University of Louisville
Plastic Surgery Residency
Training Manual

Educational Programs, Policies, and Guidelines for Progression and Graduation

Updated: June 2017
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PREFACE – THE OATH OF HIPPOCRATES

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Attachments:
- University of Louisville, Block Diagram of Rotation Schedule
- University of Louisville, Principles of Medical Ethics

*Manual originally prepared by Gordon Tobin, M.D. Updated by Bradon Wilhelmi, M.D. and Larry Florman, M.D.*
Oath of Hippocrates


I swear by Apollo the healer, by Aesculapius, by Hygeia (health) and all the powers of healing, and call to witness all the gods and goddesses that I may keep this Oath, and promise to the best of my ability and judgment:

I will pay the same respect to my master in the science (arts) as I do to my parents, and share my life with him and pay all my debts to him. I will regard his sons as my brothers and teach them the science, if they desire to learn it, without fee or contract. I will hand on precepts, lectures, and all other learning to my sons, to those of my master, and to those pupils duly apprenticed and sworn, and to none other.

I will use my power to help the sick to the best of my ability and judgment; I will abstain from harming or wrongdoing any man by it.

I will not give a fatal draught (drugs) to anyone if I am asked, nor will I suggest any such thing. Neither will I give a woman means to procure an abortion.

I will be chaste and religious in my life and in my practice.

I will not cut, even for the stone, but I will leave such procedures to the practitioners of that craft.

Whenever I go into a house, I will go to help the sick, and never with the intention of doing harm or injury. I will not abuse my position to indulge in sexual contacts with the bodies of women or of men, whether they be freemen or slaves.

Whatever I see or hear, professionally or privately, which ought not to be divulged, I will keep secret and tell no one.

If, therefore, I observe this Oath and do not violate it, may I prosper both in my life and in my profession, earning good repute among all men for all time. If I transgress and forswear this Oath, may my lot be otherwise.
I. INTRODUCTION AND ACADEMIC MISSION OF THE PROGRAM

A. Welcome
On behalf of the full-time academic faculty and the community volunteer faculty, we welcome you to the University of Louisville Plastic Surgery Residency Training Program. This is an independent model three-year program. As such, it follows prior graduate surgical training that has taught you the fundamental ACGME core competencies and basic surgical skills. Therefore, our program is designed to build upon and further enhance these core competencies and surgical skills, and to teach the art, principles and skills specific to Plastic and Reconstructive Surgery. The operative and clinical experience available to you in this program is renowned for being exceptionally diverse and challenging. We approach this experience systematically, with analytic logic and evidence-based medical principles in order to give you the finest set of general competencies and surgical skills for independent practice in Plastic Surgery and teach you how to maintain these over your full career. If diligently pursued and fully utilized, this experience will prepare you well for a rewarding lifetime career of excellent patient care. It will also prepare you well for certification by the American Board of Plastic Surgery, which is an essential credential of your career, and which should be achieved at the earliest possible time.

B. Academic Mission
This mission of the University of Louisville Plastic Surgery Residency Program is to train surgeons who are compassionate and skillful in patient care; who use scholarly principles to maintain and apply mastery of the knowledge of their discipline; who use good science and analytical logic in effective surgical problem solving and outcome review; who are careful and safe in their application of judgment and technique; who continuously improve their communications, care and care delivery systems; who stand out as impeccable examples of ethical and professional conduct, and who become Board certified and leaders in their profession and communities.
C. Guidelines
In order to maximize your experience in this program and to facilitate smooth day-to-day operational procedures, guidelines are clearly outlined for you in the following pages. These guidelines are intended to instill a program of intellectual challenge and active learning and to provide you with an unambiguous understanding of your obligations, responsibilities, and educational opportunities during your training period.

D. Manuals
This manual is a supplement to the *Department of Surgery House Staff Manual* and *The University of Louisville Resident Policies and Procedures Manual*. You are provided these documents along with this manual and must also review them to fully understand your responsibilities.

E. Attestation
If any element of this document for Plastic Surgery Residents, the Surgery Department Manual or the University Manual is unclear, contact the Program Director for clarification of policy. When you are finished reading this document you will be required to sign the attestation form at the end.
A. Teaching Philosophy of this Program

For each of you, this is a second residency. Therefore, we expect progression beyond the basic competencies and skills that you have learned to date to substantially more advanced levels, analogous to progression from undergraduate to graduate school. As such, our educational philosophy emphasizes rapid acquisition of advanced learning methods, development of keen, cognitive, and analytic skills, refinement of surgical techniques (e.g. microsurgery, gentle handling of tissues, meticulous attention to detail), and advanced applications of ACGME Core Competencies. The key elements and goals of our educational philosophy are listed below, and presented thereafter in greater detail. These key elements are:

Goal 1: Progression in the ACGME Core Competencies and their applications to the specialty of Plastic Surgery.

Goal 2: Insistence on active learning (in contrast to passive) and engagement in a variety of learning experiences and settings. Interactive conferences and the Socratic Method are used extensively.

Goal 3: Use of analytic logic, the scientific method and evidence-based medicine in patient problem analysis and solution design.

Goal 4: Rapid progression to independent judgment and practice by insisting that the resident always be challenged and always first take the lead in problem analysis, literature use, solution design, judgment and technical execution, with faculty critique at the conclusion.

Goal 5: Encouraging a diversity of technical and cognitive experience by teaching encounters with a broad array of full-time and volunteer faculty, and asking residents to critically analyze and rationally select among differences in approaches and techniques.
B. Explanation of the Goals

**Goal 1: Progression in the ACGME Core Competencies.** A primary obligation that you accept in becoming a physician and surgeon is to master the general competencies of medical practice and the specific skills of your discipline, and to maintain that mastery throughout a lifetime of patient care. To this end, the University of Louisville Plastic Surgery Residency Program incorporates and emphasizes the six ACGME core competencies in our training, our evaluation process and our goals for the outcome of your experience here. We expect you to come with basic competencies and to further refine them here.

These six competencies are as follows:

1. **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
2. **Medical Knowledge** about established and evolving biomedical, clinical and cognate sciences (e.g. epidemiological and social-behavioral) and the application of this knowledge to patient care.
3. **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal, and assimilation of scientific evidence, and improvements in patient care.
4. **Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health professionals.
5. **Professionalism**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.
6. **Systems-Based Practice**, as manifested by actions that demonstrate an awareness of a responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

We pursue these six ACGME competencies diligently through all components of our educational program and patient encounters. The ACGME core competencies are emphasized in the UofL House Staff Orientation, and then built upon in our Plastic Surgery Resident...
Orientation. These core competencies are then re-enforced through our weekly ACGME Core Competency Conference (Plastic Surgery Grand Rounds Conferences) and interaction with faculty in surgical care plan formulations for each individual patient.

**Goal 2: Engagement and Active Learning.** This program focuses on active (versus passive) learning and continuously challenges the intellectual skills of the resident. Thus, residents are given the encouragement and skills to constantly question and verify the validity and scientific accuracy of the information they are given in lectures, conferences and literature. Each judgment, diagnosis, and selection of technique or design is expected to be logically justified. Participation rather than observation is required. The purpose is to develop a more analytic process that upgrades the quality of medical knowledge and ultimately the quality of medical care that results. A welcome side effect is an enhanced acquisition and retention of information for Board and other examination processes.

**Goal 3: Use of Analytic logic, the scientific method and evidence-based medicine.** Our philosophy emphasizes the analysis of practice principles and treatment of individual patient problems using logical processes, such as deductive reasoning, inductive reasoning, the scientific method and evidence-based medicine. For example, the scientific method would translate into terms of clinical medicine as follows: observation=disease or deformity; hypothesis=differential diagnosis or suspected condition cause; hypothesis testing=problem analysis, medical workup and data analysis; conclusion=diagnosis and the treatment or reconstructive procedure derived logically from the conclusion.

A classic method used in Plastic Surgery for logical design of reconstructive procedures is to formally analyze the missing elements of a defect needing reconstruction, and to surgically restore or replace “like with like or with the most similar”. Furthermore, we expect the resident to generate a hierarchy of approaches and solutions and the rank order to be defended by logic and evidence based citations (e.g., the “reconstructive ladder”). Our approach requires that the resident be the first to go through this process, with critique by faculty to follow, rather than the reverse order. This causes judgment and analytic skills to grow most rapidly, and thus best prepare residents to smoothly make the transition into independent practice.
The ability to access the scientific literature of our discipline, and to analyze it critically for acceptance or rejection, is essential to the best quality patient care and to lifelong learning. We emphasize literature use and analysis and evidence-based medicine/evidence-based practice (EBM/EBP) in each clinical challenge. EBM/EBP principles are learned early in our ACGME Core Competency Conference and practiced in each patient care plan formulation and each literature analyses session of Journal Club and conference presentations.

**Goal 4: Accelerated Progression to Independent Practice.** Our educational program is specifically designed to accelerate progression to independence in judgment and practice. We foster this by challenging the resident to be the first to evaluate the patient, analyze the problem, derive the diagnoses, make the judgments and design the solution. Only then is the faculty critique and input given—rather than in the reverse order as done in many programs. In addition, we strive to provide graduated responsibility based on progressive acquisition of knowledge, progressively increasing judgment challenges and progressive refinement of technical skills. Requiring residents to take the intellectual lead in problem analysis and solution design and presenting increasing challenging judgment decisions with expectations of increasingly skilled performance requires a great degree of interaction between the attending faculty and the resident. The faculty must constantly encourage and require resident analytic thinking in surgical problem-solving, resident application of the scientific method of data analysis, and resident use of a sound physiologic and evidential basis for surgical practice, all in keeping with the values incorporated in the core competencies.

Optimal growth of technical skills in rapid fashion is also achieved by an analogous process by encouraging the resident to take the lead as a supervised primary surgeon, rather than an observer. The resident is given progressive technical responsibility under faculty supervision or rapidly as performance allows. The senior residents are expected to have progressed further than the junior residents, but all are encouraged to progress as rapidly and fully as their capabilities permit. Our Microsurgery Laboratory and Fresh Tissue Dissection and Practice Laboratory substantially serve the growth of advanced technical skills.

By the final semester of the senior year, if not sooner, each resident is expected to have matured
sufficiently in judgment, knowledge and technical skill so as to be ready for independent practice and for the Board certification examinations.

**Goal 5: Optimal Use of Our Diversity of Experience.** This program has been blessed with a rich amount of clinical material that spans the entire spectrum of the field and gives in-depth challenges of great complexity. We also have an exceptionally large number of challenging cases that require interaction with other specialties for complex, interdisciplinary management. Our full-time faculty is supplemented by a large, active volunteer community faculty who welcome resident teaching and who participate actively. This provides a diversity of technical and cognitive approaches to problem solving and technical execution. We use this diversity by insisting that the residents critically analyze the alternative approaches they encounter in order to logically choose the best and most appropriate cognitive approaches and technical procedures for each patient. The residents are continually challenged to logically justify these choices and defend them with basic anatomic and physiologic rationale and evidence-based practice.

C. **The UofL ACGME Core Competency Orientation**

The UofL Graduate Medical Education Office holds a full day of orientation in the ACGME Core Competencies during the house staff orientation process that is mandatory for all incoming house staff. Then, our Plastic Surgery Residency Orientation emphasizes the ACGME Competencies and their application to our specialty. This orientation is mandatory for all residents and staff each year.

D. **ACGME Core Competency Conference**

In order to enhance ACGME competencies in our curriculum and to adapt them most accurately to plastic surgery, an ACGME Core Competency conference is held each week (Wednesday). During each session, a Plastic Surgery topic representing an important aspect of every competency is presented and discussed in rotation. This conference schedule is posted in the Division offices.

E. **ACGME Core Competencies in Each Patient Encounter**

This program requires that each new patient or new problem in an established patient be first
analyzed by the resident in perspective of the relevant ACGME competencies, and a solution outlined that is also in perspective of the ACGME competencies and evidence-based practice. This analysis and proposed solution is then presented to the attending (or the Patient Care Plan Conference) and discussed with the same orientation to ACGME competencies and evidence-based practice principles.

F. ACGME Core Competencies in the Clinical Rotations
We have adopted the goals of the curriculum outlined by the American Council of Academic Plastic Surgeons (ACAPS), and administered by the Accreditation Council for Graduate Medical Education (ACGME). This Milestone Project identifies the knowledge and skill sets to be acquired during each clinical rotation. These are to be reviewed by each resident at the time of each rotation change and midway through each rotation. The ACAPS has organized these Milestones along lines of the ACGME Core Competencies (Section 5: The Clinical Services).

G. ACGME Core Competencies in the Evaluation Process
Evaluation of resident performance and progress is done in perspective of the ACGME core competencies. Beginning July 2017, this will be performed with a standardized process uniform to all University of Louisville Residency programs called MedHub. This computer-driven system will be explained to you in great detail.
3. GENERAL OBJECTIVES AND RESIDENT EVALUATION PARAMETERS  
(COMMON TO ALL CLINICAL SERVICES)

Fundamental skills that are essential objectives common to all clinical rotations also become major components of the resident performance evaluation process. These skills and evaluation parameters are as follows:

A. Patient Care

1. Residents must show proficiency in obtaining, documenting, and communicating an accurate medical history.
2. Residents must show proficiency in performing, documenting, and communicating an accurate physical examination.
3. Residents must show proficiency in judicious selection of laboratory and imaging studies that are most relevant and specific to the diagnostic workup process.
4. Residents must show proficiency in integration and analysis of the history, physical findings, laboratory, and imaging data in producing an accurate diagnosis and patient problem list.
5. Residents must document a comprehensive care plan, including progress monitoring and follow-up.
6. Residents must respond to the psycho-social aspect of the illness or injury, including disfigurement and functional limitations.
7. Residents must promote health education for prevention of disease and injury.
8. Residents must demonstrate commitment to their role as patient advocate.

B. Medical Knowledge and Application to Patient Care

1. Residents must develop a comprehensive and scientifically accurate medical knowledge base through advanced literature searches and analysis, plus other scientific inquiry methods.
2. Residents must develop skill in selection and use of evidence-based medicine from texts and journal articles selected by effective library and internet search techniques.
3. Residents must supply knowledge of scientific study design and appropriate
statistical methods to the appraisal of medical studies and other information relevant to the diagnostic and therapeutic needs of the patient.

4. Residents must use Information Technology to manage and organize information, to enhance their education.

5. Residents must appropriately select the medical knowledge set relevant to the patient’s condition and problems.

6. Residents must develop skill in integrating medical knowledge with clinical data and diagnostic procedures to refine the diagnosis, and problem list and management plan.

7. Residents must develop skills in application of medical knowledge to managing complex problems, such as multiple injuries and co morbid conditions, with logical prioritization of therapeutic goals and interventions.

C. Practice-Based Learning and Improvement

1. Residents must develop habits of continually analyzing practice experience and converting this to improvements in care.

2. Residents must develop an openness and eagerness to seek and accept feedback from faculty, peers, and patients.

3. Residents must prepare a portfolio developed around cases presented in the weekly Indication and Care Plan Conferences that provide evidence of learning and shows the processes used. This will include PowerPoint summaries of presentations, journal articles, or internet searches demonstrating additional information sources and readings and any correspondence from faculty, staff, or patients.

D. Interpersonal and Communication Skills

1. Residents must communicate clearly and accurately to patients and their families, and confirm understanding of key concepts.

2. Residents must communicate clearly and effective with other health professionals.

3. Residents medical records must be completed, timely and legibly.

4. Residents must work effectively in team settings.

5. Residents must develop refined listening skills.

6. Residents must facilitate education of students, staff, therapists, patients and
their families.

E. Professionalism
1. Residents must develop professional attitudes showing:
   a. reliability and punctuality;
   b. ethics and integrity,
   c. initiative and leadership.
2. Resident must show cooperative attitudes that promote teamwork and mutual respect;
3. Residents must accept responsibility for their actions and their consequences.
4. Residents must develop humanistic qualities that include:
   a. establishment of ethically sound patient relationships;
   b. demonstrations of compassion, sensitivity, and respect for the dignity of patients and their families; and
   c. sensitivity and respect to age, culture, disabilities, ethnicity, gender and sexual orientation.
5. Residents must respect patient confidentiality in all settings and meticulously conform to HIPAA guidelines.

F. System-Based Practice
1. Residents must demonstrate a thorough understanding of the systems influencing the delivery of care to their patients, and integrate their practice approximately within the larger care systems.
2. Residents must fully evaluate the risks/benefits, limitations, and cost of available resources used in their practices.
3. Residents should improve the system of care by thoughtful analysis and advocacy for improvement.
4. CLINICAL COMPONENTS OF THE FIELD OF PLASTIC SURGERY

We cover the broad field of plastic surgery in a balanced, comprehensive fashion. The 12 components of the Plastic Surgery field, as designated by the Plastic Surgery Residency Review Committee (RRC), are each addressed in our designated reading program, in the topic rotation of our conference schedule (Appendix 7, 8), in our clinical rotations (Attachment 2 of this Manual), and in the description of clinical rotations that follows (Section 5). Within each of the 12 components of the Plastic Surgery field, specific knowledge and skill goals have been outlined by the American Council of Academic Plastic Surgery, and published as the Plastic Surgery Curriculum (PSC) (Appendix 1). You are advised to review these PSC components and skill goals at the beginning and mid-point of each clinical rotation.

