and artistic anatomy
4. Surgical physiology and pharmacology
5. Wound healing
6. Surgical pathology and microbiology
7. Adjunctive oncological therapy
8. Biomechanics
9. Rehabilitation
10. Surgical instrumentation

Residents completing the program must display judgment and technical capability for achieving satisfactory surgical results.

Instruction in the basic sciences is provided as an integrated part of the clinical training. Formal conferences and lectures enable discussion to broaden the resident's knowledge in basic sciences (anatomy, pathology, physiology, embryology, radiation biology, genetics, microbiology, and pharmacy) and surgical principles fundamental to clinical plastic surgery. These didactic sessions and discussions allow time for evaluation of current medical literature and studies. Each faculty member is assigned didactic lectures in their area of expertise. In addition, attending physicians provide a great deal of one-on-one teaching regarding specific cases and problems encountered during on-going patient care. Residents participate in the presentation of educational material at the conferences.

The University of Tennessee College of Medicine Chattanooga no longer sponsors residency programs in Ophthalmology, Pathology, and Radiology. Faculty members are available in those areas for specific consultation and teaching. Morbidity and mortality experiences are reviewed at a monthly conference where each case is discussed.

The continuity of patient care is emphasized as an important part of training, specifically in regard to the care of non-private patients. Once a patient is initially seen by a given resident via one of the clinics, the emergency departments at The Erlanger Health System, or T.C. Children's Hospital, that patient continues to be followed by that resident throughout his tenure in the program. The full-time faculty on a rotating basis provides supervision of the resident clinic. Private patients who are admitted as

inpatients (and out-patient) are also assigned to residents for work-ups prior to surgery. That resident assists the faculty member with any surgery, as well as patient care. The faculty requires residents to continue to follow private patients with scheduled time postoperatively in the office setting.

The residents have the responsibility for teaching medical students and for teaching their junior residents in surgery and plastic surgery. These responsibilities are shared with the faculty. General Surgery residents, Transitional Year residents, and medical students on rotation to plastic surgery are expected to participate in conferences and educational schedules, which are required of the Plastic Surgery residents.

Residents are not encouraged to emphasize a particular area of plastic and reconstructive surgery during the 3-year program; e.g. hand, head and neck, aesthetic, microvascular, or craniofacial surgery. However, if residents develop a specialized interest during their training, they are encouraged to seek a fellowship at another institution or remain with our program for an additional year to develop further expertise in that specialized area.

Department of Plastic and Reconstructive Surgery  
Specific Rotation  
Goals and Objectives

The following outline includes specific goals and objectives of the three different plastic rotations and one hand rotation that residents are assigned to during their three-year residency program. *New rotations are being developed for the additional third year that will meet the updated plastic surgery requirements.* These written objectives and clinical activities are used to assess their progress through the different rotations and residency program.

All the goals and objectives of the upper extremity are accomplished exclusively on the Hand Service rotation and plastic rotations concentrate on specific areas, however, each also includes experience in general plastic surgery (burns, skin lesions, breast surgery, trauma, etc.)

During each rotation the resident gains a clear understanding of medicolegal and psychiatric aspects of plastic surgery practice. Residents regularly obtain informed consent from the patient and complete an effective basic psychological evaluation when appropriate.

**During training each resident demonstrates the following:**

|    | Description  | Competency   |
|----|--|--|
| 1. | Obtains informed consent from all patients and effectively document the consent agreement. | Patient Care, Interpersonal and Communication Skills, Professionalism                    |
| 2. | Evaluates patients for aesthetic surgery from a physical and psychological perspective.    | Patient Care, Medical Knowledge, Interpersonal and Communication Skills, Professionalism |

**Upon completion of training, the resident demonstrates competence as follows:**

|    | Description   | Competency  |
|----|---|---|
| 1. | Identifies the medical and legal perspectives of the contractual agreement between physician and patient. | Patient Care, Medical Knowledge, Practice-Based Learning and Improvement, Professionalism, Systems-Based Practice |
| 2. | Identifies the concepts of informed consent and implied guarantee.  | Patient Care, Interpersonal and Communication Skills, Professionalism   |
| 3. | Identifies the role of the medical record as a legal document.  | Professionalism, Systems-Based Practice   |
| 4. | Identifies the impact physical deformity  | Patient Care, Medical   |

|    |   |   |
|----|---|---|
|    | can have on patients and their families.  | Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism                       |
| 5. | Recognizes and implements techniques to explore the motivations of patients seeking cosmetic surgery and how to distinguish acceptable, unacceptable, and pathological motivations. | Patient Care, Medical Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism |

All residents upon entering our program are board eligible in general surgery or have both dental and medical degrees and are fully trained (board eligible) in Oral and Maxillofacial Surgery, as well as additional training in general surgery. As a result, our residents have frequently had 5 to 7 years of surgical training prior to beginning our residency program. This also means that each resident has met the necessary requirements and general competencies to successfully complete a surgical residency training prior to the start of our specialized training program.

It is the goal and objective of our training program to produce clinically and professionally competent independent surgeons in Plastic Surgery. Competency in the following six general areas is assessed on each rotation by the faculty member(s) to whom the resident is assigned.

1. **Patient Care:** Compassionate, appropriate, effective management of responsibilities and promotion of health. Gathers essential and accurate information. Performs all essential skills. Works effectively with patients, families, and other professionals.
2. **Medical Knowledge:** Demonstrates investigative and analytical thinking in problem solving. Knows and applies basic and clinical sciences.
3. **Practice-Based Learning and Improvement:** Analyzes practice experience. Locates evidence from scientific studies. Uses information technology. Understands study design and statistical methods. Teaches others.
4. **Interpersonal and Communication Skills:** Maintains ethically sound relationships and communicates effectively with patient, family, and other members of the healthcare team.
5. **Professionalism:** Demonstrates respect, integrity, and responsiveness that supercedes self-interest. Has a commitment to excellence and professional development and high ethical standards of confidentiality and sensitivity to patients regardless of culture, age, gender or disabilities.

6. **Systems-Based Practice:** Demonstrates awareness of larger context of healthcare. Practices cost-effective care and resource allocation. Assists patients in dealing with system complexities. Partners with managers to coordinate and improve healthcare and system performance.

The close daily working relationship with a faculty member allows direct observation and interaction by the faculty with the resident in the clinics, office, conference, and operating room; providing an excellent way to assess the general competencies and the accomplishment of all goals and objectives.

Evaluations are completed by the faculty on each resident upon completion of each 3-month rotation. These evaluations use a 0-4 scale (0=not observed, 1=unsatisfactory, 2=satisfactory average, 3= satisfactory above average and 4=superior). Each of the 6 competencies is evaluated through this assessment tool. The completed evaluations for each resident are combined and scores are averaged using the 0-4 scale. First year residents are expected to score at least satisfactory average (2). While satisfactory average (2) is acceptable for both years, our goal is to have second year residents increase their scores to satisfactory above average (3) and/or superior (4).

Department of Plastic and Reconstructive Surgery  
Program Rotation  
Faculty Assignments

Program Rotations

**I. Congenital Craniofacial Surgery, Cleft Lip and Palate, Maxillofacial Trauma, and Aesthetic**

Faculty Instructor:            Larry A. Sargent, MD, Professor and Chairman.

**II. Hand and Upper Extremity**

Faculty Instructors:        Marshall Jemison, MD, Associate Professor\*  
Mark Brzezienski, MD, Assistant Professor\*  
Woody Kennedy, MD, Assistant Professor  
Jason Rehm, MD, Assistant Professor

**III. General Reconstructive, Wound Care, Burn Care, and Microsurgery**

Faculty Instructors:        Woody Kennedy, MD, Assistant Professor  
Jason Rehm, MD, Assistant Professor

**IV. General Reconstructive and Aesthetic**

Faculty Instructors:        Mark Brzezienski, MD, Assistant Professor\*  
Jimmy Waldrop, MD, Clinical Instructor

- Faculty have dual appointments in the Departments of Plastic and Reconstructive Surgery and Orthopedic Surgery.

*Rotation descriptions are currently being reviewed due to the new plastic surgery program requirements. New rotations are being developed and current rotations will be re-distributed with faculty.*

*New Rotations will include:  
Oculoplastic Surgery, Oral and Maxillofacial Surgery, Anesthesia, Dermatology and Orthopedic Surgery.*

**Department of Plastic and Reconstructive Surgery  
Congenital Craniofacial Surgery, Cleft Lip and Palate, Maxillofacial Trauma, and  
Aesthetic Surgery Rotation  
Competency-Based Goals and Objectives**

Faculty Instructor:                    Larry A. Sargent, MD, Professor and Chairman

Goals and Objectives

Craniofacial Surgery - Congenital Disorders

Craniofacial Surgery - Trauma

Plastic Surgery of the Head and Neck - Benign and Malignant Tumors

Plastic Surgery of the Head and Neck - Aesthetic and Functional Problems

Plastic Surgery of the Head and Neck - Reconstruction

Plastic Surgery of the Trunk and Breast - Anatomy/Physiology/Embryology

Plastic Surgery of the Breast - Aesthetic

Plastic Surgery of the Breast - Tumors and Reconstruction

Benign and Malignant Skin Lesions

Rotation Description

Dr. Sargent is Director of the Craniofacial Center and head of the Cleft Lip and Palate Team. On this rotation the resident obtains extensive exposure to the evaluation and treatment of congenital facial deformities, as well as acute maxillofacial injuries. In addition, experience in aesthetic surgery and general plastic surgery is obtained.

General plastic surgery principles are taught on each rotation. The third year rotation differs from years 1 and 2 in that the chief residents are expected to assume increasing, graded responsibilities in patient operative care, increased responsibility in administrative and clinical areas, as well as supervision of junior residents.

**Department of Plastic and Reconstructive Surgery  
Hand and Upper Extremity Rotation  
Competency-Based Goals and Objectives**

Faculty Instructors:            Marshall Jemison, MD, Associate Professor\*  
   Mark Brzezienski, MD, Assistant Professor  
   Woody Kennedy, MD, Assistant Professor  
   Jason Rehm, MD, Clinical Instructor

\* Orthopedic Hand Surgeon

Goals and Objectives

Plastic Surgery of the Upper Extremity - Anatomy/Physiology/Embryology

Plastic Surgery of the Upper Extremity - Congenital Disorders

Plastic Surgery of the Upper Extremity - Benign and Malignant Tumors

Plastic Surgery of the Upper Extremity - Trauma

Plastic Surgery of the Upper Extremity - Aesthetic and Functional Problems

Plastic Surgery of the Upper Extremity - Reconstruction

Microsurgery

Rotation Description

The Hayes Hand Center is a division of the Department of Plastic and Reconstructive Surgery. Its faculty consists of five surgeons all of whom are fellowship trained in Hand Surgery. Four of the faculty has the certificate of added qualifications in Surgery of the Hand. The fifth faculty member is currently in the process of obtaining the added qualifications in Surgery of the Hand. Dr. Jemison is board certified in Orthopedic Surgery which adds an additional dimension to the Hand Surgery service. Due to the large variety and volume of hand patients, the orthopedic residents obtain their hand experience on this service. During each hand rotation there is one plastic surgery resident and one orthopedic resident.

Residents are required to attend monthly combined plastic and orthopedic hand lecture conferences, as well as weekly hand clinic and office participation.

General plastic surgery principles are taught on each rotation. The third year rotation differs from years 1 and 2 in that the chief residents are expected to assume increasing, graded responsibilities in patient operative care, increased responsibility in administrative and clinical areas, as well as supervision of junior residents.

**Department of Plastic and Reconstructive Surgery  
General Reconstructive, Wound Care, Burn Care, and Microsurgery Rotation  
Competency-Based Goals and Objectives**

Faculty Instructors:           Woody Kennedy, MD, Assistant Professor  
  Jason Rehm, MD, Assistant Professor

Goals and Objectives

Burns

Microsurgery

Plastic Surgery of the Lower Extremity - Anatomy/Physiology/Embryology

Plastic Surgery of the Lower Extremity - Trauma Reconstruction

Plastic Surgery of the Trunk and Breast - Anatomy/Physiology/Embryology

Plastic Surgery of the Trunk - Trauma and Reconstruction

Plastic Surgery of the Trunk - Aesthetic and Functional Problems

Rotation Description

Dr. Rehm and Dr. Kennedy are involved in general and reconstructive surgery to include free tissue transfers, as well as aesthetic surgery. The Plastic Surgery residents also obtain experience in burn, wound care and reconstruction.

