OTOLARYNGOLOGY
POLICIES & PROCEDURES

The following policies and procedures are specific to the Department of Otolaryngology-Head and Neck Surgery and are in addition to the University of South Florida College of Medicine Resident Policies and Procedures and the University of South Florida College of Medicine House Officer Contract, which govern all House Officers within this institution.

You are responsible for reading and complying with the policies and procedures within this manual and those put forth in the College of Medicine House Staff Policies and Procedures Manual and the University of South Florida College of Medicine House Officer Contract.

Department of Otolaryngology-Head and Neck Surgery
Orientation Manual

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THE UNIVERSITY OF SOUTH FLORIDA
OTOLARYNGOLOGY RESIDENCY PROGRAM

Program Overview

The goal of our training program is to prepare residents to function independently and expertly in the prevention and management of diseases and disorders in the field of otolaryngology.

The Otolaryngology Residency Program consists of five years of special, comprehensive education in the diagnosis and treatment of diseases of the ear, nose, throat, and maxillofacial region. This five year period of education trains the resident in the prevention, diagnosis, medical and surgical management of otolaryngology disorders in patients of all ages and provides a protected period for a research project. Training occurs on the public and private service of four affiliated institutions - Tampa General Hospital; James A. Haley Veterans' Hospital; H. Lee Moffitt Cancer Center and Research Institute and All Children's Hospital.

This program is designed to provide the resident with an academic and clinical education that allows for progressively responsible patient care as the resident advances through the five years of training. By the end of the PGY-2 year, the otolaryngology resident should be able to perform the following under supervision of attendings and senior residents: a comprehensive history and physical examination for evaluation of patients presenting with complaints referable to the head and neck region and order appropriate laboratories and radiographs; soft tissue surgery; endoscopies; septoplasties; simple mastoidectomies; antral surgery; minor oncologic surgery; and repair of maxillofacial injuries.

PGY-3 year residents form a broad based otologic foundation with experience in chronic ear surgery and neuro-otologic procedures, pediatric otolaryngology, facial plastic surgery, rhinology, and head and neck oncology. Demonstration of ability to teach medical students is expected.

PGY-4 year residents continue to expand their skills and fund of knowledge in otology, facial plastic surgery, pediatric otolaryngology, and head and neck oncology. A three-month block of time is scheduled for a research project under the supervision of a committee of basic science and clinical research faculty. Demonstration of ability to train junior residents is expected. In addition, the PGY-4 year resident is expected to utilize the microvascular surgery laboratory for training.

The PGY-5 year resident should be proficient in sinus endoscopy, advanced temporal bone, and head and neck surgery of all types as well as clinical and operating room management, and in the preparation of formal teaching conferences.

Residents' skills are evaluated quarterly by full time faculty, clinical faculty and by all nursing staff. Evaluation results are then reviewed at a meeting of Education Committee. The Program Director, Dr. Thomas V. McCaffrey then meets on an individual basis with the residents to discuss each quarterly evaluation.

DEPARTMENT OF OTOLARYNGOLOGY – PGY-1

General Overview: This tract includes the general goals and objections of each of the rotations in which the resident will participate throughout the year. These include rotations in General Surgery, Neurosurgery, Emergency Medicine, Anesthesiology and Otolaryngology/Head and Neck Surgery.

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OVERALL EDUCATIONAL GOALS FOR USF DEPARTMENT OF SURGERY

The goal of the University of South Florida surgical residency program is to prepare each resident to function as a qualified practitioner of surgery at the high level of performance expected of a board-certified specialist in general surgery.

PGY1

1. Care of surgical patient on the ward; including preoperative evaluation, writing preoperative and postoperative orders, postoperative care. Assessment: faculty evaluations, ABSITE
2. Basic pathophysiology of surgical disease. Assessment: ABSITE
3. ACLS and ATLS certification Assessment: Course test
4. Basic procedures: start IV, placement of central lines, swan ganz catheters, chest tubes Assessment: Supervision/log book
5. Surgery: basic techniques, sterile technique, surgeon in simple procedures, excision subcutaneous lesions, breast biopsies, hernia repair. First assist on larger procedures. Assessment: Observation in OR, Faculty evaluation
6. Communicate as a professional with patients, hospital staff, students, fellow residents and attending staff. Assessment: 360 degree evaluation via web based evaluation program including review of core competencies.
7. Begin developing adult learning skills. Assessment: Faculty and advisor evaluations
8. Provide oversight of all aspects of pre, peri and postoperative care. Coordinate evaluation, input, and care from consultants and other health care professionals. Assessment: faculty evaluations.

A. Goals and objectives

Insert the goals and objectives for each assignment (rotation specific) and for each level (year) in the program.

SERVICE SPECIFIC EDUCATIONAL GUIDELINES

<u>Trauma</u>

PGY1

1. ATLS certification
2. Insert a variety of tubes: endotracheal, thoracostomy, intravenous, intra-arterial
3. Define the categories of shock based upon type, and explain the etiology and pathophysiology of each type of shock: cardiogenic, hypovolemic, septic, tamponade, tension pneumothorax
4. Care for trauma patients on the ward and formulate their rehabilitation plans
5. Communicate effectively with consultants, ancillary staff, patients and family
6. Function as the multi-specialty team leader by coordinating timing and sequencing of operative interventions of the chest, abdomen, head, urologic and orthopedic considerations.
7. Manage penetrating wounds through understanding the injury potential of wounding mechanisms
8. Perform operative and management procedures for trauma to the chest, abdomen, extremities, and head with direct supervision
9. Direct all surgical management of patients in the ICU, including taking direct responsibility for admission and discharge.

General Surgery (TGH Gold, TGH Blue, James A Haley VA-1 and Bay Pines VA)

PGY1

1. Specify characteristics of the history, physical examination findings, and mechanism of visceral and somatic pain for the following processes: acute appendicitis, perforated ulcer, diffuse peritonitis, bowel obstruction.
2. Illustrate use of the following diagnostic studies in the work-up of the above process: blood chemistries (white blood count, hematocrit), urinalysis, plain x-rays, ultrasound CT scan.
3. Describe the anatomy, clinical presentation, and complications of non-operative management for these hernias: direct, indirect, inguinal, and femoral, ventral, umbilical and differentiate between incarceration and strangulation.
4. Perform, record, and report complete patient evaluation and assessment.
5. Evaluate and diagnose the acute abdomen.
6. Assist with hernia repairs in the groin or umbilical regions, demonstrating a basic understanding of the anatomy and surgical repair.
7. Interpret the following in coordination with attending radiologists and staff: Acute abdominal series (identify free air, small bowel obstruction, ileus, colonic pseudo-obstruction, volvulus; the presence of ascities, atelectasis vs. pneumonia), Upper GI series, Barium enema (identify neoplasms, signs of ischemia) Abdominal ultrasound and CT scans.
8. Evaluate and institute management of abdominal wound problems, including infection, evisceration, dehiscence
9. Coordinate pre- and post- operative care for the patient with the acute abdomen
10. Perform less complicated surgical procedures such as: gastrostomy, appendectomy, hemorrhoidectomy, incision and drainage of perirectal abscess
11. Accept responsibility for (under the guidance of the chief resident and attending surgeon) the postoperative management of: nasogastric tubes, intra-abdominal drains, abdominal incisions, foley catheters, IV catheters and fluid
12. Evaluate and manage nutritional needs (enteral and parenteral) of surgical patients until normal GI function returns.
13. Outline the pathophysiology, evaluation, and management of the following: symptomatic gallstones, acute cholecystitis, gallstone pancreatitis, cholangitis, acalculous cholecystitis and gallstone ileus.

MINIMALLY INVASIVE SURGERY (TAMPA GENERAL GOLD/BLUE SURGERY SERVICES

Understand Laparoscopic Surgery

1. General concepts – ports, pneumo peritoneum, scopes, magnification; general limitations, general indicators, general techniques, general risks.
2. Understand commonly undertaken minimally invasive surgery techniques especially pertinent to the Gold Service. Understand the diseases/disorders being treated: achalasia, gastro esophageal reflux, bariatric surgery, cholecystitis. To a lesser extent: splenectomy (ITP), adrenalectomy (adenoma), colectomy (polyps), hepatic cysts
3. Understand preoperative concerns unique to minimally invasive (laparoscopic) surgery: cardiac, pulmonary, previous operations.
4. Understand postoperative concerns, especially unique to laparoscopic surgery: pulmonary, cardiac, pain, potential complications, especially related to, pneumo-peritoneam insufflation, and specific operations.

METHODS THROUGH WHICH GOALS AND OBJECTIVES WILL BE MET:

1. Clinics – residents at all levels attend clinic and see patients and participate in evaluation, preoperative workup, postoperative follow-up, counseling, and care.
2. Rounds – All residents round on patients with attendings on a regular basis, though often informally and at unscheduled times. Additionally, at 5:00 PM Monday each week, all residents, medical students, and attendings round together on all patients. Thorough descriptions and discussions of patho physiology occur. Discussions of care, operations, and complications, of any are undertaken. Rounds last, generally 2 ½ hours.
3. Conferences – Once per week, at 4:00 PM Tuesday, all surgeons meet with members of the Division of Digestive Disorders, Department of Medicine, and members of the Department of Radiology. X-rays and patient care are reviewed with emphasis on diagnosis and treatments, especially nonoperative care.At 7:00 AM Tuesday, attendings, residents, and medical students on Gold Surgery meet with interventional radiologists, other surgeons from other services, and medical oncologists. This conference focuses on nonoperative diagnosis and care of a host of disorders/diseases, especially involving the liver and biliary tree.

Surgical Oncology (H Lee Moffitt Cancer Center)

Cancer care is rapidly evolving. Modern cancer management now requires multidisciplinary strategies at all levels. The surgical resident of the new millenium must become facile with cancer management that frequently involves the disciplines of surgery, radiotherapy, chemotherapy, biological therapy, and immunotherapy. In addition, it is becoming clear that a strong background in molecular biology may be necessary to exploit the burgeoning body of genetic and epigenetic discoveries related to cancer biology. The surgery resident of the future will need to develop strong interpersonal communication skills and a team approach to cancer management to facilitate these important interactions

Clinical Objectives:

A. The resident is expected to develop and understanding of the *natural history* and the *multidisciplinary approach* to the management of each of the following primary disease foci: Breast cancer, Melanoma, Disorders of the spleen (benign and malignant), Gastrointestinal cancer; [Esophageal cancer, Gastric cancer, Hepatobiliary primary (hepatocellular and Klatskin tumors) and secondary malignancies, Pancreatic cancer, Colorectal cancer, Small bowel cancer (including carcinoid tumors) and Anal cancer], Lung cancer (primary and metastatic) and Soft tissue sarcomas.

B. Preoperative evaluation:

History and physical examination pertinent to disease focus

Appropriate use of preoperative testing to include Ultrasound, Nuclear medicine scans (i.e., Octreoscan, Red cell tagged scan, bone scans, lymphoscintigraphy) CT scans, PET scans, MRI scans, ECRP, EUS, EGD, Colonoscopy, MRCP, Angiography, CT or US guided biopsies (FNAs or cores)

Appropriate preoperative preparation to include use of bowel preps, cardiac echo, exercise and chemical stress tests, use of coronary artery stenting.

C. Common operative procedures (not a complete list): Ivor Lewis Esophagectomy, Orringer Esophagectomy, Whipple, distal pancreatectomy, Hepatectomies, formal and partial, Biliary resections, Colectomies, LAR, APR, Coloanal procedures, Ileoanal procedures, Pounches, Colostomies, ileostomies, Pelvic exenteration, Hemipelvectomy

(Internal and external), Soft tissue sarcoma resection, Wide local excisions, Transanal excisions, Plastic surgical reconstruction with tissue flaps, implants, and expanders, Splenectomy, Gastrectomy (Partial distal, proximal, Total, D1, D2, D3, BI, BII, roux-en-y reconstructions), Mastectomy, lumpectomy, sentinel lymph node biopsy, axillary dissection, Limb perfusion, Pulmonary resections and staging procedures, Oncologic thoracic procedures such as pericardial window, pleurodesis.

D. Principles of Surgical Oncology: the resident should understand the concept of proximal, distal and radial margin assessment for each disease focus and the pathologic procedures used to monitor these margins

E. Multidisciplinary Cancer Management Objectives: Understand indications and application of adjuvant chemotherapy, Understand indications and application of adjuvant radiotherapy, Understand indications and applications of neo-adjuvant chemo-radiotherapy, Understand identities and basic mechanisms of action, and associated toxicities of commonly used chemotherapeutics, Develop an appreciation for the value of multidisciplinary interactions between surgeons, pathologists, radiologists, medical oncologists, radiotherapists, and gastroenterologists.

MECHANISM: Weekly multidisciplinary tumor conferences

Breast Surgery (H Lee Moffitt Cancer Center)

Breast Cancer:

1. Describe the epidemiology and biostatistics and changing incidence of breast cancer.
2. Describe the effect of hormone replacement therapy on the development of breast cancer. Understand the basic concepts of lead time bias in screening and of length time bias on prevention trials.
3. Describe the NSABP prevention trial and its impact on the use of Tamoxifen as a prevention agent.
4. Describe the benefit versus risks of taking Tamoxifen. Be able to describe the risks of Tamoxifen on the development of uterine cancer, the incidence of stroke and the risk of thrombophlebitis and pulmonary embolism.
5. