
# *OTOLARYNGOLOGY*

# *HEAD & NECK SURGERY*

# RESIDENCY MANUAL

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# TABLE OF CONTENTS

# INTRODUCTION

The purpose of this handbook is to provide Otolaryngology residents with an orientation and overview of the Otolaryngology ─ Head and Neck Surgery Training Program at SIU School of Medicine. This manual provides a competency-based set of educational goals and objectives, residency program guidelines, resident responsibilities, expectations, as well as institutional and program policies for the residents' training

The Residency Program is conducted under the Requirements established by the Accreditation Council for Graduate Medical Education (ACGME) of which the Residency Review Committee (RRC) for Otolaryngology has direct responsibility for formulating policies for the organization and conduct of the Otolaryngology residency program. In the Appendix A of this manual is a copy of the ACGME Program Requirements for Graduate Medical Education in Otolaryngology. Please read this document and become familiar with its contents. The reader may also view the Common Program Requirements on the ACGME website at www.acgme.org.

## STRUCTURE OF THE RESIDENCY PROGRAM

This is a five-year training program in Otolaryngology-Head and Neck Surgery. The PGY-1 year is designed to prepare residents for specialty education in otolaryngology. It consists of one month rotations in general surgery, trauma care, anesthesia, neurosurgery, plastic surgery and pediatric surgery; as well as six months of otolaryngology. The remaining four years (PGY-2 ─ PGY-5) comprise specialty-specific training in otolaryngology including clinical and surgical training as well as a structured research experience. For purposes specific to the SIU Otolaryngology Residency program, a "Junior Resident" is defined as a resident in the second and third postgraduate years of training. A"Senior Resident" is a surgical resident in postgraduate year four. The "Chief Resident" is an individual in the final (fifth) year of Otolaryngology training.

# ADMINISTRATIVE INFORMATION

**RESIDENCY PROGRAM COORDINATOR:** The Residency Program Coordinator is responsible for the scheduling and coordination of the weekly Resident Core conferences, Surgical Skills Labs, Journal Clubs, Near Miss, Morbidity & Mortality Conferences, and Grand Rounds. She is responsible for all administrative aspects of the program, including processing travel and vacation requests, reimbursements, purchasing educational materials, managing evaluations, as well as coordinating the Annual In-Service Exam and Resident Research Day. The office is located in St. John's Pavilion, Room 5B501 and the phone number is 217-545-4777.

# GENERAL EXPECTATIONS OF OTOLARYNGOLOGY RESIDENTS

At all times during the course of the surgical residency, the individual surgical resident will have a variety of clinical and educational responsibilities, including research, teaching of medical students and resident colleagues, inpatient and outpatient care, operative cases, postoperative care, and medical documentation.. Each of these various clinical responsibilities will be integrated into a team-oriented approach to patient care and shared with a variety of individuals, including co-residents, the Chief Resident on the service and the patient's attending physician. In each instance, the individual resident's responsibility will be commensurate with the current level of clinical experience of the resident, the present working relationship with that attending surgeon, and the complexity of the patient's surgical illness. The individual surgical resident should always initiate the communication with both the Chief Resident and the surgical attending to assure involvement and input from all responsible parties. Ongoing communication between these individuals is the key to optimum patient care.

**JUNIOR RESIDENTS:** First, second and third year residents will be expected to assume significant responsibility for perioperative care of patients, which is vital for the personal growth and maturation of the individual resident into a competent physician and surgeon. To conduct time appropriately on this service, there is no official "starting time' each morning, but each resident

should arrive in time to see ALL patients, before clinical or surgical duties begin. A progress note should be recorded in a timely fashion.

**OPERATING ROOM DUTIES:** The resident should always be promptly available when their patient is taken into the operating room. For mid-morning and cases later in the day, it is advisable to check the operating room schedule for cancellations and for cases moved forward. Should the resident be detained on another case, or for some other cause is unable to scrub on his/her assigned case, he/she should immediately notify the patient's attending, and simultaneously contact the Chief Resident for provision of alternate resident coverage. When the patient enters the operating room, the resident should be present to load relevant imaging, confirm equipment availability, assist with patient positioning, and to be present for consultation with the anesthesiologist during the induction of anesthesia. The resident should oversee and direct the prepping and draping of the operative field. The resident is responsible for notifying the Chief Resident of all surgical cases added to the schedule during the week.

**Residents must review information about the case before the day of surgery.** This is a vital and required aspect of preparation for the surgical procedure. Pre-operative review of the indications for surgery, relevant past history (e.g. audiograms, x-ray findings), and the surgical plan will enable the resident to participate fully in the case and maximize their learning in each situation. Pre-operative review provides an excellent opportunity to direct the resident' learning in a case-specific manner.

The resident will always have read about the pertinent surgical anatomy, pathophysiology of the patient's problem, and the conduct of the operative procedure prior to entering the operating room. It is recommended that the resident review the recent medical literature related to the patient's diagnosis and treatment plan. In addition, any resident expecting to participate as the operating surgeon MUST meet the patient pre-operatively and perform a directed physical examination relevant to the proposed surgery.

**FAMILY MEDICINE RESIDENTS:** Family Medicine residents obtain the most benefit from the Otolaryngology rotation by actively participating in clinical patient care. The Chief Resident will

be notified of the clinical assignments of Family Practice residents and will organize the clinic schedules of Otolaryngology residents accordingly.

**MOONLIGHTING:** Moonlighting is not permitted.

**OPERATIVE NOTE DICTATION:** The resident will dictate the surgical procedure unless instructed otherwise by the designated faculty for that case.

**The operative note MUST ALWAYS be dictated immediately following completion of the operation and the brief operate note entered into the hospital EHR prior to leaving the operating room.** Outlines and forms are available at both hospitals, which indicate the format for this dictation.

In general, the format is as follows:

1. State name, surgical resident and appropriate year, dictating operative note for Dr. _____.
2. Patient's name.
3. Date.
4. Preoperative diagnosis
5. Postoperative diagnosis
6. Operative procedure
7. List the names of the surgeons, surgical assistants (including scrubbed students).
8. Indication for procedure and Consent obtained for _____
9. Operative procedure (The operative procedure includes the dictation of):

a. The type and induction of anesthesia.
b. The type of prepping and draping.
c. The manner and location of the incision.
d. The intra-operative findings.
e. The operative procedure including types of suture used
f. Closure technique.
g. The details of number of transfusions and number and placement of drains.

h. Sentence stating that sponge and instrument count was correctly noted at the end of the procedure.

i. Notation regarding the status and condition of the patient at the end of the operative procedure.

j. Statement noting the presence of the teaching faculty during the case.

k. Summary statement of the operative findings, particularly in otologic cases, and a list of the prosthesis type used, if applicable.

**GENERAL WARD DUTIES:** General ward duties include the performance of all history and physical work-ups on those patients admitted when the resident was on-call. After the patients are evaluated, the resident should communicate with the attending physician if there are issues or questions that need to be resolved.

**POSTOPERATIVE MANAGEMENT RESPONSIBILITIES:** The resident's share in the post-operative management role will be commensurate with the complexity of the surgical illness and that resident's level of clinical experience. The patient's attending and the Chief Resident will provide the other input in the shared responsibility. It is each resident's responsibility to maintain good lines of communication with the attending and to keep the attending surgeon well informed regarding any changes in the patient's condition. The attending surgeon and Chief Resident should be consulted prior to initiating any unusual therapeutic measures including transfusions, diagnostic studies, or specialty consultations. Consultations, if required, should be reviewed with the Chief Resident or the patient's attending as these individuals may have prior knowledge as to the patients being seen by other physicians, surgeons or surgical sub-specialists. It is the daily responsibility of each resident to examine the imaging on his/her patient service, to be aware of the pathological diagnosis and, when possible, reviewing the pathology specimen personally. The resident is expected to know all laboratory data, medications and the general progress status of all patients on his/her service. He/she should easily be able to present and to report details to the attending surgeon, Chief Resident, or to a Visiting Professor.

**RESIDENT RESPONSIBILITY IN OUTPATIENT AREAS:** The special requirements for residency training in Otolaryngology-Head and Neck Surgery clearly mandate that an adequate out-patient

clinic in which patients are seen, admitted and followed is necessary for residency accreditation. A resident out-patient experience must be one in which the residents are given appropriate responsibility and the opportunity to make diagnostic and therapeutic decisions concerning the need for surgery and for continuity of care outside of the hospital for those patients who have had surgery. This requirement necessitates that the residents have specific times assigned to out-patient experiences without conflict, except for emergencies. Professionalism and patient courtesy dictate that the ***resident must be prompt in attendance to clinic.*** The residents should take the initiative for seeing patients, making preliminary evaluations and formulating decisions on patient care. Whenever possible, patient follow-up should be planned so that the residents directly involved in the hospital care will be involved in the post hospital care. As a part of their training, the residents must write or dictate appropriate office notes and have the experience in communicating with referring and consulting physicians.

**MEDICAL RECORDS:** All members of the hospital staff regardless of their department or their level in the hierarchy are responsible to complete their medical records **promptly**. Incomplete discharge summaries and operative notes will delay payment of surgical fees as well as hospital charges. Individuals, whether a full-time staff member or house staff, who become delinquent (as defined by each hospital and its Executive Committee) may receive notification that they are suspended from duty. Normally such notification gives the individual five to seven days to complete the delinquent records before the suspension of privileges goes into effect. Loss of hospital privileges in either hospital means that the individual resident is relieved of all clinical duties (no operating, ward, emergency room, or chart privileges) and will forfeit pay for the duration of the suspension. The resident will be required to make up this time lost from residency duties either from vacation time or as an add-on after otherwise completing the training period. Therefore, the loss of hospital privileges or even the threat of such is not to be taken lightly and virtually always assures a letter from the hospital Executive Committee to your permanent resident file. Please be sure to avoid such marks in your record by being both responsive and responsible with operative notes, discharge summaries, and chart completion. The General Surgery Program Director has the right to suspend any resident's clinical privileges at any time that the delinquent records are excessive. To avoid problems with the medical record department, it is a good idea to set aside time on a weekly basis. Nothing should be written in a chart that you

do not wish to explain in court. You are requested to indicate in your dictation of discharge summaries the primary physician who is to receive a copy.

**MEDICAL STUDENT LEARNERS:** Otolaryngology Residents have the privilege of working with third and fourth year medical students during their training. This is an opportunity for each resident to share their knowledge and to have the pleasure of teaching a junior colleague. This is also the best opportunity to educate students about the field of Otolaryngology, and to recruit future residents to the field.

Residents are expected to attend courses for developing effective teaching skills during their residency training and to apply these skills when working with students. Resident teaching performance in the clinic, operating room, and in-patient wards will be evaluated by students. This information will be included in the semi-annual resident evaluations used for promotion and satisfactory completion of training.

The faculty mentor, with the oversight of the Director of Third Year Student Curriculum in the Division, is responsible for third year students on the Otolaryngology Clerkship. The Chief (or his/her designate) will ensure that the students are oriented to the service, understand the learning objectives outlined for the elective, and are assigned to appropriate clinic and operative experiences to achieve the learning objectives as directed by the faculty mentor. Residents participating in student education will evaluate the student's performance during the rotation. Students will take call during 3rd and 4th year rotations at the discretion of the faculty mentors. This experience will enhance their appreciation of the breadth and depth of Otolaryngology.

## CHIEF RESIDENT RESPONSIBILITIES

The goals of the Chief Resident year are to develop advanced technical skills, solidify clinical knowledge including diagnostic and management skills, develop administrative skills, and complete on-going research projects and submit completed manuscripts for publication. The responsibilities of the Chief Resident are centered on these training goals. The Chief Resident will provide the leadership for the Otolaryngology service. S/he will serve as a role model for

junior residents and will demonstrate the expected standards of work ethics, responsibility to patient care, professionalism and dedication to educational goals.

**TECHNICAL SKILLS:**

- The Chief Resident is expected to become competent in performing complex surgical procedures and will assign cases accordingly. In addition, s/he will develop technical skills by assisting junior residents in surgical cases.

**PATIENT MANAGEMENT:**

- The Chief Resident is responsible for the care of all patients on the service, regardless of his/her level of involvement in the operative procedure. The Chief will appropriately delegate patient care to junior residents.

- The Chief Resident is responsible for organizing Teaching Rounds. This will occur on a weekly basis. The Chief will determine the location, time and teaching points.

- The Chief Resident is responsible for ensuring that patient care on the service is provided in a timely manner. The Chief will ensure that in-patient consults are seen on the day of the consult; only unusual or extenuating circumstances will prevent this from occurring. S/he will promote a "team" approach to patient care to facilitate this goal.

- The Chief Resident will ensure that the junior and senior residents' duties are equitably shared and appropriately completed.

- The Chief Resident will provide direct assistance to junior residents and off-service residents when they are "on-call".

**ADMINISTRATIVE RESPONSIBILITY:**

- Completion of the weekly operative schedule. This will be accomplished in a timely manner to permit resident preparation/staffing of cases for the following week.

- Delegate administrative assignments when appropriate (M&M Conference, Head and Neck Oncology Team conference). The Chief Resident, however, is responsible for the satisfactory completion of these duties.