These 12 areas comprise the basic clinical arenas of the specialty, and the designated goals within each arena must be mastered over the length of the program. Your experience must be reflected in your Plastic Surgery Operative Log (PSOL) with depth and balance in all areas. These 12 areas are as follows:

1. **Congenital defects** of the head and neck, including clefts of the lip and palate, 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/upper extremities**.
7. Plastic surgery of the **lower extremities**.
8. **Plastic surgery of 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.
5. THE CLINICAL SERVICES: THE EDUCATIONAL GOALS AND EVALUATION PARAMETERS FOR EACH ROTATION

The 12 areas of plastic surgery are covered by the service rotations of our hospitals. There are specific educational goals for each rotation of the residency. These include the general goals stated above as well as more specific goals of acquiring the knowledge and skills of the clinical focus of each rotation. Each hospital in our program makes a unique and substantial contribution to these goals. Each major rotation is described below, along with the relevant milestones and evaluation parameters from the Plastic Surgery Curriculum (PSC) of the American Council of Academic Plastic Surgeons and background readings. The PSC outline of milestones (Appendix 1) is distributed along with the Plastic Surgery Residency Training Manual annually. It is also assessable on-line. You must review the goals listed below and the related sections of the PSC at the beginning of the program, and again at the midpoint of each rotation. The background readings should be completed by the beginning of each rotation in the first year. They are selected from the current textbook, *Grabb and Smith Plastic Surgery*. By the second year of the plastic surgery residency, residents are expected to have progressed from textbooks to peer-reviewed journal and review articles.

Additionally, the ACGME has designed a Milestone Project to provide a framework for assessment of the development of the resident in key dimensions of the elements of physician competency. The Milestones are designed to use in semi-annual review of resident performance and reporting to the ACGME. Milestones are knowledge, skills, attitudes, and other attributes for each of the ACGME competencies organized in a developmental framework from less to more advanced. They are descriptors and targets for resident performance as a resident moves from entry into residency through graduation. The Review Committee will examine milestone performance data for each resident to determine whether they are progressing overall.

The Milestone levels are designed to best describe a resident’s current performance and attributes. Milestones are arranged into numbered levels. Tracking from Level 1 to Level 5 is synonymous with moving from novice to expert. These levels do not correspond with post-graduate year of education.
Selection of a level implies that the resident substantially demonstrates the milestones in that level, as well as those in lower levels.

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

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

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

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

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

1. **The University of Louisville Hospital Rotation**

   The UofL Hospital rotation has a broad clinical base with a concentration of trauma, burn, and critical care experience. The Hospital is designated as a Level I Trauma Center, and it houses our adult burn unit. Thus, the clinical goals of this rotation are to become skilled in the following principles and techniques:
   
   a. critical care
   b. trauma and burn resuscitation
   c. maxillofacial trauma, extremity trauma, and general trauma surgery
   d. burn care, grafting, and reconstruction
   e. major flap and microvascular reconstructions.

   These clinical goals of this rotation are supported by several weekly bedside teaching rounds. These include Plastic Surgery Service rounds, with the University attending, interdisciplinary Burn Service rounds, and multidisciplinary trauma rounds, involving all services participating in trauma care. The multi-disciplinary structure of this service also
serves the goal of developing skills in effective interdisciplinary relationships for care of critically ill patients, which is present to a degree found in few other programs. In addition, the University of Louisville Hospital rotation serves the goal of enhancing progress toward independent judgment and responsibility, as it is a resident-run service, with the faculty serving in supervisory roles as attending consultants and teaching first assistants. The University clinics are resident-run, and serve the goal of developing skills in pre- and post-operative care and in non-operative management of appropriate conditions. Supervision by attending surgeons is always present at the clinics. Larry D. Florman, M.D. and Joshua H. Choo, M.D. provide overall supervision at the University Hospital. They are complemented by all faculty when the needs arise.

The Outpatient Clinic with progressive responsibilities and continuity for Plastic Surgery residents. This clinic gives our residents the experience and responsibility for being the primary plastic surgeon for the patient in the context of appropriately supervised care. Increased responsibility and autonomy are encouraged in progressing PGY-levels. Safe opportunities for independent activity are provided.

**University Hospital Level 1 (PGY-6) Goals**
The fundamental ability to diagnose patients’ medical conditions and initiate a treatment plan will be achieved at this level. The resident will be responsible for Patient Care with the University Ward Service patients and operations specifically for patients that will be following up at the ACB. The resident’s primary responsibilities will be to University patients admitted through ER as traumas or that have been preoperatively seen through the ACB. The resident is expected to evaluate and treat patients with the supervision of the faculty for their level of training using their appropriate level of Medical Knowledge. The resident is expected to demonstrate Practice-Based Learning and Improvement for their level of training and experience as deemed appropriate by the attending supervising. The resident is expected to utilize effective Interpersonal and Communications Skills in working with patients, families and other health professionals. Professionalism should be adhered to in performing duties ethically and sensitively with this diverse patient
population. Residents should apply System-Based Practice principles in caring for these patients through effectively using system resources in providing optimal care.

**University Hospital Level 2 (PGY-7) Goals**

The main objective for residents to develop on this rotation will be to demonstrate the ability to devise an appropriate treatment plan. The resident will be responsible for providing Patient Care to ACB initiated or University Plastic Surgery trauma patients. The resident is expected to evaluate and treat patients with the supervision of the faculty for their level of training using their appropriate level of Medical Knowledge. The resident is expected to demonstrate Practice-Based Learning and Improvement for their level of training and experience as deemed appropriate by the attending supervising. The resident is expected to utilize effective Interpersonal and Communications Skills in working with patients, families and other health professionals appropriate for their level. Professionalism should be adhered to in performing duties ethically and sensitively with this diverse patient population. The resident should apply System-Based Practice principles in caring for these patients through effectively using system resources in providing optimal care for their level of experience.

**University Hospital Level 3 (PGY-8) Goals**

In the last year, the resident is expected to demonstrate superior operative skills to at the level to safely teach other residents through complex cases. The resident will also be expected to provide Patient Care for all ACB initiated and University Trauma initiated patients that are admitted to the hospital. The resident is expected to evaluate and treat patients with the supervision of the faculty for their level of training using their appropriate level of Medical Knowledge. The resident is expected to demonstrate Practice-Based Learning and Improvement for their level of training and experience as deemed appropriate by the attending supervising. The resident is expected to utilize effective Interpersonal and Communications Skills in working with patients, families and other health professionals. Professionalism should be adhered to in performing duties ethically and sensitively with this diverse patient population. The resident should apply System-Based Practice principles in caring for these patients through effectively using
system resources in providing optimal care by striving to practice cost-effective measures.

**Background Reading:** Negligan/Mathes’ *Plastic Surgery; Selected Readings In Plastic Surgery*

2. **Hand and Upper Extremity Rotation**
   This rotation is done with U of L Hand Surgery at Jewish, University and Children’s Hospitals. The primary goal that this rotation serves is mastering the principles of management, surgery and therapy of hand and upper extremity disorders in adults and children. It also provides a strong digit and extremity replantation experience and reinforces the goals of strengthening microsurgical experience. This rotation is supplemented by weekly conferences that covers all areas of hand surgery and by several annual symposia in anatomy, internal fixation and other relevant topics. Bradon Wilhelmi, M.D. is charged with the Hand Service.

**Hand Level 1 (PGY-6) Goals**
The focus of this rotation is to demonstrate the ability to recognize and manage post-operative problems. The resident will take hand call weekly and see all hand patients admitted to Plastic Surgery with hand conditions. With regard to Patient Care, the resident is expected to develop and execute a proper patient care plan. In demonstrating Medical Knowledge the resident is expected to prepare and have knowledge of operative procedures appropriate for treated patients. The resident will demonstrate Practice-Based Learning through participation in the education of patients, family and junior learners. Interpersonal and Communication Skills will be developed and demonstrated by counseling and educating these patients and their families in an understandable and respectful manner. Professionalism should be exhibited by consistently demonstrating ethical behavior and recognizing ethical issues in these patients. System-Based Learning will be achieved through recognizing basic elements needed to establish a practice (staffing, insurance, accreditation).
Hand Level 2 (PGY-7) Goals
The emphasis of this rotation will be on how to manage multiple patients and surgical consultations. Patient Care will be assessed by your demonstration of appropriate manual dexterity for training level. This will be taught and stressed during the rotation. Medical Knowledge will be developed by use of collateral reading in preparing for cases. Practice-Based Learning will be determined by observing and developing the resident’s ability to critique personal practice outcomes. Interpersonal and Communication Skills refined and evaluated through the residents communication with members of the healthcare team skills. Professionalism will be taught to extend the residents patient management skills to demonstrate compassion and sensitivity towards others. System-Based Practice will be taught to the resident at this level through developing the use of tools (checklists, briefings) to prevent adverse events.

Hand Level 3 (PGY-8) Goals
The overall objective of this will be to help the resident independently perform routine procedures in the care of the hand surgical patient. Patient Care will be assessed by the residents’ ability to demonstrate a superior manual dexterity and appropriate economy of motion in the operating theatre. Medical Knowledge will be assessed through one’s ability to demonstrate knowledge base in the clinical setting and operating room for their level. Practice-Based Learning will be assessed by the resident’s ability to discuss ongoing research in the field of hand surgery. Interpersonal and Communication Skills will be developed through managing transitions of care and optimizing communications across systems. Professionalism will be emphasized through striving to maintain one’s personal health and wellness. System-Based Practice through discussing strategies on cost-effectiveness in patient care in the hand surgery field. (managing length of stay, operative efficiency)

Background Reading: Green’s Operative Hand Surgery; Neligan/Mathes’ Plastic Surgery.
3. **The Adult Reconstructive Rotation**

The adult reconstructive service at Jewish and Norton Hospitals provides a rich and diverse exposure to all areas of adult plastic surgery, and serves goals of developing general reconstructive judgment and skills. The thoracic and cardiovascular service at Jewish Hospital provides challenging thoracic reconstructions and provides the goals of developing both reconstructive skills and critical care management. This rotation also includes a large transplant service and serves the goals of developing skills and knowledge in difficult wound problems as well as basic transplantation biology. The adult oncologic service at the Norton Hospital Cancer Center and the Brown Cancer Center serves the goal of enhancing judgment and experience in breast reconstruction, head and neck oncologic reconstruction, gynecologic oncologic reconstruction, and orthopedic oncologic reconstruction. Terry McCurry, M.D. and Gordon Tobin, M.D. mentor and direct this service.

**Reconstruction Level 1 (PGY-6) Goals**

The overall focus of this rotation will be to develop the ability to recognize and manage post-operative problems. In this rotation, the resident will work under the direction of Dr. Tobin and Dr. McCurry. Patient Care will be stressed to have the ability to develop and execute patient care plan. Medical Knowledge will be developed through the resident’s ability to prepare and knowledge of operative procedures for reconstructive patients. Practice-Based Learning will be emphasized by having the resident participate in the education of patients, families and junior learners. Interpersonal and Communications Skills will be enhanced through observation of counseling and educating patients and their families in an understandable and respectful manner. Professionalism will be developed by the resident who will be expected to consistently demonstrate ethical behavior and recognize ethical issues in reconstructive patients. System-Based Practice will be enhanced through teaching basic elements needed to establish a practice (staffing, insurance and accreditation).
**Reconstruction Level 2 (PGY-7) Goals**
The emphasis of this rotation will be on developing the ability to manage multiple patients and surgical consultations. In this rotation the resident will work under the direction of Dr. Tobin and Dr. McCurry. Patient Care will be developed by teaching the resident to have appropriate manual dexterity and technical efficiency. Medical Knowledge will be stressed through providing resources for collateral reading to prepare for reconstructive cases. Practice-Based Learning goals will help the resident to develop a better ability to critique personal practice outcomes in the outpatient setting. Interpersonal and Communication Skills will be refined through communicating with the members of the health care team effectively. Professionalism requirements will stress performing clinical and administrative responsibilities in a timely manner. System-Based Practice will be demonstrated by observing the residents ability to consistently utilize tools to prevent adverse events such as checklists, briefings, smart phone.

**Reconstructive Level 3 (PGY-8) Goals**
The thrust of this rotation is for the resident to demonstrate the ability to independently perform routine procedures in the care of the surgical patient. In this rotation, the resident will work under the direction of Dr. Tobin and Dr. McCurry. Patient Care will be demonstrated by the residents’ ability to independently manage multiple patients and surgical consultations. Medical Knowledge will be assessed as demonstrated in practice in the clinical setting. Practice-Based Learning will be reinforced through attention to demonstration and commitment to life-long learning and self-improvement. Interpersonal and Communication Skills will be enhanced through the ability to manage transitions of care and optimizing communication across systems. Professionalism will be developed through demonstration of consistent commitment to continuity of patient care. System-Based Practice will be encouraged through discussions on cost effectiveness (Managing length of stay, operative efficiency) in the reconstructive patient.
**Background Reading:** Neligan/Mathes’ *Plastic Surgery: Selected Readings In Plastic Surgery.*

4. **The Veterans Affairs Medical Center Rotation**

This resident-run rotation is based in a large Veterans Affairs Medical Center Hospital ten minutes from the main campus. Its primarily mission serves the goals of acquiring experience in head and neck oncology and reconstruction, cutaneous malignancy oncology and reconstruction, and management of neurological injury complications, such as decubitus ulcers. In addition, this rotation serves the important goal of developing independent judgment and responsibility; both the service and its clinics are resident-run with a full-time plastic surgeon attending serving in a supervisory role. Morton Kasdan, M.D. is charged with all plastic surgery services at the VAMC.

**VAMC Level 1 (PGY-6) Goals**

On this rotation, the main goal will be to learn how to develop the ability to diagnose conditions and execute patient care plan. The VAMC Plastic Surgery rotation is under the direction of Dr. Kasdan. Patient Care will develop the ability to recognize and manage post-operative problems. Medical Knowledge will be achieved through the preparation for operative procedures. Practice-Based Learning is attained though the participation in the education of patients, families and junior learners. Interpersonal and Communication Skills will be encouraged by having residents counsel and educate patients and their families in an understandable and respectful manner. Professionalism is consistently encouraged allowing the resident to demonstrate ethical behavior and recognize ethical issues in practice. System-Based Practice is optimized though learning how to recognize basic elements (staffing, insurance, accreditation) needed to establish a practice from Dr. Kasdan extensive clinical experience.

**VAMC Level 2 (PGY-7) Goals**

This rotation will emphasize development of manual dexterity for training level. The VAMC Plastic Surgery rotation is under the direction of Dr. Kasdan. Patient Care
will involve independent management of multiple patients and surgical consultations. Medical Knowledge will be honed in preparation and knowledge of operative procedures. Practice-Based Learning is developed through participation in the education of patients, families and junior learners. Interpersonal and Communication Skills are refined through counselling and educating patients and their families in an understandable and respectful manner. Professionalism is developed through consistent mentoring under Dr. Kasdan demonstrating ethical behavior and reinforcing ethical issues in practice. System-Based Practice will be outlined consistently using tools to prevent adverse events.

**VAMC Level 3 (PGY-8) Goals**

The thrust of this rotation will be developing independence to perform procedures in the care of the plastic surgical patient. The VAMC Plastic Surgery rotation is under the direction of Dr. Kasdan. Patient care will involve demonstrating the ability to improve operative skills through economy of technique. Medical Knowledge will be attained through application of knowledge base in the clinical setting with Dr. Kasdan. Practice-Based Learning is obtained through commitment to life-long learning and self-improvement under Dr. Kasdan’s mentorship. Interpersonal and Communication Skills are refined by using ability to manage transition of care and optimizing communication across systems and in sign outs. Professionalism is advanced through demonstration of consistent commitment to continuity of patient care. System-Based Practice will be addressed through consistently practicing cost effective care as taught by Dr. Kasdan.

**Background Reading:** Neligan/Mathes’ *Plastic Surgery.*

5. **Head and Neck Rotation.** An in-depth head and neck experience is available. This is a rotation at the University Hospital, Norton Hospital and Kosair Children’s Hospital under the mentorship and direction of Dr. Jarrod Little. The primary goal of this rotation is to learn the principals of head and neck anatomy, oncology, trauma and reconstruction. This rotation provides a very diverse exposure to head and neck plastic surgery and other plastic surgery. The goal of learning, evaluation and pre- and post-operative care of the head and neck patient is served by the experience of taking care of
these specialized patients at a variety of hospitals to intensively teach these specialized skills. Residents will learn a multidisciplinary approach to the management of these complex patients from the perspective of an otolaryngology trained plastic surgeon.

**Head and Neck Level 1 (PGY-6) Goals**
The emphasis of this rotation will be on ability to recognize and manage post-operative problems. The Head and Neck rotation will be primarily at Norton Hospital under the direction of Dr. Little. Patient Care will be developed through the ability to execute a patient care plan. Medical Knowledge will be achieved preparation and development of operative plan and procedures. Practice-Based Learning will be learned through participation in the education of patients and their families. Interpersonal and Communication Skills will be obtained through counseling patients and their families in an understandable and respectful manner. Professionalism will be expected and taught consistently expecting proper ethical behavior and recognition of ethical issues in practice. System-Based Practice will be reviewed to emphasize the basic elements needed to establish a practice.

**Head and Neck Level 2 (PGY-7) Goals**
The thrust of this rotation will be to learn how to independently manage multiple patients and surgical consultations. The Head and Neck rotation will be primarily at Norton Hospital under the direction of Dr. Little. The resident will be expected to develop the appropriate manual dexterity for level. Medical Knowledge will be facilitating to providing collateral reading for head and neck patients and operations. Practice-Based Learning will be developed by teaching the resident the ability to critique personal practice outcomes. Interpersonal and Communication Skills will stress effective communication with members on the health care team. Professionalism will be refined by demonstration of compassion and sensitivity towards the head and neck patients. System-Based Practice will be established through consistent use of tools (checklists, briefings) to prevent adverse events.
**Head and Neck Level 3 (PGY-8) Goals**

The overall objective of this rotation will be to have the resident be able to independently perform routine procedure in the care of the surgical patient. The Head and Neck rotation will be primarily at Norton Hospital under the direction of Dr. Little. Patient Care will emphasize management of multiple patients and surgical consultations. Medical Knowledge allow for demonstration of knowledge base in the clinical setting. Practice-Based Learning will be developed through teaching commitment to life-long learning and self-commitment. Interpersonal and Communication Skills will be enhanced through management of transition of care and optimizing communication across systems. Professionalism will be taught and obtained through monitoring own personal health and wellness. System-Based Practice will be attended by striving to achieve and teach cost-effective care.

