

# UNIVERSITY OF PITTSBURGH SCHOOL OF MEDICINE DEPARTMENT OF OTOLARYNGOLOGY

Manual for Residents



## PREFACE

Ladies and Gentlemen:

Residency training in otolaryngology requires a minimum of one year postdoctoral training in general surgery and four more years in a formal otolaryngology program. We view this training program as far more than a surgical apprenticeship. Residency training at the University of Pittsburgh is a commitment to education. During your residency, you will have an opportunity to provide patient care under the direction of outstanding volunteer and full-time faculty. You will be afforded the opportunity to attend a multitude of didactic conferences, seminars, and medical meetings. You may avail yourself of an outstanding medical library.

This manual has been developed to afford structure to this complicated educational process. As a resident of otolaryngology, you will have responsibilities to our patients, faculty, and to yourself. It is expected that you will be familiar with the information provided in the manual. When changes occur, efforts will be made to formally alert you to these changes.

I call your attention to the educational objectives associated with each of our educational rotations. Educational objectives have been organized to reflect growth in skills in six categories: 1) Medical Knowledge, 2) Patient Care, 3) Professionalism, 4) Interpersonal and Communication Skills, 5) Practice-Based Learning and Improvement, 6) Systems-Based Practice. You are encouraged to familiarize yourself with the entire manual. As each rotation approaches, the educational objectives and resident responsibilities should be reviewed to better prepare you for that rotation.

Residency training in otolaryngology is an exciting and challenging experience. Please commit yourself to becoming the best otolaryngologist that you can be. In so doing, you can partner with the faculty in the development of your future.

Sincerely,

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<b><u>EMERGENCY ROOM FACULTY CALL SCHEDULE</u></b>	

The purpose of the faculty call schedule is to ensure that there is always a faculty member available for phone

consultation, emergency admissions or surgery. The faculty member on call does not have to be used for all patients. If the patient has an attending surgeon that individual should be called first. If the patient is unassigned or the attending surgeon is not available, the call schedule should be used. Monthly call schedules will be provided at the beginning of each month. If there are conflicting schedules, the answering service at 361-5600 should be contacted.

## **Daily Call Schedule**

### **Head and Neck**

Call will be rotated on a weekly basis and will be shared by the active Head and Neck attending and fellows. The call schedule is published monthly and is available through Beverly Johnson, Administrative Assistant, 647-8186.

### **Trauma**

Call during the week will be shared by active Trauma attending and fellows. The call schedule is published monthly and is available through Beverly Johnson, Administrative Assistant, 647-8186. We rotate in the maxillofacial trauma-call with Plastic Surgery and Oral and Maxillofacial Surgery in cycles of every three weeks. However, we are "on-call" at all times for airway and neck trauma.

### **Otology**

Call will be rotated on a monthly basis and will be shared by the Otology attendings and fellow. The call schedule is published monthly and is available through Otology, Office Coordinator, 647-2115.

### **VA, Shadyside, St. Margaret**

Attending emergency room call schedules at the VA, Shadyside, and St. Margaret Hospitals vary from that above and are coordinated through the respective hospital-specific system.

## RESIDENT RESPONSIBILITIES

### *Duty Hours*

Monday-Friday	7:00 a.m.- 5:00 p.m.
Saturday	7:00 a.m.-10:00 a.m.

On Sundays and Holidays continuing care of inpatients can be arranged at the discretion of the resident team in consultation with the attending staff.

Residents must communicate effectively with on-call residents when arriving in the hospital in the morning and when leaving at the completion of the day. This is especially important on weekends and on holidays.

### *Inpatient Responsibilities*

1. The chief resident on the head and neck service is the administrative chief resident.
2. Each resident will report to the hospital to which he is assigned early enough to make rounds and to discharge patients prior to beginning assignments in the OR or outpatient offices. Each resident has the responsibility for follow-up care and progress notes on the patients on the service to which he has been assigned. If the resident is uncertain about orders or disposition of the patient, contact the patient's attending physician for clarification. Progress notes are required for every patient every day and more frequently if conditions warrant it. At discharge, an appropriate note will be made.
3. Residents and faculty should round together daily on inpatients, as schedules permit and patient census requires. Communication between resident and faculty is essential to assuring optimal patient management and resident education.
4. The residents are responsible for completion of history and physicals, work rounds and daily documentation, surgical assignments, and discharge summaries. There are times when some services will be less busy, and it is expected that the residents will distribute the workload evenly amongst themselves. In order that all residents complete their daily responsibilities within a reasonable amount of time, cooperation is of prime importance. Residents are expected to communicate with one another in order to cross-cover and share the workload.
5. Decisions as to which cases the residents will assist in should be made between the resident and attending staff on a day prior to surgery. Assignments to major surgical cases will be made by the Administrative Chief Resident.
6. The resident on call is responsible for in-patient emergency care from 5:00 p.m. until 7:00 a.m. and whenever the primary care team is not available. In essentially every case the patient should be seen personally by the on-call resident. Any verbal orders must be signed, and any changes documented in the medical record. The resident must notify the staff physician immediately of any untoward developments or complications with their patient. The resident on-call will cover Children's Hospital for in- and out-patient emergencies. The on-call resident will advise the appropriate service resident of any changes in their patients before the on-call resident assumes their regular daytime duties.

In the unusual circumstance of concurrent emergencies in 2 hospitals, help must be sought from either another available resident, fellow or the attending physician.

7. The resident on-call should make every reasonable effort to assist in emergency surgical cases performed between 7:00 p.m. and 7:00 a.m.
8. Emergency inpatient consultations at night, weekends, and on holidays from the UPMC or Children's Hospital will be seen by the resident on-call. The chief resident assigned to the service, fellow (CHP) and the attending physician should be notified at the time of admission of any patient admitted to their service at any time.

Magee Womens Hospital inpatient consults on evenings and on weekends are first to be screened by the otolaryngology in-house resident on call and if care is urgently required, the ENT staff member on call will be contacted by the resident. Non-emergent weekend consults will be negotiated between the ENT staff member on call and the third year consult resident.

Residents on call may be contacted for consultation regarding the potential referral of patients to the otolaryngology service. It is essential that these referrals be handled in a professional and collegial manner. When possible, referrals should be rotated through referral communications (412-647-7000). Transfers to the UPMC should be facilitated and the attending physician notified upon arrival of the patient. If consultation services are needed from the specialties this is, of course, arranged.

The UPMC physicians frequently provide consultative services and coverage for community otolaryngologists. Care for these patients should be provided in a collegial way. **(SEE CONSULT POLICY)**

9. Outpatient emergency room consults at the UPMC ER and at Children's must be seen promptly (e.g., within 20 minutes). If urgent patient issues take precedence, the responsible ER physician must be contacted. If the delay is likely to be excessive, it may be necessary to contact the second call resident, the appropriate fellow, or on-call faculty member. All ER consults must include some plan for follow-up.
10. On-call coverage of Children's Hospital and the UPMC remains the responsibility of the in-house resident until 7:00 a.m. It is the responsibility of all residents to be available by 7:00 a.m.
11. The resident on-call on Saturday and Sunday will begin their shift at 9:00 a.m. so that ward rounds may be made before beginning duty. The resident on-call will not leave the hospital until they have discussed the in-house problems with the next resident on-call.

### ***Teaching Responsibilities***

An important duty of residents in this program is to teach second, third and fourth year medical students, family practice and pediatric residents, visiting scholars, nurse practitioners, fellow otolaryngology residents and other members of the medical community.

The major teaching responsibility of the residents vis-à-vis medical students occurs during the medical student's required clerkship outpatient experience (one week) and the one-month otolaryngology elective (4 weeks). During the elective, medical students are assigned to a variety of services. Medical students (no more than two at any one time) are assigned to the appropriate chief resident, who serves as their preceptor. The objectives of the elective are: 1) to increase competence in the examination of the head and neck, 2) to improve skills in history taking, and 3) to begin to accumulate sufficient knowledge about otolaryngologic conditions such that the student begins to understand the differential diagnosis process. Medical students are to be integrated into the respective resident team, and provided with both a clinic experience and operative exposure. One-month elective students are expected to write and present a case report during their rotation. The chief resident should assist in case selection and direct them to appropriate references for additional readings. The chief resident will be requested to complete a written evaluation of the student. This evaluation contributes to the overall evaluation of the student and the final grade assignment.

The one-month elective offered by the Department of Otolaryngology is now available to third and fourth year students due to changes in the curriculum. These have become popular among the medical students. This is in response to the time and effort expended by the residents toward each student who has taken the elective.

Medical students in the required clerkship rotate through the outpatient clinics and offices on one week schedules. These students should be instructed in basic skills and common disease processes encountered in the ambulatory setting. [Outpatient clinics take precedence over operating room exposure for this rotation.]

### ***Medical Records Responsibilities***

Each resident is responsible for their own medical records. Residents should make every attempt to complete their charts on a daily basis. Discharge summaries must be dictated prior to patient discharge, and all verbal orders must be signed. Delinquent or incomplete medical records charts will result in fines for the **ATTENDING** physician.

### ***Resident Conference Responsibilities [May be appropriate to remove days of the week because many of these conferences have moved from day to day]***

Resident conferences are held July through June on Wednesday mornings at 8am – 10am. **Attendance is mandatory.** A Temporal Bone Course for first year, otolaryngology residents is customarily held in the early Fall. In the fall, a Head and Neck Surgical Anatomy Course is held during a time to be announced (customarily spring). Mandatory attendance for certain portions of this course will be announced annually. In general, attendance at conferences is **mandatory.**

### ***Tumor Board***

The Department of Otolaryngology Head and Neck Case Discussion Conference is held three mornings per month at 7:00 a.m. to discuss and review patients with malignant or benign tumors of the head and neck. **Attendance is mandatory.** All major head and neck cancer sites found in patients seen at the UPMC are discussed at this forum with recommendations made for treatment of problem cases.

Head and Neck Case Discussion Conferences serve as a teaching mechanism for staff, residents, medical students and patient care providers of all disciplines. Conferences are regularly attended by representatives of the multidisciplinary group of head and neck professionals from the following departments: Otolaryngology, Plastic and Reconstructive Surgery, Pathology, Medical Oncology, Oral-Maxillofacial Surgery, and Maxillofacial Prosthodontics, Radiation Oncology, Radiology, Nursing, Social Work, and Tumor Registry.

Prospective Tumor Board Conferences are held weekly at the Hillman Cancer Center. The emphasis of these conferences is patient management. At these conferences, discussion about the patient occurs among the various disciplines. At each Tumor Board Conference a pathologist and radiologist review pertinent findings. All residents who are able to attend should participate in these conferences, which are held Fridays at noon.

The senior resident may decide which patients will be presented at Tumor Board; however, the junior resident is responsible for Tumor Board presentations. The Tissue Committee also refers interesting cases, which it has reviewed to the senior head and neck resident for presentation at Tumor Board. Any staff member may have a patient discussed for consultative purposes by contacting the senior head and neck resident. In preparation for the Tumor Board Conference, the senior head and neck resident contacts the attending physician of the patient being presented so that this physician will attend Tumor Board Conference. Recommendations for treatment may be made to the attending physician at Tumor Board Conferences.

Tumor Board may be used for scientific presentation and reports of new research work. The chief resident will work with the faculty in using the time for the Tumor Board to facilitate the scientific and educational exchange.

### ***Grand Rounds***

The Department of Otolaryngology meets for Grand Rounds on a weekly basis. The meeting begins promptly at 7:00 a.m. **Attendance is mandatory.** Topics are rotated between Pediatric Otolaryngology, Otology/Neurotology, Head and Neck/General Otolaryngology. Once a month, the Grand Rounds format is used for the departmental CQI Morbidity and Mortality Conference. On several occasions each year we have a joint Trauma Conference with Plastic Surgery and Oral/ Maxillofacial Surgery. The Grand Rounds format is suspended during July and August, however, the CQI Morbidity and Mortality/Patient Safety Conference continues.

The Department of Otolaryngology conducts multiple continuing medical education courses annually. This includes mini seminars and the Alumni Day Program. Registration is required for conference planning, so each resident must complete the appropriate form for each course or dinner (contact the meetings section at 412-648-6304). Attendance at educational courses is mandatory. Elective work will be rescheduled and only an emergency team should remain at the hospital.

## **CONFLICT OF INTEREST POLICY**

Subsidies to underwrite the costs of resident conferences or professional meetings can contribute to the improvement of patient care and therefore are permissible. Since the giving of a gift directly to a resident by a company's sales representative creates a relationship which could influence the use of the company's products, subsidies will be accepted by the Residency Coordinator ONLY who in turn will deposit the money into the Otolaryngology Resident's Education Fund to improve the quality of the conference. Payments to defray the costs of a conference should not be accepted directly from the company by the residents attending the conference. Subsidies should not be accepted to pay for the costs of travel, lodging or other personal expenses, nor should they be accepted to compensate for the resident's time. Subsidies for hospitality should not be accepted outside of events held as part of the conference or meeting. No gifts should be accepted if there are strings attached. For example, residents should not accept gifts if they are given in relation to the resident's prescribing practices. In addition, when companies underwrite conferences or lectures other than their own, responsibility for selection of content, faculty, educational methods and materials should belong to the organizers of the conference or lectures, who should act independently.

For UPMC GME Policy please go to: GME KNOWS. <http://spis.upmc.com/psd/home/gme>

Shared files -> Policy and Procedures -> Vendor Interactions

## GENERAL COMPETENCIES

Minimum Program Requirements Language  
Approved by the ACGME, September 28, 1999

### Educational Program

The residency program must require its residents to obtain competencies in the 6 areas below to the level expected of a new practitioner. Toward this end, programs must define the specific knowledge, skills, and attitudes required and provide educational experiences as needed in order for their residents to demonstrate:

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

## **PROGRAM GOALS AND OBJECTIVES**

The following four competencies are considered to be the “global” resident competencies defined for all residents. The competencies of Medical Knowledge and patient care skills are defined specifically by each rotation and per year.

### **A. Professionalism:**

- a. Demonstrates respect, compassion and integrity to the patient
- b. Demonstrates a commitment to ethics, confidentiality, and informed consent
- c. Demonstrates sensitivity and responsiveness to patient’s age, culture, gender and disabilities
- d. Interacts effectively with professional colleagues and staff

### **B. Interpersonal and Communication Skills:**

- a. Creates sound relationship with patients and families
- b. Works effectively with faculty and staff
- c. Builds and supports high performance treatment teams.