- The Chief Resident is responsible for documenting the resident educational conferences that occur on Wednesday afternoons by ensuring that a sign-in sheet is completed for each conference. The date, time, location and topics of the didactic conferences will be organized by the Chief Resident with the assistance of the Program Director, Associate Program Directors and Program Coordinator. Lack of documentation means the meeting didn't occur and places this conference time in jeopardy. These conferences are mandatory and all residents are expected to attend with the exception of patient care that is emergent or urgent in nature or if involved in a surgical case that requires continuity of care.

**ACADEMIC AND EDUCATIONAL RESPONSIBILITY:**

- The Chief Resident may attend one educational meeting (Academy, COSM, ARO, Allergy Conference) during the year.

- The Chief Resident is responsible for the organization of the resident didactic conferences. The Chief will work with the Program Director and Program Coordinator in planning educational conferences, didactics, and resident lectures for the year, with attention to the Curriculum Guides and the Educational Goals and Objectives.

# OTOLARYNGOLOGY DIVISION POLICY FOR RESIDENT DUTY HOURS

Residents' duty hours shall be arranged to provide the resident with optimal opportunity for excellence in the educational experience, while assuring that patient care, including continuity of that care, is optimal.

1) Call shall be taken routinely no more frequently than every third night on average. Call is taken from home. Time spent in the hospital by residents on at-home call must count toward the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.

2) The Chief Resident will assure that the residents "off call" for each night have completed their responsibilities sufficiently so that the "on call" resident is not left with an inordinate number of tasks compromising his/her ability to responsibly carry out their "on call" duties. The "on-call" resident will be aware of management plans of all in-patients on the Otolaryngology service.

3) Duty hours must be limited to 80 hours per week, averaged over a four-week period.

4) Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

5) Residents should have 10 hours, and must have 8 hours, free of duty between scheduled duty periods.

6) Duty periods of PGY-1 residents must not exceed16 hours in duration.

7) Duty periods of PGY-2 - 5 residents may be scheduled to a maximum of 24 hours of continuous duty in the hospital. All residents are strongly encouraged to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested. Residents may be allowed to remain on-site an additional four hours for transition of patient care.

8) All residents are required to have, on average, one day in seven that is free of hospital and clinical duties.

9) The Chief Resident is responsible for providing "back-up" call. This responsibility is directed to PGY 1 – 3 residents and off-service residents. The purpose of this duty is to provide the chief resident with the experience of acting as a junior attending and to develop skills for teaching junior residents patient management.

10) The Chief Resident is responsible for evaluating patients with complications related to surgery in which they were directly involved. Junior residents should be aware of this policy and notify the Chief Residents appropriately. The purpose of this policy is to provide continuity of care and to maximize learning when complications occur.

11) The Chief Resident will monitor resident work hours. If the "on-call" resident did not receive 2 hours of uninterrupted rest the preceding call period, they will be released from duty by noon on the post-call day.

12) The Program Director, Coordinator and all SIU faculty members monitor residents for signs of fatigue. See Appendix B for more information.

13) Moonlighting is prohibited in the Otolaryngology residency program.

# RESIDENT TRAVEL POLICIES

Resident funds from the Department of Surgery are available as follows:
Up to $500 per resident will be allocated annually for one regional or national meeting for a resident presenting an abstract, paper, or poster session.
Residents are encouraged to present scientific and clinical research at regional and national meetings related to the specialty of Otolaryngology. Participation in these meetings enhances the educational opportunities for the resident and provides an opportunity to develop collegial relationships within the otolaryngologic community.

The resident may be permitted to take up to seven (7) calendar days of paid educational leave at the discretion of the Program Director. Residents must be in good academic standing for consideration of attendance at industry-sponsored educational events. Use of educational leave shall be subject to approval in advance by the Program Director with the concurrence of the Affiliated Hospital.

Residents will be provided funding for attendance at domestic meetings and/or educational materials per the following schedule contingent on availability of funds:

- Years 2-4: $500/year for travel and/or educational materials
- Year 5: $1000/year for travel and/or educational materials
- Year 2-5: The balance of the cost for presenting at a national meeting will be covered after the $500 (years 2-4) or $1000 (year 5) above is used for initial travel expense.

A "Request for Travel" form, obtained from the Residency Program Coordinator, MUST be completed and submitted for approval six weeks prior to travel, and NO travel arrangements should be made until the request for travel is approved by the Division Chair.

Oral PODIUM presentations take precedence over POSTER presentations for determining allocation of funding. All papers to be submitted for presentations at meetings must be approved

by the faculty mentor prior to submission. A copy of the presentation must be submitted to the Program Coordinator before travel reimbursement will be processed.
Delinquent medical records, time cards, logs and evaluations must be made current before the resident may proceed with educational leave.

In order to control lodging costs, resident are strongly encouraged to share a hotel room with someone else when appropriate. Other cost-saving measures should be considered such as staying at a hotel near the conference site with a more competitive rate than the meeting hotel "headquarters" Exceptions must be approved in advance by the Residency Program Director.

Expenses for rental cars will not be reimbursed unless public transportation is not available. Exceptions must be approved in advance by the Residency Program Director.

Airline tickets may be purchased through a division account or through travel websites and charged to the resident's personal credit card. A purchase receipt must be submitted to the Residency Program Coordinator for reimbursement if airline tickets are charged to a personal credit card. Only non-refundable coach class tickets may be purchased. The Residency Coordinator can assist with the purchase of tickets.

Amtrak tickets must be in coach class. The purchase policy is the same as for airline tickets. You are required to reimburse the Division for any pre-paid expenses made by the Division on your behalf should you cancel your trip.

All **original** receipts and the meeting itinerary must be turned into the residency office within **three** working days of trip return. SIU Foundation reimbursement policy requires submission of original printouts of all registration course fees, hotel bills, airfare bills *(that show departure and arrival times)*, taxi or airport shuttle receipts, airport parking receipt, etc. Food receipts are not required since there is a per diem for meals. Any meals included with the registration fee will be deducted from the allotment.

**PERMISSION FOR TRAVEL WILL NOT BE GRANTED UNLESS ALL MEDICAL RECORDS AT BOTH HOSPITALS AND DUTY HOURS ARE COMPLETED.**

# VACATION AND OTHER LEAVES OF ABSENCE POLICIES

Provides the resident with vacation, educational leave, family and medical leave, parental leave, bereavement leave, sick leave and military leave as follows:

**VACATION**

The resident may be permitted to take up to three (3) weeks per year of paid vacation.# A week of vacation will be defined as 5 weekdays (Monday – Friday) and 2 weekend days (Saturday – Sunday). Requests for any leave of absence must be emailed to the Program Coordinator who will fill out the vacation request form, add to the google calendar and New Innovations duty hours. A scanned approval/denial will be emailed to the resident and the chiefs for future reference. Use of vacation leave shall be subject to approval in advance by the Program Director with the concurrence of the Affiliated Hospital. In determining whether to grant the resident's request for vacation, the Program Director may take into consideration patient care and the operational needs of the residency program. The resident shall be responsible for arranging appropriate coverage of patient care and other obligations as necessitated by the requested vacation; which arrangements shall be coordinated by the chief resident and the Program Director. Delinquent medical records, time records, logs and evaluations must be made current before the resident begins vacation. The resident shall not be entitled to accumulate unused vacation leave beyond the term of appointment.

If the physician appointment is terminated in the middle of the year, the vacation the resident has available to him/her will be pro-rated by month. Residents who leave mid-contract will not have access to all 3 weeks of vacation.

Residents who leave the country for vacation or other reasons and are then unable to return to the US may not have their position held beyond the approved vacation time granted by the Program Director, at the sole discretion of the Program Director and the Affiliated Hospital.

## EDUCATIONAL LEAVE

The resident may be permitted to take up to one (1) week per year of paid educational leave at the discretion of the Program Director.# Use of educational leave shall be subject to approval in advance by the Program Director with the concurrence of the Affiliated Hospital. In determining whether to grant the resident's request for educational leave, the Program Director may take into consideration patient care, the operational needs of the residency program and the educational value to the resident of the requested educational leave. The resident shall be responsible for arranging appropriate coverage of patient care and other obligations as necessitated by requested educational leave, which arrangements shall be coordinated by the chief resident and the Program Director. Delinquent medical records, time records, logs and evaluations must be made current before the resident begins educational leave. The resident shall not be entitled to accumulate unused educational leave beyond the term of appointment.

## FAMILY AND MEDICAL LEAVE

The resident may be permitted to take up to twelve (12) weeks per year of family and medical leave without compensation (other than paid vacation and/or sick leave used in accordance with the policies of the Affiliated Hospital) during the term of appointment, in accordance with the Family and Medical Leave Act of 1993, state law, and the policies of the Affiliated Hospital. The resident shall make requests for family and medical leave in accordance with the existing policies of the Affiliated Hospital and should consult those policies for further information.

## BEREAVEMENT

The resident may be permitted to take up to three (3) calendar days per year of paid bereavement leave for a member of his/her immediate family, subject to approval in advance by the Program Director with the concurrence of the Affiliated Hospital. For these purposes, the immediate family is defined as spouse, child, parent, brother, sister, grandparent, grandchild, and corresponding in-laws. The policy of the Affiliated Hospital will be followed. The resident shall not be entitled to accumulate unused bereavement leave beyond the term of appointment.

## SICK LEAVE

The Resident may be permitted to take up to two (2) weeks per year of paid sick leave, to be used in accordance with the existing policies of the Affiliated Hospital. # If the resident is successful in being re-appointed to the residency program, sick leave may be accumulated and carried to successive appointment years. Sick days shall be documented by the program coordinator and an up-to-date report of the number of sick days used by the resident shall be available from the residency program and/or the Office of Residency Affairs. All paid sick leave not taken is forfeited and is not compensated upon termination of the resident's contract.

## PARENTAL LEAVE

Maternity Leave

Maternity leave will be granted upon request to all pregnant residents. The resident may be permitted to take up to a total of twelve (12) weeks of family and medical leave per year without compensation in accordance with the federal Family and Medical Leave Act of 1993, state law, and the policies of the Affiliated Hospitals. Maternity leave will be paid leave by initially using any available sick (up to 2 weeks) or vacation leave (up to 3 weeks). Once available vacation and sick leave is exhausted, any additional maternity leave will be family leave without pay. Maternity leave greater than twelve (12) weeks duration, except in cases of illness of mother or infant, will require approval by the Residency Program Director. Health insurance and other benefits will be provided while using vacation and sick leave. Health insurance and other benefits may be continued at the resident's expense while on family leave without pay.

The pregnant resident should notify the Residency Program Director as soon as possible regarding her need for a maternity leave. The resident and program director should develop a plan regarding timing and duration of maternity leave. Leave which exceeds that period of time defined by the resident's specialty board as a leave of absence for which time need not be made up, must be made up at the end of the usual training interval. Upon return to work the resident will be reinstated without loss of training status, provided that her return is on the date previously approved by the program director. If leave is requested for more than twelve (12) weeks due to medical reasons, approval for return to

the training program will be at the discretion of the Residency Program Director. For leave beyond twelve (12) weeks a doctor's certificate verifying the condition of the resident may be requested. In those cases where a resident must make up time missed in order to fulfill board requirements, the resident will be paid for days worked and the institution will continue benefit coverage during the extension of training time. Schedule accommodations will meet the needs of the resident and the program (including other residents) so that special requirements of that discipline are met.

Adoption

The resident may be permitted to take up to twelve (12) weeks of family and medical leave per year without compensation in accordance with the federal Family and Medical Leave Act of 1993, state law, and the policies of the Affiliated Hospitals. The resident must discuss the impending adoption with the Residency Program Director in as much advance as possible, and leave should be granted to any mother or father during the first month after adoption of a child. Adoption leave will be paid by initially using any available vacation leave. Once available vacation time is exhausted, Family Leave will be unpaid and health insurance and other benefits may be continued at the resident's expense. If leave exceeds that period of time defined by the resident's specialty board as a leave of absence for which time not be made up, it will be made up at the end of the usual training interval. In those cases where a resident must make up time missed in order to fulfill board requirements, the resident will be paid for days worked and benefit coverage will continue during the extension of training time.

Paternity Leave

The resident may be permitted to take up to twelve (12) weeks of family and medical leave per year without compensation in accordance with the federal Family and Medical Leave Act of 1993, state law, and the policies of the Affiliated Hospitals. Such leave should be requested in as much advance as possible, and should be granted to any father during the first month after delivery or adoption of a child. Paternity leave will be paid by initially using any available vacation leave. Once available vacation time is exhausted, Family Leave will be unpaid and health insurance and other benefits may be continued at the resident's expense. If leave exceeds that period of time defined by the resident's

specialty board as a leave of absence for which time need not be made up, it will be made up at the end of the usual training interval. In those cases where a resident must make up time missed in order to fulfill board requirements, the resident will be paid for days worked and the institution will continue benefit coverage during the extension of training time.

## ADDITIONAL TIME TO COMPLETE WORK

If any specialty or sub-specialty Board requirements are more stringent than those outlined in this section, then the respective Board requirements shall govern and supersede these. In the event that the resident accumulates a total of more than the maximum allowable* days of absence from the Residency Program during a year (including vacation, educational, child care, bereavement and sick leave, suspension [with or without pay] or other absence), the resident shall be notified in writing by the Program Director as to whether such absence necessitates remedial work in order to fulfill the requirements of the Residency Program and Specialty Board. Such notification shall be provided to the resident prior to any planned leave (or at the earliest practicable time after any unplanned leave) which causes the resident to exceed this limit of absence from the Residency Program.