**Background Reading:** *Grabb and Smith’s Plastic Surgery; Neligan/Mathes’ Plastic Surgery*

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7. **Interdisciplinary Subspecialty Training Opportunities**

The major rotations listed above provide the major clinical experiences for our program and serves the goals of developing the specialty knowledge and skills associated with the specific patient populations and educational experiences of each hospital. In addition, within these major rotations certain multidisciplinary subspecialty goals and in-depth experiences are incorporated. The Division of Plastic and Reconstructive Surgery supports this interdisciplinary approach to shared educational programs in order to fulfill the goals of providing experiences that utilize specialized skills held or shared by other disciplines.

**Short Elective Rotations Level 3 (PGY-8) Goals**

Residents will have an opportunity to select electives as suggested by the RRC in the above areas. During these third level rotations the residents will be able to further refine their knowledge base and skills in their selected rotation. The resident is expected to continue to advance their Patient Care skills and operative technique when appropriate.
They will have an opportunity to further their Medical Knowledge on that specific elective through collateral reading and preparation for cases. Practice-Based Learning will be addressed varying on rotation and specialty. Interpersonal and Communication Skills will have an opportunity to flourish in working within a new team and system. The resident will still be expected to demonstrate appropriate Professionalism as a representative of the University of Louisville Plastic Surgery program. These super specialty electives will provide the resident with a multitude of practice models to help develop practice management strategies with staffing, insurance, and accreditation.

a. **Oculoplastic Surgery.** An in-depth Oculoplastic experience is available. This is provided primarily by Dr. Douglas Gossman, a skilled oculoplastic surgeon and Plastic Surgery volunteer faculty member. His background is in the discipline of ophthalmology, with previous training in neurosurgery. He works closely with the University full-time and volunteer plastic surgery faculty in major reconstructions of orbital trauma, cranial base oncologic resections, and craniofacial operations, as well as providing experience in congenital ptosis and other orbital reconstructions, not common to most plastic surgery programs.

**Background Reading:** *Grabb and Smith’s Plastic Surgery*

b. **Aesthetic Rotation**
The primary goals of this rotation are to acquire the principles and techniques of aesthetic surgery and skills in management of the aesthetic patient. Jewish Hospital and the Norton Medical Pavilion house aesthetic units where many plastic surgeons in this community perform aesthetic procedures. This provides a very concentrated aesthetic clinical exposure for the rotating resident. The goal of learning, evaluation, and pre- and post-operative care of the aesthetic patient is served by experience in the office practice of selected aesthetic surgeons, both voluntary faculty and full time faculty who are willing to intensively teach these skills. During this rotation residents are initiated to their own “private practice” in esthetic surgery by using the office facilities of the full time faculty, to consult
with aesthetic patients that they have procured. This is done under the supervision of the full time faculty. This rotation is supplemented by an aesthetic conference that covers all major areas of aesthetic surgery in sequence over a 2-year period. Gerry O’Daniel, M.D. has responsibility for this rotation.

**Background Reading:** Negligan/Mathes’ *Plastic Surgery*; Nahai’s *The Art of Aesthetic Surgery*

c. **Burn Surgery.** An in-depth experience in burn care and reconstruction is available. Adult burns are treated by Plastic Surgery and General Surgery burn teams based at the University of Louisville Hospital under the supervision of the Plastic and General Surgery faculties. Children’s burns are similarly co-managed with the Pediatric Surgery Service at Kosair Children’s Hospital Pediatric Burn Unit.

**Background Reading:** *Grabb and Smith’s Plastic Surgery*

d. **The Craniofacial Rotation**

This rotation is centered on the Pediatric Plastic Surgery Service of Kosair Children’s Hospital, and the primary goals of this rotation are to learn the principles and techniques of cleft lip and palate, craniofacial, and pediatric plastic surgery, including pediatric burns. The related goals of out-patient pre- and post-operative evaluation and management of these pediatric subspecialties are gained by attendance at outpatient facilities of *The Cleft and Craniofacial Clinics of the Commission for Children with Special Healthcare Needs, The University of Louisville Child Evaluation Center Clinic*, and patient encounters in the office of pediatric plastic surgeons. Mark Chariker, M.D. coordinates the activities of this rotation. Special note must be made concerning the experience in cleft lip and palate surgery. These cases are not numerous in the Commonwealth of Kentucky. They must be considered a precious quantity, and all must be attended by at least one resident.
Background Reading:  *Grabb and Smith's Plastic Surgery*; Neligan/Mathes’ *Plastic Surgery*; Millard’s *Cleft Craft*; *Selected Readings In Plastic Surgery*

e. **Orthopaedic / Hand Surgery**

This rotation is at the Norton Hospital under the direction of Dr. Amit Gupta an orthopedic surgeon. He has a team of orthopaedic surgeons that the plastic surgery residents rotate with to learn the principles of orthopedic surgery, bone anatomy and physiology and internal fixation.

Background Reading:  Campbell’s Orthopaedic Surgery, Green’s *Operative Hand Surgery*

f. **Outpatient Anesthesia**

This rotation is at an outpatient surgery center called the CaloSpa. During this rotation the residents learn the principals of outpatient anesthesia in an ambulatory setting under the direction of Dr. Calobrace and his anesthesia team. This is a unique and treasured opportunity for the residents to learn how to preoperatively assess and provide patients for safe anesthesia for outpatient procedures.

Background Reading:  Neligan/Mathes’ *Plastic Surgery*; Nahai’s *The Art of Aesthetic Surgery*
g. **Cosmetic Dermatology**

This rotation is performed under the mentorship and direction of Marc Salzman, M.D. and the Jewish East Outpatient Facility. Through this rotation the residents learn about skin care and skin care products. They also have an opportunity to diagnose and manage unique skin conditions. Ultimately, the residents obtain experience with chemical peels, dermabrasion and laser in the management of facial burns, depigmentation and facial rhytids.

**Background Reading:** Neligan/Mathes’ *Plastic Surgery*; Nahai’s *The Art of Aesthetic Surgery*

8. **Special Facilities**

The opportunities for residents to expand and achieve their educational goals are enhanced by several specialized facilities developed within the University and Teaching hospitals of our program. They include the following:

**The Microsurgery Training Laboratory.** This facility for basic and advance training in microsurgery was developed by the late Dr. Robert Acland and is located in the Price Institute of Surgical Research, in the Medical Dental Research Building. It has trained more micro-surgeons than any other facility in the world. Each of our residents receives formal training course in microsurgery on matriculation, and can return as needed for additional practice.

**Background Reading:** Acland’s Microsurgical Practice Manual; *Grabb and Smith’s Plastic Surgery*

**The Fresh Tissue Dissection & Surgical Practice Laboratory.** This facility was created by Dr Robert Acland and is devoted to anatomic dissection of fresh cadavers for both training and research purposes and has become a model for fresh tissue laboratories both nationally and internationally. Our residents have material available for dissection
virtually constantly. This is used for our formal dissection courses, such as the Fresh Tissue Dissection Conference, and The Focus on Anatomy Course, as well as informal group’s individual dissections to learn anatomic detail or practice surgical procedures. Additionally, residents are encouraged to undertake anatomic research projects.

**Background Reading:** Dr. Tobin’s monograph, Myocutaneous Muscle Flaps in *Grabb and Smith’s Plastic Surgery*

**The Aesthetic Centers.** One of the strengths of our aesthetic rotation is that the overwhelming majority of aesthetic surgery in the community is done in the units specialized for aesthetic surgery in our teaching hospitals. This places the residents in immediate proximity to virtually all practitioners and exposes them to the full spectrum of technical and conceptual approaches and to the most advanced techniques.

**Background Reading:** *Grabb and Smith’s Plastic Surgery*
6. EDUCATIONAL CONFERENCES AND ROUNDS

The Program goals and ACGME competency of medical knowledge are supported by a comprehensive educational program of conferences, rounds, courses, and tests of progress in medical knowledge. Although extensive, these group activities are not intended to be a substitute for a disciplined, regular individual reading program. Rather, they are intended to guide and supplement such a program. All residents must attend these conferences, unless specifically designated as limited to residents on a specific rotation, and these become options to residents not currently on that rotation.

The University campus, our teaching hospitals, and the Medical Society Buildings are clustered in a four-block area (except the VAMC, which is five minutes away), and all conference sites are within these teaching facilities. Attendance of all residents is mandatory at all the above listed conferences, rounds, courses, symposia, Journal Clubs, Visiting Professor lectures, and research seminars except conferences specific to individual rotations, for which mandatory attendance applies only to the resident on that rotation.

The full time faculty always attends the plastic surgery conferences when in town. Quite often, members of the volunteer faculty also attend. The educational input from experienced faculty is vital to the success of the education program.

Faculty and resident attendance will be monitored by the Program Director.

A. General Conferences – all residents to attend

1. Reconstructive Conference (Grand Rounds) (Wednesdays, 7:00 a.m., Jewish Hospital Rudd Heart & Lung Building). This weekly conference progresses through the core curriculum of reconstructive surgery over the year’s schedule. These lectures are given by faculty, visiting professors, and residents, who present topics in their area of interest and expertise. A high degree of interactivity by the residents is expected. Reconstructive Grand Rounds cover the 11 clinical areas of Reconstructive Plastic Surgery, as defined by the RRC (aesthetic topics are covered on alternate weeks). Additionally relevant ACGME core competencies, medical-legal, ethics, practice...
management, and basic science topics are covered when relevant. The Conference schedule is Appendix 7.

2. **ACGME Core Competencies Conference** (Wednesday, 8:00 a.m., Jewish Hospital Rudd Heart & Lung Building). This weekly conference is focused on enhancing the ACGME Core Competencies and applying them to Plastic Surgery. The first half hour is devoted to a discussion of topics from the 6 ACGME Core Competencies in rotating sequence. The second half hour is devoted to the Indications and Care Plan Conference twice monthly, alternatively with faculty meeting and Quality Improvement Conference.

3. **Indications and Care Plan Conference** (Mondays, 1:30 pm, ACB). This weekly conference focuses on management plans for upcoming challenging cases and indications for surgery. The patients are presented to the faculty and resident group by the resident responsible for care of the patient. Relevant ACGME core competencies in the plan are cited and emphasized. As with all patient presentations, the resident must generate and describe a complete management plan prior to faculty input. This plan will then be analyzed and refined by the faculty and other residents in a Socratic format.

4. **Quality Improvement and Morbidity Analysis Conference** (8:00 a.m., one Wednesday each month, Jewish Hospital Rudd Heart & Lung Building). This monthly conference analytically reviews quality improvement and patient safety issues, including the morbidity and mortality experience of the service. Cases are presented and analyzed first by the resident involved in the patient’s clinical care and then discussed by the other residents and faculty. The format of the review is to use analytic logic and the scientific method to identify the cause and then the prevention or correction of the complication. A systems approach to patient safety is incorporated and balanced with individual responsibility as appropriate. The ACGME Competency of Practice-Based Learning is directly served by this conference.

Each resident is expected to present all cases of complications, mortality or “near miss” events from the preceding month. The classical patient presentation format will be used
and all relevant data (including autopsy results for mortalities) will be made available. The discussion will always include the following components;

a. The complication will be clearly stated.
b. The case will be presented in classical format.
c. A hypotheses of cause based on all available data will be given.
d. An analysis of the hypothesis will follow.
e. A conclusion and recommendation for future avoidance of such events based on the analysis will be made. When relevant, pertinent references regarding the complication should be distributed.

5. **Basic Science, Research and Evidence-Based Medicine Conference** (first Mondays 1:00 pm, ACB). This conference covers basic science topics relevant to plastic surgery (e.g. wound healing). It also reviews progress of ongoing research projects in our Plastic Surgery Research Laboratory or in clinical studies and it allows residents and faculty to prepare and present scientific papers for upcoming regional and national meetings, such as the annual KSPS presentation each September. It is used to teach the principles of evidence-based medicine and demonstrate application to clinical decision making. This conference has been incorporated into our Reconstructive Conference and ACGME Core Competency schedule and is held at least quarterly.

6. **Hand Conference** (every other Monday, 3:00 p.m., Hagan Library) (alternates with Cosmetic Conference). These conferences are given by the faculty, the residents, or the visiting professors to the program. The schedule includes 25 plastic surgery specific hand topics as chosen by the Program Director and the residents.

7. **Fresh Tissue Dissection and Surgical Practice Lab Sessions** (every other Monday, 4:00 pm, MDR Building). This exercise is a dissection of clinically relevant anatomy done on a fresh cadaver in our Fresh Tissue Dissection and Surgical Practice Laboratory. Anatomy relevant to clinical practice, such as flap design frequently used on a challenging upcoming case is dissected and discussed.
The discussion is led by a designated faculty member or expert, with residents doing the technical dissection to enhance their skills. Handouts and graphic supplements are frequently used.

8. **Surgery Grand Rounds** (Fridays, 7:00 a.m., ACB Auditorium). This weekly conference is presented by faculty or a visiting expert. Plastic Surgery residents will be notified when the subject is of relevance to our specialty. In such an instance, conference attendance will be required.

9. **Surgery Department Resident Grand Rounds and Teaching Conferences** (Fridays, 8:15 a.m., ACB Auditorium). This weekly conference is scheduled for resident education by the Surgery Department for all surgical services. Plastic Surgery residents are required to attend those which ACGME core competency cover basic science, medico-legal, ethics, and practice management issues that are relevant to Plastic Surgery. The conference is given by academicians or clinicians from the University faculty or by outside experts in specific topics.

10. **Journal Club Meetings** (Quarterly, on the 3rd Monday, 6:30 p.m.). This quarterly conference uses both classic, current, and journal papers from *Plastic and Reconstructive Surgery*, and other relevant journals. The articles are briefly summarized, critically analyzed and related to clinical practice by the presenting residents, followed by an organized general discussion by other residents and faculty. The articles are chosen by the educational chief resident with faculty guidance. The location is usually at a restaurant conference room or the home of a Division member. It will be the responsibility of the faculty discussant and Education Chief Resident to select the articles. The articles chosen will then be assigned by the Education Chief Resident to each of the other residents for review, presentation and critical analysis, at the conference.

11. **Board Preparation Quiz Sessions** (every Monday, 2:30 p.m., Hagan Library). A 1-hour session with pre-assigned reading and multiple choice questions conceived by a faculty
member. This will be followed by an in-depth discussion of the subject. Mock-oral exams will be given simulating examinations given by the American Board of Plastic Surgery.

12. **Plastic Surgery Research Conference** (every Mondays, 1:00 p.m., Hagan Library). This conference is held to discuss ongoing research efforts as well as the prospects for future research projects.

13. **Facial Trauma Conference** (third Wednesday of every month, 7:00 a.m., Ambulatory Care Building Auditorium). This is a combined conference with Plastic Surgery, Otolaryngology, Oral/Maxillofacial Surgery, and Oculoplastic Surgery.

14. **Cosmetic Surgery Clinic** (every other Monday) (alternates with Hand Conference & Fresh Tissue Dissection Lab). This clinic is held at the private office and is attended by one or more of the full-time faculty.

15. **Workshops.** Discussion on particular topics with hands-on participation in management of specific challenging plastic surgery areas or defects. In these workshops, residents will learn algorithms and approaches to specific defects.

16. **Hand Case Presentations.** The resident on the Hand Rotation presents the interesting cases from the prior week of hand call and hand rotation.

17. **Craniofacial Case Presentations.** The resident on the Head & Neck Rotation presents one of the 50 assigned craniofacial syndromes in PowerPoint form, including photos and genetic risk factors.

**B. Conferences Specific to Individual Rotations:** The following conferences are organized for residents on specific services. Most of these conferences are multidisciplinary and provide excellent opportunities for interdisciplinary interaction, information exchange and development of professional communication skills. The resident assigned to the specific rotation identified
must attend, and others may attend optionally.

1. **Burn Rounds** (Monday, 8:00 a.m., UofL Hospital, 8th Floor Burn Unit). These multidisciplinary weekly bedside teaching rounds in the University Hospital Burn Unit refine burn care teaching and management judgment for cases in the burn unit. These rounds are held in conjunction with the General Surgery Trauma Service. The patients are presented to the faculty and resident groups by the resident responsible for the patient, and discussion is led by the Plastic and Trauma Surgery Faculty. The Plastic Surgery resident rotating at University Hospital is to attend.

2. **Multidisciplinary Breast Oncology Conference** (Thursday, 8:00 a.m., Brown Cancer Center). A multidisciplinary team approach to breast cancer is presented and includes representatives from diagnostic radiology, surgical oncology, medical oncology, radiation oncology, plastic surgery, pathology, social services, tumor registry and tumor genetics. This weekly conference is attended by the reconstructive service resident at Norton and Jewish Hospitals.

3. **James Graham Brown Cancer Center Oncology Conference** (Friday, noon, James Graham Brown Cancer Center, 2nd Floor Conference Room). A formal presentation on topics relating to cancer care is presented. When relevant topics are presented, this weekly conference is to be attended by the plastic surgery resident rotating on the University Hospital service. On rare occasions, the plastic surgery resident is requested to present a case on topic.

4. **Melanoma Conference** (Monthly, Wednesday, 7:00 a.m., ACB Auditorium). A multidisciplinary team approach to melanoma is presented and includes representatives from diagnostic radiology, surgical oncology, medical oncology, radiation oncology, plastic surgery, pathology, social services, tumor registry and tumor genetics.
7. ETHICS CURRICULUM

Basic knowledge of medical ethics principles and practices is included in our educational curriculum, by case example upon occurrence, by presentations, in the General Competencies Conference, by other conferences and special seminars and printed matter for self-study. These avenues for the ethics curriculum are described below

A. **ACGME Core Competencies Conference:**
   An ethics topic is presented at least each semester.

B. **Plastic Surgery Ethics Round-Table Discussion**
   An ethics dilemma will be discussed in round-table fashion at least quarterly.

C. **Reconstructive and Aesthetic Conference:**
   Ethics discussions are integrated into the topic presented whenever relevant.