### **C. Practice Based Learning and Improvement:**

- a. Appraises evidence from literature related to patients
- b. Apply knowledge of studies and statistical methods to evaluate studies
- c. Uses informatics technology effectively
- d. Facilitates the learning of students and others junior to him/her

### **D. Systems-Based Practice:**

- a. Understands how their patient care relates to other healthcare providers
- b. Practices cost effective healthcare and uses resources appropriately
- c. Assists patients with system complexities
  - Facilitates testing
  - Facilitates consultations
  - Understands home health care
  - Provides follow up care

**OTOLARYNGOLOGY I: RESIDENCY BENCHMARKS**  
**EDUCATIONAL GOALS AND OBJECTIVES**

**I. Medical Knowledge**

1. Know and be able to apply principles of ATLS and ACLS
2. Know pharmacologic management of unstable patients to include cardiac, vasoactive, metabolic, neurologic, and infectious agents.
3. Know how to perform neurologic evaluation
4. Know how to evaluate the unstable patient
5. Know the principles of perioperative management
6. Know the names, uses, and appropriate handling of various surgical instruments
7. Know the essentials of critical surgical practice to include:
  - a. Shock and sepsis, acute hypovolemic shock, multiorgan failure, cardiac failure, pulmonary failure, urologic disorders, and vascular compromise.
8. Know basic and specialty specific radiology
9. Know basic and specialty specific pathology
10. Know essentials of anesthesia
11. Know critical communication strategies for team, consultant, nursing, patients and families.
12. Know critical communication and humanitarian skills required for effective management of the critically ill and/or dying patients.

**II. Skills**

1. Be able to manage airway emergencies
2. Be able to manage sepsis
3. Be able to manage fluid and electrolyte balance
4. Be able to manage acute cardiac dysfunction
5. Be able to manage acute neurologic deterioration
6. Be able to manage acute blood loss
7. Be able to insert, evaluate effectiveness, and manage various tubes, catheters, central lines, etc.

**OTOLARYNGOLOGY I: RESIDENCY BENCHMARKS**  
**EDUCATIONAL GOALS AND OBJECTIVES**  
**PATHOLOGY**

**I. Knowledge**

1. Become acquainted with the indications, contraindications and technical issues of frozen sections performed on head and neck specimens.
2. Learn the significance of close and adequate margins of resections for a variety of tumors.
3. Become familiar with basic criteria that pathologists use in separating benign and malignant tumors.
4. Learn the value of submitting adequate histories to the pathologist.
5. Learn how tumors grow and metastasize.

**II. Skills**

1. Observe and participate in the performance of frozen sections.
2. Observe how pathologists evaluate margins of resection.
3. Take part in the daily microscopic evaluation of benign and malignant tumors
4. Observe how medical histories may help pathologists in arriving at a diagnosis
5. Observe gross cancer specimens to see how tumors behave.

**OTOLARYNGOLOGY I: RESIDENCY BENCHMARKS**  
**EDUCATIONAL GOALS AND OBJECTIVES**  
**RADIOLOGY**

**I. Knowledge**

1. Understand the relative advantages of MR and CT in imaging the head and neck
2. Understand the complimentary nature of MR and CT in regions such as the petrous apex, floor of mouth, and ear
3. Understand the applications of PET/CT to oncologic imaging of the head and neck
4. Observe the professional interactions of radiologists with medical personnel such as speech pathologists, physician assistants, and imaging technologists
5. Be aware of the advantages of direct consultation with a radiologist on complex cases

**II. Skills**

1. Apply MR and CT to the clinical situations where each is most appropriate.
2. Classify lesions of the head and neck into those that are best biopsied surgically, endoscopically, or under radiologic guidance
3. Correctly apply appropriateness criteria to the prescription of radiologic services
4. Identify major anatomic structure on cross-sectional imaging of the head and neck
5. Identify clinical situations in which consult with a radiologist is mandatory before imaging studies are initiated

**OTOLARYNGOLOGY I: RESIDENCY BENCHMARKS**  
**EDUCATIONAL GOALS AND OBJECTIVES**  
**OTOLARYNGOLOGY/HEAD AND NECK**

**I. Knowledge**

1. An understanding of the pathophysiology and clinical course of patients with tumors of the head and neck.
2. Knowledge of the surgical anatomy of the head and neck.
3. An understanding of the preoperative evaluation of patients being considered for head and neck surgery.
4. Knowledge of several of the basic head and neck procedures including laryngoscopy, neck dissection, thyroidectomy, submandibular gland excision and parotidectomy.
5. Management of postoperative head and neck surgical patients.
6. Prevention and management of postoperative complications.

**II. Skills**

1. Be able to perform a head and neck examination.
2. Know basic OR protocols for the management of head and neck surgical patients.
3. Be able to manage the routine postoperative care for head and neck patients who have undergone head and neck surgery.
4. Be able to recognize deviations from the normal postoperative course.
5. Be able to suggest initial management strategies for management of postoperative complications.

**OTOLARYNGOLOGY I: RESIDENCY BENCHMARKS**  
**EDUCATIONAL GOALS AND OBJECTIVES**  
**THORACIC SURGERY**

**I. Knowledge**

1. Know the indications for and contraindications to thoracic surgical procedures.
2. An understanding of the preoperative evaluation for patients who are being considered for thoracic surgery.
3. An understanding of the preoperative preparation of patients scheduled for thoracic surgical procedures.
4. Knowledge of the bronchial and lobar anatomy of the lungs.
5. Management of the postoperative course of patients who have undergone thoracic surgical procedures.

**II. Skills**

1. Be able to perform the preoperative evaluation of patients being considered for thoracic surgical procedures.
2. Be able to recognize basic anatomy through the bronchoscope and thoracoscope.
3. Know basic operating room protocols for endoscopic, thoracoscopic, and open thoracic surgical procedures.
4. Be able to manage the routine postoperative care for patients undergoing thoracic surgery.
5. Recognize deviations from a normal postoperative course for thoracic surgical patients.
6. Manage chest tubes and accompanying hardware.

**OTOLARYNGOLOGY I: RESIDENCY BENCHMARKS**  
**EDUCATIONAL GOALS AND OBJECTIVES**  
**CRITICAL CARE**

**I. Knowledge**

1. Discuss the fundamental physiologic physiology of critically ill patients.
2. Describe the basic concepts of the care of patients who are critically ill.
3. Interpret physiologic patient data.
4. Provide a differential diagnosis for critical illness.
5. Develop diagnostic strategies for critical illness.
6. Evaluate the outcome of therapeutic interventions for critically ill patients.

**II. Skills**

1. Learn proficiencies in basic ICU procedures including intubation, central venous pulmonary artery, and arterial catheter placement.
2. Understand the collaborative practice style that applies to the ICU setting.
3. Be able to participate in discussions of complex care issues such as withdrawal of life support.
4. Participate in the postoperative respiratory management of patients who require ventilatory support.
5. Respond in an appropriate matter to alterations in patient parameters.

**OTOLARYNGOLOGY I: RESIDENCY BENCHMARKS**  
**EDUCATIONAL GOALS AND OBJECTIVES**  
**VA1- GENERAL SURGERY**

**I. Knowledge**

1. Know physiology of pre- and postoperative care for general surgical patients to include fluid and electrolytes, nutrition, and wound healing.
2. Basic knowledge of surgical disease with concentration on diseases involving the endocrine system, hepatobiliary system, GI tract, pancreas, and head and neck tumors.
3. Know the diagnostic evaluation management of general surgical patients with a wide variety of disease processes.
4. Recognize cost-effective strategies for patient evaluation.
5. Know the fundamental precepts necessary in decision-making during both pre- and postoperative management.

**II. Skills**

1. Manage pre-operative general surgical patients.
2. Learn to use the VA electronic health record in active management of general surgical patients.
3. Manage post-operative general surgical patients.
4. Perform a basic history and physical.
5. Assist in the performance of general surgical procedures in the operating room.

**OTOLARYNGOLOGY I: RESIDENCY BENCHMARKS**  
**EDUCATIONAL GOALS AND OBJECTIVES**  
**EMERGENCY MEDICINE**

**I. Knowledge**

1. Know the appropriate evaluation for patients with chest pain.
2. Learn how to employ standard monitoring techniques in the ED.
3. Know the appropriate evaluation of patients with abdominal pain.
4. Know how to treat patients who present with acute pulmonary emergencies.
5. Know the indications for endotracheal intubation.
6. Know the management of common otorhinolaryngologic emergencies such as epistaxis, acute pharyngitis, sinusitis, otitis media as well as foreign bodies.
7. Know the dosages, indications, and contraindications of common outpatient and inpatient antibiotic therapy.

**II. Skills**

1. Perform basic wound skills, including irrigation, suturing, and the use of other closure strategies.
2. Perform initial emergency treatment of common orthopedic problems, including the ordering of appropriate radiographs and the their interpretation.
3. Be able to perform basic urogenital examinations, including pelvic examinations and the obtaining of appropriate culture and other test materials as well as interpretation of the results.
4. Be able to generate a comprehensive differential diagnosis of back pain and know when imaging is required.
5. Evaluate the patients with common neurologic emergencies such as strokes and order appropriate tests and consultations.

**OTOLARYNGOLOGY I: RESIDENCY BENCHMARKS**  
**EDUCATIONAL GOALS AND OBJECTIVES**  
**ANESTHESIA**

**I. Knowledge**

1. Know the accepted guidelines for preoperative anesthesia evaluation.
2. Know specific risk factors for various forms of anesthesia.
3. Know the rationale for selection of appropriate forms of anesthesia for specific patients and procedures.
4. Be familiar with common drugs used for induction and maintenance of general anesthesia.
5. Know the complications of anesthesia.
6. Know specific airway problems likely to be encountered in head and neck surgical patients.

**II. Skills**

1. Be able to manage the airway and perform intubation.
2. Be able to utilize paralytic agents appropriately for intubation.
3. Be able to administer regional anesthesia.
4. Be able to monitor and maintain anesthesia.
5. Be able to place appropriate monitoring equipment and interpret the results.

**OTOLARYNGOLOGY I: RESIDENCY BENCHMARKS**  
**EDUCATIONAL GOALS AND OBJECTIVES**  
**PLASTIC SURGERY**

**I. Knowledge**

1. The resident will know the anatomy, physiology, embryology of the head and neck, and will apply this knowledge to the medical management of disorders and processes in this anatomic area.
2. Be able to describe the benign and malignant tumors of the head and neck.
3. Be familiar with mechanisms of traumatic head and neck injuries.

**II. Skills**

1. Be able to access priorities involved in treating patients.
2. Be able to discuss the operative management of traumatic head and neck injuries
3. Be able to serve as an active surgical assistant during the treatment of head and neck lesions.

**OTOLARYNGOLOGY I: RESIDENCY BENCHMARKS**  
**EDUCATIONAL GOALS AND OBJECTIVES**  
**PEDIATRIC SURGERY**

**I. Knowledge**

1. Know the unique characteristics of surgical diseases of the pediatric population.
2. Know the principles of resuscitation and care of the multiply injured child.
3. Be able to describe the outpatient evaluation and management of children with inguinal hernia, undescended testicles, and thyroglossal duct cysts.

**II. Skills**

1. Be able to perform a routine history and physical examination of the child.
2. Be able to utilize effectively the electronic health record system of Children's Hospital.
3. Be able to participate in an active manner during the management of pediatric trauma in the ED.
4. Actively participate in the surgical management of children with surgical disease.
5. Manage routine postoperative care of children who have undergone surgical procedures.

**OTOLARYNGOLOGY I: RESIDENCY BENCHMARKS**  
**EDUCATIONAL GOALS AND OBJECTIVES**  
**TRAUMA SURGERY**

**I. Knowledge**

1. Know the basic physiology of trauma and its effects.
2. Understand the mechanism of wounding and wound-repair.
3. Know the hemodynamic changes that occur in shock and their management.
4. Know the basic examination of the multiply injured patient.

**II. Skills**

1. Be able to perform an initial evaluation of a multiply injured patient.
2. Be able to recognize and manage shock.
3. Be able to recognize and participate in the management of airway compromise in the trauma patient.
4. Be able to perform peritoneal lavage.
5. Be able to manage acute pneumothorax with needle decompression and insert chest tube.
6. Be able to prioritize patient injuries and participate in care planning.
7. Manage postoperative trauma patients.

**OTOLARYNGOLOGY II: RESIDENCY BENCHMARKS**  
**EDUCATIONAL GOALS AND OBJECTIVES**  
**CONSULT SERVICE**

**I. Knowledge**

1. Understand role of consultant in inpatient setting
2. Understand role of consultant in Emergency Department setting
3. Recognize common underlying medical conditions in the immuno-competent host responsible for:
  - a. Epistaxis
  - b. Oro-pharyngeal bleeding
  - c. Bacterial sinusitis
  - d. Fungal sinusitis
  - e. Vocal cord immobility
  - f. Abscesses of the head and neck
4. Recognize role of immuno-incompetency in diseases of the head and neck
5. Know infection control practices and hand hygiene in consultative practice

**II. Skills**

1. Consistently demonstrate adherence to infection control practices and hand hygiene
2. Be able to prioritize otolaryngologic disease processes in the context of the patient's overall medical, social, and psychiatric status
3. Obtain an appropriate history from available sources
4. Be able to select appropriate evaluation techniques for specific consult
5. Demonstrate appropriate care of instrumentation
6. Be able to perform required system-specific examination to include:
  - a. Otoscopy
  - b. Nasal endoscopy
  - c. Oral cavity examination
  - d. Flexible trans-nasal laryngoscopy
  - e. Fiberoptic examination of swallowing
7. Be able to manage epistaxis occurring in the patient with normal coagulation parameters
8. Be able to manage epistaxis occurring in the coagulopathic patient
9. Be able to perform sinus tap
10. Be able to manage sinusitis in the immunocompetent patient
11. Be able to manage infections of the soft tissues, sinuses, oral cavity, and pharynx in the immunocompromised patient.
12. Be able to effectively and efficiently record pertinent findings.
13. Be able to communicate effectively with consulting service

**OTOLARYNGOLOGY II: RESIDENCY BENCHMARKS**

**EDUCATIONAL GOALS AND OBJECTIVES**  
**HEAD AND NECK**

**I. Knowledge**

1. Preoperative evaluation: The resident should understand the essential components and the evaluation of the following entities.
  - a. Obstructive sleep apnea
  - b. Neck mass
  - c. Hoarseness
  - d. Head and neck cancer
  - e. Neck dissection
  - f. Stridor
2. The resident should study and understand:
  - a. Staging of head and neck cancer
  - b. Understand neck zone anatomy
  - c. Discuss indications for selective zone dissection
  - d. Epidemiology
  - e. Second primary tumor
  - f. Post-treatment monitoring

**II. Patient Care**

1. Surgical treatment options:
  - a. Obstructive sleep apnea
  - b. Head and neck cancer
  - c. Airway emergencies
2. Postoperative care:
  - a. Obstructive sleep apnea
  - b. Neck dissection
  - c. Tracheotomy
3. Identification and management of surgical complications:
  - a. Wound infection
  - b. Airway compromise
  - c. Nutritional deficiency
  - d. Postoperative fever

**III. Skills**

1. Physical examination
2. Flexible and rigid laryngoscopy
3. Tracheotomy
4. Tonsillectomy
5. Uvulopalatopharyngoplasty
6. Excision of neck mass

**OTOLARYNGOLOGY II: RESIDENCY BENCHMARKS**  
**EDUCATIONAL GOALS AND OBJECTIVES**  
**OTOLOGY**

**I. Knowledge**

1. Know the embryology of the ear and temporal bone.
2. Know the anatomy and physiology of pathways for auditory, vestibular and facial function.
3. Know anatomy of the temporal bone through reading, Dr. Sando's lectures and hands-on experience in the temporal bone laboratory.
4. Understand the anatomy of the eustachian tube and sequela from dysfunction.
5. Be able to interpret audiograms, acoustic reflexes, tympanometry, otoacoustic emissions and brain stem evoked audiometry.
6. Know the classification systems for grading facial paralysis and describing tympanomastoid surgery.
7. Know the classification for describing tympanoplasty . Identify critical structures and interpret MRI and CT images of the skull base and temporal bone.