General plastic surgery principles are taught on each rotation. The third year rotation differs from years 1 and 2 in that the chief residents are expected to assume increasing, graded responsibilities in patient operative care, increased responsibility in administrative and clinical areas, as well as supervision of junior residents.

**Department of Plastic and Reconstructive Surgery  
General Reconstructive and Aesthetic Surgery Rotation  
Competency-Based Goals and Objectives**

Faculty Instructors:           Mark Brzezienski, MD, Assistant Professor  
  Jimmy Waldrop, MD, Clinical Instructor

Goals and Objectives

Plastic Surgery of the Breast - Aesthetic

Plastic Surgery of the Breast - Tumors and Reconstruction

Microsurgery

Benign and Malignant Skin Lesions

Plastic Surgery of the Lower Extremity - Anatomy/Physiology/Embryology

Plastic Surgery of the Lower Extremity - Trauma and Reconstruction

Surgery of the Head and Neck - Benign and Malignant Tumors

Surgery of the Head and Neck - Aesthetic and Functional Problems

Surgery of the Head and Neck - Reconstruction

Plastic Surgery of the Trunk - Trauma and Reconstruction

Plastic Surgery of the Trunk - Aesthetic and Functional Problems

Rotation Description

Dr. Brzezienski and Dr. Waldrop both practice general reconstructive plastic surgery. Dr. Brzezienski also dedicates a significant portion of his plastic surgery practice to aesthetic surgery. In this rotation residents are exposed to a wide spectrum of general plastic surgery and aesthetic surgery.

General plastic surgery principles are taught on each rotation. The third year rotation differs from years 1 and 2 in that the chief residents are expected to assume increasing, graded responsibilities in patient operative care, increased responsibility in administrative and clinical areas, as well as supervision of junior residents.

University of Tennessee College of Medicine – Chattanooga Unit  
Department of Plastic and Reconstructive Surgery

Resident Recruitment – Selection - Eligibility  
Policy

**Recruitment** – Applicants applying to the Plastic Surgery Residency Program must participate in the Plastic Surgery Matching Program sponsored by the Association of Academic Chairmen of Plastic Surgery. The Central Application Service (CAS) handles the application process and is the distributor of documents from applicants and training programs. Once the application process has been accomplished, the CAS copies and distributes applications to each of the programs that are selected by the applicant.

Individuals inquiring of our program are provided with an informational letter and directions to the UT website for an overview of our program.

**Eligibility** - Applicants must have completed three years in an accredited general surgery residency as a minimum requirement. Preference is given to applicants who will have completed a general surgery program and will have met the requirements for board eligibility. The program has accepted people with four years of General Surgery. Individuals who only have three years of General Surgery when they would potentially become Plastic Surgery residents are at a definite disadvantage and rarely match with our program.

**Selection** – All verified and completed applications received from CAS are reviewed by the program director and faculty for consideration. Once appropriate applicants are determined, an interview is arranged.

Interviews are conducted twice each spring where applicants meet the Program Director and faculty, tour the hospital facilities, and are introduced to current residents. While interviewing, evaluation forms are completed on each applicant; scoring the individual on *Program Interest, Assertiveness, Professionalism and Answers*. After the interview process, faculty meets to discuss the applicants and develop a rank list for submission to The Plastic Surgery Matching Program. Once the match is completed and our vacancies are filled, a letters of confirmation, commitment and verification are sent to the resident for completion.

University of Tennessee College of Medicine – Chattanooga Unit  
Department of Plastic and Reconstructive Surgery

Resident Advancement and Dismissal  
Policy

**Advancement** – The advancement/promotion to the subsequent year of training require satisfactory and cumulative evaluations by faculty that indicate satisfactory progress in scholarship and professional growth. This includes proficiency in:

1. Incremental increase in clinical competence including performing applicable procedures;
2. Appropriate increase in fund of knowledge; ability to teach others;
3. Clinical judgment;
4. Necessary technical skills;
5. Humanistic skills; communication with others;
6. Attendance, punctuality, availability and enthusiasm;
7. Adherence to institutional standards of conduct, rules and regulations, including program standards and hospital and clinic rules with respect to infection control policies, scheduling, charting, record-keeping, and delegations to medical staff;
8. Adherence to rules and regulations in effect at each health care entity to which assigned;
9. Others – e.g. satisfactory scores on examinations if designated for that purpose by specialty, research participation, etc.
10. Appropriate competence for the level of training in the six General Competency Areas designated by the ACGME.

Residents not demonstrating satisfactory performance and progress in accordance with the aforementioned items, as well as specific program requirements, may face non-renewal of their appointment to the program. Every effort will be made to give a resident in this situation at least four months notice of the intent not to re-appoint him/her to the program.

**USMLE Step III** – The Chattanooga Unit requires that each resident must pass USMLE Step 3 prior to progression of their PGY-3 year. Since residents enter our program at the PGY 5 or 6 levels, and to comply with the institutional policy, we are now requiring that new residents provide proof of passing USMLE Step 3 before entering the program.

**Dismissal** – When deficiencies are noted in a resident’s academic performance, there are discussed with the resident including recommendations for correction. Depending on the level of the deficiencies, the resident may be placed on Academic Conditional Probation. This is an opportunity for the resident to remediate deficiencies and to develop and demonstrate appropriate levels of proficiency for patient care and advancement in the program. Being placed on conditional probation is notice to the resident of failure to progress satisfactorily as reflected by evaluations and/or other assessment modalities. It is not discipline and residents in probationary status have continued enrollment at the University. Forms of remediation may include:

1. repeating one or more rotations;
2. participation in a special program;
3. continuing in scheduled rotations with or without special conditions;
4. supplemental reading assignments;
5. attending undergraduate or graduate courses and/or additional clinics or rounds; and/or
6. extending the period of training. The resident may also be referred to the Resident Assistance Program if indicated.

