LOYOLA UNIVERSITY MEDICAL CENTER

DEPARTMENT OF OTOLARYNGOLOGY
HEAD AND NECK SURGERY

STRITCH SCHOOL OF MEDICINE

2010-2011

RESIDENT HANDBOOK

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TABLE OF CONTENTS

Section 1	Introduction
Section 2	Mission Statement
Section 3	ACGME Competencies
Section 4	Faculty & Staff
Section 5	Residents
Section 6	Rotations
Section 7	Service Distribution
Section 8	Clinical Responsibilities
Section 9	Resident Responsibilities
Section 10	Education Program
Section 11	Academic Requirements & In-Service Exam
Section 12	Resident Research
Section 13	Evaluations
Section 14	Resident Supervision
Section 15	Duty Hours
Section 16	Resident Benefits-Travel and Reimbursement
Section 17	Scheduling for Chart Notes & Consults

INTRODUCTION

Welcome to the Department of Otolaryngology-Head and Neck Surgery at the Loyola University Medical Center. Congratulations on being selected into a unique and rewarding specialty. We believe you will find the training program rigorous but rewarding. The faculty of our department is committed to excellence in patient care, research-both clinical and basic sciences, and education. As a function of our educational mission, we remain committed to our program of post-graduate specialty training in Otolaryngology-Head and Neck Surgery. This Residency Handbook has been compiled to facilitate effective communication between the attending staff and the residents. We have outlined both the clinical and academic requirements, as well as, the educational opportunities we hope to provide. Our goal is to prevent misunderstanding and miscommunication by defining our expectations "up front". Please read this manual carefully. If there are questions or areas of conflict, please call them to the attention of the program director. We look forward to this academic year with great anticipation.

James A. Stankiewicz, M.D.
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Department of Otolaryngology-Head and Neck Surgery

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Professor
Residency Program Director

Kevin Welch, MD
Assistant Professor
Assistant Program Director

Lauren Nagle
Residency Program Coordinator

MISSION STATEMENT

- The Department of Otolaryngology-Head & Neck Surgery of the Loyola University Health System is committed to leadership in:
  - Compassionate, comprehensive, high-quality patient care for comprehensive preventative, diagnostic, and therapeutic services for adult and pediatric patients with disorders of the ears, nose and paranasal sinuses, neck, larynx, pharynx, and vocal tract
  - State-of-the-art biomedical and clinical research
  - Striving to form partnerships with our patients and their families to provide the highest quality, outcomes driven, and cost effective medical care.
  - Providing excellence in clinical care, state of the art biomedical research and technology, and a commitment to the education of our patients and their families, students and trainees, and the medical community in the greater Chicago metropolitan area.
  - In conjunction with our partners in the Loyola Neurosciences Service Line, we support multispecialty comprehensive treatment for patients with disorders of the cranial base, auditory and vestibular systems, cranial nerves, and spine.
  - Finally, as an integral component of the Loyola University Health System, we also serve the psychological, emotional, and spiritual needs of our patients

ACGME COMPETENCIES

The Department of Otolaryngology requires its residents to demonstrate progressive competence in the following six areas:

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

Residents will be evaluated on their progression in the ACGME competencies during their training using multiple assessment tools

OTOLARYNGOLOGY FACULTY &STAFF
ATTENDING SERVICE DISTRIBUTION

HEAD AND NECK #1 (RED SERVICE)
Richard Barrowdale, MD
Francis Ruggerio, MD
Kamil Muzaffar, MD
Gregory Matz, MD

HEAD AND NECK #2 (OTOLOGY/PEDS)(GOLD SERVICE)
Andrew Hotaling, MD
Sally McDonald, MD
Laura Rosenthal, MD
John Leonetti, MD
Sam Marzo, MD

HINES VA HOSPITAL
Carol Bier-Laning, MD (Chief)
Su-Min Kim, MD
Gregory Matz, MD
Kamil Muzaffar, MD
Kevin Welch, MD
Sam Marzo, MD

PLASTICS/RECONSTRUCTIVE/MICROVASCULAR
Raymond Konior, MD
Francis Ruggerio, MD
Richard Borrowdale, MD
Darl Vandevendar, MD

RESEARCH
Eileen Foecking, PhD
Keith Fargo, PhD
Carol Bier-Laning, MD
Sam Marzo, MD

SINUS/RHINOLOGY/ALLERGY

James Stankiewicz, MD
Kevin Welch, MD
Balitzar Espiritu, MD

VESTIBULAR/AUDIOLOGY
Michael Raffin, PhD

GENERAL CLINICAL RESPONSIBILITIES

The following are the Clinical Responsibilities for residents in the Department of Otolaryngology-Head and Neck Surgery at Loyola University Medical Center.

1) The residents will report to the hospital to which they are assigned early enough to make rounds and discharge patients prior to beginning assignments in the OR or Outpatient Clinics. Each resident has the responsibility for follow-up care and progress notes on the patient on the service to which they are assigned. If the resident is uncertain about the orders of disposition of a patient, contact the patient's attending physician for further instructions.

2) Residents must document all patient related activity in the electronic medical record (EPIC)

a. All patient contact, including follow-up phone calls, must be documented in EPIC. An event did not happy unless it is recorded in the patient's medical record.
b. Admission history and physical examination must be completed in EPIC when the patient is seen for preadmission testing. The patient should then be checked by the residents in the preoperative area on the day of surgery to sign the consent and to make sure any changes to the H&P are noted.
c. Postoperative notes are required on all patients.
d. Daily progress notes must include a problem list. If medical students are writing notes these MUST be reviewed and co-signed by a resident.
e. The Guidelines for Chart Notes are found at the conclusion of the Clinical Responsibilities section.
f. All inpatient operative consents should be checked for content by residents, not interns or students.

