

UF

College of Medicine

Department of Otolaryngology

UNIVERSITY of FLORIDA

RESIDENCY MANUAL

2021 - 2022

INTRODUCTION

This manual is meant to provide guidelines regarding residency issues. Read and familiarize yourself with these guidelines; you are responsible for this information. These requirements are necessary to allow us to run an orderly and effective residency program.

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“The measure of a person’s worth is the degree to which they strive for excellence no matter what their chosen pursuit.”
-Vince Lombardi

“If you do not have time to do it right, when will you have time to do it over?”

-John Wooden

"Half of what you'll learn in medical school will be shown to be either dead wrong or out of date within five years of your graduation; the trouble is that nobody can tell you which half -- so the most important thing to learn is how to learn on your own."

- Dr. David Sackett, a pioneer of "evidence-based medicine,"

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I. EDUCATIONAL GOALS

The overall educational goals of the Department of Otolaryngology Residency are:

1. To provide a strong background in the basic and clinical sciences related to Otolaryngology
2. To assist in the development of clinical and surgical expertise
3. To provide the opportunity to learn and practice research skills

All residents participate in a series of didactic lectures, clinical conferences, journal reading assignments, and independent reading which is directed primarily toward achieving the first goal. The effectiveness of this program is monitored by resident evaluation of the program, results of AAO-HNS FLEX Course testing, results of the Annual Otolaryngology Examination, and success with the American Board of Otolaryngology certification process.

The goals for each major rotation, which relate primarily to the second and third major goals above, will be outlined in the following sections. Common to all years will be these specific goals:

Interpersonal and Communication skills:

- Understand the importance of good communication, and its impact on patient care.
- Develop excellent communication skills with patients, peers, staff, and attendings.
- Learn how to interact with other health care professionals in a courteous manner.

Professionalism:

- Learn how to ethically treat patients and always work in their best interest.
- Understand the importance of timeliness in dictations, rounding, charting.
- Understand the need for showing sensitivity to patients' ethnicity, age and disabilities.
- Learn how to practice medicine with integrity and honesty.

Systems-based practice:

- Learn how to work with an interdisciplinary team in the pre- and post-operative care of the surgical patient.
- Become adept at interacting with social work for the post-hospital care of our patients.
- Learn how to approach patient care problems from a systems-based approach rather than the "band-aid" approach.
- Begin to develop a feel for providing cost-effective medicine without compromising patient care.

Practice-based learning:

- Learn how to evaluate your own practice of medicine and correct any inefficient or incorrect behaviors.
- Learn how to use evidence-based medicine to better care for the patients.
- Become proficient at using the electronic medical record and the use of the Internet to look up medical information.
- Understand how professionals learn and the best way to teach medical students.

A. Head & Neck and Reconstruction Service

Head & Neck

Residents on the Head and Neck and Reconstruction Service are exposed to head and neck oncology, rhinology, endocrinology, general otolaryngology and facial plastics. This experience is attained in the clinic, on the wards, and in the operating room. Chief resident on rotation will be required to sign the “Head and Neck Chief Resident Roles and Expectations” (see Appendix F).

Year-Specific Goals

PGY-1 residents see Goals and Objectives for Intern year.

PGY-2

Medical Knowledge:

- Acquire advanced knowledge of the anatomy of the head and neck
- Develop an understanding of normal physiologic properties of the head and neck.
- Know TNM staging for head and neck cancer sites
- Learn the pathophysiology of head and neck cancer.
- Learn pathophysiology of thyroid/ parathyroid disease.
- Learn airway management for the critical airway
- Learn mechanics and application of regional and free flaps

Patient Care:

- Become efficient in clinic and on rounds
- Be able to supervise PGY-1 residents with inpatient consults
- Become proficient at the head and neck exam
- Begin to learn treatment algorithms for outpatient otolaryngologic disorders
- Learn surgical techniques of tracheostomies; approaches to the neck, oral, and sinonasal areas; endoscopies including laryngoscopy, bronchoscopy and esophagoscopy; skin graft harvest; and closure of complex wounds.
- Understand and show competence in management of epistaxis.

Interpersonal and Communication skills:

- Become proficient at communicating results/ patient care issues with the chief and intern of the service and with Attendings
- Learn to discuss sensitive issues with cancer patients

Systems-based practice:

- Become proficient at obtaining consults from Communicative Disorders, Social Work, Radiation Oncology, Endocrinology, Oral Surgery and Interventional Radiology
- Understand the importance of the head and neck junior resident on obtaining quality patient care
- Look for ways to improve the efficiency of the service

Practice-based learning:

- Read before every surgical case
- Develop the habit of researching disease processes seen in clinic that day
- Recognize mistakes made and develop solutions to prevent them from reoccurring

PGY-3 residents are expected to improve on all of the above as well as the following:

Medical Knowledge:

- Will learn enough of head and neck cancer management to discuss prognosis and treatment options
- Show advanced knowledge of head and neck anatomy
- Show advanced acquisition of head and neck physiology
- Improve understanding of pathophysiology of thyroid/ parathyroid, head and neck cancer,

granulomatous diseases, salivary gland disorders, and sinonasal disorders.

- Understand underlying disorder/ treatment for GERD/LPR, dysphagia, dysphonia.

Patient Care:

- Obtain skills necessary to handle the acute airway.
- Become facile with head and neck trauma
- Be able to staff consults with the junior residents
- Improve surgical skills in neck dissections, parotidectomies, thyroidectomies, endoscopic sinus surgery
- Be able to perform lower level cases independently: tracheotomies, DL, bronchoscopy, esophagoscopy, complex wound closure

Interpersonal and Communication skills:

- Be able to discuss end of life issues professionally
- Learn how to communicate effectively with junior residents

Systems-based practice:

- Take an active role in medical student and junior resident education.

PGY-4 residents are expected to improve on the above skills and progress in their ability to arrive at appropriate diagnoses and institute treatment plans.

Medical Knowledge:

- Advance knowledge of otolaryngologic diseases to be able to develop a reasonable short differential diagnosis
- Expand knowledge base of head and neck tumors, granulomatous disease, endocrine dysfunction, vasculitides, maxillofacial trauma, and difficult airway management

Patient Care:

- Be able to independently perform neck dissections, parotidectomy, thyroidectomies, maxillofacial trauma repair and perform routine endoscopic sinus surgery
- Be able to perform partial maxillectomies, closure of surgical defects with local or regional flaps
- Be able to care for post-operative issues for the head and neck team patients
- Be able to formulate a treatment plan for patients seen in outpatient clinic.

Interpersonal and Communication skills:

- Show excellent communication with medical students, junior residents and attendings

Systems-based practice:

- Demonstrate the ability to be chief of service
- Be able to teach the junior resident surgical procedures.
- Learn how to fix patient care problems by making system changes

Practice-based learning:

- Be able to lead M&M conference for the service.

PGY-5 residents are expected to improve on the above skills as well as the following:

Medical Knowledge:

- Will acquire the full breadth of knowledge of otolaryngologic disorders

Patient Care:

- Will be able to independently diagnose and develop treatment plans for outpatient disorders
- Will be able to perform all operations except for those that require a tertiary care referral

Systems-based practice:

- Be able to schedule patients for surgery
- Learn administrative duties necessary for running a practice

Practice-based learning:

- Show mastery of habits that will lead to life-long learning.

Reconstruction

PGY-4 and 5 residents will rotate on this service. The scope of this service includes treatment of sinonasal disorders, repair of cutaneous facial defects secondary to Moh's micrographic surgery, facial cosmetic surgery, treatment of vascular malformations, hair transplantation, surgical treatment of certain congenital malformations, aging face surgery and craniofacial trauma. It is intended that the resident will participate in the workup of all patients. They will participate in the planning of reconstructive events. They will learn the preoperative and postoperative care of the above-mentioned patients. At all times there will be supervision and immediate feedback available from the attending on the service.

Medical Knowledge:

- Develop an understanding of nasal airway obstruction and sinonasal disorders.
- Learn the anatomy and physiology of the nose.
- Understand local flap physiology and the vasculature dynamics, including radiation effects.
- Learn the deficits and treatments associated with the aging face, congenital malformations and alopecia.
- Understand the pathophysiology and outcomes of skin cancer and its treatment, including MOH's.
- Understand the basics of craniofacial trauma.

Patient Care:

- Learn the fundamentals of rhinoplasty, septoplasty, functional nasal surgery, browlift, blepharoplasty, treatment of vascular malformations and the surgical correction of the aging face
- Learn the fundamental of planning and executing local flaps in the head and neck area for the purposes of reconstructing cutaneous defects.
- Learn the fundamentals of photography necessary to accurately document preoperative and postoperative conditions. Each resident should also become familiar with the methods available for archiving medical photography information.

Interpersonal and Communication skills:

- Become proficient at communicating results/ patient care issues with the Attending on the service.
- Learn to discuss sensitive issues with cosmetic patients.
- Be able to discuss risks and complications of the various surgeries with the patient and obtain informed consent.
- Learn to interact with adjunct specialists in caring for these patients.

Systems-based practice:

- Become proficient at obtaining consults from the trauma service.
- Understand the uniqueness of a facial plastic service in context of the U.S. medical system particularly in its fee for service practice
- Understand the importance of the role of the resident in obtaining quality patient care
- Look for ways to improve the efficiency of the service

Practice-based learning:

- Read before every surgical case
- Develop the habit of researching disease processes seen in clinic that day
- Recognize mistakes made and develop solutions to prevent them from reoccurring

B. Otolaryngology / Laryngology Service

This rotation consists of otology/neurotology and laryngology. Both junior and senior residents rotate at the same time on this rotation. Our goal on this rotation is to facilitate an orderly progression from the more simple knowledge and skills, to the more complex clinical and surgical problems.

PGY-2

Medical Knowledge:

- Acquire advanced knowledge of the anatomy of the ear and temporal bone
- Develop an understanding of normal physiologic properties of hearing and balance.

- Know TNM staging for otologic and temporal bone cancer
- Learn the pathophysiology of cholesteatoma.
- Learn the pathophysiology of balance disorders.
- Learn the pathophysiology of hearing loss both conductive and sensorineural.
- Learn pathophysiology of infections of the ear.
- Understand the physics of hearing and audiometry
- Understand dysphagia, GERD/ LPR and how it relates to these patients
- Acquire advanced knowledge of the anatomy of the head and neck
- Develop an understanding of normal physiologic properties of the swallowing and phonation.
- Learn airway management for the critical airway
- Learn the pathophysiology of dysphonia and dysphagia
- Learn the pathophysiology of neurological diseases of the larynx
- Learn to interpret reports and examinations from Speech pathology

Patient Care:

- Become efficient in clinic and on rounds
- Be able to supervise PGY-1 residents with inpatient consults
- Become proficient at the otologic exam
- Learn surgical techniques of microscope use, cerumen debridement, foreign body removal of the external canal, and tympanostomy tube placement.
- Learn the basic set up for otologic procedures.
- Know the risks and benefits of otologic procedures and be able to relate these to the patient in appropriate language.
- Develop an understanding for the post-operative course of patients undergoing otologic procedures
- Become proficient at the head and neck exam
- Begin to learn treatment algorithms for outpatient otolaryngologic disorders including which diagnostic endoscopy to perform
- Learn surgical techniques of tracheostomies; laryngoscopy, bronchoscopy and esophagoscopy with biopsy; microscopic examination
- Learn to perform outpatient endoscopic procedures including Transnasal laryngoscopy with and without stroboscopy and fiberoptic endoscopic evaluation of swallow; assist in flexible biopsy
- Begin to learn interpretation of stroboscopy examination
- Become familiar with the setup for jet ventilation

Interpersonal and Communication skills:

- Become proficient at communicating results/ patient care issues with the chief and intern of the service and with Attendings
- Learn to discuss sensitive issues with patients suffering from hearing loss, vertigo, infections and tumors
- Learn to discuss sensitive issues with patients
- Learn to discuss findings of examination in manner that patient may understand
- Learn to discuss airway concerns with Anesthesiology team and operating room nursing staff to properly prepare for the potential difficult airway

Systems-based practice:

- Become proficient at obtaining consults from Communicative Disorders, Social Work, Audiologists, Neurosurgery and Interventional Radiology
- Understand the importance of the otology junior resident on obtaining quality patient care
- Look for ways to improve the efficiency of the service
- Become proficient at obtaining consults from Communicative Disorders, Social Work,
- Understand the importance of the junior resident on obtaining quality patient care

Practice-based learning:

- Read before every surgical case
- Develop the habit of researching disease processes seen in clinic that day

- Recognize mistakes made and develop solutions to prevent them from reoccurring
- Review laryngeal examination prior to surgical case

PGY-3 residents are expected to improve on all of the above as well as the following:

Medical Knowledge:

- Learn the treatment of otologic emergencies including mastoiditis, acute hearing loss, acute onset of vertigo.
- Show advanced knowledge of otologic anatomy
- Show advanced acquisition of otologic pathophysiology to include vertigo, hearing loss, infections and tumors.
- Will learn enough of dysphagia and dysphonia management to discuss prognosis and treatment options
- Show advanced knowledge of head and neck anatomy
- Show advanced acquisition of swallowing and phonation
- Understand underlying disorder/ treatment for GERD/LPR, dysphagia, dysphonia.

Patient Care:

- Improve skills started in the PGY-2.
- Improve diagnostic and therapeutic skills in the outpatient clinic.
- Be able to staff consults with the junior residents
- Improve surgical skills in simple tympanoplasty, mastoidectomy and tympanostomy tube placement.
- Obtain skills necessary to handle the acute airway.
- Improve surgical skills in vocal fold injection, biopsy, esophagoscopy, tracheo-esophageal puncture
- Be able to begin to identify esophageal pathology
- Be able to perform lower level cases independently: tracheotomies, DL, bronchoscopy, esophagoscopy
- Be able to determine anesthetic technique appropriate for operative case

Interpersonal and Communication skills:

- Learn how to communicate effectively with junior residents
- Be able to discuss dysphagia issues professionally (i.e. need for G Tube, inability to tolerate oral intake)

Systems-based practice:

- Take an active role in medical student and junior resident education

PGY-4 residents are expected to improve on the above skills and progress in their ability to arrive at appropriate diagnoses and institute treatment plans.

Medical Knowledge:

- Advance knowledge of otolaryngologic diseases to be able to develop a reasonable short differential diagnosis
- Expand knowledge base of hearing loss: conductive, sensorineural and mixed, vertigo: BPPV, neural, central, infections: external middle and inner ear, tumors: paraganglioma, acoustic neuromas, carcinomas, sarcomas, cholesteatoma
- Expand knowledge base of dysphonia and dysphagia
- Become competent in interpretation of stroboscopy examination
- Become competent in interpretation of esophageal examination

Patient Care:

- Be able to independently perform simple mastoidectomies, tympanoplasty and tympanostomy tube
- Be able to care for post-operative issues for the otologic patients
- Be able to formulate a treatment plan for patients seen in outpatient clinic.
- Be able to independently stroboscopy, vocal fold biopsy
- Be able to perform microflap excision, thyroplasty
- Be able to care for post-operative issues for the dysphagia and dysphonia patient

- Be able to formulate a treatment plan for patients seen in outpatient clinic.

Interpersonal and Communication skills:

- Show excellent communication with medical students, junior residents and attending

Systems-based practice:

- Demonstrate the ability to be chief of service including scheduling OR cases
- Be able to teach the junior resident surgical procedures.
- Show the ability to teach medical students and junior residents in the clinic, OR and temporal bone lab.
- Learn how to fix patient care problems by making system changes

Practice-based learning:

- Be able to lead M&M conference for the service.
- Be able to communicate with Speech pathology needs and concerns for patient

PGY-5 residents are expected to improve on the above skills as well as the following:

Medical Knowledge:

- Will acquire the full breadth of knowledge of otolaryngologic disorders

Patient Care:

- Will be able to independently diagnose and develop treatment plans for outpatient disorders
- Will be able to perform all operations except for those that require a tertiary care referral to include tympanomastoidectomy, ossicular chain reconstruction, and stapedectomy.
- Will be able to perform all operations except for those that require a tertiary care referral

Systems-based practice:

- Be able to schedule patients for surgery
- Learn administrative duties necessary for running a practice

Practice-based learning:

- Show mastery of habits that will lead to life-long learning.

C. Pediatric and General Otolaryngology

Residents on the Pediatrics and General Otolaryngology are exposed to children with Otolaryngological problems and general otolaryngology. This experience is attained in the clinic, on the wards, and in the operating room.

PGY-2

Medical Knowledge:

- Acquire advanced knowledge of the embryology and anatomy of the head and neck
- Develop an understanding of normal physiologic properties of pediatric airway and paranasal sinuses.
- Proficient at the pediatric ENT exam
- Begin to learn treatment algorithms for outpatient pediatric otolaryngologic disorders
- Learn surgical techniques of microscope use, cerumen debridement, foreign body removal of the external canal, and tympanostomy tube placement.
- Become proficient at adenotonsillectomies.
- Be able to perform direct laryngoscopy, bronchoscopy and esophagoscopy.
- Develop an understanding for the post-operative course of patients undergoing pediatric and general ENT procedures

Interpersonal and Communication skills:

- Become proficient at communicating results/ patient care issues with the chief of the service and with attendings
- Become proficient at communicating results with patients
- Learn to discuss sensitive issues with patients and/or their parents.

Systems-based practice:

- Become proficient at obtaining consults from Communicative Disorders, Social Work, and Audiologists
- Understand the importance of the junior resident on obtaining quality patient care
- Look for ways to improve the efficiency of the service

Practice-based learning:

- Read before every surgical case.
- Come to the OR prepared, knowing the patient's history, work-up and indications for surgery.
- Develop the habit of researching disease processes seen in clinic that day
- Recognize mistakes made and develop solutions to prevent them from reoccurring

PGY-3 residents are expected to improve on all of the above as well as the following:

Medical Knowledge:

- Learn the treatment of pediatric emergencies including airway emergencies
- Show advanced knowledge of head and neck anatomy and embryology
- Show advanced acquisition of pediatric pathophysiology to include otitis media, retropharyngeal/neck abscesses, neck masses, airway distress.
- Show advanced acquisition of adult pathophysiology to include sinonasal disorders, obstructive sleep apnea, and dysphagia

Patient Care:

- Improve skills started in the PGY-2.
- Improve diagnostic and therapeutic skills in the outpatient clinic.
- Be able to staff consults with the junior residents
- Improve surgical skills in adenotonsillectomy, tympanostomy tube placement, endoscopy of the aerodigestive tract, sinus endoscopy and treatment of OSA.

Interpersonal and Communication skills:

- Learn how to communicate effectively with junior residents

Systems-based practice:

- Take an active role in medical student and junior resident education

PGY-4 residents are expected to improve on the above skills and progress in their ability to arrive at appropriate diagnoses and institute treatment plans.

Medical Knowledge:

- Advance knowledge of otolaryngologic diseases to be able to develop a reasonable short differential diagnosis
- Expand knowledge base of pediatric airway disorders, foreign bodies of the aerodigestive tract, congenital neck masses, OSA, sinonasal disorders, infections of the head and neck

Patient Care:

- Be able to independently perform basic sinus surgery, surgery for OSA, foreign body removal, endoscopy of the aerodigestive tract/ pediatric trachs
- Be able to care for post-operative issues for the general ENT and pediatric patients
- Be able to formulate a treatment plan for patients seen in outpatient clinic.

Interpersonal and Communication skills:

- Show excellent communication with medical students, junior residents and attendings

Systems-based practice:

- Demonstrate the ability to be chief of service including scheduling OR cases
- Be able to teach the junior resident surgical procedures.
- Show the ability to teach medical students and junior residents in the clinic, and OR.
- Learn how to fix patient care problems by making system changes

Practice-based learning:

- Be able to lead M&M conference for the service.

PGY-5 residents are expected to improve on the above skills as well as the following:

Medical Knowledge:

- Will acquire the full breadth of knowledge of otolaryngologic disorders

Patient Care:

- Will be able to independently diagnose and develop treatment plans for outpatient disorders
- Will be able to perform all operations except for those that require a tertiary care referral to include removal of aerodigestive foreign bodies, excision of congenital neck masses, supraglottoplasty, tracheostomy on the infant/small child, microsurgery of the larynx, medialization laryngoplasty, and endoscopic sinus surgery.

Systems-based practice:

- Be able to schedule patients for surgery
- Learn administrative duties necessary for running a practice

Practice-based learning:

- Show mastery of habits that will lead to life-long learning.

D. Rhinology Rotation

PGY2

Medical Knowledge:

- Explain differences between acute and chronic sinusitis time course
- Explain differences in microbiology of acute vs chronic sinusitis
- Explain side effects and risks of medical treatment for sinusitis
- Explain risks of FESS
- Identify the following structures on CT scan: optic nerve, carotid artery, V2, vidian
- Identify complications of acute and chronic sinusitis

Patient Care:

- Perform adequate history of chronic sinusitis patients
- Explain medical treatment options for sinusitis
- Perform nasal endoscopy safely
- Perform trans-oral greater palatine injection
- Perform septoplasty
- Perform inferior turbinate reduction
- Successfully manage epistaxis

Interpersonal and Communication skills:

- Explain indications for endoscopic sinus surgery
- Become proficient at communicating results/ patient care issues with the chief of the service and with attendings
- Become proficient at communicating results with patients
- Learn to discuss sensitive issues with patients and/or their parents.

Systems-based practice:

- Become proficient at obtaining consults from Communicative Disorders, Social Work, and Audiologists
- Understand the importance of the junior resident on obtaining quality patient care
- Look for ways to improve the efficiency of the service

Practice-based learning:

- Read before every surgical case.
- Come to the OR prepared, knowing the patient's history, work-up and indications for surgery.
- Develop the habit of researching disease processes seen in clinic that day
- Recognize mistakes made and develop solutions to prevent them from reoccurring

PGY3

Medical Knowledge:

- Identify the following on CT scan: haller cell, Onodi cell, Supraorbital ethmoid cell
- Formulate evaluation and plan for complications of acute and chronic sinusitis

Patient Care:

- Set up image guidance system
- Medialize middle turbinate
- Open Maxillary sinus
- Perform anterior ethmoidectomy

Interpersonal and Communication skills:

- Learn how to communicate effectively with junior residents

Systems-based practice:

- Take an active role in medical student and junior resident education

PGY4

Medical Knowledge:

- Explain how to manage complications of FESS

Patient Care:

- Perform Posterior Ethmoidectomy
- Identify Superior turbinate
- Perform sphenoidotomy
- Perform post operative debridements on awake patients in clinic

Interpersonal and Communication skills:

- Show excellent communication with medical students, junior residents and attendings

Systems-based practice:

- Demonstrate the ability to be chief of service including scheduling OR cases
- Be able to teach the junior resident surgical procedures.
- Show the ability to teach medical students and junior residents in the clinic, and OR.
- Learn how to fix patient care problems by making system changes

Practice-based learning:

- Be able to lead M&M conference for the service.