Determination by the department chair that the resident fails to correct a deficiency or that they deficiency or violation of University rules is of sufficient gravity to warrant dismissal, the resident may be dismissed without being placed on probation. However, the chair must consult with the Office of Graduate Medical Education prior to instituting a dismissal that is not preceded by a period of probation. In that instance, the resident may obtain review under the Graduate Medical Education policy of Academic Due Process. This policy may be obtained through the Graduate Medical Education Office.

University of Tennessee College of Medicine – Chattanooga Unit  
Department of Plastic and Reconstructive Surgery

Guidelines for Supervision of Residents

**Supervision of Residents** - The written guidelines for faculty supervision of residents are given to new residents, senior residents and faculty at orientation in July of each year, where they are fully explained and discussed. The goals and objectives are also reviewed prior to the start of each rotation.

On each rotation the plastic surgery resident will be assigned to a specific attending or attendings whom he will work with on a daily basis. The attending will be evaluating the resident's performance (first hand) on his progress toward completion of his goals and objectives for that particular rotation. This close working relationship is designed for teaching and assisting the following six general competencies:

1. **Patient Care:** Compassionate, appropriate, effective management of responsibilities and promotion of health. Gathers essential and accurate information. Performs all essential skills. Works effectively with patients, families and other professionals.
2. **Medical Knowledge:** Demonstrates investigative and analytical thinking in problem solving. Knows and applies basic and clinical sciences.
3. **Practice-Based Learning and Improvement:** Analyzes practice experience. Locates evidence from scientific studies. Uses information technology. Understands study design and statistical methods. Teaches others.
4. **Interpersonal and Communication Skills:** Maintains ethically sound relationships and communicates effectively with patient, family, and other members of the healthcare team.
5. **Professionalism:** Demonstrates respect, integrity and responsiveness that supercedes self-interest. Has a commitment to excellence and professional development and high ethical standards of confidentiality and sensitivity to patients regardless of culture, age, gender or disabilities.
6. **Systems-Based Practice:** Demonstrates awareness of larger context of healthcare. Practices cost-effective care and resource allocation. Assists

*Updated 2/10*

*Page 1 of 4*

*\\Fserver01\stacey\Program Guidelines & Curriculum for website\2009 - 2010 Guidelines\11 Resident Supervision Policy.doc*

patients in dealing with system complexities. Partners with managers to coordinate and improve healthcare and system performance.

**Pre-Intra and Post-Operative Care-** The residents provide pre-and postoperative care on a daily basis for each faculty rotation to which they are assigned. Each inpatient case to which a particular resident is assigned is worked-up and followed by that resident until discharged. A pre-operative work-up would include a history; physical examination, laboratory data, surgical plan and/or a plan outlining complete patient management. The faculty member must then approve the plan of management and is expected to monitor the progress of the patient during hospitalization. Faculty must approve changes in the patient's management plan, decision for discharge, as well as ensure completeness of the medical record and appropriateness of each therapeutic maneuver. Residents must evaluate patients prior to surgery; adequately counsel patients concerning the proposed surgical treatment; explain alternative methods of treatment; and obtain informed consent. Residents are involved in the intraoperative care of private and non-private patients. Their surgical role depends on their level of training and experience. Faculty closely monitors surgical performance and their independence gradually increased over their two-year training period. All patients (in or outpatients) have a responsible attending that round with the residents on a daily basis on all inpatients. Postoperative results are monitored by the faculty on a regular basis, including presentation of complications at mortality and morbidity conference.

Any patient going to the operating room must have faculty supervision present and documented in the chart. The degree of supervision varies according to the level of training and competence of the individual resident. All residents are encouraged to develop their own care plans, which are reviewed with faculty members, both daily and weekly. Faculty members are available by beeper and supervise patients directly or indirectly as required by hospital policy and the individual case. Operative cases require direct faculty supervision. The staff has a formal call schedule for Plastic Surgery and a call schedule for Hand Surgery for all patients (private and non-private). The residents, therefore, always have a faculty member on call with them for both Plastic Surgery and Hand Surgery. This is to insure adequate supervision of the residents, especially at night and on weekends. On weekends, both the faculty and resident on call perform routine care of patients.

**Operating Room Supervision-** Operating room supervision by the faculty is consistently required for all cases. The amount of individual supervision relates to the difficulty of the procedure and the skill and experience of the

*Updated 2/10*

*Page 2 of 4*

*\\Fserver01\stacey\Program Guidelines & Curriculum for website\2009 - 2010 Guidelines\11 Resident Supervision Policy.doc*

resident. In most cases, the attendings are present for the important part of the procedure. As the resident progresses in maturity and responsibility during the training program, an increasing share of the decision making (both preoperatively and postoperatively and during surgery) is made by the residents, progressing to independent responsibility at the end of the program. The attending is always available within the hospital or operating room depending on the degree of supervision required.

Faculty must approve changes in the patient's management plan or discharge of the patient, as well as ensure completeness of the medical record and appropriateness of each test or therapeutic maneuver. Residents must evaluate patients prior to surgery; adequately counsel patients concerning the proposed surgical treatment; explain alternative methods of treatment; and obtain informed consent. Performance of surgical procedures is monitored, depending upon the specific procedure and the expertise of the individual resident, either by the faculty as a member of the surgical team or as an observer. A faculty member or chief resident is always available to assist the resident in performing any procedure.

### **Ambulatory Care Facilities**

A. Outpatient Clinics- Erlanger has numerous outpatient facilities including its clinics, emergency departments, and the Plaza Ambulatory Care Center, a freestanding ambulatory surgery and diagnostic testing center. The outpatient clinics located on Erlanger's first floor are where the residents have their own patients and participate in the care of plastic surgery patients with faculty supervision. The Plastic Surgery Clinic meets Monday morning every week; the Hand Surgery Clinic meets on Wednesday mornings of each week; the Burn and Wound Clinic, staffed by Lesley Wong, M.D. on Monday. A faculty person is assigned to supervise each of these clinics. We evaluate approximately 65 patients each week in Plastic and Hand Clinic. In addition, minor surgery (local anesthesia) such as small skin lesions, arch bar removal, etc., is performed in the Plastic Surgery Clinic.

The University and Erlanger Health System approved reduced hospital charges for senior resident aesthetic cases. These patients are evaluated by a senior resident in the Plastic Surgery Clinic and staffed by a faculty member.

B. Emergency Department- The plastic surgery residents are assigned consultation responsibilities at the emergency departments at The Erlanger Health System and T.C. Thompson Children's Hospital (both within The Erlanger Health System complex). A faculty member is also on call for the emergency department to provide appropriate supervision of the residents.

*Updated 2/10*

*Page 3 of 4*

*\\Fserver01\stacey\Program Guidelines & Curriculum for website\2009 - 2010 Guidelines\11 Resident Supervision Policy.doc*

C. Time Spent in Private Offices- The residents are required to spend time in the office each week where patient follow up is obtained from outpatient surgery. There is a formal schedule with specific times to assure resident attendance.

This allows time for instruction in preoperative evaluation, as well as postoperative follow up of patients that the residents have participated in their operative care. In addition, the resident gains experience in office management and office practice. This time is important to provide continuity of care.

Graduated and Progressive Responsibility- Day-to-day teaching management is the responsibility of the various faculty members, under the direction of the Program Director to ensure supervision of patient care. The faculty members make rounds with the residents on a regular basis and are available as needed to see and evaluate patients, with residents, who have clinical problems. Each inpatient case to which a particular resident is assigned is worked-up and followed by that resident. A pre-operative work-up would include a history, physical examination, laboratory data, surgical plan and/or a plan outlying complete patient management. The faculty member must then approve the plan of management and is expected to monitor the progress of the patient during hospitalization.

During the three-year program as a resident's professional maturity and skills increase, faculty gives him increasing patient care responsibility for the medical and surgical management of the patients. Responsibility steadily increases over the three years so that at the end of their training they are making the majority of the decisions with minimal amount of supervision to encourage the development of surgical and medical independence.

University of Tennessee College of Medicine – Chattanooga Unit  
Department of Plastic and Reconstructive Surgery

Resident Duty Hours Policy

The Department of Plastic and Reconstructive Surgery has adopted the Resident Duty Hours policy instituted by the ACGME effective July 1, 2003.

**Duty Hours**

1. 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.
2. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
3. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
4. Adequate time for rest and personal activities must be provided between all duty periods. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

**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 workday when residents are required to be immediately available in the assigned institution.

1. In-house call must occur no more frequently than every 3<sup>rd</sup> night, averaged over a 4-week period.
2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, and conduct outpatient clinics.
3. No new patients may be accepted after 24 hours of continuous duty. A new patient is defined as any patient for whom the resident has not previously provided care.
4. At-home call (pager call) is defined as call taken from outside the assigned institution.

- a. The frequency of at-home call is not subject to the every 3<sup>rd</sup> 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 4-week period.
- b. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.
- c. 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.

### **Moonlighting (see separate policy)**

1. Because residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
2. The program director must comply with the sponsoring institutions written policies and procedures regarding moonlighting, in compliance with the Institutional Requirements III, D.1.k.
3. Moonlighting that occurs within the residency program and/or the sponsoring institution or the non-hospital sponsor's primary clinical site(s), i.e. internal moonlighting, must be counted toward the 80-hour weekly limit on duty hours.

### **Oversight**

1. To ensure an appropriate balance between education and service, duty hours of plastic surgery residents will be monitored closely. Residents are required to keep a daily log of hours worked and are to provide those to the resident coordinator for monitoring.
2. Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.
3. If back-up support is needed, the resident is to immediately notify their supervising faculty and/or chief resident for appropriate assistance.

It is the responsibility of the resident to notify their supervising faculty and/or back-up resident if they have worked 24 consecutive in-house hours. At that time, it will be determined if that resident may remain on duty for the additional 6 hours (Refer to "On-Call Activities" # 2 & 3).

## **Back-up Support System**

To assure continuity of care and to maintain adequate resident coverage, a back-up support system is outlined as follows:

- In rare occurrences when the Department of Plastic and Reconstructive Surgery covers 1<sup>st</sup> hand-call months (August, October, December, February, April, June) it may become necessary for the resident on-call to notify another resident or the on-call attending for relief of call for the remaining shift.
- If the hand resident is scheduled for call and works 24 consecutive hours, he must discontinue patient care at that time and re-assign his hand call. The hand call will be re-assigned to the plastic resident scheduled for call that day.

Any changes in the duty schedule must be reported to the resident coordinator for appropriate notification of staff and documentation of call schedule.

## **Monitoring of Duty Hours**

Residents are required to complete a time card and turn in to the residency coordinator each Monday morning after pre-op walk rounds. The duty hours are then logged into the *New Innovations Residency Management Suite* for calculation and reviewed for adherence to duty hour regulations.

## **ACKNOWLEDGEMENT**

I have received a copy of the *Resident Duty Hours Policy* of the Department of Plastic and Reconstructive Surgery. I have read this information and understand its content. I also am in agreement to uphold my responsibility in monitoring and reporting my hours, and notifying the appropriate faculty/residents/staff when necessary to maintain the standards of this policy.

---

Resident Signature

---

Date

University of Tennessee College of Medicine – Chattanooga Unit  
Department of Plastic and Reconstructive Surgery

Resident Fatigue and/or Stress  
Policy

The Department of Plastic and Reconstructive Surgery has established a policy on resident fatigue and/or stress based on the *Institutional Policy for Resident Fatigue and/or Stress* adopted on September 27, 2005.

**Purpose**

Symptoms of fatigue and/or stress are normal and expected to occur periodically with the resident population, just as it would in other professional settings. Not unexpectedly, residents may on occasion experience some effects of inadequate sleep and/or stress.

**Recognition of Resident Excess Fatigue and/or Stress**

Signs and symptoms of resident fatigue and/or stress may include but are not limited to the following:

- Inattentiveness to details
- Forgetfulness
- Emotional lability
- Mood swings
- Increased conflicts with others
- Lack of attention to proper attire or hygiene
- Difficulty with novel tasks and multitasking
- Awareness is impaired (fall back on rote memory)

**Response**

The demonstration of resident excess fatigue and/or stress may occur in patient care settings or in non-patient care settings such as lectures and conferences. In patient care settings, patient safety, as well as the personal safety and well-being of the resident, mandates implementation of an immediate and a proper response sequence. In non-patient care settings, responses may vary depending on the severity of and the demeanor of the resident's appearance and perceived condition. The following is intended as a general guideline for those recognizing or observing excessive resident fatigue and/or stress in either setting.

*Updated 9/06*

*Page 1 of 5*

*\\Fserver01\stacey\Program Guidelines & Curriculum for website\2009 - 2010 Guidelines\13  
Resident Fatigue and Stress.doc*

## **Patient Care Settings**

### **Attending Clinician**

1. In the interest of patient and resident safety, the recognition that a resident is demonstrating evidence for excess fatigue and/or stress requires the attending or supervising resident to consider immediate release of the resident from any further patient care responsibilities at the time of recognition.
2. The attending clinician or supervising resident should privately discuss his/her opinion with the resident, attempt to identify the reason for excess fatigue and/or stress, and estimate the amount of rest that will be required to alleviate the situation.
3. The attending clinician must attempt, in all circumstances without exception, to notify the chief/supervising resident on-call, program director or department chair, respectively, depending on the ability to contact one of these individuals, of the decision to release the resident from further patient care responsibilities at that time.
4. If excess fatigue is the issue, the attending clinician must advise the resident to rest for a period that is adequate to relieve the fatigue before operating a motorized vehicle. This may mean that the resident should first go to the on-call room for a sleep interval no less than 30 minutes. The resident may also be advised to consider calling someone to provide transportation home.
5. The attending should notify the on-call hospital administrator for further documentation of advice given to the resident removed from duty.
6. If stress is the issue, the attending upon privately counseling the resident, may opt to take immediate action to alleviate the stress. If, in the opinion of the attending, the resident stress has the potential to negatively affect patient safety, the attending must immediately release the resident from further patient care responsibilities at that time. In the event of a decision to release the resident from further patient care activity; notification of program administrative personnel shall include the chief/supervising resident on-call, program director or department chair, respectively, depending on the ability to contact one of these individuals.
7. A resident who has been released from further immediate patient care because of excess fatigue and/or stress cannot appeal the decision to the responding attending.

8. A resident who has been released from patient care cannot resume patient care duties without permission of the program director or chair when applicable.

### **Allied Health Care Personnel**

1. Allied health care professionals in patient service areas will be instructed to report observations of apparent resident excess fatigue and/or stress to the observer's immediate supervisor who will then be responsible for reporting the observation to the respective program director.

### **Residents**

1. Residents who perceive that they are manifesting excess fatigue and/or stress have the professional responsibility to immediately notify the attending clinician, the chief resident, and the program director without fear of reprisal.
2. Residents recognizing resident fatigue and/or stress in fellow residents should report their observations and concerns immediately to the attending physician, the chief resident, and/or the program director.

### **Program Director**

1. Following removal of a resident from duty, in association with the chief resident, determine the need for an immediate adjustment in duty assignments for remaining residents in the program.
2. Subsequently, the program director will review the resident's call schedules, work hour time cards, extent of patient care responsibilities, any known personal problems, and stresses contributing to this for the resident.
3. The program director will notify the departmental chair and/or program director of the rotation in question to discuss methods to reduce resident fatigue.
4. In matters of resident stress, the program director will meet with the resident personally as soon as can be arranged. If counseling by the program director is judged to be insufficient, the program director will refer the resident to the Aid to Impaired Residents Program (AIRS) by direct contact with the Designated Institutional Official (DIO) and Director of Graduate Medical Education (GME).
5. If the problem is recurrent or not resolved in a timely manner, the program director will have the authority to release the resident

indefinitely from patient care duties pending evaluation from an individual designated by the AIRs Program. (This will represent academic deficiency as described in the institutional policy of Academic Review.)

6. The program director will release the resident to resume patient care duties only after advisement from the AIRs Program and will be responsible for informing the resident as well as the attending physician of the resident's current rotation.
7. If the AIRs Program feels the resident should undergo continued counseling, the program director will be notified and should receive periodic updates from the AIRs representative.
8. Extended periods of release from duty assignments that exceed requirements for completion of training must be made up to meet RRC training guidelines.

### **Non-Patient Care Settings**

If residents are observed to show signs of fatigue and/or stress in non-patient care settings, the program director should follow the program director procedure outlined above for the patient care setting.

### **Education**

During institutional and program orientation residents are provided the policy for review.

The Department of Plastic and Reconstructive Surgery distributes this policy to residents and faculty and asks them to sign an acknowledgement as noted at the end of this policy.

Residents and faculty are provided an educational handbook entitled "*Fight Fatigue – A Training Handbook for Residents*" written by Adrienne E. Avillion, DEd, RN and Acacia Aguirre, MD, PhD; distributed by HCPRO.

The University of Tennessee College of Medicine – Chattanooga Unit schedules an Institutional Core Curriculum conference annually discussing *Fatigue and/or Stress in Residents*. Residents are required to attend.

### **Monitoring**

Residents are required to complete a time card and turn in to the residency coordinator each Monday morning after pre-op walk rounds. The duty hours are then logged into the *New Innovations Residency Management Suite* for calculation and reviewed for adherence to duty hour regulations.

*Updated 9/06*

*Page 4 of 5*

*\\Fserver01\stacey\Program Guidelines & Curriculum for website\2009 - 2010 Guidelines\13 Resident Fatigue and Stress.doc*

In addition, the Program Director periodically meets with each resident and inquires of the residents well-being and if they are receiving adequate rest. This is documented in their semi-annual and annual evaluations with the Program Director.

### **ACKNOWLEDGEMENT**

I have received a copy of the *Resident Fatigue and/or Stress Policy* of the Department of Plastic and Reconstructive Surgery. I have read this policy and understand its content. I also am in agreement to uphold my responsibility in notifying the appropriate faculty/residents/staff when necessary to maintain the standards of this policy.