D. **Surgery Department Resident Teaching Conference:**
   Ethics, medical-legal, practice management and basic science topics are regularly scheduled in this weekly conference held every Friday at 8:15 A.M. You will be informed when any of these topics are scheduled. Attendance is mandatory for these topics.

E. Special seminars in medical ethics are regularly held by the UofL, our Teaching Hospitals and the Medical Society. You will be notified of these seminars when they occur.

F. Each resident will receive a copy of *The Principles of Medical Ethics* and *The Fundamental Elements of the Patient - Physician Relationships* from the *Code of Medical Ethics of the AMA*. They are Attachment 2 of this manual.

G. The current edition of the Code of Medical Ethics of the AMA is available to all residents in the Division office for reference and self-study, and is provided to all residents joining the Greater Louisville Medical Society, and Kentucky Medical Association ($40.00 for the entire residency).
It is Supplemental Reference Manual #1. Basic knowledge of medical-legal principles and current legal issues are included in our educational curriculum by case example upon occurrence, by presentations in the General Competencies Conference, by special seminars and by self-study courses described below.
8. MEDICAL-LEGAL CURRICULUM

A. **ACGME Competencies Conference**
   A medical-legal topic is given at least each semester. Dr. Morton Kasdan has given particularly valuable presentations on medical-legal topics and is our faculty expert on the subject.

B. **Reconstructive and Aesthetic Conference**
   Medical-legal discussions are integrated into the topics presented whenever relevant.

C. **CD-ROM Course**
   Dr. Gordon Tobin has arranged for each resident to receive a CD-Rom on Basic Medical-Legal principles and risk management by joining the Greater Louisville Medical Society and Kentucky Medical Association.

D. **Special seminars** in medical-legal issues are held by the UofL, our teaching hospitals, our Medical Society, and our medical liability carrier. Your attendance is mandatory at all of these. You will be informed when these seminars are scheduled.

E. Residents will receive a summary of basic medical-legal principles and periodic updates. This summary is reprinted from the *Law and Medicine* series published in the *Journal of the American Medical Association*.

F. The current edition of the *Legal Handbook for Kentucky Physicians* (KMA) is available to all residents in the Division Reference Library and is provided to all residents joining the Greater Louisville Medical Society and Kentucky Medical Association.

G. The ASPS manual, *Patient Consultation Resource Book*, is available to all residents in the Division Reference Library. The informed consent templates it contains may be used to improve your patient informed consent or council you to design your individual informed consent forms.
9. SOCIOECONOMICS & PRACTICE MANAGEMENT EDUCATION

Basic knowledge of socioeconomics and practice management principles are included in our educational curriculum by case example upon occurrence, by presentations in the General Competencies Conference, by other Conferences and by special seminars and self-study courses described below.

A. ACGME Core Competencies Conference
A practice management, topic is given at least once each semester.

B. Reconstructive and Aesthetic Conference
Socioeconomic discussions are integrated into the topics presented whenever relevant.

C. Surgery Department Resident Teaching Conference
Practice management, topics are regularly scheduled in this weekly conference. You will be informed when any of these topics are scheduled. Attendance is mandatory for these topics.

D. Special seminars in practice management are held by the UofL Compliance office, our teaching hospitals and the Greater Louisville Medical Society (GLMS). You will be notified of these seminars when they occur. The GLMS provides a comprehensive on-line course for entering practice that includes contract negotiations with employing groups, contract negotiations with insurers, personnel and office management. This is available to resident members ($40 for the entire residency).

E. The UofL Compliance Office holds an annual seminar in Medicare compliance regulations and documentation at the beginning of each academic year. Attendance is mandatory.

F. The Department of Surgery holds an annual seminar in CPT coding early in each academic year. Attendance is mandatory.

G. A summary of Medicare Compliance Regulations is available through the University of Louisville Compliance Office.
H. A set of manuals on basic practice management principles are available to all residents for a self-study course. These are most useful during the senior year, or whenever practice arrangements are being made.

I. The manual from the AMA course, Establishing Yourself in Medical Practice is available. Sections include: personnel, facilities, patient flow, patient records, financial, practice setting and legal.

J. The Resource Book for Plastic Surgery Residents (ASPS) is available to all residents. The section “How to Select a Practice” is most useful for that purpose. It is Appendix 5 and Supplemental Reference Manual #9.

K. The AMA Handbook, Marketing Strategies for Private Practice is available. It contains excellent instructions on good communications to patients and referring physicians. Skill, compassion, good care and good communications are all the marketing you will ever need. It is Supplemental Reference Manual #5.

L. The Greater Louisville Medical Society Department of Practice Services provides an excellent introduction to managed care issues, and managed care contracts. This information is available by joining the Medical Society. It is Supplemental Reference Manual #6.


N. The Annually updated and issued CPT manual (AMA) contains and defines all the CPT codes, modifiers, and detailed instructions for their use. It is Supplemental Reference Manual #7.

A. **Annual Symposia**

The Division sponsors or co-sponsors a number of annual courses or symposia. All residents must attend. These courses include the following:

1. **Microsurgery Course**

   At the beginning of the residency, each resident spends time in the *Microsurgery Training Course* that is offered by our Microsurgery Laboratory (Section 5:8). Additional practice time can be arranged individually thereafter. The course is taught by Dr. Bradon Wilhelmi. A widely acclaimed videotape teaching series is used, which was produced by former faculty member Robert Acland, M.D.

2. **Surgical Anatomy Course**

   Each year the Divisions of Plastic Surgery and Hand Surgery co-sponsor a surgical anatomy course or flap dissection. The topics covered alternate between flap and upper extremity anatomy. The course uses fresh cadaver dissections done in our Fresh Tissue Dissection and Surgical Practice Laboratory. Simultaneously, lectures on the dissection topic are given by the faculty of the Divisions of Plastic and Hand Surgery, or by visiting professors and a useful course syllabus of anatomic diagrams and relevant journal reprints are distributed.

3. **Maxillofacial Fixation Course**

   Each year a hands-on course in maxillofacial plating and internal fixation is sponsored by the Division and supported by plate manufacturing companies. Demonstrations are given by the faculty, with residents performing the technical exercises at individual practice stations.
4. **Hand Internal Fixation Course**

Each year a hands-on weekend course in upper extremity plating and internal fixation is sponsored by the Division of Hand Surgery and AO/Synthes for the Hand Fellows and Plastic Surgery Residents. Demonstrations are given by the faculty, with residents repeating the technical exercises at individual stations.

5. **Research Symposium**

“Research!Louisville,” is a weeklong research symposium that contains courses, a keynote speaker and research presentations, and is sponsored by the University of Louisville and our teaching Hospitals. The keynote speaker has often been Nobel Prize recipients or scientists of international distinction.

6. **Other Courses/Symposium**


7. **Visiting Professors**

The Division of Plastic Surgery, The Kentucky Society of Plastic Surgery, and The Louisville Surgical Society, closely related units such as Hand Surgery, sponsor several visiting professors and invited lecturers each year. Current and recent examples include the following:


In addition, the Department of Surgery and Louisville Surgical Society maintain active Visiting Professor Programs, including the annual Yandell lectureship. Many of these lectures are relevant to plastic surgery and the residents will be invited.
11. KEEPING THE PLASTIC SURGERY OPERATIVE LOG (PSOL)

In order for the Division Director to certify program completion and allow you to sit for your Board examinations, you must have gained sufficient clinical experience during your training. The current standard is to have performed enough procedures to be well above the minimum standards defined by the Residency Review Committee in all 12 PSOL categories (Section 4). PSOL documentation of cases performed is by current procedural terminology (CPT) coded and logged by each resident at least weekly, on both a personal record and on the ACGME website (www.acgme.org) designed for this purpose. You will be given a user I.D. and password to access your log. You are expected to have at least one quality procedure experience each weekday (M-F). A weekly confirmation that your PSOL is up-to-date with experience recorded each day must be confirmed with the Division’s Program Coordinator, and the quality of experience should be reviewed with the faculty member designated as the service supervisor on your rotation. Vacation approval, elective experience, and operative privileges may not be granted if the case logs are not up to date with daily entries. You are required to be up-to-date on operative logs prior to being allowed to participate in weekly clinical activities on Monday mornings or you will be subject to being placed on probation. Disciplinary actions may be invoked as described in Section 34. You cannot graduate from this training program unless your PSOL logs are completed and reflect an adequate volume and balance of operative experience in every category.

The PSOL documentation of your experience in residency has become of prime importance in confirming service to the University and its hospitals in maintaining resident salary lines, and in obtaining your hospital operative privileges after graduation, although these were not the original intent of the PSOL. Be sure that each and every one of your procedures are recorded. If procedures involving new technology (e.g., new lasers, new endoscope, etc.) are not on the document, record them under “other” and record the exact device (e.g., type of laser). Keep a copy of your PSOL for the purpose of credentialing after graduation, with a spare copy in a safe place. The ACGME will keep copies of your operative logs for a short time, but not permanently. The Division will not keep copies beyond your graduation. It is in your best interest for you to keep these records securely and permanently, as all hospital and other credentialing agency requests will be referred to you.
Instructions for the ACGME Resident Data Collection System are online at www.acgme.org.
12. BASIC SCIENCE EDUCATION AND RESEARCH EXPERIENCE

The University of Louisville Division of Plastic Surgery has a strong academic commitment to basic and clinical research. We maintain active basic science and clinical research programs that provides important experience to all residents. Both residents who are pursuing an academic career and those who plan a community practice need to understand the principles of scientific analysis and investigation in order to analyze literature and practice evidence-based medicine necessary for optimal patient care.

A. Participation in and reporting of original research is an important facet of this program, and we expect all residents to develop skills in experimental design, data analysis and scientific writing. The standard of care that you practice will be determined to a significant degree by published data and papers. It is essential to be able to critically evaluate scientific papers, to recognize quality versus junk or weak science, and to recognize therapies that are evidence-based. Whether or not your future career plans involve an academic position, this is an essential skill and a requirement for completing this residency.

B. Grand Rounds Reconstructive and General Competencies Conferences:
Presentations of research topics at least once each semester are included in these conferences.

C. An annual Basic Science Symposium, “Research!Louisville” is held each fall. This includes basic science courses, a nationally renowned keynote speaker, grant writing and project design seminars, and presentations of University of Louisville research projects.

D. It is required that each graduating senior will have published or have prepared for submission to a peer reviewed journal at least one article from work largely or completely done during the plastic surgery residency here and co-authored with a full-time clinical faculty member. Such publications can include a clinical series, chart review, or basic research from involvement with one of the many basic science studies underway in our laboratory at the Price Institute of Surgical Research, and the subject must be approved by the Program Director and the faculty. Make an appointment with a faculty member early in your program to begin this project. It
cannot be realistically accomplished in less than one year. The graduating resident does not necessarily need to be the first author on the publication, but he/she needs to perform a sufficient amount of the work and writing to allow authorship and he/she must write a draft of the manuscript. Failure to satisfy this requirement voids the senior resident the opportunity to attend a national meeting (Section 26) and the opportunity for an elective at the end of the senior year rotation. Failure to do this also may become grounds for not signing your residency completion certificate (Section 31) and subsequent ineligibility to sit for the American Board of Plastic Surgery certification examination. Being the primary author of a book, or a book chapter will satisfy the research requirement.

E. It is required that each resident present a paper, each year, at the annual meeting of the Kentucky Society of Plastic Surgery held each September. This may be the paper described in Section D, or another appropriate clinical or experimental report. Presenting a paper at this conference, and preparing it (or another paper) for submission to a peer-reviewed journal is one element of the prerequisites for the senior elective (Section 16) and the senior opportunity to attend a national meeting (Section 25) or the Program Director may not certify the resident to sit for the American Board of Plastic Surgery Examination.
13. ETHICS, HONESTY AND CONDUCT

A. Absolute honesty, integrity and professional conduct must be maintained in all professional situations and the highest standards of personal and professional ethics always upheld. Physicians are among the most trusted and respected of all members in our society, and this trust must be earned and maintained by each of us on an ongoing basis.

B. Courtesy, respect and professional conduct is expected in all interactions at all times. This standard must be maintained irrespective of the behavior of other parties. Aggravating behaviors is part of human nature and is occasionally encountered from patients or other professionals. You must discipline yourself to not be drawn into lessening your standards, irrespective of the level of aggravation.

C. Dress at work must be neat, professional and traditional at all times. White laboratory coats, with business shirts, ties and slacks (or equivalent dress for women) are acceptable substitutes for suits or conservative business jackets and slacks. For military residents, uniforms may be worn in appropriate settings, and the uniform protocols of your service apply. We do not observe “casual Fridays” or other breaches of professional dress or demeanor.
14. TEACHING RESPONSIBILITIES

This is a teaching service at all times. Residents are expected to teach medical students and rotating residents from other services in all activities whenever they are present. Involve them in all aspects of our educational program. Offer them technical opportunities, such as monitored suturing and wound care when appropriate, and offer them opportunities to develop analytical reasoning skills in patient care in the same manner used by the faculty in your education.
15. SERVICE ROTATION SCHEDULE

A. The service rotations are designed to provide the plastic surgery resident with a rich, comprehensive and balanced exposure to all areas of plastic and reconstructive surgery. The primary rotations are outlined in the Block Diagram of service rotations (Attachment 1) take place at the following institutions:

1. University of Louisville Hospital
2. Veterans Affairs Medical Center
3. Kosair Children’s Hospital
4. Norton Hospital
5. Jewish Hospital
6. Jewish Hospital East
7. Frazier Rehabilitation Center
8. Plastic and Aesthetic Center of Jewish Hospital
9. Plastic and Aesthetic Center of the Alliant Medical Pavilion
10. Outpatient Operating Suite of University Surgical Associates
11. Operating Suite at the Brown Cancer Center

These each offer a unique and valuable educational experience to the resident, and these facilities are considered to be the core facilities of the University of Louisville Plastic Surgery Resident Training Program. Most are in immediate proximity to the conference sites, libraries and educational services of the program.

B. The resident assigned to the service encompassing each of these sites must first cover the cases of his/her assigned service. To spend any time away from these hospitals, specific permission must be given by either the Program Director or the full-time academic faculty who have cases on that service that day. However, we strongly encourage requesting this permission for cases of strong educational value or critical PSOL need, wherever they might occur.
C. The service rotation schedule is designated to cluster the educational experience provided by our core facilities into blocks of a meaningful level of concentration for a meaningful length of time. The service rotation schedule (Attachment 1), and the educational goals of each rotation are described in Section 5. The first obligation of the plastic surgery residents is to significant cases of full-time academic faculty members of the Division, for assisting in surgical cases and supervised patient care. If a conflict occurs between educationally valuable cases of full-time academic faculty members or community faculty members, the conflict must be discussed at least 24-hours in advance in order to allow sufficient time for resolution or arranging alternative assistance if needed. This pertains to all situations including vacation time, any leave of absence, or if the resident wishes to perform a case with other divisions or with a member of the volunteer faculty. When there are conflicts in staffing cases, it is the responsibility of the chief administrative resident to resolve the issue. It is the administrative chief resident’s right to assign another resident to the full-time academic faculty case, if this is discussed with the full-time academic faculty member at least 24-hours ahead of time. If these policies are violated, the offending resident will be disciplined, including loss of permission to participate in cases of the volunteer faculty for the remaining duration of the rotation. Unexcused absence from cases of the academic full-time faculty, without approval for good educational reason, warrants disciplinary action and possible training termination as detailed in Section 34.

D. Each hospital has an assigned faculty supervisor, who is also responsible for the service rotation most closely associated with that hospital. These supervisors report to the Program Director. They are as follows:

1. University of Louisville Hospital and Clinics Service – **Dr. Larry Florman and Dr. Joshua Choo**

2. Adult Reconstruction – **Dr. Terry McCurry and Dr. Gordon Tobin**

3. Veterans Affairs Medical Center Hospital and Clinics/Adult Oncology – **Dr. Morton Kasdan**

4. Head and Neck Aesthetic and Reconstruction – **Dr. Jarrod Little**

5. Hand Service – **Dr. Bradon Wilhelmi**
6. Kosair Children’s Hospital/Pediatrics Plastic Surgery Service – Dr. Mark Chariker

Note: All cleft lip and palate cases must be attended by at least one resident. These operations are always performed at Kosair Children’s Hospital. It is the responsibility of the rotating resident to always check the schedule for these cases. If a senior resident is not up to date on the required number of these cases, then these cases will take priority over any other cases being performed in the program. Attendance at cleft cases takes priority over attending requirements or needs.

E. It should be understood that the plastic surgery service rotation continues until June 30 in the year of your graduation.
16. DUTY HOURS LIMITATIONS

The 80-hour work hour limits call structure and conditions recommended by the ACGME Plastic Surgery RRC Program Requirements and the University are observed.

A. **Resident duty hours** must not exceed 80 hours per week when averaged over 4 weeks, which is inclusive of all in-house call activities and moonlighting. “Duty hours” are defined as:
   1. Patient care (both inpatient and outpatient).
   2. Administrative duties related to patient care (i.e., dictation).
   3. In-house call activities.
   4. Academic activities (conferences).

B. **“Work site”** is defined as University Hospital, Jewish Hospital, Norton Hospital, VAMC, Jewish Hospital East, Frazier Rehabilitation Hospital, Norton Children’s Hospital, University of Louisville Clinics, all private offices.

C. Residents will be given 10 hours off for rest and personal activities between duty periods.

D. In-house call is not a requirement of the Plastic Surgery Residency Program with the exception of the Hand Service Rotation, and that will be no more frequent than every third night, averaged over a four-week period.

E. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 4 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics and maintain continuity of medical and surgical care. Residents will be released from duties by 1:00 pm the next day following in-house call. No new patients may be accepted by the resident after 24 hours on call.

F. Resident time spent in the hospital when on second call, reserved call or University call will be counted towards the 80 hours.
G. Residents will be given 1 day off out of 7 free of all educational, clinical and administrative activities, averaged over a four-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities. At-home call cannot be assigned on these days.

H. Residents will be verbally questioned in regards to their mental alertness whenever necessary. Residents will have access to on-call rooms during the day for resting as necessary especially during post-call periods. Any resident needing back-up support with post-call patient care responsibilities must contact the Program Director immediately.

