# TABLE OF CONTENTS

PREFACE ................................................................................................................................. 4

Oath of Hippocrates .................................................................................................................. 4

1.  INTRODUCTION & ACADEMIC MISSION OF THE PROGRAM ....................................... 5

2.  EDUCATIONAL PROGRAM: TEACHING PHILOSOPHY, ACGME CORE COMPETENCIES, & SPECIALTY GOALS .......................................................................................................................... 7

3.  GENERAL OBJECTIVES & RESIDENT EVALUATION PARAMETERS (COMMON TO ALL CLINICAL SERVICES) ..................................................................................................................... 13

4.  CLINICAL COMPONENTS OF OTOLARYGOLOGY-HEAD AND NECK SURGERY ............. 16

5.  CLINICAL SERVICES: EDUCATIONAL GOALS & EVALUATION PARAMETERS FOR EACH ROTATION ................................................................................................................................. 17

   PGY-1 OTOLARYNGOLOGY GOALS AND OBJECTIVES .......................................................... 17

   GENERAL SURGERY ROTATION ......................................................................................... 17

   ANESTHESIA & CRITICAL CARE ROTATION ..................................................................... 20

   THORACIC SURGERY ROTATION ......................................................................................... 22

   EMERGENCY MEDICINE ROTATION .................................................................................... 23

   NEUROSURGERY ROTATION ................................................................................................. 25

   OTOLARYNGOLOGY ROTATION ............................................................................................ 27

   PGY 2- 5 OTOLARYNGOLOGY GOALS AND OBJECTIVES ............................................... 29

   UNIVERSITY OF LOUISVILLE ROTATION ......................................................................... 29

   NORTON, Jewish, & KOSAIR CHILDREN’S HOSPITAL ROTATION ........................................... 33

   VA MEDICAL CENTER ROTATION ....................................................................................... 38

   PLASTIC & RECONSTRUCTIVE SURGERY ROTATION ......................................................... 40

   RESEARCH ROTATION ......................................................................................................... 41

6a.  EDUCATIONAL CONFERENCES & ROUNDS ................................................................. 50

6b.  RESPONSIBILITIES OF RESIDENTS AND FACULTY FOR CONFERENCE PREPARATION AND ATTENDANCE ............................................................................................................. 52
7. ETHICS CURRICULUM ........................................................................................................ 54
8. MEDICAL-LEGAL CURRICULUM ...................................................................................... 55
9. SOCIOECONOMICS & PRACTICE MANAGEMENT EDUCATION .................................................. 56
10. ANNUAL SYMPOSIA & VISITING PROFESSORS ................................................................. 57
11. MAINTAINING AN OPERATIVE LOG .................................................................................. 59
12. BASIC SCIENCE EDUCATION & RESEARCH EXPERIENCE .................................................. 60
13. ETHICS, HONESTY, & CONDUCT ....................................................................................... 63
14. TEACHING RESPONSIBILITIES ......................................................................................... 64
15. SERVICE ROTATION SCHEDULE ...................................................................................... 65
16. DUTY HOUR LIMITATIONS ............................................................................................... 67
17. CALL RESPONSIBILITY ....................................................................................................... 69
18. TRANSITIONS IN CARE ....................................................................................................... 72
19. FACULTY SUPERVISION & STAFFING .............................................................................. 74
20. CHIEF RESIDENT RESPONSIBILITIES .............................................................................. 78
21. MEDICAL RECORDS ........................................................................................................... 80
22. MEDICAL RECORD DOCUMENTATION for COMPLIANCE .................................................. 81
23. ACCURATE BILLING PROTOCOL ....................................................................................... 82
24. HIPAA COMPLIANCE ......................................................................................................... 83
25. VACATIONS AND LEAVE ................................................................................................. 87
26. NATIONAL MEETING ATTENDANCE .................................................................................... 89
27. OVERSEAS HUMANITARIAN MISSIONS ............................................................................ 90
28. MOONLIGHTING / OUTSIDE EMPLOYMENT ...................................................................... 91
29. ROLE OF THE RESIDENT IN THE EDUCATION OF MEDICAL STUDENTS ......................... 96
30. PROGRAM & FACULTY EVALUATION ............................................................................... 97
31. RESIDENT PERFORMANCE EVALUATION ....................................................................... 98
32. GUIDELINES FOR ADVANCEMENT, PROMOTION & COMPLETION ................................. 99
33. IN-SERVICE EXAMINATION ........................................................................................... 104
34. RESIDENT GRIEVANCES PROCEDURE .......................................................................................105
35. DISCIPLINARY ACTIONS & GROUNDS FOR DISMISSAL ......................................................106
36. POLICY ON RESIDENT RECRUITMENT and Selection .........................................................108
37. FATIGUE, SLEEP DEPRIVATION, STRESS, & SUBSTANCE ABUSE ~ THE IMPARIED
   PHYSICIAN ..................................................................................................................................111
   RESIDENT STRESS & FATIGUE MONITORING POLICY ................................................................111
38. APPLICATION FOR EXAMINATION BY THE AMERICAN BOARD OF OTOLARYNGOLOGY -
   HEAD & NECK SURGERY .............................................................................................................115
39. PERSONAL & UPFRONT ...........................................................................................................116
40. GUIDE TO SUPPLEMENTAL REFERENCE MANUALS ................................................................117
41. CONFIRMATION OF UNDERSTANDING ..................................................................................118
Attachment 1 .................................................................................................................................119
   PRINCIPLES OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION ............119
Attachment #2 ................................................................................................................................120
   CODE OF ETHICS OF THE AMERICAIN ACADEMY OF OTOLARYNGOLOGY - ..................120
   HEAD AND NECK SURGERY .........................................................................................................120
Attachment 3
   TRAVEL and LEAVE forms
I swear by Apollo the healer, by Aesculapius, by Hygeia (health) and all the powers of healing, and call to witness all the gods and goddesses that I may keep this Oath, and promise to the best of my ability and judgment:

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

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

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

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

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

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

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

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

A. Welcome.

On behalf of the full-time academic faculty and the community gratis faculty, we welcome you to the University of Louisville Otolaryngology-Head and Neck Surgery Residency Training Program. This is a five-year program. As such, it follows graduation from medical school. Our program is designed to build upon and further enhance your medical knowledge and to teach the art, principles and skills specific to Otolaryngology-Head and Neck Surgery. The operative and clinical experiences available to you in this program are renowned for being exceptionally diverse and challenging. We approach this experience systematically, with analytic logic and evidence-based medical principles in order to give you the finest set of general competencies and surgical skills for independent practice in Otolaryngology-Head and Neck Surgery and teach you how to maintain these over your full career. If diligently pursued and fully utilized, this experience will prepare you well for a rewarding lifetime of excellent patient care. It will also prepare you well for certification by the American Board of Otolaryngology which is an essential credential of your career, and which should be achieved at the earliest possible time.

B. Academic Mission.

This mission of the University of Louisville Otolaryngology-Head and Neck Surgery Residency Program is to train surgeons who are compassionate and skillful in patient care; who use scholarly principles to maintain and apply mastery of the knowledge of their discipline; who use good science and analytical logic in effective surgical problem solving and outcome review; who are careful and safe in their application of judgment and technique; who continuously improve their communications, care and care delivery systems; who stand out as impeccable examples of ethical and professional conduct, and who become board certified and leaders in their profession and communities.

C. Guidelines.

In order to maximize your experience in this program and to facilitate smooth day-to-day operational procedures, guidelines are clearly outlined for you in the following pages. These guidelines are intended to instill a program of intellectual challenge and active learning and to provide you with an unambiguous understanding of your obligations, responsibilities, and educational opportunities over these next five years.

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

E. Attestation.

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

The general educational goal of the Otolaryngology program at the University of Louisville is to help our residents obtain the knowledge, skills, and attitudes necessary to be competent otolaryngologists-head and neck surgeons and to prepare them for practice in the twenty-first century. The specific knowledge and skill objectives that we focus on are those defined in the Special Requirements for Residency Education in Otolaryngology published by the Residency Review Committee of the Accreditation Council for Graduate Medical Education (ACGME). These include bronchoesophagology, facial plastic and reconstructive surgery, head and neck surgery, laryngology, rhinology, otology, otolaryngologic allergy, immunology, endocrinology, and neurology. In addition to these specialty specific objectives, there are issues and challenges facing residents today as they enter practice that are included in their curriculum. These include competency in providing high quality, cost-efficient care, and a general knowledge of population-based medicine and practice management. The attitudes addressed in the curriculum include communication skills, humanistic skills, and professionalism.

Our educational goals are met by a curriculum consisting of instruction and service on clinical rotations, formal didactic conferences, assigned text and journal readings, assigned temporal bone and cadaver dissections, and formal continuing education courses. Residents are exposed to broad based clinical environments and patient populations throughout their residency, spending time at the University Hospital, Veterans Administration Medical Center, two private adult hospitals (Norton's Hospital and Jewish Hospital) and Kosair Children's Hospital. Rotations are assigned to provide the residents with a comprehensive inpatient hospital experience, an outpatient clinic experience, and both an inpatient and outpatient operative experience.

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

**Goal 1:** Progression in the ACGME Core Competencies and their applications to the specialty of Otolaryngology-Head and Neck Surgery.

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

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

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

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

B. **Explanation of the Goals**

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

These six competencies are as follows:

1. Patient Care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

2. Medical Knowledge about established and evolving biomedical, clinical and cognate sciences (e.g. epidemiological and social-behavioral) and the application of this knowledge to patient care.
3. Practice-Based Learning and Improvement that involves investigation and evaluation of their own patient care, appraisal, and assimilation of scientific evidence, and improvements in patient care.

4. Interpersonal and Communication Skills that result in effective information exchange and teaming with patients, their families, and other health professionals.

5. Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

6. Systems-Based Practice, as manifested by actions that demonstrate an awareness of a responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

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

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

**Goal 3: Use of Analytic logic, the scientific method and evidence-based medicine.** Our philosophy emphasizes the analysis of practice principles and treatment of individual patient problems using logical processes, such as deductive reasoning, inductive reasoning, the scientific method and evidence-based medicine. For example, the scientific method would translate into terms of clinical medicine as follows:
Observation = disease or deformity;

Hypothesis = differential diagnosis or suspected condition cause;

Hypothesis testing = problem analysis, medical workup and data analysis;

Conclusion = diagnosis and the treatment or reconstructive procedure derived logically from the conclusion.

A classic method used in surgery for logical design of procedures is to formally analyze the missing elements of a defect needing reconstruction, and to surgically restore or replace “like with like or with the most similar”. Furthermore, we expect the resident to generate a hierarchy of approaches and solutions and the rank order to be defended by logic and evidence based citations (e.g., the “reconstructive ladder”). Our approach requires that the resident be the first to go through this process, with critique by faculty to follow, rather than the reverse order. This causes judgment and analytic skills to grow most rapidly, and this best prepare residents to smoothly make the transition into independent practice.

The ability to access the scientific literature of our discipline, and to analyze it critically for acceptance or rejection, is essential to the best quality patient care and to lifelong learning. We emphasize literature use and analysis and evidence-based medicine/evidence-based practice (EBM/EBP) in each clinical challenge. EBM/EBP principles are learned early in our ACGME Core Competency Conference and practiced in each patient care plan formulation and each literature analyses session of Journal Club and conference presentations.

**Goal 4: Accelerated Progression to Independent Practice.** Our educational program is specifically designed to accelerate progression to independence in judgment and practice. We foster this by challenging the resident to be the first to evaluate the patient, analyze the problem, derive the diagnoses, make the judgments, and design the solution. Only then is the faculty critique and input given—rather than in the reverse order as done in many programs. In addition, we strive to provide graduated responsibility based on progressive acquisition of knowledge, progressively increasing judgment challenges and progressive refinement of technical skills. Requiring residents to take the intellectual lead in problem analysis and solution design and presenting increasing challenging judgment decisions with expectations of increasingly skilled performance requires a great degree of interaction between the attending faculty and the resident. The faculty must constantly encourage and require resident analytic thinking in surgical problem solving, resident application of the scientific method of data analysis, and resident use of a sound physiologic and evidential basis for surgical practice, all in keeping with the values incorporated in the core competencies.
Optimal growth of technical skills in rapid fashion is also achieved by an analogous process by encouraging the resident to take the lead as a supervised primary surgeon, rather than an observer. The resident is given progressive technical responsibility under faculty supervision as rapidly as performance allows. The more senior residents are expected to have progressed further than the junior residents, but all are encouraged to progress as rapidly and fully as their capabilities permit. Our Temporal Bone Laboratory and Fresh Tissue Dissection and Practice Laboratory substantially serve the growth of advanced technical skills.

By the final semester of PGY-5, if not sooner, each resident is expected to have matured sufficiently in judgment, knowledge, and technical skill so as to be ready for independent practice and for the Board certification examinations.

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

**C. The U of L ACGME Core Competency Orientation.**

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

**D. ACGME Core Competency Conference.**

In order to enhance ACGME competencies in our curriculum and to adapt them most accurately to Otolaryngology-Head and Neck Surgery, an ACGME Core Competency conference is held each week (Friday). Each session, an Otolaryngology topic representing an important aspect of each competency is presented and discussed in rotation. This conference schedule is posted in the Division offices.
E. ACGME Core Competencies in Each Patient Encounter.

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

F. ACGME Core Competencies in the Clinical Rotations.

We have adopted the goals of the Special Requirements of the ACGME Residency Review Committee. These goals are delineated for each service rotation in Section 5 of this manual.


Evaluation of resident performance and progress is done in perspective of the ACGME Core Competencies. Beginning January 2006, this continues to be done with a standardized process uniform to all University of Louisville Residency programs called New Innovations. This computer driven system will be explained to you in great detail.
3. GENERAL OBJECTIVES & RESIDENT EVALUATION PARAMETERS (COMMON TO ALL CLINICAL SERVICES)

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

A. Patient Care:

1. Residents must show proficiency in obtaining, documenting, and communicating an accurate medical history.

2. Residents must show proficiency in performing, documenting and communicating an accurate physical examination.

3. Residents must show proficiency in judicious selection of laboratory and imaging studies that are most relevant and specific to the diagnostic workup process.

4. Residents must show proficiency in integration and analysis of the history, physical findings, laboratory, and imaging data in producing an accurate diagnosis and patient problem list.

5. Residents must document a comprehensive care plan, including progress monitoring and follow-up.

6. Residents must respond to the psycho-social aspect of the illness or injury, including disfigurement and functional limitations.

7. Residents must promote health education for prevention of disease and injury.

8. Residents must demonstrate commitment to their role as patient advocate.

B. Medical Knowledge and Application to Patient Care

1. Residents must develop a comprehensive and scientifically accurate medical knowledge base through advanced literature searches and analysis, plus other scientific inquiry methods.

2. Residents must develop skill in selection and use of evidence-based medicine from texts and journal articles selected by effective library and internet search techniques.
3. Residents must supply knowledge of scientific study design and appropriate statistical methods to the appraisal of medical studies and other information relevant to the diagnostic and therapeutic needs of the patient.

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

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

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

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

C. Practice-Based Learning and Improvement.

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

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

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

D. Interpersonal and Communication

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

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

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

4. Residents must work effectively in team settings.

5. Residents must develop refined listening skills.

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

1. Residents must develop professional attitudes showing:
   a. reliability and punctuality;
   b. ethics and integrity,
   c. initiative and leadership.

2. Resident must show cooperative attitudes that promote teamwork and mutual respect;

3. Residents must accept responsibility for their actions and their consequences.

4. Residents must develop humanistic qualities that include:
   a) establishment of ethically sound patient relationships;
   b) demonstrations of compassion, sensitivity, and respect for the dignity of patients and their families; and
   c) sensitivity and respect to age, culture, disabilities, ethnicity, gender and sexual orientation.

5. Residents must respect patient confidentiality in all settings and meticulously conform to HIPAA guidelines.

F. Systems Based Practice

1. Residents must demonstrate a thorough understanding of the systems influencing the delivery of care to their patients, and integrate their practice approximately within the larger care systems.

2. Residents must fully evaluate the risks/benefits, limitations, and cost of available resources used in their practices.

3. Residents should improve the system of care by thoughtful analysis and advocacy for improvement.
4. CLINICAL COMPONENTS OF OTOLARYNGOLOGY-HEAD AND NECK SURGERY

We cover the broad field of Otolaryngology-Head and Neck Surgery in a balanced, comprehensive fashion. All of the components of the field of Otolaryngology-Head and Neck Surgery, as designated by the Otolaryngology Residency Review Committee (RRC), are each addressed in our designated reading program, in the topic rotation of our conference schedule, in our clinical rotations (Attachment 1 of this Manual), and in the description of clinical rotations that follows (Section 5).

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

1. General Otolaryngology
2. Head and Neck Surgery
3. Facial Plastic Surgery
4. Rhinology
5. Pediatric Otolaryngology
6. Otolaryngologic Allergy
7. Otology
5. CLINICAL SERVICES: EDUCATIONAL GOALS & EVALUATION PARAMETERS FOR EACH ROTATION

The Otolaryngology Residency Program at the University of Louisville is based at the University of Louisville Hospital and the integrated hospitals in our Health Sciences Campus including the Norton Hospital, Kosair Children’s Hospital, Jewish Hospital and the Louisville Veterans Administration Medical Center. The rotations are hospital based with the exception of the Plastic Surgery Rotation, which represents a month long rotation for the PGY-3 and 4 residents that is not institution specific; additionally, the Plastic Surgery Rotation does not represent the only plastic surgery experience that the residents are afforded, considerable Facial Plastic and Reconstructive Surgery is accomplished in the University Hospital and VAMC rotations. Below is listed the Description of the Educational Program, chronologically, for each of our rotations.

PGY-1 OTOLARYNGOLOGY GOALS AND OBJECTIVES

GENERAL SURGERY ROTATION

The Goals and Objectives for these rotations are adapted from the “Prerequisites for Graduate Surgical Education. A Guide fro Medical Students and PGY1 Surgical Residents” published by the American College of Surgeons. This document was produced a few years ago, after the Graduate Education Committee of the American College of Surgeons convened a group of surgeons representing all of the surgical specialties (General Surgery, Neurological Surgery, Obstetrics & Gynecology, Ophthalmology, Orthopedic Surgery, Otolaryngology, Plastic Surgery, Urology, Thoracic Surgery, Pediatric Surgery,
The purpose of the meeting was to “brain-storm” about what a PGY-1 surgical resident should learn before continuing in specialty surgical education. The lists of knowledge and skills were then circulated to 400 surgeons who ranked the lists according to priority: essential, desirable, or supplementary. Those areas of knowledge and skills that are pertinent to the formation of residents beginning their Otolaryngology residency have been selected and supplemented as deemed appropriate by the Residency Review Committee. These are adapted at the University of Louisville Otolaryngology Program in the context of the General Competencies, understanding this is an interconnected framework of learning:

The main goal of the general surgery rotation is to provide a broad exposure to the skills and knowledge base necessary for the appropriate evaluation, assessment, and management of the surgical patient. Secondary goals include learning to work as part of a health care team and developing the communication and professionalism skills necessary to become a successful physician.

