Index

1. Goals
2. Objectives
3. Syllabus
4. Teaching Programme
5. Schedule of Posting
6. Thesis
7. Assessment
8. Job Responsibilities
9. Suggested Books & Journals
10. Model Test Papers
Curriculum M.Ch. Plastic Surgery

The infrastructure and faculty of the department of plastic surgery will be as per MCI guidelines

1. **Goals:**
   The goal of MCh course is to produce a competent surgeon who:
   - Recognizes the health needs of patients and carries out duties in keeping with principles of National Health Policy and professional ethics.
   - He should acquire skills in communicating with the patients, family and the community;
   - Is aware of the contemporary advances and developments in medical sciences. Acquires a spirit of scientific enquiry and is oriented to principles of research methodology;
   - and Has acquired skills in educating medical and paramedical professionals.

2. **Objectives**
   At the end of the MCh Plastic Surgery, the student should be able to:
   - Recognize the key importance of medical problems in the context of the health priority of the country;
   - Practice the specialty of plastic surgery in keeping with the principles of professional ethics;
   - Identify social, economic, environmental, biological and emotional determinants of adult Plastic Surgery and know the therapeutic, rehabilitative, preventive and promotion measures to provide holistic care to all patients; Take detailed history, perform full physical examination and make a clinical diagnosis; Perform and interpret relevant investigations (Imaging and Laboratory); Perform and interpret important diagnostic procedures; Diagnose illnesses in adults based on the analysis of history, physical examination and investigative work up;
   - Plan and deliver comprehensive treatment for illness in adults using principles of rational drug therapy;
   - Plan and advise measures for the prevention of diseases;
   - Plan rehabilitation of adults suffering from chronic illness, and those with special needs;
• Manage emergencies efficiently; Demonstrate skills in documentation of case details, and of morbidity and mortality data relevant to the assigned situation;

• Demonstrate empathy and humane approach towards patients and their families and respect their sensibilities;

• Demonstrate communication skills of a high order in explaining management and prognosis, providing counseling and giving health education messages to patients, families and communities.

• Develop skills as a self-directed learner, recognize continuing educational needs; use appropriate learning resources, and critically analyze relevant published literature in order to practice evidence-based medicine;

• Demonstrate competence in basic concepts of research methodology and epidemiology; Facilitate learning of medical/nursing students, practicing surgeons, para-medical health workers and other providers as a teacher-trainer;

• Play the assigned role in the implementation of national health programs, effectively and responsibly;

• Organize and supervise the desired managerial and leadership skills; Function as a productive member of a team engaged in health care, research and education.
3. Syllabus
3.1 Theory

Syllabus for M.Ch. (Plastic and Reconstructive Surgery)

PAPER - I

MCH01 : Applied Basic Sciences in Plastic Surgery Paper

General Principles

1. Plastic Surgery and innovation in medicine
2. Historical Perspectives
3. Outcomes Research : The Path to Evidence-Based Decisions in Plastic Surgery
4. Genetics
5. Psychological Aspects of Plastic Surgery
6. Ethics in Plastic Surgery
7. Liability Issues in Plastic Surgery : Legal and insurance Perspective
8. Digital imaging in Plastic Surgery
9. Anesthesia For Plastic Surgery
10. Wound Healing : Repair Biology, Scar prevention, Treatment and revision
11. Transplantation in Plastic Surgery
12. Repair & Grafting of Dermis, Fats, & Fascia, Tendon, Skeletal muscles, cartilage, bone and peripheral nerves
13. Alloplastic Materials
15. Exfoliative Disorders
16. Radiation Injury
17. Cold Injuries
**General Principles**

1. Skin Grafts
2. Vascular Territories
3. Flap Classification, Applications and Physiology
4. Principles & Techniques of Microvascular Surgery
5. Principles and Application of Tissue Expansion
6. Burn & Electrical Injury

**The Head & Neck**

8. Anthropometry and Cephalometric Facial Analysis.
9. RHINOPLASTY: Principles And Techniques
10. Aesthetic Reconstruction of the Nose.
12. Acute Care and Reconstruction of Facial Burns.
13. Pediatric Facial Injuries.
15. Temporomandibular Joint Dysfunction.
16. Acquired Cranial And Facial Bone Deformities.
17. Scalp Reconstruction.
18. Reconstruction of the Auricle.
19. Forehead Reconstruction.
20. Reconstruction of the Periorbital Adnexa.
22. Lower Third Face and Lip Reconstruction.
23. Midface Reconstruction.
24. Facial Paralysis.