## JOB SEARCH

Successful career placement of the resident is a goal of the Residency Program. The Program Director may grant up to six (6) calendar days total during the last two years of training for this purpose, using prudent discretion. If approved by the RRC, this time may be counted as work days when tabulating days for RRC accreditation.

## ACCUMULATION OF LEAVE TIME

Residency employment agreements are for a maximum of one year. The resident shall not be entitled to accumulate unused vacation, educational, job search, or bereavement leave from one period of appointment to the next. Nor shall the resident be entitled to any allowance or compensation for such leave not used during the contract period in which it is earned.

**MILITARY LEAVE**

All affiliated hospitals have current policies regarding military leave for their employees which preserve the employee's position and coordinate benefits, such as health insurance. In the event that it becomes necessary for a resident or fellow to be called into active duty, the policy of the employing hospital will become effective. It will be the responsibility of the resident to work with the appropriate employing hospital to ensure that the necessary paperwork is completed before the resident leaves for duty.

*****For duty hour/time reporting purposes, a number of days in a week of leave time will be determined by the respective residency program. For example, a week may be defined as 5 days (ambulatory rotation) or 6 days (inpatient rotation).

* Maximum Allowable Absences

Family Medicine - Carbondale, Decatur, Quincy and Springfield = 31 days (Not including educational leave. 5 days educational leave allowed)

Sports Medicine - Carbondale and Quincy = 31 days (Not including educational leave. 5 days educational leave allowed)

All other programs - 42 days

*Amended and Approved by GMEC April 20, 2007*
*Amended and Approved by GMEC December 19, 2008*
*Amended and Approved by GMEC March 19, 2010 to become effective June 26, 2010*

# OVERVIEW OF EDUCATIONAL GOALS, OBJECTIVES AND COMPETENCIES

The information below serves as an overview of the global educational goals and objectives for the SIU Otolaryngology Residency Program. The goal of the Residency Program is to prepare the resident to function as a qualified practitioner of Otolaryngology and Head & Neck Surgery at the advanced level of performance expected of a board-certified specialist. Certain aspects of the program may be individualized for a given resident. The Primary goal of the training program is to provide a comprehensive education in the medical and surgical management of patients of all ages having diseases and disorders of the ears, upper respiratory and upper alimentary systems and related structures, and the head and neck. The specific goals are to provide the resident with an appropriate fund of knowledge and technical skills, based on the six ACGME core competencies: Patient Care, Medical Knowledge, Practice Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism and Systems Based Practice. This is accomplished by didactic instruction in the basic and clinical sciences of Otolaryngology and Head & Neck surgical diseases and conditions, as well as by education in procedural skills and operative techniques.

## LEARNING OBJECTIVES

Surgical training is structured to provide a clinical curriculum that is sequential, comprehensive, and organized from basic to complex. The clinical assignments are organized to ensure that graded levels of responsibility, independence, continuity in patient care, a balance between education and service, and progressive clinical experiences are achieved for each resident. The overall learning objectives for the program are outlined below.

## EDUCATIONAL GOALS

- The resident must acquire a fundamental knowledge base in the basic sciences applicable to otolaryngology.
- The resident must demonstrate proficiency in both medical management and surgical procedures intrinsic to the practice of otolaryngology.

- The resident must develop the skills necessary for safe and effective clinical decision making necessary for a practitioner of otolaryngology.
- The resident must demonstrate the ability to care for his/her patients in an ethical and professional manner and to be an active participant in the overall context of the health care system by obtaining competencies in the following areas:

## PATIENT CARE

Residents must be competent in the following:

- Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
- Obtaining a history that includes essential and accurate patient information.
- Develop and execute patient care plans appropriate for the resident's level, including management of pain.
- Counseling and education of patients and their families.
- Performance of all medical and surgical procedures essential to Otolaryngology.
- Demonstrate level appropriate manual dexterity.

## MEDICAL KNOWLEDGE

Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (epidemiological, social-behavioral) sciences and apply this knowledge to patient care.

Residents are expected to:

- Demonstrate inquisitive and analytical approach to clinical situations
- Describe and discuss the fundamentals of basic science as applied to clinical surgery, including: applied surgical anatomy and surgical pathology; the elements of wound healing; homeostasis, shock and circulatory physiology; hematologic disorders; immunobiology and transplantation; oncology; surgical endocrinology; surgical nutrition, fluid and electrolyte balance; and the metabolic response to injury, including burns.

## PRACTICE-BASED LEARNING AND IMPROVEMENT

Residents must be able to investigate and evaluate their personal patient care practices, and improve this practice using scientific evidence.

Residents are expected to:

- Systematically analyze their experiences and perform a practice-based improvement
- Apply knowledge of study designs and statistical methods to appraise clinical studies
- Facilitate the learning of students and other health care professionals
- Demonstrate the ability to investigate and evaluate the care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning.
- Identify strengths, deficiencies, and limits in one's knowledge and expertise and set learning and improvement goals.
- Describe basic concepts of patient safety and error prevention.

## INTERPERSONAL AND COMMUNICATION SKILLS

Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and partnership with patients, patient families, and professional associates.

Residents are expected to:

- Use effective listening skills
- Provide information clearly verbally and in writing
- Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds.
- Communicate effectively with physicians, other health care professionals, and health related agencies

## PROFESSIONALISM

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

Residents are expected to:

- Demonstrate respect, compassion, integrity, and a commitment to excellence and on-going professional development

- Demonstrate compassion, integrity, and respect for others;
- Respect patient privacy and autonomy;
- Demonstrate sensitivity to a diverse patient population.
- Demonstrate sensitivity and responsiveness to patients' culture, age, gender and disabilities
- Certain personal attributes are also expected of our residents. It is essential that individuals placed in a position of trust be honest, dependable, exercise sound judgment, and maintain personal integrity. The resident's manner and appearance should be consistent with these attributes.

## SYSTEMS-BASED PRACTICE

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively utilize system resources to provide care that is of optimal value.

Residents are expected to:

- Practice cost-effective health care and resource allocation that does not compromise quality of care
- Advocate for quality patient care and assist patients in dealing with system complexities.
- Understand how their patient care and other professional practices affect other health care professionals and the health care organization.
- Coordinate patient care within the health care system relevant to their clinical specialty;
- Work in interprofessional teams to enhance patient safety and improve patient care quality.

**All Residents:**

1. Maintain a log of operative procedures using the ACGME web-based case log reporting system. The activity on this database will be monitored weekly by the Chief Residents and monthly by the program administrative staff, Program Director and Associate Program Director. Residents are expected to accurately update their ACGME case log on

a weekly basis. Failure to update the log at the conclusion of scheduled surgical cases will result in forfeiture of assigned surgical cases for the following week.

2. Maintain a list of your ICU experiences in a manner acceptable to the RRC and ABS.
3. Complete all electronic medical records in a timely fashion. Clinic notes must be completed within 48 hours. Operative reports are completed within 24 hours.
4. Attend at least 80% of all didactic and educational meetings conducted by the residency program.
5. Spend at least two half-days per week in an ambulatory setting appropriate for the rotation. This experience will focus on providing pre and post-operative care to the patient.

# THE CURRICULUM GUIDE

## RESIDENT CORE CONFERENCES

The core conference is a two-year cycle of lectures that cover the following subjects: General and Pediatric Otolaryngology, Otology, Facial and Plastic Surgery and Head and Neck Oncology. The conference schedule is updated annually and resident input/modification of the lecture series is encouraged to facilitate self -directed learning and respond to specific educational needs and advancements in the field of Otolaryngology Head and Neck Surgery.

## SURGICAL SKILLS LABS

A series of Surgical Skills Labs have been developed to address specific topics that are best learned in a laboratory setting. Resident participation in these sessions is mandatory and successful completion of the skills labs will be required for promotion to the next level of training. All labs will require senior residents to teach junior residents the procedures.

**Surgical Skills Modules**

- Broncho-Esophagoscopy
- ENT Trach, BMT, PTA, Frenulectomy and Epistaxis
- Free Flaps
- Microvascular Anastomosis

- Head & Neck Robotic Surgery
- Local Flaps
- Occular Plastic Procedures & Orbital Anatomy
- Rhinology & Endoscopic Skull Base Surgery
- Temporal Bone Dissection Course
- Thyroid & Parathyroid
- Laser Safety Course
- Mandibular & Mid-Face Fractures
- Rhinoplasty/Rhytidectomy
- Thyroplasty, Larynx Anatomy, Laryngectomy & Tracheal Resection
- Local and Regional Anesthesia in OMFS

## AUDIOLOGY AND VESTIBULAR SKILLS ASSESSMENT

Residents are expected to acquire a minimum level of proficiency in the audiological and vestibular sciences as part of their training. Understanding the theory and practice of audiologic and vestibular testing is a fundamental skill required of all Otolaryngologists. The expectations for skill development are outlined in the Practicum (page 61). Residents are required to satisfactorily complete the skills noted for each level of training. Skill development sessions facilitated by the audiologists are available on a rotating basis throughout the training for all residents.

## GRAND ROUNDS

Each resident will be responsible for one Grand Rounds presentation(s) during the year. Grand Rounds will be held on the first Thursday of each month at 7:00 a.m.

## ENT RESIDENT RESEARCH DAY

This conference is a day-long event scheduled each Spring. Residents are responsible for presenting a 15-minute presentation of their research to the faculty, staff and Visiting

Professor who is the guest lecturer for the event. The resident learns skills for presenting scientific data and participating in organized conferences with this event.

**DEPARTMENT OF SURGERY RESIDENT RESEARCH DAY**

This conference is a half day event hosted by the Department of Surgery. The senior and chief residents are expected to submit abstracts to the Department of Surgery and present their research project(s). Junior residents are encouraged to present their work as well.

**JOURNAL CLUB**

Journal Club will be conducted bi-monthly, alternating with Morbidity and Mortality Conference. Residents will be assigned articles by the faculty on a rotating basis. Each meeting will include in-depth review of two noteworthy articles. A statistical concept will be reviewed and presented by a junior resident. In conjunction with Journal Club and M&M, updates on resident Research Projects and Quality Improvement/Patient Safety projects will be presented by the residents on a rotating schedule.

**MORBIDITY AND MORTALITY CONFERENCE**

This conference is held bi-monthly, alternating with Journal Club. The PGY5 is responsible for organizing the conference format, selection of M&M cases for presentation, and identification of appropriate literature for discussion. The chief residents will collect near miss reports from the residents and will present and discuss as a group at this conference. The goal of this conference is to identify solutions and possible Quality Improvement and Patient Safety initiatives.

Resident attendance at educational conferences is mandatory. Attendance will be obtained by marking a sign-in sheet and documented by the Program Coordinator. Unexcused absences are recorded and will be included in the semi-annual evaluations.

# TEACHING GOALS AND OBJECTIVES

Teaching is an ongoing responsibility of the residents. Teaching not only shares the knowledge base and attitudes of the residents with others but also solidifies the residents own information base and comprehension of the material.

**GOALS:** Develop skills necessary for teaching patients, colleagues, students, and other healthcare personnel.

****Competency Key**

MK - Medical knowledge
PC - Patient Care
IP - Interpersonal skills and communication
P - Professionalism
SB - Systems based practice
PBL- Practice based learning

| Learning Objective | Year | Competency |
|---|---|---|
| The resident should teach a medical student assigned to him/her, primarily discussing patient care of surgical cases. | | PC, IP |
| The resident should teach at the level of the listener. The resident should communicate the subject matter based on terminology and concepts familiar to the listener. Any terms or concepts that the listener is unfamiliar with should be defined and explained. | | MK, IP |
| The resident should develop handouts and teaching materials for medical students and residents. | | MK,IP,PBLI |
| The resident should advise the faculty of the needs of the residents in general and as needed specifically for a given resident. | | MK,IP,PBLI |
| The resident should assist in selecting lectures for the didactic series. | | MK, PBLI |
| The senior residents should teach procedures in skills labs to junior residents and medical students. | 3-5 | MK, PBLI |
| The resident should maintain a compendium of knowledge to serve as adequate source of information that is respected by his/her colleagues. | | MK |
| The resident should provide in-service lectures for nurses. | | MK, IP, SB |
| The resident should provide Otolaryngology lectures for individuals in other specialty areas. | | MK, IP, SB |
| The resident should provide feedback to other residents regarding the efficacy of their teaching and provide constructive criticism. | | PBLI, IP |
| The resident should teach medical students on a one-on-one basis in the operating room. | | IP |
| The resident should participate in walk rounds with medical students. | | IP |
| The resident should stimulate interest in Otolaryngology among medical students, prospective medical students, Otolaryngology residents, and | | IP, SB |

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| professionals working in other specialties. | | |
| The resident should promote and encourage medical students and fellow residents. | | IP |
| The resident should maintain a positive communicative environment that will foster an exchange of information and attitudes among medical students, residents, nurses, physicians and professionals in other specialties. | | IP, P |
| The resident should serve as a role model for medical students and other residents. | | P |

## RESEARCH GOALS AND OBJECTIVES

### GOALS:

The goal of the Otolaryngology resident research program is to support resident involvement in clinical and laboratory research during the PGY 2, 3, 4 and 5 years.