**OBJECTIVES:**

**MEDICAL KNOWLEDGE:**

- Develop understanding of surgical aspects of physiology and homeostasis in the management of surgical patients
- Develop and enhanced understanding of diagnosis and management of medical comorbid conditions impacting surgical care
- Develop and enhanced understanding of assessment and intervention impaired nutritional status in the surgical patient
- Develop and enhanced understanding of the general surgical diseases affecting the following organ-systems: respiratory, alimentary, cardiovascular, urinary, endocrine, integument, and nervous
- Develop an understanding of the interfaces between General Surgery and Otolaryngology and understand areas that benefit from multidisciplinary assessment and management.

**PATIENT CARE:**

- Perform a comprehensive History and Physical Exam for a variety of surgical patients, with an emphasis on accurate documentations of pertinent positive and negative findings, identification of surgical risks, formation of an appropriate working and differential diagnosis, and development and documentation of a cogent plan with the assistance of more senior residents and attending supervision.
- Perform daily rounds with documentation of pertinent positive and negative findings on pre and postsurgical patients and consultations
- Write logical and pertinent orders and use appropriately order sets that are relevant to surgical patients
• Order and begin to interpret with input from senior residents and attending physicians laboratory and radiological tests that are patient centered, relevant and appropriate. Additionally avoiding the ordering of excessive or unnecessary tests.

INTERPERSONAL AND COMMUNICATION SKILLS

• Demonstrate appropriate interactions and attitudes with the following: patients, patient families, attending physicians, residents of all specialties, nursing staff, ancillary hospital staff, office staff and administration.
• Learn effective and appropriate communications regarding presentation of patients to other residents and attending physicians including but not limited to admission, changes in status, and critical physical, laboratory and other test results.
• Perform adequate written documentation of History and Physicals, Progress Notes, Preoperative and Operative notes, Postoperative notes and perioperative and maintenance orders.
• Perform dictations of operative reports and discharge summaries where appropriate that are accurate and meaningful.

PROFESSIONALISM

• Maintain appropriate appearance, attire, and demeanor for a physician/surgeon
• Maintain ethical relationships with patients, families, colleagues, and staff as prescribed in the Hippocratic Oath, AMA Ethics Statement and the Ethics Statement of the American Academy of Otolaryngology-Head and Neck Surgery
• Fullfill responsibilities to patients and healthcare team members
• Maintain appropriate and accurate medical records.
• Maintain and complete required dictations, signatures of records, completion of operative log, completion and appropriate observation of duty hours.
• Maintain appropriate sleep and rest in order to provide optimal and safe care when on service
• If unable to discharge clinical responsibilities in a safe and efficacious manner, notify senior resident(s), attending staff, and Otolaryngology Program Director

PRACTICE BASED LEARNING INITIATIVES ON THE GENERAL SURGERY ROTATION(S)

• Assist senior residents in the accumulation of data and preparation of presentation of cases for Quality Assurance/Morbidity and Mortality Conference in the Department of Surgery
• Attend Morbidity and Mortality Conference for the relevant General Surgery Service

SYSTEMS BASED PRACTICE ON THE GENERAL SURGERY SERVICE:

• Develop Safe Practices relevant to patient care including but not limited to the following:
  o Good hand washing and other mechanical means of limiting patient sepsis between and among patients on the surgical service
  o Understanding and Demonstration of practice of Universal Precautions and other infection limiting initiatives
o Understand and demonstrate effective utilization of Medicine Reconciliation in order to avoid use of medicines in which patients are allergic or in which adverse or multi-drug reactions can occur.

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ANESTHESIA & CRITICAL CARE ROTATION

The main goal of this rotation is to provide the PGY1 resident an organized experience to enable him/her to acquire the basic knowledge and skills in preoperative care including preanesthetic evaluation, anesthetic risk assessment, airway evaluation and immediate postoperative care.

OBJECTIVES:

MEDICAL KNOWLEDGE:

- Pharmacology of local and general anesthetic agents
- Pharmacology and application of critical care drugs including, but not limited to pressor agents, antiarrhythmic drugs, antihypertensives, alpha and beta adrenergic drugs and blockers, respiratory drugs, and the implications of drugs commonly used in medical practice and their implications on the safe delivery of local and general anesthesia.

PATIENT CARE:

- Perform appropriate airway stabilization
- Perform basic orotracheal and nasotracheal intubations
- Perform appropriate amбу bag and ventilator based ventilation of patients
- Establish safe and efficacious venous access peripherally and centrally with appropriate supervision
- Become familiar with appropriate use of local, general and other supportive anesthetic medications
- Perform appropriate fluid management of the stable and unstable patient
- Assess and maintain appropriate patient oxygenation and ventilation of anesthetized and critically ill patients
- Develop and understanding of the interface of Anesthesiology and Otolaryngology in the management of the difficult airway and in the performance of critical care procedures such as open and percutaneous tracheostomy

INTERPERSONAL AND COMMUNICATION SKILLS:

- Understand the multidisciplinary relationship between Surgeon and Anesthesiologist in the service of the surgical/critical care patient (see also Professionalism)
• Communicate appropriately regarding patient stability, status changes, use of muscle relaxants and adequacy of anesthesia with regard to time and execution of surgical maneuvers
• Complete appropriate anesthetic notes and maintenance of anesthesia record with appropriate supervision of senior anesthesiology residents and attending staff
• Communicate information regarding anesthetic management to patients, family, staff, and other physicians with appropriate supervision of senior anesthesiology residents and attending staff

PROFESSIONALISM

• Develop a respect and understanding for the complex activities and management of our colleagues in anesthesiology and nurse anesthesia
• Maintain respect and optimal care for the anesthetized patient
• Maintain safe and optimal administration of anesthesia and pain relieving medications
• Maintain personal and environmental cleanliness in the operative theater and critical care environment

PRACTICE-BASED LEARNING

• Attend all Anesthesia didactic, patient and quality assurance (Morbidity and Mortality) conferences and learning activities while on the service
• Follow patients perioperatively to determine efficacy and complications of anesthetic management
• Complete and turn in one case analysis of anesthetic case management with sign off with the attending anesthesiologist and delivery to the Associate Program Director in Otolaryngology for evaluation and inclusion in the Otolaryngology resident’s learning portfolio.

SYSTEMS-BASED PRACTICE

• Attend Quality Assurance Conference on the Anesthesiology Service and increase understanding of Operating Room and Hospital Systems with implications for the safe and efficacious delivery of anesthetic care to patients
• Attend Quality Assurance Conference on the Anesthesiology and Critical Care Service and increase understanding of ICU/Critical Care Systems with implications for the safe and efficacious care of patients
THORACIC SURGERY ROTATION

The main goal of this rotation is to provide the PGY1 resident an organized experience to enable him/her to acquire the basic knowledge and skills in the evaluation and management of patients with common cardiac and pulmonary surgical problems.

OBJECTIVES:

MEDICAL KNOWLEDGE:
- Demonstrates understanding of basic and applied cardiovascular physiology
- Demonstrates understanding of basic and applied pulmonary physiology
- Demonstrated knowledge of indications for basic cardiothoracic surgical procedures
- Demonstrates knowledge of the interface between the thorax, mediastinum and structures of the head and neck

PATIENT CARE:
- Performs complete history and physical examination, with emphasis on pertinent positive and negative findings on the cardiothoracic surgical patient
- Performs basis bedside procedures (see above) on cardiothoracic surgical patients with appropriate senior resident and attending supervision

INTERPERSONAL AND COMMUNICATION SKILLS
- Develops and understanding and respect for the role of the Cardiothoracic Surgeon in the care of patients, especially where there is a multidisciplinary interface with the Otolaryngologist Head and Neck Surgeon (see also Professionalism)
- Communicates patient history, physical findings, daily care, changes in status, and other patient related issues as appropriate with more senior surgical and cardiothoracic residents, attending physicians, staff, patients and families
- Performs and completes adequate written (or EMR entry) communications for history and physicals, daily care notes, procedural notes, and discharge summaries for patients on the Cardiothoracic service

PROFESSIONALISM
- Develops and understanding and respect for the role of the Cardiothoracic Surgeon in the care of patients, especially where there is a multidisciplinary interface with the Otolaryngologist Head and Neck Surgeon (see also Interpersonal and Communication Skills)
- Acts as an effective team member on the Cardiothoracic Surgical Service toward the safe and effective treatment of patients
- Acts in a respectful manner to patients, families, physicians and staff on the Cardiothoracic Surgical Service
PRACTICE BASED LEARNING

- Attends all appropriate didactic and patient care conferences relevant to the Cardiothoracic Surgical Rotation while on service
- Attends and participates (where appropriate) in the Quality Assurance (Morbidity and Mortality) Conference while on the Cardiothoracic Surgical Rotation
- Performs one written reflective analysis of a patient’s care with an emphasis on evidence-based medicine while on the Cardiothoracic Surgical Service. This must be signed off by a Cardiothoracic Surgical Attending and turned into the Associate Program Director in Otolaryngology for evaluation and inclusion in the resident’s learning portfolio

SYSTEMS BASED PRACTICE

- Attends the Quality Assurance Conference of the Cardiothoracic Surgical Service with the goal of enhance understanding of the hospital system based factors having implications on the care of cardiothoracic patients, with an emphasis on safe and efficacious care
- Seeks opportunities to learn the systems at Jewish Hospital and the University of Louisville Hospital in order to provide safe and efficacious care of patients

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EMERGENCY MEDICINE ROTATION

The main goal of this rotation is to provide the PGY1 resident an organized experience to enable him/her to acquire the basic knowledge and skills in the evaluation and management of patients presenting to the emergency room with emphasis on patients presenting with head and neck complaints. The PGY1 resident should also gain a better appreciation of medical conditions often seen as co-morbidities in head and neck patients including, diabetes mellitus, hypertension, stroke, congestive heart disease, respiratory distress and myocardial infarction.

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OBJECTIVES:

MEDICAL KNOWLEDGE:

- Demonstrate and understanding of the ABC’s of acute patient evaluation
- Demonstrate and understanding of acuity and triage of patients in the Emergency Room Setting
- Demonstrate and understanding of the multidisciplinary and collaborative care environment in the emergency setting
• Demonstrate and understanding of common medical and surgical emergencies seen in the Emergency Room setting, with an emphasis on Otolaryngology related emergencies

PATIENT CARE
• Perform Initial assessment and triage of Emergency patients with appropriate senior resident and attending supervision
• Perform appropriate history and physical examination on Emergency Room patients for common and appropriate patients
• Perform common emergency procedures as listed in detail above in the Goals and Objectives

INTERPERSONAL AND COMMUNICATION SKILLS
• Develop appropriate and effective communication with patients experiencing medical and surgical emergencies with an emphasis on establishing effective rapport that facilitates diagnosis and management
• Efficiently communicate history, physical findings and appropriate test results to senior Emergency Medicine Residents, Attending Faculty and Consulting Physicians/Services
• Perform clear and concise write ups of history and physical, procedure notes, orders and discharge instructions for patients encountered in the Emergency Room

PROFESSIONALISM
• Learn and respect the role of the Emergency Physician in the care of medical and surgical patients, especially patients with Otolaryngology related problems
• Learn the appropriate interaction and communication with Emergency Medicine Physicians regarding patients entering the inpatient and outpatient consultation environments
• Demonstrate adequate, safe and compassionate care for patients and families experience emergent medical and surgical illness

PRACTICE-BASED LEARNING
• Attend and participate (where appropriate) in all Emergency Medicine Didactic Conferences and learning activities while on the ER Rotation
• Attend and participate (where appropriate) in the Emergency Medicine Quality Assurance (Morbidity and Mortality) Conference while on the Emergency Rotation
• Complete one surgical learning and instructional portfolio (SLIP) assignment based on an emergency department patient encounter. This must be signed and reviewed by the attending Emergency Department physician and turned into the Associate Program Director in Otolaryngology for evaluation and inclusion in the resident portfolio

SYSTEM-BASED PRACTICE
• Become familiar with the community disaster plan through the perspective of the Emergency Medicine Service
• Learn role and responsibilities in a disaster management plan
The main goal of this rotation is to provide the PGY1 resident an organized experience to enable him/her to acquire the basic knowledge and skills in the evaluation and management of patients presenting with neurosurgical complaints. The resident should gain an appreciation for the collaborative efforts between the ORL and NES specialties.

**OBJECTIVES:**

**MEDICAL KNOWLEDGE:**

- Demonstrate basic and applied knowledge of neuroanatomy and physiology
- Demonstrate understanding of normal and abnormal neurological examination findings and the implications thereof
- Recognize common neurological/neurosurgical emergencies and become familiar with emergent interventions
- Recognize the interface areas of the Neurosurgeon and the Otolaryngologist Head and Neck Surgeon with respect to cranial base, sinonasal, orbital, ear and temporal bone, and neck neurovascular structures and the cerebrospinal fluid spaces for both neoplastic and non-neoplastic disease
- Recognize the multidisciplinary role in the management of patient with craniofacial trauma with respect to initial evaluation and management and definitive repair

**PATIENT CARE:**

- Perform history and physical on Neurosurgical patients in the outpatient, emergency room and inpatient settings under the appropriate supervision of senior residents and attending staff
- Perform daily assessment, notes and appropriate orders on Neurosurgical inpatients under the appropriate supervision of senior residents and attending staff
- Participate in outpatient Neurosurgery clinics and complete assessments and documentation under the appropriate supervision of senior residents and attending staff
- Participate in call or night float systems with the Neurosurgery resident staff, with strict adherence to ACGME duty hours requirements

**INTERPERSONAL AND COMMUNICATION SKILLS**

- Verbally present initial and continuing care, including changes in patient status to senior neurosurgery residents and attending staff
- Communicate findings to patients, family and staff as deemed appropriate by senior neurosurgery residents and staff
• Complete concise and accurate written (EMR) history and physical exams, inpatient notes, outpatient notes, consultation reports, orders and discharge summaries under the appropriate supervision of senior neurosurgery residents and attending staff
• Communicate in an appropriate and professional manner at all times with patients, families, residents, attending staff and all other constituents involved in patient care while on the Neurosurgery Rotation

PROFESSIONALISM

• Learn and respect the role of the Neurosurgeon in the care of patients
• Learn the appropriate interface and communication between the Neurosurgeon and the Otolaryngologist in the appropriate multidisciplinary collaborative care of patients
• Act as a respectful member of a team caring for patients on the Neurosurgical Service

PRACTICE BASED LEARNING

• Attend and participate in Quality Assurance/Morbidity and Mortality Conference while rotating on the Neurosurgery Service
• Attend and participate in didactic conferences while on the Neurosurgery Service
• Complete one surgical learning and instructional portfolio (SLIP) assignment based on a neurosurgical patient encounter. This must be completed prior to going off service and signed by a Neurosurgical Attending. It must be turned into the Associate Program Director in Otolaryngology for evaluation and inclusion in the resident’s learning portfolio

SYSTEM BASED PRACTICE

• Attend and participate in Neurosurgery patient care and Quality Assurance/Morbidity and Mortality Conferences with an emphasis on understanding the impact of systems and resources in patient care
OTOLARYNGOLOGY ROTATION

The main goal of this rotation is to acquire the basic knowledge and surgical skills necessary for evaluation and management of the Otolaryngology Head and Neck Surgery patient. The PGY-1 resident should acquire basic skills in Otolaryngology procedures such as otomicroscopy and flexible fiberoptic laryngoscopy so that transition to full time training as a PGY-2 resident will be smooth and less stressful. The primary emphasis will be on providing the experiences necessary to move from direct supervision to indirect supervision (with direct immediately available) as a PGY-2 trainee.

OBJECTIVES:

MEDICAL KNOWLEDGE
- The resident should demonstrate basic knowledge in applicable head and neck and temporal bone anatomy.
- The resident should demonstrate awareness and recognition of common clinical presentations of adult and pediatric otolaryngology patients, in both the inpatient and outpatient setting.
- The resident should be able to interpret commonly used diagnostic tests, including CT and MRI scans and basic audiometry.

PATIENT CARE
- The resident should be able to perform evaluation and management of a patient admitted to the hospital, including history and physical exam, formulation of a plan of therapy, and necessary orders for therapy and tests.
- The resident should be able to perform preoperative evaluation and management, including history and physical exam, formulation of a plan of therapy, and specification of necessary tests.
- The resident should be able to perform evaluation and management of postoperative patients, including the conduct of monitoring, specifying necessary tests to be carried out, and preparing orders for medication, fluid therapy, and nutrition therapy.
- The resident should be able to perform basic venous access procedures, placement of nasogastric tubes and feeding catheters, and arterial puncture; with direct supervision, the resident should be able to perform closure of surgical incisions, repair of skin and soft tissue lacerations, excision of skin/subcutaneous tissue lesions, endotracheal intubation and non-emergent tracheostomy.

INTERPERSONAL AND COMMUNICATION SKILLS
- The resident shall demonstrate the ability to concisely and accurately present clinical findings to the attending physician or senior resident on bedside rounds and in the outpatient clinic.
• The resident shall demonstrate the ability to effectively communicate treatment plans and findings to patients and their families.

PROFESSIONALISM

• The resident shall demonstrate sensitivity to the needs of other members of the patient care team regarding work load and fatigue.
• The resident shall be punctual for all operative cases, clinic assignments, and conferences.
• The resident shall be responsive to questions and consultations from other services.

PRACTICE BASED LEARNING AND IMPROVEMENT

The resident shall attend and participate in the monthly Otolaryngology Quality Improvement/Morbidity and Mortality conference.

• The resident shall complete and submit a case report manuscript based on a patient encounter.

SYSTEMS BASED PRACTICE

• The resident shall complete all documentation including operative dictations, history and physical exams, discharge summaries, and progress notes, in a timely fashion according to Joint Commission standard timelines.
• The resident shall demonstrate an awareness of basic evaluation and management and CPT coding principles as they pertain to Otolaryngology documentation.
PGY 2- 5 OTOLARYNGOLOGY GOALS AND OBJECTIVES

UNIVERSITY OF LOUISVILLE ROTATION

The University of Louisville Hospital is a large city hospital with a diverse patient population, including a busy Level I Trauma center. This hospital provides the bulk of the indigent care for the city of Louisville and surrounding areas and is the site of the largest volume of surgical procedures, both elective and emergent, for the residency program.

The goals and objectives specific to the University of Louisville Rotation and applicable to all PGY-levels rotating on the service are listed below:

GOALS:

1. To learn to provide appropriate in-patient assessment, care, and coordination of care and consultation to all patients under the care of the Otolaryngology service. Progressive levels of responsibility are assigned as experience warrants but basically follow the PGY-level.

2. To provide accurate assessment of emergency and trauma patients in the Emergency Department of the University of Louisville Hospital in consultation with the Emergency Medicine Service and the Trauma Surgery Service during evening, weekend, and holiday schedules. The resident will learn to perform an accurate assessment of the emergency and trauma patient under the supervision of the PGY-4 and PGY-5 level resident and ultimately the Otolaryngology attending faculty member. The goal will be to perform an accurate assessment of the ENT related emergency, to determine through triage the management priorities of such patients, and to execute a treatment plan that requires close coordination from other disciplines and services that have an impact on the multiply injured patient. The residents will learn how to coordinate otolaryngology operative care in the complex and multiply injured patient, with more complex levels of management being acquired through the assumption of additional levels of responsibility.