**II. Patient Care**

1. Through appropriate history taking and physical diagnosis be able to evaluate patients complaining of hearing loss, tinnitus, dizziness, or facial weakness.
2. Be competent in identifying a normal tympanic membrane and common pathology including otitis externa, serous otitis media, tympanic membrane perforation and cholesteatoma.
3. Understand the use and interpretation of tuning fork testing.
4. Assess the nasopharynx by fiberoptic endoscopy.
5. Perform a Dix-Hallpike test and a particle-repositioning maneuver.
6. Administer eye care for facial paralysis patients.
7. Have basic surgical skills for the following procedures:
8. Use of operating microscope.
9. Removal of cerumen impaction.
10. Placement of external canal wicks.
11. Placement of myringotomy tubes in patients under general anesthesia.
12. Be able to inject a local anesthetic into the EAC and perform necessary skin incisions for most otologic approaches and a complete mastoidectomy.

**III. Attitudes**

1. Achieve and maintain the respect of the faculty, nursing staff and co-residents.
2. Be sensitive to the confidential needs of patients. When in their presence, conduct discussions of medical findings, management, and other interactions in a professional manner.
3. See patients and consults in a gracious and timely manner.

**OTOLARYNGOLOGY II: RESIDENCY BENCHMARKS**  
**EDUCATIONAL GOALS AND OBJECTIVES**  
**SINO-NASAL DISORDERS AND ALLERGY**

**I. Knowledge**

1. Symptoms of Rhinosinusitis
  - a. Be able to differentiate subtleties in symptoms related to cause: viral, bacterial, allergy, fungal, structural, impaired mucociliary transport
  - b. Appreciation of non-sinus etiologies mimicking Sino-nasal disorders: GERD, migraine, CSF leak, psychological issues
2. Allergic Rhinitis
  - a. Pathophysiology of Allergic Rhinitis
  - b. Methods of detecting Allergy to inhalants and foods: skin (prick, intradermal dilutional testing) and in vitro testing
  - c. Food allergy: mechanism of elimination challenge diet
  - d. Role of environmental control in allergic rhinitis and basic interventions in environmental control
3. Facility with Directed Therapeutic Interventions - Pharmacologic
  - a. Nasal steroid sprays, antihistamines, decongestants, anticholinergics, leukotriene modulators, oral and topical antibiotics – knowledge of mechanism of action, effects, interactions and side effects
4. Facility with Therapeutic Interventions - Surgical
  - a. Anatomy of the nose and paranasal sinuses
  - b. Awareness of complications of nasal surgery and ESS and appropriate management

**II. Patient Care**

1. Symptoms of Rhinosinusitis
  - a. Be able to take a directed history in a timely manner
  - b. Be able to be a “detective” regarding triggers or possible causes of patient’s symptomatology
  - c. Ability to diagnosis comorbid conditions and initiate workup to diagnose or treat, including: extra esophageal reflux, obstructive sleep apnea, migraine, sino-genic facial pain, reactive airway disease
  - d. Be able to diagnose and manage complications of rhinosinusitis (orbital, intracranial)
2. Appreciation of the Role of Diagnostic Maneuvers in Management of Rhinosinusitis
  - a. CT scan, nasal endoscopy, cultures, smell tests, mucociliary transport, allergy testing, immunodeficiency evaluation, plane films, sino-nasal biopsies, evaluation of response to therapeutic interventions.
  - b. Effective communication regarding elimination challenge diet
3. Facility with Directed Therapeutic Interventions - Pharmacologic
  - a. Appropriate choice of pharmacologic intervention based on diagnosis and symptomatology as well as clear communication with the patient regarding how to use these medications.
  - b. Awareness of side effects and efficacy of different medication and appropriate education of patient
  - c. Effective communication regarding environmental controls
4. Facility with Therapeutic Interventions - Surgical
  - a. Appropriate pre-surgical evaluation with failure of appropriate pharmacologic intervention
  - b. Able to perform limited Endoscopic sinus surgery (ESS), antral taps, sinus aspirates, sinus irrigation and nasal endoscopy with minimal discomfort to patient by end of rotation
  - c. Able to perform a Septoplasty & turbinate reduction by end of rotation
  - d. Able to perform in office - somnoplasty, microdebridement of polyps, steroid injections by end of rotation
  - e. Able to diagnosis site of epistaxis endoscopically and control with minimal packing
  - f. Able to manage complications of above interventions

**OTOLARYNGOLOGY II, III, IV: RESIDENCY BENCHMARKS**  
**EDUCATIONAL GOALS AND OBJECTIVES**  
**RESEARCH**

**I. Knowledge**

1. The research project identified and developed should build on relevant medical knowledge of otolaryngology (basic or clinical).
2. The research mentor should demonstrate expertise in the defined area of research.
3. The research mentor should have a successful track record of mentoring trainees, with an emphasis on prior successful mentoring of otolaryngology residents.
4. The trainee should develop research questions to be addressed during the rotation.
5. The trainee should generate a proposal to study the topic chosen (ideally, a NIH-style grant proposal).
6. The trainee should take and pass the web-based research training modules at the University of Pittsburgh.
7. The trainee should demonstrate the ability to initiate and complete a research project.
8. The trainee should recognize the importance of the literature review, be familiar with internet-based search engines and on line retrieval of relevant manuscripts.
9. The trainee should learn to prepare a research report/manuscript including familiarity with reference manager programs to readily incorporate the referenced sources.

**II. Patient Care**

1. If the research is clinical in nature, then the trainee is expected to become familiar with good clinical research practices including regulatory guidelines, criteria for informed consent, and the role of the IRB.
2. Trainees who participate in clinical research should be properly trained and ideally designated as co-investigators on the protocol materials.
3. All research projects involving patients and/or patient-related materials must have IRB approval or approved exemption.
4. Recording and reporting of patient data must observe guidelines set forth to protect patient confidentiality.

**III. Attitudes**

1. Professionalism:
  - a. The resident must be appropriately instructed if charged with obtaining informed consent from study subjects.
  - b. The resident must be appropriately trained to perform study-related procedures.
  - c. The resident should demonstrate respect and compassion for all study patients with special attention to sensitivity to patients' age, gender, culture, and disabilities.
2. Interpersonal and Communication Skills:
  - a. Work towards a constructive relationship with patients and staff.
  - b. Elicit the help of senior co-investigators, the PI and/or mentor if any questions or concerns arise.
3. Practice-Based Learning and Environment:
  - a. Applies knowledge of study design and statistical methods to evaluate studies.
  - b. Uses informatics technology appropriately with care taken to respecting patient confidentiality.
4. Systems-Based Practice:
  - a. Recognize how some research may be translated to improved patient care.
  - b. List cost of biomedical research and sources of funding.

**OTOLARYNGOLOGY III: RESIDENCY BENCHMARKS**  
**EDUCATIONAL GOALS AND OBJECTIVES**  
**PLASTIC SURGERY OF THE HEAD AND NECK**

**I. Medical Knowledge**

**A. Anatomy/Physiology/Embryology**

1. Goal: The resident will achieve detailed knowledge of the anatomy, physiology, embryology of the head and neck, and will apply this knowledge to the medical management of disorders and processes in this anatomic area.
2. Objectives:
  - a. Describe the anatomy of the skull including sutures, foramina, and cranial nerves.
  - b. Identify the anatomy of the facial bones.
  - c. Identify the anatomy of the eye including normal dimensions, bony structures, eyelids, extraocular muscles, innervation, vascular supply, and lacrimal apparatus.
  - d. Identify the anatomy of the ear including common measurements, relationships to other structures, and the vascular and sensory supply.
  - e. Draw the anatomy of the nose and septum including bones, nerves and vascular supply.
  - f. Recite the anatomy of the oropharynx including muscular structures and contiguous neurovascular structures.
  - g. Recite the physiology of the oropharynx including palatal function, speech, and swallowing.
  - h. Explain the general principles of embryology of the head and neck, with special reference to the development of the facial structures and the occurrence of congenital anomalies such as cleft lip and palate.
  - i. Recite the basic anatomy of the dental structures and the TMJ.

**B. Congenital Disorders**

1. Goal: The resident will achieve familiarity with the anatomy, embryology and principles of treatment of congenital disorders of the head and neck.
2. Objectives
  - a. Demonstrate intimate knowledge of the common congenital disorders of the head and neck including cleft lip and palate, craniofacial syndromes, vascular malformations, and auricular abnormalities
  - b. Discuss the etiology, genetics, embryology and anatomy of congenital disorders of the head and neck.
  - c. Be familiar with growth and development of the craniofacial skeleton and its affect on anomalies and their treatment
  - d. Be able to recite the diagnostic criteria and discuss the evaluation and treatment for congenital anomalies such as:
    1. craniosynostosis
    2. hemifacial microsomia
    3. rare craniofacial clefting
    4. orbital hypertelorism
    5. Pierre-Robin sequence
    6. craniofacial tumors
  7. choanal atresia

8. nasal anomalies
9. ear anomalies (prominent ear, microtia)
10. vascular anomalies
11. branchial cleft cysts
12. thyroglossal
13. duct cysts
- e. Discuss the cephalometric landmarks and analysis in the presurgical planning of patients with congenital head and neck anomalies.

### **C. Benign and Malignant Tumors**

1. Goal: The resident will obtain knowledge of benign and malignant tumors of the head and neck, understand the biologic basis of treatment options for these lesions, and perform complete management of such lesions including diagnosis, surgery and nonsurgical therapy.
2. Objectives:
  - a. Recognize the clinical presentation of squamous cell carcinoma of the head and neck.
  - b. Recite the lymphatic drainage pattern of the head and neck structures and the relationship to the management of malignant tumors.
  - c. Recite the methods for diagnosis and the options for treatment of squamous cell carcinomas of the head and neck.
  - d. Recite the TNM staging system for tumors of the head and neck; know the features and biologic behavior of these lesions.
  - e. Describe the general principles and techniques of adjuvant therapy such as radiation therapy and chemotherapy for head and neck malignancies.
  - f. Discuss the indications for and the role of neck dissection in the treatment of head and neck malignancies.
  - g. Recite the process of long-term follow-up for patients with head and neck malignancies.
  - h. Recite the diagnosis of and principles of care for:
    1. rhinophyma
    2. eyelid and lacrimal neoplasms
    3. infections of the head and neck
    4. disease of nasal cavity and paranasal sinuses
  - i. Discuss the differential diagnosis of hemangiomas and vascular malformations.
  - j. Discuss the treatment options, including steroid therapy, laser therapy, and surgery for hemangiomas and vascular malformations of the head and neck.

### **D. Trauma**

1. Goal: The resident will be familiar with the mechanisms of traumatic head and neck injuries, understand the diagnostic techniques and therapeutic options for such problems, and perform complete management of traumatic injuries of the head and neck.
2. Objectives:
  - a. Describe the priorities involved in treating patients with head and neck injuries.
  - b. Describe the mechanical and structural properties of the facial skeleton as they relate to fracture patterns in facial trauma.
  - c. Describe the concepts of primary bone healing, malunion, nonunion and osteomyelitis.
  - d. Discuss the advantages and disadvantages of various techniques of treatment of facial fractures including:
    1. nonoperative treatment
    2. closed reduction

3. mandibulomaxillary fixation
4. open reduction with and without fixations
5. intraoral splints
6. external fixation
7. bone grafting.
- e. Describe the treatment of facial fracture complications including:
  1. secondary deformities
  2. infections and osteomyelitis
  3. malocclusion
  4. nonunions
  5. malunions.
- f. Describe the neuroanatomy, cranial nerve anatomy and soft tissue anatomy pertinent to facial fractures.
- g. Recite the treatment of soft tissue injuries of the head and face including:
  1. parotid gland and duct
  2. facial nerve
  3. lacrimal apparatus.
- h. Describe the evaluation and treatment of secondary deformities of facial fracture including:
  1. malocclusion
  2. enophthalmos
  3. frontal sinus mucoceles
  4. facial nerve paralysis
  5. soft tissue contractures.
- i. Discuss the principles of care and the surgical steps in the treatment of the following facial fractures:
  1. frontal sinus
  2. naso-orbital ethmoid
  3. orbital
  4. zygomatic
  5. nasal
  6. maxillary
  7. mandibular
  8. pan-facial.

## II. Patient Care

- A. Goal: The resident will provide patient care that is compassionate, appropriate, and effective for the treatment of hand and neck problems.
- B. Objectives:
  1. Obtain cephalometric measurements and analyze cephalometric data in the presurgical planning.
  2. Perform a comprehensive head and neck exam followed by facial form analysis.
  3. Utilize radiographic and special diagnostic studies to evaluate head and neck anomalies.
  4. Formulate a definitive short- and long-term treatment plan for common congenital disorders, choosing the most appropriate surgical or nonsurgical modality.
  5. Draw the reconstruction of a cleft lip and palate.
  6. Diagnose and develop a treatment plan for velopharyngeal incompetence.
  7. Coordinate nonsurgical treatment of congenital head and neck disorders.
  8. Participate in the Cleft-Craniofacial Team's multidisciplinary evaluation and treatment planning for congenital disorders of the head and neck.
  9. Provide perioperative care and participate in surgical treatment of patients with craniofacial anomalies.
  10. Utilize diagnostic techniques for head and neck tumors including radiographic methods (e.g., sialogram, MRI scan, etc) and fine needle aspiration.

11. Perform fine needed aspirate biopsies.
12. Recite the steps in the surgical treatment of:
  - a. oropharyngeal tumors
  - b. salivary gland tumors
  - c. neck dissections
  - d. tumors of bony and dental origin.
13. Participate in the extirpative surgery for oropharyngeal tumors, including performing neck dissection.
14. Evaluate and treats patients with head and neck tumors of a vascular origin.
15. Perform an orderly and systematic physical examination of the patient with facial trauma.
16. Interpret radiographic diagnostic studies including panorex films, cephalograms, CT/3D CT scans, MR imaging, and angiography with respect to the head and neck trauma patient.
17. Perform the staged management of devastating open facial injuries including wound care, debridement and reconstruction.
18. Perform surgical procedures of facial fracture management including:
  - a. maxillary
  - b. mandibular
  - c. orbital
  - d. frontal sinus
  - e. zygomatic
  - f. zygomatic arch
  - g. nasal
  - h. panfacial
19. Perform all surgical techniques of access to the craniofacial skeleton.
20. Perform a comprehensive examination of the facial nerve.
21. Perform acute repair of soft tissue facial trauma.
22. Perform secondary scar revision from facial trauma.
23. Perform primary facial nerve repair, and associated procedures (i.e. global weight, static, and dynamic reconstruction) for the patient with facial paralysis.
24. Perform systemic therapy and local injection of steroids for treatment of facial hemangiomas.
25. Perform laser treatment for vascular malformations.