3) Residents are required to see on-service patients at least two times per day. Consult patients should be seen as often as necessary.

a. Daily Rounds
    1. All residents on the service must see each patient everyday, including on morning rounds. The chief resident may wish to split the team for more efficient data collection and work rounds, but the service must round as a group at least twice a day.
    2. Chief residents should be present for all dressing changes and should evaluate surgical wounds frequently.
    3. The daily progress note in EPIC should include a Problem List that summarizes all active surgical and non-surgical conditions for which the patient is receiving treatment.

b. Weekend/Holiday Rounds

1. A PGY-5 or PGY-4 resident must see every patient on weekends and holidays.
2. On the Hines VA service, one member of the Hines team must round on the patients on the weekends and holidays. If the Hines PGY-4 is not available to round then a Loyola chief resident must round at Hines.

c. Teaching Rounds

1. Attending staff physicians make their rounds at different times. The resident should make arrangements with the attendings about rounding together. The more personal contact between attending and residents, the greater degree of responsibility usually delegated to the resident.
2. Occasionally, a faculty member will make rounds on a particular service. This is an academic opportunity in which all residents should attempt to participate.

4) On-Call

a. Residents will prepare a rotation call schedule that is due three weeks prior to the beginning of the next month. The schedule is submitted to Lauren Nagle.

b. The call schedule is rotated so it is compliant with the requirements of the 80-hour work week.

c. While on-call, the residents are responsible for the inpatient adult and pediatric services at Loyola, Hines VA service, and the Emergency Rooms of both Loyola and Hines.

d. While on-call, residents may have to take calls from patients calling the Loyola Physician Answering Service.

e. Residents on-call will notify the chief resident on-call with problems as necessary. The Chief Resident or resident on-call will notify the patient's attending on-call attending as appropriate.

f. Pediatric cases should be referred to the Pediatrics Otolaryngologist on call or if not available to the adult attending on-call.

g. No transfers from other hospitals of unstable patients will be accepted without approval of the attending. All patients from other hospitals must be stabilized prior to transfer. Only an ENT attending physician can approve transfers of patients after it is cleared by the hospital.

h. Residents are responsible for making sure their pagers are working. Clinical Engineering is available if they are not.

i. The PGY-3 resident on the Head and Neck Service is to see all adult Otolaryngology consults throughout the day while the PGY-2 resident on the Otology/Pediatrics Service is to see all pediatric consults throughout the day. Depending on the nature of the consult, if the consult resident is off-campus or scrubbed in the Operating Room, he/she may call another resident on the service to see the consult.

j. Emergency (STAT) consults after 5:00pm are seen by the resident on-call. The following morning, they are then turned over to the appropriate adult or pediatric service. The on-call resident is NOT to "triage" consultations requested after 5:00pm to the following day. All request for Otolaryngology consults are to be seen in a timely fashion. Participation in surgical cases at night is NOT AN EXCUSE to delay seeing a patient. Chief residents are available for back-up in this situation.

5) Medical Student Teaching

a. Dr. Gregory Matz and Lauren Nagle coordinate the medical student and medical student rotations on the Otolaryngology-Head and Neck Service.
b. Residents are asked to provide students with practical instruction on physical examination and procedural techniques during daily activities; i.e. rounds, wards, operating rooms, and the outpatient center.
c. Residents will provide students with journal and textbooks references appropriate to each clinical case on the service.
d. Student evaluations/grades are prepared by Dr. Gregory Matz. Students will be evaluated based upon in-service and clinical observation, the Operating Room and a grand rounds presentation (for the 4-week student elective).

6) Operating Room

a. Outpatient surgery requires an attending present in the Operating Room prior to starting. Residents must be in close communication with attending regarding case start times.
b. Operative consents on the Inpatient Service, if not obtained at the patient's initial outpatient visit, <u>must</u> be obtained by a resident familiar with the surgical procedures to discuss adequately the procedure(s), risks, complications, and alternatives and their risks. Students and interns do <u>not</u> qualify.
c. The chief resident is responsible for assigning resident coverage for all cases taken to the Operating Rooms. (Loyola, Hines, Clinical sites)
d. Each patient is to be marked regarding site of surgery and sidedness. Marking should consist of side and initials. Midline surgery should be clearly noted in the chart. Bilateral surgery requires marking. The marking should be checked against the chart and the patient's own understanding of surgery and sidedness.
e. One resident is to appear in the Operating Room at least 15-30 minutes prior to the scheduled start of the case to supervise and facilitate patient care.
    I. Prior to the start of the case, the patient's biopsy report (if appropriate), audiology results, and imaging studies are to be displayed in the Operating Room.
    II. When appropriate, residents should reinforce with the Anesthesia service concerns regarding potential airway difficulties or the need for local tracheostomy.
f. A "time out" in the OR is required before the surgical incision can be performed. The attending performing the surgery is required to do the time out in person in the Operating Room. This is necessary to check that the correct patient receives the correct surgical procedure on the correct side.
g. In an emergency life-or-death situation, in which waiting for an attending to arrive at the Operating Room to perform a "time-out" and start the case would result in patient harm, injury, or death (such as an emergency surgical airway), the resident is allowed to start the case.

7) Outpatient Center and Satellite Clinics

a. In a surgical residency program, much of the learning occurs in the clinic. In the clinic, the residents learn how to accurately diagnose and treat patients medically and surgically. Residents are expected to attend clinic regularly with attending on their service.

b. Individual attending have different expectations for the resident in the Outpatient Clinic. It is the responsibility of the resident to discuss these expectations with the attending prior to clinic.
c. Appropriate attire is required when seeing patients in the Outpatient Center, such as a clean jacket, dress pants, shirt and tie. OR scrubs are not suitable for clinic.