3. To provide assessment, planning and coordination of care of head and neck oncology patients through the Multidisciplinary and Ambulatory Clinics of the University of Louisville Hospital. The resident will attend the weekly Multidisciplinary Cancer Clinic and accompanying conference to learn to perform the initial assessment and subsequent presentation of complex head and neck cancer patients. The resident will learn the appropriate indications for application and sequencing of treatment modalities. Furthermore, the resident will be exposed to purpose,
design, and practical application and enrollment of patients into clinical trials regarding the
treatment of head and neck cancer patients. The resident will become familiar with assessment
of response, staging, diagnosis, and management of recurrent cancer, and diagnosis and
management of complications that may occur in the multimodality management of head and
neck cancer patients.

OBJECTIVES:

1. All PGY-levels shall attend all didactic conferences specific to the rotation and residency, including
   Monday morning Clinical Case conference, Friday Core Curriculum conference, and and monthly
   Facial Trauma conference.

   Evaluation methods: attendance forms, direct observation of participation, competency-based
   end of rotation global assessments by faculty.

   Competency emphasis: primary-medical knowledge; secondary-professionalism, practice based
   learning and improvement, interpersonal and communication skills.

2. All PGY-levels shall attend the Ambulatory Care Otolaryngology clinic and the Friday afternoon
   Continuity of Care clinic, and attain proficiency and competency in evaluation and management of
   patients seen in this setting.

   Evaluation methods: direct observation by attending faculty, 360 degree evaluations by ancillary
   personnel, patients and peers, competency based end of rotation global assessments by faculty.

   Competency emphasis: primary-patient care; secondary-medical knowledge, professionalism,
   interpersonal and communication skills, systems-based practice

3. All PGY-levels shall attend and display progressive proficiency and skill in the operating room at
   the University of Louisville Hospital. PGY-level specific procedure skills will be listed below.

   Evaluation methods: direct observation by attending faculty, Global Rating for Technical Skills
   (GRITS) evaluation forms, competency based end of rotation global assessments by faculty.

   Competency emphasis: patient care, medical knowledge

4. All PGY-levels shall demonstrate proficiency in the assessment of inpatients admitted to the
   University of Louisville Hospital and cared for by the Otolaryngology service, directly or
   indirectly. The resident will be assessed as to his/her ability to perform a focused history taking,
   physical examination pertinent to the patient’s problem, assessment of pertinent risk factors and
   comorbidities, presentation and communication, and the presence and organization of a medical
   data base sufficient to formulate a treatment plan specific to the patient’s problem. Furthermore,
   the residents at all levels of training will be expected to gain proficiency in medical documentation
   and utilization of and proficiency with the electronic medical record. All residents will be held to a
   high standard of professionalism and effective communication skills when dealing with coworkers,
   regardless of status in the hospital hierarchy.
Evaluation methods: direct observation, 360 degree evaluation by ancillary personnel, patients, and peers, competency based end of rotation global evaluations by faculty.

Competency emphasis: primary-patient care, professionalism; secondary-medical knowledge, interpersonal and communication skills, systems-based practice.

5. All residents shall demonstrate progressive proficiency and skill in evaluating and managing the adult patient with emergent or trauma-related otolaryngologic disease.

Evaluation methods: direct observation by faculty, competency based end of rotation global evaluations by faculty.

Competency emphasis: patient care, systems-based practice.

6. The PGY-2, 3 residents will demonstrate attendance of and progressive proficiency and competency in the evaluation and development of a management plan of head and neck cancer patients seen in a Multidisciplinary Head and Neck Oncology clinic setting. Further stressed in this clinic will be the resident’s ability to work effectively as a member of the head and neck cancer patient care team. Communication and professionalism skills will be acquired with the resident assuming progressive responsibility for discussion and management of patients with radiation oncologists, medical oncologists, social workers, psychologists, nutritionists, nursing and oncology research staff.

Evaluation methods: direct observation, 360 degree evaluation by ancillary personnel, competency based end of rotation global evaluations by faculty.

Competency emphasis: primary- patient care, systems-based practice; secondary- professionalism, interpersonal and communication skills, medical knowledge, practice-based learning and improvement.

Specific surgical objectives to be achieved by PGY-year should include but not be limited to:

PGY-2: adult tonsillectomy, tracheostomy, diagnostic direct laryngoscopy/esophagoscopy/bronchoscopy, incision and drainage of deep neck abscesses, biopsy of neck masses, open reduction and internal fixation of noncomplex midfacial and mandible fractures.

PGY-3: continued proficiency in PGY-2 level procedures; also, uncomplicated neck dissection, total laryngectomy, open reduction and internal fixation of more complex midfacial and mandible fractures, simple tympanoplasty without mastoidectomy.

PGY-4: continued proficiency in PGY-3 level procedures: also, thyroidectomy, parathyroidectomy, complex head and neck resections and myocutaneous flap reconstruction, parotidectomy, tympanomastoidectomy, rhinoplasty.
PGY-5: continued proficiency in PGY-4 level procedures; also, stapedotomy and complex ossicular chain reconstruction, endoscopic sinus surgery and skull base procedures, transoral robotic resections of head and neck tumors.

Competency emphasis: primary-patient care, medical knowledge; secondary-professionalism, interpersonal and communication skills, systems-based practice.
KOSAIR CHILDREN’S HOSPITAL COMPONENT

Component Overview:

The Kosair-Children’s Hospital is the only free standing children’s hospital in the state of Kentucky and provides a wide breadth and depth of complex pediatric medical and surgical patient experience to the residency program. The PGY-2 resident plays the primary role in this rotation, with the PGY-3, -4, and -5 residents participating in the surgical and medical management of more complex pediatric otolaryngology disorders.

COMPONENT SPECIFIC GOALS AND OBJECTIVES

PGY-2 GOALS

1. To learn the basic tenets of pediatric otolaryngologic care, both inpatient and outpatient, emergent and routine, and operative and office based.

2. To learn how to provide timely consultative care and to work collaboratively with other physicians and providers.

3. To learn to assess surgical candidacy for a variety of pediatric conditions including otitis media and adenotonsillar disease, and to learn to effectively manage pediatric perioperative care in both healthy children and children with comorbid conditions.

PGY-2 OBJECTIVES

1. The resident will be provided with sufficient operative experience and exposure to develop technical proficiency in a prescribed list of pediatric otolaryngologic surgical procedures, and shall demonstrate adequate knowledge of perioperative pediatric otolaryngologic surgical management.

   Competency emphasis: patient care, medical knowledge, practice-based learning and improvement

   Evaluation instruments: operative case logs, direct observations with Global Rating of Technical Skills (GRITS) form, competency based end of rotation global evaluation by faculty.

2. The resident shall develop working knowledge of common otolaryngologic conditions encountered in the pediatric population, as well as the ability to formulate appropriate diagnostic treatment plans.

   Competency emphasis: medical knowledge, patient care
Evaluation instruments: direct observation, competency based end of rotation global evaluation by faculty.

3. The resident will attend the weekly outpatient clinic and monthly multidisciplinary craniofacial clinic and provide first-line care to the attendees.

   Competency emphasis: patient care, systems-based practice, professionalism

   Evaluation instruments: direct observation, competency based end of rotation global evaluation by faculty

4. The resident will provide otolaryngologic consultation in a variety of settings, including the emergency department, general medical-surgical inpatient wards, the pediatric intensive care unit and the neonatal intensive care unit.

   Competency emphasis: patient care, medical knowledge, professionalism, systems-based practice, interpersonal communication

   Evaluation instruments: direct observation, 360 degree evaluation by peers, patients, and ancillary personnel, competency based end of rotation global evaluation by faculty

5. The resident will attend didactic conferences including resident book club, Journal club, Otolaryngology Grand Rounds, Pediatric Medicine Grand Rounds (when applicable), and the Kosair-Children’s Quality Improvement conference.

   Competency emphasis: professionalism, practice-based learning and improvement

   Evaluation instruments: attendance logs from New Innovations, direct observation, competency based end of rotation global evaluation by faculty

6. The resident will develop interpretive abilities for commonly used diagnostic tests including polysomnography and audiometry.

   Competency emphasis: patient care, medical knowledge

   Evaluation instruments: direct observation, competency based end of rotation global evaluation by faculty.

7. The resident shall demonstrate collaborative patient care skills, including coordination of care with the patient, family, and other members of the health care team. The resident will learn to interact appropriately with all involved in his patients’ care.

   Competency emphasis: patient care, interpersonal and communication skill, professionalism, systems based practice.

   Evaluation instruments: direct observation, 360 degree evaluations by peers, patients, and ancillary personnel, competency based end of rotation global evaluation by faculty.
PGY-2 shall be able to perform the following procedures by the end of the rotation:

- myringotomy with/without tube placement
- adenoidectomy with/without tonsillectomy
- ear tube removal with/without granulation polyp removal
- removal of foreign bodies from the ear and nose
- excision of noncomplex congenital, inflammatory and neoplastic neck masses
- repair of complex lacerations of the head and neck
- drainage of superficial and deep neck abscesses
- closed reduction of nasal fractures
- maxillomandibular fixation
- aspiration/drainage of peritonsillar abscesses
- Neonatal and Pediatric diagnostic laryngoscopy and bronchoscopy
- Neonatal and Pediatric tracheostomy

Basic Pediatric airway interventional procedures such as excision of laryngeal papillomata

**PGY-3, 4, 5 GOALS**

1. The goal of the Kosair Children’s Hospital rotation for PGY – 3, 4, and 5 levels is to advance technical skills in pediatric procedures, participating in more complex surgical cases and providing more advanced levels of pediatric care. Opportunities for teaching medical students and more junior residents will be increased, and more autonomy in clinical areas will be offered as appropriate.

**PGY-3, 4, 5 OBJECTIVES**

1. The resident will participate in more complex surgical procedures, including basic otologic procedures, (tympanoplasty, mastoidectomy, cochlear implantation), advanced airway management (rigid bronchoscopy with/without laser, tracheostomy, airway reconstructive procedures), excision of complex congenital, inflammatory and/or neoplastic neck masses, and repair of complex facial fractures.

   **Competency emphasis**: patient care, medical knowledge, practice-based learning and improvement
Evaluation instruments: direct observation, operative case logs, competency based end of rotation global evaluation by faculty.

2. The resident will serve as consultant to the junior resident and accompany them to evaluate patients when requested. The resident will attend the outpatient clinic as time permits.

   Competency emphasis: patient care, professionalism, interpersonal and communication skill.

   Evaluation methods: direct observation, 360 degree evaluation by peers, competency based end of rotation global evaluation by faculty.

3. The resident will learn to recognize and manage more complex pediatric otolaryngologic conditions, including common syndromes and velopharyngeal insufficiency. The resident will provide primary evaluation of complex consultations from the pediatric and neonatal intensive care units.

   Competency emphasis: patient care, medical knowledge, interpersonal and communication skills, professionalism

   Evaluation instruments: direct observation, 360 degree evaluation by peers, competency based end of rotation global evaluation by faculty

NORTON/JEWISH HOSPITAL COMPONENT

Component Overview:

The Norton Hospital and Jewish/St. Mary’s Hospital are both integrated teaching hospitals for adults with a large primary care base from both University of Louisville faculty and community based physicians. They are central to the mission of our program, providing a major adult operative experience in otolaryngology.

COMPONENT SPECIFIC GOALS AND OBJECTIVES

GOALS:

1. To expose the Otolaryngology resident to the practice of Otolaryngology in a large community hospital with a primary care constituency from both the academic and private community.

2. To teach the Otolaryngology resident the essential and specific elements of history, physical examination, and ancillary testing in the adult inpatient setting.
3. To teach (with PGY-specific progression) operative care of adult patients with head and neck diseases including the skin of the head and neck including melanoma and non-melanoma skin cancers, the upper aerodigestive tract including the salivary glands, the nose and paranasal sinuses, the ear and related organs, and the soft tissues of the head and neck.

4. To teach the resident communication and professionalism skills through patient, physician and staff interaction in a large adult community based teaching hospital. This is to include informal communications with patients, family, medical staff, nursing, and other ancillary staff.

5. To teach the resident skills in deriving information and contributing quality information to and from the electronic medical record. This will include education regarding the clinical and economic importance of efficiently and correctly written and coded patient encounters.

**OBJECTIVES:**

1. All PGY-levels shall be able to work efficiently in a private community hospital system, while providing effective Otolaryngologic care, both medical and surgical.
2. Residents shall learn to efficiently manage surgical patients in an outpatient setting.

   **Evaluation methods:** direct observation, competency based end of rotation global evaluation by faculty.

   **Competency emphasis:** systems-based practice, patient care.
Overview:

The Louisville Veterans Affairs Medical Center is a part of VISN 9 group of national Veterans Hospitals. This is a busy facility with the principle mission of serving the needs of veterans. Because of the aging of the veteran population, it allows our Otolaryngology residents the opportunity to learn the intricacies of operative and non-operative care in a geriatric population with considerable medical comorbidities. Because of the comorbidities of the population, this rotation serves as an effective source of education of residents in complex decision making in Otolaryngology.

The following are two rotation specific conferences that are required of rotating residents:

1. VAMC Tumor Board: This conference meets approximately monthly at the VAMC and is an institution wide tumor board in an American Joint Commission on Cancer (CoC) accredited program. Head and Neck Cancer Cases are presented by the Chief Resident assigned to the VA rotation on a monthly basis. This enables the resident to refine presentation skills to a multidisciplinary body. Cases are discussed regarding the application of decision to treat or palliate. Additionally, decision making regarding application of modalities such as surgery, radiation and chemotherapy are discussed. The impact of medical comorbidities on oncology a treatment decision is emphasized in this rotations patient population. Furthermore, availability and application of clinical trials is reviewed.

2. VAMC Morbidity and Mortality Conference: This is a Surgery Morbidity and Mortality Conference for all surgical disciplines active at our VAMC. The conference is held quarterly. At this conference the Chief Resident or PGY-3/4 resident presents case load data, morbidity and mortality. The emphasis of the Conference is the early identification, prevention, and treatment of medical and surgical complications seen in patients treated at the facility.

ROTATION SPECIFIC GOALS AND OBJECTIVES

GOALS:

1. To expose the resident to the Federal Veterans Administration Healthcare System in order to understand the health risks and nuances of this patient population.
2. To understand the impact of medical comorbidities in Otolaryngologic decision making.
3. To gain an enhanced understanding of Otolaryngology in an aging population.
4. To gain understanding of and facility with a sophisticated Electronic Medical Record (CPRS-Computerized Record System) of the VA hospital in order to ascertain specific and important historical information regarding patients.
5. To gain facility with a sophisticated Electronic Medical Record system and develop appropriate skills in making record entry, include the use of Otolaryngology Specific templates.
6. To gain increased skills in performing adult Otolaryngology procedures including, but not limited to endoscopic sinonasal surgery, laryngoscopy, Bronchoesophagology, facial plastic and reconstructive surgery, sleep apnea surgery, head and neck oncologic surgery, and otology.

**OBJECTIVES:**

1. All residents shall demonstrate understanding of policy and procedures affecting patient care in a complex federal healthcare system. Evaluation methods: direct observation, focused chart review, competency based end of rotation global evaluation by faculty

   **Competency emphasis:** systems based practice

2. All residents shall demonstrate understanding of medical comorbidities in patient care. Evaluation methods: direct observation, oral examination, competency based end of rotation global evaluation by faculty

   **Competency emphasis:** patient care, medical knowledge

3. All residents shall understand the otolaryngologic aspects of the care of geriatric patients. Evaluation methods: direct observation, oral examination, 360 degree evaluation by ancillary personnel, competency based end of rotation global evaluation by faculty

   **Competency emphasis:** medical knowledge, patient care

4. The resident shall demonstrate understanding of the Electronic Medical record system at the VAMC in his/her ability to successfully navigate the system and extract pertinent information and make appropriate documentation and order entry. Evaluation methods: focused document review, competency based end of rotation global evaluation by faculty

   **Competency emphasis:** systems based practice, interpersonal and communication skills

5. The resident shall demonstrate progression of technical competence in the execution of Otolaryngology procedures in the adult population, specifically endoscopic sinonasal surgery, head and neck oncology, Laryngology, bronchoesophagology, facial plastic and reconstructive surgery (especially local flap reconstructions from skin cancer, Rhinoplasty and upper eyelid blepharoplasty), sleep apnea surgery and otology. Evaluation methods: direct observation, Global Rating of Technical Skills (GRITS) forms, and competency-based end of rotation evaluation by faculty

   **Competency emphasis:** patient care, medical knowledge
PLASTIC & RECONSTRUCTIVE SURGERY ROTATION

The Plastic and reconstructive surgery rotation is an addition to the specific experiences at each of the hospital-based rotations it is specifically targeted to the PGY-4 and -5 residents to strengthen their overall exposure to the discipline.

ROTATION SPECIFIC GOALS AND OBJECTIVES

GOALS:

1. To gain understanding of patient and physician goals in the treatment of patients seeking aesthetic and reconstructive surgery of the head and neck.
2. To gain an understanding of appropriate soft tissue handling skills in surgery of the head and neck.
3. To increase skills in the performance of soft tissue and bony surgery for aesthetic and reconstructive purposes in the head and neck.
4. To develop an increased understanding of indications, contraindications, limitations, techniques and complications of aesthetic and reconstructive procedures of the head and neck.

OBJECTIVES:

1. The resident shall demonstrate understanding of methods designed to integrate patient and physician goals in patients seeking aesthetic and reconstructive surgery of the head and neck. Evaluation methods: direct observation, oral examination, and competency-based end of rotation global evaluation by faculty.
   
   Competency emphasis: interpersonal and communication skills, professionalism

2. The resident shall demonstrate appropriate soft tissue handling skills in the head and neck. Evaluation methods: direct observation, competency-based end of rotation global evaluation by faculty.

   Competency emphasis: patient care

3. The resident shall demonstrate progression in surgical performance of soft tissue and bony procedures for aesthetic and reconstructive purposes in the head and neck. Evaluation methods: direct observation, surgical case logs, competency based end of rotation global evaluation by faculty.

   Competency emphasis: patient care, medical knowledge

4. The resident shall demonstrate understanding of indications, contraindications, limitations, techniques and complications of aesthetic and reconstructive procedures of the head and neck. Evaluation methods: direct observation, oral examination, competency based end of rotation global evaluation by faculty.

   Competency emphasis: medical knowledge, practice based learning and improvement
RESEARCH ROTATION

The research rotation shall consist of 3 nonconsecutive months in the PGY-3 and -4 years, two months during the PGY-3 year and 1 month during the PGY-4 year. During this rotation the resident shall be excused from all clinical duties except night call. There are PGY-specific goals and objectives for each year of residency and they are listed below.

GOALS for all PGY levels:

1. to develop understanding of research design, including formulating a hypothesis and designing an experimental strategy to evaluate it.
2. To become familiar with the regulatory and ethical requirements for the proper conduction of research.
3. To execute a clinical and/or basic science research project from conception to publication.
4. To become competent at oral and written presentation of research findings.

PGY-specific objectives

PGY-1

1. the resident shall complete all prerequisite training required for submission to the IRB.
2. During the Otolaryngology rotations, the resident shall identify a research mentor and possible topic for PGY-2 project.
3. If available, the resident shall attend the “Resident as Researcher” symposium.