### **III. Practice Based Learning and Improvement**

- A. Goal: The resident will investigate and evaluate his or her own patient care practices, appraise and assimilate scientific evidence, and improved patient care practices.
- B. Objectives:
  1. Use information technology to prepare for surgical cases, bringing to the OR the knowledge of current modalities of care for patients with head and neck diagnoses and the scientific evidence for that care.
  2. Routinely analyzes the effectiveness of own practices in caring for head and neck patients.
  3. Improve own practices in the care of head and neck patients by integrating appropriately gathered data and feedback.
  4. Educate medical students and other healthcare professional in the practices of head and neck surgery.
  5. Function independently with graduated advancement and appropriate faculty supervision in the evaluation and treatment of patients with head and neck diagnoses.
  6. Participate in, and appreciate the value of outcome studies as they apply to diagnoses of the head and neck.

### **IV. Interpersonal and Communication Skills**

- A. Goal: The resident will demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families, and professional associates.
- B. Objectives
  1. Educate patients and families in pre- and post-operative care of head and neck patients.

2. Demonstrate compassion for patients and families with congenital and acquired anomalies of the head and neck.
3. Provide adequate counseling and informed consent to patients.
4. Listen to patients and their families.
5. Assimilate data and information provided by the craniofacial team and other members of the health care team, in the care of patients with congenital head and neck anomalies.
6. Assimilate data and information provided by the head and neck team and tumor board in the care of patients with congenital head and neck cancer.

## **V. System Based Practice**

- A. Goal: The resident will demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.
- B. Objectives:
  1. Function within the organization of specialty clinics (Cleft Palate Center, Craniofacial Clinic) including the coordination of all special services in the evaluation of children with these anomalies.
  2. Be able to coordinate the nonsurgical treatment of patients with congenital anomalies among contributing specialties (prosthetics, orthodontics, speech therapy).
  3. Recognize the value of and function within a team approach to treat patients with head and neck malignancies
  4. Participate in tumor-board conference.
  5. Participates in multidisciplinary planning and treatment for patients with head and neck malignancies.
  6. Coordinate all aspects of head and neck rehabilitation, including physical therapy, sensory reeducation, and maxillofacial prosthetics.
  7. Direct the rehabilitation of head and neck patients by partnering with the following:
    - a. physical therapy
    - b. occupational therapy
    - c. prosthetic and orthotics specialists
    - d. ENT cancer services
    - e. Speech and swallow specialists.
  8. Demonstrate knowledge of cost-effective head and neck reconstruction.
  9. Advocate for congenital craniofacial patients within the health care and insurance system.
  10. Recognize the benefits and functionality of multidisciplinary craniofacial teams.
  11. Refer craniofacial patients to the appropriate practitioners and agencies.
  12. Appreciate the functioning of the multispecialty fetal diagnosis and treatment committees and the potential role prenatal diagnosis plays in the family unit.
  13. Facilitate the timely discharge of head and neck patients.
  14. Partner with pediatricians in the combined care of infants undergoing systemic steroid therapy for head and neck hemangiomas.

## **VI. Professionalism**

- A. Goal: The resident will demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.
- B. Objectives:
  - 1. Develop a sensitivity of the unique stress placed on families under care for congenital craniofacial anomalies.
  - 2. Exhibit an unselfish regard for the welfare of head and neck patients.
  - 3. Demonstrate firm adherence to a code of moral and ethical values.
  - 4. Be respectful to head and neck patients and their families especially in times of trauma and stress to the family unit.
  - 5. Respect and appropriately integrate other members of the craniofacial team.
  - 6. Provide appropriately prompt consultations when requested.
  - 7. Demonstrate sensitivity to the individual patient's profession, life goals, and cultural background as they apply to head and neck diagnoses of trauma, malignancy, and congenital anomalies.
  - 8. Be reliable, punctual, and accountable for own actions in the OR and clinic.

## **OTOLARYNGOLOGY III: RESIDENCY BENCHMARKS AT UPMC ST. MARGARET** **EDUCATIONAL GOALS AND OBJECTIVES**

### **I. Knowledge**

- a. List otolaryngologic manifestations of systemic diseases.
- b. Describe the anatomy of the paranasal sinuses, the extratemporal facial nerve, and the larynx.
- c. Identify the staging system for head, neck and temporal bone cancers.
- d. List definitions and parameters for evaluating obstructive sleep apnea and sinusitis.
- e. Acquiring the ability to follow a diagnostic algorithm for otologic complaints, sinusitis, nasal obstruction, head and neck mass, dysphagia and hoarseness.

### **II. Skills**

- a. Appropriate examination skills:
  1. Thorough head and neck physical examination.
  2. Nasal endoscopy.
  3. Flexible fiberoptic laryngoscopy.
  4. Comprehensive otolaryngologic bedside evaluation.
  5. Mirror examination.
  6. FEES examination.
- b. Data Interpretation:
  1. CT scans of the neck, axial and coronal CT scans of the sinuses, CT scan interpretation of the temporal bone.
  2. Evaluation of barium esophagogram.
  3. Ability to evaluate modified barium swallows.
  4. Ability to interpret diagnostic studies such as audiograms.
  5. Ability to interpret FEES.
- c. Surgical Skills:
  1. Modified radical and selective neck dissection, laryngectomy, partial laryngeal surgery, excision of head and neck tumors, microlaryngoscopy, and diagnostic laryngoscopy and esophagoscopy.
  2. Ability to perform tracheostomy.
  3. Ability to perform parotidectomy.

### **III. Interactions**

- a. Interaction with a variety of health care providers.
- b. Interact with family practice residents.
- c. Ability to impart knowledge to family practice residents in a professional, soothing manner.
- d. Ability to serve as consultant in a community hospital.

### **IV. Attitudes**

- a. Effective communication with members of community health care team.
- b. Willingly and actively teach medical students, as well as family practice residents.
- c. The ability to formulate working diagnoses on inpatient and outpatient consults.
- d. The ability to relate to patients and families and to provide both adequate objective information as well as emotional support.
- e. The ability to work with the operating room staff, as well as residents from other surgical specialties rotating at UPMC St. Margaret.

**OTOLARYNGOLOGY IV: RESIDENCY BENCHMARKS**  
**EDUCATIONAL GOALS AND OBJECTIVES**  
**ENDOSCOPIC CRANIAL BASE SURGERY**

**I. Responsibilities**

The PGY IV Cranial Base resident is responsible for inpatient and outpatient activities at UPMC Presbyterian and Montefiore Hospitals under the care of Dr. Carl Snyderman and members of the Endoscopic Cranial Base Surgery Team. This includes an outpatient clinic one and a half days per week and surgery on the remaining days. Occasionally surgeries are also performed at Children's Hospital, Western Pennsylvania Hospital, and Magee Hospital.

This resident will cover trauma cases when the team is on call for trauma. The resident covers all consultations.

**II. Knowledge**

- a. Evaluation of patients with olfactory and gustatory complaints
- b. Management of patients with epistaxis
- c. Treatment of neoplasms of the paranasal sinuses and cranial base
- d. Role of nutrition in head and neck cancer
- e. Anatomy of the anterior and lateral cranial base
- f. Diagnosis and management of cerebrospinal fluid leaks

**III. Skills**

- a. Cervical approaches to the cervical spine
- b. Endoscopic sinus surgery for inflammatory disease
- c. Surgical approaches to the sphenoid sinus and pituitary gland
- d. Surgical management of epistaxis
- e. Surgical approaches to the anterior and lateral skull base
- f. Local and regional flaps for cranial base reconstruction
- g. Emergency airway management

**IV. Index Cases**

- a. Anterior cervical approach to the cervical spine
- b. Endoscopic sphenoethmoidectomy
- c. Endoscopic approach to sphenoid sinus and pituitary gland
- d. Surgical approach to anterior skull base
- e. Surgical approach to lateral skull base

**OTOLARYNGOLOGY IV: RESIDENCY BENCHMARKS**  
**EDUCATIONAL GOALS AND OBJECTIVES**  
**SHADYSIDE ROTATION**

**I. Knowledge:**

Preoperative evaluation:

The resident should understand the essential components and the evaluation of the following entities:

1. Acute facial paralysis
2. Chronic facial paralysis
3. Acute sinusitis with or without complications
4. Chronic sinusitis
5. Primary and secondary rhinoplasty
6. Cosmetic deformities of the face
7. Cutaneous malignancies

The resident should know:

1. Anatomy of the facial nerve
  - a. Anatomy of the facial nerve and muscles: central, temporal bone, extratemporal
  - b. Radiology of facial nerve normal and in pathology
  - c. Pathophysiology of facial paralysis
  - d. Common electrical tests of facial paralysis MST, EMG, ENOG (EEMG)
  - e. Treatment of acute facial paralysis
  - f. Facial reanimation approach to patients with various deficits eye reanimation
  - g. Reconstruction of soft tissue defects with “plastic” technique using local facial flaps
  - h. Basics of MOH’s histographic surgery
2. Nasal physiology, anatomy, and radiology
  - a. Embryology and anatomy of the paranasal sinuses: uncinata, bulla, posterior ethmoid, phenoid, agger nasi, frontal, maxillary, turbinates, osteomeatal complex, nasal lacrimal system
  - b. Interpretation of sinus radiographs
  - c. Office evaluation of nasal sinus disorders
  - d. Medical management of sinusitis pathophysiology
  - e. Surgical principles of endoscopic sinus surgery avoidance and management of complications of ESS
  - f. Management of epistaxis
  - g. Anatomy of the aging face

**II. Patient Care**

A. Surgical treatment options:

1. Acquired and congenital facial deformities
2. Aging face
3. Facial and eye reanimation
4. Endoscopic Sinus Surgery (ESS)
5. Rhinoplasty
6. Parotidectomy
7. MOHS technique

B. Postoperative care:

1. Facial Reanimation
2. Rhinoplasty
3. Endoscopic sinus surgery

- C. Identification and management of surgical complications:
  - 1. Wound infection
  - 2. Airway compromise
  - 3. Orbital complications of ESS
  - 4. CNS complications of ESS
  - 5. Facial paralysis after rhytidectomy

### **III. Skills:**

- A. Physical examination
- B. Anterior rhinoscopy
- C. Nasal endoscopy
- D. Analysis of eye for reanimation, age related changes, orbital complications
- E. Analysis of lower face for reanimation and age related change
  - 1. Gold weight and Bick procedure
  - 2. Parotidectomy with facial nerve dissection

### **IV. Index Cases:**

- A. Minimally invasive endoscopic sinus surgery
- B. Facial nerve identification
- C. Nasal Septal reconstruction
- D. Turbinate reduction

**OTOLARYNGOLOGY IV: RESIDENCY BENCHMARK**  
**EDUCATIONAL GOALS AND OBJECTIVES**  
**LARYNGOLOGY AND CARE OF THE PROFESSIONAL VOICE**

**I. Knowledge**

1. Laryngeal physiology and anatomy
2. Specialized history evaluation of singers
3. Evaluation and decision making of a patient with an immobile vocal fold
4. Principles and indications of behavioral management of patients with voice disorders
5. Identification and treatment of patients with paradoxical vocal fold motion disorder
6. Method of multi-disciplinary evaluation and care of voice disorders
7. Identification and treatment of laryngeal dystonias

**II. Skills**

1. Dynamic voice assessment using flexible laryngoscopy
2. Rigid, per-oral laryngoscopy with stroboscopy
3. Interpretation of laryngovideostroboscopy
4. Phonomicrosurgery
5. Medialization laryngoplasty

**III. Attitudes**

1. Importance of consultants (pathology, speech-language pathology, anesthesiology)
2. Talking with patients
3. Teaching medical students
4. Be sensitive to confidential needs of patients. When in their presence, conduct discussions of medical findings, management and other interactions in a professional manner.
5. Follow up on lab data, pathology, and radiology reports without reminders

**IV. Procedures not expected to perform**

1. Microflap approach for removal of intracordal pathology
2. Arytenoid adduction
3. Treatment of sulcus vocalis

**V. Index Cases**

1. Microlaryngeal surgery
2. Videostroboscopy
3. Medialization laryngoplasty

**OTOLARYNGOLOGY V: RESIDENCY BENCHMARKS**  
**ROTATION DESCRIPTION**  
**SWALLOWING/TRAUMA SERVICE**

The Swallowing/Trauma residents will share trauma calls from the UPMC ER and will be responsible, with the consult resident, as first call for Head and Neck Trauma during regular duty hours. The ER on-call resident will be responsible for answering trauma calls during evenings, weekends, and holidays. The Swallowing/Trauma resident will be responsible for informing the on-call resident of any pending studies or management of trauma patients. In the rare instance that the on-call resident cannot respond to a trauma call in a timely fashion, the on-call resident will contact the trauma resident who should then respond to the trauma call. It is the responsibility of the resident to contact the appropriate faculty staff when responding to trauma calls.

Prior arrangements for coverage should be made before scheduling vacation or at a CME meeting.

In addition to the Inpatient Consultation Service, the consult resident will participate in outpatient activities including the Swallowing Disorders Center and the third floor office. The resident will participate in all surgical procedures performed in patients of Dr. Carrau's from the Outpatient Clinic, the Inpatient Consultation Service or the Trauma Service. During the rotation the resident will be responsible to prepare a "case report" for the Trauma Grand Rounds and to prepare a Grand Rounds conference for the Swallowing Disorders Center. The subject of this conference will be chosen on the basis of clinical interests and available topics.

**I. Knowledge**

1. List manifestation of systemic diseases
2. Recognize methods for diagnosis and management of swallowing disorder
3. Identify serious and emergency situations
4. Learn basic concepts of documentation and coding of consultation service

**II. Skills**

1. Perform comprehensive assessment at bedside
2. Initiate focused interventions
3. Fracture reduction and plating skills
4. Endoscopic evaluation of swallowing. Interpretation of swallowing studies.