Residents are exposed to the field of Otolaryngology Head and Neck Surgery during 6 month rotations on the service in the PGY1 year. The resident should identify a research mentor during this time and begin reading the literature in the area of interest and outlining ideas for their research project.

During PGY2 the resident should plan future research activities in detail, write the research protocol and submit their proposal to the faculty during their scheduled research update time slot (Journal Club and Research Update and QI/PS Update). Projects requiring approval by the animal or human 'subjects research committees must have applications submitted by the conclusion of the PGY2 year.

The resident will be provided with research time to accomplish the following objectives. It is anticipated that throughout PGY3 the resident will be working towards completion of these research objectives.

Residents are expected to have a project identified, goals and objectives outlined, a time-line for project completion in place, and all Laboratory Animal Care and Use Committee (LACUC) and Springfield Committee on Research in Human Subjects (SCRIHS) approvals in place by the PGY 2 year. Funding is provided by the sponsoring lab, department funds and/or grants obtained by the resident.

The resident will be provided with up to 3 months of protected research time during their residency training period to accomplish the following research objectives:

****Competency Key found on page 28**

| Learning Objective | Year | Competency |
|---|---|---|
| To prepare the resident to critically evaluate published research and to incorporate this information into clinical practice. | | PBL |
| To prepare the physician to continuously improve their clinical performance with practice-based learning | | PBL |
| To provide research experience so that the resident has exposure to the opportunities of a career as a clinician-scientist. | | P |
| The resident should gain an overview of research activities in the Division of Otolaryngology at SIU School of Medicine. | 1 | SB |
| The resident should select a mentor and begin reading in an area of interest for future research activity | 1 | IP,SB |
| The resident should complete a review of the literature in the research area of his/her interest. | 2 | MK,PBL |
| The resident should design a testable hypothesis and design a study to test that hypothesis. | 2 | MK |
| The resident should obtain approval for his/her research project from the Human Subjects or Animal Subjects committee as required. | 2 | SB |
| The resident should employ good scientific writing style in critiquing other literature, writing the review of the literature, and in the protocol describing his/her research project. | 2 | MK,PBL, IP |
| The resident should collect the data for his/her research project. Objectives 1, 2, and 3 must be met before obtaining research time for data collection. | 2 | PBL |
| The resident should analyze data from an existent data set or one that s/he has collected. | 2 | PBL |
| The resident should outline and describe the appropriate statistical analysis that will be used for the study's data set. The resident should be encouraged to work in conjunction with a statistician for both study design and analysis. | 2 | SBP, IP |
| The resident should assist in data collection on an ongoing study. | 3 | PBLI |
| The resident should learn the techniques necessary to do research in his/her chosen area. | 3 | MK |
| The resident should objectively analyze other studies in the literature through journal group experience and the review of the literature for his/her own research project. This analysis should include a critique of the scientific hypothesis, the rationale for developing the hypothesis, the methods employed to test the hypothesis including: the selection of subjects, measures made, techniques employed to obtain these measures, and methods of analysis. Additionally the resident should be able to critically analyze the researchers' interpretation of their findings in light of their original hypothesis and potential applicability and implications of the study. | 3 | PBLI |
| The resident is encouraged to prepare a grant application to support their research and presentation of their work at a national meeting. | 3 | IP |
| The resident should prepare a paper and/or presentation from the data | 4 | PBLI |

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| collected in PGY 3-4 year. | | |
| The resident should finish the self-designed study that was initiated in postgraduate year #3 and prepare it in publication format under the advice of the faculty mentor. | 4 | MK |
| The resident should prepare a manuscript and submit their work to a peer-reviewed journal for publication. | 5 | IP, MK |
| The resident should prepare a manuscript describing a case report or case series and submit the manuscript for publication in a peer-reviewed journal. | 5 | IP |
| The resident should present his/her research at a regional or national meeting. | 5 | IP |
| To develop public speaking skills, the resident will present his/her research in a lecture format. In lieu of this format, the resident may substitute a poster presentation and present his/her research in a lecture style format for the residents and faculty at the Annual Department of Surgery Research Day or the Annual Otolaryngology Head and Neck Surgery Research Day. | 5 | IP |

## CURRICULUM GOALS AND OBJECTIVES

**GOALS:**

Cognitive proficiency in the evaluation, diagnosis and management of common problems in otolaryngology (e.g., otitis, neck masses, tonsillitis, etc.) will be measured by faculty evaluation of clinical knowledge and performance on the In-Service Training Examination. Inadequate proficiency will be addressed by remediation in the specific areas identified using directed reading as discussions with a faculty mentor, and directed clinical opportunities with faculty supervision.

Cognitive performance will be assessed using faculty evaluations of knowledge observed during interactions with resident in clinic and on rounds, resident performance in tumor board discussions, performance on in-service examination, mock orals, and/or other sources of in-service preparation.

Critical performance indicators will be monitored by faculty directly observing the resident perform an examination of a patient during clinic and/or hospital consults.

Competency in “Systems-Based Practice” will be evaluated by assessing critical indicators in performance during “Case Conferences, CCC meetings, GR presentations” and review of the “Resident Portfolio”

****Competency Key found on page 28**

| Learning Objective | Year | Competency |
|---|---|---|
| | | |
| The resident will become accomplished in the goals and objectives for the 6 different medical rotations including General Surgery/Trauma, Anesthesia, Medical ICU, Neurosurgery, Plastic Surgery, and Pediatric General Surgery during their internship year. | 1 | PC, MK |
| During the first two years of training the resident needs to become competent in performing a history and physical examination including the use of the pneumatic otoscope, operating microscope, laryngeal mirror, rigid and flexible laryngoscopes and sinus scopes. The painless cleaning of the ears and nose are also required objectives. | 1,2 | PC,MK |
| The resident should develop an understanding of common disease processes such as serous otitis media, otitis media and externa, airway obstruction, obstructive sleep apnea, pharyngitis, neck mass, tonsillitis and peritonsillar abscess. He/she should know the evaluation options for treatment and indications for surgery. | 1.2 | PC,MK |
| Learn to evaluate the symptoms of hoarseness, dysphagia, tinnitus, hearing loss, and vertigo. Initiate evaluation and treatment in an emergency and office setting. | 1,2 | PC, MK |
| The resident will be able to recognize and treat common disease processes such as acute and chronic otitis media, otitis externa, airway obstruction, viral and bacterial pharyngitis, neck masses, tonsillitis, and peritonsillar abscess with minimal supervision. | 3,4 | MK, PC |
| The resident will become competent in performing the operations for these common problems, and be able to recognize and treat common complications. | 3,4 | PC, MK |
| The resident will supervise and teach the younger residents in recognizing, treating, and becoming competent in performing the operations for acute and chronic otitis media, otitis externa, airway obstruction viral and bacterial pharyngitis, neck masses, tonsillitis, and peritonsillar absecess among other general ENT problems and fundamentals of medicine. | 5 | SBP,PBL, MK, P, IP |
| The resident will be able to evaluate and treat the symptoms of hoarseness, dysphagia, tinnitus, hearing loss, and vertigo with minimal supervision. | 3,4 | PC, MK |
| The resident will supervise and teach the younger residents during evaluation and treatment of the symptoms of hoarseness, dysphagia, tinnitus, hearing loss, and vertigo. | 5 | SBP,PBL, MK, P, IP |
| The resident will gradually become competent in the interpretation of radiographs including CT and MRI. | 1,2,3 | PC, MK |
| The resident will be competent in the interpretation of radiographs including CT and MRI. | 3,4,5 | PC, MK |
| The resident will be competent in systems-based practice as demonstrated by the appropriate referral of patients for evaluation by other services including neurology, infectious disease, pulmonary medicine or surgery. | 4,5 | SBP |
| The resident will be able to describe the pathophysiology of allergy, | 3,4 | MK, PC |

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| recognize the patients at risk for allergies, demonstrate the performance of an accurate history and physical examination of the patient with symptoms of allergy, describe treatment options, and be capable of interpreting MT/MQTs. | | |
| The resident will be able to describe the pathophysiology of head and neck masses, recognize the patients at risk for head and neck tumors, demonstrate performance of an accurate history and physical examination of the patient with symptoms of a head and neck mass, describe treatment options and be capable of presenting the TNM staging. | 3 | MK, PC |
| The resident will be able to describe and perform the medical and surgical treatment options for various head and neck masses and the indications and expectations for the different treatments. | 4,5 | MK, PC |
| The resident will be able to describe the pathophysiology of laryngologic/bronchoesophagologic disorders, recognize the patients at risk for these disorders, demonstrate performance of an accurate history and physical examination of the patient with symptoms of voice, swallowing, and airway disorders, and be capable of performing videostroboscopy and FEES. | 3 | MK, PC |
| The resident will be able to describe and perform medical and surgical treatment options for laryngologic and bronchoesophagologic disorders. | 4,5 | MK,PC |
| The resident will be able to describe the pathophysiology of otologic disorders, recognize the patients at risk for these disorders, demonstrate performance of an accurate history and physical examination of the patient with symptoms of an otologic disorder, and be capable of interpreting audiological exams and vestibular testing. | 3 | MK, PC |
| The resident will be able to describe and perform the medical and surgical treatment options for various otologic manifestations and the indications and expectations for the different treatments. | 4,5 | MK, PC |
| The resident will be able to describe the pathophysiology of pediatric disorders, demonstrate performance of an accurate history and physical examination of the pediatric patient, and describe treatment options for these patients with their parents/caregivers appropriately. | 3 | MK,PC,IP,P |
| The resident will be able to describe and perform the medical and surgical treatment options for various pediatric disorders and explain the indications and expectations for the different treatments to the parents/caregivers appropriately. | 4,5 | MK,PC,IP,P |
| The resident will be able to describe the pathophysiology of various plastic and reconstructive surgical disorders including facial trauma, recognize the patients at risk for these disorders, demonstrate performance of an accurate history and physical examination of the patient with manifestations of these disorders, and be able to perform facial analysis. | 3,4 | MK, PC |
| The resident will be able to describe and perform the medical and surgical treatment options for various plastic and resconstructive surgical procedures as well as facial trauma and the indications and expectations for the different treatments. | 4,5 | MK,PC |
| The resident will be able to describe the pathophysiology of various rhinological and skull base disorders, recognize the patients at risk for | 3 | MK,PC |

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| these disorders, demonstrate performance of an accurate history and physical examination of the patient with manifestations of these disorders, and be able to interpret CT/MRI Scans and use of image guidance. | | |
| The resident will be able to describe and perform the medical and surgical treatment options for various rhinological and skull base surgical procedures and the indications and expectations for the different treatments. | 4,5 | MK,PC |
| The resident will be able to describe the pathophysiology of obstructive and central sleep apnea, recognize the patients at risk for sleep apnea, demonstrate the performance of an accurate history and physical examination of the patient with symptoms of sleep apnea, and be capable of interpreting polysommograms. | 3 | MK, PC |
| The resident will be able to describe the medical and surgical treatment options for sleep apnea, and the indications and expectations for the different treatments. | 3 | MK, PC |
| The resident will supervise and teach the younger residents during evaluation, treatment, and performance of the operations described above for the various curriculum topics and also provide explanation to other housestaff, nurses, and medical colleagues when appropriate. | 5 | MK,SBL,P,IP, PBL |

# ALLERGY AND IMMUNOLOGY

## GOALS:

Cognitive proficiency in the pathophysiology, evaluation, diagnosis and management of allergic disease and related otolaryngic problems (allergic rhinitis, chronic hoarseness, nasal congestion) will be assessed by faculty evaluation of clinical knowledge (Form 1, Evaluation Forms, page 47), as well as, performance on the in-service training examination. Inadequate proficiency will be addressed by remediation in the specific areas identified using directed reading as discussions with a faculty mentor, and directed clinical opportunities with faculty supervision.