---

Resident/Faculty Signature

---

Date

University of Tennessee College of Medicine – Chattanooga Unit  
Department of Plastic and Reconstructive Surgery

Evaluation of Residents, Faculty, Rotation and Program  
Policy

**Residents** - Evaluations are completed on every resident after each assigned rotation is completed. Faculty assigned to that rotation evaluates the resident. These evaluations are discussed in a confidential manner with the resident and signed by both the faculty member and the resident. The Program Director and faculty communicate verbally with the residents in order to address weakness and strengths during each rotation. The progress of the resident is evaluated and summarized in a written review by the Program Director semi-annually and annually. This evaluation process is explained in writing to residents entering the program. The written evaluation is a major component of the decision for advancing residents.

The resident evaluations use a 0-4 scale (0=not observed, 1=unsatisfactory, 2=satisfactory average, 3= satisfactory above average and 4=superior). Each of the 6 competencies is evaluated through this assessment tool. The completed evaluations for each resident are combined and scores are averaged using the 0-4 scale. First year residents are expected to score at least satisfactory average (2). While satisfactory average (2) is acceptable for both years, our goal is to have second year residents increase their scores to satisfactory above average (3) and/or superior (4).

Rotation Evaluation – completed by each faculty and discussed with the resident assigned to their rotation.

Semi-Annual Evaluation & Summary – completed by Program Director. Resident and Program Director meet to discuss.

Annual Advancement Evaluation & Summary – completed by Program Director. Resident and Program Director meet to discuss.

Final Evaluation & Summary – completed by Program Director at the end of residency. Resident and Program Director meet to discuss.

**Faculty** - After every rotation the resident evaluates the faculty member(s) assigned to that rotation. Each evaluation is completed on-line through the *New Innovations Residency Management Suite* and is strictly confidential and

Updated 2/10

Page 1 of 2

\\Fserver01\stacey\Program Guidelines & Curriculum for website\2009 - 2010 Guidelines\14  
Evaluation of Residents Faculty Program.doc

anonymous. The GME Director, Pam Scott, monitors evaluation summaries to address immediate concerns while still maintaining anonymity and confidentiality. A summary of the comments is provided to the Program Director on an annual basis who then evaluates the faculty based on the summaries. An individual summary of comments is then forwarded to each faculty member.

**Rotation** – After every rotation the resident evaluates that rotation. Each evaluation is completed on-line through the *New Innovations Residency Management Suite* and is strictly confidential and anonymous. The GME Director, Pam Scott, monitors evaluation summaries to address immediate concerns while still maintaining anonymity and confidentiality. A summary of the comments is provided to the Program Director on an annual basis. This summary is used in evaluating the program and its rotations at the annual program review. A summary of the results is provided to the faculty for review and discussion.

**Program** – Semi-annually the resident evaluates the program. Each evaluation is completed on-line through the *New Innovations Residency Management Suite* and is strictly confidential and anonymous. The GME Director, Pam Scott, monitors evaluation summaries to address immediate concerns while still maintaining anonymity and confidentiality. A summary of the comments is provided to the Program Director and faculty annually and are used in the annual evaluation of the program held every September.

\* Note: Due to the small number of residents in our program and to assure confidentiality and anonymity, no staff or faculty of the Department of Plastic and Reconstructive Surgery have any access to the evaluation section in the New Innovations Management Suite. The GME Director monitors evaluation summaries to address immediate concerns while still maintaining anonymity and confidentiality. All evaluation summaries are provided by the GME Director.

## Department of Plastic and Reconstructive Surgery

### Research Project

---

Plastic Surgery residents must prepare a research paper and submit it for publication by May 1<sup>st</sup>, prior to completing the residency program. This project must be approved by the Program Director and assessed as a suitable scholarly endeavor. This is a requirement which must be met before the chairman can verify to the Plastic Surgery Board that the resident is board eligible. The project assignment carries with it a requirement for a written paper suitable for publication in peer-reviewed literature. The final written paper must be submitted to an appropriate peer-reviewed journal prior to completing the residency.

The Program Director conducts a quarterly research conference, during the Core Curriculum Plastic Grand Round, where current research projects and the research process is discussed and reviewed. Dr. Cauley Hayes, Director of Plastic Surgery Research, also meets with the residents on a monthly basis to assist the residents in the research protocols.

---

Please remember to follow appropriate journal formats when submitting your final research paper. Those formats can be found in the following journals (or their websites):

- ▶ Annals of Plastic Surgery
- ▶ Plastic and Reconstructive Surgery
- ▶ The Journal of Craniofacial Surgery
- ▶ The Journal of Hand Surgery

All residents are encouraged to participate in submitting abstracts to national meetings such as the American Society of Plastic Surgeons and the American Association of Plastic Surgeons. The Southeastern Society of Plastic and Reconstructive Surgeons sponsors a resident competition at its annual meeting each year.

*Chief residents are encouraged* to submit abstracts to the Senior Residents Conference. This meeting is held specifically for Chief residents in Plastic Surgery Training Programs throughout the country.

*Chief residents are **required*** to submit an abstract to the Annual Resident Research Week that is sponsored by UT and Erlanger in the spring of each year. The abstract must be about an interesting case report or a formal research paper. *First year residents are also encouraged to participate.*

Travel expenses to present at these meetings will be met by the Department of Plastic Surgery even if all other allocated funds have already been used.

The Graduate Medical Education department of The University of TN provides a research symposium annually. This symposium was developed to teach the residents research design, implementation and analysis. It was designed to equip the residents to carry out effective research projects through criteria selection, bench research and effective presentation and publication of their material. All residents are required to attend their first year of residency.

Research Project Approval

Resident:

Attending(s):

Expected Start Date:

Expected Completion Date:

IRB Approval Needed (?): Yes  or No

Provide a brief outline including methods in accomplishing project.

---

Resident Signature

Date

---

Chairman's Signature and Approval

Date

## Grand Round Conference Topics

The topics listed below are covered in a two-year time period. The topics relevant to orienting new residents will need to be covered each year.