PGY5

Medical Knowledge:

Patient Care:

- Manage complications of FESS
- Dissect ethmoid skull base
- Perform frontal recess dissection

Systems-based practice:

- Be able to schedule patients for surgery
- Learn administrative duties necessary for running a practice
- Teach junior residents how to perform maxillary and ethmoid surgery

Practice-based learning:

- Show mastery of habits that will lead to life-long learning.

E. Research Rotation

Residents enter into a research rotation during their **PGY- 3** year. The intent of this rotation is to acquaint residents with the protocols used to create, plan, implement, and collect data relative to a hypothesis being tested. To ensure the greatest utilization of time during this rotation, each resident is given guidelines which consist of: means to select a research topic and to prepare a research proposal, how to write specific aims, how

to write the background and significance of the given research topic, and how to create experimental designs and methods. These guidelines are intended to be used prior to and in the process of writing research papers from data acquired during the rotation.

Medical Knowledge:

- Develop an understanding of the research process. This includes identifying a research topic, finding a mentor, developing a proposal, and submitting an IRB proposal all during the PGY-2 year.
- The research should become an expert on their field of inquiry by researching all available information.
- The resident must seek out expert help in the performing of the experiments.
- They will learn how to write a paper for submission to a refereed journal.

Patient Care:

- The resident's time will be protected from clinical duties, with the exception of on-call duties.

Interpersonal and Communication skills:

- Become facile at communicating with various experts in their chosen area of study.
- Learn how to communicate well with laboratory staff, clinical research staff, animal care handlers as needed for the completion of the project.
- Show excellent communication skills with the research mentor by keeping them updated as to the progress of the project at least weekly.

Systems-based practice:

- Understand the importance of research in developing quality physicians.
- Learn how to utilize the expertise found at a major medical center for furthering medical research.
- Understand the role of scientific research in the development of our current medical system.

Practice-based learning:

- Recognize mistakes made and develop solutions to prevent them from reoccurring.
- Understand that each experiment may not succeed at first and develop methods for correcting either the design or the mistake made.
- Use the latest literature on which to base your research project.

F. VA Medical Center

The Gainesville VA Medical Center rotation for Otolaryngology-Head and Neck Surgery is staffed by junior residents and senior level residents at the chief or acting chief level. The service is a broad-based secondary and occasionally tertiary care practice. Clinics are managed by two residents and a nurse practitioner, and the operating room schedule is appropriate for two residents with attending coverage. The attendings also play a role with problem cases in the outpatient clinic setting, staffing each clinic.

PGY-2/ 3

Medical Knowledge:

- Acquire advanced knowledge of the anatomy of the head and neck
- Develop an understanding of normal physiologic properties of the head and neck.
- Learn the pathophysiology and TNM staging of head and neck cancer.
- Learn pathophysiology of hearing loss and vertigo.
- Learn airway management for the critical airway
- Learn the differential diagnosis for neck masses.
- Understand the principles of obstructive sleep apnea and its sequelae.

Patient Care:

- Become efficient in clinic and on rounds
- Become proficient at the head and neck exam, including flexible nasolaryngoscopy
- Begin to learn treatment algorithms for outpatient otolaryngologic disorders
- Learn surgical techniques of tracheostomies; approaches to the neck, oral, and sinonasal areas;

endoscopies including laryngoscopy, bronchoscopy and esophagoscopy; skin graft harvest; and closure of complex wounds, cerumen debridement and tympanostomy tube placement.

- Understand and show competence in the management of epistaxis.

Interpersonal and Communication skills:

- Become proficient at communicating results/ patient care issues with Attendings, the chief and the nurse practitioner of the service.
- Learn to discuss sensitive issues with cancer patients
- Be able to discuss risks and complications of the various surgeries with the patient and obtain informed consent.

Systems-based practice:

- Become proficient at obtaining consults from Communicative Disorders, Social Work, Radiation Oncology, Audiology and Radiology
- Understand the importance of the role of the junior resident on obtaining quality patient care
- Look for ways to improve the efficiency of the service

Practice-based learning:

- Read before every surgical case
- Develop the habit of researching disease processes seen in clinic that day
- Recognize mistakes made and develop solutions to prevent them from reoccurring

PGY-4 residents are expected to improve on the above skills and progress in their ability to arrive at appropriate diagnoses and institute treatment plans.

Medical Knowledge:

- Advance knowledge of otolaryngologic diseases to be able to develop a reasonable short differential diagnosis for many areas including cancer, hearing loss, vertigo, laryngeal pathology, thyroid disease and OSA

Patient Care:

- Be able to independently perform neck dissections, parotidectomy, thyroidectomies, and perform routine endoscopic sinus surgery, simple tympanomastoidectomies and middle ear exploration, surgery for OSA and control the acute airway.
- Be able to perform partial maxillectomies, closure of surgical defects with local or regional flaps
- Be able to care for post-operative issues for all of these patients
- Be able to formulate a treatment plan for patients seen in outpatient clinic.

Interpersonal and Communication skills:

- Show excellent communication with medical students, junior residents and attendings
- Show consideration for all staff

Systems-based practice:

- Demonstrate the ability to be chief of service
- Be able to teach the junior resident surgical procedures, handling the outpatient visit and proper ethical behavior.
- Learn how to fix patient care problems by making system changes

Practice-based learning:

- Be able to lead M&M conference for the service.
- Be able to schedule surgeries for the service to include contacting patients and performing all pre-operative procedures

PGY-5 residents are expected to improve on the above skills as well as the following:

Medical Knowledge:

- Will acquire the full breadth of knowledge of otolaryngologic disorders

Patient Care:

- Will be able to independently diagnose and develop treatment plans for outpatient disorders

- Will be able to perform all operations except for those that require a tertiary care referral; eventually becoming sufficiently proficient to operate with minimal guidance from attendings: neck dissection, total laryngectomy, thyroidectomy, parotidectomy, mastoidectomy, middle ear exploration sinonasal procedures, OSA surgery and complicated airway management

Systems-based practice:

- Be able to schedule patients for surgery
- Learn administrative duties necessary for running a practice

Practice-based learning:

- Show mastery of habits that will lead to life-long learning.

G. Intern Rotation Goals and Objectives

1. Anesthesia

As part of their first year of residency, the Otolaryngology interns are required to participate in a month long rotation in anesthesia. The expectations are that they will learn to deal with all perioperative anesthetic concerns in the patients who they will be caring for.

Medical Knowledge:

- Learn the types of local anesthetics and know their mechanism of action, appropriate use and dosages. Also understand the side effects and toxicity and how to prevent and control any overdose.
- Learn regional anesthetic blocks (especially, but not limited to the head and neck). Also be able to identify the location of the nerves needing to be blocked, which drugs are appropriate, and any side effects and toxicity associated with their use.
- Learn the use of sedation for both minor and major procedures. Also know the most common agents used in sedation, their dosages, side effects and toxicities. Understand when the application of sedation is necessary.
- Learn the application of general anesthesia in regards to the drugs used, their benefits and why each is chosen. Also understand the side effects, toxicities and ability to reverse the drugs.
- Learn the algorithm for handling the difficult airway.
- Understand the risks of anesthesia and how to deal with the perioperative complications

Patient Care:

- Learn how to an appropriate history and physical for the patient undergoing anesthesia and which auxiliary tests are necessary..
- Show competence in venipuncture, arterial line placement, and endotracheal intubation.
- Show competence in monitoring patients undergoing anesthesia, to include understanding blood acid-base relationships and how to correct them.
- Develop a care plan for patients in the PACU.

Interpersonal and Communication skills:

- Understand the importance of good communication, especially between anesthesiologists and surgeons.
- Develop excellent communication skills with patients, peers, staff, and attendings

Professionalism:

- Learn how to ethically treat patients and always work in their best interest.
- Understand the importance of timeliness in dictations, rounding, charting.
- Understand the need for showing sensitivity to patients' ethnicity, age and disabilities.
- Learn how to practice medicine with integrity and honesty.

Systems-based practice:

- Learn how to work with an interdisciplinary team in the pre- and post-operative care of the surgical patient.
- Learn how to approach patient care problems from a systems-based approach rather than the "band-aid" approach.

- Begin to develop a feel for providing cost-effective medicine without compromising patient care.

Practice-based learning:

- Learn how to evaluate your own practice of medicine and correct any inefficient or incorrect behaviors.
- Learn how to use evidence-based medicine to better care for the patients.
- Become proficient at using the electronic medical record and the use of the Internet to look up medical information.
- Understand how professionals learn and the best way to teach medical students

2. General Surgery (GI)

One of the months required in the first year will be General Surgery. The expectations are that they will learn the approach and the care for patients with various general surgical disorders.

Medical Knowledge:

- Define the anatomy and physiology of the alimentary tract as it applies to common surgical diseases.
- Outline the essential characteristics of routine diagnostic evaluation of the alimentary tract.
- Explain medical and surgical management of common GI abnormalities such as peptic ulcer disease, gallstones, upper and lower GI hemorrhage, diverticulitis, and pancreatitis.
- Describe the anatomy and physiology of the thyroid, parathyroid and adrenal glands.
- Understand the current management and surgical options for the management of inflammatory bowel disease.
- Explain the rational use of antibiotics in surgical practice.
- Recognize the indications and surgical options for the use of minimally invasive techniques in surgical practice.
- Understand the indications and recognize complications associated with operations for morbid obesity.

Patient Care:

- Learn how to perform an appropriate history and physical for the General Surgical patient.
- Show competence in the peri-operative management of the surgical patient including stoma, drain and tube care and management of common complications.
- Manage the nutritional needs for the peri-operative patient.
- Show competence in minor surgical procedures.

Interpersonal and Communication skills:

- Understand the importance of good communication.
- Develop excellent communication skills with patients, peers, staff, and attendings.

Professionalism:

- Learn how to ethically treat patients and always work in their best interest.
- Understand the importance of timeliness in dictations, rounding, charting.
- Understand the need for showing sensitivity to patients' ethnicity, age and disabilities.
- Learn how to practice medicine with integrity and honesty.

Systems-based practice:

- Learn how to work with an interdisciplinary team in the pre- and post-operative care of the surgical patient.
- Learn how to approach patient care problems from a systems-based approach rather than the "band-aid" approach.
- Begin to develop a feel for providing cost-effective medicine without compromising patient care.
- Become proficient at working with social services in the care of the surgical patient.

Practice-based learning:

- Learn how to evaluate your own practice of medicine and correct any inefficient or incorrect behaviors.
- Learn how to use evidence-based medicine to better care for the patients.

- Become proficient at using the electronic medical record and the use of the Internet to look up medical information.
- Understand how professionals learn and the best way to teach medical students.

3. Intensive Care Unit

The Otolaryngology interns are required to participate in a month long rotation in the ICU. The expectations are that they will learn to understand the care of the critical care patient and develop the ability to initiate care in this patient population.

Medical Knowledge:

- Learn the principles behind ATLS.
- Learn the principles behind ventilator management and the physiology of the respiratory system.
- Learn the principles behind the management of cardiovascular disease including diagnosis and pharmacotherapy.
- Learn the presentation, pathophysiology and treatment of renal failure.
- Learn the pathophysiology and treatment of coagulopathies.

Patient Care:

- Learn how to perform an appropriate history and physical for the critical care patient.
- Show competence in intubating patients and how to handle the emergent airway.
- Show competence in placing central lines, chest tubes, and arterial lines.
- Show competence in placing Foley catheters and nasal feeding tubes.
- Learn how to manage the critical care patient

Interpersonal and Communication skills:

- Understand the importance of good communication
- Develop excellent communication skills with patients, peers, staff, and attendings

Professionalism:

- Learn how to ethically treat patients and always work in their best interest.
- Understand the importance of timeliness in dictations, rounding, charting.
- Understand the need for showing sensitivity to patients' ethnicity, age and disabilities.
- Learn how to practice medicine with integrity and honesty.

Systems-based practice:

- Learn how to work with an interdisciplinary team in the care of the critical care patient including arranging care by consult teams.
- Learn how to approach patient care problems from a systems-based approach rather than the "band-aid" approach.
- Begin to develop a feel for providing cost-effective medicine without compromising patient care.

Practice-based learning:

- Learn how to evaluate your own practice of medicine and correct any inefficient or incorrect behaviors.
- Learn how to use evidence-based medicine to better care for the patients.
- Become proficient at using the electronic medical record and the use of the Internet to look up medical information.
- Understand how professionals learn and the best way to teach medical students.

4. Otolaryngology

As part of their first year of residency, the Otolaryngology interns will do six rotations on the Otolaryngology service. The expectations are that they will begin to learn the full breadth of their specialty. This first year will emphasize learning emergency protocols, basic ENT procedures, and coordinating pre and post op care of patients on the head and neck service.

Medical Knowledge:

- Re-learn the anatomy of the head and neck by participating in the cadaver dissection series.
- Learn the emergency care protocols for epistaxis, emergent airway, penetrating and blunt neck trauma, maxillofacial injuries (fractures and lacerations), foreign body (nasal, ear, airway, esophageal) and caustic aspiration, and CSF leak.
- Learn the pathophysiology, bacteriology/ mycology, and management of sinusitis.
- Understand the indications and treatment for tonsillitis.
- Understand the pathophysiology and bacteriology of middle ear disease.
- Learn the physics behind audiometry and be able to interpret an audiogram.
- Learn the important issues in dysphagia and maneuvers to improve swallowing dysfunction.

Patient Care:

- Learn how to an appropriate history and physical for patients undergoing head and neck procedures.
- Show competence in direct laryngoscopy, esophagoscopy, and tracheotomy.
- Become an expert first assist for major head and neck cases.
- Learn how to perform appropriate free-flap evaluations.

Interpersonal and Communication skills:

- Understand the importance of good communication, and its impact on patient care.
- Develop excellent communication skills with patients, peers, staff, and attendings.
- Learn how to interact with other health care professionals in a courteous manner.

Professionalism:

- Learn how to ethically treat patients and always work in their best interest.
- Understand the importance of timeliness in dictations, rounding, charting.
- Understand the need for showing sensitivity to patients' ethnicity, age and disabilities.
- Learn how to practice medicine with integrity and honesty.

Systems-based practice:

- Learn how to work with an interdisciplinary team in the pre- and post-operative care of the surgical patient.
- Become adept at interacting with social work for the post-hospital care of our patients.
- Learn how to approach patient care problems from a systems-based approach rather than the "band-aid" approach.
- Begin to develop a feel for providing cost-effective medicine without compromising patient care.

Practice-based learning:

- Learn how to evaluate your own practice of medicine and correct any inefficient or incorrect behaviors.
- Learn how to use evidence-based medicine to better care for the patients.
- Become proficient at using the electronic medical record and the use of the Internet to look up medical information.
- Understand how professionals learn and the best way to teach medical students.

5. Emergency Medicine

As part of their first year of residency, the Otolaryngology interns are required to participate in a month long rotation in the Emergency Department. The expectations are that they will learn the emergency management of Otolaryngological disorders, especially in regards to the emergent airway, as well as basic management of trauma patients and other patients presenting to the ED.

Medical Knowledge:

- Learn the principles behind ATLS.
- Learn the anatomy and pathophysiology of epistaxis.
- Learn the anatomy, pathophysiology and bacteriology behind deep neck space abscesses.
- Learn the anatomy, pathophysiology and bacteriology behind acute otitis externa, acute otitis media, and acute sinusitis.

Patient Care:

Learn how to perform an appropriate history and physical for the emergency room patient.

- Show competence in suturing facial lacerations.
- Show competence in assisting in the resuscitation of the multi-trauma patient
- Learn how to take care of patients with epistaxis.
- Learn how to take care of a peritonsillar abscess.
- Learn how to handle the emergent airway, including foreign bodies.

Interpersonal and Communication skills:

- Understand the importance of good communication
- Develop excellent communication skills with patients and families, peers, staff, and attendings

Professionalism:

Learn how to ethically treat patients and always work in their best interest.

- Understand the importance of timeliness in dictations, rounding, charting.
- Understand the need for showing sensitivity to patients' ethnicity, age and disabilities.
- Learn how to practice medicine with integrity and honesty.

Systems-based practice:

- Learn how to work with an interdisciplinary team in the care of the trauma/ emergent patient.
- Learn how to approach patient care problems from a systems-based approach rather than the "band-aid" approach.
- Begin to develop a feel for providing cost-effective medicine without compromising patient care.

Practice-based learning:

- Learn how to evaluate your own practice of medicine and correct any inefficient or incorrect behaviors.
- Learn how to use evidence-based medicine to better care for the patients.
- Become proficient at using the electronic medical record and the use of the Internet to look up medical information.
- Understand how professionals learn and the best way to teach medical students.

6. Plastic Surgery

One of the required months will be Plastic Surgery. The expectations are that they will learn the pathophysiology behind congenital abnormalities and their reconstruction. Also, they will learn delicate tissue handling, the management of chronic wounds and cutaneous malignancies and assist with complex reconstructions.

Medical Knowledge:

- Learn the pathophysiology of wound healing and skin grafting.
- Understand the developmental process of cleft lips and palate and the surgical and non-surgical means for correcting them.
- Learn the pathophysiology behind bone remodeling and trauma.
- Learn the pathophysiology behind skin/ wound necrosis and its management.
- Learn the etiology, pathophysiology, and management behind cutaneous malignancies.

Patient Care:

- Learn how to perform an appropriate history and physical for the Plastic Surgery patient.
- Learn the approach and repair of maxillofacial trauma.
- Show competence in delicate tissue handling and closing of lacerations and surgical wounds.
- Become an expert assist at complex closure and flaps in dealing with wounds. and cutaneous malignancies
- Be able to provide peri-operative care for the plastic surgery patient.

Interpersonal and Communication skills:

- Understand the importance of good communication between different specialties, with allied health care and patients and their families.
- Develop excellent communication skills with patients/ families, peers, staff, and attendings

Professionalism:

- Learn how to ethically treat patients and always work in their best interest.
- Understand the importance of and demonstrate timeliness in dictations, rounding, charting.
- Demonstrate sensitivity to patients' ethnicity, age and disabilities.
- Learn how to practice medicine with integrity and honesty.

Systems-based practice:

- Learn how to work with an interdisciplinary team in the pre- and post-operative care of the plastic surgery patient.
- Learn how to approach patient care problems from a systems-based approach rather than the "band-aid" approach.
- Begin to develop a feel for providing cost-effective medicine without compromising patient care.

Practice-based learning:

- Learn how to evaluate your own practice of medicine and correct any inefficient or incorrect behaviors.
- Learn how to use evidence-based medicine to better care for the patients.
- Become proficient at using the electronic medical record and the use of the Internet to look up medical information.
- Understand how professionals learn and the best way to teach medical students.

7. Surgical Oncology

One of the required months will be Surgical Oncology. The expectations are that they will learn the pathophysiology behind different cancers, learn the peri-operative care of the cancer patient, and participate in the surgical treatment of the cancer patient.

Medical Knowledge:

- Discuss current theories of carcinogenesis including genetic, immune and environmental influences
- Learn the pathophysiology and treatment for carcinomas of the digestive tract.
- Learn the pathophysiology and treatment of soft tissue sarcomas.
- Learn the pathophysiology and treatment of lymphomas.
- Learn the pathophysiology of thyroid cancers.
- Learn the pathophysiology and treatment of skin cancers including melanoma, basal cell and squamous cell carcinomas.

Patient Care:

- Learn how to perform an appropriate history and physical for the General Surgical oncology patient.
- Show competence in the peri-operative management of the cancer patient including stoma care.
- Manage the nutritional needs for the peri-operative patient.
- Show competence in minor procedures.

Interpersonal and Communication skills:

- Understand the importance of good communication.
- Develop excellent communication skills with patients, peers, staff, and attendings.

Professionalism:

- Learn how to approach the cancer patient.
- Learn how to ethically treat patients and always work in their best interest.
- Understand the importance of timeliness in dictations, rounding, charting.
- Understand the need for showing sensitivity to patients' ethnicity, age and disabilities.
- Learn how to practice medicine with integrity and honesty.

Systems-based practice:

- Learn how to work with an interdisciplinary team in the pre- and post-operative care of the cancer patient.
- Learn how to approach patient care problems from a systems-based approach rather than the "band-aid" approach.

- Begin to develop a feel for providing cost-effective medicine without compromising patient care.
- Become proficient at working with social services in the care of the cancer patient.

Practice-based learning:

- Learn how to evaluate your own practice of medicine and correct any inefficient or incorrect behaviors.
- Learn how to use evidence-based medicine to better care for the patients.
- Become proficient at using the electronic medical record and the use of the Internet to look up medical information.
- Understand how professionals learn and the best way to teach medical students.

8. Trauma Surgery

One of the required months will be Trauma Surgery. The expectations are that they will learn the approach and the care for patients with various surgical disorders.

Medical Knowledge:

- Learn the pathophysiology of traumatic injuries, particularly as they relate to head and neck injuries.
- Learn the treatment options for priority evaluation of trauma patients.

Patient Care:

- Learn to perform an appropriate evaluation of a critically ill trauma patient.
- Learn to properly assess the urgency and prioritization of tasks in the evaluation and treatment of a trauma patient.
- Understand the management options in evaluating patients with penetrating neck trauma.

Interpersonal and Communication skills:

- Understand the importance of good communication.
- Develop excellent communication skills with patients, peers, staff, and attendings.

Professionalism:

- Learn how to ethically treat patients and always work in their best interest.
- Understand the importance of timeliness in dictations, rounding, charting.
- Understand the need for showing sensitivity to patients' ethnicity, age and disabilities.
- Learn how to practice medicine with integrity and honesty.