****Competency Key found on page 28**

| Learning Objective | Year | Competency |
|---|---|---|
| The resident will understand the relationship between allergic disease (including all body systems) and the field of medicine. The resident will recognize the allergic etiologies in otolaryngic problems that seemingly are nonallergic in nature; such as the pathogenesis of hyperfunctional dysphonia and vocal nodules, inner ear disease. | 1,2 | MK |
| The resident will develop a knowledge base in basic immunology. This includes an understanding of the general concepts of immunogenic reactions, the evolution of immunogenic cell lines, the classification of hypersensitivity reactions, the physiology of inflammation, the arachidonic acid pathways, cyclic AMP, cytokines and leukotrines, early and late phase reactions. The resident should be able to compare the similarities between nasal and lung allergic pathophysiology. | 1,2 | MK |
| The resident will become proficient in recognizing the clinical signs of otolaryngic allergy | 1,2 | PC,MK |
| The resident will have a thorough understanding of the pharmacologic categories of drugs used in the treatment of allergic disease. This knowledge will include the rationale for using antihistamines, decongestants, mucolytic agents, systemic and topical steroids. Special problem areas should be well understood, such as the use of drugs in pregnancy, the effects of drug interactions, and the rationale for using topical versus systemic medications. | 1,2 | PC,MK |
| The resident will be able to recognize drugs with immunogenicity provoking capabilities or may interfere with the treatment of allergic disease, such as beta blockers, tricyclic antidepressants, MAO inhibitors, ACE inhibitors, non steroidal anti-inflammatory drugs, and aspirin. | 1,2 | MK |
| The resident will understand, recognize and know the treatment of anaphylaxis. | 1,2 | MK,PC |
| The resident will have a basic understanding of the biology of aeroallergens. This should include perennial and seasonal concepts, identification of classes, and cross reactivity along with the concept of total allergic load. | 1,2 | MK |
| The resident will be able to recognize and discuss the basic immunology of food and chemical sensitivity. This should include the concept of fixed and cyclic food hypersensitivity, mediated by IgE and non IgE mechanisms. | 3 | MK |

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| The resident will be able to apply specific aspects of history taking as it relates to the presumptive diagnosis of specific inhalant and food allergens as well as chemical irritants. | | |
| The resident will be able to discuss various aspects of clinical immunology. This should include an understanding of the immunology of collagen vascular disease, vasculitis, tumor biology, autoimmune inner ear disease, and acquired immune deficiency problems. | 3 | MK |
| The resident will be able to appropriately utilize tests of immune deficiency screening. This includes the rationale for studies such as immunoglobulins, IgG subscripts, tetanus antibodies, tetanus skin testing, and complement studies, among others. | 3 | PC |
| The resident will be able to discuss the allergic and nonallergic aspects of disease entities such as asthma, rhinitis, hyperplastic rhinitis, angioedema, urticaria among others. | 3 | MK |
| The resident will be able to discuss miscellaneous allergic problems such as venom allergy, latex allergy, and drug allergy. Have a firm understanding conceptually of oto-naso-sino-physiology and related syndromes that would also include adult variant cystic fibrosis, ciliary dyskinesia syndromes. | 3 | MK |
| The resident will be able to discuss the immunology of skin reactivity. There should be a firm knowledge of the various modalities of skin testing including epidermal skin testing such as the prick test, the now defunct scratch test, as well as intradermal skin testing (fixed dilution intradermal and serial endpoint titration). The pros and cons of each methodology should be mastered. Variations such as the multi-test should be understood. | 4 | MK |
| The resident should be able to perform serial endpoint dilution titration. This should include a firm understanding of wheal and endpoint reading, vial mixing and advancement, the mastery of dilutants controls preserving potency, and the understanding of standardized and non standardized extracts. | 4 | PC |
| The resident should be familiar and knowledgeable of various in vitro tests such as the Immuno-Cap, the modified RAST with the Fadal-Nalebuff scoring system, ELISA, FAST, MAST, etc. | 4 | MK |
| The resident should have a thorough understanding of the pros and cons of various in vitro and in vivo methods. This should also include the pros and cons for the concept of allergen screens. | 4 | MK |
| The resident should know when to include the rationale for when immunotherapy is indicated. This is up and above the concepts of elimination, avoidance, environmental control and symptomatic medical management. | 4 | MK, PC |
| The resident will know the principals of immunotherapy, the physiologic changes that result from the use of immunotherapy and the rationale for the length of treatment of immunotherapy. The resident will understand the controversies of immunotherapy with regard to such entities as collagen vascular disease, concomitant neoplasia and fungal hypersensitivity pneumonitis. | 4 | MK |
| The resident will understand the pathophysiology of food allergy as it | 4 | MK |

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| applies to the methodologies of the testing. | | |
| The resident will understand the rationale for in vitro testing and how immunotherapy may be based on quantitative in vitro studies. | 4 | MK |
| The resident will understand the treatment goals and the approach to following patients treated with immunotherapy. | 4 | MK, PC |
| The resident will understand how CLIA and OSHA impact on the allergy practice. | 4 | SBP |
| The resident will be proficient in the diagnosis and treatment of the complex allergy patient. | 5 | PC |
| The resident will understand how to evaluate the patient, who has difficulty with current allergy management, i.e. is a poor responder to therapy or has difficulty with immuno-therapy. | 5 | PC |
| The resident will understand advanced methods of diagnosis and treatment of food allergy, including provocation testing and sublingual therapy. | 5 | MK, PC |
| The resident will understand various diagnostic and treatment modalities for chemical irritant sensitivities and current thoughts on skin testing and provocation. | 5 | MK, PC |
| The resident will understand how to integrate allergy and the otolaryngic practice including the dynamics of starting a practice. This includes mastery of CPT coding, federal and state regulations. | 5 | IP, SBP |
| The resident will understand the importance of nutrition in the management of the allergic patient in addition to basic concepts; this should include some knowledge on the use of vitamins and anti-oxidants. | 5 | MK, PC |
| The resident will understand the effect of allergic considerations in the facial plastic and reconstructive patient. | 5 | MK, PC |

# AUDIOLOGY & COMMUNICATION DISORDERS

## GOALS:

Cognitive proficiency in the assessment of audiologic and communication problems in otolaryngology (types of hearing loss, impact of hearing loss on communication, detection of hearing loss) will be measured by faculty evaluation of clinical knowledge and performance on the In-Service Training Examination. Technical and cognitive proficiency will be evaluated by faculty and staff observing residents complete the Auditory and Vestibular Skills Assessments criteria (see page 64) Inadequate proficiency will be addressed by remediation in the specific areas identified using directed reading as discussions with a faculty mentor, and directed clinical opportunities with faculty supervision.

****Competency Key found on page 28**

| Learning Objective | Year | Competency |
|---|---|---|
| The resident should be able to accurately interpret an audiogram and be able to categorize it according to type, degree, and configuration of hearing loss. | 1,2 | PC, MK |
| The resident should be able to describe the technical aspects of performing a tympanogram, describe the types of tympanogram, and accurately interpret a tympanogram in relation to various etiologies of hearing loss. | 1,2 | PC |
| The resident can recognize the signs and symptoms of hearing loss and construct an appropriate differential diagnosis. | 1,2 | MK, PC |
| The resident can describe the set of tuning fork tests used in clinical diagnosis (Weber, Rinne, Bing, Schwabach) including their applications, interpretation, and limitations. | 1,2 | MK, PC |
| The resident can accurately describe the concept of clinical masking, particularly when masking is indicated in audiometric testing. | 1,2 | MK,PC |
| The resident can explain the basic physics of sound and apply that knowledge to the interpretation of clinical signs and symptoms, as well as audiometric findings. | 1,2 | MK, PC |
| The resident will know the indications for testing and be able to interpret results of speech audiometry and acoustic reflex testing. | 3 | PC |
| The resident will be able to recognize functional hearing loss and the appropriate diagnostic and treatment strategies. | 3 | PC |
| The resident will be able to describe the basic pharmacology of the peripheral and central auditory system. | 3 | MK |
| The resident can describe the basic anatomy and physiology of the outer and middle ear, and the mechanisms of sound transduction and amplification. | 3 | MK |
| The resident can describe the basic anatomy and physiology of the cochlea, 8th nerve, and central auditory pathways. | 3 | MK |
| The resident can correlate audiometric findings with auditory pathology. | 3 | PC |
| The resident will be able to describe the basic components of a hearing aid. | 3 | MK |
| The resident will be able to discuss the various test methods and their | 4 | PC |

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| interpretation for pediatric audiology. | | |
| The resident will be able to discuss auditory evoked potentials including the neural generators, principles of evoked response testing, stimuli, rationale, and the procedure for performing auditory brainstem response testing and electrocochleography. | 4 | MK, PC |
| The resident will be able to interpret auditory evoked potential testing results for otoneurologic evaluation and threshold determination | 4 | PC |
| The resident will be able to discuss the tests and interpretation of tests of pseudohypoacusis. | 4 | PC |
| The resident will be able to discuss the types of hearing aids and the reasons for fitting each type. | 4 | MK, PC |
| The resident will be able to discuss the basic components of hearing aids. | 4 | MK |
| The resident will be able to discuss the basic types of assistive devices and recognizes when each would be appropriate. | 4 | MK, PC |
| The resident will know noise exposure criterion levels and the basic concepts of industrial hearing conservation. | 5 | MK |
| The resident will know the importance of early identification of hearing loss and the procedures of neonatal screening. | 5 | MK, PC |
| The resident will know the basic components of a cochlear implant, considerations in selecting candidates, and the range of benefits that may or may not be expected. | 5 | MK, PC |
| The resident will be able to adequately interpret any audiometric test for any patient s/he sees and relate it to otologic findings. | 5 | PC |
| The resident will be able to select the appropriate type of rehabilitation needed for any patient. | 5 | PC |

# BLEPHAROPLASTY

****Competency Key found on page 28**

| Learning Objective | Year | Competency |
|---|---|---|
| The resident will demonstrate knowledge of upper and lower eyelid anatomy and the relationship with adjacent structures and craniofacial skeleton. | 4 | |
| The resident will be able to perform an exam and assessment of periorbital anatomy and pertinent pre-operative planning. | | |
| The resident will demonstrate knowledge of indications for upper and lower lid surgery. | | |
| The resident will demonstrate the ability to execute the surgical procedure. | 4 | PC |
| The resident will be able to discuss the various surgical approaches to blepharoplasty, periorbital rejuvenation. | 4 | PC |
| The resident will know how to identify and treat complications of blepharoplasty. | 5 | PC |
| The resident will know the indications for adjuvant procedures and be able to perform the procedures.<br>a. brow lift<br>b. chemical peel, LASER resurfacing<br>c. Botox injections | 5 | MK, PC |

# PLASTIC SURGERY & SOFT TISSUE TECHNIQUES

**GOALS:** Cognitive proficiency will be assessed by faculty evaluations of the resident's knowledge in the areas of anatomy, facial aesthetics and wound healing. Technical proficiency will be assessed by faculty specifically evaluating resident's ability to display good technique in handling tissues, wound care, and post-operative management of simple lacerations.

****Competency Key found on page 28**

| Learning Objective | Year | Competency |
|---|---|---|
| The resident will be able to describe the details of facial anatomy with special emphasis in the area of orbit and its associate muscles and the submuscular aponeurotic system (SMAS) as it relates to rhytidectomy. | 1,2 | MK |
| The resident will be able to discuss how aging changes the facial appearance and the skin. | 1,2 | MK |
| The resident will have an understanding of fat compartments, and their role in blepharoplasty. | 1,2 | MK, PC |
| The resident will describe the physiology of wound healing, the special aspects of healing and infection risk in the head and neck. | 1,2 | MK |
| The resident will develop basic skills in wound closure including atraumatic handling of skin, closure of traumatic lacerations. Appreciation of visually sensitive areas of the face requiring meticulous attention to closure. The resident will be able to perform wound closures with satisfactory cosmetic result. | 1,2 | PC |

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| The resident will be able to describe the stages of scar development. | 1,2 | MK |
| Anticipate wound closure problems (excessive tension, dog ears, etc.) and avoid or address them. | 1,2 | MK, PC |
| Describe the bony and cartilaginous structure of nose and nasal septum. Recognize abnormal position and anatomy of the nasal skeleton. | 1,2 | MK |
| Understanding of structural causes of the nasal obstruction and development of a surgical plan in cases of valve compromise/collapse. | 1,2 | MK, PC |
| The resident will be able to describe the roles of LASER resurfacing, chemical peel, and dermabrasion in treatment for skin disorders and rhytids. | 1,2 | MK, PC |
| The resident will be able to perform a complete pre-operative assessment of the patient desiring functional and aesthetic blepharoplasty. | 3 | IP, PC |
| The resident can describe the possible complications of blepharoplasty and methods of prevention. | 3 | MK, PC |
| The resident will be able to draw the precise anatomy of both upper and lower eye lids and peri-orbital regions, including the ethnic variations of lid anatomy. | 3 | MK |
| The resident will be able to describe the role of lower lateral cartilage in tip surgery and be able to describe tip support theories (tripod theory, M-arch theory, caudal septal support) | 3 | MK |
| The resident will be able to discuss the different approaches to nasal surgery and understand the various incisions used. | 3 | MK, PC |
| The resident will be able to describe various osteotomies. | 3 | MK, PC |
| The resident will know the dynamics of rhinoplastic surgery effecting nasal function and external appearance. | 3 | MK |
| The resident will be able to describe the most common pitfalls of rhinoplastic surgery. | 3 | MK, PC |
| The resident will be able to perform a septoplasty and primary rhinoplasty. | 3 | PC |
| The resident will begin to develop an understanding of the role of adjuvant cosmetic procedures (i.e. liposuction, autologous fat grafting, botulinum toxin injection, fillers, etc) in the head and neck. | 3 | PC |
| The resident will be able to discuss the factors underlying forehead wrinkles, the nasolabial fold, and fine rhytids and the surgical treatments of these areas. | 3 | MK, PC |
| The resident will become familiar with the congenital anomalies associated with external ear deformities (prominotia, microtia, anotia, skin tags and appendages, clefting of ear structures, etc) and the pre-surgical evaluation of these patients. | 3 | MK, PC |
| The resident will be familiar with congential craniofacial anomalies, including micro-retro-gnathia, craniosynostosis, cleft lip and palate, and other facial malformations and evaluation and treatment plan development of these patients. | | |
| The resident will be able to discuss the various types of otoplasty and the complications of each approach. | 3 | MK, PC |
| The resident will be able to perform scar revision by simple excision with Z-plasty, W-plasty, or geometric broken line closure. | 3 | PC |

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| The resident will be able to discuss the principles of scar revision including resurfacing and treatment of hypertrophic scars or keloids. | 3 | MK, PC |

## LARYNGOLOGY AND BRONCHOESOPHAGOLOGY (VOICE, SWALLOWING, AND AIRWAY)

**GOALS:** Cognitive performance will be evaluated using faculty evaluations of resident knowledge demonstrated in tumor board, clinic and hospital patient encounters, and operating room technical skills. Resident performance in the Skills Assessment Laboratory "Bronchoscopy, Esophagoscopy, and Removal of Aerodigestive Tract Foreign Bodies" and "Laryngectomy and Airway Anastomosis" directed at airway management and foreign body removal skills will be evaluated on an annual basis.