### Plastic Topics:

#### **(Scheduled Annually)**

1. ORIENTATION of Program/ CPT Coding
2. Facial Anatomy & Testing
3. Facial Fractures - Lower One-Third
4. Facial Fractures - Upper Two-Thirds
5. Burn Mgmt. & HBO
6. Pressure Sores
7. Wound Healing, Scars And Keloids
8. Skin Tumors - Melanoma
9. Skin Tumors – Non Melanoma
10. Grafts/ Tissue Expanders/ Implantation
11. Flaps
12. Craniofacial - Cephalometrics
13. Craniofacial - Syndromes & Surgeries
14. Cleft Lip - Primary Deformities
15. Cleft Palate And VPI
16. Augmentation Mammoplasty
17. Reduction Mammoplasty And Mastopexy
18. Subcutaneous Mastectomy And Breast Reconstruction
19. Rhinoplasty
20. Blepharoplasty
21. Rhytidectomy
22. Medical Ethics
23. Head and Neck Tumors

#### **(Scheduled to be covered over a 2 year period)**

24. Cheek & Lip Reconstruction
25. Ear Reconstruction
26. Eyelid Reconstruction
27. Nasal Reconstruction
28. Chest / Trunk Reconstruction
29. Lower Extremity Reconstruction
30. Body Contouring
31. Local Aesthetics/ Cocaine / CPR
32. Vascular Anomalies (lymphedema)
33. Facial Nerve Disorders
34. Genitourinary Reconstruction
35. Head And Neck Reconstruction
36. Brow Lift/Hair Transplant

37. Facial Implants/Injectables/Genioplasty
38. Free Flaps
39. Lasers
40. Jungle Plastic Surgery

### Hand Topics:

1. Anatomy And Pathophysiology On The Intrinsic Muscles And Digital Extensor Mechanism
2. Hand Evaluation / Anesthesia For Operative Hand Procedures/ Splinting - Annually
3. Vascular Disorders Of The Hand
4. Compressive Neuropathies Of The Upper Extremities
5. Burns And High Pressure Injection Injuries
6. Flexor Tendon Injuries - Annually
7. Hand Infections
8. Compartment Syndromes
9. Fractures Of The Hand / Articulation Fractures & Joint Injuries
10. Replantation / Amputation / Microsurgery
11. Anatomy Of The Wrist - Annually
12. Treatment Of Fractures And Ligament Injuries Of The Wrist
13. Distal Radial Fractures
14. Tenosynovitis - Hand And Forearm
15. Osteoarthritis Of The Hand/Rheumatoid Arthritis - Evaluation /Treatment
16. Dupuytren's Disease
17. Congenital Anomalies Of The Hand - Annually
18. Soft-Tissue Cover And Fingertip Injuries
19. Peripheral Nerve Repair
20. Principles Of Tendon Transfers To The Hand
21. Benign / Malignant Tumors Of The Hand And Wrist
22. The Painful Upper Extremity

# Overview of Conferences

Attendance to all conferences is mandatory. The administrative chief resident is **responsible** for obtaining signatures on sign in sheets and **forwarding** to resident coordinator.

**Plastic Surgery Grand Rounds** – Scheduled every Wednesday of each month. Located in the Craniofacial Conference Room from 7:00 – 9:00 a.m. Topics are presented by residents, attendings, and visiting professors. Residents are to address the current Corequest questions in each presentation. The current Corequest topic information is maintained by the Resident Coordinator who will print and distribute at least a month before the scheduled conference.

**Journal Club** – Scheduled every 3<sup>rd</sup> Monday of each month from 6:00 – 8:00 p.m. The administrative chief is responsible for providing the journal articles for the residents to choose from.

**Mortality & Morbidity / Photo Conference** – Scheduled the 4<sup>th</sup> Wednesday of each month. Located in the Craniofacial Conference Room from 7:00 – 9:00 a.m. Residents are required to give the chief administrative resident written M & M case information no later than the day before conference. Residents are asked to bring photos of any cases needing discussion.

**Hand Conference** – Scheduled the 3<sup>rd</sup> Thursday of each month. Located in the Orthopedic Department Conference/Library from 7:00 – 9:00 a.m. This conference schedule is coordinator with the Department of Orthopedic Surgery. Topics are presented by residents, attendings, and visiting professors. Residents are to address the current Corequest questions in each presentation. The current Corequest topic information is maintained by the Resident Coordinator who will print and distribute at least a month before the scheduled conference. On a quarterly basis **Hand Journal Club** will be held during this scheduled conference time.

**Research Conference** - Scheduled quarterly during a Core Curriculum Plastic Grand Round. The Program Director will discuss research projects/topics with the residents and review the process and deadlines for completion.

**Trauma Rounds** – Scheduled every Monday from 7:00 – 8:00 a.m. Residents discuss with faculty cases that have been admitted over the weekend as well as operations scheduled during the week. The preoperative planning and treatment options are discussed.

**Craniofacial Conference** – Scheduled once a month - usually the 2<sup>nd</sup> Friday of each month. (Reference Dr. Sargent's calendar for exact monthly date) Approximately 10-15 patients are presented and discussed by the craniofacial team. (resident on this rotation must attend)

**Institutional Core Curriculum** – Scheduled at various times throughout the academic year by the GME staff. Resident Coordinator will notify you when a schedule of topics and dates are confirmed. This also includes an annual loss prevention seminar geared specifically to resident malpractice issues.

**This is not a complete listing of conferences for the academic year. Each month conference calendars are distributed with the call schedule.**

## Educational Materials Provided by the Department of Plastic Surgery

---

- ▶ *Selected Readings & PRS Journals* – are ordered for you and delivered to the office. (attached is a listing of *Selected Readings for your first year of residency*)
- ▶ *Thomas Jefferson University Hand Surgery Study Guide* – a copy of this guide is provided.
- ▶ *Essentials of Hand Surgery*
- ▶ *Interactive Hand CD*
- ▶ *Trauma Quarterly* – Maxillofacial Injuries
- ▶ *Improving Results in Facial Fracture Treatment* – article by Dr. Larry Sargent & Dr. Paul Manson
- ▶ *ICD-9 Coding Course (ASPS)*
- ▶ *Oculoplastic and Breast Symposium Meeting in Atlanta, GA*
- ▶ *Inservice Exam* – we will provide a copy of the last 5 years summaries of the Inservice Exam to assist you in preparing for the exam. The exam is given the first week of March.
- ▶ *Resident Library* –current textbooks are purchased on a regular basis.
- ▶ *Computerized Textbook & On-line Journal Library*
- ▶ *Other resources are purchased as warranted.*