Residents and faculty will be constantly on guard for signs of stress and fatigue and take appropriate action whenever needed.

I. The University of Louisville School of Medicine has instituted a “Cab Voucher System”, which is available to residents and on-call medical students, 24 hours a day. For details, go to: http://louisville.edu/medschool/gme/hsc_files/cabprogram.htm.

J. Monitoring
1. Random monitoring by the Program Director and Full Time Faculty will be performed.
2. Residents are required to complete the work duty log every week in MedHub. This will be checked weekly for completeness, timeliness and compliance.

All violations of the Duty Hour Policy must be immediately reported to the Program Director regardless of time or date.

A thorough explanation of these rules is available in the University of Louisville School of Medicine Resident Policies and Procedures Manual, Section VII.A, Pages 10-11.
17. CALL RESPONSIBILITY

A. During **weekdays**, from 06:00 to 16:00, the resident on each service will be responsible only for that service and its emergency room consults, intraoperative consults, floor calls and consults, and calls from resident or faculty patients of only that service, that are directed to the resident. The only exceptions to the day call responsibilities described in Section 15, above, are when covering for another resident and true emergencies requiring response from the most readily available resident, irrespective of rotation assignment. Each resident in the Division of Plastic Surgery is required to take night and weekend call based upon the monthly resident call schedule that is posted prior to the first day of each month.

B. **Night and weekend** call and work hours follow Department of Surgery Standards, as outlined in the current House Staff Manual.

C. The overall **attending and resident call schedule** is made monthly by the Program Director. The administrative chief resident assists by assigning first call, second call and chief resident on call, for each day (see below). Modifications to this call schedule may be made after the schedule is posted, if deemed necessary by the Program Director. Weekend call changes at 06:00 the morning of the call day and lasts for 24 hours. Weekday night call is from 16:00 to 06:00 the next morning. On night and weekend call, the first call resident will cover all teaching services, all consults to them and emergency rooms, all telephone calls. The second-call resident and chief resident on-call will be responsible and available for backing up the first-call resident with either physical and/or intellectual support. The second-call resident and chief resident on call will be available by pager and telephone contact at all times to provide this back-up support. Both resident and faculty monthly call schedules are published each month on-line and posted in the Division office.

D. Be reminded that all residents are acting under the auspices of the University of Louisville and University Surgical Associates, P.S.C., and the Plastic Surgery attending on call in particular. All night and weekend cases that the first-call resident sees in consultation in the Hospitals or
Emergency Rooms, Operating Rooms or Wards, will be presented initially to the senior-call resident. It is then the responsibility of either the first-call or the senior-call resident to present each case and all pertinent data pertaining to that case to the attending of record. This may be modified based upon the attending’s preference, which should be clearly determined at the beginning of each call period. (For example, some attendings will wish to be called by the first-call resident, while others may agree to let the senior-call resident make clinical decisions up to a pre-determined level.) Similarly, any patient phone calls that are not straight-forward and require more complex decision making, or that could significantly impact upon a patient’s care should be presented to the senior-call resident. The need to contact the attending in this situation will be determined by the senior-call resident, acting on attending guidelines.

Outpatient cases at Kosair Children’s Hospital (KCH) Emergency Room will be discussed directly with the KCH medical staff member on-call that month who has been assigned responsibility for the patient by the KCH call schedule rotation. Admissions by the University faculty to KCH (from ER or direct) and inpatient consults are to be discussed with the faculty attending on call. Similarly, other affiliated hospitals, University faculty cases and referrals will be discussed directly with the responsible attending. Failure to meet call responsibilities may result in disciplinary actions or dismissal, as described in Section 34.

E. First call may be taken from home, if responses are prompt and conscientious. An in-house call room is available if convenient for the resident on any specific night. All prior consults and obligations must be met promptly, thoroughly, and courteously, both during work hours and while on night call.

F. All admissions to the plastic surgery service must be approved by the attending plastic surgeon, as residents do not have independent admitting privileges. Failure to obtain attending approval of an admission, transfer or a treatment plan will leave the resident legally liable for any complications, mismanagement, or malpractice action that ensues. This will also constitute grounds for disciplinary action or dismissal, as described in Section 34.
G. The first-call resident’s primary responsibility is to see the Emergency Department consultations, ward consultations and patient care calls of the University Plastic Surgery Services at the University of Louisville Hospital, Veterans Affairs Medical Center (VAMC), Norton HealthCare Hospitals (Norton, Kosair Children’s, Alliant Medical Pavilion and the Norton HealthCare affiliates), Jewish Hospital and Frazier Rehabilitation Center. However, based upon the request of the full-time faculty, the first-call resident may be asked to see patients at other emergency departments or hospitals with which the University of Louisville Plastic Surgery full-time faculty are affiliated. Currently, we take no ER calls at hospitals other than those listed above, but we do receive occasional consultation requests.

H. Calls originating from any of the aforementioned emergency departments or hospitals for consults directed toward volunteer faculty or community surgeons on an affiliated medical staff will be handled as follows:

1. Based upon the learning value and complexity of the case the resident may assist in the case as an agent under the supervision of the community surgeon responsible for the patient’s care. The primary responsibility for care of these patients cannot be transferred from the responsible community surgeon to the resident under any circumstances, although the resident may perform minor outpatient procedures (e.g., lacerations, abrasions, minor burn care, etc.) for the community surgeon under his/her supervision and responsibility and send the patient for follow-up to the community surgeon’s office or admit the patient to the community surgeon’s service. If a volunteer faculty member who is an active teacher in the program specifically requests the on-call resident’s assistance with a case, and the on-call resident is not engaged in another case, every effort should be made to accommodate that request. The on-call resident should not, however, be excessively burdened with time-consuming cases of marginal or no educational value. If the resident feels that he/she is being taken advantage of in this process, the Program Director and the full-time faculty should be informed, he will instruct the responsible volunteer faculty member in proper protocol.
2. Consults originating from the affiliated emergency departments (such as Kosair Children’s) when a community volunteer faculty member or is on call will be covered by the on-call resident only for actively teaching volunteer faculty and only on days (currently every third) when the University of Louisville Hospital Plastic Surgery team is on maxillofacial trauma call. During months when the Plastic Surgery full-time attendings are on call at any of the UofL affiliated hospitals, the on-call resident will cover consults and admissions to the full-time faculty members at all times, irrespective of the UofL Hospital 3-day rotation maxillofacial trauma call schedule.

3. Plastic surgery residents do not have independent practice or admitting privileges, therefore, they are not allowed to admit, accept transfer from another institution, nor treat any patient at any hospital without the expressed authorization of the attending or staff surgeon responsible for the patient. At UofL Hospital and VAMC, this is the full-time faculty. At other affiliated hospitals, these actions must be authorized by the fully licensed staff plastic surgeon that is responsible for the specific case and recorded in the patient’s medical records. These actions or any other care can be done only on behalf of the staff surgeon. Taking independent action to accept an admission, treat a patient or see a consult without appropriate authorization by the staff surgeon exposes the resident to liability and is forbidden. This constitutes grounds for disciplinary action and possible dismissal, as described in Section 33. In the event that you are asked to assume responsibility for a patient without prior staff authorization and chart documentation, courteously refer the request to the appropriate surgeon on call at that hospital, or to the service on call if a rotating schedule is in effect, but do not assume independent responsibility or give any impression that you are permitted to do so.
18. FACULTY SUPERVISION AND RESIDENT OPERATING ROOM STAFFING

A. The following resident supervision guidelines are designed to provide graded, surgical responsibility with a maximum rate of conceptual, judgmental and technical growth while simultaneously providing the highest quality of patient care, and compliance with supervision standards of our hospitals, the University and all accrediting bodies. These supervisory responsibilities apply to all of our teaching hospitals.

B. The faculty is ultimately responsible for all patient care, and the residents provide care only under faculty supervision. Residents are given progressive graded responsibility, but always with accountability to the responsible faculty. As described in Sections 1, 2 and 3, however, the resident must be fully intellectually accountable for a complete analysis and solution of the medical problem(s). This includes: (1) an evaluation sequence leading to an accurate diagnosis or an accurate analysis of a defect, (2) design of an appropriate solution (including non-surgical treatment when indicated) and (3) articulation of the hierarchy of options with a well-supported rationale for their ranking. This analysis should always be done first, and should always be presented to the faculty. The attending should only then give the appropriate feedback and critique of the plan (including probing questions) refinements, other options that merit consideration, references, approval and ultimately supervised implementation. Further discussions should cover avoidance of complications and plans for follow-up. This interactive process is at the heart of our program to maximize conceptual and judgmental growth. This step should be observed at all levels of resident experience, even very early in the program when the resident has incomplete knowledge of many clinical conditions. Ultimately the faculty must be available and present for at least the key portion of the procedure.

RESPONSIBILITIES OF THE RESIDENT

1. It is the responsibility of the resident to communicate about every patient that they see in the course of their duties with an attending physician.

2. If the resident feels they do not have the appropriate level of faculty supervision, they - 64 -
are to immediately contact the Program Director. If the Program Director is not available then the resident can contact the next in line attending on call and back up call resident.

3. It is the responsibility of the resident to communicate with the attending physician about both inpatients and outpatients referred and/or seen by our service.

4. It is the responsibility of the resident to discuss acceptance of new patients to the service with the appropriate attending physician.

5. It is the responsibility of the resident on-call in the evenings, on weekends, and on holidays to notify the attending physician of any new patients seen, and to communicate and/or round with the attending physician(s) on call.

6. It is the responsibility of the resident to notify the appropriate attending physician of any and all patients going to the operating room.

7. It is the responsibility of the resident to notify the attending physician of any changes in the patient’s status.

8. It is the responsibility of each resident to monitor their own Duty Hours thereby assuring the duty hours limitations are not exceeded. When there is about to be a Duty Hour violation, the resident is to immediately request that another resident take his/her place. If this is not possible, then the Program Director must be immediately contacted.

9. We frequently have medical student rotating on our service. The plastic surgery residents are the primary teachers of these medical students. It is the responsibility of the resident to proctor, and even mentor, the students. The resident is also responsible for the behavior, professionalism, supervision, and education of the
medical students.

**RESPONSIBILITIES OF THE FACULTY (ATTENDING PHYSICIANS)**

1. It is the responsibility of the attending faculty member of each clinic and service to communicate with the resident staff regarding all inpatient and outpatient aspects of patient care.

2. It is the responsibility of the attending faculty member assigned to rotations / clinics to be available for discussion and examination of patients encountered by the resident staff.

3. It is the responsibility of the attending faculty member to be available by phone or beeper during the normal hours of operation. If a given attending will be unavailable to the residents for any prescribed period of time (i.e. vacation), that attending must have signed out to another responsible faculty member and notified the Program Director.

4. It is the responsibility of the attending faculty member who is on-call to discuss and see patients with the resident staff during his/her call period. This means that the resident will have full access to the on-call faculty member by personal interaction, telephone, and beeper during the call period.

5. It is the responsibility of the attending faculty member to post an accurate call schedule such that the resident staff and hospital partners are aware of who is the attending faculty on call at all times.

6. It is the responsibility of all faculty members to be aware of the signs and symptoms of stress and fatigue among the residents, and to immediately notify the Program Director.
RESPONSIBILITIES OF THE PROGRAM DIRECTOR

1. It is the responsibility of the Program Director to communicate to the residents at orientation and reiterate throughout the academic year that they must discuss clinical care of all patients with the attending staff.

2. It is the responsibility of the Program Director to communicate with the faculty that it is the faculty who is ultimately responsible for all clinical care.

3. It is the responsibility of the Program Director to make certain that the faculty call schedule provides an opportunity for 24 hour, seven days per week supervision of resident clinical activity.

4. It is the responsibility of the Program Director to make certain sufficient faculty are available for staffing purposes of all inpatient and outpatient clinical activities involving resident staff.

5. It is the responsibility of the Program Director to be aware of all issues concerning resident stress and fatigue, and to assure that the resident is directed for appropriate care of these issues.
C. The level of technical responsibility given to the resident will progress sequentially as determined by the growth of technical skill:

1. Residents will first learn the key elements of new procedures as an observing assistant.
2. The key portions are then progressively turned over to the residents as their ability permits, with supervision by the attending as a teaching first assistant.
3. In selected procedures, practice in the fresh cadaver lab may be helpful.
4. Next, the resident assumes the role of surgeon for the entire procedure, with the faculty member observing or serving as a teaching first assistant only as required by the level of complexity or by compliance regulations.
5. As resident skill further improves, the resident care progresses to full independence in selected teaching settings such as University Hospital, with the attending always readily available for consultation or assistance.

D. When properly informed of scheduling, it will be the attending’s responsibility to be physically present in the operating room at the key points of appropriate cases for both supervision and education. The faculty members will also hand-write a note in the chart or complete a UofL attestation form. This type of presence and documentation is required by Medicare compliance, hospital protocol or reimbursement criteria. The same presence and documentation applies for procedures performed in the emergency room or hospital ward, and for consultations and history and physicals (H&Ps) that require physical presence and documentation for compliance or reimbursement. In the University Hospital operating room, the faculty attestation form fulfills the requirement of a hand written note by faculty.

E. Surgery residents at the UofL Hospital and the Louisville VAMC (but not at other affiliated hospitals) are allowed to perform certain cases in the operating room under attending supervision and availability, but without the physical presence of an attending in the operating room. However, a plastic surgery resident cannot take any patient to the operating room without previously discussing the case and formulating an operative and management plan with the attending of record and approved by him. No operation can be
done without previous consultation and notification of scheduling with the attending. The attending must be made aware that an operation is to be scheduled and exactly when. Failure to do so will leave the resident legally liable for any potential complications, mismanagement or malpractice that may ensue from such treatment. This may also constitute grounds for disciplinary action and possible dismissal from the University of Louisville Plastic Surgery Resident Training Program, as described in Section 34.
19. CHIEF RESIDENT RESPONSIBILITIES

A. At any given time, one of the two senior residents will serve as Administrative Chief Resident. The senior resident, who is responsible for the UofL Hospital, either primarily or as the main back-up support to a junior for the quarter, will be designated as the Administrative Chief Resident or will carry out the duties associated with this administrative position as follows:

1. He/She will be responsible for making the monthly on-call schedule and submitting it at least ten (10) days prior to the start of the month to the residency coordinator for posting on the website, or by transmittal via email.

2. He/She will insure that cases are adequately covered and the educational opportunities best used at the affiliated hospitals. The chief resident is not expected to review the operative schedule at every hospital on a daily basis. However, if a conflict arises, the chief resident is responsible to correct the problem to the best of his/her ability. Consultation with the designated attending supervisor of the hospital service is available, if needed.

3. The resident designated as Chief at University of Louisville Hospital will be responsible for the preparation and the presentation quality of all walk rounds. This includes making certain that any relevant data needed, such as radiographs or prior records are available near the bedside, and to insure that concise and polished formal presentation of the cases are made in the traditional format and style.

B. When not serving as Administrative Chief Resident, the other senior resident will serve as Education Officer, whose duties are as follows:

1. He/She will be responsible for organizing the Grand Rounds speaker schedule and for organizing the format along the guidelines of the 12 RRC mandated topics. Each month will be assigned to one of the RRC mandated topics (unless a separate conference is dedicated to that field). Also, medical legal, ethics, practice
management and basic science topics will be each included at least once each semester as a Grand Rounds or General Competencies Conferences topic.

2. He/She will be responsible for collecting attendance sign-in sheets and distributing CME evaluation forms at all conferences and rounds. This may be delegated to a designated junior resident, with faculty approval.

3. He/She will be responsible for organizing bedside teaching rounds whenever scheduled, for making certain that each of the other residents will also have cases to present at Indications Conference and Core Plan, and that Quality Improvement and Morbidity Analysis Conference presentations are organized and timely (Section 6).

4. He/She will be responsible for organizing the Journal Club, as detailed in Section 6:11.
20. THE MEDICAL RECORD

A. Medical records must be kept accurate, current and neat. Written records and signatures must be **highly** legible. If your signature is not **clearly and easily** readable to our nurses, you must print your name beside it. Also, you must add your pager number to the chart of each patient under your care, and to all admission and postoperative orders. All abbreviations must comply with those approved by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the participating hospitals.

B. The resident will perform the operative dictation at University Hospital and the VAMC. Some attendings prefer to do the majority of their operative dictations at the Norton and Jewish Hospitals, so clarify this individually. Who is to dictate the operative report and write orders should be clearly decided immediately at or before the completion of the case. All dictations should be done on the day of the procedure, and immediately after the case is completed.

C. The resident is responsible for dictating all H&Ps, consults, discharge summaries and operative notes, unless otherwise instructed. The attending will write a consultation note and a brief operative note in the chart unless otherwise arranged.

D. For uniformity, the Medicare (HCFA) format for encounters (H&Ps, consultations, and discharge summaries) is used for all patients. This includes the exact elements of the subunits (e.g., chief complaint, referring M.D., history of present illness, past medical and surgical history, review of systems, family/social history the items to be documented on the sections of the physical exam, lab diagnosis and recommended plan.

E. A preoperative note is to be written on all patients the night before surgery, after giving informed consent. This should document the discussion of the condition, the treatment offered and recommended, the risks of the offered treatment and alternative treatments (including no treatment) the goals of each, limitations of each, and the patient’s decision to
accept or reject the offered treatment. The patient’s status with respect to laboratory work, insulin use, anticoagulant use, and NPO status should be reviewed.
21. MEDICAL RECORD DOCUMENTATION FOR MEDICARE COMPLIANCE

A. Specific documentation guidelines must be followed for the medical records of Medicare and Medicaid patients (Supplemental Reference Manual, UofL Compliance Office Handbook). These guidelines will probably soon apply to all other records.