27. Hypopharyngeal and Esophageal Reconstruction.


**Pediatric Plastic Surgery**

29. Embryology of the Craniofacial Complex.

30. Embryology, Classifications, and Descriptions of Craniofacial clefts


33. Unilateral Cheiloplasty.

34. Bilateral Cleft Lip Repair.

35. Cleft Palate Repair.

36. Orthodontics in Cleft Lip and Palate Management.

37. Velopharyngeal Dysfunction.

38. Secondary Deformities of the Lip, Nose, & Palate.

39. Craniofacial Syndromes And Reconstruction

40. Craniofacial Microsomia.

41. Nonsyndromic Craniosynostosis.

42. Reconstruction : Orbital Hypertelorism.

43. Reconstruction Craniosynostosis.

44. Hemifacial Atrophy.

**Tumors of the Head, Neck, & Skin**

45. Pediatric Tumors

46. Vascular Anomalies

47. Salivary Gland Tumors

48. Tumors of the Craniofacial Skeleton.
49. Tumors of the Lips, Oral Cavity, and Oropharynx.

50. Tumors of the Mandible.

51. Carcinoma of the Upper Aerodigestive Tract.

52. Being Tumors of Skin.

53. Malignant Tumors of the Skin.

54. Malignant Melanoma.

55. Local Flaps For Facial Coverage.

56. Management of Nonmelanoma Skin Cancer.

57. Management of Regional Metastatic Disease of the Head & Neck: Diagnosis & Treatment.

**Trunk and Lower Extremity**

58. Reconstruction of the Chest.

59. Reconstruction of the Back.

60. Congenital Anomalies of the Chest Wall.

61. Breast Cancer: Diagnosis, Therapy, & Postmastectomy Reconstruction

62. Reconstruction of the Nipple – Areola Complex.

63. Reconstruction of the Abdominal Wall.

64. Reconstruction of Male Genital Defects: Congenital & Acquired.

65. Hypospadias.

66. Reconstruction of Female Genital Defects: Congenital.


68. Surgery for Gender Identity Disorder.

69. Pressure Sores.

70. Reconstruction Surgery: Lower Extremity Coverage.


72. Foot Reconstruction.

73. Vascular Insufficiency of the Lower Extremity: Lymphatic, Venous, and Arterial.
The Hand & Upper Limb

74. Plastic Surgery: Contributions to hand Surgery.
75. Anatomy and Biomechanics of the Hand.
76. Examination of the Upper Extremity.
77. Diagnostic Imaging of the hand & Wrist.
78. Anesthesia for Upper Extremity Surgery.
79. General Principles
80. Arthroscopy of the Wrist.
81. Principles of Internal Fixation as Applied to the Hand & Wrist.

Acquired Disorders Traumatic.

82. Fingertip Reconstruction.
83. Surgery of the Perionychium.
84. Reconstruction Surgery of Individual Digits (Excluding Thumb)
85. Thumb Reconstruction: Microvascular Methods.
86. Thumb Reconstruction: Coventional Technicals.
88. Reconstruction Surgery: Extensive Injuries to the Upper Limb.
89. Flexor Tendon Injuries & Reconstruction.
90. Extensor Tendon Injuries & Reconstruction.
91. Fractures & Joint Injuries Involving the Metacarpals & Phalanges.
92. Fractures & Dislocations of the Wrist & Distal Radioulnar Joint.
94. Adult Brachial Plexus Injuries.
95. Obstetric Brachial Plexus.
96. Replantation & Revascularization.
Appendix
98. Upper Extremity Burn Reconstruction.
100. The Stiff Hand.
Acquired Disorders Nontraumatic.

101. Tenosynovitis and Cumulative Trauma Syndrome.
102. Disorders of Musicians’ Hands.
104. Management of Dupuytren Disease.
105. Infections of the Hand.
106. Ischemic Conditions of the Hand.
107. Reflex Sympathetic Dystrophy/Chronic Regional Pain Syndrome.
110. Benign and Malignant Soft Tissue Tumors of the Upper Limb.
111. Benign and Malignant Bone Tumors of the Hand.
112. Lymphedema in Upper Extremity.
113. Embryology of the Upper Limb.
115. Management of Transverse and Longitudinal Deficiencies.
   (Failure of Formation)
117. Constriction Ring Syndrome.
118. Disorders of Duplication.
119. Failure of Differentiation & Overgrowth.
120. Hypoplastic or Absent Thumb.
121. Vascular Anomalies of the Upper Extremity.
122. Pediatric Upper Extremity Trauma.
123. Hand management For Patients with Epidermolysis Bullosa.

Paralytic Disorders

125. Tendon Transfers in the Upper Limb.
126. Free Functioning Muscle Transfers in the Upper Limb.

128. Management of the Spastic Hand

**Rehabilitation**

129. Hand Therapy.

130. Upper Limb Functional Prosthetics.


---

**PAPER – III**

**MCH03 : Principles & Practice of Plastic Surgery (Aesthetics Surgery)**

**The Head & Neck**

1. Analysis of the Aesthetic Surgery Patient.

2. Forehead Correction of Aging.


5. Aging face & Neck.


7. Face Lift (Midface) : Current Techniques.

8. Face Lift (Lower Face) : Current Techniques.


10. Facial Resurfacing.

11. Pharmacologic Skin Rejuvenation.


15. Secondary Rejuvenation of the Face.

**Trunk and Lower Extremity**


17. Breast Reduction.
18. Mastopexy.
19. Abdominoplasty Techniques.
20. Body Contouring
21. Liposuction Principles and Techniques

### General Principles

2. Prenatal Detection of Fetal Anomalies.
3. Tissue Engineering And Digital Technology.
4. Fetal Surgery.
5. Telemedicine.
7. Fat grafting
8. Liposuction
9. Lasers
10. Recent advance in Burns management
11. Distraction Osteogenesis
12. Emerging Techniques : Aesthetic Plastic Surgery

### The Head & Neck

14. Face Lift (Lower Face) : Current Techniques.
15. Face Lift (Neck) : Current Techniques.
3.2. Practical:

**History, examination and writing of records:**

- History taking should include the background information, presenting complaints and history of present illness, history of previous illness, family history, social and occupational history and treatment history.

- Detailed physical examination should include general examination and systemic examination (Chest, Cardio-vascular system, Abdomen, Central nervous system, locomotor system and joints), with detailed examination of the abdomen.

- Skills in writing up notes, maintaining problem oriented records, progress notes, and presentation of cases during ward rounds, planning investigations and making a treatment plan should be taught.

**Bedside procedures & Investigations:**

- Therapeutic skills: Venepuncture and establishment of vascular access, Administration of fluids, blood, blood components and parenteral nutrition, Nasogastric feeding, Urethral catheterization, Administration of oxygen, Cardiopulmonary resuscitation, Endotracheal intubation.

3.3. Clinical Teaching

General, Physical and specific examinations of Maxillofacial & Hand Injuries should be mastered. The resident should able to analyse history and correlate it with clinical findings. He should be well versed with all radiological procedures like CT Angio, CT Face with 3D Reconstruction and X-Ray of face. He should present his daily admissions in morning report and try to improve management skills, fluid balance, and choice of drugs. He should clinically analyse the patient & decide for pertinent Investigations required for specific patient.

4. Teaching Programme

4.1 General Principals

Acquisition of practical competencies being the keystone of postgraduate medical education, postgraduate training is skills oriented. Learning in postgraduate program is essentially self-directed and primarily emanating from clinical and academic work. The formal sessions are merely meant to supplement this core effort.
4.2 Teaching Sessions
The teaching methodology consists of bedside discussions, ward rounds, case presentations, clinical grand rounds, statistical meetings, journal club, lectures and seminars. Along with these activities, trainees should take part in inter-departmental meetings i.e clinico-pathological and clinico-radiological meetings that are organized regularly. Trainees are expected to be fully conversant with the use of computers and be able to use databases like the Medline, Pubmed etc. They should be familiar with concept of evidence based medicine and the use of guidelines available for managing various diseases.

4.3 Teaching Schedule
Following is the suggested weekly teaching programme in the Department of Plastic Surgery:

<table>
<thead>
<tr>
<th>Sr no.</th>
<th>Description</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Combined clinical meet</td>
<td>Once a week</td>
</tr>
<tr>
<td>2</td>
<td>Seminar/</td>
<td>Once a week</td>
</tr>
<tr>
<td>3</td>
<td>Journal Club</td>
<td>Once a week</td>
</tr>
<tr>
<td>4</td>
<td>Case Presentation</td>
<td>Twice a week</td>
</tr>
<tr>
<td>5</td>
<td>Mortality Meet</td>
<td>Once a month</td>
</tr>
</tbody>
</table>

Each unit should have regular teaching rounds for residents posted in that unit. The rounds should include bedside case discussions, file rounds (documentation of case history and examination, progress notes, round discussions, investigations and management plan), interesting and difficult case unit discussions.

Central hospital teaching sessions will be conducted regularly and MCh residents would present interesting cases, seminars and take part in clinico-pathological case discussions.

4.4 Conferences and Papers

A resident must attend at least one national and one state level conference. One poster, one paper should be presented at national and state level conference during residency. One paper should be published or accepted for publication in MCI recognized journals during his tenure.

5. Schedule of Posting:
OPD: Twice a week
OT: Twice a week
Emergency: Twice a week

• The M Ch resident should do the dressings of the patient that have been operated/assisted by them and of patients in Burns ICU.

• The M Ch resident should note down the History and examination of admitted patients and should daily put progress notes in files.

• The normal working hours will be from 8.00 AM to 8.00 PM. When on emergency duty, the resident is supposed to stay overnight in the resident room.

• The M Ch resident shall be posted in other departments as per the following schedule:

Radiology 1 month
Radiotherapy : 1 month
Hand clinic : 6 months

Log Book:
All the day to day work done during the course will be recorded by the candidate in the log book duly signed by the consultant.
One log book of operated clinical cases of at least 20 patients should be prepared and submitted at the end of residency before exams.

6. Thesis
Every candidate shall carry out work on an assigned thesis under the guidance of a recognized postgraduate teacher, the thesis shall be written and submitted at least 6 months before the exams.
The student will (i) identify a relevant research problem, (ii) conduct a critical review of literature, (III) formulate a hypothesis, (iv) determine the most suitable study design, (v) state the objectives of the study, (vi) prepare a study protocol, (viii) undertake a study according to the protocol, (viii) analyze and interpret research data, and draw conclusion, (ix) write a research paper.

7. Assessment
All the PG residents are assessed daily for their academic activities and also periodically.
7.1. General Principles
The assessment is valid, objective and reliable. It covers cognitive, psychomotor and affective domains. Formative, continuing and summative (final) assessment is also conducted in theory as well as practical. In addition, research project is also assessed separately.

7.2. Formative Assessment
The formative assessment is continuous as well as end of term. The former is based on the feedback from the consultants concerned. Formative assessment will provide feedback to the candidate about his/her performance and help to improve in the areas they lack. Record of internal assessment should be presented to the board of examiners for consideration at the time of final examination.

7.3. Internal Assessment
The performance of the resident during the training period should be monitored throughout the course and duly recorded in the log books as evidence of the ability and daily work of the student. Marks should be allotted out of 100 as followed.

<table>
<thead>
<tr>
<th>Sr. No</th>
<th>Items</th>
<th>Marks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Personal Attributes</td>
<td>20</td>
</tr>
<tr>
<td>2</td>
<td>Clinical Work</td>
<td>20</td>
</tr>
<tr>
<td>3</td>
<td>Academic Activities</td>
<td>20</td>
</tr>
<tr>
<td>4</td>
<td>End of term theory Exam</td>
<td>20</td>
</tr>
<tr>
<td>5</td>
<td>End of term practical Exam</td>
<td>20</td>
</tr>
</tbody>
</table>

1. Personal attributes:
Behavior and Emotional Stability: Dependable, disciplined, dedicated, stable in emergency situations, shows positive approach.
Motivation and Initiative: Takes on responsibility, innovative, enterprising, does not shirk duties or leave any work pending.
Honesty and Integrity: Truthful, admits mistakes, does not cook up information, has ethical conduct, exhibits good moral values, loyal to the institution. Interpersonal Skills and Leadership Quality: Has compassionate attitude towards patients and attendants, gets on well with colleagues and paramedical staff, is respectful to seniors, has good communication skills.

2. Clinical Work:
Availability: Punctual, available continuously on duty, responds promptly on calls and takes proper permission for leave.
Diligence: Dedicated, hardworking, does not shirk duties, leaves no work pending, does not sit idle, competent in clinical case work up and management. Academic ability: Intelligent, shows sound knowledge and skills, participates adequately in academic activities, and performs well in oral presentation and departmental tests.
Clinical Performance: Proficient in clinical presentations and case discussion during rounds and OPD work up. Preparing Documents of the case history/examination and progress notes in the file (daily notes, round discussion, investigations and management) Skill of performing bed side procedures and handling emergencies.

3. Academic Activity: Performance during presentation at Journal club/ Seminar/ Case discussion/Stat meeting and other academic sessions. Proficiency in skills as mentioned in job responsibilities.

4. Every year there will be 2 PG evaluation tests which should include topics of syllabus.

5. End of term practical/oral examinations after 2 years 9 months.

6. Thesis review: After every six months the candidate should present his progress of thesis writing.
Marks for personal attributes and clinical work should be given six monthly by all the consultants under whom the resident was posted during the year. Average of the three years should be put as the final marks out of 20.
Marks for academic activity should be given by the all consultants who have attended the session presented by the resident.
The Internal assessment should be presented to the Board of examiners for due consideration at the time of Final Examinations.

7.4. Summative Assessment
Ratio of marks in theory and practical will be equal. The pass percentage will be 50%. Candidate will have to pass theory and practical examinations separately.

<table>
<thead>
<tr>
<th>Theory examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sr. No.</td>
</tr>
<tr>
<td>Paper I</td>
</tr>
<tr>
<td>Paper II</td>
</tr>
<tr>
<td>Paper III</td>
</tr>
</tbody>
</table>
### Paper IV

<table>
<thead>
<tr>
<th></th>
<th>Recent Advances in plastic surgery</th>
<th>100</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>400</td>
</tr>
</tbody>
</table>

#### B. Practical & Viva-Voce Examination

<table>
<thead>
<tr>
<th>Sr.No.</th>
<th>Marks</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
<td>Long Case</td>
<td>100</td>
</tr>
<tr>
<td>2)</td>
<td>Short cases (2)</td>
<td>75 marks each</td>
</tr>
<tr>
<td>3)</td>
<td>Procedure</td>
<td>50</td>
</tr>
<tr>
<td>4)</td>
<td>Grand Viva</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>400</td>
</tr>
</tbody>
</table>

#### 8. Job Responsibilities

**Outdoor Patient (OPD) Responsibilities**
- The working of the residents in the OPD should be fully supervised.
- They should evaluate each patient and write the observations on the OPD card with date and signature.
- Investigations should be ordered as and when necessary using prescribed forms.
- Residents should discuss all the cases with the consultant and formulate a management plan.
- Patient requiring admission according to resident’s assessment should be shown to the consultant on duty.
- Patient requiring immediate medical attention should be sent to the casualty services with details of the clinical problem clearly written on the card.
- Patient should be clearly explained as to the nature of the illness, the treatment advice and the investigations to be done.
- Resident should specify the date and time when the patient has to return for follow up.

**In-Patient Responsibilities**

Each resident should be responsible and accountable for all the patients admitted under his care. The following are the general guidelines for the functioning of the residents in the ward:
- Detailed work up of the case and case sheet maintenance:
- He/She should record a proper history and document the various symptoms. Perform a proper patient examination using standard methodology. He should develop skills to ensure patient comfort/consent for examination. Based on the above evaluation he/she should be able to formulate a differential diagnosis and prepare a management plan. Should develop skills for recording of medical notes, investigations and be able to properly document the consultant round notes.
• To organize his/her investigations and ensure collection of reports.
• Bedside procedures for therapeutic or diagnostic purpose.
• Presentation of a precise and comprehensive overview of the patient in clinical rounds to facilitate discussion with senior residents and consultants.
• To evaluate the patient twice daily (and more frequently if necessary) and maintain a progress report in the case file.
• To establish rapport with the patient for communication regarding the nature of illness and further plan management.
• To write instructions about patient’s treatment clearly in the instruction book along with time, date and the bed number with legible signature of the resident.
• All treatment alterations should be done by the residents with the advice of the concerned consultants and senior residents of the unit.
Each Resident has responsibility for teaching interns and junior residents posted along with them in concerned unit.

Admission day
Following guidelines should be observed by the resident during admission day.
• Resident should work up the patient in detail and be ready with the preliminary necessary investigations reports for the evening discussion with the consultant on duty.
• After the evening round the resident should make changes in the treatment and plan out the investigations for the next day in advance.

Doctor on Duty
• Duty days for each Resident should be allotted according to the duty roster.
• The resident on duty for the day should know about all sick patients in the wards and relevant problems of all other patients, so that he could face an emergency situation effectively.
• In the morning, detailed over (written and verbal) should be given to the next resident on duty. This practice should be rigidly observed.
• If a patient is critically ill, discussion about management should be done with the consultant at any time.
• The doctor on duty should be available in the ward throughout the duty hours.

Care of Sick Patients
• Care of sick patients in the ward should have precedence over all other routine work for the doctor on duty.
• Patients in critical condition should be meticulously monitored and records maintained.
• If patient merits ICU care then it must be discussed with the senior residents and consultants for transfer to ICU.

Resuscitation skills
At the time of joining the residency programme, the resuscitation skills should be demonstrated to the residents and practical training provided at various work stations.
• Residents should be fully competent in providing basic and advanced cardiac life support.
• They should be fully aware of all advanced cardiac support algorithms and be aware of the use of common resuscitative drugs and equipment like defibrillators and external cardiac pacemakers.
• The resident should be able to lead a cardiac arrest management team.

Discharge of the Patient
• Patient should be informed about his/her discharge one day in advance and discharge cards should be prepared 1 day prior to the planned discharge. • The discharge card should include the salient points in history and examination, complete diagnosis, important management decisions, hospital course and procedures done during hospital stay and the final advice to the patient. • Consultants and DM Residents should check the particulars of the discharge card and counter sign it. • Patient should be briefed regarding the date, time and location of OPD for the follow up visit.

In Case of Death
• In case it is anticipated that a particular patient is in a serious condition, relatives should be informed about the critical condition of the patient beforehand. • Residents should be expected to develop appropriate skills for breaking bad news and bereavements. • Follow up death summary should be written in the file and face sheet notes must be filled up and the sister in charge should be requested to send the body to the mortuary with respect and dignity from where the patient’s relatives can be handed over the body. • In case of a medico legal case, death certificate has to be prepared in triplicate and the body handed over to the mortuary and the local police authorities should be informed. • Autopsy should be attempted for all patients who have died in the hospital especially if the patient died of an undiagnosed illness.

Bedside Procedures
The following guidelines should be observed strictly:
• Be aware of the indications and contraindications for the procedure and record it in the case sheet. Rule out contraindications like low platelet count, prolonged prothrombin time, etc. • Plan the procedure during routine working hours, unless it is an emergency. Explain the procedure with its complications to the patient and his/her relative and obtain written informed consent on a proper form. Perform the procedure under strict aseptic precautions using standard techniques. Emergency tray should be ready during the procedure. • Make a brief note on the case sheet with the date, time, nature of the procedure and immediate complications, if any. • Monitor the patient and watch for complications(s).

OT responsibilities
• The 1st year resident observes the general layout and working of the OT, understands the importance of maintaining sanctity of the OT, scrubbing, working and sterilization of all the OT Instrument, know how of microscopes. He/ She is responsible shifting of OT patients, for participating in surgery as 2nd assistant and for post operative management of patient in recovery and in ward. The 2nd year resident is responsible for pre op work up of the patient, surgical planning and understanding the rationale of surgery. He/she is the first assistant in surgery and is responsible for anticipating intra op and post op complications and managing them. The final year resident should be able to perform minor/medium/major surgeries independently and assist in medium/major/extra major surgeries. He/she should be able to handle all emergencies and post op complications independently and is responsible for supervision and guidance of his/her juniors.

Medico-Legal Responsibilities of the Residents
• All the residents are given education regarding medico-legal responsibilities at the time of admission in a short workshop. 100 Curriculum MCh (Plastic Surgery)
• They must be aware of the formalities and steps involved in making the correct death certificates, mortuary slips, medico-legal entries, requisition for autopsy etc.
• They should be fully aware of the ethical angle of their responsibilities and should learn how to take legally valid consent for different hospital procedures & therapies. They should ensure confidentiality at every stage. 9.

Suggested Books & Journals
: 9.1 Suggested Books
  • Neligan : Principles & Practices of Plastic surgery
  • Mathes: Principles & Practices of Plastic surgery
  • Grabb & Smith: Plastic surgery
  • Mc Gregor: Fundamental techniques of Plastic surgery
• Mc Carthy: Current therapy in Plastic surgery
• Rees: Aesthetic plastic surgery Green’s: Operative Hand surgery Grab’s: Encyclopedia of flaps
• Textbook of plastic , Reconstructive, and Aesthetic Surgery.
• Essentials of plastic surgery : Archer Queen
• Core Procedures in plastic Surgery : Peter Neligan
• Congenital Malformations of the Hand And Forearm : Dieter Buck Gramcko
• Manual of peripheral Nerve Surgery

9.2 Suggested Journals
• Plastic and Reconstructive Surgery journal
• Journal of Plastic Reconstructive and Aesthetic Surgery
• Burns
• Plastic Surgery Clinics
• Hand Clinics
  • Aesthetic Plastic Surgery
• JAMA Facial Plastic Surgery
• Annals Of Surgery
• British Journal of Surgery
• Journal of Oral And Maxillofacial Surgery