8) Moonlighting

Residency training in Otolaryngology-Head and Neck Surgery at Loyola is a full-time occupation. Employment in a professional capacity outside the resident program is prohibited. Employment in such a capacity is sufficient grounds for immediate dismissal from the Residency Program.

9) Consultation Service

Drs. Matz, Muzaffar, Ruggiero and Welch will see adult consultations on a rotating basis. All consult patients must have a consultation note completed in EPIC in a timely fashion. Pediatric consults should be discussed with Dr. Hotaling, Dr Rosenthal, and/or Dr McDonald. . Consultations seen after 5pm, on weekends, or holidays should be discussed with the chief resident and attending on call.

RESIDENT SPECIFIC RESPONSIBILITIES

Loyola Chief Resident (PGY-5)

- Has read goals and objectives for the service
- Responsible for all clinical and patient care activities on the service.
- Receives and reviews information from junior residents.
- Charts notes on all patients admitted - on the day of admission.
- Charts preoperative notes on surgical patients.
- Keeps list of names and phone numbers of patient's relatives.
- Reviews all imaging studies.
- Identifies patients eligible for entrance into protocols or clinical trials.
- Evaluates recommendations of consulting services.
- Supervises all dressing changes and monitors all surgical wounds.
- Requests autopsies when instructed by attending.
- Prepares list of patients to be presented at Tumor Board.
- Assumes responsibility for room reservations and audiovisual equipment for Tumor Board.
- Maintains list of patients to be presented at monthly morbidity and mortality conference and supervises presentation of M&Ms in powerpoint format
- Make sure operative consents are appropriate to the case and re-enforced.
- Make sure patient is marked and ready for the O.R.

Hines Chief Resident (PGY-4)

- Has read goals and objectives for the service.
- Receives and reviews information from junior residents
- Examines all patients prior to surgery and assists in determining appropriate attending coverage
- Charts notes on all patients admitted - on the day of admission
- Charts preoperative notes on surgical patients
- Liaison with families throughout course of hospitalization and during out-of-hospital recovery period
- Keeps list of names and phone numbers of patient's relatives
- Reviews all imaging studies
- Identifies patients eligible for entrance into protocols or clinical trials
- Evaluates recommendations of consulting services
- Maintains list of patients to be presented at monthly M&M conference

- Supervises all dressing changes and monitors all surgical wounds
- Requests autopsies when instructed by attending
- Prepares a list of patients to be presented at Tumor Board
- Sends letters of condolence to all families of patients who have died
- Triage consults and assigns residents to see patient
- Attends monthly Surgery Staff Meeting at Hines VA
  (3rd Wednesday of each month 7:30-8:30)
- Follows patients undergoing adjuvant or neoadjuvant treatment programs
  (chemotherapy/radiotherapy) to assure continuity of care
- Responsible for seeing Hines chart work completed in a timely fashion by all residents
- Makes sure attendings preoperative note is on the chart PRIOR to surgery
- Makes sure attendings sign all charts following Monday morning attending rounds
- Make sure operative consents are appropriate to the case and re-enforced.

Loyola Resident (PGY-4)

- Has read goals and objectives for the service.
- Check rotation schedule and contact Chief Resident and/or Attending.
- Determine from Attending or Chief Resident what teaching materials are
  necessary for that rotation.
- Tracks all important laboratory and patient data appropriate to service.
- Makes a planned program of learning appropriate to each service.
- Uses appropriate educational materials to aid learning and expands data
  base.
- Develop and enhance communication skills.
- Performs all duties as assigned by Chief Resident and/or Attending at
  senior resident level of responsibility.

Hines Resident (PGY-3)

- Has read goals and objectives for the service.
- Determines duties and responsibilities of research rotation while on service.
- Performs duties as assigned by a Senior Resident
- Tracks all pathology reports, both inpatient and outpatient. Monitors results
  and status of all inpatient surgical cases with attention to status of surgical
  margins, pathologic status of the neck nodes, and presence of extra
  capsular nodal disease.

- Copies all cancer data into tumor registry (green) chart
- Follows chemotherapy, radiotherapy, and tracheotomy patients on the off service, monitors for toxicities or side effects of treatments. Arranges appropriate clinic follow-up when discharged from Hines.

Loyola Resident (PGY-3)

- Has read goals and objectives for the service.
- Checks rotation schedule and contacts chief resident and/or attending for rotation schedule.
- Determines from chief resident and/or attending what teaching materials, aids etc, which are necessary for that rotation.
  Performs duties as assigned by Chief Resident and/or attending
- Obtains a monthly schedule of the Consult Service attending physician schedule from Lynn Harris.
- Examines inpatient consults at LUMC from 7-5pm
- On call for LUMC Emergency Room Monday – Friday, 9:00 am –5:00 pm.
- Tracks all important lab testing important to service for appropriate serves and patient needs
- Determines duties and is responsibilities for research rotation while on service.
- Reads and/or obtains all available learning materials to create an appropriate data base.
- Fine-tunes communications skills.
- Follows patient during hospitalization as appropriate.

Loyola Red Service Junior Resident (PGY-2)

- Has read goals and objectives for the service.
- Performs duties as assigned by Chief Resident.
- Completes History and Physical examinations on all patients.
- Writes daily progress notes with problem list. If medical students are writing notes, these **MUST** be reviewed and cosigned by the resident.
- Obtain appropriate operative consent and marks patients for surgery.
- Learns communication skills.

Loyola Gold Service Junior Resident (PGY-2)

- Has read goals and objectives for the service.