PGY-2

1. the resident shall perform a case control study with chart review, to be completed by Resident Research Day in June of the academic year.
2. The resident shall have the project proposal submitted to the Research committee by August 15, with IRB approval obtained prior to the next quarterly meeting of the Research committee (November).
3. The resident shall schedule a training session in the use of the online submission system in order to submit the approved research protocol.
4. The resident shall submit a written progress report to the Research committee at the 3rd quarter meeting (February-March).
5. The resident shall submit an abstract (in Triologic Society format) and draft manuscript for approval prior to presentation on Resident research day. The manuscript will be submitted in its final form for publication in a peer-reviewed journal.

6. The resident will submit the project abstract for presentation at the section meeting for the Triologic Society or other approved meeting.
PGY-3

1. The resident shall develop a research project which entails prospective collection of data and written informed consent.
2. The resident shall be assigned 2 months of dedicated research time, one month during the first 6 months of the academic year and one month during the second six months of the academic year.
3. The resident shall have a written project proposal submitted to the Research committee by August 15; IRB application should be submitted prior to the first day of the first research month. IRB approval should be completed prior to the end of the first research month, if not sooner.
4. The research resident shall not have other clinical responsibilities except call; prior approval of the Program Director will be required to “pull” the resident for other clinical coverage.
5. The resident shall have weekly meetings with Dr. Goldman during the rotation to assess progress and discuss obstacles to performance of research.
6. Written progress reports will be submitted to the Research committee quarterly.
7. The resident shall present an interim summary of his/her research findings at Resident Research day. An abstract (in Triologic Society format) with interim findings will be due prior to the presentation.

PGY-4

1. The resident shall be assigned 1 month of dedicated research time, during the first 6 months of the academic year.
2. The resident shall not be assigned other clinical responsibilities during this time except backup call; if progress toward completion of the project is deemed satisfactory, the resident may be able to take advantage of operative cases in which they are lacking relative to their co-resident and key indicator goals.
3. The resident shall submit written progress reports to the Research committee quarterly.
4. The resident shall have weekly meetings with Dr. Goldman during the rotation to assess progress and discuss obstacles to the performance of research.
5. The resident shall submit an abstract (in Triologic Society format) and a draft manuscript for approval prior to the presentation on Resident Research day.
6. The resident shall submit the project abstract for presentation at the Combined Otolaryngologic Spring Meetings or other approved meeting.
7. The resident shall submit the final manuscript for publication in a peer-reviewed journal.
PGY-5

1. The resident shall serve on the Research committee and attend all called meetings.
2. The resident shall be responsible for initial editing of the PGY-2 and -4 residents’ draft manuscripts.
3. The resident shall attend the COSM if presenting, either podium or poster. Expenses for meeting attendance will be covered by divisional funds.
4. The resident will be expected to complete any outstanding project from the previous year (i.e. submit a final manuscript) by August 31st.

OFFICE BASED OTOLARYNGOLOGY ROTATION

During the PGY-4 year, the resident shall spend one month seeing outpatients in the faculty practice in order to obtain exposure to management of otolaryngic allergy, laryngology, rhinology and pediatrics in a private practice setting. The resident is expected to follow this general schedule:

Monday Morning—allergy
Monday PM—General Otolaryngology or Pediatric Otolaryngology
Tuesday AM and PM—Dr. Gadre otology clinic (every other Tuesday)
Tuesday AM and PM—Dr. Little Plastic clinic
Wednesday—Dr. Chandran laryngology clinic
Thursday—Dr. Winstead rhinology clinic
Friday PM—continuity clinic

The goals of the Office Based rotation are as follows:

1. To understand the breath of general and subspecialty otolaryngology office practice
2. To understand the components of the preoperative and postoperative general and subspecialty otolaryngology patient visit
3. To understand the daily practice of office evaluation, billing and coding and outpatient utilization of ancillary testing in an otolaryngology private/academic practice.

Specific subspecialty objectives are stated below:

Objectives for Laryngology

1. The resident should achieve proficiency in videostroboscopic examination and diagnosis using both flexible and rigid laryngoscopy with the digital KayPENTAX videostroboscopic equipment.

2. The resident should achieve a basic understanding of voice therapy techniques used for dysphonia, muscle tension dysphonia, and vocal cord dysfunction.

3. The resident should be able to take an adequate voice history in the assessment of the voice clinic patient.

4. The resident should understand the surgical vs. medical decision-making process in patients with various voice disorders.

5. The resident should be able to adequately utilize ancillary services for evaluation of hoarseness, such as labs and imaging as well as other consulting physicians.

Objectives for Pediatric Otolaryngology:

1. The resident should achieve proficiency in the preoperative evaluation of otitis media, adenotonsillar disease, pediatric chronic rhinosinusitis, pediatric airway issues, and pediatric nasal/neck masses.

2. The resident should be able to document experience in performing adequate history and physical exam in a spectrum of pediatric patients from newborn through adolescence.

3. The resident should be able to formulate a differential diagnosis of various pediatric otolaryngology conditions.

4. The resident should be able to adequately obtain informed consent from patients and parents regarding basic surgical and office procedures.

5. The resident should be able to assess postoperative results for adequacy of treatment.

OTOLARYNGIC ALLERGY: The resident is expected to obtain sufficient knowledge to diagnose and treat allergy related disorders of the upper respiratory tract.

The resident is expected to gain this knowledge by reading appropriate textbook assignments, attending lectures given by faculty, participating in Allergy focused Grand Rounds and Journal
Clubs, attending intramural and extramural didactic and hands-on courses, and performing supervised patient evaluations in the outpatient setting.

The resident is expected to learn and gain practical hands-on experience with otolaryngic allergy testing and treatment techniques in the clinical setting.

Curriculum

Specific Reading Assignments

> Allergy in ENT Practice: The Basic Guide, King, et al, 2005
> Food Allergy, Trevino, et al, 1997

Cognitive Goals and Objectives:

1. Learn basic immunology related to allergic etiology and symptomatology.
   - Exhibit an understanding of basic immunology related to the Gel and Coombs Classification with emphasis on Type I (IgE mediated) and Type III (Immune complex mediated) immunologic responses.
   - Exhibit knowledge of cellular and chemically mediated responses and their affect on symptom production.

2. Learn concepts, specific etiologies and symptomatology of seasonal and perennial allergies.
   - Become familiar with seasonal allergens, their classification, and timing of pollination/prevalence.
   - Become familiar with local and regional environmental factors affecting antigenicity and potency of allergens.
   - Understand the multiple etiologies of perennial allergies.
• Learn common allergic symptoms related to the ears, nose, mouth and throat and the head and neck region in general.

3. Learn theory and principles of food related allergy, etiology and diagnosis.

• Exhibit an understanding of fixed ("anaphylactic") food allergy, its causes and symptoms.
• Exhibit an understanding of cyclic ("delayed") food allergy, its causes and symptoms.

4. Expand knowledge about medications useful for the treatment of allergy, their indications, contraindications, appropriate dosing and side effects.

• Become familiar with the proper patient selection, use and dosing of antihistamines, decongestants, mucolytics/expectorants, corticosteroids (oral and topical), leukotriene inhibitors, and other "allergy" medications.
• Understand potential side effects and contraindications of allergy medications.

5. Learn principles, techniques and indications for testing the suspected allergic patient.

• Exhibit knowledge and understanding of allergy testing principles as they relate to skin reactivity (erythema and whealing) to allergens when applied topically, by prick method, intradermal injection and progressive dilutional testing.
• Gain knowledge of different testing techniques including skin testing and in-vitro testing and the applications of each.
• Understand indications for testing the suspected allergy patient and the indications and contraindications of specific testing techniques.

6. Learn clinical indications for and techniques for immunotherapy.

• Exhibit understanding of when to recommend immunotherapy to the allergy patient.
• Exhibit understanding of how immunotherapy affects the patient’s immune system and how it results in symptom control.

7. Learn the signs, symptoms and treatment of anaphylaxis.

• Develop knowledge of the physical signs and symptoms of anaphylaxis and be able to differentiate them from those of the vasovagal reaction.
• Develop knowledge of basic and advanced treatment methods for anaphylaxis.
**Technical Goals and Objectives:**

1. Learn to interpret symptoms and physical signs of inhalant allergy.
   - Develop basic and advanced history skills in order to recognize the common symptoms of otolaryngic allergy.
   - Develop basic and advanced physical exam techniques to recognize common physical signs of otolaryngic allergy.

2. Learn techniques for inhalant allergy testing.
   - Gain practical experience with basic skin testing techniques and interpretation by observing and performing prick, intradermal and dilutional techniques in the clinic and laboratory setting.
   - Learn in-vitro testing techniques (with emphasis on RAST-type) and be able to interpret results.
   - Apply knowledge of etiologic factors of inhalant allergy to techniques of environmental control and avoidance measures.

3. Learn application of avoidance and medical management for inhalant allergy.
   - Understand and recommend allergy avoidance measures, including environmental controls measures, for the treatment of inhalant allergies.

4. Learn methods for diagnosis and treatment of fixed and cyclic food allergy.
   - Recognize methods of diagnosing fixed food allergies to include detailed history and in-vitro testing for IgE mediated reactions and principles of avoidance.
   - Recognize the major steps in the food allergy “cycle” and be able to apply them in the clinical setting.
   - Be able to utilize the Elimination/Challenge test for the diagnosis of cyclic food allergy in the clinical setting.
   - Understand and be able to apply use of the Rotary Diversified diet in the management of cyclic food allergies.

5. Learn techniques necessary for providing immunotherapy (Both SCIT and
SLIT).

- Apply skin and in-vitro testing results for application to immunotherapy treatment.
- Prepare skin testing treatment boards.
- Prepare multi-dose multi-antigen vials based on test results.
- Perform and interpret vial tests.
- Administer allergy shots to patients.
- Manage immunotherapy dose escalation.
- Understand maintenance immunotherapy.
- Understand problem solving during immunotherapy.
6A. EDUCATIONAL CONFERENCES & ROUNDS

The Program goals and ACGME competency of medical knowledge are supported by a comprehensive educational program of conferences, rounds, courses, and tests of progress in medical knowledge. Although extensive, these group activities are not intended to be a substitute for a disciplined, regular individual reading program. Rather, they are intended to guide and supplement such a program.

The University campus, our teaching hospitals, and the Medical Society Buildings are clustered in a four-block area (except the VA, which is five minutes away), and all conference sites are within these teaching facilities. Attendance of all residents is mandatory at all the above listed conferences, rounds, courses, symposia, Journal Clubs, Visiting Professor lectures, and research seminars except conferences specific to individual rotations, for which mandatory attendance applies only to the resident on that rotation. The residents are provided 3.5 hours (8:30 AM-10:30 AM Monday and 7:00 AM-8:30 AM Friday) of protected didactic time per week, during which their primary responsibility is to attend scheduled conferences and courses. Absences during this time must be approved in advance by the Program Director.

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

1. Core Curriculum Conference (Friday, weekly, 7:00 a.m., BCC)
2. Clinical Case Conference ((Monday, Weekly, 8:30 a.m., VAMC)
3. Quality Improvement Conference (2nd Monday, monthly 9:15 AM, VAMC)
4. Otolaryngology Study Group (mandatory for PGY-2 and other invited guests), weekly August-December
5. Facial Trauma Conference (4th Wednesday, 7:00 AM, HCOC)

The clinical case conference focuses on management plans for upcoming challenging cases and indications for surgery. The patients are presented to the faculty and resident group by the resident responsible for care of the patient. Relevant ACGME core competencies in the plan are cited and emphasized. As with all patient presentations, the resident must generate and describe a complete management plan prior to faculty input. This plan will then be analyzed and refined by the faculty and other residents in a Socratic format.

6. Quality Improvement Conf. – Surgery (M & M) (Last Thursday, Monthly, 8:00 a.m., VAMC) (Last Wednesday, Monthly, 7:00 a.m., ULH Pathology Department)
7. Plastic Surgery Conference (Wednesday, Weekly, 7:00 a.m., JH) Facial Plastic Surgery topics held in conjunction with the Division of Plastic Surgery.
8. Book Club (Monday, Weekly, 9:30 a.m., VAMC; follows Quality Improvement conference on 2nd Monday)
9. Head and Neck Tumor Board (Friday, Quarterly, 12:00, BCC)
10. Head and Neck Conference (Weekly, 9:30 a.m., BCC)
11. Journal Club (Fourth Wednesday, Monthly, 6:00 p.m., TBA)
   This monthly conference uses both classic and current journal papers. The articles are briefly
   summarized, critically analyzed and related to clinical practice by the presenting residents,
   followed by an organized general discussion by other residents and faculty. The articles are
   chosen by the residents with faculty guidance. The location is usually at a restaurant conference
   room or the home of a division member.
12. Fresh Tissue Laboratory Dissection Conference (Bi Monthly, TBA)
   This exercise is a dissection of clinically relevant anatomy done on a fresh cadaver in our Fresh
   Tissue Dissection and Surgical Practice Laboratory. Anatomy relevant to clinical practice, such as
   flap design and neck dissections are frequently used on a challenging upcoming case. The
   discussion is led by a designated faculty member or expert, with residents doing the technical
   dissection to enhance their skills. Handouts and graphic supplements are frequently used.
13. Surgery Grand Rounds (Fridays, 7:00 a.m., Weekly, ACB).
   This weekly conference is presented by faculty or a visiting expert. Otolaryngology residents will
   be notified when the subject is of relevance to our specialty. In such an instance, conference
   attendance will be required.
14. Surgery Department Resident Teaching Conferences
    (Fridays, Weekly, 8:15 a.m., ACB).
    This weekly conference is scheduled for resident education by the Surgery Department for all
    surgical services. Otolaryngology residents are required to attend those in which ACGME core
    competencies cover basic science, medico-legal, ethics, and practice management issues that
    are relevant to Otolaryngology. The conference is given by academicians or clinicians from the
    University faculty or by outside experts in specific topics.
15. Pediatric Grand Rounds (Weekly, NKS)
    General pediatric grand rounds which have relevance to Otolaryngology from time to time.
16. Temporal Bone Course (Annual, Dr. Gadre)
17. Sinus Course (Annual, Dr. Winstead)
18. Head & Neck Course (Annual, Dr Bumpous)
What kind of responsibility do residents have for the preparation and presentation of conferences?

Resident responsibility for the preparation and presentation of all conferences is as follows:

Generally, all residents are responsible for preparing for each mandatory conference regardless of PGY level. However, residents are not required to present at conferences on otolaryngology subjects until their PGY-2 year.

For Morbidity and Mortality/Quality Improvement Conferences, the otolaryngology resident may be called upon to present. This presentation requires considerable preparation and is performed in a meticulous fashion using the protocol described in Gordon’s Guide to the Surgical Morbidity and Mortality Conference (In: Gordon, LA: Hanley & Belfus Medical Publishers, 1995). A PowerPoint presentation is most often used.

Tumor Board Conferences are generally chaired by attending surgeons. The otolaryngology residents are responsible for bringing the support documentation such as laboratory results and x-rays. The quarterly Tumor Board at the Veterans Affairs Medical Center is completely resident run. This requires considerable preparation.

Each resident is expected to deliver a 30-45 minute Power Point presentation, several times annually as part of the weekly core curriculum conference. Clinical conferences are often supplemented with a basic science component. Again, these presentations are prepared and presented by the resident on any given rotation. The schedule of topics and assignments are prepared at the beginning of the academic year by the chief residents and Associate Program Director; each resident is assigned a faculty mentor for their topic(s) and the faculty member is responsible for vetting the presentation and being present at the conference to facilitate discussion.

Recently, as a program improvement initiative, all residents participate in practice-based learning and activity via the surgical learning and instructional portfolio (SLIP), which requires self-reflection on a
particular patient they have encountered and allows for critical evaluation of patient care outcomes. The SLIP is required 4 times annually, with faculty feedback provided on each submission.

Residents are expected to obtain permission from the program director prior to missing any scheduled educational activities. Resident participation and attendance is reviewed with the resident at the semiannual and annual evaluation.

**What responsibility does the faculty have for preparation and presentation of conferences?**

Faculty frequently prepare and present at conferences specific to their discipline. The faculty preceptor is expected to review assigned weekly book club reading materials and to prepare a written, board format, 10 question quiz for each session. All faculty are expected to attend the weekly clinical case Conference, Morbidity and Mortality/Quality Assurance Conference at their designated institution, and Tumor Boards when applicable. The scheduling of routine clinical activity is discouraged for faculty and prohibited for residents during these times. Other conferences are attended depending on the area of expertise of the individual faculty member.

**How is conference attendance monitored?**

Conference attendance is recorded electronically in New Innovations. Attendance is entered and monitored in the electronic record by the Associate Program Director.
7. ETHICS CURRICULUM

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

1. **Core Curriculum Conference:** An ethics topic is presented at least annually.
2. **Book Club:** Ethics discussions are integrated into the topic presented whenever relevant.
3. **Surgery Department Resident Teaching Conference:** Ethics, medical-legal, practice management and basic science topics are regularly scheduled in this weekly conference held every Friday at 8:15 A.M. You will be informed when any of these topics are relevant to Otolaryngology. Attendance is mandatory for these topics.
4. Special seminars in medical ethics are regularly held by the U of L, our Teaching Hospitals and the Medical Society. You will be notified of these seminars when they occur.
5. Each resident will receive a copy of The Principles of Medical Ethics and The Fundamental Elements of the Patient - Physician Relationships from the Code of Medical Ethics of the AMA. They are Attachment 2 of this manual.
6. The current edition of the Code of Medical Ethics of the AMA is available to all residents in the Division office for reference and self-study, and is provided to all residents joining the Jefferson County Medical Society, and Kentucky Medical Association ($40.00 for the entire residency). It is Supplemental Reference Manual #1. Basic knowledge of medical-legal principles and current legal issues are included in our educational curriculum by case example upon occurrence, by presentations in the General Competencies Conference, by special seminars and by self-study courses described below.
8. MEDICAL-LEGAL CURRICULUM

1. **Core Curriculum Conferences**: Medical-legal discussions are integrated into the topics presented whenever relevant.

2. **CD-ROM Course**: A CD-Rom on Basic Medical-legal principles and risk management is available by joining the Jefferson County Medical Society and Kentucky Medical Association.

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

4. When available, residents will receive a summary of basic medical-legal principles and periodic updates. This summary is reprinted from the Law and Medicine series published in the Journal of the American Medical Association.

5. The current edition of the Legal Handbook for Kentucky Physicians (KMA) is available to all residents in the Division Reference Library and is provided to all residents joining the Jefferson County Medical Society and Kentucky Medical Association.
9. SOCIOECONOMICS & PRACTICE MANAGEMENT EDUCATION

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

1. Core Curriculum Conference:
   A practice management, topic is given at least once each semester.

2. Book Club Conference:
   Socioeconomic discussions are integrated into the topics presented whenever relevant.

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

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

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

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

7. A summary of Medicare Compliance Regulations is available through the University of Louisville Compliance Office.

8. A set of manuals on basic practice management principles are available to all residents for a self-study course. These are most useful during the senior year, or whenever practice arrangements are being made.

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

10. The AMA Handbook, Marketing Strategies for Private Practice is available. It contains excellent instructions on good communications to patients and referring physicians. Skill, compassion, good care and good communications are all the marketing you will ever need. It is Supplemental Reference Manual #4.

11. The Jefferson County Medical Society Department of Practice Services provides an excellent introduction to managed care issues, and managed care contracts. This information is available by joining the Medical Society. It is Supplemental Reference Manual #5.