**III. Attitudes**

1. Interact with referring physicians as consultant
2. Communicate effectively with medical resources

**OTOLARYNGOLOGY IV and V: RESIDENCY BENCHMARKS**  
**EDUCATIONAL GOALS AND OBJECTIVES**  
**HEAD AND NECK**

**I. Knowledge**

1. Employs and interprets modern imaging to facilitate investigation of head and neck tumors.
2. Employs appropriate use of antimicrobial therapy in both the prophylactic and therapeutic setting.
3. Recognizes the indications for radiation therapy in both the primary and adjuvant setting.
4. Indicates the uses of chemotherapy for primary and adjuvant therapy.
5. Comprehends the staging classification system.
6. Understands anesthesia and airway management as it pertains to patients with cancer of the head and neck.
7. Recognizes laser safety and basic laser surgery principles.
8. Recognizes perioperative management principles as it pertains to patients with cancer of the head and neck.
9. Has a thorough knowledge of the head and neck anatomy including the surgical zones of the neck.
10. Lists thyroid neoplasms and is able to propose appropriate treatment.
11. Lists the various cutaneous malignancies and is able to propose appropriate treatment.
12. Lists the various types of salivary gland neoplasms and is able to discuss appropriate treatment.
13. Familiar with the identification and care of surgical complications.
14. Recognizes the long term consequences of surgery and irradiation and is able to help the patients' to accommodate to these.
15. Knows the anatomy and utility of the various reconstructive alternatives such as skin grafts, local, regional and free-flaps.
16. Describes the role and utility of conservation laryngeal surgery.
17. Lists the various congenital cysts in sinuses of the head and neck. Knows the surgical approaches for each.
18. Lists the options for the reconstruction of the cervical esophagus and hypopharynx.

**B. Patient Care**

- A. Index Cases: By the end of the head and neck rotation, the resident should feel comfortable performing the following procedures:
1. Lateral rhinotomy approach
  2. Complete and partial maxillectomy
  3. Wide local excision of aerodigestive tract mucosal lesions
  4. Split thickness skin graft reconstruction
  5. Pectoralis myocutaneous regional flap reconstruction
  6. Marginal and segmental mandibulectomy
  7. Partial laryngectomy surgical procedures (less than total laryngectomy)
  8. Total laryngectomy, laryngopharyngectomy and laryngopharyngoesophagectomy
  9. All forms of elective and therapeutic neck dissections
  10. Thyroidectomy
  11. Parotidectomy and other salivary gland procedures
  12. Reconstruction of cutaneous surgical defects
  13. Management of the difficult airway
  14. Transoral endoscopic laser excision techniques
  15. Bicornal incision and orbitozygomatic osteotomy

**OTOLARYNGOLOGY V: RESIDENCY BENCHMARKS**  
**EDUCATIONAL GOALS AND OBJECTIVES**  
**OTOLOGY**

**I. Knowledge**

1. Review and understand the information base required of first year otology residents.
2. Know anatomy of the temporal bone through reading, Dr. Sando's lectures and hands-on experience in the temporal bone laboratory.
3. Understand the anatomy of the eustachian tube and sequela from dysfunction.
4. Identify critical structures and the interpret MRI and CT images of the skull base and temporal bone.
5. Through appropriate history taking and physical diagnosis be able to develop a detailed differential diagnosis for otologic and neurotologic complaints. Propose a reasonable treatment plan for patients complaining of hearing loss, tinnitus or dizziness.
6. Be knowledgeable regarding appropriate hearing aid amplification and different amplification devices available (analog, digital, CROS, BICROS).
7. Be able to interpret standard vestibular testing (ENG, Rotational Chair) as well as ECoG, ENOG, otoacoustic emissions, facial EMG results.
8. Be a resource for the first year resident regarding educational opportunities within the division of otology including audiology, vestibular lab, temporal bone lab, and Dr. Sando's otopathology lectures.

**II. Skills**

1. Be responsible for seeing consultations in a timely manner, assisting the first year resident with bedside consultations, and presenting a plan for work-up and treatment to the attending.
2. Be competent in identifying a normal tympanic membrane and common pathology including otitis externa, serous otitis media, tympanic membrane perforation and cholesteatoma.
3. Understand the use and interpretation of tuning fork testing.
4. Perform a Dix-Hallpike test and a particle-repositioning maneuver.
5. Be competent in recognizing common and subtle pathologic changes of the EAC, tympanic membrane and middle ear.
6. Formulate a treatment plan for patients with various degrees of conductive, sensorineural and mixed hearing loss.
7. Provide a differential diagnosis and treatment plan for patients complaining of dizziness.
8. Provide a differential diagnosis and treatment plan for patients presenting with facial palsy
9. Have basic surgical skills for the following procedures:
  - a. Use of operating microscope.
  - b. Removal of cerumen impaction and mastoid cavity debridement.
  - c. Placement of myringotomy tubes in patients in the clinic
  - d. Tympanomeatal flap elevation for transcanal procedures
  - e. Facial recess approach
  - f. Canal wall down mastoidectomy
  - g. Tympanoplasty (medial and lateral technique)
  - h. Labyrinthectomy
  - i. Middle ear ossiculoplasty
  - j. Use of lasers in otologic surgery
  - k. Understand and deliver appropriate postoperative care for common otologic/neurotologic procedures including stapedectomy, tympanoplasty/tympanomastoidectomy, acoustic tumor surgery.
  - l. Be able to identify and provide a reasonable management plan for cerebrospinal fluid leaks.

**OTOLARYNGOLOGY V: RESIDENCY BENCHMARKS**  
**EDUCATIONAL GOALS AND OBJECTIVES**  
**FACIAL PLASTICS AND RECONSTRUCTIVE SURGERY**

**I. Knowledge**

1. Know etiology of skin malignancies
2. Understand histologic progression of malignancies of the skin
3. Know diagnostic criteria for skin malignancies
4. Understand staging system for skin malignancies
5. Describe steps in excision and MOHS pathologic preparation of the surgical specimen
6. Describe principles of wound management following excision of skin malignancies
7. Describe common local flaps utilized in skin excision
8. Describe use of skin grafts in wound closure
9. Describe principles in post-operative management of skin flaps
10. Know scientific basis of changes occurring in aging skin
11. Know underlying scientific basis, therapeutic choices, and techniques of chemical peel.
12. Know instrumentation and techniques of dermabrasion

**II. Patient Care Skills**

1. Be able to describe skin lesions of the head and neck
2. Be able to list differential diagnosis for common skin disorders
3. Be able to select appropriate management strategy for skin malignancies
4. Be able to perform surgical excision of skin malignancies
5. Be able to accurately register pathologic diagram with surgical specimen
6. Be able to accurately prepare, section, and examine surgical specimen
7. Be able to accurately draw map of surgical specimen
8. Be able to register re-excisions accurately with surgical map
9. Be able to select optimal wound management scheme for commonly encountered defects
10. Be able to perform common local flap closure techniques including:
  - a. Advancement
  - b. W-plasty
  - c. Z-Plasty and multiple Z-plasty
  - d. Broken-line closure
  - e. V-Y closure
  - f. Pedicled rotation flaps
  - g. Bilobed rotation flaps
11. Be able to describe histologic changes present in aging skin
12. Be able to draw the relaxed skin tension lines on representative facial illustration
13. Be able to identify aesthetic units and the association of these units with planned procedure.
14. Be able to select appropriate intervention for common facial skin abnormalities and defects
15. Be able to describe techniques of cervical liposuction
16. Be able to describe the details of common facial surgical reconstructive procedures to include:
  - a. Face lift/Brow lift
  - b. Blephorplasty
  - c. Skin peel and dermabrasion
17. Be able to perform facial dermabrasion with less than 0.05 mm tolerances
18. Be able to perform cervical liposuction under direct supervision
19. Be able to manage post-operative patients following facial reconstructive surgery
20. Be able to communicate care options, recommendations, risks and benefits, as well as discuss outcomes with patients and families accurately and compassionately.

**NARRATIVE DESCRIPTION OF THE EDUCATIONAL PROGRAM (P.R.V)**

Please provide the following information for each institution offering educational experiences. Add additional pages numbered 10a, etc. so that a well-developed and complete description of the residents' education is provided.

<b>2. PARTICIPATING INSTITUTION</b>		
Name of Institution: <b>Children's Hospital of Pittsburgh</b>		
Is Otolaryngology a separate department in this participating institution?	YES <b>X</b>	NO
To whom does the Otolaryngology Program Director report?		
Name: <b>Jonas J. Johnson, M.D.</b>	Title: <b>Professor and Chairman</b>	
What percentage of the operative experience at this site is available for resident education?	<b>100%</b>	
Are all patients utilized for teaching purpose?	YES <b>X</b>	NO
If no, explain why:		
Provide a narrative description for <u>each year</u> of the educational program at this site. Include the goals and objectives for each assignment, an outline of the resident duties during the assignment; a description of the progression of resident responsibilities; the organization of the teaching service(s) and clinic(s) where residents are assigned. Also include a description of all educational conferences that residents are required to attend while assigned to this clinical site. (P.R. V. B).		

All the second and third year otolaryngology residents (PGY2 and PGY3) rotate through the Pediatric Otolaryngology Service at the Children's Hospital of Pittsburgh (CHP), with both a second and third year resident on the service at all times. Second year residents spend three consecutive months and third year residents spend three consecutive months at CHP. During their second year, residents spend two days per week in the operating rooms and three days in the outpatient department, and the third year residents spend three days in the operating rooms and two days in the outpatient department. The residents are always supervised by a full-time attending pediatric otolaryngologist in both the operating rooms and outpatient department. All patients are seen in the same outpatient setting and operating room; i.e., there is no "private" versus "service" clinic or operating rooms, and all patients are afforded treatment by the same group of physicians.

There are four full-time (two first year and two second year) pediatric otolaryngology residents (aka, fellows). There is

always one pediatric otolaryngology resident present in the operating rooms and outpatient department, as well as on call, to supervise the otolaryngology residents.

During both years of the CHP rotation, the otolaryngology residents are also responsible for evaluating the patients in the emergency room, inpatient consultations, and twice daily inpatient otolaryngology ward rounds. An average of two to four patients are seen daily (not including night call) in the CHP emergency room by the otolaryngology residents. Patients seen by an otolaryngology resident in the emergency room are also seen by a pediatric otolaryngology resident and an attending pediatric otolaryngologist. Both the attending pediatric otolaryngologist and the pediatric otolaryngology resident on call make daily rounds with the otolaryngology residents (including weekends). The third year otolaryngology resident acts as the “chief” resident for the pediatric otolaryngology service, and may supervise the first year otolaryngology resident on rounds and in the emergency room.

In the operating room, the PGY2 otolaryngology resident learns to perform basic procedures, including myringotomy and tube placement, tonsillectomy and adenoidectomy, tracheotomy, direct laryngoscopy, bronchoscopy, and esophagoscopy (See Attachment I). Second year residents may also assist in tympanoplasty and mastoid surgery, (taking the graft, lifting the flap, etc), resection of neck masses, laryngotracheoplasty (LTP), and sinus surgery. Third year residents, in addition to the above, are the primary surgeons (under supervision) for tympanoplasty, straightforward mastoid surgery, and excision of neck masses (See Attachment II). They may also harvest the rib graft for LTP, and perform some sinus surgical procedures and assist on more major sinus surgical procedures. With regard to emergency procedures, the otolaryngology resident present in the operating rooms, regardless of year, is supervised in the removal of airway and esophageal foreign bodies, esophagoscopy for caustic ingestion, tracheotomy, and otologic and sinus procedures.

There is a full academic and didactic program at CHP which is attended by otolaryngology residents, pediatric otolaryngology residents, all full-time pediatric otolaryngology attendings, medical students on the service, and visiting scholars. All conferences take place weekly. The second year resident is responsible for presentation of the patients at the Morbidity and Mortality conference once a week (schedule rotates). The Thursday and Friday morning educational conferences rotate between journal club, research conferences, and presentations given by invited speakers as well as members of the pediatric otolaryngology faculty. The morning lecture series includes invited speakers from immunology, allergy, neurology, gastroenterology, pulmonology, audiology, hematology/oncology, radiology and other services. This is in addition to active consultation with most of these services on the inpatients, as many of these children have complex medical as well as surgical problems (i.e. transplant patients). Every Wednesday morning, the residents attend the Department of Otolaryngology Grand Rounds.

There are also conferences in other departments which are available to the residents and include a weekly Hematology/Oncology Pediatric Tumor Board Conference, a monthly Plastic and Craniofacial Conference, and weekly Cleft Palate Clinic.

# **RESIDENCY BENCHMARKS IN PEDIATRIC OTOLARYNGOLOGY EDUCATIONAL GOALS AND OBJECTIVES**

Second Year Otolaryngology Resident

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## **I. Medical Knowledge:**

Obtain understanding of diseases and disorders specific to infants and children, and differences in medical management of infants, children, and adults in the area of the ear, nose and throat – head and neck

- A. Develop understanding of the impact of congenital disorders on the care of pediatric patient
- B. Assessment and management including surgical indications for infants and children for the following conditions:
  - 1. Recurrent tonsillitis
  - 2. Hypertrophic adenotonsillar disease/ obstructive sleep apnea
  - 3. Otitis media
  - 4. Airway emergencies
  - 5. Foreign bodies in the aerodigestive tract
  - 6. Sinusitis
  - 7. Inflammatory and infectious conditions of the head and neck
  - 8. Evaluation of stridor
  - 9. Congenital head and neck anomalies

## **II. Patient Care:**

Skills:

- A. Demonstrate skills in:
  - 1. physical examination of infants and children
  - 2. pneumatic otoscopy
  - 3. interpreting tympanometry, and behavioral audiometry results
  - 4. tracheostomy change in infants and children.
- B. Learn basic surgical skills for the care of common ear, nose and throat – head and neck, and bronchosopagologic diseases and disorders in infants and children:
  - 1. Bilateral myringotomy and tube insertion
  - 2. Paper patch/Fat graft myringoplasty
  - 3. Adenoidectomy and tonsillectomy
  - 4. I&D of peritonsillar abscess
  - 5. Tracheotomy
  - 6. Excision of minor neck masses
  - 7. Nasal endoscopy
  - 8. Antral irrigation
  - 9. Flexible laryngoscopy
  - 10. Direct laryngo-bronchoscopy in children
  - 11. Esophagoscopy and biopsy in children
  - 12. Removal of uncomplicated foreign bodies of the esophagus
  - 13. Closed reduction of nasal fracture
- C. Identification and management of post-surgical complication:
  - 1. Post-operative bleeding
  - 2. Wound infection
  - 3. Tissue ischemic
  - 4. Airway problem
  - 5. Postoperative pneumonia

## **III. Professionalism:**

1. Demonstrates respect, compassion and integrity
2. Demonstrates a commitment to ethics, confidentiality, and informed consent
3. Demonstrates sensitivity and responsiveness to patient's age, culture, gender and disabilities

**IV. Interpersonal and Communication Skills:**

1. Creates sound relationship with patients and staff
2. Works effectively with others

**V. Practice Based Learning and Improvement:**

1. Appraises evidence form literature related to patients
2. Apply knowledge of studies and statistical methods to evaluate studies
3. Uses informatics technology effectively
4. Facilitates learning of others

**VI. Systems-Based Practice:**

1. Understands how their patient care relates to other healthcare providers
2. Understands healthcare costs
3. Practices cost effective healthcare and uses resources appropriately
4. Assists patients with system complexities