- Performs duties as assigned by Chief Resident.
- Completes History and Physical examinations on all patients
- Writes daily progress notes with problem list. If medical students are writing notes, these **MUST** be reviewed and cosigned by the resident.
- Provide primary resident coverage for Pediatric Otolaryngology under the direction of Dr. Andrew Hotaling. This includes attending Dr. Hotaling's outpatient clinics, inpatient and outpatient surgical cases, and Pediatric Otolaryngology consultations.
- Obtain appropriate operative consent and marks patients for surgery.
- Learns communication skills.

Hines Service (PGY-2)

- Has read goals and objectives for the service.
- Determines and understands dates and responsibilities for service.
- Performs duties as assigned by Chief Resident.
- Tracks all laboratory data in each outpatient and inpatient
- Maintains appropriate records for each patient encounter.
- Applies appropriate diagnosis and treatment under direction by Attending and/or Chief Resident.
- Manages medical care of inpatients appropriate to clinical level.
- Develops and improves upon surgical skills.
- Develops communications skills.

Monthly Rotations during PGY-1 year

- Residents will rotate on Otolaryngology-Head and Neck Surgery #1 (RED) Service for 3 separate months during the PGY-1 year.
- Residents report to the chief resident
- Residents will complete history and physicals, obtain surgical consents, help see consults, and scrub in and participate in selected cases
- Residents on other month-long rotations (ex Burns, Critical Care, Gen Surgery) should report the respective chief resident
  Goals and objectives should be reviewed during the rotation

Individual Rotations (i.e. Laryngeal, Sinus, Otology, Plastic, etc.)

- History and Physicals
- Inpatient Care
- Outpatient Clinic Attendance
- Inpatient and Outpatient Surgery
- Appropriate Educational Materials
- Inpatient operative consents and marking of patient's.

EDUCATION PROGRAM

Residents are expected to continue a year round program of self-directed education. This includes reading textbooks, Self-Instruction Packages and Monographs, scientific and clinical journals, completing the Home Study Course (see section on Home Study Course and In-Service Examination), and completing the computerized Patient of the Month Program.

The Department of Otolaryngology-Head and Neck Surgery also coordinates an academic conference schedule. Attendings and residents alternate conferences covering the clinical side of Otolaryngology – Head and Neck Surgery. The departmental academic teaching day is Wednesday, and the schedule is as follows:

Grand Rounds

6:30-7:30 a.m.	Grand Rounds Conference Room Bldg. 105, Rm. 2826	WEDNESDAY

Attendings and residents alternate conferences covering the clinical side of Otolaryngology – Head and Neck Surgery.

M&M
6:30-7:30 AM – monthly – last Wednesday of each month

At these conferences, residents present interesting clinical cases with questions moderated by the attending staff. Topics are mainly pediatric otolaryngology, otology/neurotology, facial plastic and reconstructive surgery, and trauma.

Multidisciplinary Tumor Board

7:30-9:00 AM.	Multidisciplinary Tumor Board Conference Room Bldg. 105, Rm. 2826	WEDNESDAY

This conference is attended by staff of the Departments of Otolaryngology-Head and Neck Surgery, Oral and Maxillofacial Surgery, Radiation Oncology, and Medical Oncology. Patients are presented prospectively and an appropriate treatment program is developed for each patient. Resident planned lectures, local guest speakers, and visiting speakers will also be presented at this conference.

Basic Science Resident Education Lecture

4:00 - 6:00 P.M.	Resident Education Conference Otolaryngology Conference Room Bldg. 105, Rm. 1870	MONDAY

This is the primary departmental basic science educational conference. The new Monday format is two hour series of lectures on topics within Otolaryngology-Head and Neck Surgery or related disciplines. The conference may also take the format of Journal Club, Pathology, or Radiology with selected readings assigned to the residents. Lectures from other departments will be scheduled to provide their expertise as well. Basic science lectures and discussion along with clinical relevance are discussed.

The conference schedule is distributed at the beginning of each Academic year. Much of the material presented at these conferences is selected based on the In-Service and Board Examinations, therefore attendance at these conferences in mandatory.

The conference schedule is coordinated by the Residency Program Director.

Journal Club

6:00 – 7:30 A.M.	Resident Education Conference Conference Room Bldg. 105, Rm. 2826	Wednesday

This conference is attended by Otolaryngology residents and staff. This conference is dedicated to review of recent and historical articles in the literature.

Temporal Bone Dissection Lab

3:00 – 5:00 P.M.	Resident Education Conference Temporal Bone Lab Bldg. 105, Rm. 1870	Tuesday Oct - March

ACADEMIC REQUIREMENTS

The following are the Academic Requirements for residents in Otolaryngology-Head and Neck Surgery at the Loyola University Medical Center:

1. Residents are encouraged to prepare one scientific publication per year which will be submitted to a peer- reviewed journal.*

2. Residents shall submit one project for presentation at a national meeting every year.

3. Residents will submit a paper for presentation at the Chicago Laryngological and Otological Society meeting in April-May via the Girgis Competition. Papers will be presented at the Girgis Competition preceding the CL & O and selected paper entered in the CL & O Competition.

4. Residents will present departmental Grand Rounds in Otolaryngology-Head and Neck Surgery once per academic year. The lecture date and topic date will be assigned by the residency program director. The topic has to be coordinated with the overall clinical lecture program.

5. At times during the year, senior residents may be asked to present additional Grand Rounds Lectures.

6. All residents will participate in ongoing departmental clinical and basic sciences research programs. Resident research is under the direction of Dr. Eileen Foecking. Additional requirements for resident research projects are detailed in the section entitled "Resident Research".

7. All Residents will submit an individual research project (not a case report) for presentation at the Peter Girgis Resident Research Competition as noted above.

8. All residents will take the Home Study Course and Annual Otolaryngology In-Service Examination every year. Residents are expected to score at or better than the 50th percentile for their respective year. Failure to achieve this score may result in the resident being placed on academic probation.

9. Residents will be evaluated by the faculty. The Chairman and Program Director will review these evaluations with the resident. Specific concerns may be reviewed on an individual basis.

10. The R3 on the research rotation must plan a project before the rotation starts. In addition, a research paper must be developed, written, and published from the research rotation prior to graduation. No resident will be allowed to take the boards without completing the criteria.

RESIDENT LEARNING PORTFOLIO

In order to stay organized and assimilate the necessary knowledge to obtain and remain board certified, each resident is required to build and maintain a learning portfolio. In an effort to limit unnecessary paperfiles and to speed communication, most of the learning materials provided during your training will be distributed electronically. Furthermore, you will be required to write and present articles and presentations during M&M as well as during your grand rounds presentations. Residents should keep track of these documents in electronic format such as a laptop computer, desktop computer, or backup drive. Residents should also maintain a current curriculum vitae listing their educational background, accomplishments, presentations, meetings attended, awards, presentations, etc.

RESIDENT SEMIANNUAL REVIEW

Each resident will have the opportunity to meet with the program director twice a year to review their performance and set goals for the upcoming year. Residents should send an updated copy of their curriculum vitae to the program director before this meeting.

EVALUATION SYSTEM

The Department primarily uses the E-value electronic system to evaluate residents in their progression in the ACGME competencies. Evaluations are performed by attending, staff, nurses, etc regularly and compiled by the program coordinator. The purpose of the evaluations is to ensure adequate progression in the ACGME competencies and to provide the residents feedback. Most of the evaluations utilize a 5-point Likert scale.

Residents also have the opportunity to evaluate the program and individual faculty yearly

PERFORMANCE IMPROVEMENT PROGRAM/PROBATION/DISMISSAL

Our goal in the department is for each resident to achieve competence in the ACGME competencies and to develop the skills and strategies necessary to master the information necessary for a successful Otolaryngology career. At times it may be necessary, based on below average performance, for a resident to be placed in a performance improvement program. This program will be devised and supervised by the program director. Residents not showing progress in this program will be placed on probation and may be dismissed if the terms of probation are not followed/completed.

RESIDENT SURGICAL CASE LOGS

Residents are required to maintain their surgical case logs weekly. All surgical procedures including complex laceration repair in the emergency department are to be documented. Residents will review their case logs with the program director at their semiannual review. Residents should document each surgical case in which they participate as surgeon or assistant.

ANNUAL OTOLARYNGOLOGY IN-SERVICE EXAMINATION AND THE HOME STUDY COURSE

Participation of the Annual Otolaryngology In-Service Examination and Home Study Course Program is MANDATORY for residents in the PGY-2 thru PGY-5 years. The results of these examinations are reviewed by the Program Director and become part of the resident's permanent file. The in-service examination occurs in the spring of each year, typically in March or April, usually on a Saturday. The scores on the in-service examination are a very good predictor of success on the Otolaryngology Board Exam, which the graduating resident takes the year after his graduation.

Residents must show progressive improvement in their annual inservice scores. Residents must score better than the 50th percentile both for their group and individual years. Those scoring less than the 50th percentile or now showing a steady improvement in their scores will meet with program director and devise a learning program designed to address educational deficiencies.

The Department pays registration and scoring fees for the Home Study Course and In-Service Examination. Failure to return the Home Study Course in time for the computer scoring will result in curtailment of clinical activities. Residents who fail to participate in the Home Study Course will have the fee automatically deducted from their educational stipend.

RESIDENT RESEARCH

A. A Research Rotation is a component of the second year of Otolaryngology-Head and Neck Surgery Training (PGY3). The Resident Research Program is under the direction of Dr. Eileen Foecking, Dr. Carol Bier-Laning, and Dr. Sam Marzo.

1. During the period of July to September of the PGY2 year, the name of the faculty member the resident has identified as the Research Advisor should be forwarded to Dr. Bier-Laning. The resident should submit a written commitment of the faculty sponsor and a brief abstract of the research project.

2. Six months prior to beginning the PGY 3 year, the resident must submit a written 2 page research proposal to Dr. Bier-Laning (see following pages). This must include a review of the literature and rationale, a detailed research plan including experimental methods and statistics, and a budget. The sponsoring faculty member must approve this proposal. NOTE: Animal research projects require approval of the University Committee on Animals in Research. The University Committee must approve a detailed form outlining the project. Approval by this committee takes in excess of 2-3 months. The resident MUST begin the process early.

3. All basic science and animal studies MUST be approved by the research committee-Dr. Eileen Foecking, Dr. Carol Bier-Laning, and Dr. Sam Marzo.

4. Half way through the research rotation, the resident must meet with their research mentor to give a research Progress Report.

5. By 6 months after the completion of the research rotation, a written Research Summary must be submitted to their research mentor. If the project has not been completed, the timetable and mechanisms for completing the project must also be presented.

6. **FAILURE TO FOLLOW THE ABOVE TIMETABLE GUIDELINES OR FAILURE TO OBTAIN APPROVAL BY THE UNIVERSITY INSTITUTIONAL REVIEW BOARD WILL MOST LIKELY RESULT IN LOSS OF THE RESEARCH SLOT. THE RESIDENT WILL THEN BE ASSIGNED TO A CLINICAL SERVICE.**

B. Additionally, PGY 2, 3, 4, and 5 residents participate in ongoing research projects throughout the academic year with faculty members. The projects culminate in a research presentation at the yearly Peter Girgis Resident Research Competition.