10. ANNUAL SYMPOSIA & VISITING PROFESSORS

A. Annual Symposia

The Division sponsors or co-sponsors resident and faculty participation in a number of annual courses and symposia. These courses include the following:

1.) University of Louisville Temporal Bone Course (Annual)

PGY-3 residents attend an extramural Temporal Bone Dissection course annually, with tuition paid by the Division.

3.) University of Indiana Head and Neck Basic Science and Histopathology Course

This is a seven day course given in Indianapolis and attended by the PGY-4 residents. The Division pays for the tuition and travel expenses. It is a comprehensive didactic course at Indiana University. It is now in its 52nd year, the longest standing otolaryngology basic science course in the U.S.A. Our program director is part of the course faculty.

4.) AAOA Basic Allergy Course

This course occurs in July annually and is attended by the PGY-5 residents. The Division pays the tuition and travel.

5.) AAO-HNS Annual Meeting

University of Louisville chief residents attend this meeting at Division expense; any other residents who have papers accepted for oral or poster presentation may also attend at Division’s expense.

6.) Kentucky ENT Society (annually)

Residents participate in the research competition annually. All faculty and residents are required to attend when the conference site is Louisville; in alternate years, representative faculty and at least 3 residents will attend.
8.) University of Michigan – Temporal Bone Dissection Course.

This extensive five-day course is designed as a complete temporal bone dissection course for our PGY-3 residents in training. The objectives of the course are to improve the surgical skill of the participants through a series of dissection exercises and to review essential topics in otology, neurotology and skull base surgery.

9.) Maxillofacial Fixation Course

Each year a hands-on course in maxillofacial plating and internal fixation is sponsored by the Division and supported by plate manufacturing companies. Demonstrations are given by the faculty, with residents performing the technical exercises at individual practice stations; it is attended by PGY-2 residents.

10.) Research Symposium

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

11.) Visiting Professors

The Division of Otolaryngology-Head and Surgery, The Kentucky ENT Society and the Louisville ENT Society sponsor several visiting professors during the year.

In addition, the Department of Surgery and Louisville Surgical Society maintain active Visiting Professor Programs including the annual Yandell lectureship. Many of these lectures are relevant to Otolaryngology and the residents will be invited.
11. MAINTAINING AN OPERATIVE LOG

In order for the Division Director to certify program completion and allow you to sit for your Board examinations, you must have gained sufficient clinical experience during your training. The current standard is to have performed enough procedures to be well above the National Medians defined by the Residency Review Committee in all categories (Section 4).

Operative log documentation of cases performed is by current procedural terminology (CPT) coded and logged by each resident daily, on both a personal record and on the ACGME website (www.acgme.org) designed for this purpose. You will be given a user I.D. and password to access your log. A weekly confirmation that your operative log is up-to-date with experience recorded each week must be confirmed with the Division Secretary, and the quality of experience should be reviewed with the faculty member designated as the service supervisor on your rotation.

Vacation approval, elective experience, and operative privileges may not be granted if the case logs are not up to date with daily entries. Disciplinary actions may be invoked as described in Section 34. You cannot graduate from this training program unless your operative logs are completed and reflect an adequate volume and balance of operative experience.

The operative log documentation of your experience in residency has become of prime importance in confirming service to the University and its hospitals in maintaining resident salary lines, and in obtaining your hospital operative privileges after graduation. Be sure that each and every one of your procedures are recorded. If procedures involving new technology (e.g., new lasers, new endoscope, etc.) are not on the document, record them under “other” and record the exact device (e.g., type of laser).

Keep a copy of your operative log for the purpose of credentialing after graduation, with a spare copy in a safe place. The ACGME will keep copies of your operative logs for a short time, but not permanently. The Division will not keep copies beyond your graduation. It is in your best interest for you to keep these records securely and permanently, as all hospital and other credentialing agency requests will be referred to you.

Handheld (Palm) software from the ACGME is available for use by all residents. Instructions for the ACGME Resident Data Collection System are online at www.acgme.org.
12. BASIC SCIENCE EDUCATION & RESEARCH EXPERIENCE

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

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

B. Core Curriculum Conferences: Presentations of research topics at least once each semester are included in these conferences.

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

D. Please refer to the Section describing the Research Rotation for specific requirements; there are clearly delineated requirements for each PGY level which are described in detail in that section.

Support mechanisms for research are myriad and growing. The following funded programs have resident participation:

1. Parathyroid Surgery Studies
An extensive prospective clinical database of over 500 patients is available for resident prospective study and evaluation. Recently, parathyroid tissue biochemistry has also been included in the laboratory which will provide further collective studies for the residents. Collaborative opportunities for microassaygenomics are in place.

Support: Norton HealthCare, $50,000 annually

Research Mentors:
Jeffrey M. Bumpous, M.D.
Richard Goldstein, M.D., Ph.D.
Michael Flynn, M.D.

2. Nasal Neural Progenitor Cell Program

This is a program designed to develop, define and enhance endoscopic minimally-invasive retrieval of nasal progenitor cell harvest. Techniques including contact endoscopy and cell in-situ autofluorescence are utilized and taught to research residents. Both animal model (rat) and human endoscopy and retrieval represent elements of this program.

Support: NIH and Rhinocyte, Inc.

Research Mentors: Welby Winstead, M.D.
Fred Roisen, Ph.D., Chairman, Dept. of Anatomy

5. Head and Neck Cancer Quality of Life Outcomes Program

Disease specific and general quality of life outcome studies research.

Support: NIH and Brown Foundation, Humana Foundation
Research Mentors: Jeffrey M. Bumpous, M.D.
Jennifer Scharfenberger, R.N., Ph.D.

6. Anatomic Surgical Studies: (Otology, Head & Neck, Facial, Plastics)
Utilizes the fresh tissue cadaver laboratory to answer pertinent anatomic questions, and tests hypotheses related to otolaryngology-head and neck surgical anatomy, approaches, and minimally invasive techniques.

Support: Michael Nolph Fund
Division of Otolaryngology ($2000 - $5000 annually)

Research Mentors: Jeffrey Bumpous, M.D.
Robert Acland, M.D.
Arun Gadre, M.D.
Thomas O’Daniel, M.D.
13. ETHICS, HONESTY, & CONDUCT

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

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

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

D. It is very important to read, and fully understand the ethics documents in Appendix 3 and 4 of this manual.
14. TEACHING RESPONSIBILITIES

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

Periodic conference time and educational materials are integrated into the overall educational program in an effort to help develop the teaching skills of the residents.
15. SERVICE ROTATION SCHEDULE

A. The service rotations are designed to provide the Otolaryngology resident with a rich, comprehensive and balanced exposure to all areas of the specialty. The primary rotations as outlined in the Block Diagram of service rotations (Attachment1) take place at the following institutions:

1.) University of Louisville Hospital, Louisville

2.) Veterans Administration Medical Center

3.) Kosair Children’s Hospital

4.) Norton Hospital

5.) Jewish Hospital

6.) Outpatient Operating Suite of the University Surgical Associates & the Brown Cancer Center

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

B. The resident assigned to the service encompassing each of these sites must first cover the cases of his/her assigned service. To spend any time away from these hospitals, specific permission must be given by either the Program Director or the full-time academic faculty who have cases on that service that day. However, we strongly encourage requesting this permission for cases of strong educational value or critical operative log need, wherever they might occur. This will permit flexibility to exist such that these operative educational needs are met with the highest priority.
C. The service rotation schedule is designated to cluster the educational experience provided by our core facilities into blocks of a meaningful level of concentration for a meaningful length of time. The service rotation schedule (Attachment 1), and the educational goals of each rotation are described in Section 5. The first obligation of the Otolaryngology residents is to significant cases of full-time academic faculty members of the Division, for assisting in surgical cases and supervised patient care. If a conflict occurs between educationally valuable cases of full-time academic faculty members or community faculty members, the conflict must be discussed at least 24-hours in advance in order to allow sufficient time for resolution or arranging alternative assistance if needed. This pertains to all situations including vacation time, any leave of absence, or if the resident wishes to perform a case with other divisions or with a member of the volunteer faculty.

When there are conflicts in staffing cases, it is the responsibility of the chief resident to resolve the issue. It is the chief resident’s right to assign another resident to the full-time academic faculty case, if this is discussed with the full-time academic faculty member at least 24-hours ahead of time. If these policies are violated, the offending resident will be disciplined, including loss of permission to participate in cases of the volunteer faculty for the remaining duration of the rotation. Unexcused absence from cases of the academic full-time faculty, without approval for good educational reason, warrants disciplinary action and possible training termination as detailed in Section 34.

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

1.) Jewish and Norton Hospital – Arun Gadre, M.D.
2.) Kosair Children’s Hospital – Swapna Chandran, M.D.
3.) Veterans Administration Medical Center Hospital – Welby Winstead, M.D.
4.) University of Louisville Hospital and Clinics service – Larry Florman, M.D.
5.) Norton Hospital – Jeffrey Bumpous, M.D.
16. DUTY HOUR LIMITATIONS

The 80-hour work hour limits call structure and conditions recommended by the ACGME Otolaryngology-Head and Neck Surgery RRC Program Requirements and the University of Louisville are observed.

A. Resident duty hours must not exceed 80 hours per week when averaged over a 4 week period. “Duty hours” are defined as:

1. Patient care (both inpatient and outpatient).
2. Administrative duties related to patient care (i.e., dictation).
3. In-house call activities.
4. Academic activities (conferences).

B. “Work site” is defined as University Hospital, Jewish Hospital, Norton Hospital, VA Hospital, Kosair Children’s Hospital, University of Louisville Clinics, all private offices.

C. PGY-1 through 3 residents should be given 10 hours, and must be given 8 hours, off for rest and personal activities between duty periods.

Senior residents, in order to prepare for the practice of medicine and providing care over irregular or extended periods of time, may be allowed to remain in the hospital to provide patient care in exception to the 8 hour duty-free period. These exceptions must be closely monitored by the program director and in the context of the 80 hour-averaged-over-4-weeks, one day free in 7 work hours model.

D. In-house call is not a requirement of the Otolaryngology Residency Program. A permanent call room has been assigned to our division if needed.

A. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours for PGY-2 and above residents; the resident may remain on duty for up to 4 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics and maintain continuity of medical and surgical care. Strategic napping is recommended after 16 hours of continuous duty, especially between the hours of 10:00 PM and 6:00 AM. No new patients may be accepted by the resident after 24 hours on call.

B. PGY-1 residents may not work longer than a 16-hour continuous duty period.
F. Resident time spent in the hospital when on second call, reserved call or University call will be counted towards the 80 hours.

G. Residents will be given one day off out of 7 free of all educational, clinical and administrative activities.

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

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

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

J. Monitoring

  - 1. Random monitoring by the Program Director and Full Time Faculty will be performed.

  - 2. According to the Department of Surgery policy, residents must complete a duty log in New Innovations every week.

  - 3. The Chief Resident on Service shall be responsible for reporting concerns of duty hour violation to the Program Director.

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

A thorough explanation of these rules is available in the University of Louisville Resident Policies and Procedures Manual Section 8, Pages 10-11.
17. CALL RESPONSIBILITY

A. During weekdays, from 07:00 to 17:00, the resident on each service will be responsible only for that service and its emergency room consults, intraoperative consults, floor calls and consults, and calls from resident or faculty patients of only that service, that are directed to the resident. The only exceptions to the day call responsibilities described in Section 16, above, are when covering for another resident and true emergencies requiring response from the most readily available resident, irrespective of rotation assignment. Each resident in the Division of Otolaryngology is required to take night and weekend call based upon the monthly resident call schedule that is posted prior to the first day of each month.

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

C. The overall attending and resident call schedule is made monthly by the chief resident and program director. The administrative chief resident assists by assigning first call, second call and chief resident on call, for each day (see below). Modifications to this call schedule may be made after the schedule is posted, if deemed necessary by the Program Director. Weekend call changes at 07:00 the morning of the call day and lasts for 24 hours. Weekday night call is from 17:00 to 07:00 the next morning. On night and weekend call, the first call resident will cover all teaching services, all in hospital and emergency department consults, and all telephone calls. The second-call resident and chief resident on-call will be responsible and available for backing up the first-call resident with either physical and/or intellectual support. The second-call resident and chief resident on call will be available by pager and telephone at all times to provide this back-up support. Both resident and faculty monthly call schedules are published on-line and posted in the Division office.

D. Be reminded that all residents are acting under the auspices of the University of Louisville and University Surgical Associates, P.S.C., and the Otolaryngology attending on call in particular. All night and weekend cases that the first-call resident sees in consultation in the Hospitals or Emergency Rooms, Operating Rooms or Wards, will be presented initially to the senior-call resident. It is then the responsibility of either the first-call or the senior-call resident to present each case and all pertinent data pertaining to that case to the attending of record. This may be modified based upon the attending’s preference, which should be clearly determined at the beginning of each call period. (For example, some attendings will wish to be called by the first-call resident, while others may agree to let the senior-call resident make clinical decisions up to a pre-determined level.) Similarly, any patient phone calls that are not straight-forward and require more complex decision making, or that could significantly impact upon a patient’s care should be presented to the senior-call resident. The attending will be informed of all consultations, admissions, changes in patient status, or need to perform procedures in the emergency department, wards or operating room. Outpatient cases at the Kosair Children’s Emergency Room will be discussed directly with the Kosair medical staff member on-call that month who has been assigned responsibility for the patient by the Kosair call schedule rotation. University Kosair admissions (from ER or direct) and inpatient consults are to be discussed with the faculty attending on call. Similarly, other affiliated hospitals, University faculty cases and referrals will be discussed directly with the responsible
attending. Failure to meet call responsibilities may result in disciplinary actions or dismissal, as described in Section 34.

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

F. All admissions to the Otolaryngology service must be approved by the attending otolaryngologist, as residents do not have independent admitting privileges. Failure to obtain attending approval of an admission, transfer or a treatment plan will constitute grounds for disciplinary action or dismissal, as described in Section 34.

G. The first-call resident’s primary responsibility is to see the Emergency Department consultations, ward consultations and patient care calls of the University Otolaryngology Services at the University of Louisville Hospital, Veterans Administration (VA) Medical Center, Norton HealthCare Hospitals (Norton, Kosair Children’s, Alliant Medical Pavilion and the Norton HealthCare affiliates), and Jewish Hospital. Currently, we take no ER calls at hospitals other than those listed above, but we do receive occasional consultation requests. Such requests should always be discussed with the appropriate attending.

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

1.) Based upon the learning value and complexity of the case the resident may assist in the case as an agent under the supervision of the community surgeon responsible for the patient’s care. The primary responsibility for care of these patients cannot be transferred from the responsible community surgeon to the resident under any circumstances, although the resident may perform minor outpatient procedures (e.g., lacerations, abrasions, minor burn care, etc.) for the community surgeon under his/her supervision and responsibility and send the patient for follow-up to the community surgeon’s office or admit the patient to the community surgeon’s service. If a volunteer faculty member who is an active teacher in the program specifically requests the on-call resident’s assistance with a case, and the on-call resident is not engaged in another case, every effort should be made to accommodate that request. The on-call resident will not, however, be excessively burdened with time-consuming cases of marginal or no educational value. If the resident feels that he/she is being taken advantage of in this process, the Program Director should be informed, and he will instruct the responsible volunteer faculty member in proper protocol.

2.) Consults originating from the affiliated emergency departments (such as Kosair Children’s) when a community volunteer faculty member or is on call will be covered by the on-call resident only for actively teaching volunteer faculty and only on days (currently every third) when the University of Louisville Hospital Otolaryngology team is on maxillofacial trauma call. During months when the Otolaryngology full-time attendings are on call at any of the U of L affiliated hospitals, the on-call resident will cover consults and admissions to the full-time faculty members at all times, irrespective of the U of L Hospital 3-day rotation maxillofacial trauma call schedule.
3.) Otolaryngology residents do not have independent practice or admitting privileges, therefore, they are not allowed to admit, accept transfer from another institution, nor treat any patient at any hospital without the expressed authorization of the attending or staff surgeon responsible for the patient. At the U of L and VA hospitals, this is the full-time faculty. At other affiliated hospitals, these actions must be authorized by the fully licensed staff Otolaryngologist that is responsible for the specific case, and recorded in the patient’s medical records. These actions or any other care can be done only on behalf of the staff surgeon. Taking independent action to accept an admission, treat a patient or see a consult without appropriate authorization by the staff surgeon exposes the resident to liability and is forbidden. This constitutes grounds for disciplinary action and possible dismissal, as described in Section 35. In the event that you are asked to assume responsibility for a patient without prior staff authorization and chart documentation, courteously refer the request to the appropriate surgeon on call at that hospital, or to the service on call if a rotating schedule is in effect, but do not assume independent responsibility or give any impression that you are permitted to do so.

RESIDENT-FACULTY COMMUNICATION DURING ON-CALL PERIODS

The first call resident must notify the backup resident and the attending on call of all consults and admissions received during the on-call period.

The first call resident may use his/her discretion regarding timing of this call, i.e. whether the backup resident and attending should be notified right away or if the call can wait until closer to the end of the call night. Residents should err on the side of caution when making this determination.

During the last hour of on-call duty, the first call resident should notify the backup resident of all consults and admissions received; the junior resident should use this call as an opportunity to “rehearse” his presentation prior to calling the attending and informing him of the overnight events. This will allow the backup resident to guide the junior resident in “filling in the blanks” in the workup with lab values, scans, or pertinent physical findings. The junior resident should then call the on call faculty member and give him the report.

Do not assume any consult is too minor to be discussed; all patients seen need to be presented.
18. TRANSITIONS IN CARE

DEFINITIONS:

TRANSITION OF CARE:
Transition of care is defined as when a physician transfers the care of a patient to another physician. This includes sign-out as well as sign-in. It also includes the transfer of a patient from one level of care to another or a new admission or consult to the service. By definition, it also occurs when a physician transfers the care of a patient at the end of a rotation and a new physician assumes the care of the patients on that service.

PROPER HANDOFF OF PATIENTS:
The proper handoff of patients should include at least the following: the junior resident on the service should contact the on-call resident and give a proper verbal checkout of the service’s patient list, starting with the most difficult or most problematic patients first in case the checkout is interrupted by an emergency. Information provided to the on call resident should include active problems, recent or upcoming procedures, outstanding laboratory or radiology tests, current therapies, and nature of anticipated problem along with a suggested course of action. The exiting resident should then post his patient list with aforementioned information as an email to the secure Otolaryngology Service account (otolaryn@louisville.edu) where it may be viewed by the attending faculty and other residents. The verbal handoff should take place face-to-face when feasible but the physical distance between hospitals may preclude this, so telephone contact is acceptable. All attempts should be made to perform the handoff in an unhurried manner as to convey all necessary information.

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

DETAILS:

TIMING OF HANDOFFS:
Morning handoffs should occur by 7 AM; evening handoffs should occur by 5 PM. The morning handoff should be done verbally, face to face if possible, and include information about any overnight problems, new admissions/consults, transfers to a higher level of care, and pending test results.

END OF SERVICE HANDOFFS:
End of service handoffs should be done by all members of the resident team together when possible; the most senior resident on the team assuming care should initiate the handoff which should take place face-to-face and be comprehensive and detailed.