**RESIDENCY BENCHMARKS IN PEDIATRIC OTOLARYNGOLOGY**  
**EDUCATIONAL GOALS AND OBJECTIVES**

Third Year Otolaryngology Resident

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**I. Medical Knowledge:**

- A. Assessment and management including surgical indications for infants and children for the following conditions:
  - 1. Reconstruction of the airway
  - 2. Sensorineural hearing loss
  - 3. Tumors of the head and neck

**II. Patient Care:**

Skills:

The resident should have developed skills to perform the following procedures:

- A. Expand surgical skills for the care of infants and children:
  - 1. Tympanoplasty/ ossicular reconstruction
  - 2. Cortical mastoidectomy
  - 3. Exploration of middle ear for perilymphatic fistula
  - 4. Endoscopic sinus surgery
  - 5. Septoplasty
  - 6. I & D of subperiosteal abscess
  - 7. Excision of submandibular gland
  - 8. I & D of neck abscess
  - 9. Excision of thyroglossal duct cyst and simple brachial cleft cysts
  - 10. Direct laryngo-bronchio-esophagoscopy in infant/children
  - 11. Removal of simple laryngo-bronchio-esophageal foreign bodies
  - 12. Assist in (not primary surgeon)
    - a. Laryngotracheal reconstruction
    - b. Tympanomastoidectomy for cholesteatoma
    - c. Cochlear implants
    - d. Microtia atresia repair
    - e. Complicated tumors in the head and neck
    - f. Surgery involving facial nerve (ear, parotid, branchial clefts cysts).
- B. Identification and management of post-surgical complication:
  - 1. Post-operative bleeding
  - 2. Wound infection
  - 3. Tissue ischemic
  - 4. Airway problem
  - 5. Postoperative pneumonia

**III. Professionalism:**

- A. Demonstrates respect, compassion and integrity
- B. Demonstrates a commitment to ethics, confidentiality, and informed consent
- C. Demonstrates sensitivity and responsiveness to patient's age, culture, gender and disabilities

**IV. Interpersonal and Communication Skills:**

- A. Creates sound relationship with patients and staff

- B. Works effectively with others

**V. Practice Based Learning and Improvement:**

- A. Appraises evidence form literature related to patients
- B. Apply knowledge of studies and statistical methods to evaluate studies
- C. Uses informatics technology effectively
- D. Facilitates learning of others

**VI. Systems-Based Practice:**

- A. Understands how their patient care relates to other healthcare providers
- B. Understands healthcare costs
- C. Practices cost effective healthcare and uses resources appropriately
- D. Assists patients with system complexities

# University of Pittsburgh Medical Center Medical Education Program Policies and Procedures

Approved by: GME  
Committee: 1/14/2009 Latest  
Revision: 6/9/2009

Department: Graduate Medical Education

## Title: **Duty Hours and Learning Environment Policy and Procedure for Residents/Fellows**

Purpose: The University of Pittsburgh Medical Center Medical Education Program (UPMCMEP) establishes this policy regarding resident and clinical fellow duty hour requirements to ensure program compliance with ACGME resident duty hour regulations. In addition, this document describes the culture and the academic leadership support to ensure attention to the letter and spirit of these regulations and those regarding the learning environment. Residents/Fellows must be provided a sound academic and clinical education. Their training must be carefully planned and balanced to insure optimal patient care and safety, which requires a diligent commitment to resident well-being. Each program must ensure that the learning objectives of the program are not dependent on residents/fellows to fulfill service obligations. Didactic and clinical education must have priority in the allotment of resident/fellows' time and energies. Clinical assignments must respect that faculty and residents/ fellows collectively have responsibility for the safety and welfare of patients. GME will join and support department efforts to comply with this policy which may require that a program request from the Health System additional resources. Scope: All UPMCMEP Sponsored Residency and Fellowship programs Responsible Parties: ACGME/NRMP Designated Institutional Official; Vice President, Graduate Medical Education

### **Procedure I. Supervision of Residents**

A. Qualified faculty must supervise all patient care as specified in the "Supervision Policy". The program director must ensure, direct, and document supervision and faculty support appropriate for the level of training of residents/fellows at all times. Residents/Fellows must be provided with efficient, reliable systems for communicating with supervising faculty.

B. Faculty schedules must be structured to provide residents/fellows with continuous supervision and consultation.

Duty Hour and Learning Environment Policy and Procedures for Residents/Fellows Page 2 of 6

C. Faculty and residents/fellows must be educated to recognize the signs of fatigue and adopt and apply practices to prevent and counteract the potential negative effects.

### **II. Duty Hours**

A. Duty hours are defined as all clinical and academic activities related to the residency/fellowship 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. All academic or administrative activities that residents/fellows are required to attend should be counted towards the duty hours standards. This should include required onsite educational activities such as meetings, conferences and research. Duty hours do not include reading and preparation time spent away from the clinical site.

B. Duty hours are averaged over a four-week period, inclusive of all in-house call activities and must be limited to 80 hours per week on average.

C. Averaged over a four-week period, inclusive of call, residents must be provided with 1 day in 7 free from all educational and clinical responsibilities. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.

D. A required 10-hour time period for rest and personal activities should be provided between all daily duty periods, and after in-house call as per ACGME guidelines for resident duty hours.

E. Each Department/Division must be in full compliance with both the letter and spirit of these and respective specialty duty hour requirements.

**III. On-Call Activities** The objective of on-call activities is to provide residents/fellows with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal workday when residents/fellows are required to be immediately available in the assigned institution.

A. Averaged over a four-week period, in-house call must occur no more frequently than every third night.

B. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents/Fellows may remain on duty for up to 6 additional hours to participate in didactic activities, maintain continuity of medical and surgical care, transfer care of patients, or conduct outpatient continuity clinics.

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

D. At-home call is defined as call taken from outside the assigned institution.

i. 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/fellow. Residents/Fellows 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.

ii. When residents/fellows are called into the hospital from home, the hours spent in-house are counted toward the 80-hour limit beginning from the time the resident/fellow arrives at the hospital.

iii. The program director, faculty, and residents/fellows 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.

**IV. Moonlighting** A. Moonlighting is defined as any outside activity for which compensation is received, especially when not related to the training program. Because residency/fellowship education is a full-time endeavor, the program director must approve and monitor all moonlighting to 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 University of Pittsburgh Medical Center Medical Education Program's written policies and procedures regarding moonlighting. This includes this policy and the UPMCMEP policy on resident/fellow moonlighting. C. Moonlighting must be counted toward the 80-hour weekly limit on duty hours and other provisions of the duty hour ACGME general and specialty specific requirements. D. Moonlighting hours must be entered into the system-wide tracking program (GME ROCS or equivalent)

## **V. Learning Environment**

A. UPMCMEP is committed to providing all medical learners with a safe and positive learning environment which stimulates intellectual, professional, and personal growth.

B. The academic climate in our training programs will foster the above in an open and nonthreatening manner. This climate will be concordant with the UPMCMEP policies

and procedures outlined in the resident contract as well as the policies on Teacher /Learner Interactions and Harassment.

C. The physical environment of our training programs will also facilitate safety and learning. Components of this include call rooms, lounges, meal services, parking, security, and adequate ancillary patient care services such as patient transport, phlebotomy teams and IV teams. An adequate physical environment is guaranteed in the resident/fellow contract.

D. Oversight and monitoring of the Learning Environment is the responsibility of the entire GME system. Programs and the facilities that they reside in must have local monitoring that includes trainee involvement. The GMEC will provide oversight and monitoring through the Resident/Fellow Duty Hour and Learning Environment Subcommittee as outlined below and in compliance with the other policies as mentioned above.

## **VI. Oversight**

A. Each program must have written policies and procedures consistent with the ACGME/RRC Institutional and Program Requirements for resident/fellow duty hours and the learning environment. These policies must be distributed to the residents/fellows and the faculty. Duty hours must be monitored on an ongoing basis to ensure an appropriate balance between education and service. UPMCMEP is committed to ensuring that programs have adequate support to provide a safe ACGME compliant learning environment as well as the ability to monitor duty hours. Residents/Fellows must obtain written approval from the Program Director for moonlighting before any outside activity is conducted. Failure to do so may result in disciplinary action up to and/or including dismissal. Department/divisions must monitor at least monthly duty hours and the overall learning environment. Program Directors will be required to attest to their review of duty hour reports and their response to violations of the duty hours standards. Trainees must have input into this process. The ACGME resident survey is an important component of this monitoring process. Programs must ensure a minimum of 70% participation in the survey. It is strongly recommended that residents/fellows be oriented to the survey before completing it. Training programs should use the survey at least annually as an internal monitoring tool. Program Directors and Department Chairs will be formally notified if the program is in significant noncompliance with this policy and reported to the GMEC. The following may be considered as significant noncompliance: RRC citations, concerns on institutional internal reviews, surveys, consistent violation reports in the system-wide duty hours tracking system, persistent concerns raised through programmatic or institutional committees that evaluate components of the learning environment. (The special circumstances surrounding duty hour concerns raised by the ACGME resident survey are addressed below.) Focused monitoring by the Resident/Fellow Duty Hour and Learning Environment Subcommittee will begin when substantial noncompliance is discovered. Programs on warning must demonstrate two consecutive months of compliance to be reinstated to good standing status. A program out of significant compliance for 2 consecutive months after non-compliant status notification shall have 30 days to rectify all outstanding issues related to this policy. If the program remains out of compliance after this time, the Resident/Fellow Duty Hour and Learning Environment Subcommittee will recommend specific action to the GMEC and the UPMCMEP Board of Directors. These actions may include mandatory oversight of resident/fellow scheduling, curtailing resident/fellow involvement in specific clinical activities, removing staff and faculty from the learning environment, mandated improvement of hospital facilities or services, or program closure. The UPMCMEP Board shall decide the specific action to be applied in such situations up to and including closure of the program. Special concerns are raised when there are ACGME reports of duty hour noncompliance as a result of the resident survey. Poor results on the ACGME resident survey are associated with diminished educational quality of the surveyed program. These reports can shorten program

accreditation cycles and threaten institutional accreditation. Upon notification of such a report from the ACGME, the following will occur:

- a. Program must immediately compare GMEROCs data and ACGME Resident Survey data and provide report to Chair of Duty Hours Subcommittee.
- b. There will be immediate communication between the residency/fellowship leadership and: GME department leadership, the chair of the affected department, the chair of the GMEC Subcommittee on Resident Duty Hours and Learning Environment. Responsible senior leadership in UPP will be informed by the GME Department.
- c. Action plan from program to Duty Hours Subcommittee Chair is expected with regard to the following:
  - i. Re-education of Program Director, Program Coordinator, residents/ fellows and faculty regarding ACGME Duty Hours Standards, metrics, and their importance at the GMEC.
  - ii. Re-education regarding monitoring of duty hours (i.e. GME ROCS) at the program level and monitoring of training program action plan through committee structure.
  - iii. That there is a resident/fellow HOTLINE for duty hours reporting with confidentiality maintained [Marlene Cooper, ombudsperson, 412-647-5815].
  - iv. Review of ACGME Resident Survey with residents/fellows with explanation on questions (FAQ duty hour sheet).
  - v. Review of Program Letter of Agreement for all residents/ fellows rotating from external sites.
  - vi. Review with faculty/residents/fellows role of resident survey and duty hours.

Most importantly, it is to be clear that there is no RETALIATION to a resident/fellow or program from anyone involved.

A worksheet to assist in developing a duty hours action plan is available through the GME Department. Progress of the action plan will be monitored through the Subcommittee until resolution.

B. Each Department/Division is responsible to ensure that back-up support systems are provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care. Residents/Fellows have mechanisms in place to address concerns without fear of reprisal and are encouraged to contact the GME Office in strictest confidence.

C. GME Policies and procedures to request an exception to the resident/fellow duty hours requirement must be followed. An RRC may grant exceptions for up to 10% of the 80-hour limit, to individual programs based on a sound educational rationale. Requests for approval for such exceptions must be forwarded in a timely fashion to the GMEC prior to communication with the RRC.

D. The Resident/Fellow Duty Hour and Learning Environment Subcommittee shall review all applications for the exception. All exceptions requests must be based on sound educational rationale and in accordance with the UPMCMEP policy on this topic.

**VII. Monitoring & Auditing** A. Each department/division is responsible to maintain an accurate schedule for each resident/fellow defining the workday (start and end) and coverage structures including tools to make each resident/fellow's schedule transparent to attendings.

B. Each Department/Division is responsible for submitting verified and accurate resident/fellow duty hours information into the automated system-wide tracking system

The Department/Division is also responsible for monitoring and responding to the automated duty hours reports. C. The GMEC will monitor duty hours at both scheduled and random intervals. This process will include: monitoring of automated duty hours reports by the GME office, review of duty hours reporting during the institutional internal review, review of resident surveys, and meetings with Department/Division staff, faculty and trainees as is needed. The information obtained through these processes is reported to the GMEC through the Resident/Fellow Duty Hour and Learning Environment Subcommittee.

## **SUPERVISORY LINES OF RESPONSIBILITY FOR PATIENT CARE**

In keeping with the laws of the State of Pennsylvania and the rules of the University of Pittsburgh Medical Center as well as the Veterans Administration Hospital, all patients are assigned to a faculty physician. Residents participating in the care of these patients do so under the direct supervision of the faculty. This includes operative services, consultation, inpatient care and outpatient visits.

When residents are “on call” or see and evaluate patients in either the inpatient or outpatient setting without faculty immediately available, it is essential that the responsible faculty be notified of all significant changes in the patient’s status. Critical or life threatening changes require immediate notification of faculty.

Junior residents assigned to clinical services report directly to the chief resident of the service and through the chief resident to the appropriate faculty.

## **RESIDENT CONSULTATION SERVICES**

It is the policy of the Department of Otolaryngology that all patients seen in consultation by residents must be discussed with an attending. If the consultation is to a specific attending, that attending should be contacted first. Unassigned consultations will be covered by the attendings on the Consult services or by an attending with appropriate expertise (e.g. Voice, Swallowing, Otology, etc).

Outpatients seen in consultation in the Emergency Room should be provided with access to an otolaryngologist for follow-up. If the patient indicates an established relationship with an otolaryngologist, the patient should be offered an opportunity to return to see that individual in follow-up. Under circumstances in which the patient does not have a relationship with an otolaryngologist an opportunity for follow-up with an appropriate physician should be established.

When inpatients are seen in consultation, it is essential that follow-up be provided during the hospitalization if further needs are anticipated. Under circumstances in which no further otolaryngologic care is anticipated, the access to further consultation should be clearly indicated in the chart so we can be consulted again if necessary.

Consults that are seen after hours or on the weekends should be discussed by phone with an attending when appropriate and signed out to the Consult service resident for continuity of care.

## **RESIDENT PROCEDURES**

One-on-one direct supervision by an experienced senior resident or surgeon is required for all invasive procedures performed by on-call residents or those on the consult service. Experience is defined as that documented in the resident procedure log for each procedure. Residents are not to perform these procedures without direct supervision until the book has been completed.

## MEDICAL RECORD PRIVACY

The third floor office in the Eye and Ear Institute (The Faculty Private Office) is a secure facility and is off limits to residents when closed. Do not enter the office when closed without faculty supervision.