2-page outline for PGY-3 basic research rotation

Specific Aims

This should include a brief **rationale**, leading to the **hypothesis** and **specific aim(s).**

Background and review of the literature

Include only the most pertinent (less than 10) papers on your topic

Experimental methods and statistics

List these for each specific aim if there is more than one

Budget

Status of approval by the Institutional Animal Care Use Committee (for experiments involving animals) and/or Institutional Review Board (for experiments involving any type of human research including use of blood or tissue)

Bibliography

*An example of a Basic Science Research proposal has been enclosed.

STANDARDIZED ABSTRACT for Girgis

Title
Objectives
Study design (retrospective observational, prospective observational, prospective randomized experimental)
Methods
Results
Conclusion

300 word limit including title

LOYOLA UNIVERSITY OF CHICAGO STRITCH SCHOOL OF MEDICINE OFFICE OF RESEARCH SERVICES GUIDELINES FOR AUTHORSHIP

Authorship on manuscripts should be granted to those individual(s) who are responsible for and knowledgeable about the reported research. It is usually limited to the person or people who made significant contributions to the work. These contributions include: a) conception and research design, b) data collection and analysis, and c) preparation, revision and/or approval of the manuscript. There is, however, some disagreement regarding the level of contribution required for authorship. The Uniform Requirements for Manuscripts Submitted to Biomedical Journals, established by the International Committee of Medical Journal Editors (ICMJE), sets relatively high standards. It indicates that all authors should play a role in:

1. Drafting or revising the manuscript AND
2. Approving the final manuscript AND
3. Conception/design of the study or data acquisition OR
4. Data analysis and interpretation.

ICMJE standards indicate that authorship is not justified solely by acquisition of funding, data collection OR supervision of the research group. Other groups are not as restrictive in their requirements, and the exact guidelines used to determine authorship vary widely among disciplines, research groups and laboratories. Thus, the final decision about authorship is best made collectively by those individuals involved in the study, and this decision should be made early in the study. People who were involved in the study, but who do not qualify for authorship, should be acknowledged in the manuscript. Decisions regarding the order of listed authorship are also best made collectively by individuals involved in the study. Order is often listed by the importance in the study. However, those individuals listed as first or last (or senior) author are usually perceived as having major roles. Some journals have specific rules for listing authors. In addition, many journals require identification of a corresponding author. This individual should be able to assume responsibility for the accuracy of the data, the selection of authors, approval of the final manuscript and handling of all correspondence. The corresponding or senior author should insure that all deserving individuals are included in the list of authors.

Scientific misconduct is broadly defined as fabrication, falsification, plagiarism, etc. in proposing, conducting or reporting research. Issues regarding inappropriate authorship fall within this definition. Concerns regarding authorship should be reported to the Senior Associate Dean for Research.

EVALUATION/RESIDENT SUPERVISION PLAN

1. All residents are supervised at every level of training by attending physicians, senior residents, staff audiologists, and speech therapists.

2. Every surgical procedure that is done is observed by an attending physician.

3. Academic work is approved and supervised by the residency program director.

4. Clinical work is evaluated and supervised by individual attending physicians on whose service the resident is rotating.

5. Outcome measures as to how each resident is progressing in the 6 ACGME competencies will include the following:

   A. Faculty Evaluation of Resident.
   B. Resident Evaluation of Faculty.
   C. Resident evaluation of program.
   D. 360^0 evaluation by ancillary staff.
   E. Research Rotation Evaluation of Resident.
   F. Inservice Exam (annual)
   G. Quarterly meeting with residents.
   H. Performance on the American Board of Otolaryngology (ABO) examination of finishing chief residents.
   I. Final GME Training form to be completed by Chief Residents.

6. The Department of Otolaryngology Head Neck Surgery abides by ACGME policy recommendations regarding resident duty hours. This policy shall include the following:

   1. No every-other-night calls. Calls to be taken only every third night or less.
   2. No on-call coed sleeping rooms.
   3. No service will be left with only one resident.
   4. A junior resident will always have a senior resident and an attending physician as back up when on-call.
   5. Eighty hour work week or less.
   6. One day in seven off per week.
   7. 18 hour period between call and the next work day.

DEPARTMENT OF OTOLARYNGOLOGY
HEAD AND NECK SURGERY
POLICY FOR DUTY/ON CALL HOURS

The educational goals of the Department of Otolaryngology-Head and Neck Surgery and the learning objectives of the residents in the program will not be compromised by excessive reliance on residents to fulfill the institutional service obligations. Duty hours, however, will reflect the fact that responsibilities for continuing patient care are not automatically discharged at specific times. The Department will ensure that residents are provided backup support when patient care responsibilities are particularly difficult or prolonged.

The Department of Otolaryngology-Head and Neck Surgery abides by the ACGME policy recommendations regarding resident duty hours. This policy includes the following:

1) Residents must not be scheduled for more than 80 duty hours per week, averaged over a four-week period. Call is divided between in house call (PGY 2 and PGY 3) and home call (PGY 5). Hours are reviewed weekly by the Program Director using time cards.

2) One day in seven free of patient care responsibilities, averaged over a four-week period.

3) Call no more frequently than every third night, averaged over a four-week period.

4) A 24 hour limit on call duty, with an added period of up to 6 hours for inpatient and outpatient continuity and transfer of care, educational debriefing and didactic activities; no new patients may be accepted after 24 hours. Service call ends at 7:00am. If not academic session exists, residents will be excused for the day. Otherwise, a resident will be excused no later than 1:00pm.

5) A 10 hour minimum rest period should be provided between duty periods. Each resident will be made aware of the necessity to have a minimal 10 hour period between daily periods. In essence, they have to be out of the hospital by 7:30pm and not return until 5:30am the next morning. This is monitored individually by the Program Director.

6) Continuous in house duty with need of separation from service after call: an additional 6 hours for academic purposes is understood as necessary.

7) When residents take call from home and are called into the hospital, the time spent in the hospital must be counted towards the weekly duty hour limit.