All history and physicals (for consults, admissions and office visits) must include:

1. A **Chief Complaint** (one sentence describing the main reason for consultation, admission or evaluation).
2. The **service or referring physician and reason** for the opinion requested must be stated.
3. Documentation must include a **History of Present Illness (HPI)**, which should include all features and associated events of the condition.
4. The **Review of Systems** must systematically cover the standard systems.
5. The **Past Medical/Surgical History PM/SH** must include a surgical history, a medical history, medication allergy section, and a medication listing.
6. A **Family History and Social History (F/SH)** should be included.
7. The **physical examination** should cover all systems, but focus in detail on the area responsible for the consultation, and significant positive findings. The physical should also include, and specifically list, a general status report, vital signs, a brief examination of the head, eyes, ENT, neck, heart, chest, breasts, lungs, abdomen, each of four extremities and pelvis/genitalia/rectum (if these exams are appropriate).

B. The University of Louisville Compliance Office annually conducts compliance courses and distributes a comprehensive compliance manual (Medicare Documentation and Billing Guidelines, Supplemental Reference, #8) and pocket reminder cards. Each resident must attend the compliance course and maintain the manual and cards. If lost, replacements are
available from the UofL Compliance office.

C. It is the responsibility of the resident to determine and inform the faculty member whether or not a patient is a Medicare or Medicaid patient. This will allow both the resident and the faculty member to provide the appropriate level of presence and written documentation required for compliance on the patient’s chart.

D. All residents must complete medical records in a timely manner for the entire length of their training or may not be eligible to sit for American Board of Plastic Surgery Examination.
22. ACCURATE BILLING PROTOCOL

A. Billing for operative procedures, consultations, and admissions done at Norton, Jewish, and Kosair Children’s Hospitals is the responsibility of the attending surgeons. At University Hospital, all operations, new patient evaluations, H&Ps, consultations and ward, or ER procedures must be documented in the medical record and reported by the plastic surgery resident using the current yellow card system. These yellow cards must be submitted to the Division secretary on a daily basis each morning. The cards must be filled out completely to allow our billing personnel to submit the appropriate charges in an efficient and timely manner. Required data includes the attending of record, the patient’s name and hospital number, and the procedure performed with appropriate CPT language or code and appropriate clinical detail to allow for adequate coding and billing. For example, laceration repair should cite the number of centimeters closed, locations of the laceration, and whether or not it was a simple, closed in one layer, intermediate (multiple layers) or complex (with debridement and/or advancement repair). Skin flaps and skin grafts are described in square centimeter of area. These billing protocols serve two main purposes: (1) to fully return appropriate compensations for the services rendered; and (2) to familiarize residents with proper billing procedures. In your future practices, each of you will be highly dependent upon complete knowledge of the proper coding and billing process. Lack of knowledge, unintended errors, or inadequate documentation of services rendered may subject you to severe penalties for fraud, irrespective of intent. It is in your best interest to now learn how to do this accurately and with precise documentation.

B. Residents not yet thoroughly familiar with CPT coding should become so. This will be the language of communication with third party payers for your practice lifetimes. Each resident must have access to a current CPT manual and one will be made available to you (Supplemental Reference Manual, #7).
DEFINITIONS:

Transition of Care

Transition of care is defined as when a physician transfers the care of a patient to another physician. This includes sign-out as well as sign-in. It also includes the transfer of a patient from one level of care to another, e.g. transfer of a patient from the wards to the ICU or vice versa. By definition, transition of care also occurs when a physician transfers the care of a patient at the end of a rotation and a new physician assumes the care of the patients on that service.

Proper Hand-Over of Patients

The proper hand-over of patients should include at least the following. The exiting physician must notify the attending and co-resident(s) who will be responsible for patient care that they will be leaving. The exiting physician must give a proper verbal checkout which includes the patient’s active problems, advanced directives, diagnostic tests pending, current medications, and the diagnostic and therapeutic plan. The exiting physician should also attempt to anticipate any events that may occur with his or her patient in their absence and give the best course of action. The exiting physician should also make aware any orders that have been or need to be placed. This should all be done face-to-face to ensure accuracy and proper evaluation of the exiting physician’s checkout to ensure patient care and safety as well as improving resident education.

RATIONALE:

Effective communication is vital to safe and effective patient care. Many errors are related to ineffective communication at the time of transition of care. In order to provide consistently excellent care, it is vitally important that we communicate with one another consistently and effectively when the care of a patient is handed off from one physician to another. This policy is meant to define the expected process involved in transition of care, and applies to each of our teaching sites where we provide inpatient and outpatient care.
All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient’s care to another qualified and rested provider. It is also essential for residents and faculty members to do so by abiding by current duty hour policy.

**SPECIFICATIONS:**

I. **Service Schedules**
   
   A. It is the duty of the Plastic Surgery Chief Resident to determine the call schedule at least 1 month prior to the start of the rotation and for this information to be updated at the University of Louisville Hospital Switchboard. It will also be transmitted to each faculty member and resident via email.

   B. It is the duty of the Program Chairman to determine the call schedule for the faculty at least one month in advance. This information will be updated monthly at the University of Louisville Hospital Switchboard and posted on the Division’s bulletin board. It will also be transmitted to each faculty member and resident via email.

   C. All vacations and times away from duties will be reported to the Program Coordinator who will inform the faculty and residents via email.

   D. All residents take call from home. When called into the hospital, the 80-hour Duty Policies will be strictly adhered to.

   E. With the exception of vacations and illness, all residents will be available for discussions of patients with the on-call resident.

II. **On-Call Principles**

   A. There are presently 6 residents at the PGY-6, PGY-7, or PGY-8 level.
B. Each night the residents will sign out to the on call resident and transfer care of the patients to the on call resident until 6:00 AM the next morning.

C. The hand-off will occur either in person or by telephone. This should not be by text message or email. A list of patients on all services must be transmitted by email or text message.

D. Hand-over information should include the following:
   1. Patient location (e.g. Bed # and Institution #).
   2. Active problems, including ongoing management plans.
   3. Tasks requiring completion or results/findings requiring follow-up.
   4. “Watch out for…”
   5. Emphasis must be given to critically ill or unstable patients.

III. End of Rotation/Off Service

A. On completion of an inpatient rotation, the resident physician must communicate with the resident physician that is coming on service to assume the care of his or her patients. This will ensure that each patient on the service continues to receive continuous, high quality care without interruption.

B. Communication must include an off-service note written by the resident rotating off service. The off-service note must briefly summarize the patient’s course to date, and include any active problems, advanced directives, diagnostic tests pending, current medications, and the diagnostic and therapeutic plan.

C. Communication should also include a face-to-face hand off that provides an opportunity to discuss each patient and allow questions and clarification of any issues. If for some compelling reason this is not possible, then the residents should at least review the list of patients over the telephone and a patient list must be left by the resident rotating off service for the incoming resident in a prearranged location.
IV. Resident Evaluation

A. Residents will be verbally evaluated via in person or by telephone on his or her transfer skills by the attending(s) and/or the senior co-residents weekly unless otherwise specified above.

B. A question will be added to the quarterly evaluations from attending and for peer evaluations to comment about resident’s “transfer of care” performance.
24. HIPAA COMPLIANCE

(Excerpted from “Portable Surgical Mentors,” Larry D. Florman, M.D., Springer-Verlag, 2007)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was instituted in the United States to ensure the protection of individuals’ health information while also allowing communication between parties involved with patient care. It was not until 1999, however, when the U.S. Department of Health and Human Services developed the Privacy Rule that made implementation of HIPAA mandatory. Effective April 2003, organizations (i.e., “covered entities”) subject to HIPAA regulations were required to comply with patient information protection policies. “Covered entities” refers to health plans, healthcare providers, and health care clearinghouses.

Required disclosures of identifiable individual health information include a request by a patient for his/her information or a request by the U.S. Department of Health and Human Services in special instances, such as a review. The privacy rule outlines six permitted disclosures of individual health information, including the following:

1. Per request of the patient.
2. For treatment, payment, and healthcare operations.
3. To individuals identified by the patient, who may be informed; in emergency situations, the healthcare provider must use his/her professional judgment to determine the best interest of the patient.
4. Incidental disclosure.
5. Limited data set with the removal of certain individual identifiers.
6. Public interest, which encompasses disclosures required by law; public health activities; abuse, neglect, and domestic violence; health oversight activities; judicial and administrative proceedings; law enforcement purposes; decedents; cadaver organ and tissue donation; research with permission of governing body, such as Institutional Review Board; threat to health or society; essential government functions; workers compensation.
State governments reserve the right to have supplemental policies to further increase patient privacy protection. Check with your institution to determine additional policies and guidelines.

In short, treat identifiable health information as patient property. Be careful how, where, and to whom you discuss and distribute patient information. Protection of patient privacy rights is required by law.

Suggestions for HIPAA Compliance

- Be aware of your surroundings. Do not discuss patients in public places such as elevators, waiting rooms, public hallways, and lobbies.

- Dispose of identifiable health information, such as patient lists, in the appropriate manner. Most hospitals have labeled containers for material that is to be shredded.

- Do not publicly display patient information. This includes both in hospitals and outpatient clinics (i.e., do not leave patients charts unattended).

- When discussing scenarios or presenting a case to individuals not directly involved in the care of a patient, do not disclose identifiable patient information.

- Do not identify patients over the internet.
HIPAA AT A GLACE

What is HIPAA?

- Governs the use and disclosure of protected health information (PHI) that is created or received by a covered entity that relates to:
  1. The physical or mental health of an individual (living or deceased).
  2. The provision of health care.
  3. The payment for health care.
  4. Identifies the individual or reasonably may be used to identify the individual.

- Gives individuals the following rights. The right to…
  1. Request restrictions on use or disclosure of their personal health information.
  2. Access medical records (including research records).
  3. Amend medical records.
  4. An accounting of disclosure of their personal health information.
  5. Request alternate confidential communications.
  6. Lodge complaint with covered entity and/or the Department for Health and Human Services.

- Administrative requirements. The covered entity must…
  1. Designate a privacy official.
  2. Develop policies and procedures that are HIPAA compliant.
  3. Provide privacy training to the workforce.
  4. Implement administrative, technical, and physical safeguards to protect the privacy of personal health information.
  5. Develop sanctions for violations of the HIPAA Privacy Rule.
  6. Meet the documentation requirements.
• Enforcement / penalties (individual, not institutional)
  1. Civil penalties
     • $100 for each violation, up to $25,000/person/year.
     • Liability exists if a person knew, or reasonably should have known, of a violation and did not try to rectify the situation.
  2. Criminal penalties
     • Knowing
       o Up to $50,000/year and/or imprisonment of up to 1 year
     • False pretenses
       o Up to $100,000/year and/or imprisonment of up to 5 years
     • Intent to sell, transfer, or use for commercial advantage, personal gain or malicious harm
       o Up to $250,000/year and/or imprisonment of up to 10 years

• Impact on researchers
  1. Recruitment of subjects
  2. If a subject refuses to authorize the use and disclosure of public health information, the individual cannot participate in the research study
  3. Accounting for disclosures
  4. Preparatory to research
     • Waiver of authorization
     • Decedent data

• Allowable uses and disclosures of PHI for research
  1. Authorization from subject
  2. Waiver of authorization from IRB
  3. Use of de-identified data
  4. Use of limited data set
  5. Preparatory to research
6. Decedent data

It is obvious that HIPAA has necessitated a whole new nomenclature for physicians, all individuals in the health care industry, and certainly for the patients who are protected by it. Interestingly, HIPAA is nothing new to physicians. In 400 B.C.E. Hippocrates, acclaimed as the father of medicine, proclaimed in his oath that we should uphold the privacy of our patients.
25. TIME OFF POLICY

Bereavement, Maternity Leave/ Paternity Leave, Job/Fellowship Interviewing, Scientific Meeting, etc.

Time off, in addition to regularly scheduled days off, and approved vacation time, may be granted at the discretion of the Program Director or the Associate Program Director for a variety of reasons. These reasons include bereavement, maternity leave/paternity leave, job/fellowship interviewing, attendance at a scientific meeting, etc. In addition, there may be other extenuating reasons that a resident would request additional time off during the course of their training. The Resident Time-Off Request Form is mandatory to be filled out for this time and leave to be approved. The form is available from the Plastic Surgery Resident Coordinator or on MedHub. All important elements of this form must be completed in order for a time off request to be approved.

It is the resident’s responsibility to arrange coverage for their duties during their absences, as well as notification of the attending physician responsible for the educational site at which they are rotating. Those faculty include, Drs. Wilhelmi, Florman, and Choo (ULH), Dr. Kasdan (VAMC), Dr. Little (NH, NKC), and Drs. McCurry or Dr. Tobin (JH). Depending on the timing, the service, and the resident’s specific duties, additional faculty may require notification to ensure the smooth flow of patient care responsibilities. The Resident Time-Off Request Form must be signed by the Program Director or Associate Program Director before the time off request is approved and valid. These forms will be maintained in the Residency Coordinator’s office and in the resident’s file as a permanent record of time off during the residency training program.

As the rotations in the ancillary services (i.e. Anesthesiology, Oral-maxillofacial Surgery, Dermatology, etc) are relatively short, no time off for any reasons will be given. Vacation time is not to be taken during these rotations.

Time off is readily granted when a resident is presenting a paper at a scientific meeting, but also needs to be approved. Time off is typically granted for fellowship and job interviews, but this must be approved and will be limited to 7-10 working days during the course of the year.
Additional time off for interviewing may require the use of the resident’s allotted vacation time. Extended periods of time off for medical leave and maternity/paternity leave may also be necessary and require approval by the Program Director and subsequent notification of the University’s GME office depending on the length of time and nature of the request. Additional training time may be required by the American Board of Plastic Surgery. Please refer to the Medical Leave and Maternity/Paternity Policy for additional details.

**Vacation Time**

A. The residents in the University of Louisville Plastic Surgery Resident Training Program are entitled to 10 (ten) days of vacation annually. Prior approval for any vacation or leave must be requested by submitting both the Resident Time-Off Request Form and a verbal notification to the Division’s Program Director at least six weeks prior to the beginning date of absence. The form must be signed first by the covering resident, and then by the Program Director. Unauthorized absences will result in loss of subsequent vacation time and disciplinary measures, as described in Section 34.

B. An additional leave of 10 weekdays is available for residents who qualify for attendance at a national meeting (Section 26), for interviews, and foreign volunteer surgical missions (Section 27). These 10 days are at the discretion of the Division Director. Interviews must be verified in writing, to include who and where the interview is with, and submitted six (6) weeks prior to date of absence to the Division Program Director.

C. Vacations and absences taken during the hand rotation must be pre-approved by both the hand service attending and the Program Director.

D. Vacations, leave, or interviews may not be taken during the months of June and July, as these are both periods of resident transition and heavy clinical loads. Time off is also discouraged around UofL’s Winter Break, and potential days off during this time will be
arranged by the Program Director. Any urgent matters requiring leave during this time require a letter of explanation to be countersigned by the Program Director.

E. No more than one week of absence during the three-year training period is allowed from the UofL Hospital Chief rotation, and none between June 15, and September 15 due to trauma coverage responsibilities.

F. Only one resident can be absent at any given time, be it for vacation, leave, microsurgery lab training, or any other cause. Consult with each other well ahead of vacation plans to prevent overlap.
26. NATIONAL MEETING ATTENDANCE

A. Junior and senior residents may travel to one (1) approved national ASPS, ASPS sponsored, AAAPS or Senior Residence conference. Travel expenses must be individually arranged from pharmaceutical companies or other outside sponsors according to UofL travel guidelines (up to $1000 as of 2007). From time to time, limited Division funds may be available. Registration, airfare, hotel accommodations, and meals up to the allowable per diem are included in this limitation. Resident surgeon fees from aesthetic patients may, within certain limits, be used for these activities. However, $1000 is the absolute limit of these contributions. All expenses in excess of $1000 must be borne by the resident. The time for these conferences will not be counted against vacation, but it is limited to the length of the conference plus one-day travel time on each end and, must not exceed eight days total. The resident must notify the Program Director and the faculty in time to submit early ASPS registration and receive the early ASPS registration discount and obtain low airfares for the chosen meeting. For the ASPS, early registration usually closes in late July. A preliminary draft of the paper described in Section 10 must be turned in to the Program Director by senior residents. If the Senior Residents Conference is chosen, the registration date is in January. An abstract for presentation at the meeting must be submitted and an advanced draft of the paper described in Section 12 must be submitted to the Program Director. Also, the resident must have fulfilled the following criteria:

1. The resident must have demonstrated satisfactory clinical performance as determined in his/her written evaluations.
2. The resident must have exceeded the 30th percentile in all categories of the annual Plastic Surgery In-Service Training Examination.
3. Senior residents must have exceeded the RRC minimal required experience in all categories on the Plastic Surgery Operative Log (PSOL).
4. The resident must have given, or be prepared to give, the KSPS presentation.
27. OVERSEAS HUMANITARIAN MISSIONS

An extra week of leave will be provided to allow senior residents to participate in travel abroad for approved humanitarian activities in the field of cleft lip and palate or craniofacial surgery. This trip will be at your own expense or with travel covered by contributions arranged from pharmaceutical or equipment supply companies. In the past few years, this time has been used to travel with operation HOPE to the Philippines with Dr. Rigor from the UofL Department of Anesthesiology. Permission for this trip is dependent upon the satisfactory accumulation of PSOL cases as detailed in Section 5, upon satisfactory overall performance, and the senior presentation at KSPS, with preparation of a paper for peer reviewed journal submission. Contact the Program Director to obtain essential information needed for this opportunity. A certain amount of funding may be available for this activity, keeping in mind that all expenses in excess of $1000 must be paid by the resident.
28. OUTSIDE EMPLOYMENT

1. The Plastic Surgery Program subscribes full to the “Policy on Resident Moonlighting,” as established and revised by the Graduate Medical Education Committee of the University of Louisville School of Medicine.

2. The Plastic Surgery Program does not require residents to participate in outside employment activities (moonlighting). A resident may engage in moonlighting to a limited extent in their junior or senior years. This privilege may be withdrawn or denied at any time by the Department Chair, or the Program Director. The Program Director is required to monitor and approve in writing all moonlighting hours and locations for residents and maintain this information in the resident’s file.