EVALUATION OF HANDOFF SKILLS:
Junior resident handoffs will be monitored by the senior resident cohort for the first month of their Otolaryngology call; verbal feedback will be given in real time to reinforce the learning process. Attending faculty will monitor the Service Account for completeness of information and timeliness of postings and may choose to request verbal checkout from the junior resident until satisfied with their performance. A question will be added to the monthly faculty evaluation of resident performance as well as the peer evaluation of resident performance.
19. FACULTY SUPERVISION & STAFFING

OVERVIEW:

The ultimate responsibility for care of patients treated by the Division of Otolaryngology-Head and Neck Surgery at the University of Louisville is that of the attending physician and surgeon. Residents are principally involved in the care of patients for educational purposes; it is the attending physician who is ultimately responsible for the development and delivery of care to any given patient.

A. RESPONSIBILITIES OF THE RESIDENT

1. It is the responsibility of the resident to communicate about every patient that they see in the course of their duties with an attending physician.
2. It is the responsibility of the resident to communicate with the attending physician about both inpatients and outpatients referred and/or seen by our service.
3. It is the responsibility of the resident to discuss acceptance of new patients to the service with the appropriate attending physician.
4. It is the responsibility of the resident on-call in the evenings, on weekends, and on holidays to notify the attending physician of any new patients seen, and to communicate and/or round with the attending physician(s) on call.
5. It is the responsibility of the resident to notify the appropriate attending physician of any and all patients going to the operating room or being transferred to an increased level of care.
6. It is the responsibility of the resident to notify the attending physician of any significant changes in the patient’s status; major changes in the patient care plan must be discussed with the responsible attending. Any plans for withdrawal of care (i.e. DNR orders) MUST be written by the attending physician.
7. It is the responsibility of the resident to monitor their own Duty Hours thereby assuring the duty hours limitations are not exceeded. When there is about to be a Duty Hour violation, the resident is to immediately request that another resident take his/her place. If this is not possible, then the Program Director must be immediately contacted.

We frequently have medical students rotating on our service. It is the responsibility of the resident to assist faculty in monitoring and mentoring the students.

B. RESPONSIBILITIES OF THE FACULTY (ATTENDING PHYSICIANS)
1. It is the responsibility of the attending faculty member of each clinic and service to communicate with the resident staff regarding all inpatient and outpatient aspects of patient care.

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

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

4. It is the responsibility of the attending faculty member who is on-call to discuss and see patients with the resident staff during his/her call period. This means that the resident will have full access to the on-call faculty member by personal interaction, telephone, and beeper during the call period. Any decisions regarding withdrawal of care must be made and the order written and signed by the attending.

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

6. It is the responsibility of all faculty members to be aware of the signs and symptoms of stress and fatigue among the residents, and to immediately notify the Program Director such instances occur.

C. RESPONSIBILITIES OF THE PROGRAM DIRECTOR

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

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

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

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

5. It is the responsibility of the Program Director to be aware of all issues concerning resident stress and fatigue, and to assure that the resident is directed for appropriate care of these issues.

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

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

F. The level of technical responsibility given to the resident will progress sequentially as determined by the growth of technical skill:

(1) Residents will first learn the key elements of new procedures as an observing assistant.

(2) The key portions are then progressively turned over to the residents as their ability permits, with supervision by the attending as a teaching first assistant.

(3) In selected procedures, practice in the fresh cadaver lab may be helpful.

(4) Next, the resident assumes the role of surgeon for the entire procedure, with the faculty member observing or serving as a teaching first assistant only as required by the level of complexity or by compliance regulations.

(5) As resident skill improves the resident care progresses to full independence in selected teaching settings such as University Hospital, with the attending always readily available for consultation or assistance.

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

H. Otolaryngology residents at the U of L Hospital and the Louisville VA Hospital (but not at other affiliated hospitals) are allowed to perform certain cases in the operating room under attending supervision and availability, but without the physical presence of an attending in the operating room. However, a resident cannot take any patient to the operating room without previously discussing the case and formulating an operative and management plan with the attending of record and approved by him. No operation can be done without previous consultation and notification of scheduling with the attending. The attending must be made aware that an operation is to be scheduled and exactly when. The attending physician must be immediately available to the resident. This may also constitute grounds for disciplinary action and possible dismissal from the University of Louisville Residency Training Program, as described in Section 34.
20. CHIEF RESIDENT RESPONSIBILITIES

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

1.) He/she will be responsible for making the monthly on-call schedule and submitting it at least ten (10) days prior to the start of the month to the residency coordinator for posting on the website, or by transmittal via email. The call schedule must not conflict with work hours policies (see Section 16).

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

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

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

1.) He/she will be responsible for organizing the Grand Rounds speaker schedule and for organizing the format along the guidelines of the 12 RRC mandated topics. Each month will be assigned to one of the RRC mandated topics (unless a separate conference is dedicated to that field). Also, medical legal, ethics, practice management and basic science topics will be each included at least once each semester as a Grand Rounds or General Competencies Conferences topic.
2.) He/she will be responsible for assuring that electronic attendance logs are completed and distributing CME evaluation forms at all conferences and rounds. This may be delegated to a designated junior resident, with faculty approval.

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

4.) He/she will be responsible for organizing the Journal Club, as detailed in Section 6:11.
21. MEDICAL RECORDS

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

B. The resident will perform the operative dictation at University Hospital and the V.A. Some attendings prefer to do the majority of their operative dictations at the Norton and Jewish Hospitals, so clarify this individually. Who is to dictate the operative report and write orders should be clearly decided immediately at or before the completion of the case. All dictations should be done on the day of the procedure, and immediately after the case is completed. NOTE: This is also the best opportunity for entry of the record in to the ACGME web-based operative log.

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

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

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

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

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

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

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

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

A. Billing for operative procedures, consultations, and admissions done at Norton, Jewish, and Kosair Hospitals is the responsibility of the attending surgeons. At University Hospital, all operations, new patient evaluations, H&Ps, consultations and ward, or ER procedures must be documented in the medical record and reported by the otolaryngology resident using the current yellow card system. These yellow cards must be submitted to the Division Secretary on a daily basis each morning. The cards must be filled out completely to allow our billing personnel to submit the appropriate charges in an efficient and timely manner. Required data includes the attending of record, the patient’s name and hospital number, and the procedure performed with appropriate CPT language or code and appropriate clinical detail to allow for adequate coding and billing. For example, laceration repair should cite the number of centimeters closed, locations of the laceration, and whether or not it was a simple, closed in one layer, intermediate (multiple layers) or complex (with debridement and/or advancement repair).

All otolaryngology emergency room and inpatient consultations must be dictated, with an indication of who is the attending of record. Consultations on the VAMC CPRS medical record must use the Otolaryngology Consultation Template. These billing protocols serve two main purposes. First, to fully return appropriate compensations for the services rendered. Second, to familiarize residents with proper billing procedures. In your future practices, each of you will be highly dependent upon complete knowledge of the proper coding and billing process. Lack of knowledge, unintended errors, or inadequate documentation of services rendered may subject you to severe penalties for fraud, irrespective of intent. It is in your best interest to now learn how to do this accurately and with precise documentation.

B. Residents not yet thoroughly familiar with CPT coding should become so. This will be the language of communication with third party payers for your practice lifetimes. Each resident must have access to a current CPT manual and one will be made available to you (Supplemental Reference Manual, #6).
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was instituted in the United States to ensure the protection of individuals’ health information while also allowing communication between parties involved with patient care. It was not until 1999, however, when the U. S. Department of Health and Human Services developed the Privacy Rule that made implementation of HIPAA mandatory. Effective April 2003, organizations (i.e., “covered entities”) subject to HIPAA regulations were required to comply with patient information protection policies. “Covered entities” refers to health plans, healthcare providers, and health care clearinghouses.

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

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

State governments reserve the right to have supplemental policies to further increase patient privacy protection. Check with your institution to determine additional policies and guidelines.

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

Suggestions for HIPAA Compliance

1. Be aware of your surroundings. Do not discuss patients in public places such as elevators, waiting rooms, public hallways, and lobbies.
2. Dispose of identifiable health information, such as patient lists, in the appropriate manner. Most hospitals have labeled containers for material that is to be shredded.
3. Do not publicly display patient information. This includes both in hospitals and outpatient clinics (i.e., do not leave patients charts unattended).
4. When discussing scenarios or presenting a case to individuals not directly involved in the care of a patient, do not disclose identifiable patient information.
5. Do not identify patients over the internet.

HIPAA AT A GLANCE

What is HIPAA?

Governed the use and disclosure of protected health information (PHI) that is created or received by a covered entity that relates to:

1. The physical or mental health of an individual (living or deceased).
2. The provision of health care.
3. The payment for health care.
4. Identifies the individual or reasonably may be used to identify the individual.

Gives individuals the following rights. The right to...

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

Administrative requirements. The covered entity must...

1. Designate a privacy official.
2. Develop policies and procedures that are HIPAA compliant.
3. Provide privacy training to the workforce.
4. Implement administrative, technical, and physical safeguards to protect the privacy of personal health information.
5. Develop sanctions for violations of the HIPAA Privacy Rule.
6. Meet the documentation requirements.

Enforcement / penalties (individual, not institutional):

1. Civil penalties:
   a. $100 for each violation, up to $25,000/person/year.
   b. Liability exists if a person knew, or reasonably should have known, of a violation and did not try to rectify the situation.

2. Criminal penalties:
   a. Knowing:
      i. Up to $50,000/year and/or imprisonment of up to 1 year.
   b. False pretenses:
      i. Up to $100,000/year and/or imprisonment of up to 5 years.
   c. Intent to sell, transfer, or use for commercial advantage, personal gain or malicious harm:
      i. Up to $250,000/year and/or imprisonment of up to 10 years.

Impact on researchers:

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

Allowable uses and disclosures of PHI for research:

1. Authorization from subject
2. Waiver of authorization from IRB
3. Use of de-identified data
4. Use of limited data set
5. Preparatory to research
6. Decedent data

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

A. The residents in the University of Louisville Otolaryngology-Head and Neck Surgery Resident Training Program are entitled to 4 weeks of vacation annually (4 week vacations with 2 weeks of vacation every 6 months. Prior approval for any vacation or leave must be requested by submitting both the vacation/leave form and a verbal notification to the Division Secretary at least one month prior to the beginning date of absence. The form must be signed first by the covering resident, and then by the Program Director. Unauthorized absences will result in loss of subsequent vacation time and disciplinary measures, as described in Section 34.

B. An additional leave of a maximum of 10 weekdays is available for residents who qualify for attendance at a national meeting (Section 25), and foreign volunteer surgical missions (Section 26). These 10 days are at the discretion of the Division Director.

C. Vacations, leave, or interviews may not be taken during June, July, December (other than the 1st week), the week of the In Service Examination, or the Week of the Annual Academy meeting. Any urgent matters requiring leave during this time require a letter of explanation to be countersigned by the Program Director.

D. Only one resident is allowed to take vacation at a time. Consult with each other well ahead of vacation plans to prevent overlap. Every attempt should be made to not take vacation the same month as another missed weekday absence (meetings, courses, etc.), especially if within 2 weeks of above mentioned weekday absence.

E. If needed, graduating senior residents may be excused of taking call the last week of June, as well as first call for the last 2 weeks of June.
Policy for Resident Time Off

(bereavement, maternity leave/ paternity leave, job/fellowship interviewing, scientific meeting, etc.)

Time off in addition to regularly scheduled days off and approved vacation time may be granted at the digression of the Program Director or the Associate Program Director for a variety of reasons. These reasons include bereavement, maternity leave/ paternity leave, job/fellowship interviewing, attendance at a scientific meeting, etc. In addition there may be other extenuating reasons that a resident would request additional time off during the course of their training. The resident time off request form is mandatory to be filled out for this time and leave to be approved. The form is available from the Otolaryngology Office or on New Innovations. All important elements of this form should be completed in order for a time off request to be approved. The referenced forms can be found in attachment 3.

It is the resident’s responsibility to arrange coverage for their duties during their absences, as well as notification of the attending physician responsible for the educational site at which they are rotating. (Refer to New Innovations Rotation Assignment Schedule.)

Depending on the timing, the service, and the resident’s specific duties, additional attendings may require notification to ensure the smooth flow of patient care responsibilities.

The resident time off request form should be signed by the Program Director or Associate Program Director before the time off request is approved and valid. These forms will be maintained in the Residency Coordinator’s office and the residents file as a permanent record of time off during the residency training program.

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

I. Absences
When it is necessary for a house staff member to be absent from duty, he should inform his senior resident, his attending staff, hospital operators, and Steven Gonzales, Otolaryngology Program Coordinator at 561-7268.
26. NATIONAL MEETING ATTENDANCE

A. Senior residents are expected to travel to one (1) approved national AAO-HNSF meeting in their PGY-5 year. Travel expenses are covered by the Division of Otolaryngology according to University of Louisville travel guidelines (up to $995 as of 2007). Registration, airfare, hotel accommodations, and meals up to the allowable per diem are included in this limitation. All expenses in excess of $995 must be borne by the resident. The time for these conferences will not be counted against vacation, but it is limited to the length of the conference plus one-day travel time on each end and, must not exceed eight days total.

Also, the resident must have fulfilled the following criteria:

1. The resident must have demonstrated satisfactory clinical performance as determined in his/her written evaluations.

2. The resident must have exceeded the 25th percentile in all categories of the annual Otolaryngology In-service Training Examination.

3. The Senior resident’s operative log must be on par with their PGY level.

4. Chief residents attending the AAO-HNSF annual fall meeting must have completed the Academy’s Travel Grant Award Application in a timely fashion such that the Division is eligible for resident travel reimbursement from the AAO-HNSF.

B. Residents with an accepted paper at a plenary session of an otolaryngology national meeting will be allowed to travel with expenses covered up the previously discussed University of Louisville monetary limits. Residents with an accepted poster presentation may be allowed to attend meetings with the same divisional program support at the discretion of the program director and the availability of travel funds.
27. OVERSEAS HUMANITARIAN MISSIONS

An extra week of leave will be provided to allow senior residents to participate in travel abroad for approved humanitarian activities in the field of Otolaryngology-Head and Neck Surgery. This trip will be at your own expense or with travel covered by contributions arranged from pharmaceutical or equipment supply companies. Permission for this trip is dependent upon the satisfactory accumulation of cases as detailed in Section 5, and upon satisfactory overall performance. Contact the Program Director to obtain essential information needed for this opportunity. A certain amount of funding may be available for this activity, keeping in mind that all expenses in excess of $995 must be paid by the resident.

Our program has a proud heritage in regard to humanitarian missions, with two past residents having received the American Academy of Otolaryngology-Head and Neck Surgery Humanitarian Service Award.

To be eligible for such an opportunity, residents must be in good standing with the program as determined by the faculty and program director.
1. The Otolaryngology Program subscribes full to the “Resident Moonlighting Policy,” as established and revised by the Graduate Medical Education Committee of the University of Louisville School of Medicine.

2. The Otolaryngology Program does not require residents to participate in outside employment activities. PGY-1 and -2 residents are forbidden from moonlighting; residents may engage in moonlighting to a limited extent in their PGY-3 to PGY-5 years. This privilege is contingent upon meeting performance-based criteria and may be withdrawn or denied at any time by the Department Chair, or the Program Director.

3. All residents must sign a Moonlighting Status form at least every six months. This form, which will be kept in each resident’s file, will be used to monitor the number of residents engaged in moonlighting in the program.

4. If a resident wishes to moonlight, he or she must first complete a Moonlighting Request form and obtain written approval by the Otolaryngology Residency Program Director. The proposed site and number of moonlighting hours must be approved by the Program Director prior to the initiation of moonlighting. Any changes to the proposed moonlighting schedule must be approved as well.

5. Moonlighting privileges are contingent upon achieving a minimum score of 50th percentile overall on the previous year’s Otolaryngology In-Training Examination, timely completion of all projects and assignments, and satisfactory progression toward peer-based standards of operative cases.

6. Time spent moonlighting must be counted toward the 80-hour maximum for work hours, averaged over a 4 week period; these limits will be strictly enforced and any encroachment of regular duty hours by moonlighting hours will not be tolerated or allowed, and will result in revocation of moonlighting privileges. Moonlighting hours must be logged into New Innovations at least monthly. Moonlighting must NOT interfere with the resident’s ability to achieve the goals and objectives of the educational program.
7. Moonlighting must be done outside of the usual time where the resident would be expected to be present in the hospital or clinic on a particular service. Chief Residents on the service must have signed out to an equivalent level resident to cover during the moonlighting period. Moonlighting internally at University Hospital, Norton Healthcare, Jewish Hospital, or the Veteran’s Administration Medical Center is strictly prohibited.

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

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

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

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

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

The following has been extracted from the University of Louisville School of Medicine “Red Book”:

UNIVERSITY OF LOUISVILLE

RESIDENT MOONLIGHTING POLICY

SCHOOL OF MEDICINE

1. Programs must not require residents to participate in outside employment activities (moonlighting).

2. Resident physicians who hold either a Regular or a Residency Training (RT) license in Kentucky shall be free to use off-duty hours in appropriate related activities, including engaging in outside employment activities, so long as the resident obtains the prior written approval of the Department Chair or Program Director for such outside employment activities, and so long as such activities do not interfere with the resident’s obligations to the University, impair the effectiveness of the educational program engaged in, or cause detriment to the service and reputation of the hospital to which the resident is assigned.

3. Each program must develop a moonlighting policy that is consistent with the Resident Moonlighting Policy of the University of Louisville. The policy must give guidelines for outside employment activities of residents, including defining the hours and rotations when such outside employment activities may be permitted, and under what circumstances permission may be denied for outside employment activities. Residents are required to comply with individual program policies.

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

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

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

7. Resident physicians who hold J-1 or H-1B visas are not permitted to engage in activities or have additional income other than what is listed on their forms DS2019 (J-1 holders) or I-797C (H-1B
holders). Federal regulations specifically prohibit outside or additional income for individuals with J-1 visas. Employment of H-1B holders is limited to the petitioner (employer) and activities listed on the I-797C.

8. Residents found to be in violation of this policy will be subject to disciplinary action as detailed in the University of Louisville School of Medicine Resident Agreement.

9. Program Directors are required to monitor and approve in writing all moonlighting hours and locations for residents and maintain this information in the resident’s file.

10. Programs are encouraged to monitor all individual resident moonlighting hours each month to assure outside activity does not contribute to excess fatigue or detrimental educational performance.

Approved by GMEC: 4/17/2000

Revision approved by GMEC: 3/21/01

Revision approved by GMEC: 5/21/03

Revision approved by GMEC: 2/18/04

Revision approved by GMEC: 11/15/06

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New Innovations Policy for Residents and Fellows

1. New Innovations is a web-based graduate medical education management system. This system helps programs and institution to manage scheduled, evaluations, duty hours, and procedures.

2. Residents and fellows in University of Louisville School of Medicine training programs are required to use the New Innovations Residency Management Suite.

3. Residents and fellows may use the New Innovations system to:
   a. Track their patient encounters
b. Log their duty hours  
c. Complete their evaluations  
d. Log their procedures*  
e. View their block, call, clinic, and conference schedules  

4. Residents and fellows will be trained by their Program Coordinators to use the New Innovations system.

*Residents who are required to log their procedures directly with ACGME or their specialty board can provide summary reports of these entries to their program coordinators instead of logging procedures in New Innovations.
29. ROLE OF THE RESIDENT IN THE EDUCATION OF MEDICAL STUDENTS

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

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

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

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

Toni Ganzel, M.D., faculty in pediatric otolaryngology, is also the Dean of the University of Louisville, School of Medicine. She represents an important resource with regards to the resident’s role in medical student education.
A. Faculty Evaluation of the Program

The faculty will review the program goals and objectives at least once a year. The faculty also have the opportunity to evaluate the program anonymously in writing via survey annually.