8) Moonlighting is not allowed in the Department of Otolaryngology-Head and Neck Surgery.

The Program Director and faculty are sensitive of the need for timely provision of confidential counseling and psychological support services to residents. Training situations that produces undesirable stress on residents will be evaluated and modified.

The Department will ensure that resident performance is not impaired by excessive fatigue caused by program duties or other activities. The ration of hours work to on-call time will vary, particularly at the senior levels. In all cases, the ACGME duty hour policies will be upheld.

All attending physicians will provide coverage for residents during duty hours. This includes supervision in operating rooms, clinics, consultations, and calls.

9) Each resident is given a weekly time card. This time card is filled out by each resident weekly and turned in for review by the Program Director. Any resident felt to not be in compliance with duty hour restrictions averaged over 4 weeks will be informed and their schedule will be modified.

EMPLOYEE NAME:

ROTATION:

BEGINNING DATE: ENDING DATE:

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INDICATE DAY OF WEEK	TIME IN	TIME OUT	TOTAL REGULAR HOURS	TOTAL OVERTIME HOURS (>80)	TIME LEFT HOSPITAL AFTER OVER NIGHT CALL
Sunday (/ /)					
Monday (/ /)					
Tuesday (/ /)					
Wednesday (/ /)					
Thursday (/ /)					
Friday (/ /)					
Saturday (/ /)					
Weekly Total					

Resident Signature: Program Director/Chairman Signature

RESIDENT BENEFITS

A. Vacation

The academic calendar extends from 7/1 to 6/30 for all residents. Residents are allowed three weeks vacation.

1. All vacations, courses, and meetings must be approved at least one month in advance by the Residency Program Director. Residents must submit a Request for Leave to their Chief Resident for approval. Chief Residents interviewing for employment or Fellowship positions should provide as much advanced notice as possible and arrange coverage by another Chief Resident. Please send all requests for vacation electronically to Dr. Sam Marzo and Lauren Nagle.

2. Only one resident may be on vacation from one service at a time.

3. No resident may take two weeks of vacation in the same month.

4. The Mission Trip must be used as a week of vacation.

B. Educational Policy Update for Travel Reimbursement

This policy covers expenditures for faculty, residents and staff traveling to further the educational, research and service mission of the department of Otolaryngology, when the source of the funds is University, Research and Education funds. Grants, restricted and designated funds may have different policies toward travel and business expenditures. The more restricted policy will prevail. It is the responsibility of the traveler to understand the restrictions

PRIOR APPROVALS

- All travel must be in the continental United States
- All residents must have approved educational leave by the Program Director
- It is the traveling individual's responsibility to assure that this prior approval is obtained
- Car rental is generally not reimbursed and only if approved in advanced by the Chairman. When approved the corporate policy applies.

SCOPE OF COVERAGE

The Department covers registration costs of the following courses, and their cost are not deducted from the annual stipend.

PGY 1 ATLS Course
PGY 2 Indiana University Anatomy Course Registration Fee
PGY 5 ATLS Course Refresher
ACLS and BLS

The Department allows travel to the following meeting and courses.
PGY 2 Indiana University Anatomy Course
American Academy of Otolaryngology Head and Neck Surgery Annual Meeting
COSM
Middle Section Meeting

AIR TRAVEL

The University will reimburse coach class fares only. Any upgrades are considered personal expenses and not reimbursable.

Effort must be made to purchase the lowest fare possible.

Airfare purchased in a package with lodging is not reimbursable.

Reimbursement

- An original airline ticket stub, E-ticket or itinerary showing evidence of payment is accepted as proof of payment for reimbursement.
- Boarding passes must be included as proof of travel for reimbursement.
- A charge card statement alone is not sufficient for reimbursement.

- Airfare purchased in a package including lodging is not reimbursable.

LODGING

Modestly priced accommodations are reimbursed. For meetings or seminars, reimbursement will be for the price of a mid-range single occupancy at the host hotel.

Residents of the same gender are expected to share a room when possible. For residents who choose not to share a room, one half of the room is reimbursed.

Reimbursement

- A detailed hotel statement and or detailed receipts are necessary for lodging reimbursement.
- Lodging purchased in a package with airfare is not reimbursable.
- Lodging without a detailed statement is not reimbursable.
- A charge card statement alone is not sufficient for reimbursement.

REGISTRATION

Registration for conferences and meetings can be purchased in advance using department credit card.

Reimbursement

- A detailed receipt is necessary for registration reimbursement.

GROUND TRANSPORTATION

The most economical form of public ground transportation should be used to and from airports.

Reimbursement

- Reimbursement for ground transportation is limited to $75 per leg of travel and limited to four legs per trip.
  - From home to the airport
  - From the airport to the hotel
  - From the hotel to the airport
  - From the airport to home

MEALS

There is no meal allowance entitlement for travel of 10 hours or less within the same calendar day. When the travel period is more than 10 hours but less than 24 hours, you may claim expenses for those meals for which you were not at home.
For activities involving overnight lodging meals are covered by the department at the per diem rate of

$9.00 Breakfast

$11.00 Lunch

$25.00 Dinner

When meals are covered by the registration of the event no per diem applies.

SUBMISSION OF TRAVEL/EXPENSE REPORT

Individuals must submit their Travel/Expense Report to Accounts Payable **within 30 days** of end of travel to Lauren Nagle. Travel/Expense Reports must be signed by the employee and approved prior to submission.

Retroactive reimbursement from PGY Year to PGY Year is prohibited. Carrying over funds not used during your current PGY Year will not be carried over into the next Academic Year

ANNUAL LIMITS

The Expense report limit for each resident is limited to the following amount for the department.