****Competency Key found on page 28**

| Learning Objective | Year | | Competency |
|---|---|---|---|
| The resident will be competent in performing a history and physical examination of the upper Aerodigestive tract of children and adults. The resident will demonstrate proficiency in performing indirect laryngoscopy using head mirror and laryngeal mirror, 90 degree telescope and flexible laryngoscope in the office. | 1,2,3 | | PC, MK |
| The resident will be able to evaluate and discuss the etiology of stridor in the infant. | 1,2 | | PC, MK |
| The resident will recognize acute epiglottitis, vocal cord paralysis, paradoxical cord motion, and impending airway emergencies in the adult and the child. | 1,2 | | PC, MK |
| The resident will demonstrate competency in establishing an emergency airway by intubation, bronchoscopy or tracheotomy | 1,2 | | PC |
| The resident will satisfactorily perform diagnostic laryngoscopy, rigid and flexible bronchoscopy and esophagoscopy. | 1,2 | | PC |
| The resident will be able to evaluate and manage complications of caustic ingestion in the adult and the child. | 1,2 | | PC, MK |
| The resident will be able to describe the detailed anatomy of the larynx. | 1,2 | | MK |
| The resident will be able to describe the detailed anatomy of the tracheobronchial tree | 1,2 | | MK |
| The resident will be able to describe the detailed anatomy of the esophagus and relate this anatomy to techniques for rigid and flexible esophagoscopy. | 1,2 | | MK, PC |

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| The resident will be familiar with the TNM classification of tumors of the larynx, hypopharynx, nasopharynx, pyriform sinuses and esophagus. | 1,2,3 | | MK |
| The resident will be able to perform endoscopic evaluation and intubation in infants or adults with stridor. | 3 | | PC |
| The resident will be able to perform endoscopic evaluation of infants or adults with caustic ingestion. | 3 | | PC |
| The resident will be able to perform endoscopic removal of laryngotracheal foreign bodies. | 3 | | PC |
| The resident will be able to perform endoscopic removal of esophageal foreign bodies. | 3 | | PC |
| The resident will be able to perform dilatation of esophageal strictures. | 3 | | PC |
| The resident will be able to perform and discuss both flexible and rigid videostroboscopy and describe the functional and anatomic findings of these procedures in detail. | 3 | | PC,MK |
| The resident will be able to perform and discuss laryngeal Botox A injections for spasmodic dysphonia as well as discuss the aspects of various laryngeal dystonias. | 3 | | PC,MK |
| The resident will be able to perform and discuss Functional Endoscopic Evaluation of Swallowing (FEES) with adults, children, and infants and discuss the findings and develop an appropriate treatment plan. | 3 | | PC,MK |
| The resident will be able to evaluate and discuss the etiology, assessment, and management of various voice and swallowing disorders including those of the professional voice. | 3,4 | | PC,MK |
| The resident will be able to discuss reasons for performing and/or perform the operative procedure of a cricoid split. | 4 | | PC, MK |
| The resident will be able to perform total laryngectomy. | 4 | | PC |
| The resident will be able to perform laryngotracheal evaluation and reconstruction after acute trauma. | 4 | | PC |
| The resident will be able to discuss the rationale for performing and/or perform partial laryngectomy and reconstruction. | 4 | | PC,MK |
| The resident will be able to perform tracheal resection and anastomoses with hyoid release and discuss the rationale for performance of these procedures. | 4 | | PC,MK |
| The resident will be prepared to teach the procedures and evaluations learned in previous years. | 5 | | IPC, SBP |
| The resident will be able to perform laryngopharyngeal resection and reconstruction. | 5 | | PC |

# FLAPS & GRAFTS

**GOALS:** Cognitive performance will be evaluated using faculty evaluations of resident knowledge demonstrated in tumor board, clinic and hospital patient encounters, and operating room technical skills. Resident performance in the Skills Assessment Laboratory "Facial Anatomy and Reconstruction Techniques" will be evaluated. The resident will be prepared to teach the evaluation and decision-making process learned in earlier years.

****Competency Key found on page 28**

| Learning Objective | Year | Competency |
|---|---|---|
| The resident will be able to discuss the "reconstructive ladder" and the rationale for each type of reconstructive technique, including simple local flaps and the principles of their use. | 1,2 | MK, PC |
| The resident will be able to identify relaxed skin tension lines and lines of maximal extensibility as they relate to incision orientation in all areas of the face. | 1,2 | MK,PC |
| The resident will be able to design and perform a Z-plasty using the appropriate orientation for a given facial lesion and understand the changes in scar orientation and tension related to the design of these flaps. | 1,2 | MK, PC |
| The resident will be able to describe the techniques of skin grafting and be able to harvest split thickness grafts and full thickness grafts. | 1,2 | MC, PC |
| The resident will be able to use the classic or modified Rhomboid flap and other simple local flaps (note, bilobed, etc). | 3 | PC |
| The resident will be able to describe the larger flaps available for specific large head and neck defects, including axial pattern flaps and microvascular free tissue transfer. | 3 | MK |
| The resident will be able to perform facial repairs that are complex and skillfully choose techniques to maximize function and minimize morbidity and deformity. | 3 | PC |
| The resident will be able to perform large resections and reconstruct them | 4 | PC |
| The resident will be able to describe in detail, develop, and use myocutaneous flaps (e.g. pectoralis major, Karaparzian, Latissimus dorsi, tranpezius, etc.) | 4 | MK, PC |
| The resident will be familiar with various microvascular free flaps and their indications in reconstruction. | 4 | MK, PC |

# HEAD & NECK CANCER

**GOALS:** Cognitive performance will be assessed using faculty evaluations of knowledge observed during interactions with resident in clinic and on rounds, resident performance in tumor board discussions and performance on in-service examination.
Critical performance indicators will be monitored by faculty directly observing the resident perform an examination of patients.
Competency in "Systems-Based Practice" will be evaluated by assessing critical indicators in performance during "Case Conference" and review of the "Resident Portfolio".

****Competency Key found on page 28**

| Learning Objective | Year | Competency |
|---|---|---|
| The resident will be able to describe the detailed anatomy of the head and neck. | 1,2 | MK |
| The resident can obtain a history related to disorders of the head and neck with special reference to<br>a. symptoms suggestive of malignancy<br>b. etiologic risk factors promoting malignancy. | 1,2 | PC. IP |
| The resident will be able to perform a complete head and neck examination to include:<br>a. general observation of the patient with attention to communication difficulties, social circumstances<br>b. ear exam including microscopic examination of tympanic membrane and recognition of middle ear structures<br>c. nasal examination including endoscopic evaluation<br>d. oral cavity examination including examination of the lips and dental arches<br>e. examination of the nasopharynx with mirror, Hopkins rod, flexible nasopharyngolaryngoscope<br>f. examination of the pharynx including the tongue base, including by palpation<br>g. examination of hypopharynx and larynx with the mirror, with the Hopkins rod, and with the flexible nasopharyngolaryngoscope<br>h. neck examination, including thyroid palpation, auscultation for bruits, and examination of the salivary glands<br>i. examination of skin of face and neck<br>j. cranial nerve neurologic examination | 1,2 | PC |
| The resident will be able to describe the diagnostic laboratory and radiologic studies appropriate for evaluation of the patient with a head and neck neoplasm, and demonstrate awareness of cost, resource utilization. | 1,2 | PC, SBP |
| The resident will demonstrate awareness of the contributions of appropriate consultations – e.g. internal medical or cardiac, oncologic, radiation therapy, speech therapy, social services. | 1,2 | SBP |

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| The resident will be able to identify additional diagnostic procedures necessary in the evaluation of the head and neck neoplasm, including the indications for endoscopic biopsy, needle aspiration biopsy, and open biopsy. The resident will be able to successfully perform these procedures under supervision. | 1,2 | PC |
| The resident will be able to manage the preoperative and postoperative head and neck patient with supervision. They will be able to assess risk factors for complications in the post-operative period. | 1,2 | PC |
| The resident will demonstrate awareness and sensitivity to the emotions, social issues, and cultural influences of the patient and their family. They will demonstrate good communication with patient and families. | 1,2 | P, IP |
| The resident will utilize the appropriate supportive health care services; e.g. speech pathology, social services. They demonstrate interdisciplinary care and management of the patient. | 1,2 | PC, SBP, P |
| The resident will be familiar with and be able to discuss the presenting signs and symptoms, risk factors, and diagnostic evaluation of the basic tumor types in the following regions:<br>a. lip<br>b. oral<br>c. oropharynx<br>d. nasopharynx<br>e. larynx and hypopharynx<br>f. paranasal sinuses, nasal cavity<br>g. odontogenic tumors and tumors of bone<br>h. thyroid/parathyroid<br>i. major and minor salivary glands<br>j. neoplasms of the ear and temporal bone<br>k. melanomas of the head and neck<br>l. non-melanotic skin carcinomas of the head and neck<br>m. connective tissue malignancies of the head and neck<br>1) soft tissue sarcomas in the head and neck in adults<br>2) connective tissue malignancies of the head and neck in children<br>n. esophageal neoplasms<br>o. tracheal neoplasms<br>p. bronchial neoplasms | 1,2 | MK |
| The resident will be able to discuss the application and utility of the various techniques for radiographic diagnosis of head and neck malignancy, including CT scan and MR scan. | 1,2 | MK, PC |
| Familiarity with the general principles of primary and late reconstruction. | 1,2 | MK |
| The resident will be able to discuss the general principles of radiation therapy in the treatment of head and neck malignancies. The resident will be able to describe the short-term and long-term complications of radiation therapy to the head and neck. | 1,2 | MK |

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| The resident will be able to discuss the general principles of chemotherapy and the types of protocols available. | 1,2 | MK |
| The resident will be able to describe the lymphatic drainage pathways of the head and neck, and be able to formulate specific considerations related to the cervical lymphatics regarding management of existing or potential cervical nodal metastases. | 1,2 | MK, PC |
| The resident will be familiar with the concepts of palliative care in relation to the management of recurrent or uncontrolled head and neck cancer | 1,2 | PC, SBP |
| The resident will be able to describe methods of communication, swallowing, and functional rehabilitation methods available for patients with head and neck cancer | 1,2 | MK |
| The resident will be able to discuss the concepts of tumor biology and immunology. | 1,2 | MK |
| The resident will be able to describe the diagnostic and treatment management of patients with metastases from the occult or unknown primary. | 2,3 | MK, PC |
| The resident will be able to describe the management of complications of head and neck cancer treatment. | 2,3 | MK |
| The resident can correlate physical findings with histologic findings and demonstrate the ability to interpret histologic specimens. | 2,3 | PC |
| The resident will be considerably more advanced in his/her understanding of all those items listed for the first through third year. | 3 | MK, PC, IP, SBP |
| Be able to manage the preoperative and postoperative course with a high degree of responsibility. | 3 | PC |
| The resident will be able to recommend definitive treatment, e.g. total laryngectomy, partial laryngectomy, various types of neck dissection for neoplasms of the head and neck. | 3 | PC |
| Be able to perform most of the advanced operations under careful supervision of the attending or of a senior resident. The operations the resident at the end of his/her PGY3 year should be able to perform the following:<br>a. routine parotidectomy<br>b. neck dissections<br>c. total laryngectomy<br>d. composite resections<br>e. maxillectomies<br>f. submaxillary gland excision<br>g. thyroidectomy and parathyroidectomy | 3,4 | PC |
| The resident should be able to discuss the appropriate applications of various reconstructive techniques for the cervical esophagus including:<br>a. secondary skin tubes<br>b. deltopectoral flap<br>c. pectoralis myocutaneous flap<br>d. jejunal transplantation | 4 | MK, PC |

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| e. gastric tube esophagoplasty<br>f. esophagocoloplasty<br>g. gastric transposition | | |
| The resident should become increasingly adept at the reconstructive procedures that are performed by head and neck surgeons and be aware of the usefulness of the procedures which are done in cooperation with other specialties. | 4 | SBP, PC |
| The resident will demonstrate the ability to perform all but the most complex procedures under faculty supervision. In addition to those listed for the PGY3 year resident, the PGY4 year resident should be able to perform conservation laryngectomies. These would include:<br>a. laryngofissure<br>b. hemilaryngectomy<br>c. supraglottic laryngectomy<br>d. supraglottic laryngectomy with resection of one arytenoid<br>e. partial pharyngolaryngectomy for superior hypopharyngeal tumors<br>f. partial pharyngectomy for posterolateral hypopharyngeal wall tumors<br>g. anterior transhyoid pharyngotomy<br>h. median labial mandibular glossotomy<br>i. totallaryngopharyngectomy-cervical esophagectomy | 5 | PC |
| Th resident will have the ability to performessentially all surgical procedures in the head and neck area, including reconstruction using:<br>a. myocutaneous flap reconstructions of various types<br>b. primary and secondary skin flaps and tubes | 5 | PC |
| At the end of the PGY5 year, the resident should have a full understanding of the clinical course of the various lesions in order to be able to have a proper perspective regarding aggressive management where it might be beneficial, conservatism when it might be more reasonable and palliation when total control does not seem possible. | 5 | MK, PC, SBP, P |
| The resident should be adept and anxious to display his/her knowledge and competence by teaching junior residents, medical students, and nurses. | 5 | MK, IPC, SBP |
| The resident should have a good understanding of the course of malignant disease and prognosis and be able to help in home health care, hospice care and counseling of dying patients and their families. | 5 | MK, PC, SBP, P, IPC |

# MANDIBULAR & MAXILLARY TRAUMA

**GOALS:** Cognitive performance will be assessed using faculty evaluations of knowledge observed during interactions with resident in clinic and on rounds, resident performance in tumor board discussions, and performance on in-service examination and on the home-study course, and patient-of-the-month examination.
Critical performance indicators will be monitored by faculty directly observing the resident perform an examination of a patient. Competency in "Systems-Based Practice" will be evaluated by assessing critical indicators in performance during "Case Conference" and review of the "Resident Portfolio". The senior residents will be able to teach procedures learned in previous years to junior residents.