B. Resident Review of Program and Faculty

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

C. Internal Review

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

D. ACGME Evaluation

The RRC for Otolaryngology-Head and Neck Surgery of the ACGME evaluates all programs periodically. Residents, without faculty presence, are interviewed in this process. You are excused from all clinical duties and obligations for these interviews.
31. RESIDENT PERFORMANCE EVALUATION

The performance of each resident will be reviewed and discussed at least twice yearly. A formative evaluation will be held in January with the Associate Program Director and a summative evaluation will be held in June with the Program Director. Significant concerns will be documented and communicated to the resident. Formal remediation plans will be formulated as necessary and written copies given to the resident.

Twice yearly, any significant concerns from these evaluations will be formally summarized in a letter of advancement or non-advancement and presented to the resident for his/her review and records. If individual circumstances require more frequent formal reviews and closer monitoring, this will be arranged.
32. GUIDELINES FOR ADVANCEMENT, PROMOTION & COMPLETION

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

1. Absolute honesty, integrity and highest ethical standards must be maintained in all circumstances.
2. Upon the admission of every patient, and prior to each and every significant operative procedure, you must contact the responsible faculty member to present your analysis and your management plan for review, and to arrange scheduling.
3. Completion of your Operative Log at levels exceeding the minimum standards in all categories, especially Key Indicators as prescribed by the Otolaryngology RRC.
4. Completion of all hospital charts, and full compliance with all required documentation in records for billing and Medicare compliance is required.
5. All Medicare patients must be identified to the responsible faculty member at each encounter for proper documentation of Medicare compliance requirements.
6. Attendance and participation in all conferences must be faithful.
7. A strong performance on the in-service examination is expected and you must maintain an active and ongoing program of reading and study.
8. Responses to consultations and pages must be prompt and courteous.
9. Courtesy and respect in all interactions is expected.
10. Your record must be free of sexual harassment, dependency or abuse of drugs or alcohol.
11. A certain level of skill must have been gained in the actual performance of the surgical operations that have been learned. These technical skills will be finely tuned during the entire course of your career in otolaryngology.

The residents assume progressively increasing responsibility for patient care according to their level of training, their ability and their experience (i.e., patient care, teaching rounds, preparing and presenting at conferences, research).
The program is organized to facilitate progressive levels of clinical, administrative, and teaching responsibilities with advancing PGY level of training. PGY-1 residents participate in a junior level of training that includes entry level Advanced Cardiac Life Support (ACLS) and Advanced Trauma Life Support (ATLS) training. Furthermore, the course of study for the PGY-1 resident emphasizes pre and postoperative care of the surgical patient and critical care skills that are fundamental for a surgical specialist. Additionally, the PGY-1 year is designed to introduce the resident to closely related and interfacing clinical specialties of relevance including Pediatric Surgery, Emergency Medicine, Trauma and Critical Care, Thoracic surgery, and Neurosurgery. Course work in the PGY-1 year additionally includes laboratory exercises in the basic handling of soft-tissue and suturing skills, Clinical Competency Awareness, and programs on the ‘resident as teacher’ to name a few. Basic surgical procedures such as laceration repair, incision and drainage of abscesses, and tracheostomy are also taught to this resident level to the point where they are confident as the operating surgeon.

PGY-2

In the PGY-2 year the more intensive introduction to Otolaryngology occurs and the resident has the entire year to become familiar with the basic evaluation and management of inpatient and outpatient adult and pediatric otolaryngology patients. Furthermore, the PGY-2 resident begins to perform in-patient consultations primarily with the supervision of more senior residents and attending staff. The PGY-2 resident becomes a primary resident on the Pediatric Otolaryngology services and learns and performs procedures such as myringotomy with tube placement, tonsillectomy and adenoidectomy, removal of pediatric neck masses, pediatric laryngoscopy and bronchoscopy. The PGY-2 residents in our program and the PGY-5 residents in our program are the primary presenters at our Monday Morning Pre and Postoperative Conference. The PGY-2 resident becomes responsible for attending the Multidisciplinary Head and Neck Clinic and Conference which subjects them to considerable didactic and Socratic teaching on the basics of management of patients with malignancies of the head and neck. It is in the PGY-2 year that the resident, for the first time, is responsible for delivering 45-minute grand rounds on a basic science topic in Otolaryngology-Head and Neck Surgery. The PGY-2 year is the first year in which the resident becomes responsible for an independent research project with a faculty member or an improved mentor in the University of Louisville School of Medicine.

PGY-3

In the PGY-3 year, the resident assumes much greater responsibility in the operative management of more complex patients. The PGY-3 year is the first year in which the resident becomes the primary or first line resident at the Norton Hospital rotation. This is a seminal year, because this represents one of the earliest
opportunities for the resident to become the “primary” surgeon in adult head and neck cases such as thyroidectomy and neck dissections, endoscopic sinus procedures, tympanoplasty, mastoidectomy, and laryngectomy, to name a few. At the University of Louisville Hospital rotation, the PGY-3 resident develops skills in the operative repair of maxillofacial injuries and the AO/ASIF principles of maxillofacial fracture repair. The University of Louisville and VAMC rotations give additional opportunities for further growth as primary surgeon in the full range of adult head and neck procedures including facial plastic and reconstructive procedures such as rhinoplasty, blepharoplasty, minor and major facial flaps, and skin tumor excision. The PGY-3 residents attend the Indiana University Basic Science and Histopathology Course in Otolaryngology, which is a two-week course with laboratory in which they have no clinical responsibilities.

PYG-4

In the PGY-4 year, the resident develops for the first time some administrative responsibility in that he/she becomes part of the “second line,” or back-up call resident. This allows the PGY-4 an opportunity to mentor and teach junior residents and medical students, as well as interact with the students as the “senior resident.” The residents at the PGY-4 level rotate on the Norton rotation, University of Louisville rotation, the VAMC rotation, and for the first time the Plastic and Reconstructive Surgery rotation. This resident is seldom if ever in the operative assistant role in our program and has taken on a primary role as an “operative” surgeon. At the University Hospital rotation, the PGY-4 begins to take on an introductory role as “teaching” surgeon to their PGY-2 counterparts. It is in this year that the resident begins to participate in hospital and program-based tumor boards and multidisciplinary conferences. The PGY-4 residents also serve as chief residents at the times when their PGY-5 counterparts are on vacation or are at meetings. In the outpatient clinics, the PGY-4 residents are given greater autonomy in assessment, decision-making and planning for patients.

PGY-5

In the PGY-5 year the residents are placed into responsibilities and activities, which promote independence in clinical assessment, decision-making and therapeutic interventions. In a program with nine residents, there is no administrative chief resident; rather the two chief residents share this role. The principle sites of rotation for the PGY-5 residents are at the VAMC and at the University of Louisville Hospital. The chief residents operative role is as operative surgeon or teaching surgeon, under the supervision of the attending faculty. This year provides opportunity for greater independence in the operating room on cases such as composite resection, maxillectomy, advanced endoscopic procedures, and more complex otologic, and plastic and reconstructive surgery cases. In terms of education, the PGY-5 residents are expected to mentor their junior colleagues in fresh tissue cadaver dissections, the temporal bone lab, and participate as instructors in the didactic lectures of the program. The chief residents play a collaborative role in the education of medical students at the University of Louisville School of Medicine.

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

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

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

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

5. The faculty will recommend whether promotion will occur at the spring semi-annual resident evaluation meeting. The Program Director will make the final decision on promotion based on the faculty recommendation.

Remediation and Dismissal of Residents

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

A. Remedial Individual Education Plan – Consists of specific reading and examination sessions under the direction of the program director.

B. Probation – Involves heightened scrutiny, increased monitoring and specific reporting requirement by the resident, but without loss of clinical privileges.

C. Non-advancement – Ends training at an annual or semi-annual point short of program completion and prevents eligibility to sit for the certification examination of the American Board of Otolaryngology. Annual advancement and program completion are confirmed by a formal letter.

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

   1.) Theft

   2.) Sexual harassment as defined by the University. (House Staff Policy and Procedures, page 32-33)

   3.) Cheating on the in-service training examination.

   4.) Lying
5.) **Gross acts of insubordination**, as determined by Program Director and the full-time academic faculty.

6.) **Negligence or incompetence** in patient care.

7.) **Criminal acts**

8.) **Drug, alcohol, or substance abuse, or dependence.**

9.) **Medical practice or other employment outside the residency program ("moonlighting"), without the express knowledge and consent of the Program Director**

10.) **Failure to complete medical records and dictations and failure to comply with Medicare compliance regulations.**

11.) **Any other infraction** specifically named as grounds for dismissal by the Department of Surgery or the University of Louisville.

Academic discipline actions leading to dismissal will be handled with full due process, as defined in the United States Constitution. The process outlined in the Department of Surgery House staff Manual and the U of L Redbook will be followed.

**D. Non-award of the certificate of completion.** It is the right of the Program Director, based upon your performance and/or faculty evaluations, to not sign the certificate of residency training completion. Without this certificate, a resident is ineligible to sit for the written and oral examinations of the American Board of Otolaryngology-Head and Neck Surgery and he/she cannot claim graduation from this program, or be certified by the American Board of Otolaryngology.
Annual evaluation of core curriculum knowledge in Otolaryngology-Head and Neck Surgery will be measured by the In-Service Examination. The In-Service Examination is a standardized test administered every spring (usually early in March). The examination takes approximately 5 hours and is given online in one location. The Division will register you for this examination and will also assume all fees involved. All residents must participate in this examination.

No vacations may be taken during this time period. Failure to participate may result in disciplinary action or dismissal.

Most training programs in Otolaryngology-Head and Neck Surgery administer this examination. Your performance will be compared to that of all other otolaryngology residents overall and in your year of training. The results of your performance will become part of your permanent resident file and will be used as a factor in the overall summative evaluation. Continued poor performance will serve as evidence of failure of the resident to acquire sufficient knowledge to pass the written part of the otolaryngology board examination. In addition, the exam scores may be distributed to the otolaryngology residents, full time academic faculty and volunteer faculty to allow these individuals to assist in providing educational opportunities and counseling. Remedial education plans may be developed for residents with a poor performance, as determined by the program director. A score equivalent to the 3rd stanine or below puts the resident at increased risk of failure of the qualifying exam for Board certification; those at this level or below will be required to attend weekly study group sessions with the Associate Program Director.

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

Resident grievances will be addressed using the process outlined by the University of Louisville School of Medicine, House Staff Policies and Procedures Manual, Section XXIII, Page 44.

If discussion with the person involved does not provide resolution, the person’s supervisor should be involved. The Program Director and/or the faculty may be asked to become involved at this point.

If this does not resolve the issue, the student Grievance Officer may be requested to mediate. If the issue still persists, the formal process will then be used as outlined by the University of Louisville, School of Medicine, House Staff and Procedures Manual involving a written statement to the Academic Unit Grievance Committee through the Office of the Dean, as outlined in the House Staff Policies and Procedures Manual, Section XXIII, Page 44.
35. DISCIPLINARY ACTIONS & GROUNDS FOR DISMISSAL

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

A. Remedial Individual Education Plan – Consists of specific reading and examination sessions under the direction of the program director.

B. Probation – Involves heightened scrutiny, increased monitoring and specific reporting requirement by the resident, but without loss of clinical privileges.

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

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

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

E. **Non-award of the certificate of completion.** It is the right of the Program Director, based upon your performance and/or faculty evaluations, to not sign the certificate of residency training completion. Without this certificate, a resident is ineligible to sit for the written and oral examinations of the American Board of Otolaryngology-Head and Neck Surgery and he/she cannot claim graduation from this program, or be certified by the American Board of Otolaryngology.
36. POLICY ON RESIDENT RECRUITMENT AND SELECTION

I. Purpose

To insure a fair and equitable process in the evaluation of prospective trainees and the selection of highly qualified individuals for subspecialty training in Otolaryngology-Head and Neck Surgery.

II. Eligibility and Residency Application

A. The Otolaryngology-Head and Neck Surgery Residency Program will adhere to all Department of Surgery and University of Louisville institutional policies regarding eligibility for participation in residency training programs at the University of Louisville.

B. Applicants will complete all of the following prior to entry into the program:
   1) M.D. degree at an Accredited Medical School in the United States of America or recognized international medical school with similar accreditation.
   2) Successful completion of a PGY-1 year in surgery at the University of Louisville.
   3) Ability to obtain and maintain licensure to practice medicine in the states of Kentucky and Indiana.
   4) Ability to obtain and sustain a current unrestricted DEA certificate for the prescribing of controlled substances.
   5) Foreign medical graduate applicants must be fully certified by the ECFMG to be an eligible candidate. Applicants who are not citizens of the United States must possess or be eligible for one of the following:
      i. J1 Clinical Visa
      ii. Valid Employment Authorization Document
      iii. Valid Permanent Resident Card
   6) In addition, as of the 2010-2011 academic year, schools located outside the U.S. and Canada must:
      i. Be officially recognized in good standing in the country where they are located
      ii. Be registered as a medical school, college, or university in the International Medical Education Directory
      iii. Require that all courses must be completed by physical on-site attendance in the country in which the school is chartered
      iv. Possess a basic course of clinical and classroom medical instruction that is
          1. not less that 32 months in length; and
          2. under the educational institution’s direct authority
   7) The following are not accepted for residency or fellowship training
      i. J1 Research Visa
ii. J2 Dependent Visa
iii. H1B Visa

The enrollment of non eligible residents may be cause for withdrawal of accreditation of the involved program and/or the sponsoring institution.

III. Procedure

A. The Division of Otolaryngology-Head and Neck Surgery at the University of Louisville participates in the National Residency Match Program (ERAS-NRMP) which is a national matching program for Otolaryngology-Head and Neck Surgery. All residents are selected through the NRMP match. In the event of transfer of residents in to fill a vacant position, the policies of the Common Program Requirements of the ACGME and the Residency Review Committee in Otolaryngology will be strictly adhered to.

B. Residents will apply to the NRMP within the specified deadlines for the anticipated academic year in which they will begin as a PGY-1 resident.

C. Once NRMP applications are received for a given year, the Faculty Residency Selection Committee will select candidates for an interview. The committee consists of the program director and 2 full time faculty members.

D. Approximately 45 candidates will be selected for an interview. Three groups of 15 candidates will be interviewed during 3 or 2 days. Interviews are conducted by all of the full-time faculty and two residents from the PGY-4 level. All residents will have the opportunity to meet and talk to the candidates. They will provide input and feedback to the program director, faculty members and two resident representatives.

E. Once all interviews are concluded, the faculty and residents will meet to discuss the candidates. Each will submit a rank order list to the program director.

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

A. Once the match process has occurred, the program director will contact the matched candidates both formally in writing, and informally by phone.

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

V. Resident Complement

The Otolaryngology-Head and Neck Surgery Residency Program at the University of Louisville School of Medicine is approved by the Accreditation Council for Graduate Medical Education (ACGME) for 2 residents per year for a total complement of 10 residents.

VI. Falsification of Application or Other Materials

A. Falsification of information on the NRMP application, Resident Contract or supporting documents for these aforementioned forms may result in termination of the resident from the program.

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

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

VII. Conclusion

The system of future resident selection that we use is quite democratic and well thought out. It assures the Program, the University, and the specialty that we have taken every initiative in selecting the finest representatives of the class.
The Otolaryngology-Head and Neck Residency Program is committed to a healthy supportive environment for all.

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

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

2. The mid-year, semi-annual evaluation meeting, the informal rotation evaluation meetings, and the frequent faculty meetings that residents attend are additional opportunities to discuss and resolve stressful situations.

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

**RESIDENT STRESS & FATIGUE MONITORING POLICY**

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

**Prevention strategies**

1. Work hour limitations - All rotations will adhere to the eighty-hour clinical workweek limitation, including moonlighting.

2. Moonlighting time is restricted and will be granted only in unusual circumstances.

3. Didactic education on the related topics of the effective regulation of wakefulness; the neurocognitive performance consequences of a disrupted circadian timing system, a disrupted sleep-wake homeostasis with sleep debt; and sleep inertia is provided. Fatigue management strategies and countermeasures are included.

4. Didactic education on the signs and symptoms of substance abuse is provided.

5. Workplace harassment policies and procedures are reviewed.

6. Otolaryngology faculty promotes the culture of healthy lifestyle strategy and shared responsibility.

**Monitoring strategies**

1. The Program Director reviews planned work schedules and moonlighting schedules to assure duty hour requirements are met and circadian scheduling principles are demonstrated.

2. House-staff have a responsibility to communicate off-service rotation schedules believed to be out of compliance with the ACGME eighty-hour workweek over four weeks on average.

3. Faculty or Resident direct observation of the signs and symptoms of fatigue, stress, substance abuse, or mental health disorder are discussed and confidentially addressed individually by the
Program Director. Some examples include irritability, distractibility, social isolation, rapid weight shifts, excessive sleepiness; lack of interest in educational offerings; shift tardiness, acute clinical decision-making difficulty.

4. Direct resident feedback regarding resident stressors is sought via 6-week evaluations of rotations, at the semi-annual performance review, and review of the program’s ACGME resident survey results.

5. The Program Director will refer/cooperate with resident involvement in the Kentucky Physician Health Foundation, The Counseling Center, and other health services as the need arises.

6. The Program Director will meticulously follow the guidelines as set forth in the Department of Surgery, Surgical Resident Manual, P. 77, and the University of Louisville, School of Medicine, Resident Policies and Procedures, P. 24.

7. In case of fatigue issues, a Cab Voucher System has been instituted for all residents. For details, go to http://louisville.edu/medschool/gme/hsc_files/cabprogram.htm

Residents who exhibit signs of impairment due to substance abuse are referred to the Kentucky Physicians Health Foundation (KPHF) for evaluation in accordance with Kentucky medical licensure laws. KPHF evaluates and monitors impaired physicians for the Kentucky Board of Medical Licensure (KBML) under a formal contractual arrangement. The University follows the recommendations of this organization for the treatment and monitoring of impaired residents as well as the written policies of the University of Louisville Hospital. As residents begin training in University programs, they are required to complete a “Hospital Privileges Application,” which requires information about their personal health status and includes questions related to impairment due to alcohol and other drugs.

These applications are reviewed by the hospital Physicians Health Committee (PHC), which in turn makes recommendations to the hospital Credentials Committee. Residents who are in recovery are reviewed at quarterly meetings of the PHC. There is formal written exchange of information about the status of the resident’s recovery between the PHC and KPHF quarterly. Residents who are found to be impaired because of known and untreated substance abuse, or who violate the Kentucky licensure law are referred to the KBML as required by law.
Residents needing assistance or who have questions should contact their Program Director, the Medical Director of the Kentucky Physicians Health Foundation (Dr. Burns Brady at 425-7761), or the Chairman of the University of Louisville Hospital’s Physicians Health Committee.

All discussions and communications having to do with these subjects will be done with complete respect for the delicate nature of these problems, and with dignity. Residents and faculty should be aware that the same maladies which effect residents, also may affect faculty members. These should be addressed in a similar fashion.

The Chair and Program Director are constantly available any time, including at home, (McMasters: 241-6613 / Bumpous: 244-3031) for advice and counseling.
The acceptability of a candidate does not depend solely upon the completion of an approved program of education but also upon information available to the Board regarding his professional maturity, surgical judgment, technical competence, and ethical standing. A candidate who has submitted an Application for Examination will be notified by the Board as to his/her admissibility for examination.
Residents will rapidly determine that the Otolaryngology faculty will not only treat you like an Otolaryngologist, but also like a colleague, and most often like a friend. That is the way this program is run. We expect meticulous adherence to the principles, rules and purposes of this manual and of your chosen profession. And in return, you will be nourished by us, you will learn from us and others, and you will be held in the highest esteem of any medical professional. The goal of this faculty is to make you the best Otolaryngologist, One who will take immense pride in the institution, your instructors, your fellow residents, and in your specialty.

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

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

Ethics
1. Code of Medical Ethics (AMA)

Medico legal
2. Legal Handbook for Kentucky Physicians (KMA and KMIC)

Practice Management
3. Establishing Yourself in Medical Practice (AMA)

4. Marketing Strategies for Private Practice (AMA)

5. Basics of Managed Care (JCMS)

6. CPT03 (AMA) (Available in resident’s office, Medical Records Department, and Operating Room Doctor’s Lounge)

41. CONFIRMATION OF UNDERSTANDING

Otolaryngology-Head and Neck Surgery Resident’s Manual

By your signature, you indicate that you have fully read and understand all of this U of L Otolaryngology-Head and Neck Surgery Resident’s Manual, revised July 2013. If there is anything you do not understand or if you have any questions, ask the Program Director or Associate Program Director, and you will receive answers prior to signing.

SIGNED: __________________________ DATE: ________________
RESIDENT

___________________________________ DATE: ________________
PROGRAM DIRECTOR

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

By your signature, you indicate that you have fully read and understand all of this U of L Department of Surgery House Staff Manual, revised August, 2007. If there is anything you do not understand or if you have any questions, ask the Program Director, and you will receive answers prior to signing.

SIGNED: __________________________ DATE: ________________
RESIDENT

___________________________________ DATE: ________________
PROGRAM DIRECTOR
ATTACHMENT 1

PRINCIPLES OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION

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

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

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

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

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

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

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

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

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

Adopted June 1957; revised June 1980; revised June 2001
Preamble
The following Statement of Principles and Code of Ethics articulate principles of conduct that are deemed appropriate and acceptable by the American Academy of Otolaryngology-Head and Neck Surgery Foundation, Inc. The statements and principles contained herein are not laws, but rather guidelines for honorable behavior. We believe that these ethical principles should be honored by all Fellows and Members intent on maintaining good standing in the Academy. The ethical principles should serve to bring clarity and definition to areas where confusion might occur in the course of contemporary Otolaryngology practice.

The Academy further endorses the current opinions of the Council on Ethical and Judicial Affairs (CEJA) of the American Medical Association. Adhering to these principles should provide guidance to Otolaryngologists in acting honorably and professionally toward their patients.

Principles

2. The best interest of the patient must be the foremost concern of the physician in all circumstances.

3. The patient must be treated with competence, respect, dignity and honesty. Confidences shall be kept except as required by law.

4. The physician must maintain proficiency and competence through continuing study and be diligent in the administration of patient care.

5. Fees must be commensurate with the service rendered.

6. The impaired physician must withdraw from that part of the practice that is affected by the impairment.
7. Academy members should assist fellow members in complying with these principles.

The Physician-Patient Relationship

Each patient must be treated with respect, dignity, compassion, and honesty. The patient’s right to participate in the treatment process must be recognized and promulgated by the otolaryngologist. The otolaryngologist shall be free to choose whom to serve, however discrimination against a patient on the basis of race, color, gender, age, sexual orientation, socioeconomic status, religion or national origin is inappropriate. Confidentiality of patient information is to be maintained, within the constraints of the law and the obligation to protect the welfare of the individual and the community. The otolaryngologist must establish and maintain appropriate relational boundaries, avoiding exploitation of patient vulnerability and specifically avoiding sexual misconduct with patients. The otolaryngologist must disclose actual or potential conflicts of interest to patients, including but not limited to, fee arrangements and professionally related commercial interests. If a conflict of interest cannot be resolved, the otolaryngologist should withdraw from the relationship in a timely, appropriate manner. After having accepted a patient for care, the otolaryngologist may not neglect that patient.

Colleague Interactions

Interactions with colleagues should be based on mutual respect and a desire to improve patient care. Otolaryngologists must recognize their own professional limitations and expertise. Consultation and referral must be sought when appropriate. Communication with colleagues must be truthful and forthright. Disparagement of any kind is to be discouraged.

Commercial Interests

This Code of Ethics does not seek to restrict legal trade practices. However, a physician's commercial or financial interests should never be placed ahead of the interests and welfare of patients. Conflicts of interest undermine the trust that patients place in their physician. For this reason, physicians should endeavor to avoid any venture that creates a conflict of interest between personal financial interests and the best interests of the patient. Conflicts that develop between a physician's financial interests and the physician's responsibilities to the patient should be resolved to the benefit of the patient.

Referral Practices

All decisions regarding patient referral should be based primarily upon consideration of the needs and best interests of the patient. A physician's referral practice should never lead to exploitation of patients or third party payors. Referral to a health facility in which a physician has a financial interest is not in and of
itself unethical. However such referrals are best when the referring physician will be directly involved in providing care to the patient at the facility. In cases where it is not possible or feasible to provide direct care, disclosure of financial interests should be made.

**Prescribing Practices**

Financial interests that the physician might have in the company supplying the product should not influence a physician in the prescribing of drugs, devices, appliances, or treatments. Neither should a physician's referral or admission patterns be constructed so as to enhance the physician's financial interests in any health facility. Physicians should not accept gifts from industries that would influence their prescribing patterns or practices.

**Patents**

Physicians should be allowed to patent devices, but the use of these devices must be in accordance with the patient's best medical interests, without regard to the physician's financial interests. Although it is currently lawful in the United States to patent medical and surgical procedures, such patents issued after October 1, 1996, may not be lawfully enforced against physicians or their affiliated health care institutions. This law is consistent with established principles of medical ethics. Medical and surgical procedures contribute to a universal body of medical knowledge. Unrestricted access to that knowledge is one of the defining characteristics of the medical and surgical profession. Enforcing patent restrictions on medical and surgical procedures limits access to medical knowledge, denies potential benefit to patients, and thus is unethical. Physicians should be allowed to charge a reasonable fee for instructional courses which describe and teach techniques and procedures to other physicians.

**Advertising**

It is not unethical for Otolaryngologists to advertise their services. Advertisement must be truthful and not misleading. An Otolaryngologist should not misrepresent his/her qualifications and/or training, and should not exaggerate the efficacy or uniqueness of treatments rendered. Advertisements should also conform to local legal and commercial requirements with regard to format and content.

**Research**

Otolaryngologists – Head & Neck Surgeons must conduct biomedical research according to ethical, moral, medical, and legal guidelines. All research should respect the dignity and sanctity of human life. The goal of research should be the betterment of mankind, the alleviation of suffering, and the ultimate improvement of medical practice. Research that knowingly and unnecessarily jeopardizes the health, safety, or longevity of human subjects is unethical.
Biomedical research projects should be approved by institutional animal research boards, or human subject boards when appropriate. When possible, animal studies should precede the use of new and experimental techniques in humans. All human research subjects should be fully informed of the benefits and risks of the research being conducted and should give their informed consent prior to participating as a subject in any prospective trial. Further, any subject should be allowed to withdraw from a research protocol at any time without penalty. Research protocols should not be designed in a manner such that the research subject would receive a treatment which knowingly provides less benefit than the currently accepted standard of care.

The patient’s right to privacy must be observed. Communications to the public must not convey false, untrue, deceptive, or misleading information. In addition, these communications should not misrepresent a surgeon’s credentials, training, experience, or ability. Otolaryngologists should seek to avoid conflicts of interest in research. When unavoidable, such conflicts should be publicized.

Credit should be given to all investigators who contribute in a material way to a project. Conversely, co-authorship should not be assigned to individuals who do not participate in the project.

**Character Issues**

Patients and society at large place a high level of trust in physicians. Physicians are held to the highest moral standards in the community. This level of trust is based on an assumption that the physician maintains a high degree of personal integrity and adheres to a professional code of ethics. Physicians are expected to be truthful and honest. Otolaryngologists should conduct themselves morally and ethically so as to merit the confidence placed in them. Anything that detracts from the ability of an Otolaryngologist to conduct himself or herself in such a fashion should be avoided. Otolaryngologists have an obligation to their colleagues to assist them in avoiding or eliminating behavior which is not conducive to maintaining personal integrity.

**Impairment**

Physician impairment represents a potential hazard to patients and to the affected physician. Otolaryngologists should make every effort to recognize the signs of physician impairment in themselves and in their colleagues. The Otolaryngologist who suspects impairment in a colleague has an ethical obligation to the impaired physician and his/her patients. Self-referral for appropriate treatment should be advised and encouraged. The physician should withdraw from any component of practice that adequate assessment deems impaired. Appropriate management, including counseling, should follow.
Should a physician refuse to self-refer when presented with evidence of impairment, Otolaryngologists have an obligation to report to their the suspected physician to their supervisor or medical licensing authorities, particularly if the impairment is a threat to safe patient care. Confidentiality should be maintained for physicians undergoing evaluation and treatment for impairment. Physicians who have completed rehabilitation for impairment should not be restricted from practice provided that proper post-rehabilitation monitoring shows no evidence of relapse.

**Illegal Activity**
Otolaryngologists should realize that they are subject to all civil and criminal statutes applicable to the region in which they practice. They are further subject to federal regulations governing medical practice. Illegal activity by an otolaryngologist compromises his or her own personal integrity, and casts aspersions on the medical profession at large. Otolaryngologists who knowingly participate in illegal or fraudulent behavior should be reported to the appropriate local authorities.

**Fees**
Fees must be commensurate with the service(s) rendered. It is unethical for a physician to charge an illegal or excessive fee. Illegal fee arrangements include charges for services not rendered, fee-splitting in exchange for referrals, and repeated upcoding (i.e., submitting claims with higher codes than is appropriate for the services rendered). Fee collection efforts should take into account the ability of the patient to pay.

Physicians should not withhold vital and emergent treatment to a patient because of their inability to pay. Physicians should not abandon a patient in a post-operative period because of that patient's inability to pay.

**Community Relations**
Physicians have been bestowed by society with trust and respect that no other profession can claim. Physicians in turn have a responsibility to their communities that goes beyond that of other commercial enterprises. Physicians must preserve their role as health advocates within the community. This may involve participation in health education programs. It also may involve the physician adopting a protective role when the health and safety of a community is threatened. Academy members should refuse to cooperate in policies that violate the patients' interests and should become advocates for the sick whenever economics, organizations, or regulations threaten the good and welfare of our patients. Physicians may be called upon to act in other roles as civic leaders within the community. Each physician
must respond within the scope of his or her abilities. Activities that promote the health and well being of the community in a cost-effective way should be supported.

Otolaryngologists should not abandon the underprivileged segments of our society and should be encouraged to devote some time in caring for patients who are unable to pay.

Otolaryngologists should work hard to preserve their good reputation within the community, and should avoid activities that undermine the trust and high regard society places in them.

**Disciplinary Actions**

Otolaryngologists have an ethical duty to report colleagues to state licensing authorities when documentary evidence exists of illegal activity. The Academy's Board of Directors shall have the power to censure, suspend or expel any member who violates the Academy's Code of Ethics, as amended from time to time, including violations of the ethical guidelines of expert witness qualifications and testimony as stated in this code. The Board shall follow the procedures set forth in Section 2.23 of the Academy Bylaws and other procedures that it establishes before taking any disciplinary action based on violation of the Code of Ethics.

**Expert Witness Qualifications and Testimony**

The Academy believes it is important for Otolaryngologists to serve as expert witnesses in legal proceedings to assist in the administration of justice. The Otolaryngologist, as a medical expert witness, shall be appropriately qualified and shall be thoroughly prepared with relevant facts so that he or she can, to the best of his or her ability, provide the court with opinions that are accurate and capable of substantiation with respect to the matters at hand. Physicians serving as expert witnesses must provide informed, objective, and truthful testimony without adopting a position of advocacy, and serve as spokesman for the field of special knowledge the medical expert witness represents. It is unethical for physicians to accept compensation for expert witness testimony that is linked to the outcome of the case. Academy members must follow the "Statement on Qualifications and Guidelines for the Physician Expert Witnesses," attached to this Code of Ethics as Appendix A and incorporated herein by reference. **Appendix A: Statement on Qualifications and Guidelines for the Physician Expert Witness**

I. Recommended Qualifications for the Physician Expert Witness:

A. The physician expert witness must have a current, valid and unrestricted license to practice medicine in the state in which he or she practices.
B. The physician expert witness should be fully trained in a specialty or a diplomat of a specialty board recognized by the American Board of Medical Specialties and qualified by experience or demonstrated competence in the subject of the case. The specialty of that physician should be appropriate to the subject matter in the case.

C. The physician expert witness should be familiar with the clinical practice of the specialty or the subject matter of the case, and should be actively involved in the clinical practice of the specialty or the subject matter of the case, for three (3) of the previous five years at the time of the testimony.

II. Guidelines for Behavior of the Physician Expert Witness:

A. Physicians have an obligation to testify in court as expert witnesses when appropriate to assist in the administration of justice and/or necessary to protect a patient’s legal rights.

B. Physician expert witnesses should not adopt a position as an advocate or partisan in the legal proceedings.

C. The physician expert witness should review all the appropriate medical information in the case and testify to its content fairly, truthfully, and objectively.

D. Physician expert witnesses should review and be thoroughly familiar with the relevant standards of practice and medical literature prevailing at the time of the occurrence, and limit their testimony to their areas of expertise.

E. The physician expert witness should be prepared to state the basis of the testimony presented and whether it is based on personal experience, specific clinical references, or is a generally accepted opinion in the specialty field.

F. Compensation of the physician expert witness should be reasonable and commensurate with the time and effort given to preparing for deposition and court appearance. It is unethical for a physician expert witness to link compensation to the outcome of the case.

G. The physician expert witness should be aware that transcripts of their deposition and courtroom testimony are public records, subject to independent peer review.

Appendix B: Gender Equity Policy and Procedural Guidelines (Adopted 3/6/06 and 9/17/06)
I. The American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS) Code of Ethics endorses the current opinions of the Council on Ethical and Judicial Affairs (CEJA) of the American Medical Association. Opinion E-9.035 sets forth the AMA’s position against gender discrimination in the medical profession. The opinion specifically calls for pay equity for all physicians and specifically between men and women. Gender pay inequity should not exist in any practice setting, whether it be community or academic. This is a part of the broader professional equity for all practitioners of medicine, regardless of gender, race, or creed. The AAO-HNS affirms its support for this position and will continue to work to ensure that such equity is adhered to by its membership. Adopted 3/6/06

II. The AAO-HNS Ethics Committee will receive and review complaints about such discrimination in accordance with the following procedures.

A. AAO-HNS will primarily respond to concerns or complaints regarding gender equity by providing information to the complainant member regarding resources and conflict resolution strategies for consideration by the complainant member.

B. Complainants who seek information on resolution of gender equity issues from the AAO-HNS shall not hold the AAO-HNS liable based on the information provided, and will be required to waive their right to bring litigation action against the association.

C. Complaints and concerns brought forward by a member will initially be addressed by the Chair of the Ethics Committee, who will explain the limited role of the Academy in responding to such complaints or concerns. The Chair of the Ethics Committee will further explain that the Academy cannot provide the remedies that a court or govern-mental agency may be able to provide, and that if the Complainant wishes to pursue legal remedies, such as filing charges with governmental agencies and/or filing a lawsuit, a complaint with the Academy does not toll the limitations periods for so doing. If the complainant member wishes to proceed with filing a gender equity-related complaint with the Academy, he or she must first sign of the waiver referenced in paragraph two (2) above. As with all ethics proceedings, gender equity inquiries or complaints will be treated as confidential unless and until there is a final disposition by the Academy Board of Directors.

D. The Chair of the Ethics Committee will then direct AAO-HNS staff to provide the complainant member with written information on options, resources, and best practice standards and
strategies for conflict resolution of gender equity issues as prepared and/or compiled by the Academy for this purpose.

E. Should the complainant member request informal discussion with the Ethics Committee after reviewing the materials provided, the Chair of the Ethics Committee shall refer the complainant member to the “Gender Equity Resource Subcommittee” of the Ethics Committee for further discussion and review of possible avenues of conflict resolution. This subcommittee shall be composed of four (4) members, two of each gender. The purpose of this subcommittee’s activities is to provide information to the complainant member with regard to conflict resolution strategies. The subcommittee will offer no “advice,” but rather will review the resources available with the complainant member for his or her consideration.

Should the member allege violations of other sections of the AAO-HNS Code of Ethics, then the formal process for evaluation and investigation, as provided for in Procedure B, shall be invoked.
Department of Surgery
University of Louisville School of Medicine

RESIDENT TIME-OFF REQUEST FORM

Name: ___________________________ Date Submitted: ____________________

Dates / Times of Request: _______________________________________________

Please Select the Type of Time-Off Requested:

☐ Sick  ☐ Bereavement  ☐ Maternity/Paternity  ☐ Interviewing  ☐ Other

☐ Meeting - please see questions below

Name/Location of Meeting: _______________________________________________

Are you presenting a paper? ☐ YES ☐ NO

What is the title? _______________________________________________________

Emergency Contact Information: _______________________________________

_____________________________________________________________________

Resident / Service Covering for You in Your Absence: _______________________

Resident Responsible for Covering My Duties: _______________________________

I have discussed this with my service attending physician: ☐ YES ☐ NO

_____________________________________________________________________

SIGNATURE OF RESIDENT MAKING REQUEST

_____________________________________________________________________

APPROVED:

PROGRAM DIRECTOR / ASSOCIATE PROGRAM DIRECTOR
DEPARTMENTAL TRAVEL REQUEST FORM

Name: __________________________  Date Submitted: _______________________

Dates of Absence from Department: FROM _______ TO _______

Destination: ____________________________________________________________

Reason for Absence:
1. Meeting (Identify): _______________________________________________
   Presenting a Paper? YES ____ NO ____
   Title of Paper: ______________________________________________________

2. Other Activities: ___________________________________________________

Are you Requesting Reimbursement? YES ____ NO ____

From What Source?  DIVISION ____  DEPARTMENT ____  GRANT ____
PRIVATE PRACTICE OFFICE ____  OTHER ____  ~ Name of Source: ______________________

Emergency Contact Information:
Name: __________________________  Phone: __________________________
Address: __________________________

Name of Physician Covering for You in Your Absence:

_____________________________  _______________________________
Academic Duties  Patient Duties

_____________________________
Signature of Covering Physician  _______________________________
Signature of Covering Physician

This certifies that reimbursement for expense has not been requested nor is expected to be received from any other source.

_____________________________
Signature of Person Making Request

APPROVED:

_____________________________
Director  _______________________________
Chairman, Department of Surgery