3. Moonlighting must be done outside of the usual time where the resident would be expected to be present in the hospital or clinic on a particular service. Chief Residents on the service must have signed out to an equivalent level resident to cover during the moonlighting period. Moonlighting internally at University Hospital, Norton Healthcare, Jewish Hospital, or the Veteran’s Affairs Medical Center is strictly prohibited.

4. The time that residents spend Moonlighting must be counted toward the 80-hour Maximum Weekly Hour Limit. The time that residents spend Moonlighting must also be logged into MedHub.

5. Resident physicians who hold either a Regular or Residency Training (RT) license in the State of Kentucky shall be free to use off-duty hours in appropriate related activities, including engaging in outside employment activities, so long as the resident obtains the prior approval of the Division Chief/Program Director for such outside employment activities, and so long as such activities do not interfere with the resident’s obligations to the University, impair the effectiveness of the educational program engaged in, or cause detriment to the service and reputation of the hospital to which the resident is assigned.
Institutional Practice (IP) and Fellowship Training (FT) licenses are valid only for duties associated with the training program for which the license are issued, and do not cover outside employment activities.

6. The Division, Department, and University do not provide professional liability insurance or any other insurance coverage for resident off-duty activities of employment, and assumes no liability or responsibility for such activities or employment. Confirmation of professional liability insurance for resident off-duty activities or employment will be the responsibility of the moonlighting employer.

7. Resident physicians who hold J-1 visas are not permitted to engage in activities or have additional income other than what is listed on their forms DS2019. Federal regulations specifically prohibit outside or additional income for individuals with J-1 visas.

8. Resident’s must inform the Program Director in Plastic Surgery of their intent to moonlight, and must sign our Moonlighting form. They must provide the location and frequency of moonlighting or any subsequent additions, deletions, or changes in moonlighting activity prior to initiating such activity. This Moonlighting form must be signed by both the Program Director and the resident, and will be kept in the resident’s file.

Residents who choose not to moonlight must sign our Moonlighting statement indicating they plan to not moonlight. If they choose later to moonlight, this can be reconsidered at the discretion of the Program Director. This Moonlighting form must be signed by both the Program Coordinator and the resident, and will be kept in the resident’s file.

9. The Program Director will have authority to approve, disapprove, and enforce this policy.

10. The Program Director will monitor the impact the resident’s moonlighting activity to assure that the activity does not contribute to excess fatigue or is detrimental to the resident’s educational performance. Such findings of excess fatigue or adverse effect on educational
performance are grounds for immediate disapproval and termination of moonlighting privileges.

11. Residents are not to represent themselves to moonlight employers as being fully trained in their specialty. Further, residents who moonlight are not to present themselves as agents of the University of Louisville during moonlighting activities. University lab coats, name badges, and identification cards are not to be worn outside of the resident’s training program activities. It is the resident’s responsibility to assure the billing procedures of the moonlighting employer are conducted in an ethical and legal manner.

Please refer to the written policies on this matter for both the Department of Surgery as well as the School of Medicine (Appendix 3-4). Residents who violate the policies will be subject to disciplinary action as detailed in the University of Louisville, School of Medicine House Staff Agreement.

Policy Updated: 06/25/2014

The following has been extracted from the University of Louisville School of Medicine Resident Policies and Procedures Manual:

POLICY ON RESIDENT MOONLIGHTING
UNIVERSITY OF LOUISVILLE SCHOOL OF MEDICINE
GRADUATE MEDICAL EDUCATION PROGRAM

1. Resident physicians beyond the PGY-1 year shall be free to use off-duty hours to moonlight so long as the resident follows program procedures for obtaining the prior written approval of the Department Chair or Program Director for such outside employment activities. Moonlighting is defined, per the ACGME, as voluntary compensated medically related work performed inside (Internal) or outside (external) the institution where the resident is currently training. Moonlighting activities must not interfere with the resident’s ability to achieve the goals and objectives of the educational program, or obligations to the University. It must not impair the effectiveness of the educational program, or cause detriment to, the service and reputation of the hospital to which the resident is assigned.

Programs must not require residents to participate in outside employment activities (moonlighting).
2. Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.

3. Residents who wish to moonlight must hold either a Regular or Residency Training license in Kentucky. Resident Training (RT) licenses permit moonlighting only in locations authorized and approved by the resident’s Program Director. Institutional Practice (IP) and Fellowship Training (FT) licenses are valid only for duties associated with the University training program for which licenses are issued, and do not cover outside employment activities.

4. Each program must develop a moonlighting policy that is consistent with the University of Louisville School of Medicine Resident Moonlighting Policy. The policy must
   a. Give guidelines for outside employment activities of residents, including defining the hours and rotations when such outside employment activities may be permitted, and under what circumstances permission may be denied for outside employment activities.
   b. Include the statements
      i. The University does not provide professional liability insurance or any other insurance or coverage for resident off-duty activities or employment, and assumes no liability or responsibility for such activities or employment. Confirmation of professional liability insurance for resident off-duty activities or employment will be the responsibility of the moonlighting employer.
      ii. Residents are not to represent themselves to moonlighting employers as being fully trained in their specialty.
      iii. Residents who moonlight are not to present themselves as agents of the University of Louisville during moonlighting activities. University lab coats, names badges, and identification cards are not to be worn outside of the resident’s training program activities.
      iv. It is the resident’s responsibility to assure the billing procedures of the moonlighting employer are conducted in an ethical and legal manner.
   c. All programs must submit a copy of their written policy on Resident Moonlighting to the Office of Graduate Education. The office of GME must receive copies of any changes to this document.

5. Program Directors are required to monitor and approve in writing all moonlighting hours and locations for residents and maintain this information in the resident’s file. Programs are encouraged to monitor all individual resident moonlighting hours to assure outside activity does not contribute to excess fatigue or detrimental educational performance.

6. Residents are required to comply with ACGME, institutional and individual program policies. Residents found to be in violation of this policy will be subject to disciplinary action as detailed in the University of Louisville School of Medicine Resident Agreement.

Outside Employment Policy revised: 09/20/2011
While much of any resident’s energy and effort is necessarily focused upon his or her own growth and education, residents are inevitably role models, especially for “professionalism” in this program for all medical students with whom they come in contact. The relationship between students and house officers is, or should be a uniquely close one; it provides unparalleled opportunities for one-on-one teaching.

An important part of the educational process is optimizing personal communication skills with both students and patients, teaching them how best to communicate with one another. Practice-based learning is one of the six critical components of contemporary graduate education, and it needs to be exemplified in the undergraduate years. When a house officer demonstrates exactly how he does something and why he does it, this often becomes a wonderful educational experience for any student and epitomizes practice-based learning. System-based practice involves realization that the practice of medicine occurs in a vastly complex social and medical system in the United States, which is a system not duplicated around the world. Understanding the greater context in which patients develop illnesses and/or in which patients seek corrective care or alleviation constitutes a very good example of system-based practice. Correcting a surgical abnormality only to return a patient to an unattainable or intolerable social situation could present little help at all under this perspective.

Students should be treated with respect and collegiality, and at the same time be closely observed and not permitted to take on, or not given, responsibilities beyond their station. Every effort should be made to permit them a good experience during their rotation with us.

There is obviously a major expectation on the part of the Program Director and the faculty that all of our residents play vital and important roles in medical education, and your performance in that area contributes significantly to our evaluation of you. There will be no formal teaching awards. The rewards for good teaching will be in the personal pride that you give yourself – and
your chosen specialty.
30. PROGRAM EVALUATION COMMITTEE

The Program Director must appoint the members of the Program Evaluation Committee (PEC). The PEC may be a small group of Associate Program Directors, but must be composed of at least two program faculty members and should include at least one resident. The Program Director may be one of those two faculty members.

To ensure that everyone agrees on their roles, there must be a written description of the committee's and its members' responsibilities.

The PEC should actively participate in:

1. planning, developing, implementing, and evaluating educational activities of the program.
2. reviewing and making recommendations for revision of competency-based curriculum goals and objectives.
3. addressing areas of non-compliance with ACGME standards.
4. reviewing the program annually using evaluations of faculty, residents, and others.

The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering the Annual Program Evaluation (APE).

The program must monitor and track each of the following areas:

1. resident performance
2. faculty development
3. graduate performance, including performance of program graduates on the certification examination
4. program quality
   a. residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually
b. the program must use the results of residents’ and faculty members’ assessments of the program together with other program evaluation results to improve the program

5. progress on the previous year’s action plan(s)

The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed above, as well as delineate how they will be measured and monitored. The action plan should be reviewed and approved by the teaching facility and documented in meeting minutes.
The Clinical Competency Committee (CCC) for the Division of Plastic Surgery Program is comprised of the Program Director, Associate Program Director, as well as site directors from University of Louisville Hospital, Jewish Hospital, and Norton Hospital.

The Committee will meet semi-annually in December and June to review and discuss summative evaluation data points on each resident. Evaluation data includes In-Service scores, operative case logs, faculty/resident evaluation summaries, duty hour compliance, and other items as necessary. They can also propose improvement strategies for individual residents who are not successfully meeting the six core competencies.

The purpose of the Clinical Competency Committee (CCC):

- To review all Plastic Surgery Residents’ evaluation data semi-annually
- To advise the Program Director regarding resident progress, including promotion, remediation and dismissal
- To report Milestone Evaluations on each resident semi-annually to the ACGME

The Clinical Competency Committee (CCC) must:

- Review all Resident evaluation data semi-annually
- Meet with the Clinical Competency Committee semi-annually to discuss assigned residents
- Prepare a letter of summary for each resident’s file to include the committee’s recommendation regarding resident progress, promotion, remediation and dismissal
- Track Resident Progress on an ongoing basis
- Advise Program Director of resident progress
- Prepare detailed Milestone Evaluations semi-annually to the AGCME
- The Clinical Competency Committee (CCC) will meet semi-annually, or more frequently as needed.

Policy Updated: 11/19/2015
A. **Faculty Evaluation of the Program**

The faculty will review the program goals and objectives at least once a year. At least once yearly, all residents will be given the opportunity to participate in these reviews.

B. **Resident Review of Program and Faculty**

Once a year, all residents will be given the opportunity to anonymously evaluate the overall program and the individual faculty members, both full-time and volunteer. Strict measures are taken to insure anonymity, which promotes frank and genuine responses. This information is given to individual faculty members by the Program Director in the annual evaluation of the full-time faculty. Use this opportunity to strengthen our program and our educational policies and efforts.

C. **Implementation of Program Changes**

Although review of the program and faculty official occurs at least once a year, this is an ongoing process, which really occurs as a result of each monthly Faculty Meeting, a portion in which all residents participate. All suggestions made by faculty and residents are, within reason, acted upon immediately and reflected in the Meeting Minutes. All suggestions are also followed up upon in subsequent Faculty Meetings.

D. **Internal Review**

In compliance with ACGME Institutional requirements, the University of Louisville requires an internal review of each program and its educational program and policies between RRC evaluation visits. Residents, without faculty presence, are interviewed in this process. You are excused from all clinical duties and obligations for these interviews.
E. **ACGME Evaluation**

The Plastic Surgery RRC of the ACGME evaluates all programs every five years. Residents, without faculty presence, are interviewed in this process. You are excused from all clinical duties and obligations for these interviews.
33. RESIDENT PERFORMANCE EVALUATION

The performance of each resident will be reviewed and discussed by the faculty twice per year, as described in detail under Section 31 “Clinical Competency Committee.”

Significant concerns will be documented and communicated to the resident at his/her semi-annual meeting with the Program Director. Any significant concerns from these evaluations will be formally summarized in a letter of advancement or non-advancement and presented to the resident for his/her review and records. If individual circumstances require more frequent formal reviews and closer monitoring, this will be arranged. The letters of advancement or non-advancement will remain a part of the permanent file of residency training for the individual.
34. GUIDELINES FOR ADVANCEMENT AND PROGRAM COMPLETION

Advancement and program completion is by judgment of the Program Director with Faculty consensus. The principal standards that must be met for progression include the following:

1. Absolute honesty, integrity and highest ethical standards must be maintained in all circumstances.
2. Upon the admission of every patient, and prior to each and every significant operative procedure, you must contact the responsible University faculty member to present your analysis and your management plan for review, and to arrange scheduling.
3. Completion of your Plastic Surgery Operative Log at levels exceeding the minimal standards in all categories.
4. Completion of all hospital charts, and full compliance with all required documentation in records for billing and Medicare compliance is required.
5. All Medicare patients must be identified to the responsible faculty member at each encounter for proper documentation of Medicare compliance requirements.
6. A research project must have been actively pursued with a good chance of ultimate completion and publication.
7. A paper must be completed and prepared for a Kentucky Society of Plastic Surgeons presentation, by each resident, each year, in September.
8. Attendance and participation in all conferences must be faithful.
9. A strong performance on the in-service examination is expected (Section 31) and you must maintain an active and ongoing program of reading and study.
10. Responses to consultations and pages must be prompt and courteous.
11. Courtesy and respect in all interactions is expected.
12. Your record must be free of sexual harassments, dependency or abuse of drugs or alcohol.
13. A certain level of skill must have been gained in the actual performance of the surgical operations that have been learned. These technical skills will be finely
tuned during the entire course of your career in plastic surgery.

**Promotion Policy**

1. Each resident will be evaluated and promoted on the basis of clinical judgment, knowledge, technical skills, humanistic qualities, professional attitudes, behavior and overall ability to manage the care of a patient within the 6 core competencies.

2. Formal evaluations will occur at the end of each of the resident’s rotation, or every 3 months, whichever is more frequent. These written evaluations will be discussed with the resident on a semi-annual basis and placed into the appropriate resident’s file in the Program Coordinator’s office.

3. The residents have ready access to their files and shall review them on a regular basis.

4. If at any time a resident’s performance is judged to be detrimental to the care of a patient(s), action will be taken immediately to assure the safety of the patient(s). The Program Director will promptly provide written notification to the affiliate program director or department/division chairperson of the resident’s unacceptable performance or conduct.

5. The faculty will recommend whether promotion will occur at the spring semi-annual resident evaluation meeting. The Program Director and Department Chair will make the final decision on promotion based on the faculty recommendation. A score of less than 30th percentile on the ABSITE may result in repetition of the present PG year and lack of promotion to the next PGY level.

6. All residents are required to write at least 1 manuscript. The form of such a project may be a review article, clinical or experimental paper, case report, or book chapter. The manuscript must be considered suitable for submission for publication by the Department Chair or Program Director before it is submitted to a journal 6 months before graduation.

7. A copy of the submitted manuscript must also be given to the Department Chair, Residency Coordinator, and Department Medical Editor.
35. IN-SERVICE EXAMINATION

Annual evaluation of core curriculum knowledge in plastic surgery will be measured by the In-Service Examination. The In-Service Examination is a standardized test administered every spring (usually early March) and is offered by the Plastic Surgery Education Foundation (PSEF). The examination takes approximately 5 hours and is given online in one location. The Division of Plastic Surgery will register you for this examination and will also assume all fees involved. All residents must participate in this examination.

Most training programs in Plastic Surgery administer this examination. Your performance will be compared to that of other plastic surgery residents overall and in your year of training. The results of your performance will become part of your permanent resident file and can be used as a deciding factor in determining whether or not advancement to the senior year, as well as if graduation will occur. A score of less than 30th percentile denotes a poor performance and will serve as evidence of failure to acquire sufficient knowledge to pass the written part of the Plastic Surgery Board examination. Also, a score of less than 30th percentile may result in placement of the resident on academic probation. Residents may not automatically be signed to sit for the American Board of Plastic Surgery examination if on academic probation. In addition, the exam scores may be distributed to the plastic surgery residents, full time academic faculty and volunteer faculty to allow these individuals to assist in providing educational opportunities and counseling.

The In-Service Exam scores may be included in any letter of recommendation/support for future employment, as well as toward obtaining hospital-operating privileges.

To assist in your study efforts, the Division of Plastic Surgery will provide you with Neligan/Mathes’ Plastic Surgery textbooks, Volumes 1-6, at the beginning of your residency training; however, these are not yours to keep and must be returned to the Division at the end of your training. As an incentive, if you score at or above the 50th percentile on the In-Service Examination during all three years of your training, you will be permitted to keep the books as your own.
Resident grievances will be addressed using the process outlined by the UofL School of Medicine, *House Staff Policies and Procedures Manual*, Section XXIII, Page 44. If discussion with the person involved does not provide resolution, the person’s supervisor should be involved. The Program Director and/or the faculty may be asked to become involved at this point. If this does not resolve the issue, the student Grievance Officer may be requested to mediate. If the issue still persists, the formal process will then be used as outlined by the University of Louisville, School of Medicine, *House Staff and Procedures Manual* involving a written statement to the Academic Unit Grievance Committee through the Office of the Dean, as outlined in the *House Staff Policies and Procedures Manual*, Section XXIII, Page 44.
37. DISCIPLINARY ACTIONS AND GROUNDS FOR DISMISSAL

Disciplinary actions include probation, non-advancement to the next semester or year, dismissal and non-award of a certificate of completion.

A. **Probation** involves heightened scrutiny, increased monitoring and specific reporting requirement by the resident, but without loss of clinical privileges.

B. **Non-advancement** ends training at an annual or semi-annual point short of program completion and prevents eligibility to sit for the certification examination of the American Board of Plastic Surgery. Annual advancement and program completion are confirmed by a formal letter.

C. **Grounds for dismissal** from the training program include, but are not limited to the following infractions:

1. **Theft.**
2. **Sexual harassment** as defined by the University (House Staff Policy and Procedures, page 32-33).
3. **Cheating** on the in-service training examination.
4. **Lying.**
5. **Gross acts of insubordination**, as determined by Program Director and the full-time academic faculty.
6. **Negligence** or incompetence in patient care.
7. **Criminal acts.**
8. **Drug, alcohol or substance abuse or dependence.**
9. **Medical practice or other employment outside the residency program** (“moonlighting”), without the express consent of the Program Director.
10. **Failure to complete medical records and dictations and failure to comply with Medicare compliance regulations.**
11. **Any other infraction** specifically named as grounds for dismissal by the Department of Surgery or the University of Louisville.

   Academic discipline actions leading to dismissal will be handled with full due process, as defined in the United States Constitution. The process outlined in the *Department of Surgery House Staff Manual* and the *University of Louisville School of Medicine Resident Policies and Procedures Manual* will be followed.

D. **Non-award of the certificate of completion.** It is the right of the Program Director, based upon your performance and/or faculty evaluations, to not sign the certificate of residency training completion. Without this certificate, a resident is ineligible to sit for the written and oral examinations of the American Board of Plastic Surgery and he/she cannot claim graduation from this program, or be certified by the American Board of Plastic Surgery.
I. **Purpose**
To insure a fair and equitable process in the evaluation of prospective trainees and the selection of highly qualified individuals for subspecialty training in Plastic Surgery.

II. **Eligibility and Residency Application**
A. The Plastic Surgery Residency Program will adhere to all Department of Surgery and University of Louisville institutional policies regarding eligibility for participation in residency training programs at the University of Louisville.

B. Applicants will complete all of the following prior to entry into the program:

1. Resident selection is made without unlawful discrimination in terms of age, color, disability status, national origin, race, religion or sex, in keeping with UofL standards as an Affirmative Action/Equal Opportunity Employer.

2. M.D. or D.O. degree at an Accredited Medical School in the United States of America or recognized international medical school with similar accreditation.

3. Successful completion of residency training in general surgery, orthopedic surgery, otolaryngology, urological surgery, neurosurgery or oral maxillofacial surgery with an M.D. or D.O. degree.

4. Ability to obtain and maintain licensure to practice medicine in the states of Kentucky.

5. Ability to obtain and sustain a current unrestricted DEA certificate for the prescribing of controlled substances.

6. Graduates of the medical schools outside of the United States and Canada who have current valid certificates from the Educational Commission for Foreign
Medical Graduates (ECFMG) must:

a) Be officially recognized in good standing in the country where they are located

b) Be registered as a medical school, college or university in the International Medical Education Directory

c) Require that all courses must be completed by physical on-site attendance in the country in which the school is chartered

d) Possess a basic course of clinical and classroom medical instruction that is:
   i) not less than 32 months in length; and
   ii) under the educational institution’s direct authority

C. University of Louisville School of Medicine Policy on Resident Selection.
   1. Please refer to the attached policy that was updated on 09/16/2014.

III. Procedures

A. The Division of Plastic Surgery at the University of Louisville participates in the Plastic Surgery Matching Program (PSMP) which was established by the American Council of Academic Plastic Surgeons to coordinate appointments for Plastic Surgery Residency programs and to relieve the pressure on applicants and program directors resulting from early appointments and uncoordinated appointment dates. The PSMP is administered by the San Francisco Residency and Fellowship Matching Services. All residents are selected through the SF Match. In the event of transfer of residents in to fill a vacant position, the policies of the Common Program Requirements of the ACGME and the Residency Review Committee in Plastic Surgery will be strictly adhered to. To file for the match, the applicant must meet the American Board of Plastic Surgery requirements.

B. Residents will apply to the SF Match within the specified deadlines for the anticipated academic year in which they will begin as a junior resident.

C. Once SF Match applications are received for a given year, the Faculty Residency - 110 -
Selection Committee will select candidates for an interview. The committee consists of the Program Director and 2 full time faculty members.

D. Consideration for interviewing is based institutional guidelines. Criterion for interview selection depends on completion of pre-requisite training, quality of training program, quality of medical school, letters of recommendation, USMLE scores, In-Service scores, research quality and quantity. Non-U.S. citizens can apply and will be evaluated based on other qualifications with other applicants.

E. Approximately 25 candidates will be selected for an interview each year to fill 2 open positions. Interviews are conducted by all full-time faculty. All residents will have the opportunity to meet and talk to the candidates. They will provide input and feedback to the Program Director and faculty members.

F. Once all interviews are concluded, the faculty and residents will meet to discuss the candidates. Each will submit a rank order list to the Program Director.

G. The Program Director will weigh each faculty member and resident rank list equally. A final rank order list will be generated and transmitted to the SF Match prior to the program deadline.

IV. The Match
A. Once the match process has occurred, the Program Director will contact the matched candidates both formally in writing and informally by phone.

B. A letter of intent and a resident contract will be sent to the candidate in keeping with the institutional policy of the University of Louisville School of Medicine.

V. Resident Compliment
The Plastic Surgery Residency Program at the University of Louisville School of Medicine is approved by the Accreditation Council for Graduate Medical Education (ACGME) for 2
residents in each of 3 years for a total compliment of 6 residents.

VI. **Falsification of Application or Other Materials**
   A. Falsification of information on the NRMP application, Resident Contract, or supporting documents for these aforementioned forms may result in termination of the resident from employment by the University of Louisville School of Medicine.

   B. All terminations are subject to the policies and regulations of the University of Louisville Redbook, the School of Medicine, the Department of Surgery and the ACGME.

VII. **Conclusion**
    The system of future resident selection that we use is quite democratic and well thought out. It assures the Program, the University, and the specialty that we have taken every initiative in selecting the finest representatives of the class.

The following has been extracted from the *University of Louisville School of Medicine Resident Policies and Procedures Manual*:

**Policy on Resident Selection**

*University of Louisville School of Medicine*  
*Graduate Medical Education Programs*

The sponsored residency training programs of the University of Louisville School of Medicine exist for the purpose of training the highest quality physician possible in each program's respective discipline. The following is the official policy for the selection of candidates for training. This policy is consistent with the Accreditation Council on Graduate Medical Education (ACGME) Institutional Requirements and the Commonwealth of Kentucky Medical and Osteopathic Practice Act Regulations and Statutes. Program directors and coordinators should also be familiar with the “Medical Licensure Policy for Residents” published in the Resident Policies and Procedures manual. Program directors and coordinators are strongly encouraged to call the Office of Graduate Medical Education if questions, problems or uncertainty arise.

1. **Resident Eligibility**
   Applicants with one of the following qualifications are eligible for appointment to accredited residency
programs at the University of Louisville School of Medicine.

a. Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).

b. Graduates of medical schools in the United States and Canada accredited by the American Osteopathic Association (AOA).

c. Graduates of medical schools outside of the United States and Canada who have current valid certificates from the Educational Commission for Foreign Medical Graduates (ECFMG). In addition, as of the 2009-2010 academic year, schools located outside the U.S. and Canada must:
   1. Be officially recognized in good standing in the country where they are located
   2. Be registered as a medical school, college, or university in the International Medical Education Directory
   3. Require that all courses must be completed by physical on-site attendance in the country in which the school is chartered.
   4. Possess a basic course of clinical and classroom medical instruction that is
      a. not less than 32 months in length; and
      b. under the educational institution’s direct authority.

d. Graduates from accredited dental schools who are enrolled in oral-maxillofacial surgery and general practice dentistry (GPR) programs. These programs are accredited by the Council on Dental Accreditation of the American Dental Association but are under the general auspices of the University of Louisville School of Medicine Graduate Medical Education Programs. Candidates must obtain dental licensure through the Kentucky Board of Dentistry.

2. Resident Selection
   a. Programs should select from among eligible applicants on the basis of their preparedness and ability to benefit from the program to which they are appointed. Aptitude, academic credentials, personal characteristics, and ability to communicate should be considered in the selection. Personal interviews prior to selection are strongly encouraged.

   b. In selecting from among qualified applicants for first-year positions, sponsored programs must participate in the National Resident Matching Program (NRMP) when it is available.

   c. In selecting from among eligible applicants for positions other than the first-year positions, programs should select the most qualified candidates as listed in 2.a. above. Appointment to PGY2 (and above) positions is contingent upon candidates being issued Kentucky medical licenses prior to the beginning of the training year.

3. Non-US Citizens
   a. Applicants who are not citizens of the United States must possess or be eligible for one of the following:
      - J1 Clinical Visa
      - Valid Employment Authorization Document
      - Valid Permanent Resident Card

   b. The following are not accepted for residency or fellowship training:
      - J1 Research Visa
      - J2 Dependent Visa
      - H1B Visa
c. Individual programs may limit the amount of time they will hold a position open for applicants to obtain appropriate immigration status.

All resident selection must be made without unlawful discrimination in terms of age, color, disability status, national origin, race, religion or sex, in keeping with University of Louisville standards as an Affirmative Action/Equal Opportunity employer.

The enrollment of non-eligible residents may be cause for withdrawal of accreditation of the involved program and/or the sponsoring institution.
The acceptability of a candidate does not depend solely upon the completion of an approved program of education but also upon information available to the Board regarding his professional maturity, surgical judgment, technical competence, and ethical standing. A candidate who has submitted an Application for Examination will be notified by the Board as to his/her admissibility for examination.
40. STRESS AND FATIGUE IN THE WORKPLACE

The Plastic Surgery Residency Program is committed to a healthy supportive environment for all. The faculty continually strives to provide the residents with a superior educational environment. The residency will not discriminate based on age, sex, nationality, religion, or sexual orientation. Sexual harassment will not be tolerated or condoned. It is essential that each resident maintain a healthy diet, sleep, and exercise program. A stable, healthy personal life is valuable to the workplace. There are, however, circumstances that can prove difficult and stressful situations for Plastic Surgeons. The program has opportunities for each resident to discuss and resolve stressful situations. It is essential that we work to change and improve the environment.

1. It is most important to discuss any stressful situation with a faculty member as soon as they occur. This should be followed up with a discussion with the Program Director.

2. The quarterly evaluation meeting, the 6-week end of rotation evaluation meeting, and the frequent faculty meetings that residents attend are additional opportunities to discuss and resolve stressful situations.

All isolated events will be handled in the strictest confidence. In the event that a trend is noted by the Program Director, steps will be taken to change the offending situation for the betterment of all residents.

RESIDENT STRESS AND FATIGUE MONITORING POLICY

Long and strenuous operations are not infrequent occurrences in Plastic Surgery. Fatigue and its role in medical errors are regarded as a challenge to providing quality medical training and care. As such, prevention of fatigue, its recognition, and the early recognition of professional and personal stress reactions are regarded as critical to the safe and effective practice of our specialty.
PREVENTION STRATEGIES

- Work hour limitations – All rotations will adhere to the eighty-hour clinical workweek limitation, including moonlighting.
- Moonlighting time is restricted and will be granted only in unusual circumstances.
- Didactic education on the related topics of the effective regulation of wakefulness; the neurocognitive performance consequences of a disrupted circadian timing system, a disrupted sleep-wake homeostasis with sleep debt; and sleep inertia is provided. Fatigue management strategies and countermeasures are included.
- Didactic education on the signs and symptoms of substance abuse is provided.
- Workplace harassment policies and procedures are reviewed.
- Plastic Surgery faculty promotes the culture of healthy lifestyle strategy and shared responsibility.

MONITORING STRATEGIES

- The Program Director reviews planned work schedules and moonlighting schedules to assure duty hour requirements are met and circadian scheduling principles are demonstrated.
- House-staff have a responsibility to communicate off-service rotation schedules believed to be out of compliance with the ACGME eighty-hour workweek over four weeks on average.
- Faculty or Resident direct observation of the signs and symptoms of fatigue, stress, substance abuse, or mental health disorder are discussed and confidentially addressed individually by the Program Director. Some examples include irritability, distractibility, social isolation, rapid weight shifts, excessive sleepiness, lack of interest in educational offerings, shift tardiness, and acute clinical decision-making difficulty.
- Direct resident feedback regarding resident stressors is sought via 6-week evaluations of rotations, at the semi-annual performance review, and review of the program’s ACGME resident survey results.
• The Program Director will refer/cooperate with resident involvement in the Kentucky Physicians Health Foundation, The Counseling Center, and other health services as the need dictates.

• In case of fatigue or for security issues, a Cab Voucher System has been instituted. For details, consult: http://louisville.edu/medschool/gme/hsc_files/cabprogram.htm.
Residents will rapidly determine that the plastic surgery faculty will not only treat you like a Plastic Surgeon, but also like a colleague, and most often like a friend. That is the way this program is run. We expect meticulous adherence to the principals, rules and purposes of this manual and of your chosen profession. And in return, you will be nourished by us, you will learn from us and others, and you will be held in the highest esteem of any medical professional. The goal of this faculty is to make you the best plastic surgeon. One who will take immense pride in the institution, your instructors, your fellow residents, and in your specialty.

If there is anything that any of us can do for you on a personal level, do not hesitate to ask. We are available at any time of the day or night. You are one of us, and we expect that relationship to survive this residency training program, well into all of our professional careers and perhaps further.

Welcome to the Program!
42. GUIDE TO THE APPENDICES

Curriculum
Appendix 1: The Comprehensive Plastic Surgery Curriculum (ACAPS) (Distributed with Manual)
Appendix 2: The Plastic Surgery Operative Log (PSOL) and instructions for use (www.acgme.org)
Appendix 3: University of Louisville Hospitals House Staff Manual (Distributed with Manual)
Appendix 4: University of Louisville Resident Policies and Procedures (Distributed with Manual)
Appendix 5: The Resource Books for Plastic Surgery Residents (ASPS)
Appendix 6: Legal Handbook for Kentucky Physicians (Available in Resident’s office)
Appendix 7: ACGME Core Competency Conference Schedule (Posted in Resident’s office and
distributed at Orientation)

Attachments
Attachment 1: Block Outline of the Rotation Schedule
Attachment 2: Principles of Medical Ethics (AMA)
43. GUIDE TO SUPPLEMENTAL REFERENCE MANUALS

These Reference manuals provide information and self-study courses in ethics, medico legal topics, practice management and continuing education. Appropriate sections may be photocopied. Most of these publications are available on-line or directly from the publishing organizations.

Ethics
1. Code of Medical Ethics (AMA)

Medico legal
2. Legal Handbook for Kentucky Physicians (KMA and KMIC)
3. Patient Consultation Resource Book (ASPS)

Practice Management
4. Establishing Yourself in Medical Practice (AMA)
5. Marketing Strategies for Private Practice (AMA)
6. Basics of Managed Care (JCMS)
7. CPT03 (AMA) (Available in resident’s office, Medical Records Department, and Operating Room Doctor’s Lounge)
8. Billing and Documentation Guidelines (UofL Compliance Office) (Available in Resident’s Office)

Academic Basis for Practice and Continuing Medical Education
9. The Resource Book for Plastic Surgery Resident (ASPS)
10. ASPS/PSEF Catalogue
44. CONFIRMATION OF UNDERSTANDING

Plastic Surgery Resident Manual

By your signature, you indicate that you have fully read and understand all of this UofL Plastic Surgery Resident Manual, revised June 2017. If there is anything you do not understand or if you have any questions, ask the Program Director, and you will receive answers prior to signing. In addition, it is understood that your plastic surgery residency training will terminate on June 30 in the year of your graduation.

Resident Signature: ___________________________ Date: __________

Program Director Signature: ___________________________ Date: __________

Department of Surgery House Staff Manual (same language and signature)

By your signature, you indicate that you have fully read and understand all of this UofL Department of Surgery House Staff Manual, revised June 2017. If there is anything you do not understand or if you have any questions, ask the Program Director, and you will receive answers prior to signing.

Resident Signature: ___________________________ Date: __________

Program Director Signature: ___________________________ Date: __________
Attachment
1

Block Diagram of Rotation Schedule
### University of Louisville School of Medicine
#### Division of Plastic Surgery

**RESIDENT ROTATION SCHEDULE 2017 - 2018**

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### University
- Responsible for University Ward Service Case, i.e. those that have been evaluated or will follow-up at ACB.
- Covers University Trauma, Burn, and ER patients.
- Direct Monday office hours at ACB clinic.
- Will discuss all new patients with the on-call attending that week to discuss treatment plan.

### Hand/University
- Primarily works with Dr. Wilhelmi.
- Takes Hand Call on Tuesdays.
- Monday – covers the ACB for hand follow-ups.
- Tuesday – HCOC office.
- Wednesday and Thursday – OR
- Friday – covers hand cases with Dr. Scheker, Dr. Tien, or Dr. O’Daniel.

### Reconstructive
- Covers cases with Dr. McCurry or Dr. Tobin.
- Encouraged to attend office hours whenever possible.
- Thursday – allocated to pursue elective cases.

### VAMC
- At VAMC every day.
- Wednesday – office hours all day.
- Friday – Dr. Kasdan may decide to have you break for some other unique cases.

### Head & Neck
- Works with Dr. Little’s private patients.
- Tuesday – works with Dr. Chariker.
- Friday – covers Dr. Little’s office hours.

### Electives
- Oculoplastic Surgery, Dermatology, Orthopedics, Maxillofacial, Anesthesia, and Elective.
Attachment 2

Principles of Medical Ethics
I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient.

IV. A physician shall respect the right of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

IX. A physician shall support access to medical care for all people.

*Adopted by the AMA's House of Delegates, June 17, 2001.*
UNIVERSITY COVERAGE

1. All cases at University should be staffed by the Attending on call when the patient was admitted, first seen, or consulted under.

2. All revision surgery for University patients should be staffed by the Attending that was initially involved or performed the original surgery.

3. All consults, ERs, and admissions should be entered in Advertek by the resident that saw the patient for that Attending on call that week.

OTHER ISSUES AND COVERAGE RESPONSIBILITIES

1. All presenters should bring brief outline to their talk for Grand Rounds.

2. Plastic Surgery Residents that are on call for that day will continue to be first call for all downtown hospitals including JH, NH, and USA call service for the full time UofL faculty.

3. Accordingly, Sharlene will continue to distribute Resident Call Schedules to the respective hospitals: JH, NH, and USA Call Service (Rhonda).

4. Residents are responsible for completing Advertek E/M for all these patients in addition to the UofL consults, ERs, and admissions.

5. The University resident is responsible for entering all cases scheduled at the UofL on the Plastic Surgery Service Account calendar.