Systems-based practice:

- Learn how to work with an interdisciplinary team in the pre- and post-operative care of the surgical patient.
- Learn how to approach patient care problems from a systems-based approach rather than the "band-aid" approach.
- Begin to develop a feel for providing cost-effective medicine without compromising patient care.
- Become proficient at working with social services in the care of the surgical patient.

Practice-based learning:

- Learn how to evaluate your own practice of medicine and correct any inefficient or incorrect behaviors.
- Learn how to use evidence-based medicine to better care for the patients.
- Become proficient at using the electronic medical record and the use of the Internet to look up medical information.
- Understand how professionals learn and the best way to teach medical students.

9. Oral Surgery

The interns will rotate on the Oral Surgery service for 4 weeks. During that time they are expected to learn about dental anatomy, dental extractions, local and regional oral anesthesia, and disorders of the jaw.

Medical Knowledge:

- Learn dental and jaw anatomy and the indications for dental extractions.
- Learn about TMJ disorder and the multiple therapeutic options.
- Understand about ORN/ osteonecrosis and the treatment options.
- Learn about tumors of the jaws, their pathophysiology, treatment and outcomes.
- Learn about oral ulcers, their diagnosis and treatment.
- Learn the biomechanics behind bony facial trauma and rigid fixation.

Patient Care:

- Learn how to perform an appropriate history and physical for patients undergoing oral surgery procedures.
- Show competence in dental extractions.
- Show competence in local and regional oral anesthesia.
- Learn how to repair bony facial trauma.

Interpersonal and Communication skills:

- Understand the importance of good communication, and its impact on patient care.
- Develop excellent communication skills with patients, peers, staff, and attendings.
- Learn how to interact with other health care professionals in a courteous manner.

Professionalism:

- Learn how to ethically treat patients and always work in their best interest.
- Understand the importance of timeliness in dictations, rounding, charting.
- Understand the need for showing sensitivity to patients' ethnicity, age and disabilities.
- Learn how to practice medicine with integrity and honesty.

Systems-based practice:

- Learn how to work with an interdisciplinary team in the pre- and post-operative care of the surgical patient.
- Become adept at interacting with social work for the post-hospital care of your patients.
- Learn how to approach patient care problems from a systems-based approach rather than the "band-aid" approach.
- Begin to develop a feel for providing cost-effective medicine without compromising patient care.

Practice-based learning:

- Learn how to evaluate your own practice of medicine and correct any inefficient or incorrect behaviors.
- Learn how to use evidence-based medicine to better care for the patients.
- Become proficient at using the electronic medical record and the use of the Internet to look up medical information.
- Understand how professionals learn and the best way to teach medical students.

H. Otolaryngology Service Intern Daily Schedule

Interns rotating with Otolaryngology are assigned to the Head and Neck Oncology service. They are expected to function as a member of the team with participation both in inpatient care and in the operating room. Interns are expected to attend morning conference daily.

PGY1 Otolaryngology residents will also spend time with ancillary services pertinent to ENT including pathology, radiology, audiology, and speech pathology.

II. GRADUATED LEVELS OF RESPONSIBILITY

PGY I – Individuals in the PGY I year are closely supervised by more senior level residents and/or faculty. Examples of tasks that are expected of PGY I physicians include: perform a history and physical, start intravenous lines, draw blood, order medication and diagnostic tests, collect and analyze test results and communicate those to the other members of the team and faculty, obtain informed consent, place urinary catheters and nasogastric tubes, assist in the operating room performing tracheotomies and skin grafts and closure of wounds and perform other invasive procedures under the supervision of the faculty or senior residents at the discretion of the responsible faculty member. The resident is expected to exhibit a dedication to the principles of professional preparation that emphasizes primacy of the patient as the focus for care. The first year resident must develop and implement a plan for study, reading and research of selected topics that promotes personal and professional growth and be able to demonstrate successful use of the literature in dealing with patients. The resident should be able to communicate with patients and families about the disease process and the plan of care as outlined by the attending. At all levels, the resident is expected to demonstrate an understanding of the socioeconomic, cultural, and managerial factors inherent in providing cost effective care. Communication is emphasized this year including the ability to interact between health care services and exhibiting knowledge of systems-based practice

Indirect supervision is adequate for the following patient care situations:

1. Initial evaluation and management of inpatients.
2. Preoperative & postoperative evaluation and management.
3. Patient transfers between floors and/or hospitals.
4. Discharging patients from the hospital.
5. Interpretation of lab results.
6. Procedures such placement of IV's, nasogastric tubes, Foley catheters, and arterial punctures.

Direct supervision is required for the following patient care situations, until competency can be demonstrated and documented:

1. Initial evaluation and management of patients with urgent or emergent conditions. ATLS certification should be obtained.
2. Evaluation and management of postoperative complications.
3. Evaluation and management of critically ill patients.
4. Management of patients in cardiac arrest. ACLS certification should be obtained.
5. Procedures such as:
 - a. Advanced vascular access
 - b. Closure of surgical incisions and/or lacerations
 - c. Excision of superficial skin lesions
 - d. Tube thoracostomy
 - e. Paracentesis
 - f. Joint aspiration
 - g. Airway management, including orotracheal intubation and tracheostomy
 - h. Tracheotomy tube exchanges
 - i. Nasal packing for epistaxis
 - j. Drainage of peritonsillar abscess

Documentation of competency in each of the above listed skills will require being “signed off” using the Intern Sign Off Sheet (see Appendix D) by a more senior level resident and/or attending. Upon the documentation of competency, the Sign Off Sheet can be submitted to either the Program Director or his/her designee for proper documentation in New Innovations. A cumulative record of demonstrated competencies for PGY 1 residents will be maintained electronically.

PGY II – Individuals in the second post graduate year are expected to perform independently the duties learned in the first year and may supervise the routine activities of the first year residents. Beginning at the PGY II level residents may order restraints or seclusion. The PGY II may perform some procedures without direct (on-site) supervision such as facial laceration repair, debridement of wounds, endoscopy and facile foreign body removal from the nasal passageway and ear. Residents at this level can perform procedures and endoscopy under the direct supervision of faculty or senior level residents. The PGY II should be able to demonstrate continued sophistication in the acquisition of knowledge and skills in Otolaryngology and further ability to function independently in evaluating patient problems and developing a plan for patient care. The resident at the second year level may respond to consults and learn the elements of an appropriate response to consultation in conjunction with the faculty member. The resident should take a leadership role in teaching the PGY I and medical students the practical aspects of patient care and be able to explain complex diagnostic and therapeutic procedures to the patient and family. The resident should be adept at the interpersonal skills needed to handle difficult situations. The PGY II should be able to incorporate ethical concepts into patient care and discuss these with the patient, family, and other members of the health care team.

PGY III – In the third year, the resident should be capable of managing patients with virtually any routine or complicated condition and of supervising the PGY I and PGY II in their daily activities. The resident is responsible for coordinating the care of multiple patients on the team assigned. Individuals in the third postgraduate year may perform all routine diagnostic and therapeutic procedures including endoscopy without direct (on-site) supervision. The PGY III can perform progressively more complex procedures under the direct (on-site) supervision of the faculty. It is expected that the third year resident be adept in the use of the literature and routinely demonstrate the ability to research selected topics and present these to the team. At the completion of the third year, the resident should be ready to assume senior level responsibility in those specialties requiring three years of training.

PGY IV – Individuals in the fourth post graduate year assume an increased level of responsibility as the chief or senior resident on selected services and can perform the full range of complex procedures expected of Otolaryngology under the supervision of the faculty. The fourth year is one of senior leadership and the resident should be able to assume responsibility for organizing the service and supervising junior residents and students. The resident should have mastery of the information contained in standard texts and be facile in using the literature to solve specific problems. The resident will be responsible for presentations at conferences and for teaching junior residents and students on a routine basis. The PGY IV should begin to have an understanding of the role of the practitioner in an integrated health care delivery system and to be aware of the issues in health care management facing patients and physicians.

PGY V – The fifth year resident, under the supervision of the faculty, takes responsibility for the management of the major surgical teaching services. The PGY V can perform most complex and high risk procedures expected of a physician with the approval of the attending physician. During the final year of training the resident should have the opportunity to demonstrate the mature ethical, judgmental and clinical skills needed for independent practice. The PGY V gives formal presentations at scientific assemblies and assumes a leadership role in teaching on the service. The mores and values of the profession should be highly developed, including the expected selfless dedication to patient care, a habit of lifelong study and commitment to continuous improvement of self and the practice of medicine.

III. COMPETENCIES

The six competencies from the ACGME's Outcomes project have been phased into the residency teaching program. Below is the outline for this implementation.

Patient care:

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

Goals:

- To develop residents so that will be able to independently deliver compassionate, appropriate, effective, and expert medical care for otolaryngologic disorders.

Objectives:

- To teach residents how to gather and interpret thorough and accurate information.
- To teach residents to perform a complete Head and Neck history and physical.
- To teach residents how to make decisions and order diagnostic tests based on evidence based medicine and clinical judgment.
- To teach residents how to diagnose and treat medical and surgical otolaryngologic disorders
- To teach residents how to operate safely, efficiently, and independently.
- To teach residents how to develop and manage patient treatment plans.
- To develop excellent dictation skills in residents.
- To teach residents how to work with others to provide patient focused care

Teaching method:

- Direct observation and participation with graduated experience and close supervision in clinical and surgical settings.
- Question and answer sessions on teaching rounds.
- Standardized patient preparation and self-evaluation.
- Clinical skills laboratory sessions: percutaneous tracheostomy; pediatric and adult bronchoesophagoscopy course with advanced mannequins and live animals; temporal bone course; endoscopic sinus surgery course; regional and free flap course; maxillofacial repair and plating course. Clinically based lecture series (faculty and residents).
- Journal clubs (Otolaryngology specific and thyroid multidisciplinary journal club).
- Head and neck tumor conference.
- Quality Assurance conference.
- Evaluation of continuity cases

Evaluation method:

- Direct observation of the resident during patient care and bedside rounds
- Clinical outcomes of the patients under the resident's care
- The resident's patient presentations to faculty and/or senior residents
- 360 degree evaluations by faculty, peers, staff and patients
- Surgical skill assessment

Outcome measures:

- Improvement in surgical skills to the point of independence.
- Improvement in clinical acumen and skills to the point of independence.
- Improvement in clinical laboratory sessions until skill set is mastered.

Medical Knowledge:

Residents will demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral science, as well as the application of this knowledge to patient care.

Goal:

- To develop residents with broad based knowledge of clinical and basic science topics in Otolaryngology and the ability to apply medical knowledge to patient care.

Objective:

- To instill in the residents habits that will lead to lifelong learning.
- To teach the residents the clinical aspects of Otolaryngology.
- To teach the residents the basic science concepts of Otolaryngology.
- To teach the residents how to critically evaluate the literature and apply it to patient care.

Teaching Methods:

- Faculty basic science and clinical lecture series
- Journal clubs
- Resident coordinated study sessions (COCLIA)
- Teaching rounds
- Home study course (AAO based compilation of 20-25 papers on a particular topic with test for each section)
- Mentoring for their research project
- Head and Neck Tumor Board
- Quality Assurance Conference
- Temporal bone lab.

Evaluation Methods:

- In-training examination scores
- Scores on Home Study Course self-tests
- Evaluation of Annual Resident Presentation
- Publication or presentation of research activities
- Direct observation during patient care, bedside rounds, patient presentations, conferences, and OR
- Evaluation of competency in the cognate sciences (i.e. epidemiological and social-behavioral sciences) will be evaluated during directed discussion in such forums as journal club, teaching and research conferences, or in patient-specific discussions as appropriate
- 360 degree evaluations by faculty, peers, staff, and patients
- Surgical Assessments

Outcome measures:

- Score within the upper 50% for your year of training on the in-service score.
- Pass the Otolaryngology Board exam.
- Achieve a score above 80% on the Home Study Course.
- Improve participation/ answers in lectures/OR/ teaching rounds.
- Improve quality of lecture to sub specialist level.

Practice-based learning and improvement:

Residents will demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents will develop skills and habits to:

- Identify strengths, deficiencies, and limits in one's knowledge and expertise
- Set learning and improvement goals

Identify and perform appropriate learning activities

- Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement
- Incorporate formative evaluation feedback into daily practice
- Locate, appraise, and assimilate evidence from scientific studies related to their patient's health problems

Use information technology to optimize learning

- Participate in the education of patients, families, students, residents and other health professionals

Goal:

- To develop residents who are able to use evidence based medicine as the primary driving force for medical decision making.

Objective:

- To teach residents how to interpret new literature for pertinence and reliability and apply it to patient care.
- To teach residents how to critically evaluate and continually improve their own practice of medicine.
- To teach residents how to facilitate the learning of other health care professionals.

Teaching Methods:

- Quality Assurance conference: all conferences begin with an update on past QA's to follow the patients longitudinally.
- Home study course.
- Direct observation of faculty and their use of EBM in treating patients in clinic and the OR.
- Resident study group.
- Faculty and resident lectures.
- Specific lecture and tasks (teaching plan) to improve the resident's ability to teach.
- Written 6 month self-assessments and goals
- Evaluation of continuity cases

Evaluation Methods:

- Direct observation of improvement in the resident's clinical care as patient experience, knowledge and feedback grow, and through observation of improvements in surgical technique with repeated performance of procedures
- Use of evidence-based medicine, evaluation of available evidence, and use of best-available evidence is stressed during routine clinical care and during Quality Assurance Conference
- Scores on the Home Study Course
- 360 degree evaluation by faculty, peers, staff, and patients

Outcome Measures:

- Show evidence of study habits that will lead to lifelong learning.
- Show evidence of daily use of EBM in treating patients.

Interpersonal and Communication:

Residents will demonstrate interpersonal and communication skills that result in effective exchange of information and collaboration with patients, their families, and health professional. Residents will: Communicate effectively with patients, families, and the public across a broad range of socioeconomic and cultural backgrounds. Communicate effectively with physicians, other health professional, and health related agencies. Work effectively as a member or leader of a health care team or other professional group act in a consultative role to other physicians and health professionals maintain comprehensive, timely, and legible records:

Goal:

- To develop residents who can easily interact with peers, patients, staff and other medical professionals and attendings. To develop residents with excellent communication skills.

Objective:

- To teach residents the proper way to interact with staff and other medical professionals.
- To teach residents how to interact with peers and attendings.
- To teach residents how to therapeutically interact with patients, including the difficult patient.
- To teach the residents how to be an effective team leader.

Teaching method:

- Small group sessions centered on communication.
- Direct observation of faculty in clinics and in lectures.
- Standardized patient session and review.
- Giving lecture to faculty and other residents and the feedback on lecture style.
- Developing a personal portfolio over the course of the residency with major goals achieved and essays on insights into different competencies.

Evaluation method:

- Direct observation during communications with faculty, peers, staff, and patients

- 360 degree evaluation by faculty, peers, staff, and patients.
- Feedback of faculty and peers during clinics and patient checkouts.
- Faculty evaluation of lecture delivery.
- Evaluation of small group discussion.
- Program director's evaluation of the portfolio.

Outcome measure:

- To have an oral presentation style that is effective and engaging.
- To achieve consistently high marks on interpersonal skills from faculty, peers, nurses and patients.
- To be able to communicate effectively with faculty and peers regarding patient care issues.
- A well-organized, clear portfolio.

Professionalism:

Residents will demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents will demonstrate

- Compassion, integrity, and respect for others
- Responsiveness to patient needs that supersedes self-interest
- Respect for patient privacy and autonomy
- Accountability to patients, society and the profession
- Sensitivity and responsiveness to a diverse patient population, including diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

Goal:

- To develop residents who are consummate professionals in their everyday work environment.

Objective:

- To develop a sense of timeliness in the residents.
- To teach professional behavior by always acting in the best interest of the patient and demonstrating sensitivity to their special needs
- To teach the residents how to avoid becoming, and how to deal with, impaired physicians.
- To teach the residents how to best care for their patients by avoiding excessively fatigued states.
- To help foster a sense of ethics and morality in the residents.
- To teach residents to be accountable for their actions.

Teaching method:

- Small group sessions focused on the importance of professionalism and how to go about it.
- Direct observation of the faculty in their interactions with staff, residents, patients and colleagues. Standardized patients and the resident's interactions with them.
- Introspective questions and responses in the portfolio.

Evaluation method:

- Direct observation of resident's responsibility in carrying out their professional duties including:
 - Continuity of care
 - Responsiveness to changes in clinical situations
 - Overall responsiveness and availability
 - Self-sacrifice
 - Following of ethical principles in their dealings with patients, families, and other physicians and health care workers
- Faculty evaluation of small group session involvement.
- 360 degree evaluation by faculty, peers, staff, and patients
- Standardized patient report.
- Portfolio evaluation.

Outcome measure:

- To maintain high evaluation remarks for professionalism from the 360 degree evaluation.
- To pass the standardized patient exam.
- To actively participate in the small group session.

- To answer the introspective portfolio essay with introspection and careful thought.

Systems-based Practice:

Residents will demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

Residents will:

- Work effectively in various health care delivery settings and systems
- Coordinate patient care within the health care system
- Incorporate considerations of cost awareness and risk-benefit analysis in patient care
- Advocate for quality patient care and optimal patient care systems
- Work in inter professional teams to enhance patient safety and improve patient care quality
- Be familiar with ethical, socioeconomic, and medicolegal issues that affect the provision of quality and cost-effective care and the utilization of resources within the health care system

Goal:

- To develop residents with a sense of the intricate parts of the health care system and their role therein.

Objective:

- To teach residents how to advocate and fix a patient care problem by using a systems-based approach instead of a “band-aide” approach.
- To teach residents about the intricacies of the health care coding, billing and payer system.
- To teach residents how to perform cost-effective medicine.

Teaching method:

- Small group sessions focusing on a particular problem related to the residency
- Quality Assurance conference
- Didactic courses in information technology
- Didactic courses on coding and billing
- Direct observation of faculty interacting amongst the different levels of medical consults and administration
- Head and Neck Tumor Board.

Evaluation method:

- 360 degree evaluation by faculty, peers, staff and patients.
- Outcome and interaction within small group project.
- Evaluation of portfolio essay related to systems based problems.
- Completion of Quality Improvement project over the course of the 5 year residency.

Outcome measure:

- High marks on portfolio (rubric developed).
- Develop leadership skills and find solution for small group project.
- Understand issues with coding and billing.

IV. EVALUATION PROCESS

The requirements are as follows:

1. Perform all assigned operating room, clinic and ward duties for your level of training in a reasonable fashion.
2. Attendance and participation in daily otolaryngology teaching conferences. Arrive on time.
3. Complete at least two clinical or basic science research projects and submit for publication and presentation during your residency adhering to the research guidelines. Submit the resultant manuscripts for and present the work at the annual Resident Research Day.
4. Complete the entire AAO-HNS FLEX Course and submit it on time.
5. Achieve a score of at least the mean for your year on the Annual Otolaryngology Examination. If you do not achieve this goal, you will be placed on a mandatory reading program.
6. Pursue an active course of independent reading.
7. You are responsible for checking and responding to your email on a daily basis.
8. You must keep an up to date and accurate operative case log using the ACGME website to log all cases. A password will be provided for you.
9. Stay current with your medical records. Please see Record Completion for details
10. All residents must present at least three papers at the annual Resident Research Day during their tenure, one each in your PGY 4 & 5 years.
11. Meet all mutually agreed upon deadlines for manuscript preparation and submission.
12. Maintain daily and accurate duty hour log.

You will be formally evaluated by the faculty as a whole, at least semi-annually. The clinical competency committee will evaluate milestone performance every 6 months. This information will be reported to the ACGME and will be discussed with you at your semi-evaluation. There will also be a formal face-to-face evaluation every 6 months with the Program Director +/- the Associate Program Director. At that meeting, you will need to bring the following documents for review and discussion:

1. Updated CV
2. 6 month goals and objectives.
3. Self-reflection essay.
4. Updated surgical case logs from the ACGME ADS website.
5. Documentation of continuity patients.
6. Updated status report on Quality Improvement project.

You also will receive an evaluation at the end of each rotation. The criteria for these evaluations are:

1. Clinical and basic science knowledge
2. Diagnostic and clinical ability
3. Manual and technical skills
4. Teaching effort
5. Administrative skills
6. Initiative and responsibility
7. Maintaining a professional appearance
8. Attendance
9. Interpersonal relationships with staff, colleagues and patients
10. ACGME competencies

The above listed categories are to serve as an aid to assist you in completing your residency without any doubt as to what is expected of you and are meant to insure your matriculation from here as a well-trained otolaryngologist. We fully expect all our residents to strive for excellence in all areas of job performance. Failure to comply with the preceding rules and guidelines will result in a probationary status for the resident. The failure to remedy these deficiencies while on probation constitutes grounds for dismissal from the residency program. Details of your due process rights are outlined in the policies section.

V. EDUCATIONAL PROGRAMS

A. Audiology and Vestibular Training

All Otolaryngology interns will be expected to spend Thursday afternoons in the ENT Clinic learning how to perform audiometry and impedance testing. This will supersede HNTC. Special exceptions as in the case of resident vacations should be discussed with the residency director.

Residents on the Otology service will be expected to work in the Communicative Disorders Clinic to learn about ABR's, otoacoustic emissions, and hearing aids. When time permits, all residents should arrange to spend time learning to perform ENGs, rotary chair testing, and posturography.

B. Journal Club

Each month in Journal Club we will review 3 journals and selected articles. Every resident will be responsible for having read all articles in the appropriate journals. During Journal Club, a faculty member will select the appropriate articles for discussion, and you may be expected to present, very concisely, what type article it is (e.g. prospective, randomized, trial or case report, etc.). You will then summarize three or four of the high points of each article. Finally, you may offer a critique of the study design or the conclusions. The floor will then be open for discussion.

We will cover *OTOLARYNGOLOGY-HEAD AND NECK SURGERY*, *ARCHIVES OF OTOLARYNGOLOGY-HEAD AND NECK SURGERY*, and *LARYNGOSCOPE*. The first journal is given to residents free of charge. If you are not on the list, we will be happy to make arrangements for you. At present, Archive is available on-line. You are responsible for maintaining your subscriptions. Selected articles may be distributed as well. We will always review the journal from two months prior (i.e. in September's Journal Club meeting, we will review issues from the month of July). Please check with the faculty member in charge of Journal Club for a particular month to verify the plans and format.