### PRESCRIPTIONS

#### **A. Physicians Institutional DEA Number**

IMPORTANT POINTS TO REMEMBER:

- Not be used for writing for Schedule II drugs
- Prescriptions can be written using this DEA number for Schedule III, IV, V drugs only.
- This number is to be used to write prescriptions for PUH and MUH patients *only*. These prescriptions can be filled at any pharmacy.
- This number must be renewed *one year from date received*—you will keep the same number but must bring updated letter and medical license to G119 PUH to renew.
- Your four (4) digit number shall be used as a suffix at the end of the Hospitals DEA number (i.e. AP1698161- \_ \_ \_ \_)

#### **B. Prescription Writing:**

In accordance with Pennsylvania law regarding controlled substances, when writing a prescription for a controlled drug, the physician must issue the prescription for legitimate medical purposes. The prescription must bear the:

1. Full name and address of the patient.
2. The drug name, strength, dosage form, quantity prescribed and directions for use. The hospital also strongly suggests that the purpose for the medication be included on the prescription.
3. Physician's last name, printed, as well as the signature of the resident.
4. Hospital DEA number and the physician's specific identification code or the physician's DEA number.
5. Date

#### **C. Misuse of the DEA Numbers:**

Misuse of the DEA numbers includes, but is not limited to:

1. Using a hospital's specific DEA number to prescribe controlled substances to patients not followed within that hospital's system.
2. Prescribing excessive amounts of controlled substances to any patient, including the writing of an excessive number of prescriptions for an addicting or potentially harmful drug to a patient,

3. Prescribing controlled substances by a physician for his/her use or for the use of his/her immediate family,
4. Prescribing controlled substances by a physician for peers, nursing or hospital medical staff, or friends without clear documentation of a physician-patient relationship in the medical record.
5. Physicians may prescribe controlled substances only when the physician has a physician-patient relationship with that patient. This physician-patient relationship shall be clearly documented in the patient's medical record. The reason (i.e., diagnosis and plan of treatment) for each controlled substance prescription shall be documented in the medical record.

### **SUBMISSION OF MANUSCRIPTS AND ABSTRACTS**

Any contributions by residents to the scientific literature **MUST** be submitted for approval to the chairman and the program director **PRIOR** to submission of the final manuscript to the journal. The name of the journal to which the manuscript is being submitted must be indicated. This must be done whether the resident is the sole author or has co-authors on the faculty.

Residents who plan to present papers at scientific meetings outside of the department, must submit the final abstract to both the chairman and the program director **AT LEAST ONE WEEK** prior to submission. The abstract must be accompanied by the appropriate "*Abstract Submission Approval*" form, a copy of which can be found on the next page, which may be obtained from the Residency Coordinator. This must be done whether the resident is the sole author or has co-authors on the faculty. The abstract submission approval form must be signed by the faculty co-author prior to submission to the chairman and the program director.

### **ANNUAL OTOLARYNGOLOGY IN-SERVICE EXAMINATION AND HOME STUDY COURSE**

Participation in the Annual Otolaryngology Examination (AOE) and the Home Study Course Program is **MANDATORY**. The results of these examinations will be reviewed by the program director with each resident and will become part of the resident's permanent file.

It is recommended that all residents aspire to score above the 80th percentile on the AOE. Residents scoring less than the 50th percentile will be referred to the program director for educational counseling, which may include a mandatory "study hall" in lieu of surgery during the month prior to the AOE. Residents scoring between the 50th percentile and the 80th percentile will be advised that their study habits and techniques have fallen short of the ideal and must be improved.

Registration fees for these programs are supported by the Residents' Education Fund and are not the resident's responsibility. Failure to return the Home Study Course examination on-time will result in curtailment of clinical activities, that is, no hand-scored results are acceptable. Residents who fail to participate in this program will be billed.

## **RESIDENT EVALUATION PROCESS**

Appropriate faculty members within the department evaluate each resident at the end of every rotation. You should become familiar with these definitions as they are representative of the goals of the department for resident education.

The resident's evaluation will be shown to and discussed with the resident by the faculty member doing the evaluation. All evaluations are reviewed by the chairman and the program director and are discussed with the Department of Otolaryngology Residency Education Executive Committee. In the event that the resident's performance is not considered adequate in whole or in part, or there is a change in the resident's status, the program director will discuss this with the individual resident and the resident will be notified by letter of such change in status. The resident evaluation can be found attached to end of manual.

## **FACULTY EVALUATION PROCESS**

Each resident will have the opportunity to evaluate the teaching abilities of the faculty to which he/she is assigned. This evaluation provides the faculty member with feedback from the resident regarding the effectiveness of staff-resident interaction. These evaluations are maintained by the chairman and program director and are used as part of the teaching dossier when promotion is considered. Faculty evaluations will be utilized to assist in recommendations regarding promotion as well as in revising and strengthening the overall teaching program of the department. Each resident will be asked to provide a frank and honest evaluation of the program annually which will be treated **confidentially and anonymously**.

An example of the current faculty evaluation form is provide in attachment.

## **PROGRAM EVALUATION PROCESS**

The residents are asked to make a frank and honest evaluation of the program on an annual basis. This evaluation is conducted anonymously. We will ask that you return your evaluation form in an envelope which identifies the fact that you have responded. This will be used only to allow the secretarial staff to assure that every resident responds. These evaluations are used by the program director and faculty to evaluate the program on a regular basis.

We also need to have a rotation evaluation process after the completion of each rotation residents are asked to evaluate their experience on that rotation. These responses are used to evaluate the rotation in the context of the entire program. Each resident is asked to provide a frank and honest evaluation of that rotation. Suggestions for improvement are welcome. The program evaluation can be found at end of manual.

## **OPERATIVE REPORT**

Documentation of each individual resident's operative experience must be entered into the ACGME Web site so that it is available to the American Board of Otolaryngology, the program director, and the ACGME. The ACGME Residency Review Committee requires that the cumulative operative experience of each resident be reviewed at least **monthly** by the program director. Procedures must be entered at least weekly and will be monitored by the program director and the residency executive committee.

## **MALPRACTICE INSURANCE COVERAGE**

### *State Act III*

The University of Pittsburgh Medical Center hospitals are insured by Tri-Century Insurance Company. Residents rotating at the VAH will be covered by the VAH. Fellows, as a rule, are NOT covered at the VAH and may not take part in clinical meetings there.

## **GRIEVANCE AND APPEAL PROCEDURES**

A resident may file a grievance if a reasonable basis exists to support allegations that he/she has been treated contrary to existing policies governing the residency training program. A resident may appeal disciplinary, remedial or other actions which could result in dismissal or significantly threaten a resident's status in or ability to graduate from the program. Actions alleged to constitute a grievance shall be filed in writing with the program director. The program director will review the alleged grievance of the resident in a timely manner and gather additional information and/or consult with appropriate individuals in order to fairly render a determination concerning the alleged grievance. If the resident disagrees with the decision of the program director, the resident may request in writing such further review by the Associate Dean for Graduate Medical Education of the University of Pittsburgh School of Medicine whose decision shall be final. Actions alleged by a resident to constitute the basis for an appeal shall be presented to the program director in writing.

## **RESIDENT SELECTION PROCESS**

The Department of Otolaryngology participates with the National Resident Matching Program for selection of residents. All resident applicants must apply through the Match.

On or about October 1 of each year, a select group of faculty, selected by the Program Director and the Otolaryngology Residency Education Executive Committee, will review the applications of resident applicants. A subgroup will be selected for interviews.

The applicants to be interviewed will be invited to Pittsburgh to be interviewed and evaluated by a faculty and resident committee selected for the interview process. At the completion of the interviews, the committee will meet (including resident participants) to rank the order of all applicants for the Match.

## **RESIDENT PROMOTION AND DISMISSAL PROCESS**

Employment contracts are for one year. Renewal is contingent upon successful completion of the preceding year. Appropriate faculty members within the department evaluate each resident at the end of every rotation. The resident should become familiar with the evaluation form to understand the parameters of evaluation, as they are representative of the goals of the department for resident education. An example of the current evaluation forms for clinical and research rotations can be found on the following pages.

The faculty member doing the evaluation will discuss the resident's evaluation with the resident. The chairman, program director and Department of Otolaryngology Clinical Competency Committee subsequently review these evaluations. In the event that the resident's performance is not considered adequate in whole or in part, the resident will be notified in writing and performance deficiency will be discussed with the resident. Severely substandard performance may result in probation. Probationary status will be reviewed every 3 months. Failure to demonstrate improved performance may result in termination.

Egregious acts such as dishonesty or behavior that endangers patient safety may be the basis for immediate dismissal.

## I. PROBATION

### 1. Definitions

- a. Probation is the status applied to a resident identified as performing below an expected level for an individual at that stage of training. Unsatisfactory performance in any category of assessment of the Clinical Competency Committee Report, including character issues, clinical skills and knowledge deficit, can be the basis for possible probationary status.
- b. Probation with Notice of Termination indicates that dismissal from the residency program will occur at the end of the probationary period if sufficient improvement in performance has not occurred.
- c. A period of probation will be three months in duration.

### 2. Purpose

The goal of probation is to provide a learning environment that will allow the resident to focus on and improve deficient areas. To achieve this goal the following will be implemented.

- a. Written identification of areas of deficiency and expectations for improvement.
- b. Assignment of a special mentor.
- c. Monthly meetings of the resident and the Program Director to evaluate progress. Results of these meetings will be documented and forwarded to the Clinical Competency Committee.
- d. Additional didactic programs and individualized tutorials as determined by the Clinical Competency Committee.
- e. Residents facing notice of termination will be afforded a chance to address the Clinical Competency Committee.

### 3. Processes

A resident will be placed on Probation or Probation with Notice of Termination following review of applicable evaluations, test scores and comments regarding the given resident. A motion to that effect from a committee member will initiate the process and a second will lead to a vote of the committee. Probation will be initiated by a majority vote. Probation with Notice of Termination need not follow a standard period of probation. The resident's advisor will be asked to attend a committee meeting in which probation is being considered.

At the end of a three-month period of Probation the Clinical Competency Committee will examine evaluations, available test scores and relevant documentation. One of three actions will follow:

1. The resident will return to regular status.
2. The resident will be placed on an additional period of Probation.
3. The resident will be placed on Probation with Notice of Termination.

At the end of a three-month period of Probation with Notice of Termination one of three actions will follow:

1. The resident will return to regular status.
2. The resident will be placed on Probation.
3. The resident will be terminated.

### 4. Voting policy:

1. A quorum, consisting of at least two-thirds of the committee members, will be needed for a valid vote.
2. The Residency Director will be excluded from voting.
3. A simple majority will be required for action.
4. The resident will have the right to address the committee prior to a vote of termination.

## **ABSENTEEISM**

Unscheduled absenteeism must be reported to the Residency Coordinator as soon as the need to be absent is realized.

Arrangements for rotation coverage at such times are not the responsibility of the absent resident and will be handled and finalized through the Residency Coordinator in conjunction with the service chief.

### ***LEAVE OF ABSENCE/FAMILY MEDICAL LEAVE POLICY***

#### **I. POLICY:**

It is the policy of the University of Pittsburgh Medical Center Medical Education Program to provide unpaid leaves of absence (LOA) in accordance with the Family and Medical Leave Act (FMLA). Additionally, unpaid LOAs may be provided, when operationally reasonable, to qualified residents and fellows who have compelling reasons that are not within the scope of the FMLA for extended unpaid absence.

#### **II. DEFINITION:**

An LOA is an excused absence of more than two weeks. LOAs are generally unpaid, however, LOAs pursuant to the FMLA may entail some element of compensation. Compensation due to illness or accident is covered by other policies and practices.

#### **III. ELIGIBILITY AND COVERAGE**

All residents and fellows who have completed 12 months of employment and who have worked at least 1250 hours during the 12-month period are eligible to apply. Leaves covered by the FMLA shall be granted for up to 12 weeks in any 12-month period. The 12-month period includes the 12 months preceding the first day of the FMLA leave being requested by the resident or fellow. Other LOAs may be granted at the discretion of the program director and after the interests of both the resident or fellow and the program have been considered.

#### **IV. GUIDELINES FOR APPROVAL:**

##### *A. Family and Medical Leave Act LOAs*

1. Eligible residents or fellows shall be granted an unpaid LOA of up to 12 weeks in any 12 month pay year period for the: a) birth of a child; b) placement of a child for adoption or foster care; c) the need to care for a child, spouse or parent (not including in-laws) with a serious health condition; or d) a serious health condition which prohibits the resident or fellow from performing the essential functions of his or her position. The program director and executive director are responsible for tracking time counted as FMLA leave.

A serious medical condition is defined as an illness, injury, impairment, or physical or mental condition that involves:

- inpatient care in a hospital, hospice or residential medical care facility, or any subsequent treatment in connection with such inpatient care; or

- a period of incapacity of more than three consecutive calendar days and any subsequent treatment or period of incapacity that also involves either two or more treatments by a health care provider or one treatment followed by a regimen of continuing treatment such as prescription drugs or therapy requiring special equipment; or
  - any period of incapacity or treatment due to a chronic condition, even if that period is less than three consecutive days.
2. Leave for the birth of a child must conclude within 12 months of the birth or placement. Leave for health problems of the resident or fellow or specified relative may be taken intermittently at the discretion of the program director and where the program is not adversely impacted by the leave.
  3. In any case in which a husband and wife are both UPMCMEP residents or fellows and are entitled to leave under Section IV, parts A.1. (a), A.1. (b), or A.1.(c), the aggregate number of weeks to which they may be entitled may be limited to 12 work weeks in any 12 month pay year period, except in cases that pertain to caring for a sick child.
  4. Residents or fellows approved for leave under this section are required to first utilize all accrued sick leave, vacation time, personal holiday time, or short-term disability benefits, which may be compensable leave and shall be considered part of the FMLA leave.
  5. Upon return to work under the terms of this policy, the resident or fellow shall be restored to the former position or an equivalent position in his or her program with his or her former wage rate, benefits and other terms and conditions of employment. However, any resident or fellow granted leave shall be responsible for making up the leave time in terms of maintaining his or her satisfactory performance and program progression, as determined by the program director.

#### *B. Non-FMLA Leaves*

1. Reasons for which other LOAs may be granted include, but are not limited to: marriage, maternity, paternity, illness in the family, health or education. Other unpaid LOAs may be granted at the conclusion of a FMLA leave, at the program director's discretion.
2. A program director may not approve a LOA unless he or she is willing to hold a position open or otherwise guarantee (such as through turnover) a position in that program.
3. In all cases, the resident or fellow must return to the UPMCMEP's employ upon completion of the approved leave period or when the reason for which the leave has been granted no longer exists, whichever occurs first. A failure to return is considered a voluntary quit by the resident or fellow.

### **V. PROCEDURES:**

- A. The resident or fellow must submit a written request for leave of absence to the program director, stating the reason, the amount of time requested and the expected date of return to work. Where the need for leave is foreseeable, the resident or fellow must provide not less than 30 days notice before the leave is to begin. If circumstances require the leave to begin in less than 30 days, the resident or fellow must provide as much notice as is practicable. Failure to fulfill this requirement may result

in the denial or postponement of the LOA. The resident or fellow must make reasonable efforts to schedule planned medical treatment so as not to disrupt program operations. The resident or fellow is required to produce medical certification of the need for a FMLA leave prior to approval of the leave.

Upon approval of a FMLA LOA, the program director and executive director must furnish the resident or fellow with notification of the obligations surrounding the LOA and the consequences of a failure to meet these obligations. This notification must include: that the leave is counted against their annual FMLA leave entitlement; the necessity to submit medical certification; the requirement to substitute paid leave; the arrangements for payment of premiums to maintain health benefits and the consequences of nonpayment; the requirement to make up the leave time in terms of satisfactory performance and leave time in terms of program progression; the requirement for medical certification upon return to work, and the right to restoration of the same or an equivalent position upon return from leave.

- B. An unpaid LOA has the following effect on the resident or fellows benefits:
  - 1. Medical
    - a. Family and Medical Leave Act LOAs  
Any applicable UPMCMEP portion of the premium shall continue to be paid during a LOA pursuant to the FMLA.
  - 2. Other unpaid LOA
    - a. Residents or fellows wishing to continue their medical coverage during an unpaid leave of absence must exercise their COBRA option.
- C. Return to Program
  - 1. FMLA LOAs
    - a. Upon return from an approved FMLA LOA, the resident or fellow shall be reinstated to his or her former position by the program director and executive director pursuant to this policy.
  - 2. Other LOAs  
Upon return from an authorized LOA, the trainee shall be reinstated by the program director and administrative director to his or her former position, if it is available pursuant to this policy.
  - 3. A trainee returning to the program from a leave granted for medical reasons must be reinstated by the program director and administrative director after providing a written release (including an assessment of any limitations and/or accommodations necessary) from their physician.
- D. Record Keeping
  - 1. In compliance with the FMLA, all records pertaining to all LOAs are kept in trainee UHCP permanent files for a period of three years.

## ***VACATIONS/COURSES/MEETINGS***

Residents are entitled to receive three (3) weeks paid vacation. No more than one vacation week may be taken per rotation. One additional week can be taken for interviews, purchase of a home, practice start-up, etc. No vacations/courses will be granted in June.

Requests for time off for vacations, professional meetings and courses are best submitted at least six months in advance with the appropriate signatures. The program director should be the last signature obtained on the vacation/course request form (see next page for example). A separate form is available for each service and can be obtained from the Residency Coordinator.

Time off for vacations, meetings, and course requests will be granted only if service coverage is feasible. If multiple residents request the same time off, requests will be granted on a first-come, first-serve basis. For professional meetings, resident seniority is a major factor.

The requesting resident must arrange his/her own service coverage during their time away from the hospital. This is not the responsibility of the Chief Administrative Resident or the Residency Coordinator.

When choosing a course to attend, it is recommended that the choice be limited to those experiences that fill in gaps in the residency program. Once a course has been chosen by the resident, permission to attend the course must be granted by both the chairman and the program director.

Residents (PGY III, IV, V) are encouraged to attend a scientific meeting on an annual basis. Funding is provided (up to \$750/year) for approved courses. These CME monies are **not transferable and must be used during the year (carryover funds are not available)**.

Requests for vacation, meetings, and courses to be attended while assigned at CHP are best submitted and approved by July 31 of each year or as early as possible.

## **REIMBURSEMENT POLICY AND PROCEDURES**

### **Residents' Education Fund**

The Resident Education Fund was established in 1953 to provide support for the continuing educational endeavors of the residents from the Departments of Otolaryngology and Ophthalmology. From the principal, earned interest is divided according to the number of residents in each department on a quarterly basis. Otolaryngology's portion is deposited into the Residents' Education Fund which is managed by the Residency Coordinator and the Administrator of the respective departments.

### **Dues/Subscriptions**

The Residents' Education Fund supports subscriptions and memberships in the following.

- Resident Membership, American Academy of Otolaryngology-Head and Neck Surgery
- Annual Otolaryngology Examination
- Home Study Course Program
- Medical Training License Renewal

Any invoice the resident receives regarding the above mentioned, should be forwarded upon receipt to the Residency Coordinator for payment. If an invoice is received by the Residency Coordinator from the resident past the deadline, any late charges will be assumed by the resident.

The Resident Education Fund does not pay for:

- Unrestricted Medical License Application/Renewal
- Memberships or subscriptions not listed above
- DEA Application/Renewal

## Scientific Course Expenses

Allotments for reimbursement of reasonable expenses incurred as a result of **attendance** at a scientific course approved by the Program Director and the Chairman are as follows:

PGY-1	N/A
PGY-2	N/A
PGY -3	\$750.00 per resident
PGY- 4	\$750.00 per resident
PGY-5	\$750.00 per resident

The amounts listed above are the maximum amounts that can be spent by a resident for the fiscal year for attendance at a scientific course combination of two years funding is not permitted. All residents must follow reimbursement guidelines and procedures when utilizing their allotted monies.

## Scientific Presentation Expenses

Monies are available in the Residents' Education Fund for residents to attend scientific meetings on a competitive basis if the resident's abstract is accepted by the sponsor for presentation at meetings. Abstracts submitted for oral presentation but accepted for poster presentation will be funded on a case-by-case basis. Once an abstract has been presented and funded in the fiscal year, this paper cannot be presented at another meeting and funded by the Residents' Education Fund again.

When an abstract has been accepted for presentation, the resident must supply the Residency Coordinator with a copy of the acceptance letter.

**Travel and Business Expense forms must be processed by Accounts Payable within 180 days of travel or they will be rejected.**

**ORIGINAL** receipts for any and all airline tickets, hotel accommodations, automobile rentals, meals, etc. must be attached at the time of submission. Copies will only be accepted of the front and back of canceled personal checks. A credit card statement is not an acceptable receipt. Upon hotel check-out, you must obtain a print-out of your hotel bill. A credit card receipt will not be sufficient. If paying by cash, a receipt must be obtained verifying the cash transaction. All reports require the resident, the Residency Coordinator and the Administrator to approve the expenses prior to payment.

Reasonable expenses are defined below and are the only expenses that are eligible for reimbursement.

## Transportation

The department encourages residents to travel together to save transportation costs and to avoid rental vehicle fees. The type of transportation should be governed by the distance to be traveled, availability of public transportation, and the number of persons traveling together on the trip. However, please note that the combined costs of mileage, meals, hotels and incidental expenses may not exceed the cost of commercial transportation. If coach class airfare is less than the cost of driving a private automobile, coach class airfare is the maximum amount reimbursed unless prior administrative approval has been obtained.

## A. Privately-Owned Automobiles

If traveling in a privately owned automobile, the owner is reimbursed at the IRS standard mileage rate for the distance to/from his/her destination from/to his/her work location. This rate is inclusive of insurance, maintenance, fuel, etc. Expenses for repairs, collision damage, or other damage to the owner's car and any fines incurred are not reimbursable. If traveling with persons from another organization, that organization is expected to share the expenses proportionately.

## B. Rental Vehicles

1. Prior approval by employee's direct supervisor must be obtained for all vehicle rentals and the authorized UPMC travel agent must be consulted to make arrangements to obtain the best pricing. Enterprise Rental Car has a corporate contract with UPMC and should be used if possible.
2. Rental cars should be used when the nature of the trip is such that the use of local transportation, such as hotel shuttles and taxi's is not practical.
3. Rental car size must either be compact, if no more than two are traveling to the same destination, or midsize if three or more are traveling
4. Only collision insurance should be purchased; the UPMC maintains liability insurance coverage.
5. Rental cars should never be returned without a full tank of gas. The refueling charge provided by the car rental company can be as much as \$.50 per gallon higher than the gas station price.
6. The traveler is required to notify either the authorized UPMC travel agency or the car rental company directly if they do not intend to rent the car. Travelers will be held personally responsible for any no show fees assessed by the car rental company.

## C. Air Transportation

1. All airline reservations are to be made through the authorized UPMC travel agency or by the lowest available fare (Web, direct purchases, etc). Please contact Residency Coordinator for airline reservation information. All flights for domestic UPMC business must be coach class. If a non-refundable flight is purchased to contain costs, the staff member should notify the administrative representative of this in event of cancellation.
2. Employee members may participate in airline mileage programs but they must select the lowest applicable fare regardless of carrier or routing without regard to such

programs. Frequent flyer miles can be used to purchase a ticket for business travel if those miles were obtained for previous System paid business travel but no reimbursement will be given.

3. Travelers are requested to accept connecting flights (if available) within a 90-minute window of a desired direct flight departure/arrival time, if the savings realized by the UPMC is \$200 or more.

4. Fees resulting from lost or unused airline tickets are the responsibility of the traveler.

### **Accommodations**

Hotel accommodations will be reimbursed at the **single** room rate unless residents share a room. If a spouse accompanies the employee on the trip, the expense of the spouse will be the personal obligation of the resident. Hotel accommodations obtained while at the conference will not be reimbursed, unless approved by the Residency Coordinator.

### **Meals and Tips**

Reimbursement for business-related meals is based on the area to which the employee is traveling and should be kept to the Standard Meal Allowance. Meal expenditures must be supported by **ORIGINAL** receipts. Each resident should obtain their own receipt for their own meal. No group bills will be accepted.

Except for travel to major metropolitan cities, meals and all travel-related tips are reimbursed on a per diem basis at the rate of \$15 for travel days and \$30 for full days spent at the meeting or conference. Major metropolitan cities include:

Aspen	Orlando
Atlanta	Palm Beach
Baltimore	Philadelphia
Boston	Phoenix
Chicago	San Diego
Dallas	San Francisco
Detroit	Santa Fe
Las Vegas	Seattle
Los Angeles	St. Louis
Miami	Toronto
Minneapolis	Vail
New Orleans	Vancouver
New York	Washington, D.C.

Travel to these cities will be reimbursed at the rate of \$30 for travel days and \$60 for full days. Per diem rate is based on city where meeting or conference is held not flight destination. An employee may choose to be reimbursed at less than the per diem, but in those instances receipts should be maintained and submitted. If the per diem is used, meal receipts need not be retained or attached to the Travel and Business Expense Report. The per diem does not apply to meals purchased where traveling does not include at least one nights hotel stay. Meals purchased during the course of travel for normal business purposes where an overnight stay is not warranted are not reimbursable. Non-travel related meals should be submitted with receipts for approval prior to reimbursement. Travel related tips include, but are not limited to bellhops and room cleaning.

Tips for meals will be reimbursed at the maximum rate of 15%. If the tip reflected on your bill is higher than 15%, the overage will not be reimbursed.

### **Third Party Support**

If the resident's expenses are sponsored in part by a third party organization or individual, it must be so indicated on the authorization form. The Residency Coordinator will obtain written verification from the third party prior to the resident incurring any expense.

### **Miscellaneous**

This includes taxi and limousine fares, laundry, cleaning, and pressing charges (when travel extends beyond one week), and necessary business-related telephone calls. Non-reimbursable expenses include barber and/or beauty salon expenses, movies, bar/liquor bills, and any expenses incurred by an employee's spouse or guest.

## SEXUAL/RACIAL/ETHNIC HARASSMENT

### **I. Policy**

It is the policy of the University Health Center of Pittsburgh (UHCP) to strive to provide all graduate medical trainees, patients, and other persons with an environment that is free from sexual, racial, and ethnic harassment. Sexual, racial, and ethnic harassment violates UHCP policy as well as state, federal, and local laws and is not permitted or condoned.

### **II. Responsibility**

The Assistant Dean for Graduate Medical Education and the Training Program Directors shall be responsible for enforcement of this policy and shall issue procedures and operating instructions appropriate to its implementation.

### **III. Definitions**

- A. Sexual harassment includes but is not limited to unwelcome sexual advances, requests for sexual favors, and other verbal or physical contact of a sexual nature when:
1. submission to such conduct is either made or implied as a term or condition of employment;
  2. submission to or rejection of such conduct by an individual is used as the basis for employment decisions;
  3. the conduct has the purpose or effect of substantially interfering with an individual's work performance or creates a hostile or offensive work environment.
- B. Racial or ethnic slurs and other verbal or physical conduct relating to an individual's race constitute harassment when this conduct:
1. has the purpose or effect of creating an intimidating, hostile, or offensive working environment
  2. has the purpose or effect of unreasonably interfering with an individual's work performance; or
  3. otherwise adversely affects an individual's employment opportunities.

### **IV. Procedure**

- A. A graduate medical trainee, patient, or other person who believes he or she has been sexually, racially, or ethnically harassed in the UHCP is encouraged to promptly provide information regarding the matter to any one of the following individuals:
- the Assistant Dean for Graduate Medical Education or any Training Program Director;
  - the department head, clinical, nurse manager, or administrative representative of any UHCP hospital.
- B. The individual to whom a complaint of sexual, racial or ethnic harassment is made has the responsibility for reporting the complaint to the Assistant Dean for Graduate Medical Education.

- C. The Assistant Dean for Graduate Medical Education shall ensure that a thorough review is conducted. The Assistant Dean for Graduate Medical Education shall be responsible for ensuring that the review is coordinated with other involved or affected parties. The Assistant Dean for Graduate Medical Education shall then determine, in conjunction with the appropriate Training Program Director, what corrective action, if any, is appropriate to the situation.
- D. Action appropriate to the circumstances may range from reassignment of graduate medical trainee's mandatory educational efforts at a program level and/or attendance at external additional educational courses, and/or disciplinary action including written reprimand, suspension, or discharge.

## **ADDITIONAL POLICIES AND PROCEDURES**

### **I. Dress Code**

It is a policy of the Department of Otolaryngology that physicians should at all times present themselves to the public in a professional manner. This includes proper grooming and clean clothing. Surgical scrub suits should generally not be worn in the outpatient areas and always require concurrent use of a lab coat.

### **II. Policy on Personal Illness and Family Emergencies**

Personal illness and family emergencies that may arise which require temporary absence from the training program. All absences must be approved by the program director. Absences in excess of two weeks will be debited to the individual's vacation time.

### **III. Policy on Time off taken for Job/Fellowship Interviewing**

Interviews for job and fellowships arise which require time off from the training program. All time off taken must be requested and must be taken according to vacation time/conference time absences and must be approved by the service and the program director in advance. More than two days off in any one week must be debited to the individual's vacation time.

Total absences in excess of two weeks will be debited to the individual's vacation time.

### **IV. Policy on Time off taken during the research rotation**

Time off taken during the research rotation must be requested and must be taken according to vacation time/conference time. All absences must be approved by the research mentor and program director in advance.

## **REFERENCE AND ADDITIONAL GRADUATE MEDICAL EDUCATION INFORMATION**

To review policies and procedures outlined above or for more Graduate Medical Information please reference <http://spis.upmc.com/psd/home/GME/default.aspx>