****Competency Key found on page 28**

| Learning Objective | Year | Competency |
|---|---|---|
| The resident will be able to evaluate, diagnose and manage the acute trauma patient with specific regard to the primary management of dental, dentoalveolar, and mandibular trauma using clinical, laboratory and radiographic examination | 1,2 | PC |
| The resident will be able to evaluate, diagnose and manage the acute trauma patient with specific regard to the primary management of maxillary trauma using clinical, laboratory and radiographic examination, including:<br>a. LeForte I,II,III fractures<br>b. Orbital blowout fractures<br>c. Zygomaticomaxillary complex and zygomatic arch fractures<br>d. Nasal fractures | 1,2 | PC |
| The resident will be able to describe the detailed radiographic and applied surgical anatomy of the dental, and mandibulo-maxillary regions. | 1,2 | MK,PC |
| The resident will be able to discuss the mechanics of trauma with regard to fracture location, displacement forces, muscular influences, and occlusal factors | 1,2 | MK |
| The resident will understand the general perioperative and postoperative management of the facial fracture patient. | 1,2 | PC |
| The resident will be able to evaluate patients with major head and neck trauma including facial, airway and cervical injuries. | 1,2 | PC |
| The resident will understand and be able to discuss the general treatment principles and concepts, common surgical approaches, and treatment alternatives and their indications and contraindications, as well as their advantages and disadvantages | 1,2 | MK, PC |
| The resident will be able to perform open reduction and internal fixation of facial fractures, and apply interdental fixation under faculty supervision. | 1,2 | PC |
| The resident will be able to perform closed reduction of nasal fracture, and demonstrate knowledge of the perioperative care of the patient with a nasal fracture. | 1,2 | PC |

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| The resident will develop further understanding of occlusal anatomy and reduction, nonrigid and rigid fixation principles, and timing and sequencing of complex and/or multiple facial fracture patients. | 3 | MK,PC |
| The resident will understand postoperative rehabilitation and restoration of the dental, dentoalveolar, and mandibular trauma patient. | 3 | SBP, MK, PC |
| The resident will be able to interpret and understand advanced and specialized radiographic techniques used in complex maxillofacial trauma. | 3 | PC |
| The resident will be able to perform treatment of simple dental, dentoalveolar, and mandibular trauma. | 3 | PC |
| The resident will be able to perform repair of complex facial fractures. | 3 | PC |
| The resident will be able to perform open reduction of nasal fractures with septoplasty or treatment of septal fractures. | 3 | PC |
| The resident will be able to discuss the recognition, diagnosis and treatment of postoperative complications, including infection (osteomyelitis, actinomycosis, etc.), trismus, malunion, nonunion, malocclusion, ankylosis, and persistent neurological deficit. | 4 | MK, PC |
| Perform treatment of more complex injuries to the dental, dentoalveolar, and mandibular complex. | 4 | PC |
| The resident should be demonstrating skills for teaching procedures learned in previous years to junior residents. | 4 | IP |
| The resident will be prepared to teach procedures and evaluations learned in previous years. | 5 | IPC |
| The resident will develop an understanding of the treatment of complex mandibulofacial injuries. | 5 | MK, PC |
| The resident will have an understanding of the role of temporomandibular joint, mandibular, and dentoalveolar reconstructive procedures and their indications and utilization in trauma patients. | 5 | MK, PC |

# OTOLOGY

**GOALS:** Cognitive performance will be assessed using faculty evaluations of knowledge observed during interactions with resident in clinic and on rounds, resident performance in tumor board discussions, and performance on In-Service Examination, Home-Study Course, and Patient-of-the-Month Examination. Critical performance indicators will be monitored by faculty directly observing the resident perform an examination of a patient. Technical performance will be assessed using faculty evaluations of surgical skills observed in the operating room and in the surgical skills lab.
The resident's Portfolio will be reviewed to determine outcomes assessments.

****Competency Key found on page 28**

| Learning Objective | Year | Competency |
|---|---|---|
| The resident will be able to differentiate between conductive and sensorineural hearing loss by history and physical examination. Accurate differentiation between chronic and acute ear problems will be demonstrated. | 1,2 | PC |
| The resident will be able to differentiate between direct otologic pathology and referred pain. | 1,2 | PC |
| The resident will demonstrate the ability to examine the ear with the otoscope and the otomicroscope and differentiate between a normal ear examination, otitis externa, chronic serous otitis media, acute otitis media, and other chronic ear problems (both benign and malignant). | 1,2 | PC |
| The resident will be able to perform a complete history and physical examination to evaluate the patient with a balance complaint. The resident will be able to differentiate between peripheral and central causes of balance dysfunction, and be able to develop an appropriate differential diagnosis of dizziness based on the history and physical exam findings. The resident will be able to describe the appropriate tests required to evaluate the dizzy patient. | 1,2 | IP, PC |
| The resident will be able to describe the anatomy of the temporal bone in detail and perform a temporal bone dissection in the lab identifying normal structural landmarks. | 1,2 | MK |
| The resident will be able to discuss the pathophysiology of acute and chronic ear disease, the risk factors associated with development of otitis media. They will be able to recognize and treat serous otitis media and will know the indications for surgical tympanostomy and tube placement. | 1,2 | MK,PC |
| The resident will be able to discuss the embryology of the ear and temporal bone and the application of the knowledge to congenital ear anomalies. | 1,2 | MK |
| The resident will be able to perform tympanoplasties and simple middle ear explorations. | 3 | PC |
| The resident will complete the required dissections in the temporal bone laboratory. | 3 | PC |

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| The resident will be able to recognize and discuss the techniques required for tympanoplasty and mastoidectomy. | 3 | PBL, PC |
| The resident will be able to perform simple mastoidectomies. | 3 | MK, PC |
| The resident should be able to perform tympanoplasties and ossicular reconstruction. | 4 | PC |
| The resident should be able to perform tympanomastoidectomy with facial recess technique, facial nerve decompression and stapedectomy. | 4 | PC |
| The resident should be able to discuss the medical and surgical treatment options for Meniere's Disease. | 4 | MK,PC |
| The resident should be able to recognize patients at risk of perilymphatic fistula, describe appropriate testing procedures, and be able to perform middle ear exploration and fistula repair. | 4 | PC |
| The resident will be able to perform stapedectomies, facial nerve decompressions, temporal bone resection. The resident will be able to discuss the principles of acoustic neuroma surgery and treatment of malignant and benign procedures requiring partial and near total temporal bone resection and understand these techniques and anatomy involved. | 5 | MK, PC |
| The resident will have the ability to reconstruct the middle ear and perform homograft tympanoplasties and tympanomastoidectomies. | 5 | PC |
| The resident will be able to discuss the indications for various treatments for Meniere's disease, including sac decompression, surgical labyrinthectomy, chemical labyrinthectomy and 8th nerve section. | 5 | MK, PC |

## OTOPLASTY

**Competency Key found on page 28

| Learning Objective | Year | Competency |
|---|---|---|
| The resident will be able to able to perform corrective procedures of deformed ears. | 4 | PC |
| The resident will demonstrate understanding of microtia and different stages of corrective surgery, including pre-operative assessment, timing of surgery, and potential complications of repair. | 4 | MK, PC |

# PEDIATRIC OTOLARYNGOLOGY

**GOALS:** Cognitive performance will be assessed using faculty evaluations of knowledge observed during interactions with resident in clinic and on rounds, resident performance in tumor board discussions, and performance on the in-service examination, and *patient-of-the-month examination* mock orals. Critical performance indicators will be monitored by faculty directly observing the resident perform an examination of a patient in clinic and/or with hospital consults.

****Competency Key found on page 28**

| Learning Objective | Year | Competency |
|---|---|---|
| The resident will be able to obtain a prenatal and family history and perform a physical examination in infants with craniofacial abnormalities including cleft lip and palate, Crouzon Syndrome, Pierre-Robin anomaly, Down Syndrome and congenital head and neck tumors. | 1,2 | PC, IP,MK |
| The resident will be able to complete a history and physical examination on a child with a neck mass and provide a differential diagnosis and treatment algorithm. | 1,2 | PC, IP,MK |
| The resident will be able to recognize and describe speech abnormalities in children with congenital and acquired disorders of phonation, articulation including velopharyngeal insufficiency and denasal speech. | 1,2 | PC,MK |
| The resident will be able to perform a history and physical examination in children with upper airway obstruction, sleep apnea, failure to thrive, facial developmental abnormalities and other problems related to adenotonsillar hypertrophy. | 1,2 | PC, IP,MK |
| The resident will become proficient in performing tonsillectomy and adenoidectomy and be capable of handling postoperative complications. | 1,2 | PC |
| The resident will be able to perform simple endoscopic procedures of the larynx, esophagus and tracheobronchial tree in infants and children. | 1,2 | PC |
| The resident will be able to identify the hearing impaired child, and to conduct an appropriate evaluation for conductive and sensorineural hearing loss. | 1,2 | PC,MK |
| The resident will be able to diagnose pediatric head and neck trauma including:<br>a. nasal fractures<br>b. facial fractures<br>c. penetrating neck injuries<br>d. injuries of soft tissues of the head and neck | 1,2 | PC,MK |
| The resident will be able to diagnose and manage pediatric nasal allergies. | 3 | PC,MK |
| The resident will be able to evaluate velopharyngeal function in children with congenital and acquired velopharyngeal insufficiency. | 3 | PC,MK |
| The resident will be able to perform complex endoscopic procedures of the larynx, esophagus and tracheobronchial tree in infants and children including foreign body removal and easier procedures. | 3 | PC,MK |

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| The resident will be able to perform tracheotomies in children including premature infants. | 3 | PC |
| The resident should be able to perform a history and a physical examination and provide a differential diagnosis for pediatric neuro-otologic disorders including tinnitus, vertigo and facial paralysis. | 4 | PC IP |
| The resident should be able to manage orbital and intracranial complications of sinus disease and intracranial complications of chronic ear disease. | 4 | PC |
| The resident should be able to perform endoscopic sinus surgery and other sinus procedures as well as dacrocystorhinostomy. | 4 | PC |
| The resident should be able to manage major congenital head and neck tumors. | 4 | PC |
| The resident will be able to perform surgical treatments of pediatric neck masses including thyroid and parotid masses. Perform sinus procedures on children including sinus irrigations. | 4 | PC |
| The resident should be able to manage major pediatric maxillofacial trauma patients including surgical repair of traumatic CSF otorrhea and rhinorrhea. | 4,5 | PC,MK |
| The resident should be able to perform mastoid procedures in pediatric patients including facial recess approach, modified radical mastoidectomy and radical mastoidectomy. | 4,5 | PC,MK |
| The resident should be able to perform laryngotracheal reconstructive procedures on the pediatric patient. | 4,5 | PC |
| Perform middle ear surgery in children such as ossicular reconstruction and tympanic neurectomy. | 4,5 | PC |
| The resident will be able to manage congenital ear deformities including surgical reconstruction. | 5 | PC |
| The resident will be able to teach and supervise junior residents in procedures listed above. | 5 | IPC, PC |
| The resident will participate in a comprehensive team clinic for craniofacial anomalies including diagnostic and long-term treatment plans, management and rehabilitation. | 5 | PC,SBP, IPC |

# RHINOLOGY

**GOALS:** Cognitive performance will be assessed using faculty evaluations of knowledge observed during interactions with resident in clinic and on rounds, resident performance in tumor board discussions, performance on in-service examination, performance on the home-study course, and patient-of-the-month examination. Critical performance indicators will be monitored by faculty directly observing the resident perform an examination of a patient.