In order to maintain such a high level of reading, you will need to be extremely organized in your approach. Please do not attempt to read every single article as if you are memorizing them. The point is to rapidly read each article so that you are efficient in scanning the literature. Covering such a wide variety of articles will allow you to be efficient and informed in your literature review skills. I realize this is very demanding, however, I also realize this is your only opportunity to become an educated otolaryngologist.

C. Reading Assignments

It is essential, in order to progress in your otolaryngology residency, that you pursue an active course of independent reading. You will, of course, be reading for Journal Club and for Home Study Course. You need, however, to form a firm foundation for these readings from standard texts.

1. During the first two years you are required to read an otolaryngology text such as Bailey's or Cumming's otolaryngology texts.
2. In your last two years you should read from the following types of texts: head and neck cancer, otology, pediatrics, and facial plastics.

Additionally you need to read for individual cases and patients as well.

You should focus on committing yourself to your personal education over the next five years rather than worrying about being in trouble for not completing the above stated reading curriculum. There will be no formal mechanism for documenting your compliance. However, if it is apparent from your in-service scores, you will be assigned specific reading assignments with follow-up testing. If you follow these reading guidelines, you will emerge as one of the best-educated residents in the country. This will serve you well throughout your career and will, indeed, be your last chance to learn otolaryngology in the meaningful

manner.

The COCLIA program is an excellent way to organize your review of the Otolaryngology knowledge base and is recommended that you spend quality review time with this program.

D. Temporal Bone Lab

A temporal bone anatomy and dissection course is provided every year. All residents are required to attend the lecture series. Residents will be assigned laboratory sessions based on their level of training and satisfactory completion of fundamental exercises. Completion of this course does not imply competence in temporal bone surgery. All residents are expected to utilize the lab to refine their dissection techniques throughout their training.

Expectations for the course:

- Procure a copy of Nelson's Temporal Bone Dissector Manual. You can get this for a nominal fee from the House Ear Institute in LA or borrow a senior resident's copy. (Contact info: **Abel Andrade**, Finance Office, **House Ear Institute**, 2100 W. Third St., 5th Flr., Los Angeles, California 90057, **Telephone (213) 483-4431, Fax: (213) 483-8789, e-mail: aandrade@hei.org**).
- Casey Willits will provide a temporal bone manual for your review.
- PGY 2 residents should contact Carol Dirain to check out your T-bone kit.
- Casey Willits will assign your locker and provide a key.

Residents that are assigned to the temporal bone laboratory will be freed from their clinical assignments during the scheduled sessions. Second call (senior residents) will take first call for residents whose attendance is required at temporal bone dissection laboratory sessions. Conflicts that arise should be addressed with the dissection instructor.

The temporal bone lab is open to all residents year round. Residents are expected to utilize the lab to improve their temporal bone skills. Please let Carol Dirain know if supplies are running low. You are expected to clean up the lab after each use.

E. Conferences

Conferences will be held each week according to a published schedule to provide didactic and interactive teaching. All residents are expected to attend and to arrive early enough so that we can start exactly on time. You should stay until 7:50 AM unless you are given prior approval to leave early from the faculty member in charge. You are to sign in daily and complete evaluations of lectures. The conference room should be left clean and in order after each use. No equipment is to be removed from this room without permission from the faculty. Attendance is mandatory unless you are on approved leave or for medical emergencies.

If conferences are held using web conferencing technology (Zoom, Microsoft Teams) all residents must attend from a location with a functioning camera and should remain on camera for the majority of all conferences.

F. Mentors

Incoming PGY 1 level residents will have a class mentor assigned. After that time, the individual resident may select a mentor of their own choosing based on personality, career interest, and other factors. Your mentor is someone who can provide research, career, and educational counseling, as well as someone with whom you can have open dialogue about each resident's progress through training. Residents will be required to meet with their mentor on a quarterly basis (to be arranged by the resident). Meetings should focus on personal goals and objectives, assess success at attaining previous quarters' goals and objectives, discuss personal career goals, and provide feedback on the resident's progress.

G. Head and Neck Anatomy Course

A head and neck anatomy course is provided every year. PGY2 residents are not allowed to take vacation during the scheduled course. All residents are required to attend a pre-lab lecture series as well as a month long cadaver dissection hands-on course. Junior residents are assigned to a cadaver and are given assignment to complete prior to each group session. During the group sessions, senior residents and Dr. Dziegielewski will inspect the dissection and teach the junior residents the finer points of head and neck anatomy and tissue dissection. Completion of this course does not imply competence in head and neck surgery. It merely serves as a basis of anatomical knowledge needed to learn head and neck surgery. All residents are expected to utilize the anatomy lab to refine their anatomy knowledge and dissection techniques throughout the course.

Expectations for the course:

- Procure a copy of an anatomy book such as Netter's or Janfaza
- Dr. Dziegielewski will provide a dissection manual for you to utilize.
- PGY 2 residents should contact Dr. Dziegielewski prior to the course to receive assignments and to obtain dissection instruments.

Residents are expected to utilize the lab to improve their head and neck anatomy knowledge and dissection skills. Please let Carol Dirain know if supplies are running low. You are expected to clean up the lab after each use.

VI. RESEARCH PROGRAM

A. Overview

The Department of Otolaryngology views research as an invaluable component of the residency training experience. The research rotation affords residents with the opportunity to gain experience in experimental design, data accrual and analysis, manuscript preparation and publication, and presentation at regional and national scientific meetings. The research program is structured so that the residents develop a more sophisticated understanding of hypothesis-based research, methodology, and the impact that factors such as bias and confounding have on the validity of much published clinical research. Our primary aim is to train clinicians who can critically evaluate the peer-reviewed literature for evidence that could potentially alter the management decisions for a particular condition, and we believe that the research rotation is an invaluable part of that educational process.

B. Requirements

Each resident is required to complete at least two clinical or basic science research projects that are suitable for presentation at a regional or national otolaryngology meeting and for publication in a peer-reviewed journal. The research design of the resident's primary research should be hypothesis-driven, the data should be gathered in prospective fashion, and the research objectives should be designed so that the findings provide new information about a particular otolaryngologic problem. The resident's secondary research may be either prospective or retrospective, but it must also be suitable for presentation and publication. Case reports cannot be used to fulfill the resident research requirement. However, case reports, and critical reviews are also encouraged and will serve as excellent supplementary research projects that provide additional educational value and research insight. Finalized manuscripts which have been approved by the resident's research mentors must be submitted to the residency research coordinator and residency program directors by May 31st of the resident's PGY-4 year.

C. Identifying a Research Mentor

During PGY-2 year, each resident must identify a research mentor who has agreed to educate and assist the resident with his/her research. The mentor is typically chosen for his/her unique research interests and expertise. In this capacity, the mentor assists the resident with the research proposal, oversees the data accrual process, helps the resident to interpret the findings, and provides guidance with preparation of the manuscript, abstracts, poster or oral presentations. Thus, the resident is responsible for completing all aspects of the research project, using the research mentor for guidance. Residents who embrace this educational model and perform most of the research effort required for presentation and publication will derive the most educational benefit and will have also met the established criteria for first authorship, which must be earned.

Each resident will also be assigned to a research supervisor (Carol Ojano-Dirain, PhD), who will oversee research progress, quality of the resident's work product, abstract submission, presentations and manuscript preparation and completion. The research mentor and the supervisor will complete a performance evaluation at the end of the resident's research rotation. The designated research supervisor will also meet with each resident on a scheduled basis and track the completion of each milestone on the Research Approval Checklists FOR BOTH REQUIRED RESEARCH PROJECTS, which are accessible for review via the departmental portal.

D. Timeline

October: PGY2 residents choose a research mentor and a research topic. Conduct a literature search to make sure that you are not duplicating previous efforts (You are charged with performing original research that leads to new knowledge). Consider the feasibility (budget, time, sample size, etc.) of performing and completing your research, and the likelihood that your research will result in statistically significant results that also have potential clinical implications for the practice of otolaryngology. If any of the above criteria do not apply, discard your idea and reevaluate.

At the October resident research meeting, you will be expected to present your research ideas to the department and prepare a 1 to 2-page summary of your proposal. The typewritten summary should include a brief overview of the clinical question that is controversial or inadequately researched, and your proposal. The proposal should include a null hypothesis and an alternative hypothesis, primary and secondary endpoints, and a general explanation of the methodology. Be prepared to defend your research idea and its feasibility. A working knowledge of the most substantive peer-reviewed literature pertaining to your topic is essential.

November: Submit a completed research proposal which outlines the objectives, methodology, endpoints and potential significance in detail. Prepare a proposal which details the methodology so that the reviewing audience will be able to understand precisely how the study will be conducted to accrue the data necessary to prove or disprove the hypothesis. Provide supportive evidence of the feasibility of your research, including an itemized breakdown of the required budget and sample size estimates based on realistic calculations (eg., power analysis, expected enrollment rates, compliance).

Research Proposal Format

1. **SPECIFIC AIMS** - Identify research objectives and describe succinctly what specific research you intended to be conducted and the hypothesis to be tested.
2. **BACKGROUND AND SIGNIFICANCE** - Identify the background of the research proposal. Evaluate critically existing knowledge, and specifically note areas which the project is intended to address. State the importance of the research described by relating the specific aims to the objectives.
3. **EXPERIMENTAL DESIGN AND METHODS** - Outline the experimental design and the procedures that will be used to accomplish the specific aims of the project. Include means by which the data will be collected, analyzed, and interpreted. Discuss the potential difficulties and limitations of the proposed procedures and alternative approaches to achieve the specific aims. Provide a timetable for the investigation.
4. **SPONSORS/COLLABORATORS** - Provide a letter of sponsorship.

5. FACILITIES & MAJOR EQUIPMENT - Describe where your research will be performed, including the use of large or specialized equipment which will be needed to complete your project.
6. BUDGET - List any cost that may be incurred.
7. LITERATURE CITATIONS - Identify literature citations. Each literature citation must include authors, title of article, journal or book, volume, page numbers, and year of publication.

December-January: Present and defend your refined formal research proposal, statistical feasibility, budget and plan to cover the budget (grants, etc.). Meet with Research Administrative Team so that they can assist you with budgetary, regulatory and funding opportunities. Additionally, see “funding Opportunities” below for grant submission deadlines.

February: Submit research proposal/application to IRB/IACUC.

June: Finalize preparation so that you will be ready to start research project July 1.

The resident is required to meet the deadlines for each milestone and obtain advisor approval and committee approval upon completion of each milestone (See “Research Approval Checklist for Resident”). A completed copy of this checklist must be submitted to the Residency Research Coordinator and the Residency Program Director. Please note that failure to meet the deadline for each milestone could impact advancement through residency and delay advancement to next resident year or graduation.

Residents are guaranteed 12 weeks of research. If the assigned research rotation block is less than 12 weeks, the resident shall be assigned the remaining protected research time during their PGY3-5 year. The remaining research rotation days should be split evenly between the PGY3-5 years and be used in preparation for the assigned research rotation, completion of experiments or analysis, and manuscript and presentation preparation. If research is a requestable assignment in the program’s scheduling software, such days must be requested in a manner similar to vacation leave.

E. Research Administrative Team

To assist Residents with the Research Rotation, a Research Administrative Team is in place within the department. It is our intent to provide budgetary and regulatory assistance as well as facilitate the submission of all grant applications. Additionally, we will facilitate the process of obtaining proper UF signatures for all Confidential Agreements (CDAs), Grant Applications, Research Agreements and any other contractual paperwork requiring signature.

**UF Employees are NOT authorized to sign contractual or binding documents. To protect yourself and the department, please get with Carol Dirain and Tina Sporer when you have paperwork requiring UF Official signature(s).

CONTACT INFORMATION:

Carol O. Dirain, PhD, Associate Scientist, Clinical
Research Coordinator and Resident Research Director:

273-5225 ojanoc@ent.ufl.edu

Tina Sporer, HR and Finance Manager
Jennifer Brookins, Department Administrator

273-5168 tina.sporer@ent.ufl.edu

273-5199 Jennifer.brookins@ent.ufl.edu

Please speak with Carol Dirain to facilitate the following processes:

- Confidentiality Disclosure Agreements (CDA)
- Sponsor contractual paperwork
- Formal Grant submissions
- Human Subject research (IRB/WIRB)

- Use of anatomical materials for research
- Medical Chart review – if you will not be using human subjects, but plan to utilize medical chart data from human subjects there are still regulatory requirements. With a list of patient names and MRN numbers, Leigh Anne will order records for research to be pulled as well.

Please speak with Carol Dirain to facilitate the following processes:

- Animal Research (IACUC)
- Use of anatomical materials for research
- Reserve Animal Housing – this should be discussed with Carol at the preliminary planning stages.
- Lab space and equipment usage.
- Initial budget preparation for all studies with the exception of human subject research
- Animal Purchasing

Please speak with Tina Sporer to discuss purchases at least one month prior to the project start date.

It is recommended that you involve the Research Administrative Team as soon as possible. Often obtaining signatures can be a slow process. Furthermore, it is the Team’s intent to be helpful and provide insight into the various processes which will better enable you to successfully prepare for your research rotation.

F. Resources

REQUIRED TRAINING:

- **HIPAA for RESEARCH CERTIFICATES:** Required every two years and must be kept current. The online training can be found at: <http://privacy.health.ufl.edu/training/Research08/online.shtml>. Please print out a copy of the certificate for Carol Dirain to keep on file.
- **IACUC:** <http://iacuc.ufl.edu/training.htm>
- If you are involved with the care and use of laboratory animals, you may also be required to enroll in courses provided online by the American Association for Laboratory Animal Science at www.aalaslearninglibrary.org

FORMS/DEADLINES:

- **IRB** (human subjects): Ensure that all forms are the most current version found at <http://www.irb.ufl.edu/irb01/index.htm> and be submitted to Carol Dirain two weeks prior to deadline for obtaining signatures and IRB submission.
 - o **NOTE:** If you’ll be using anatomical materials for research, there are additional requirements, please see Tina or Leigh Anne.
- **IACUC** (animal subjects): Ensure that all forms are the most current version found at <http://www.iacuc.ufl.edu/forms.htm> and be submitted to Carol Dirain two weeks prior to deadline for obtaining signatures and IACUC submission. This should be started at least 3 months before starting the research rotation to ensure approval and animals are ordered in time since it takes 4-8 weeks to obtain IACUC approval.

DATA STORAGE:

- We have a cubicle in the lab dedicated to research with locking cabinets. All data is to be stored in a double-locked area that the Research Coordinator and PI both have access to.
 - UF data should NEVER be saved to portable data storage devices, including but not limited to “jumpdrive”, cd, diskette or laptops, or personal computers. All data should be password protected as it is UF property.
 - Upon ending your employment with the Department, all research data and materials are to remain at the institution.
- Any individual in violation of HIPAA requirements is personally accountable.

FUNDING OPPORTUNITIES:

The Department will help support your research project by allotting a \$4000 budget. Any overage must be covered by grants, research awards, donations, and other sources of funding that you have secured.

You are encouraged to submit grant applications to assist in the funding of your research project. Here is a list of websites to check out. The Research Administrative Team will be glad to assist in the submission of all grant proposals:

Hearing Health Foundation: <https://hearinghealthfoundation.org/emerging-research-grants>

AAO/HNS: <http://www.entnet.org/EducationAndResearch/coreGrants.cfm>

American Otologic Society: <http://www.americanotologicalsociety.org/information.html> **American**

Head & Neck Society: <http://www.ahns.info/research/grants.php>

OTHER RESOURCES:

Clinical Trial Compliance: <http://ctc.health.ufl.edu/>

Division of Sponsored Research: <http://rgp.ufl.edu/research/>

Research Administration and Compliance: <http://www.med.ufl.edu/research/rac/>

Contracts & Grants: <http://www.fa.ufl.edu/cg/>

Animal Care Services: <http://www.acs.ufl.edu/>

i. Research Checklist

The resident research checklist is stored on the ENT intranet under the research section. The checklist is in an Excel file and should be maintained by the resident and the assigned internal mentor.

Project 1

DEPARTMENT OF OTOLARYNGOLOGY				
RESEARCH APPROVAL CHECKLIST FOR RESIDENT				
RESIDENT:				
TOPIC:				
MENTOR:				
Mentor Email:				
Mentor Phone:				
Internal Research Mentor				
Milestone	Deadline	Adviser Approval & Date	Research Committee Approval & Date	Notes
Mentor & Topic Chosen	October 31 - PGY2			
Research Proposal Developed	November 30 - PGY2			
Budget Developed	November 30 - PGY2			
Key Equipment Secured	December 31 - PGY2			
Key Product Secured	December 31 - PGY2			
IRB/IACUC Submitted	February 28 - PGY2			
IRB/IACUC Approval	April 30 - PGY2			
Pilot Study Completed	Month Prior to Rotation			
Animals Delivered	Week Prior to Rotation			
Data Collection Completed	End of Rotation			
Performance Evaluation	End of Rotation			
Data Analysis Completed	One Month After Rotation			
Submitted for Presentation	Six Months After Rotation			
Submitted for Publication	Six Months After Rotation			
Publication	One Year After Rotation			

Project 2

DEPARTMENT OF OTOLARYNGOLOGY				
RESEARCH APPROVAL CHECKLIST FOR RESIDENT				
RESIDENT:				
TOPIC:				
MENTOR:				
Mentor Email:				
Mentor Phone:				
Internal Research Mentor				
Milestone	Deadline	Adviser Approval & Date	Research Committee Approval & Date	Notes
Research Proposal Developed	End of Research Rotation			
IRB / IACUC Approval	3 months after research rotation			
Data Collection	within 6 months after IRB/IACUC approval			
Abstract Submitted for presentation	January 1 of PGY4 year			
Manuscript submitted for publication	May 31 of PGY4 year			
Approval				

ii. Otolaryngology Resident Research Performance Evaluation

Otolaryngology Resident Research Performance Evaluation

Name of Resident: _____

1. The resident actively participated in the formulation of the research question (eg., central hypothesis).

1	2	3	4	5	6	7	8	9	10	NA
Best									Worst	

2. The resident reviewed the literature pertaining to the research question and developed a working knowledge of the background and rationale for his/her research.

1	2	3	4	5	6	7	8	9	10	NA
Best									Worst	

3. The resident reliably attended research meetings and conferences, and was prepared to discuss updates on his/her research.

1	2	3	4	5	6	7	8	9	10	NA
Best									Worst	

4. The resident consistently demonstrated a strong work ethic.

1	2	3	4	5	6	7	8	9	10	NA
Best									Worst	

5. Data accrual was meticulously performed by the resident.

1	2	3	4	5	6	7	8	9	10	NA
Best									Worst	

6. The resident completed the tasks listed on the "Department of Otolaryngology Research Approval Checklist" by the required deadlines

1	2	3	4	5	6	7	8	9	10	NA
Best									Worst	

7. The resident demonstrated enthusiasm for their research, intellectual curiosity, and a desire to learn about research methodology.

1	2	3	4	5	6	7	8	9	10	NA
Best									Worst	

8. The resident used constructive critical feedback to improve performance during the research rotation.

1	2	3	4	5	6	7	8	9	10	NA
Best									Worst	

9. Overall Performance During Rotation

1	2	3	4	5	6	7	8	9	10
Best									Worst

Specific Comments Regarding Performance during Rotation:

Did you discuss this evaluation with the resident? ___ Yes ___ No

Name of Faculty Member: _____

Signature: _____

VII. POLICIES

In addition to the policies below, you are to comply with all applicable policies and procedures of the University of Florida, the College of Medicine, UF Health Shands Hospital, North Florida South Georgia VA Medical Center, Florida Surgical Center, Children's Surgical Center and any other relevant clinical facilities.

A. Resident Duty Hours and the Working Environment

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

1. Supervision of Residents

- a. All patient care must be supervised by qualified faculty. The program director will ensure, direct and document adequate supervision of residents at all times. Residents will be provided with rapid, reliable systems for communicating with supervising faculty. If there are any lapses in communication that the resident identifies, they will bring it to the attention of the program director who will then be responsible for correcting the situation.
- b. Faculty and residents will be educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects.

2. Duty Hours

- a. Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.
- b. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
- c. Residents will be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational and administrative activities.
- d. Adequate time for rest and personal activities must be provided. PGY 2 & 3 level residents should have 10 hours but must have 8 hours between duty periods. PGY 4 & 5 level residents must also have adequate time for rest, however, they must also prepare for entry into medical practice. Allowable instances in which PGY 4 and 5 level residents may have less than 8 hours between duty periods include providing continuity of care for a critically ill and/or complex patient, events of exceptional educational value, or to provide humanistic attention to patients and/or their families. These instances must be monitored by the Program Director.
- e. Duty hours must be logged on a daily basis and will be checked on Monday morning at 8a for weekly compliance. You will be notified by Casey Willits if your hours are not entered for the previous work week.
 - a. Anticipation of any duty hour problems must be discussed with the program director.
 - b. Failure to maintain minimal administrative responsibilities, such as, but not limited to, timely logging of duty hours, will result in forfeiture of Gator Bites.
- f. Falsification of duty hours is grounds for termination.

3. On-Call Activities

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal work day

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

- a. In-house call must occur no more frequently than every third night, averaged over a four-week period.
- b. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics and maintain continuity of medical and surgical care, as defined in Specialty and Subspecialty Program Requirements.

No new patients as defined by any patients who have never been seen by the Otolaryngology service may be accepted after 24 hours of continuous duty.

- c. At-home call (“pager” call) is defined as call taken from outside the assigned institution.
 1. The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.
 2. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.
 3. The program director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.
 4. **When you are called in and need to remain in-house after midnight, you must contact the program director or associate program director. We will then decide if you must be sent home for adequate rest. The program director or associate program director will be responsible for re-assigning resident coverage.**

4. Moonlighting

- a. Because residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
- b. The program director must comply with the sponsoring institution’s written policies and procedures regarding moonlighting, in compliance with the Institutional Requirements III. D.1.k.
- c. The only moonlighting approved by the Department is in doing the Comp and Pen’s at the VA, and this time must be counted toward the 80-hour weekly limit on duty hours.

5. Oversight

- a. Residents are responsible for entering duty hours on a weekly basis, Casey Willits will check every Monday at 8a. Supervision is per protocol, see above.
- b. Back-up support systems will be provided when patient care responsibilities are unusually difficulty or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care. When the resident runs into these difficulties, it is their responsibility to bring it to the attention of the program director.

6. Transitions of Care

- a. Proper communication of inpatient’s pertinent clinical information must be performed on a daily basis to ensure the proper continuity of care during off duty periods such as nights, weekends, and holidays.
- b. Such clinical information should include but not be limited to patient name, inpatient location, primary otolaryngologic diagnosis, otolaryngologic surgery, secondary diagnoses, actionable items, and potential hazards in a patient’s care.

- c. This information may be transmitted in one of several formats:
 - Personal, verbal communication, either by telephone or in person is strongly encouraged for critically ill patients, or those with active ongoing clinical issues requiring actions during the duty period.
 - Email transmission via secure email accounts (such as ent.ufl.edu accounts) may be used to transmit routine patient information.

B. Educational Travel

1. Up to 5 working days per year may be granted for educational travel. These should be taken as a single block when possible and requires approval by the Program Director.
2. All travel requests must be submitted no later than 35 days (45 days if on VA rotation) in advance.
3. All hotel and airfare must be arranged through Casey Willits to ensure reimbursement.
4. Reimbursement for presenters is limited to hotel, airfare or map mileage and the meal state per diem. Reasonable parking and local transportation costs such as taxi and subway may be reimbursed. Receipts are required for these items. Meals will not be reimbursed above the state per diem for any resident travel.
5. First priority for attending desired meetings will be given based on residents accepted for oral presentation. Second priority will be given to poster presentations based seniority and whether or not the meeting was attended the year prior.
6. For PGY-2 and PGY-3 residents, it is strongly suggested that you attend either the Academy or Combined Otolaryngology Spring Meeting (COSM). Exceptions will be considered on an individual basis.
7. PGY-4 and PGY-5 may attend courses of their choice that have been approved by the Residency Director. Appropriate courses would include allergy, temporal bone, facial plastic, practice management, sinus, and facial trauma courses. This list is not all inclusive. Courses sponsored by one of our societies are usually the best.

C. Educational Fund

PGY-1 residents receive \$300 annually and PGY2-5 residents receive \$500 annually for use towards professional development. Funds may be used to purchase items such as: Otolaryngology texts, journals, educational software, professional dues, course fees, academic travel, and loupes. Funds may not be used for personal equipment including PDAs, laptops, cellphones, cameras, office supplies, and briefcases. Reimbursement requires approval of the Program Director prior to purchase and is subject to rules set forth by the University of Florida. You will not receive an incentive for publications submitted through Open Access.

1. Additional funds are available as follows:
 - Original Research Papers of research performed during residency published by Major Journal (Laryngoscope, Archives of Otolaryngology, Otolaryngology Head and Neck Surgery, New England Journal of Medicine, Journal of the American Medical Association) - \$400
 - In-service scores >89 percentile for year - \$350
 - Book Chapter - \$250
 - Case Reports and publications in minor journals - \$250
 - Oral presentation at AAO-HNS, COSM National Meeting - \$250
 - Poster Presentation at National Meeting - \$100
 - Oral Presentation at Local/Regional Meeting - \$100
 - Poster Presentation at Local/Regional Meeting - \$50
2. Resident membership in the American Academy of Otolaryngology-Head & Neck Surgery is mandatory. The department will cover the cost of Academy dues.

D. Lab Coats

Lab coats are provided during your residency. All residents get two lab coats at the start of each year. Lab coats must be clean and present a professional appearance. Cleaning service is not provided by the department.

E. Library

The library has been equipped with major texts and journals in all areas of Otolaryngology. These books are available for your use in house. We use the honor system, any book that leaves the library must be checked out in the checkout book in the library. You are responsible for return of any books and failure to return will result in required replacement by you. Books must be re-shelved in their appropriate section.

F. Record completion

All records must be completed in less than 7 days at all times. Dictations and EMR notes must be finished the same day as the event takes place per UF Health guidelines. If you will be on leave, it is your responsibility to notify HIRM. Failure to stay in compliance with maintaining timely medical records will result in:

- a. First offense- verbal warning
- b. Second offense- written warning that will be placed in your permanent file
- c. Third offense- probation
- d. Continued offenses are grounds for termination

G. Non-programmatic activities (Moonlighting)

The only exception is performing compensation-pension examinations at the VA hospital. A non-programmatic activity form, available from the residency coordinator, must be completed monthly and prior to each exam performed. This is the responsibility of the participating resident. Failure to do so will result in termination of this privilege. Any non-programmatic activity must be included in duty hours and comply with duty hour standards.

H. Parental/Medical Leave

We abide by all federal and state policies regarding parental leave. Housestaff may be provided up to 20 consecutive days of paid leave in a rolling 12-month period. Parental/Medical Leave time does not accrue from year to year and there is no provision to compensation in lieu of time off. Housestaff can use this time to cover absences related to parental leave (birth, adoption, fostering), a personal illness/injury, an immediate family member's illness/injury. Housestaff are not required to exhaust their accrued leave in order to use this benefit. Program may require use of this leave in full week increments, based on the Housestaff's regularly scheduled work week. Eligibility for medical leave will require a medical certification from the resident's or resident's immediate family member's physician and will be approved under the same conditions provided under the Family Medical Leave Act. If Parental/Medical Leave isn't not initiated and approved, residents must use their 15 vacation days and 10 sick leave days. After that all leave is unpaid, up to 6 months. According to the Residency Review Committee of the ACGME, you may not take more than 30 days off for any reason without making up the extra missed time. We will make such arrangements for you after written request. Any time off should be requested in the usual fashion through the residency coordinator and must be submitted at least six weeks prior to the expected due date.

I. Presentation Travel

1. Residents who have an oral or poster presentation accepted at a meeting are subject to travel reimbursement by the department if funds are available and travel has been approved in advance by the Program Director. (See section B. Educational Travel for priority selection).
2. Reimbursement for presentations will include:
 - a. Lowest airfare arranged for you by program coordinator
 - b. Travel to and from airport (which includes mileage on personal vehicles (not including gas), taxi, Uber (limousines not included), or car rental (including gas) and parking.
 - c. Night prior to and night of presentation based upon per diem amounts
 - d. Meeting registration
 - e. 3 days of meals at a rate of \$36/day (Breakfast \$6.00, Lunch \$11.00 and Dinner \$19.00).
NOTE: If the meeting agenda states meals are provided, the department cannot give you the per diem (even if you did not accept or participate).
3. Any additional expense incurred are the individual residents’ own responsibility
4. Travel funds will not be reimbursed if travel is covered by grant or award
5. Time off and reimbursement is limited to the day before, day of, and day after presentation. Any longer stay or expense requires use of the residents own vacation time and funds, including PDA.
6. Final reimbursement will be contingent upon completion and submission of a manuscript for the project being presented.

Table: Description of Travel Policies for Residents:

	Source of Travel Reimbursement	Leave Time
Presenter	Departmental or travel grant	Educational days, then Research Days in NI
Non-presenter	Resident PDA	Educational days

J. Promotion of Residents

The progress of the residents will be formally reviewed on a biannual basis or more frequently as necessary. This will consist of a meeting of the faculty at which time the residents’ progress and achieving the goals and objectives of the residency program will be evaluated. Those residents that have been successful in reaching these goals at the end of the year will be promoted to the next level as appropriate. Those residents that are not judged to have met these standards will be subject to the procedure described for grievance, suspension, non-renewal or dismissal. In addition, promotion to the PGY3 year of training requires successful completion of USMLE Step 3 licensure exam, per University of Florida/UF Health GME policies.

K. Resident Remediation

Residents who are found to have behavioral, academic or impairment issues will undergo remediation.

Remediation measures include (in order of increasing severity):

1. Verbal Counseling
2. Written Counseling
3. Probation
4. Non-renewal of Contract
5. Termination

*Does not need to occur in order

Verbal Counseling:

Constructive, objective and specific feedback given to resident along with corrective action plan. Will also include resident’s own self-assessment.

Written Counseling:

Documented specific examples of failure to meet expectations with written corrective action plan and resources available to resident to help meet expectations.

Probation:

Written and signed documentation of specific examples of failure to meet expectations.

Specific milestones for corrective action plan given.

Notice of actions that may be taken at reassessment date.

Resident has right to appeal.

Non-renewal:

Will be given in writing and resident will be allowed to finish academic year, but contract will not be renewed for the following year.

Resident has right to appeal.

Non-renewal may be a step in the chain of corrective actions; however, certain actions that are egregious and severe may warrant bypassing of other remediation methods.

Termination:

May occur at any time for cause.

Resident has right to appeal.

L. Procedure for Grievance, Suspension, Non-renewal or Dismissal

The position of the resident presents the dual aspect of a student in graduate training while participating in the delivery of patient care.

The Department of Otolaryngology is committed to the maintenance of a supportive educational environment in which residents are given the opportunity to learn and grow. Inappropriate behavior in any form in this professional setting is not permissible. A resident's continuation in the training program is dependent upon satisfactory performance as a student, including the maintenance of satisfactory professional standards in the care of patients and interactions with others on the health care team. The resident's academic evaluation will include assessment of behavioral components, including conduct that reflects poorly on professional standards, ethics, and collegiality. Disqualification of a resident as a student or as a member of the health care team from patient care duties disqualifies the resident from further continuation in the program.

GRIEVANCES: A grievance is defined as dissatisfaction when a resident believes that any decision, act or condition affecting his or her program of study is arbitrary, illegal, unjust or creates unnecessary hardship. Such grievance may concern, but is not limited to, the following: academic progress, mistreatment by any University employee or student, wrongful assessment of fees, records and registration errors, discipline (other than non-renewal or dismissal) and discrimination because of race, national origin, sex, marital status, religion, age or disability, subject to the exception that complaints of sexual harassment will be handled in accordance with the specific published policies of the University of Florida and the College of Medicine (as contained in the University's Housestaff Manual).

Prior to invoking the grievance procedures described herein, the resident is strongly encouraged to discuss his or her grievance with the person(s) alleged to have caused the grievance. The discussion should be held as soon as the resident becomes aware of the act or condition that is the basis for the grievance. In addition, or alternatively, the resident may wish to present his or her grievance in writing to the person(s) alleged to have caused the grievance. In either situation, the person(s) alleged to have caused the grievance may respond orally or in writing to the resident.

If a resident decides against discussing the grievance with the person(s) alleged to have caused such, or if the

resident is not satisfied with the response, he or she may present the grievance to the Chair. If, after discussion, the grievances cannot be resolved, the resident may contact the Employee Assistance Program or alternatively, the Director of Graduate Medical Education (DGME). The DGME will meet with the resident and will review the grievance. The decision of the DGME will be communicated in writing to the resident and constitute the final action of the University.

SUSPENSION: The Chief of Staff of a participating and/or affiliated hospital where the resident is assigned, the Dean, the President of the Hospital, the Chair or Program Director may at any time suspend a resident from patient care responsibilities. The resident will be informed of the reasons for the suspension and will be given an opportunity to provide information in response.

The resident suspended from patient care may be assigned to other duties as determined and approved by the Chair. The resident will either be reinstated (with or without the imposition of academic probation or other conditions) or dismissal proceedings will commence by the University against the resident within thirty (30) days of the date of suspension.

Any suspension and reassignment of the resident to other duties may continue until final conclusion of the decision-making or appeal process. The resident will be afforded due process and may appeal to the DGME for resolution, as set forth below.

NONRENEWAL: In the event that the Program Director decides not to renew a resident's appointment, the resident will be provided written notice that will include a statement specifying the reason(s) for non-renewal.

If requested in writing by the resident, the Chair will meet with the resident; this meeting should occur within 10 working days of the written request. The resident may present relevant information regarding the proposed non-renewal decision. The resident may be accompanied by an advisor during any meeting held pursuant to these procedures, but the advisor may not speak on behalf of the resident. If the Chair determines that the non-renewal is appropriate, he or she will use their best efforts to present the decision in writing to the resident within 10 working days of the meeting. The resident will be informed of the right to appeal to the DGME as described below.

DISMISSAL: In the event the Program Director of a training program concludes a resident should be dismissed prior to completion of the program, the Program Director will inform the Chair in writing of this decision and the reason(s) for the decision. The resident will be notified and provided a copy of the letter of proposed dismissal; and, upon request, will be provided previous evaluations, complaints, counseling, letters and other documents that related to the decision to dismiss the resident. If requested in writing by the resident, the Chair will meet with the resident; this meeting should occur within 10 working days of the written request. The resident may present relevant information regarding the proposed dismissal. The resident may be accompanied by an advisor during any meeting held pursuant to these procedures, but the advisor may not speak on behalf of the resident. If the Chair determines that dismissal is appropriate, he or she will use their best efforts to present the decision in writing to the resident within 10 working days of the meeting. The resident will be informed of the right to appeal to the DGME as described below.

APPEAL: If the resident appeals a decision for suspension, non-renewal or dismissal, this appeal must be made in writing to the DGME within 10 working days from the resident's receipt of the decision of the person suspending the resident or the Chair. Failure to file such an appeal within 10 working days will render the decision of the person suspending the resident or from the Chair the final agency action of the University.

The DGME will conduct a review of the action and may review documents or any other information relevant to the decision. The resident will be notified of the date of the meeting with the DGME; it should occur within 15 working days of the DGME's receipt of the appeal. The DGME may conduct an investigation and uphold, modify or reverse the recommendation for suspension, non-renewal or dismissal. The DGME will notify the resident in writing of the DGME's decision. If the decision is to uphold a suspension, the decision of the

DGME is the final agency action of the University. If the decision is to uphold the non-renewal or dismissal, the resident may file within 10 working days written appeal to the Dean of the College of Medicine. Failure to file such an appeal within 10 working days will render the decision of the DGME the final action of the University.

The Dean will inform the DGME of the appeal. The DGME will provide the Dean a copy of the decision and accompanying documents and any other material submitted by the resident or considered in the appeal process. The Dean will use his or her best efforts to render a decision within 15 working days, but failure to do so is not grounds for reversal of the decision under appeal. The Dean will notify in writing the Chair, the DGME, the Program Director and resident of the decision. The decision of the Dean will be the final agency action of the University. The resident will be informed of the steps necessary for the resident to further challenge the action of the University.

M. Resident Distribution

1. Each resident may qualify for up to 5 working days per year for educational travel. These should be taken as a single block when possible and requires approval by the Program Director. Residents must have scored greater than the 50% percentile for their year group on the in-service exam the previous year in order to qualify.
2. Reassignments: when a resident's assigned attending is out, they will be reassigned to provide alternate coverage. Please see reassignment schedule on OpenTempo.
3. If a case is added on or patients are seen in clinic on a day other than regularly scheduled, there will not be residents available unless there is an excess of available manpower. All other regularly scheduled activities will have first priority.
4. Resident distribution conflicts will be handled solely between attendings. The residents should not be expected to resolve any such conflicts should they arise.
5. Schedules will be adjusted accordingly over the 2 weeks around Christmas as we will only have one half of our resident contingent.
6. Pre-ops will be done by the designated resident of the service for which the patient is being operated. If pre-ops are scheduled to come in on a day other than your own clinic days, please provide a resident from the responsible service to perform the examination.
7. Residents on the research rotation are free from clinical duties, except call duties. Use of the research resident must be approved by the Program Director. This must be done in advance to avoid conflict with scheduled experiments. Extreme need must be demonstrated to justify this so as to preserve the integrity of the rotation.
8. Depending on the need for additional coverage, individual residents may be temporarily reassigned to another service. **Any time residents are not actively engaged in the primary clinical care duties of your service, it is your responsibility to help out the other services without being called.**
9. All residents are expected to be present for weekday rounds at the individual hospitals unless there are no patients in the hospital for that particular service. At least one resident (on a rotating basis) from each service must round on weekends when that service has a patient in house.
10. The intern is assigned to the H&N service except when otherwise specified.

N. Resident Selection

1. Applications will be accepted via the ERAS.
2. Applicants will be invited for interview based on a review of the following factors: performance on standardized tests, medical school performance, letters of recommendation, personal statement, extracurricular activities, and research activities.
3. Applicants will be ranked on the basis of the preceding factors in combination with a subjective evaluation of the interview by the faculty.

4. Residents will be accepted via the NRMP.
5. If the program does not fill through the usual matching process, the position will be posted via the Otolaryngology vacancy line and notification of program directors. The most qualified individuals based on the above factors will be invited for interview. The position will be offered based on a vote of the faculty.

O. Sexual Harassment

Sexual harassment is covered under the policies of the University of Florida and the Graduate Medical Education Office. See Attachment A. No suggestive or inappropriate, or potentially offensive material is to be viewed or left on department computers.

DEFINITION

Sexual harassment is defined as unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when:

1. Submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment or academic performance;
2. Submission to or rejection of such conduct by an individual is used as the basis for employment or academic decisions affecting such individual, or;
3. Such conduct has the purpose or effect of unreasonable interfering with an individual's work or academic performance or creating an intimidating, hostile or offensive working or educational environment.

WHAT TO DO ABOUT SEXUAL HARASSMENT:

1. Learn the University of Florida and College of Medicine (COM) policies and procedures.
2. If possible, speak up when an incident occurs and tell the offender to STOP the offensive behavior in a clear and firm manner.
3. Consider communicating with the offender by writing a letter detailing your concerns and asking the person to STOP.
4. Keep a written record and any evidence that might corroborate your story.
5. Seek information about your options from the COM designated counselor, if desired. This will not initiate a formal investigation, and will give you an opportunity to discuss your concerns confidentially; provide counseling about the options for resolving the current situation and preventing future incidents; assist in conflict resolution; and advise, if deemed appropriate, how to file a formal complaint to the Chair of the Sexual Harassment Committee to proceed with a full investigation.

P. Sick Leave

If, for any reason you need to take sick leave, call the Residency Program Director. Upon your return, notify the Residency Coordinator of your exact days out. The full sick leave policy is available from the Graduate Medical Education office.

Q. Substance Abuse

1. Substance abuse interferes with the skills and judgment required for appropriate patient care.
2. The faculty and program director are responsible for monitoring residents for signs of impairment. Any resident suspecting that they or any member of the faculty or staff may have a problem with substance abuse should report this to the program director. All reports will be confidential, and the department will be fully supportive of recovery efforts.
3. Any resident with a substance abuse problem will be offered counseling to be arranged via the Shands Housestaff office.
4. A resident with a current substance abuse problem will not be allowed to participate in patient

care until the situation has been resolved.

R. Supervision for Patient Care

Shands, Florida Surgical Center, UF Health at The Oaks, Children's Surgical Center

1. An attending will be present or immediately available for all scheduled clinics and OR sessions. If the attending is temporarily absent, they will be available by phone.
2. The on-call attending will be available by phone (as listed by the monthly schedule) for all emergencies or urgent unscheduled visits. The attending will assist the residents in the event that the level of expertise required is beyond the skills of the participating resident.
 - a. The resident will inform the attending of any pending admissions as soon as it is determined that the patient needs to be admitted.
 - b. The residents will work up each patient on call. They will call the attending for any patient requiring surgery. The attending will be present for operative cases while on call.
 - c. The junior level resident will first check out to the senior level resident on call. Unless it is a straightforward issue such as a peritonsillar abscess, epistaxis controlled in the ED, facial laceration sutured in the ED, acute otitis external / otitis media (uncomplicated), simple foreign body in the ear or nose; then the attending should be called and the case discussed.
 - d. Senior residents are expected to maintain an active and hands-on role in the evaluation and treatment of on-call patients.
3. Billing for patient care involving residents will conform to institutional and departmental policies.

VA

1. An attending will be available to see any patients and assist in any surgery. Attending physicians will be in the operating room for all cases. They will scrub per request of the resident. The assigned attending is noted on the attending coverage schedule published by the departmental office. It is the responsibility of the chief resident at the VA to discuss all scheduled surgery cases with the covering attending before surgery.
2. Any emergency cases will be handled as in number 2 above.

S. Technical Qualifications

Technical standards for Otolaryngology have been established to allow the resident candidate to determine their ability to perform the required duties in compliance with the Americans with Disabilities Act.

An otolaryngology resident must have abilities and skills in five categories: observation, communication, motor, intellectual, behavioral and social. However, it is recognized that degrees of ability vary widely between individuals.

1. Observation: A candidate must be able to observe a patient accurately at a distance and close at hand. In detail, observation necessitates the functional use of the sense of vision and other sensory modalities. Full color vision and binocular vision are necessary for the successful performance of otolaryngologic surgery.
2. Communications: A candidate must be able to communicate effectively and sensitively with patients. The focus of this communication is to elicit information, describe changes in mood, activity, and posture, and perceive nonverbal communications. Communication includes not only speech, but

reading and writing. The candidate must be able to communicate effectively and efficiently in oral and written formats with all members of the health care team.

3. **Motor:** Candidates must have sufficient motor function to elicit information from patients by palpation, auscultation, percussion, and other diagnostic maneuvers. A candidate must be able to execute motor movements reasonably required to provide general care and emergency treatments to patients. Such actions require coordination of both gross and fine muscular movements, equilibrium, and functional use of the senses of the touch and vision.
4. **Intellectual-Conceptual, Integrative and Quantitative Abilities:** These abilities include measurement, calculation, reasoning, analysis, and synthesis of complex information.
5. **Behavioral and Social Attributes:** A candidate must possess the emotional health required for full utilization of his or her intellectual abilities, the exercise of good judgment, the prompt completion of all responsibilities attendant to the diagnosis and care of patients, and the development of mature, sensitive, and effective relationships with patients. Candidates must be able to tolerate physically taxing workloads and to function effectively under stress. They must be able to adapt to changing environments, to display flexibility, and learn to function in the face of uncertainties inherent in the clinical problems of many patients. Compassion, integrity, interpersonal skills, interest and motivation are all personal qualities that are assessed during the selection and education process.

T. Vacation Scheduling

1. Each resident will be entitled to a total of 15 days of annual leave each year. These days are separate from additional days available for educational meetings. Four or five of these vacation days will be assigned around the Christmas and New Years vacation and will be coordinated by the chief residents. The next ten days of vacation time must generally be taken in five-day blocks. Exceptions may be allowed with approval of the Program Director particularly in the case of chief residents needing to interview for a position. Five of these days must be requested by August 1st and the remaining five must be requested by February 1st. The 15th day, if applicable will be granted as below or will be assigned if the criteria cannot be met. Additional days missed by residents due to travel delays, will be counted as vacation days, whether or not the delay is the fault of the individual resident. Therefore, timely travel to and from destinations must be planned to account for unforeseen circumstances.
2. Generally, no two residents may be gone on vacation at the same time. Exceptions will not be made for this except in the instance of the major otolaryngology meetings when a large number of the faculty will be gone as well, emergencies, or in the case of chief residents interviewing. Also, the APP vacation schedule must be taken into account and should be checked with the Program Director if a resident and an APP will be out at the same time.
3. No vacation may be taken during the AAO-HNS annual meeting, the first weekend March during the In-Training Exam, during scheduled departmental educational activities (including nights and weekends).
4. No vacations will be allowed in June or July, during major Otolaryngology meetings, or during the annual APP meeting. PGY-2 residents may not take vacation during the anatomy dissection or temporal bone courses. Exceptions will be considered for graduating residents and for emergencies.
5. Graduating residents will be expected to work through June 30th. Graduating residents required to start a fellowship on July 1st may leave early only with approval by the program director, and must do so by taking allowable vacation days as terminal leave.

6. Requests for time to interview for a fellowship or practice position must be submitted to the residency travel secretary for approval. This applies to personal days for weddings etc. as well. These might not be approved when a resident or an APP is out from Shands.
7. When you take a vacation during a week with a holiday, the remaining vacation day must be taken at another time when no other residents are out and if at all possible when it will not require any change in the clinical schedule, e.g. the attendings on your service are out. This applies also to the 15th day of vacation, if applicable.
8. A maximum of five (5) individual days of leave may be used during the course of either the PGY-4 or PGY-5 years for employment and fellowship interviews. This time is counted towards the total allowable time off during the academic year as mandated by the RRC not to exceed 30 days. Any additional time needed for interviews must be taken as vacation, or as education with PD approval.
9. Leave cannot be carried over year to year.
10. All days out requests must be submitted to Casey Willits via OpenTempo and approved by the Program Director or Associate Program Director at least 35 days prior to the date. Days out that occur during a VA rotation must be submitted and approved at least 45 days prior to the date.

11. Table: Resident Leave Policies

	PGY 1	PGY 2	PGY 3	PGY 4	PGY 5
Vacation*	15	15	15	15	15
Educational	5	5	5	5	5
Interview#	---	---	---	5	---
Total	20	20	20	25	20

12. Only 1 resident out on vacation at a time. Minimum 35 day notice required. No vacations allowed in June or July, except in exceptional circumstances and with PD approval.
13. + Meeting days, to be used as first priority for residents attending meetings. For presenting residents who require additional days beyond these 5 days, they will log the leave time in New Innovations as Research Days, for the day before, day of the presentation, and the day after.
14. # Five days granted, to be used at the resident's discretion with PD approval for fellowship and/or private practice interviews. Includes travel days. Additional desired interview days to be credited as education or vacation days are subject to PD approval.
15. Additional Parental/Medical Leave, Bereavement Leave, Jury Duty Leave Domestic Violence Leave, etc., are detailed in GME policy number GME-403.

U. Work Environment

1. Patient support services, such as, intravenous services, phlebotomy services and laboratory services, as well as messenger and transporter services must be provided in a manner appropriate to and consistent with educational objectives and patient care.
2. An effective laboratory, medical records, and radiologic information retrieval system must be in place to provide for appropriate conduct of the educational programs and quality and timely patient care.

3. Appropriate security measures must be provided to residents in all locations including but not limited to parking facilities, on-call quarters, hospital and institutional grounds, and related clinical facilities.

V. Living Quarters, Meals, and Laundry, Dress Code

1. A call room is furnished for the on-call resident.
2. Gator Bites will be provided in lump sums based on average annual call responsibilities. Gator Bites will only be provided when it is deemed that a resident has satisfied their minimum administrative responsibilities, including but not limited to logging of duty hours, signing off on charts, updating case logs, completing evaluations, and turning in lecture titles.
3. Dress code reflects UF Health policy (see Appendix E). Scrubs are not to be worn outside of the hospital. They are to be returned to the scrub machine at the end of the day. An ID badge must be worn at all times. Inappropriate attire (see Appendix E) will not be tolerated and you will be sent home if attending feels necessary. Residents must wear business attire in the clinic: men should wear dress slacks, dress shirt and tie; women should wear dress slacks/skirt and blouse or dress. Residents are responsible for cleaning and pressing their own white coats as laundry services are NOT provided.
 - Exceptions to the clinic dress code
 - **Dziegielewski** will allow residents to wear a freshly pressed pair of scrubs in clinic. If you would like a pair of navy scrubs with the UF Health Logo, you are responsible for purchase and cleaning.

W. Benefits

Medical, life, disability, and liability insurance are provided. Please see the Shands Housestaff Office for complete details. Residents are now able to enroll in UF Select plans offered through People First.

- Housestaff Fringe Benefits: <https://com-dean-adminaffairs.sites.medinfo.ufl.edu/files/2015/01/2015-Housestaff-Summary.pdf>
- UF Select Benefits: <http://hr.ufl.edu/benefits/>

X. Counseling

The Housestaff Affairs Office will provide you with a referral for counseling through the Resident Assistance Program (RAP) if needed.

Y. Continuity of Care

Continuity of care is important for both patients and health care providers. First and foremost, continuity of care results in better care. Second, continuity of care leads to a better understanding of what patients are going through, how to better help them, and subtleties about the disease processes. Therefore, we must insure that continuity of care is maintained. The following policy has been drawn up to insure that continuity of care is maintained at the residents' level.

Residents for each team are expected to personally round on each of their service's patients every morning. At the end of every day, a representative of the service will sign out all inpatients (both on service and consults) to the primary on-call resident.

All residents will email faculty about all patient encounters (significant phone conversations, ER evals, etc) while he/she is on call regardless of whether it was discussed with the attending. The on-call resident will be

expected to dictate a note detailing the nature of the encounter. When primary call is transferred to another resident (e.g., Friday to Saturday) all in-house patients and pending outpatient issues must be verbally signed out to the new call resident. On Monday and post-holiday mornings, the primary on-call resident for the previous day will verbally sign out to the residents of the appropriate service(s).

If you are the primary surgeon on any case that will require postoperative follow-up it is your responsibility to either perform that care or to check this care out explicitly to another resident or PE. Nasal packing removal is an excellent example.

You are here to help take care of patients rather than assume complete control of their care. Attending physicians should be notified of all major treatment changes or issue on their patients at all times.

Z. Communication of Patient Care Encounters

On call communication between the supervising Otolaryngology faculty member and resident(s) must occur to provide optimal patient care and proper supervision. A guideline for instances in which communication is required and the proper format in which to communicate is listed below:

Mandatory phone call from on call resident to on call faculty member:

1. Patient death
2. Patient requiring trip to the operating room
3. Deterioration of patient condition necessitating an increase in the level of care (i.e. transfer from floor to ICU) primarily due to otolaryngologic condition
4. End of life discussions with patient and/or families
5. Acceptance of hospital to hospital transfer
6. Life threatening airway emergency

Communication may include phone call or email via secure email accounts:

1. All consults (inpatient or ED)
2. All admissions to the Otolaryngology service
3. Transfer of patient to the ICU
4. Admission of postoperative complications, particularly to the faculty surgeon of record.

Please note that when in doubt about the proper format in which to communicate information, opt for the more direct (i.e. phone call). Also recognize that text messaging is not considered secure to transmit private health information. The above recommendations are not considered totally inclusive of all possible scenarios. On call residents are encouraged to use their clinical reasoning as well as those more experienced than themselves in determining the level of involvement of all parties.

AA. Billing and Compliance

Residents may not bill for any service. Residents are responsible for understanding and cooperating with all departmental billing and compliance issues as detailed in the departmental policies, which will be periodically reviewed with the residents. Further details are provided under the Clinic Issues section and in the Department Compliance document.

The dictated operative record should reflect exactly the same procedures and diagnoses as written by the attending on the charge sheet. If you have an ethical problem with any aspect of this, please bring it to the Program Director's attention.

BB. Vendor/Industry Interactions

Residents must comply with the University of Florida College of Medicine Policy on Industry Conflicts of

Interest/Industry Academic Relations (see policy for complete detail). This includes:

1. Residents may not accept gifts from vendors/industry, regardless of value
2. Residents are not permitted to accept books, instruments and other teaching aids from industry representatives or vendors.
3. On-site access by industry representatives or vendors is restricted to non-patient care and public areas only. Industry representatives and vendors are permitted access to patient care areas and non-public areas only when their presence is necessary for educational purposes and then only by appointment and, when appropriate, with the prior consent of the patient. Such on-site access by industry representatives and vendors must be under the constant supervision of a COM faculty member.
4. Residents may participate in educational and CME activities that conform to ACGME requirements.
5. Residents may not accept food or meals sponsored by or provided by industry representatives or vendors. This includes events with an educational component (e.g. journal club) unless this event has been approved by the CME office. Industry funding may not be accepted for departmental meetings, retreats or social events. Dinners or entertainment sponsored by and paid for by industry representatives or vendors for a small group of select individuals at national meetings/conferences is not permitted.
6. Residents are not permitted to accept travel funds or payment from industry representatives or vendors to attend a meeting or conference.

CC. Clinic Issues

1. **Appointment scheduling and ER follow-ups:** Do not send anyone to clinic without letting the clinic staff know the name, date, clinic site, and approximate time of arrival. An email will suffice. Also, you are not to overbook clinics without faculty permission. Instead have patients call the clinic for their appointments when at all possible particularly in the case of ER patients. Patients that need follow-up care for treatment you rendered will be given appointments. Other patients will be required to go through normal Departmental screening procedures. Post-op appointments are to be made at the time of pre-op.
2. **Surgery scheduling:** Surgery posting sheets are to be filled out completely and accurately and turned in immediately.
3. **Dictations:** Dictations and EMR notes should be complete, thorough documentation of the care provided based upon departmental compliance policies. Please limit your dictation and EMR notes to the minimum necessary to provide good patient care. Dictations and EMR notes must be done on the same day as you see the patient. If there is pending information, add it later.
4. **Referring physician:** You are to ask a copy to be sent to all referring physicians. This requires dictating the name and address, which should be provided to you on the dictation sheet or on the last note. You can stop doing this only when the patient no longer sees the referring physician. If you cannot find the information, ask the patient.
5. **Identification:** Inform the patient as to whom you are when you see them, and let them know the attending will be in shortly.
6. **Billing issues:** You are not to be involved in billing issues in any way. Do not discuss contract or billing issues with the patients. Refer them to the surgery schedulers, front desk, or ACU manager.

You are not to circle diagnoses codes or E&M levels during regular hours. You are supposed to fill out a routing sheet on all patients seen without an attending. These will not be billed but are important for documentation purposes.

7. **Follow-up issues:** It is your responsibility to follow-up on all labs and imaging on any patient you see in the clinic.
8. **Employee counseling:** Please do not discipline or counsel any employee regarding their job performance. Bring any issues to the ACU Manager or Program Director instead.
9. **Phone message return:** All phone messages must be returned by the end of the day and with appropriate documentation.
10. **New patients:** All new patients should have complete head and neck histories and exams appropriate for age.
11. **Sample pharmaceuticals:** Any sample given to a patient must be recorded in the sample log with patient name, date, physician name, drug name, lot number, and instructions. You are not to sign for any sample delivery to the clinic. Sample medications are limited and must only be distributed in strict accordance with Shands & UF protocols.
12. Prescriptions for narcotic pain medications will not be filled after-hours or on the weekends without evaluation of the patient.

DD: Social Networking Policy

As medical professionals, resident physicians are expected to conduct themselves with the utmost in professionalism, whether in personal interactions or when online. Residents should refrain from engaging in any unprofessional behavior, inappropriate language, posting of offensive photos or materials when engaged in online activities. For full details, please see the University of Florida GME website for detailed policies and procedures. Failure to maintain the minimum standards of professionalism may result in disciplinary action.

EE: Disaster / Hurricane Plan

If a mass casualty event occurs, UF/Shands leadership will put out a call for the Tier A providers to report to the hospital. If the number of casualties is extremely large, or injury type is specific for our specialty, then Tiers B and possibly C may also be called in. For clarification:

Tier A: includes the Senior & Junior residents on call, as well as faculty member on call.

Tier B: includes PGY 4 & 5 residents

Tier C: includes the PGY 2 & 3 residents

PGY1 residents should report to your respective rotation if called upon.

In case of a natural disaster, such as a hurricane, the plan will be slightly modified. For the “Hurricane Resident Plan” (which also applies to other disasters for which we might have advanced warning to prepare & travel might be impossible), Tier A residents should plan on arriving at the hospital before the storm (i.e. once a hurricane warning is called), and plan to stay in-house during the storm. Once the storm safely passes, & the all-clear signal is given, the residents who are scheduled to be on call at that time should report to the hospital to relieve their colleagues. Since all 3 hospitals (North Tower, South Tower, & the VA) are connected by tunnels, this should allow resident coverage of all 3 locations. Attending coverage during the storm would depend on the attending who is on call, institutional needs, and patient specific situations that

may be ongoing at the time.

FF: Holiday Leave (UF vs VA Rotations)

There are several UF and VA holidays that are different.

- **Columbus Day and Presidents Day are VA holidays but not UF. One VA attending and one VA resident will be available during the day to handle any problems and round as needed.**
- The **Friday after Thanksgiving** is NOT a VA holiday, it is a UF Holiday. One VA attending and one VA resident will be available during the day.
- **UF Homecoming** is a UF Holiday for non-essential staff. Residents are essential and must work at the VA and UF unless vacation leave is taken in advance.

HH: Haiku (Epic) / Smartphones

It is mandatory for residents to have a working smartphone with the Haiku Mobile app installed in order to fulfill on-call and other clinical duties at UF Health Gainesville. The Haiku Mobile app is a smartphone app that allows clinicians to securely send, receive, and respond to "secure messages" and photo messages from others at UF Health, all tied to Epic patient records. Nurses and support staff at UF Health Shands are using this as a secure way to communicate patient information to clinicians while they are on call. If you are not using Haiku or have your settings as "inactive" while on duty, you are impacting patient care and are not in compliance of the department policy on being available while on call.

VIII. PROGRAM EVALUATION

The faculty will review the success of the program in meeting its goals and objectives in its regular monthly meetings and during a single session devoted to this once a year. Crucial to this review will be the annual written review of the program by the residents. Additional material considered will include: board pass rates; Annual Otolaryngology Examination scores; attainment of fellowships, academic positions, and suitable private practice positions; and operative case experiences.

Below is a cumulative summary of the multiple types of evaluations performed in this program:

End of each rotation:

Faculty → each resident on service (via New Innovations: See Appendix A)

Semi-Annual Evaluation (Every 6 Months):

PD/Asst. PD → each resident (sit down & New Innovations)

Milestone Evaluation (Every 6 Months):

PD/CCC → each resident (via NI and ACGME: See Appendix B)

Every spring:

ACGME survey by residents → Overall program (ACGME website online)

End of academic year:

Each faculty → Each resident (NI)

Each resident → Each faculty (NI)

Each resident → Each resident (NI)

Each resident → Overall program (NI)

Each resident → Each clinical site (NI)

Incorporated into annual curriculum review in July

360 degree evals → Each resident (NI)

Each faculty → Overall program (NI)

Incorporated into annual program review in July

By end of residency:

Faculty → Each graduating chief resident signed out on key indicator cases

Every 1 vs. 3 vs. 5 years:

Graduate survey by alumni → Overall program (Survey Monkey in March 2015)

IX. SHANDS UF CONSULT PROTOCOL

Weekday Consult Protocol

1. Any patient able to be seen in clinic should be transported to clinic and evaluated by the attending physician and resident team. This must be cleared with clinic attending prior to transport and time arranged by clinic attending.
2. Any patient unable to be seen in clinic should be staffed as follows:
 - a. Clinic Attending and team, if available
 - b. OR Attending and team, if available
 - c. On call team
 - d. *Specific attending with specialty expertise is acceptable in some circumstances
3. Consulting resident is responsible for providing billing sheet to attending
4. The patient is to be followed by service of consulting attending
5. Initial consult form to be completed at time of consult, followed by stat dictation

Weekend and Night Consult Protocol

The on-call residents will present emergency room patients and urgent consults by phone to the on call attending physician. Non-urgent or non-emergent issues can wait until the next day but still must be discussed.

Appendix

A. New Innovations Rotation Evaluation

ABILITY:

Medical Knowledge

A: Shows complete knowledge of the basic medical principles and displays great insight in relating them to the patient's problems.

C: Demonstrates adequate comprehension of basic medical principles and relates them to the patient's problems.

F: Inadequate knowledge of medical situations relating to the patients problems.

A = Best	B	C	D	F = Worst	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Professional Judgement

A: Consistently arrives at right decisions even on highly complex matters.

C: Judgment is usually sound. Logical thinker.

F: Decisions and recommendations often wrong or ineffective.

A = Best	B	C	D	F = Worst	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Technical Skill

A: Highly skilled in performance of clinical and surgical procedures.

C: Adequate dexterity displayed in performance of clinical and surgical procedures.

F: Awkward in performance of clinical and surgical procedures.

A = Best	B	C	D	F = Worst	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Dependability, attendance and promptness:

A: Always present and punctual. Spends additional time in ward providing optimal patient care. Consistent evidence of personal ethics and professionalism.

C: Usually present and punctual, conscientious of patient care. Ethical and professional.

F: Frequently absent or tardy. Unprofessional or unethical behaviors observed. Cannot be depended on for patient care.

A = Best	B	C	D	F = Worst	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Initiative and Industry

A: Exceptionally hard worker. Conscientious, willing to take on extra work.

C: Carries his share of the load; accepts requests and sometimes volunteers.
Not well motivated. Unproductive; cannot be counted on to carry his share of the load.

F: Not well motivated. Unproductive: cannot be counted on to carry his share of the load.

A = Best	B	C	D	F = Worst	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

WORK PRODUCT:

Progress Notes

A: Charts are outstandingly written. Presentation and follow-up case reports are excellent.

C: Charts promptly and capably done. Clear, organized accounts of patient's progress.

F: Unsatisfactory charting of patient's progress.

A = Best	B	C	D	F = Worst	N/A
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History and Physical Evaluation

A: Systematic and thorough history. Well-integrated physical findings. Never overlooks even subtle problems.

C: Adequate gathering of information from patient. Satisfactory organization and interpretation of physical findings.

F: Unsystematic exploration. Overlooks important problems. Omits essential elements of physical exam.

A = Best	B	C	D	F = Worst	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Verbal Presentations

A: Concise, vivid, complete account of patients problems.

C: Patient presentation usually clear, accurate and complete. Occasionally needs to pose questions to clarify chronology or complete data.

F: Oral presentations unclear. Symptoms vague, terminology ambiguous; data incomplete, chronology confused.

A = Best	B	C	D	F = Worst	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

EDUCATIONAL EVALUATION:

Willingness to learn

A: Eager to learn. Explores literature in depth and breadth to supplement previous knowledge. Participates actively in conferences. Learns from medical practice.

C: Regularly seeks new information and consults standard textbooks. Routinely attends conferences.

F: Acquires knowledge passively. No evidence of collateral readings. Seldom present at conference.

A = Best	B	C	D	F = Worst	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Teaching, Effectiveness with Students

A: Actively involved in teaching. Enthusiastic; gives a great deal of personal help to students.

C: Moderately involved in student teaching. Provides direction to students in organized manner. Usually accessible to students.

F: Appears disinterested in teaching responsibilities. Offers no direction to the students. In accessible.

A = Best	B	C	D	F = Worst	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

PERSONAL EVALUATION:

Appearance

A: Always carefully groomed and appropriately attired.

C: Usually neat and suitable dressed.

F: Often unkempt and inappropriately dressed.

A = Best	B	C	D	F = Worst	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Team participation

A: An exceptionally active member of the health care team whose leadership qualities are sought by others.

C: Team oriented approach. Elicits the cooperation of the other members of the health care team.

F: Behavior undermines team effort. Uncooperative.

A = Best	B	C	D	F = Worst	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Professional Relationship

A: Conducts himself/herself as a true professional. Commands admiration and respect of co-workers. Consistent professionalism in behavior and interactions.

C: Maintains acceptable and workable relationships with colleagues.

F: Uncooperative with colleagues. Makes a poor impression.

A = Best	B	C	D	F = Worst	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Relationship with patients

A: Professional attitude. Listens and communicates well. Instills confidence in his ability.

C: Establishes good rapport and communicates well with patients.

F: Unable to establish rapport with patients. Seems to lack ability to communicate skills.

A = Best	B	C	D	F = Worst	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

SERVICE SPECIFIC EVALUATION:

A: Meets and exceeds all Service Goals for Education, Patient Care and Leadership.

C: Meet most Service Specific Goals with few deficiencies.

F: Does not meet most Service Specific Goals, numerous deficiencies.

A = Best	B	C	D	F = Worst	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

PRACTICE INTEGRATION SKILLS:

A: Excellent understanding of interactions of professional practices with other healthcare professionals, cost control and resource allocation. Practices cost-effective healthcare with out compromising patient safety. Advocate for patients in dealing with system complexities and partnering with other providers to coordinate improved healthcare.

C: Adequate interactions with other professionals. Understands cost and allocation control with some success in these areas. Generally able to partner with other providers to improve patient care.

F: Poor interaction with other professionals. Poor cost/resource control and allocation with waste or compromised patient care. Ineffective in navigating system complexities and partnering with other providers to aid patient care.

A = Best	B	C	D	F = Worst	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

OVERALL:

Overall Score:

A = Best	B	C	D	F = Worst	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Faculty Comments: (required)

Remaining Characters: 5000

Areas for Improvement:

Remaining Characters: 5000

Faculty Recommendations:



Remaining Characters: 5000

I have discussed this evaluation with the resident:

Yes No

B. Milestone Evaluation

Salivary Disease — Patient Care

Level 1	Level 2	Level 3	Level 4	Level 5
<ul style="list-style-type: none"> ☐ Obtains basic history and physical ☐ Understands normal salivary gland function ☐ Knows treatment of sialadenitis ☐ Knows how to scrub; performs surgical time out; maintains sterile field 	<ul style="list-style-type: none"> ☐ Obtains focused history and physical, including comprehensive head and neck exam, neck and cranial nerve exam; orders appropriate labs, fine-needle aspiration (FNA), and radiologic studies ☐ Understands factors precipitating inflammatory salivary disease ☐ Discusses treatment modality options in general terms (including adjuvant treatment) ☐ Performs intra-operative patient prep; raises skin flaps in appropriate plane; able to aesthetically close wound ☐ Lists some potential complications 	<ul style="list-style-type: none"> ☐ Interprets appropriate lab, pathologic, and radiologic studies ☐ Describes an accurate differential diagnosis of a salivary gland mass; able to clinically distinguish neoplastic from non-neoplastic etiologies ☐ Discusses appropriate therapeutic options and understands implications of those options ☐ Performs procedure with assistance; identifies neurovascular structures ☐ Recognizes common complications; obtains appropriate consultations for patient management 	<ul style="list-style-type: none"> ☐ Accurately tumor node metastasis (TNM) stages a specific patient ☐ Makes correct diagnosis from clinical, radiologic, and pathologic information; knows histopathologic findings of common neoplastic processes ☐ Formulates appropriate treatment plan for a specific salivary gland cancer patient based on primary site, disease stage, and patient factors ☐ Completes procedure with oversight ☐ Recognizes and is able to treat and/or develop treatment plan for common complications 	<ul style="list-style-type: none"> ☐ Performs ultrasound guided FNA of salivary gland mass ☐ Teaches pathophysiology ☐ Performs extended dissection of parotid bed neoplasm with preservation of neurovascular (NV) structures as appropriate; teaches procedure ☐ Treats complex complications

Aerodigestive Tract Lesions (ADT) — Patient Care

Level 1	Level 2	Level 3	Level 4	Level 5
<ul style="list-style-type: none"> ☐ Obtains basic history and physical ☐ Demonstrates limited understanding of normal laryngeal function ☐ Demonstrates limited knowledge of treatment options 	<ul style="list-style-type: none"> ☐ Obtains focused history and physical, including comprehensive aerodigestive tract and cranial nerve clinic exam with recognition of normal anatomy and obvious abnormalities ☐ Understands normal laryngeal and esophageal function; understands factors precipitating inflammatory laryngeal disease ☐ Discusses treatment modality options in general terms ☐ Positions patient properly for laryngoscopy, and sometimes able to visualize the larynx ☐ Positions patient properly for esophagoscopy, and sometimes able to visualize the esophagus ☐ Lists some potential complications (e.g., identifies and appropriately treats local injury from endoscopic instruments) 	<ul style="list-style-type: none"> ☐ Orders appropriate labs, functional, and radiologic studies; performs flexible and rigid endoscopic evaluation ☐ Knows differential diagnosis of vocal cord lesion; able to clinically distinguish neoplastic from non-neoplastic etiologies ☐ Discusses appropriate therapeutic options and understands implications of each ☐ Able to consistently visualize the larynx during laryngoscopy and perform binocular microlaryngoscopy ☐ Performs esophagoscopy with biopsy in patients with favorable anatomy ☐ Recognizes common complications; obtains appropriate consultations for patient management 	<ul style="list-style-type: none"> ☐ Interprets appropriate lab, functional, and radiologic studies ☐ Makes correct diagnosis from clinical, radiologic, and pathologic information; knows histopathologic findings of common neoplastic processes ☐ Formulates appropriate treatment plan for a specific vocal cord lesion and patient factors ☐ Performs microlaryngoscopy consistently with complete exposure of the anterior commissure ☐ Recognizes and is able to treat and/or develop treatment plan for common complications 	<ul style="list-style-type: none"> ☐ Performs flexible fiberoptic laryngoscopy with manipulation with oversight ☐ Teaches pathophysiology ☐ Teaches management of complex aerodigestive tract (ADT) lesions ☐ Performs microlaryngoscopy in the difficult to expose patient with complete exposure of the anterior commissure ☐ Performs esophagoscopy with complex intervention efficiently in the difficult to expose patient ☐ Treats complex complications

Disordered Breathing (SDB) — Patient Care

Level 1	Level 2	Level 3	Level 4	Level 5
<ul style="list-style-type: none"> ☐ Obtains general history and performs basic physical exam 	<ul style="list-style-type: none"> ☐ Recognizes signs and symptoms of SDB and the differences between children and adults; orders appropriate routine lab, radiologic, and sleep studies ☐ Demonstrates basic understanding of spectrum of sleep disorders in children and adults ☐ Demonstrates beginning understanding of treatment measures ☐ Performs tonsillectomy and/or adenoidectomy (T&A) on typical pediatric or adult patient ☐ Lists common potential complications 	<ul style="list-style-type: none"> ☐ Performs detailed examination with evaluation of upper airway anatomy and interprets basic diagnostic testing ☐ Demonstrates moderate understanding of spectrum of sleep disorders in children and adults ☐ Demonstrates deepening understanding of medical treatments, role of surveillance, and alternate therapies ☐ Performs palatopharyngoplasty on typical patient ☐ Lists rare complications; recognizes common complications and is able to initiate treatment in the typical patient 	<ul style="list-style-type: none"> ☐ Interprets examination and advanced diagnostic testing ☐ Demonstrates thorough understanding of spectrum of sleep disorders in children and adults ☐ Able to list and prioritize treatment options for the patient with SDB in complicated patient populations ☐ Performs T&A and palatopharyngoplasty on complex patients ☐ Recognizes and is able to treat and/or develop treatment plan for common and uncommon complications in the complex patient 	<ul style="list-style-type: none"> ☐ Teaches focused history and physical exam ☐ Recognizes interaction between SDB and other sleep disorders in children and adults ☐ Identifies indications and risks of non-surgical treatment plans for sleep disorders other than SDB, and disorders of initiating and maintaining sleep ☐ Teaches T&A and palatopharyngoplasty

Facial Trauma — Patient Care

Level 1	Level 2	Level 3	Level 4	Level 5
<ul style="list-style-type: none"> ☐ Obtains history and performs basic physical exam ☐ Demonstrates basic knowledge of normal facial skeleton and relationships ☐ Demonstrates limited knowledge of treatment options ☐ Knows how to scrub; Performs surgical time out ☐ Demonstrates limited familiarity with complications 	<ul style="list-style-type: none"> ☐ Recognizes symptoms of mandible and facial fractures; able to quickly assess airway, breathing, and circulation (ABC's) and need for urgent intervention ☐ Localizes zones of the traumatically involved facial skeleton (i.e., frontal, orbital, midface, and mandible) using detailed familiarity with normal facial bony and soft tissue anatomy ☐ Discusses treatment modality options in general terms; demonstrates limited knowledge of potential indications for operative open reduction and internal fixation (ORIF) of the spectrum of facial fractures ☐ Demonstrates beginning ability to apply maxillo-mandibular fixation hardware and to perform intraoral and external incisions ☐ Lists some potential complications 	<ul style="list-style-type: none"> ☐ Obtains focused history and performs focused exam, including airway evaluation and survey for other head and neck injuries; orders appropriate routine lab and radiologic studies ☐ Identifies common facial skeleton fracture patterns ☐ Discusses appropriate therapeutic options for major facial fracture types/patterns ☐ Facile at placing maxillary-mandibular fixation (MMF) and establishing baseline patient occlusion; able to perform surgical approaches (location and extent) to visualize fractures and provide adequate exposure for ORIF ☐ Recognizes common complications; makes appropriate consultations for patient management 	<ul style="list-style-type: none"> ☐ Interprets appropriate lab and radiologic studies; identifies and orders necessary adjunctive studies (i.e., angiography) ☐ Accurately diagnoses location and extent of specific facial trauma ☐ Develops appropriate treatment plan and performs ORIF for a facial fracture patient with combined mandible and midface fracture ☐ Performs uncomplicated mandibular ORIF ☐ Recognizes and is able to treat common complications 	<ul style="list-style-type: none"> ☐ Develops appropriate treatment plan for panfacial fracture patient ☐ Performs revision/infected mandibular fracture ORIF ☐ Treats complex complications

Rhinosinusitis — Patient Care

Level 1	Level 2	Level 3	Level 4	Level 5
<ul style="list-style-type: none"> ☑ Obtains basic sinonasal symptom history and performs basic head and neck exam ☑ Recognizes symptoms that indicate sinonasal pathology ☑ Demonstrates minimal knowledge of treatment options ☑ Performs surgical time out; familiar with pre-op documentation requirements (e.g., consent, history and physical, imaging) Knows how to scrub ☑ Lists some complications of rhinosinusitis 	<ul style="list-style-type: none"> ☑ Obtains focused history and physical, including detailed sinonasal symptom inventory ☑ Explains the diagnostic distinction between viral upper respiratory infections (URI) and acute bacterial sinusitis ☑ Discusses treatment modality options in general terms; prescribes medical therapy for simple common conditions (i.e., viral URI, acute bacterial rhinosinusitis [ABRS]) ☑ Performs intra-operative patient nasal decongestion and local injections under endoscopic guidance; able to apply/register stereotactic surgical guidance system ☑ Lists some potential complications of sinus surgery 	<ul style="list-style-type: none"> ☑ Performs nasal endoscopy and recognizes basic sinonasal pathology; demonstrates basic understanding of appropriate laboratory, pathologic, and radiologic diagnostic studies ☑ Provides a differential diagnosis that includes the most common spectrum of bacterial sinusitis disease ☑ Discusses appropriate therapeutic options for chronic rhinosinusitis (CRS) and chronic rhinosinusitis with nasal polyps (CRSNP) ☑ Performs endoscopic sinus surgery (ESS) procedure with guidance; recognizes endoscopic surgical landmarks ☑ Recognizes common complications; appropriate management for common complications 	<ul style="list-style-type: none"> ☑ Identifies nasal endoscopic pathologic findings in the previously operated patient; facile with interpretation/use of appropriate laboratory, pathologic and radiologic diagnostic studies ☑ Distinguishes the pathophysiologic and clinical presentations of the various subtypes of chronic rhinosinusitis ☑ Formulates appropriate treatment plan for patient with acute exacerbations of CRS or recurrent polypoid disease; tailors medical therapy to patient's symptoms level and disease presentation ☑ Completes ESS procedure with oversight ☑ Recognizes and is able to treat and/or develop treatment plan for significant complications 	<ul style="list-style-type: none"> ☑ Teaches nasal endoscopy ☑ Recognizes and diagnoses the possible uncommon etiologies of chronic bacterial sinusitis refractory to standard therapy ☑ Provides treatment of recurrent/extensive frontal sinus disease ☑ Performs revision and advanced endoscopic sinus surgery ☑ Treats complex complications

Nasal Deformity — Patient Care

Level 1	Level 2	Level 3	Level 4	Level 5
<ul style="list-style-type: none"> ☑ Obtains basic history and performs basic head and neck exam ☑ Demonstrates minimal knowledge of treatment options ☑ Performs surgical time out; knows how to scrub ☑ 	<ul style="list-style-type: none"> ☑ Obtains focused history and physical ☑ Demonstrates understanding of normal nasal physiology ☑ Discusses treatment modality options in general terms; prescribes medical therapy for simple common condition ☑ Prepares patient intra-operatively ☑ Plans, performs, and closes incisions that would be needed for adequate exposure; able to intra-operatively prepare patient (i.e., pack nose with decongestant pledgets, inject nose with local anesthetic) ☑ Demonstrates limited knowledge of potential complications 	<ul style="list-style-type: none"> ☑ Performs limited dynamic nasal function analysis and anterior rhinoscopy ☑ Differentiates between variable and fixed nasal obstruction contributors ☑ Discusses appropriate therapeutic options for common nasal deformities ☑ Plans and performs incisions that would be needed for both intranasal and external rhinoplasty; cognizant of landmarks that mark important neurovascular structures ☑ Elevates septal mucosal flaps adequately to address identified structural abnormalities ☑ Recognizes common complications 	<ul style="list-style-type: none"> ☑ Performs comprehensive dynamic nasal function analysis; identifies aesthetic/cosmetic abnormalities; correlates examination findings with underlying structural etiologies ☑ Identifies specific components of nasal pathophysiology in functional obstruction ☑ Formulates appropriate treatment plan for patient with fixed and/or dynamic nasal obstruction ☑ Resects or augments bony or cartilaginous framework, places and secure grafting material, and performs osteotomies ☑ Resects, recontours, and corrects septal abnormalities ☑ Recognizes and is able to treat and/or develop treatment plan for common complications 	<ul style="list-style-type: none"> ☑ Performs analysis in revision/post-surgical setting ☑ Formulates appropriate treatment plan for patient requiring revision surgery ☑ Performs revision rhinoplasty, including harvest and placement of graft material ☑ Performs revision septal surgery, including correction of complex septal abnormalities ☑ Treats complex complications

Chronic Ear — Patient Care

Level 1	Level 2	Level 3	Level 4	Level 5
<ul style="list-style-type: none"> ☐ Performs general history and physical ☐ Knows some common symptoms of ear infections ☐ Demonstrates limited knowledge of chronic ear disease ☐ Demonstrates little knowledge of medical/surgical treatments for ear disease ☐ Knows how to scrub; performs surgical time out; maintains sterile field 	<ul style="list-style-type: none"> ☐ Obtains pertinent otologic history and performs hand-held otoscopy; differentiates middle ear/mastoid disease from otitis externa; performs cranial nerve exam ☐ Identifies Eustachian tube (ET) dysfunction and the normal and abnormal physiologic contributors ☐ Prescribes appropriate systemic and/or topical antibiotic therapy for chronic otitis media; understands basics of post-operative wound care ☐ Positions, preps, and drapes patient; able to inject local anesthetic; makes post-auricular incision; able to aesthetically close wound ☐ Lists potential complications of ear surgery 	<ul style="list-style-type: none"> ☐ Performs reliable otomicroscopic exam; orders appropriate audiometry, laboratory, and radiologic studies ☐ Clinically differentiates otitis media (OM), otitis externa (OE), necrotizing OE, chronic otitis media (COM), mastoiditis, and cholesteatoma ☐ Recognizes clinical failure of medical management; describes surgical risks, benefits, and alternatives; understands concept of recidivism and understands need for long-term surveillance plan ☐ Performs ear canal incisions and elevates tympanomeatal flap; performs cortical mastoidectomy and identifies antrum/horizontal semicircular canal; skeletonizes posterior canal wall ☐ Able to manage routine post-operative complications 	<ul style="list-style-type: none"> ☐ Accurately interprets appropriate diagnostic studies; understands the indications for operative intervention; recognizes acute complications in the setting of COM ☐ Understands mechanisms underlying the development of intratemporal and intracranial complications of chronic ear disease ☐ Formulates appropriate treatment plan for care of a patient with complications of chronic ear disease ☐ Removes granulation tissue and/or cholesteatoma from the middle ear/mastoid; skeletonizes vertical segment of the facial nerve; performs tympanoplasty and/or ossiculoplasty ☐ Recognizes major complications 	<ul style="list-style-type: none"> ☐ Interprets less commonly utilized diagnostic tests ☐ Manages chronic otitis media in an only hearing ear ☐ Performs canal wall down mastoidectomy skillfully; able to proficiently perform facial recess approach ☐ Treats major post-surgical complications

Upper Aerodigestive Tract (UADT) Malignancy — Medical Knowledge

Level 1	Level 2	Level 3	Level 4	Level 5
<ul style="list-style-type: none"> ☐ Demonstrates basic understanding of UADT and neck anatomy ☐ Knows normal UADT function (mastication, deglutition, respiration, and phonation) ☐ Obtains basic history and physical 	<ul style="list-style-type: none"> ☐ Demonstrates moderate knowledge of UADT and neck anatomy; teaches anatomy to medical students in the operating room (OR) ☐ Knows abnormal UADT physiologic function and locoregional manifestations; knows tobacco is correlated with UADT cancer ☐ Knows most common disease state presentations for UADT malignancies ☐ Performs focused history and physical, including clinic laryngoscopy; understands appropriate labs, FNA, and radiologic studies for workup ☐ Describes basic treatment algorithm for UADT malignancies 	<ul style="list-style-type: none"> ☐ Demonstrates proficient knowledge of normal anatomy; teaches anatomy to junior residents in the OR ☐ Knows major risk factors for UADT cancer according to type of cancer ☐ Knows most common disease progression routes for UADT malignancy ☐ Interprets appropriate lab, pathologic, and radiologic studies ☐ Understands concepts of neo-adjuvant, primary, and adjuvant treatments; describes options for securing the difficult airway in the OR 	<ul style="list-style-type: none"> ☐ Correlates anatomic knowledge with disease physical examination (PE) and radiologic findings ☐ Understands molecular basis for UADT cancer; knows benign and malignant differential diagnoses of common site presentations ☐ Knows staging system for most common UADT cancers, and can accurately stage using available clinical and radiologic data ☐ Understands the prognostic indicators of tumor pathology, including molecular markers ☐ Describes treatment options based on primary site, disease stage, and patient factors 	<ul style="list-style-type: none"> ☐ Gives lectures on anatomy ☐ Articulates treatment protocol specifics for primary chemoradiation therapy

Pediatric Otitis Media — Patient Care

Level 1	Level 2	Level 3	Level 4	Level 5
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<ul style="list-style-type: none"> ☒ Performs basic history and physical examination ☒ Understands concept of OM and OE ☒ Participates in surgical time out 	<ul style="list-style-type: none"> ☒ Performs focused clinical examination and is able to correctly diagnose acute OM, OM with effusion, and OE some of the time; knows when to order basic audiometric testing ☒ Describes the etiologic organisms most commonly associated with OM and OE; understands the predisposing factors associated with each type of ear infection ☒ Appropriately prescribes topical and/or oral antibiotics for ear infections; demonstrates familiarity with effectiveness/ineffectiveness of non-antibiotic medications and alternative treatments ☒ Inserts ear speculum and safely cleans cerumen from ear canal ☒ Lists potential complications 	<ul style="list-style-type: none"> ☒ Performs pneumatic otoscopy and accurately diagnose acute OM, OM with effusion, and OE; knows when additional imaging is required for diagnosis ☒ Accurately diagnoses patients along the OM natural history spectrum and identifies ramifications of treated/untreated OM ☒ Recognizes treatment failures/refractoriness and indications for surgical intervention ☒ Identifies tympanic membrane and external auditory canal (EAC) landmark and structures; able to consistently perform appropriate myringotomy ☒ Recognizes common complications; obtains appropriate consultations for patient management 	<ul style="list-style-type: none"> ☒ Skilled pneumatic otoscopist in children of all ages; recognizes complications of acute OM, OM with effusion, and OE ☒ Diagnoses intra- and extracranial complications of ear infections ☒ Treats complications of ear infections ☒ Places tympanostomy tube safely in all patients with easy anatomy and in some patients with difficult anatomy ☒ Recognizes and is able to treat and/or develop treatment plan for common complications 	<ul style="list-style-type: none"> ☒ Skilled pneumatic otoscopist in syndromic children ☒ Places tympanostomy tube safely in patients with difficult anatomy
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Hearing Loss — Medical Knowledge

Level 1	Level 2	Level 3	Level 4	Level 5
<ul style="list-style-type: none"> ☒ Demonstrates limited knowledge of temporal bone and cochleovestibular anatomy ☒ Demonstrates limited understanding of the physiology of hearing ☒ Demonstrates limited understanding of the natural history of hearing loss 	<ul style="list-style-type: none"> ☒ Demonstrates proficient knowledge of temporal bone and cochleovestibular gross anatomy/embryology ☒ Understands normal middle ear mechanics and cochlear physiology ☒ Understands the natural history of presbycusis and noise-induced hearing loss ☒ Recognizes normal ear exam and normal audiometry; able to identify basic hearing loss classifications on an audiogram; demonstrates limited knowledge of options for diagnostic work-up of hearing loss ☒ Demonstrates awareness of non-surgical aural rehabilitation options; understands importance of hearing surveillance 	<ul style="list-style-type: none"> ☒ Demonstrates proficient knowledge of normal temporal bone and cochleovestibular histopathology ☒ Generates differential diagnosis for hearing loss in adult patients ☒ Understands the natural history of adult onset hearing loss ☒ Recognizes an abnormal ear exam/audiogram; orders appropriate routine audiometric, laboratory, and imaging tests for work-up ☒ Demonstrates comprehensive awareness of aural rehabilitation options, including surgical management of hearing loss 	<ul style="list-style-type: none"> ☒ Understands congenital variations of temporal bone and cochleovestibular anatomy ☒ Generates differential diagnosis for hearing loss in children, and identifies uncommon causes of hearing loss in adults ☒ Understands the natural history of pediatric hearing loss and uncommon causes of adult-onset hearing loss ☒ Considers unusual causes for hearing loss and orders/interprets appropriate advanced audiometric, laboratory, and imaging studies ☒ Describes indications/contraindications and complications of the surgical aural rehabilitation techniques; tailors aural rehabilitation to patient-specific needs 	<ul style="list-style-type: none"> ☒ Demonstrates knowledge of central auditory pathways

Dysphagia-Dysphonia — Medical Knowledge

Level 1	Level 2	Level 3	Level 4	Level 5
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<ul style="list-style-type: none"> ☐ Demonstrates limited understanding of aerodigestive functional anatomy ☐ Demonstrates limited understanding of common voice and swallowing disorders ☐ Demonstrates limited knowledge of disease progression and sequelae of untreated voice and swallowing disorders ☐ Obtains basic history and physical ☐ Demonstrates minimal understanding of treatment options and rationales, and risks/benefits of each treatment option 	<ul style="list-style-type: none"> ☐ Understands basic anatomy and physiology of voice and swallowing ☐ Demonstrates basic understanding of common voice and swallowing disorders ☐ Understands age-related changes to voice and swallowing ☐ Obtains focused history and physical, including clinic laryngoscopy; able to list appropriate diagnostic modalities for work-up of voice and swallowing disorders ☐ Demonstrates beginning understanding of treatment options and rationales, and risks/benefits of each treatment option 	<ul style="list-style-type: none"> ☐ Demonstrates mid-level understanding of anatomy and physiology of voice and swallowing ☐ Demonstrates mid-level understanding of common voice and swallowing disorders ☐ Demonstrates knowledge of disease progression and sequelae of untreated voice and swallowing disorders ☐ Interprets appropriate lab, pathologic, and radiologic studies ☐ Demonstrates mid-level understanding of treatment options and rationales, and risks/benefits of each treatment option 	<ul style="list-style-type: none"> ☐ Demonstrates thorough knowledge of anatomy and physiology of voice and swallowing ☐ Demonstrates comprehensive understanding of most voice and swallowing disorders, including voice and swallowing manifestations of systemic diseases (i.e., autoimmune disorders, sarcoid, neuromuscular disorders) ☐ Articulates comprehensive understanding of risk factors and timeframe for malignant transformation of premalignant conditions (laryngopharyngeal reflux disease [LPRD], Barrett's, Dysplasia/Leukoplakia, recurrent respiratory papillomatosis [RRP]) ☐ Correlates laboratory and radiologic work-up with clinical diagnosis ☐ Demonstrates understanding of treatment options and rationales, risks/benefits of each treatment option, and surveillance algorithms for malignant disease 	<ul style="list-style-type: none"> ☐ Teaches pathophysiology
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Inhalant Allergy — Medical Knowledge

Level 1	Level 2	Level 3	Level 4	Level 5
<ul style="list-style-type: none"> ☐ Demonstrates familiarity with basic nasal anatomy and normal respiratory mucosa histology ☐ Demonstrates familiarity with normal functions of nasal mucosa and nasal cavities ☐ Demonstrates limited knowledge of allergy work-up 	<ul style="list-style-type: none"> ☐ Demonstrates basic understanding of derangements in nasal anatomy and mucosal inflammation ☐ Knows pathophysiology of allergic rhinitis (AR) ☐ Describes comorbidities in AR ☐ Demonstrates familiarity with clinical presentations of allergic disease ☐ Prescribes basic medical treatment for AR 	<ul style="list-style-type: none"> ☐ Demonstrates knowledge of histopathology of allergic rhinitis and anatomic factors affecting the nasal airway ☐ Knows pathophysiology of non-allergic rhinitis ☐ Describes the natural history and components of severity in allergic disease ☐ Demonstrates knowledge of testing methods in allergic disease ☐ Prescribes advanced medical treatment for allergic disease 	<ul style="list-style-type: none"> ☐ Demonstrates thorough understanding of anatomic impact of allergic inflammation on the nasal airway ☐ Distinguishes presentations of allergic and non-allergic rhinitis patients; demonstrates knowledge of cellular and molecular features of inhalant allergy ☐ Describes systems for AR subtype and severity (e.g., seasonal vs. perennial, intermittent vs. persistent, etc.) and incorporates knowledge of severity and natural history into patient management ☐ Combines clinical features and test results to correctly diagnose allergic disease ☐ Demonstrates a working knowledge of immunotherapy for allergic disease 	<ul style="list-style-type: none"> ☐ Demonstrates advanced understanding of allergy diagnostic testing ☐ Is facile with multiple methods of immunotherapy

Patient Safety — Systems-based Practice

Level 1	Level 2	Level 3	Level 4	Level 5
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- ☐ Understands the need for formal patient safety measures (e.g., surgical time out)
- ☐ Participates in the use of tools to prevent adverse events (e.g., checklists and briefings)
- ☐ Understands and uses chain of command to develop and implement patient care plans (junior to senior resident to attending)
- ☐ Consistently uses tools to prevent adverse events (e.g., checklists and briefings)
- ☐ Identifies potential patient safety issues (patient positioning in OR, aspiration risk) and means to prevent those problems
- ☐ Presents at morbidity and mortality (M&M) conference (organizes data and identification of some pertinent patient safety issues)
- ☐ Advocates for quality patient care and optimal patient care systems
- ☐ Analyzes M&M findings and provides feedback to improve patient safety
- ☐ Educates other services re patient safety issues in otolaryngology head and neck surgery OHNS

Resource Utilization — Systems-based Practice

Level 1	Level 2	Level 3	Level 4	Level 5
☐ Uses resources (social work, patient care manager) to coordinate patient care	☐ Actively functions as part of an interdisciplinary team to care for patients ☐ Aware of socio-economic issues in patient care and takes those into consideration when developing patient care plans	☐ Incorporates cost issues into care decisions ☐ Contributes to leadership of the interdisciplinary care team ☐ Uses technology and other hospital/clinic resources in patient care	☐ Practices cost-effective care (e.g., managing length of stay, operative efficiency) ☐ Leads interdisciplinary team in patient care	☐ Designs measurement tools to monitor and provide feedback to providers/teams on resource consumption to facilitate improvement

The ability to investigate and evaluate the care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning — Practice-based Learning and Improvement

Level 1	Level 2	Level 3	Level 4	Level 5
☐ Is aware of one’s own level of knowledge and uses feedback from teachers, colleagues, and patients ☐ Identifies learning resources	☐ Continually seeks and incorporates feedback to improve performance ☐ Develops a learning plan and uses published review articles and guidelines	☐ Demonstrates improvement in clinical thought and action based on continual self-assessment ☐ Selects an appropriate evidence-based information tool to answer specific questions	☐ Demonstrates consistent behavior of incorporating evidence-based information in common practice areas ☐ Organizes educational activities at the program level	☐ Is competent at performing meta-analyses to answer complex patient care questions ☐ is a sophisticated user of learning resources

Professionalism

Level 1	Level 2	Level 3	Level 4	Level 5
☐ Demonstrates behavior that conveys caring, honesty, and genuine interest in patients and families ☐ Exhibits professional behavior (e.g., reliability, industry, integrity, and confidentiality) ☐ Maintains respect for patient confidentiality	☐ Is aware of ethical issues in patient care, including issues of autonomy, end-of-life care and research ethics ☐ Recognizes individual limits in clinical situations and asks for assistance when needed ☐ Understands and manages the issues related to fatigue and sleep deprivation ☐ Completes paperwork, administrative tasks and assignments in a timely manner	☐ Recognizes ethical issues in practice and is able to discuss, analyze, and manage common ethical situations ☐ Displays sensitivity and responsiveness toward all patient populations	☐ Analyzes and manages ethical issues in complicated and challenging situations ☐ Develops a mutually agreeable care plan in the context of conflicting physician and patient values and beliefs	☐ Helps lead institutional and organizational ethics programs

Interpersonal Communication Skills

Level 1	Level 2	Level 3	Level 4	Level 5
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- ☒ Develops a positive relationship with patients and understands patients' and families' perspectives
- ☒ Utilizes interpreters as needed

- ☒ Effectively communicates during transitions of care
- ☒ Communicates with patients and families, taking into account the socioeconomic and cultural backgrounds of these individuals
- ☒ Ensures that the medical record is timely, accurate, and complete

- ☒ Sustains effective relationships with services requesting OHNS consultation
- ☒ Works effectively as a member of a health care team
- ☒ Uses multiple forms of communication (e.g., e-mail, patient portal, social media) ethically and with respect for patient privacy

- ☒ Develops working relationships across specialties and systems of care
- ☒ Organizes and facilitates family/health care team conferences

- ☒ Develops models/approaches to managing difficult communications
- ☒ Coaches others to improve communication skills

C. Patient Handoff Checklist

Patient Handoff Checklist

- Patient Name**
- Medical Record #**
- Date of Admission**
- Primary Diagnosis**
- Secondary Diagnoses**
- Surgery, including date**
- Postoperative Course**
- On call Issues, including “To-do Tasks”**
- Expected Date of Discharge**
- “If 1 thing can go wrong with this patient tonight, what would it be?”**

D. Intern Signoff Sheet

<i>Name:</i>			
Date	Initials	Print Name	Task
			Urgent/Emergent Eval & Mgt
			E & M of postop complications
			E & M of critically ill pts
			Mgt. of cardiac arrest
			Vascular access
			Repair surgical incisions
			Repair of lacerations
			Excision of skin lesions
			Tube thoracostomy
			Paracentesis
			Joint aspiration
			Flexible laryngoscopy
			Endotracheal intubation
			Tracheostomy
			Routine trach care, including tube changes
			Mgt. of epistaxis
			Drainage of PTA

E. UF Health Dress Code

SHANDS AT THE UNIVERSITY OF FLORIDA

GUIDELINE NUMBER: CP 1.25g

CATEGORY: General Administrative

DATE: 02/17/2009

TITLE: Dress Code and Identification Badges

GUIDELINES:

- I. Scrub Clothing I
 - a. Authorized individuals wearing hospital provided scrubs are expected to follow infection control procedures established for each area.
 - b. Non-conductive paper shoe coverings, hair coverings, and masks prescribed for wear must be removed immediately upon leaving the work area and never worn about the Hospital
 - c. Scrub clothing that is Hospital property is not to be worn outside of the facility.
- II. Photo Identification
 - a. Photo I.D. badges must be worn at all times with the picture, name and title unobscured and facing forward.
 - b. Damaged badges should be replaced.
- III. Fingernails
 - a. Nails should be in good repair and of a length that does not interfere with patient care, infection control standards, or safety.
- IV. Other
 - a. In consideration of the comfort and possible allergic reactions of others, perfume, cologne and scented body products shall be minimal. Minimal is defined as inoffensive to internal and external customers.
 - b. Compliance with the dress code is the responsibility of medical staff leadership and hospital management.

SHANDS HEALTHCARE HUMAN RESOURCES POLICY AND PROCEDURE

POLICY NUMBER: HR305

CATEGORY: WORK RULES

REVISED: November 2009

TITLE: Personal Appearance and Dress HR.305

POLICY: Employee will maintain a professional appearance, in keeping with the employee's activity and work.

PURPOSE: The patients and the public have the right to expect Shands employees to be neat and clean. To define standards of appearance and dress.

- A. The Shands photo identification badge must be worn at all times while on Shands property during work hours.
- B. Departmental policies define appropriate dress for individual departments. Departmental policies should be reviewed by Human Resources prior to implementation.
- C. Shands will provide laundered scrub clothing to operational areas in accordance with Infection Control policies. These areas are restricted as defined in facility specific policies.
 - 1. Shands-supplied scrub clothing will be worn by those working in the specified areas (per Infection Control Policy) and will not be worn by any other staff.
 - 2. Staff assigned to the specified areas will, upon leaving their work areas for short periods of time (e.g., breaks, meals) wear designated protective cover garments. Disposable accessories (e.g., masks, shoe covers) will be properly discarded upon leaving areas at any time and replaced upon re-entry.
 - 3. Shands provided and laundered scrub clothing and warm-up jackets should not be removed from Shands.
- D. Good personal hygiene is required. Employees should be clean in appearance and free of offensive odors such as perspiration, cigarette smoke or the smell of tobacco. Perfume, cologne or scented after-shave must be subtle if worn by any employee.
- E. In consideration of the comfort and possible allergic reactions of others, perfume, cologne and scented body products shall be minimal. Minimal is defined as inoffensive to internal and external customers.

F. Head and Neck Chief Rotation Expectations

Head and Neck Chief Resident Roles & Expectations

This document will serve as a *guideline* for how the Head and Neck Surgery Rotation should run.

A. The Head and Neck Team (MDs)

Attendings:

Dr. Danan
Dr. Dziegielewski
Dr. Hughley
Dr. Silver

Residents:

Head and Neck Chief
Head and Neck Junior A
Head and Neck Junior B
Head and Neck Intern
+/- Off Service Junior

B. The Head and Neck Chief Resident

Description:

- *Leader of the head and neck surgery resident team.*
- *Manager of and advocate for the head and neck inpatients.*
- *Communicator and collaborator between all head and neck team members, ancillary staff and consultants involved in the care of the head and neck patients.*
- *Scholar of head and neck cancer/surgery. Continually reading around cases and striving to become an expert in head and neck surgery.*
- *Professional committed to the care of patients through ethical practice, high personal standards and accountability of his/her actions and decisions.*

Roles:

- 1) Lead team inpatient rounds and make decisions/plans on patient care
- 2) Communicate daily & prn with the Attendings, RNs, Case Managers, RTs, SLPs and other ancillary staff looking after the head and neck patients
- 3) Guide and teach junior residents and interns
 - a. Delegate tasks based on appropriate PGY level (e.g. interns should not be doing complex dressing changes by themselves). Even though you delegate, you are still responsible for the outcomes.
- 4) Take responsibility and ownership for all patient care on service.

Expectations:

1) Inpatient Team Rounds:

- a. AM Rounds: Start early enough to arrive in the OR or clinic or lecture on time. If emergencies or unforeseen events arise, notify the attending via phone call or text before arriving late.
- b. It is expected that at least 1 person on the team will carry the H&N Team supply bag stocked with *essential* equipment/supplies for rounding. E.g. tongue depressors, headlight, gauze, suture removal kits, etc.
 - i. To maximize efficiency and optimize patient care, drain pulls, wound care and tracheostomy tube care/changes, may be performed during AM rounds.

- c. Ensure that the daily H&N Update Email is sent to Attendings by the time OR/clinic starts (e.g. 730 on flap days, 800 on other days).
 - d. Ensure that the list is run with the all H&N Attendings (phone call or in person) at the start of the day. Whichever resident is working with the attending may run the list or the Chief Resident can run the list with all attendings.
 - e. PM Rounds: Ensure that all H&N Team inpatients are rounded on in the evening to make sure that all wound care was done and follow-up on procedures/tests done during the day. This can be done during the micro portion of a flap, or after clinic/OR.
 - f. Weekend Rounds: Ensure that all H&N Team inpatients are rounded on and that appropriate plans are formulated and communicated with the Attendings (HN email +/- phone call if necessary).
 - i. Text the attending first to let them know you are ready to run the list. They will then call you back. Call anytime with any urgent issues.
 - g. Make sure that daily H&N Team patient progress notes are routed/forwarded to the responsible attending(s) for co-signature.
 - h. Progress notes: as the H&N Chief resident, it is your responsibility to make sure that progress notes accurately reflect the patient's condition and plan of care ON THAT DATE. Simple copy and paste is not allowed. Progress notes must be routed to the responsible attending for review and co-signature. Notes should be completed and routed prior to OR/clinic.
- 2) **OR:**
- a. Ensure that all Pre-Op tasks (labs, imaging is completed AND transferred to visage, ECG, consults, pre-op clinic, med changes/holds etc.) are complete the week before surgery.
 - b. Prepare for the cases (know the H&P, staging, indications, imaging, anatomy, plan etc.)
 - i. Communicate (talk in clinic, email, call) with attendings the day before letting us know which resident we will be working with. This is a good opportunity to ask questions about complex cases (do you think fibula or forearm, lip split or not, which neck levels, approach, etc).
 - c. Arrive to the OR on time and be ready to work on time. Progress notes, update emails, all floor work/orders, etc. should be done prior to arriving in the OR.
 - d. Help position and prep the patient. Learn how to prepare the case including flap site marking/paddle design, identify perforators, etc. If scrub tech is prepping the patient, make sure they know what to include in the field.
 - e. Do not go home until you have checked in with the late running H&N room. i.e. if your OR finished early, it is your responsibility to check in with the late running OR to ensure that the H&N Team does not need you to help with patient care.
 - f. Discuss post-op plan of care with the attendings at end of case (ASA or not, PO trial day, drain management, restart anticoagulants, etc). Ensure that all post-op orders are complete and accurate.
- 3) **Post-Op:**
- a. Flaps: ensure that flap patients are transported to the ICU safely. On arrival in the ICU help transfer the patient, put up the warning sign above the bed (position, no ties etc), do the initial flap check with the RNs and resident on call, communicate the plan with the RNs
 - b. Ensure all post-ops from that day are rounded on.
- 4) **Consults:**
- a. All inpatient & ED consults should be seen by the Intern/Junior & Chief
 - b. See all consults that require a scope with the Intern/Junior

B. The Head and Neck Junior Residents

Description:

- Follower of the head and neck surgery chief resident.
- Advocate for the head and neck inpatients.
- Executer of inpatient tasks as delegated by the head and neck chief resident.
- Communicator between all head and neck team members, ancillary staff and consultants involved in the care of the head and neck patients.
- Scholar of head and neck cancer/surgery literature continually learning and striving to become an expert in head and neck surgery.
- Professional committed to the care of patients through ethical practice, high personal standards and accountability of his/her actions and decisions.

Roles:

- 1) Prepare the weekly “head and neck cases checklist” to ensure all pre-op tasks and evaluations are complete before surgery
- 2) Pre-round on head and neck inpatients and prepare inpatient information for the head and neck chief resident to review
- 3) Communicate daily & prn with the Attendings, RNs, Case Managers, RTs, SLPs and other ancillary staff looking after the head and neck patients
- 4) Guide and teach interns
- 5) Take responsibility and ownership for all patient care on service.
- 6) Prepare for Head and Neck Tumor Board (HNTB) and execute tasks from HNTB

Expectations:**1) Inpatient Team Rounds:**

- a. AM Rounds: arrive before the head and neck chief resident and pre-round. All relevant patient information should be collected prior to the head and neck chief resident arriving. Start early enough to arrive in the OR or clinic or lecture on time. If emergencies or unforeseen events arise, notify the chief residents and attending via phone call or text before arriving late.
- b. Execute inpatient tasks as delegated by the head and neck chief resident.
- c. PM Rounds: Ensure that all H&N Team inpatients are rounded on in the evening to make sure that all wound care was done and follow-up on procedures/tests done during the day. This can be done during the micro portion of a flap, or after clinic/OR.
- d. Weekend Rounds: If rounding on the weekend, ensure that all H&N Team inpatients are rounded on and that appropriate plans are formulated and communicated with the Attendings (HN email +/- phone call if necessary).
 - i. Text the attending first to let them know you are ready to run the list. They will then call you back. Call anytime with any urgent issues.

2) OR:

- a. Ensure that all Pre-Op tasks (labs, imaging completed and transferred to visage, ECG, consults, pre-op clinic, med changes/holds etc.) are complete the week before surgery.
 - i. This will be included in the weekly “head and neck cases checklist”
- b. Prepare for the cases (know the H&P, staging, indications, imaging, anatomy, plan etc.)
- c. Arrive to the OR on time and be ready to work on time. Progress notes, update emails, all floor work/orders, etc. should be done prior to arriving in the OR.
- d. Help position and prep the patient. Learn how to prepare the case including flap site marking/paddle design, identify perforators, etc. If scrub tech is prepping the patient, make sure they know what to include in the field.
- e. Do not go home until you have checked in with the late running H&N room. i.e. if your OR finished early, it is your responsibility to check in with the late running OR to ensure that the H&N Team does not need you to help with patient care.

- f. Discuss post-op plan of care with the attendings at end of case (ASA or not, PO trial day, drain management, restart anticoagulants, etc). Ensure that all post-op orders are complete and accurate.
- 3) **Post-Op:**
- a. Flaps: ensure that flap patients are transported to the ICU safely. On arrival in the ICU help transfer the patient, put up the warning sign above the bed (position, no ties etc), do the initial flap check with the RNs and resident on call, communicate the plan with the RNs
 - b. Ensure all post-ops from that day are rounded on.
- 4) **HNTB:**
- a. Review the entire HNTB list and understand why each patient is being presented
 - a. Prepare presentation of your own patients. Know the H&PE, Scope, Test Results and Staging:
 - i. Why is the patient being presented at tumor conference?
 - ii. Is there a specific question?
 - iii. Use the provided staging manual to stage the patient.
 - iv. What do you think the recommendation should be?
 - b. Run the HNTB list with the H&N attendings at the end of HNTB
 - c. Ensure that all your HNTB patients have a HNTB note in EPIC that accurately and completely reflects the clinical picture, the tumor conference consensus recommendations, and the patient counseling
 - d. Ensure that all your HNTB patients receive an appropriate phone call communicating the HNTB recs within 24 hrs of HNTB
 - i. The remaining pts will be presented by the attending and the H&N RN will call the pts after HNTB
 - e. If any patients are not directly contacted about the recommendations of the head and neck tumor conference, it is your responsibility to inform the responsible attending AND the H&N RN that the patient has not been counseled about the tumor conference recommendations via electronic communication. The tumor conference record must accurately document whether the patient was contacted.
- 5) **Pathology List**
- a. No longer needed

C. The Head and Neck Intern & Off-Service Residents

Roles:

- 1) Pre-round on head and neck inpatients and prepare inpatient information for the head and neck chief resident to review
- 2) Communicate daily & prn with the Attendings, RNs, Case Managers, RTs, SLPs and other ancillary staff looking after the head and neck patients
- 3) Take responsibility and ownership for all patient care on service.

Expectations:

1) Inpatient Team Rounds:

- b. AM Rounds: arrive before the head and neck chief resident and pre-round. All relevant patient information should be collected prior to the head and neck chief resident arriving. Start early enough to arrive in the OR or clinic or lecture on time. If emergencies or unforeseen events arise, notify the attending via phone call or text before arriving late.
- c. Execute inpatient tasks as delegated by the head and neck chief resident.
- d. Round on inpatients multiple times during the day as needed.
- e. Communicate patient plans with the Charge RN in the ICU and Unit 55 daily
- f. Communicate patient plans with the Case Manager in the ICU and Unit 55 daily

- g. PM Rounds: Ensure that all H&N Team inpatients are rounded on in the evening to make sure that all wound care was done and follow-up on procedures/tests done during the day. This can be done during the micro portion of a flap, or after clinic/OR.
- 2) **OR:**
- h. Check in with the H&N Chief Resident multiple times per day in the OR as per their request
 - i. Once you are caught up with inpatient tasks, come to the OR to assist, learn how to operate and close wounds

It is up to the Head & Neck Chief Resident to decide how all of these roles and expectations will be met. This is a guide to help build your team. Ultimately, if a delegated task is incomplete, it is still the Head and Neck Chief's responsibility to ensure that it gets done.

Updated June 2021

G. Program Manual Signature

I have received a copy of the 2021-2022 UF Department of Otolaryngology Program Manual. I have read, reviewed, and understand the policies stated within.

Name

Date

Print Name