PGY 1 $750.00
PGY 2 $3250 (Includes Anatomy Course Registration)
PGY 3: $2000
PGY 4 $2000
PGY5 $2000

Deviation from the policy requires prior approval from the Program Director

C. Presentation Materials

1. Residents are required to type via computer word processing, first drafts of all manuscripts. If time is available and at the discretion of the attending co-author, the attending's secretary *may* be available for manuscript revisions.

D. Miscellaneous Benefits

To facilitate resident education, the Department will provide each resident with the following materials:

1. Resident membership in the American Academy of Otolaryngology-Head and Neck Surgery. This membership includes the subscription *to* Otolaryngology-Head and Neck Surgery.

2. Membership and dinner at the Chicago Laryngological and Otological Society. This will be reimbursed after the dinner date and receipt is submitted.

3. The Home Study Course of the American Academy of Otolaryngology-Head and Neck Surgery.

4. Annual Otolaryngology In-Service Examination.

5. Three white laboratory coats with laundry.

Other dues, memberships, books, and travel will be at the resident's expense.

CONFLICT OF INTEREST POLICY

Any gifts accepted by residents individually should entail a benefit to patients and should not be of substantial value. Accordingly, textbooks and other gifts, which serve a genuine educational function, are appropriate. Cash payments should not be accepted.

Individual gifts of minimal value are permissible as long as the gifts are related to the resident's work (i.e., pens, notepads etc.)

Subsidies to underwrite costs of departmental resident conferences or professional meetings can contribute to the improvement of patient care and are therefore permissible. Since the giving of a gift directly to a resident by a company sales representative creates a relationship, which could influence the use of the companies product. The Departmental Administrator will accept subsidies. The office staff will coordinate the schedule of sponsorship on the Wednesday afternoon conferences. 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 with strings attached. For example, residents should not accept gifts in relation to a resident's prescribing practices. In addition, when companies underwrite conferences or lectures other than their own, responsibility for selection of content, faculty, and educational methods and materials should belong to the organizers of the conference or lectures who should act independently.

<u>GUIDELINES FOR CHART NOTES ON EPIC</u>
(Electronic Medical Record)

1.) Admission H & P – On chart day of admission – Not “see dictation”, COMPLETE ROS, PMH, PE. Important for DRG’s and patient care. (PAP smear, contraindications to steroids. AIDS risk factors, handedness, occupation, etc.)
Completed on <u>all</u> patients within 24 hours of admission – even those not going to OR – as data collection point.

2.) Preoperative Note – Including off-service patients

3.) Diagnosis – (Including off-service patients.

Diagnosis – (Including tumor stage/site)
Planned procedure:

Labs: ------< --/--/-< SMAC: /A:

CxR –
EXG –
TxM –
Anesthesia History –
Permit –
(Unit bed) –
Precautions/Abnormalities (patient or lab data):

Informed consent – note on chart lists complications mentioned to patient.
Examples: All: Bleeding, infection
Tracheotomy – pneumothorax requiring chest tube
Panendoscopy/esophagoscopy – Esophageal perforation with possible serious perforation chest infection
Laser – Facial burn, fire
Neck Surgery – neck dissection: Lip, shoulder, tongue weakness, (Horner’s) – open neck biopsy, related to location of mass
Operation entering alimentary tract - fistula
Parotid VII, ear numbness
Submandibular gland excision lip asymmetry ear surgery hearing loss,
Dizziness, VII paresis/paralysis (permanent or temporary possible requiring additional procedures)

4.) Operative Note -
Procedure –
Findings – (What was taken, what was saved, frozen section status, gross residual disease, etc.)
Surgeons –
EBL –
Fluids – Crystalloid –
Blood
Drains –
Complications –
Length of procedure –
Antibiotics/steroids given 0

5.) Consultation Service
Full head and neck history and physical
Endoscopy as necessary – describe results
Patient name, medical record number, and referring physician name, data.
Assessment Plan
IMPORTANT! Leave room for attending note. If not, use another sheet.

6.) Dictation of Operative Report – Include FINDINGS SECTION between short history and detailed procedure:
Should tell what was done ex: Jaw neck dissection (swing hemi/inner table
Mandibulectomy, segmental or margins resection); modified or radical neck dissection – SCM, IJV, status, partial laryngectomy was arytenoid taken, reconstruction of any.

Mention status of disease found – Location and character nodes, gross disease removed or left, frozen sections done and results, carotid “peel”, etc.

Complications.

7.) Postoperative check -
Mental status –
VS
CxR – no PTX, etc.
Drain function –

Assessment – Satisfactory p.o. course vs. complications.

8.) Postoperative daily note – Number day: e.g. POD #5 see attached memo

Mental status
VS BP max, etc.
Auscultation of lungs, abdomen –
1/O x 24 hr. with u.o. rate. Intake – record p.o. and IV separately
Drain output – 24 hour total for each
Would "Flaps down", etc.
Day of Antibiotics –
Impression – Satisfactory vs. problems
Plan for advancing diet, ambulation, etc.
List other meds. – (See attached memo) drug levels where appropriate

9.) Clinic follow-up note – Cancer patients – Monthly visits for 2 years
Every 2 months third year
Every 3 months fourth year
every 4 months fifth year
Every 6 months after fifth year

Include year in date of note

EAC/TMs
Nose
NP (Nasopharynx)
OC/OP (oral cavity, oropharynx)
LX/HP (larynx/hypopharynx) –
Neck
BOT/FOM (palpation) (base of tongue, floor of mouth)

10.) Abbreviations: Medication name and dosages have to be clearly written and numbered. Examples: c & s no longer are used. Write "with" or "without":.

1 cc is written 1cc.
.1cc is written 0.1cc.

If any question of understanding write out order. Instead of "u gm" write "in urogram".
Mgm = Milligr