****Competency Key found on page 28**

| Learning Objective | Year | Competency |
|---|---|---|
| The resident will be able to obtain a history from a patient with a smell or taste disorder and perform a complete physical exam of the nose, both externally and intranasally, using head mirror / headlight, flexible nasopharyngoscope, and sinus endoscope. | 1,2 | IP,PC |
| The resident will be able to perform an evaluation of taste and smell and describe a differential diagnosis for these disorders. | 1,2 | PC |
| The resident will be able to describe the anatomy and physiology of sense of smell. | 1,2 | MK |
| The resident will be able to describe the detailed anatomy of the nose and paranasal sinuses. | 1,2 | MK |
| The resident will be able to describe plain sinus x-rays, MRI, and CT scans of the paranasal sinuses. | 1,2,3 | PC, MK |
| The resident will be able to diagnose sinusitis (acute and chronic), allergic rhinitis, nasal tumors, and nasal fractures. | 1,2 | PC |
| The resident will be able to differentiate between types of chronic sinusitis ie eosinophilic vs noneosinophlic and polypoid versus nonpolypoid | 3,4 | MK |
| The resident will understand indications for medical and surgical management of acute and chronic sinusitis | 3 | MK |
| The resident will understand variations that occur in chronic sinusitis including allergic fungal, aspirin exacerbated respiratory disease, cystic fibrosis, ciliary dyskinesia, immunodeficiency | 3,4 | MK |
| The resident will perform maxillary antrostomy, anterior ethmoidectomy, sphenoidotomy | 3 | PC |
| The resident will perform posterior ethmoidectomy and frontal sinusotomy | 5 | |
| The resident will perform Caldwell luc procedure | 4 | PC |
| The resident will perform frontal sinus trephination | 3 | PC |
| The resident will perform endoscopic ligation of the sphenopalatine artery | 4 | PC |
| The resident will be able to perform a Draf III and frontal sinus obliteration and when to perform appropriate procedure | 5 | PC, MK |
| The resident will be able to evaluate the patient with epistaxis, identify the risk factors for recurrent epistaxis, and demonstrate a | 1,2 | PC |

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| methodical successful treatment algorithm for control of anterior and posterior epistaxis. | | |
| Perform removal of foreign body from nose. | 1,2 | PC |
| Perform simple closed reduction of nasal fracture. | 1,2 | PC |
| The resident will become proficient at performing septoplasty. | 3 | PC |
| The resident will be able to describe the TNM classification of paranasal tumors. | 1,2 | MK |
| The resident should understand the indications for open versus endoscopic resection of tumors of the paranasal sinuses and be able to perform endoscopic and open maxillectomy | 4 | PC, MK |
| The resident should be able to perform lateral rhinotomy for removal of nasal tumors. | 4 | PC |
| The resident will able to perform cranial facial resections. | 5 | PC |
| The resident will perform rhinectomy with reconstructions. | 5 | PC |
| The resident will be able to identify and perform endoscopic repair of CSF rhinorrhea | 5 | PC, MK |
| The resident will be able to perform and endoscopic approach to the skull base for combined neurosurgical procedures as well as appropriate closure of the defect | 5 | PC, MK |
| The resident will understand indications for and perform endoscopic orbital procedures including orbital decompression and dacryocystorhinostomy | 5 | PC, MK |
| The resident will master intraoperative and radiologic anatomy of the paranasal sinuses and skull base | 4 | PC, MK |
| The residents should be prepared to teach the procedures and evaluations learned in the previous years. | 5 | IPC |

# RHINOPLASTY

****Competency Key found on page 28**

| Learning Objective | Year | Competency |
|---|---|---|
| The resident should be able to perform evaluation and examination of the rhinoplasty patient and identify important findings related to nasal anatomy that will influence surgical planning. | **4** | |
| The resident should understand the differences between endonasal and external rhinoplasty, and appreciate the limitations, advantages, or disadvantages of each. | **3** | |
| The resident should be able to perform external or open approach to nasal surgery. | **4** | |
| The resident should be able to perform complicated and revision rhinoplasties. | **5** | PC |
| The resident should be able to perform correction of saddle noses. | **5** | PC |
| The resident should be able to understand risks of rhinoplasty and be able to appropriately council patients. | **5** | PC |
| The resident should be able to identify post operative complications in rhinoplasty and the appropriate management. | **5** | |

# RHYTIDECTOMY

****Competency Key found on page 28**

| Learning Objective | Year | Competency |
|---|---|---|
| The resident should be able to evaluate patients for rhytidectomy and classify them according the amount of anatomic changes that have occurred with aging. | **5** | |
| The resident should have an understanding of the different methods for face lifting and appreciate the application of each to differing patient anatomy and goals. | **5** | |
| Understanding of the steps in more complicated cases:<br>a. correction of anterior banding<br>b. correction of 'heavy neck'<br>c. correction of submental fat<br>d. correction of ptotic submaxillary gland<br>e. correction of aging ear lobe | **5** | PC |
| Identification of post operative complications and management | **5** | |
| Correction of complication from previous surgery | **5** | PC |

# VESTIBULAR SCIENCE

**GOALS:** Cognitive performance will be assessed using faculty evaluations of knowledge observed during interactions with resident in clinic and on rounds and performance on the In-Service Examination.
Critical performance indicators will be monitored by faculty directly observing the resident perform an examination of a patient.
Satisfactory completion of the Vestibular Science Skills Log will be reviewed.

****Competency Key found on page 28**

| Learning Objective | Year | Competency |
|---|---|---|
| The resident will be able to recognize and describe the various types of nystagmus and understand their implications in diagnosis. | 1,2 | MK, PC |
| The resident will be able to describe the tests available for evaluating the patient with vertigo or a balance disorder | 1,2 | MK |
| The resident will understand the effect of medications on vestibular testing. | 1,2 | MK |
| The resident will observe patients undergoing standard testing and treatment for dizziness, including evaluation with ENG, posturography, | 1,2 | PC |
| The resident will be able to complete a history and physical examination on the vestibular patient. | 1,2 | IP, PC |
| Understand the anatomy and physiology of the vestibular system and the diseases and disorders associated with it. | 3 | MK |
| Be familiar with the theory, performance, results and implications of ENG testing (gaze and spontaneous nystagmus tests, oculomotor tests, positional/positioning tests, and caloric tests), with and without computer configuration. | 3 | MK, PC |
| Be familiar with the theory, performance, results and implications of rotational testing (rotational chair and head autorotation). | 3 | MC, PC |
| Understand the significance of the other types of testing used in diagnosis of dizziness: CT scan, MR scan, audiological tests, lab studies, gait analysis and posturography (computerized platform and non-computerized sway analysis). | 3 | MK, PC |
| The resident should be able to read and interpret the results of ENG, VOR, CT scan, MR scan, audiological tests and lab studies as they relate to a patient with dizziness. | 4 | PC |
| The resident should be able to use these results with patient history and office examination to determine diagnosis of patients with dizziness and balance disorders. | 4 | PC |
| The resident should be able to discuss the concepts of vestibular rehabilitation therapy as they apply to the patient with dizziness and balance disorders and be able to appropriately refer patients for this | 4 | MK, PC |

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| treatment modality. | | |
| The resident should be able to perform the various treatment maneuvers and exercises for patients with classic benign paroxysmal positioning vertigo. | 4 | PC |
| The resident should be able to follow the patient with a vestibular disorder through a complete work-up including testing, history, differential diagnosis and treatement. | 5 | IPC, PC |

# AUDITORY AND BALANCE SCIENCES

**GOALS:** Otolaryngology residency training involves developing a basic understanding of the hearing, communication, and balance sciences, in addition to learning surgical and medical management of illnesses of the head and neck. Knowledge of the indications for testing, interpretation of test results, and the techniques of performing auditory and vestibular tests are expected learning objectives of residency training.

****Competency Key found on page 28**

| Learning Objective | Year | Competency |
|---|---|---|
| Interpret an audiogram and categorize the results according to type, degree, and configuration of hearing loss. | 2 | PC |
| Interpret the results of speech audiometry | 2 | PC |
| Interpret a tympanogram and describe the various types of results and correlate with etiology of hearing loss. | 2 | PC |
| Understand the concept of masking. | 2 | MK |
| Understand the basic physics of sound | 2 | MK |
| Observe the following test procedures: ocular motor testing, positional testing, caloric testing, rotational chair testing, posturography | 2 | PC |
| Observe performance of the particle repositioning maneuver. | 2 | PC |
| Recognize the indications for performing tests for functional hearing loss and the interpretations of these tests. | 3 | PC |
| Interpret acoustic reflex findings. | 3 | PC |
| Understand basic pharmacology of the auditory system. | 3 | MK |
| Knows the basic components of a hearing aid. | 3 | MK |
| Understand the anatomy and physiology of the vestibular system. | 3 | MK |
| Perform ocular motor studies, caloric testing and positional testing under supervision. | 3 | PC |
| Know the methods of testing neonatal and pediatric hearing loss. | 4 | PC |
| Know when and why a child is referred for other speech-language services. | 4 | SBP, PC |
| Knows how to perform and interpret otoacoustic emission test procedures for both diagnosis purposes and ototoxic monitoring. | 4 | PC |
| Understand the physiology and interpretation of auditory brainstem response testing. | 4 | MK |

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| Know the tests and interpretation of test for evaluating retrocochlear lesions. | 4 | PC |
| Understand the concept of vestibular rehabilitation therapy. | 4 | MK |
| Knows the types of hearing aids, and the fitting indications for each type. | 4 | MK, PC |
| Is aware of the types of assistive devices and the indications for use. | 4 | PC |
| Can order and interpret a Stenger test. | 4 | PC |
| Knows the concepts of early identification of hearing loss and the procedures of neonatal screening. | 5 | MK |
| Knows the principles of aural rehabilitation. | 5 | MK |
| Knows the basic components of a cochlear implant, candidate selection factors, and expected results. | 5 | MK, PC |
| Can recognize central auditory processing disorders, and know when to refer for appropriate testing and understands the results of these tests. | 5 | SBP, PC |
| Successfully perform the particle repositioning maneuver. | 5 | PC |
| Be able to participate in the evaluation and management of patients in Balance Disorders/Falls Clinic. | 5 | SBP, PC |
| Knows and understand the appropriate test battery for ototoxic monitoring. | 5 | MK |

# RESIDENT EVALUATIONS

Residents will be evaluated regularly throughout the five-year training period. These assessments have been designed to provide formative information the resident can use to improve performance in the areas of medical knowledge, patient care, systems-based practice, professionalism, and interpersonal and communication skills. Residents will be evaluated by faculty, staff, students, patients, and peers. The Resident and Program Director will review the evaluations twice a year. A final summative evaluation will occur in the spring. Advancement to the next level of training will occur after faculty evaluation of the residents' progress is completed (June). Final evaluations will be based on the Evaluation Methods noted below. Incomplete information in the resident portfolio and incomplete operative logs will delay promotion.

## EVALUATION METHODS

- American Board of Otolaryngology In-Service Training Exam (ABOto)
  *PGY2-5 will be required to take this examination. All residents are expected to obtain a score above the 50$^{th}$ percentile for his or her level of training. Scores below this level will trigger a re-assessment of the resident duties and assignment to a faculty tutor for special counseling.
- Faculty and Staff Evaluations will occur two (2) times each year.
- Clerkship Student Evaluations
- Completion of medical records.
- Conference Attendance and Participation
- Clinical Observation Evaluations
- Key Indicator Case Evaluations
- Patient Satisfaction Survey
  *The Patient Satisfaction Survey is a validated form developed by the Internal Medicine Review Board to assess skills of communication and professionalism. This questionnaire will be used to provide feedback to residents on their performance in these domains.

**PROFESSIONAL DEVELOPMENT PORTFOLIO**

This portfolio is a collection of information maintained by the resident that is periodically reviewed with the Program Director and designed to facilitate the resident's self-directed learning.

It is comprised of the following:

1. Near miss reports – description of event (systems-based, personal knowledge, technical skill), root cause analysis (communication deficit, organizational failure, knowledge gap, lack of technical skill), and documentation of solution.
2. Operative Log
3. Outcomes Assessment – the resident will monitor outcomes for specific procedures/events during their training. The purpose of monitoring these outcomes is to develop the skills and culture necessary to learn from experience, and to apply these skills to everyday practice. PGY2 residents will monitor the incidence of post-tonsillectomy/adenoidectomy bleeding, and post-ventilation tube otorrhea. PGY3 residents will monitor the outcome of septoplasty. PGY4 residents will monitor the outcome of tympanoplasty. PGY5 residents will monitor the outcome of stapes surgery.
4. Auditory and Vestibular Practical Skills

## FACULTY EVALUATIONS

Faculty members will be evaluated throughout the five-year training period. These assessments have been designed to provide information to the faculty regarding areas for improvement as well as positive areas of performance. These evaluations will occur two times a year.

## PROGRAM EVALUATIONS

The program will be evaluated throughout the five-year training period on a yearly basis. These assessments have been designed to provide information to the Division of Otolaryngology/Department of Residency Affairs regarding areas for improvement as well as positive areas in the Division.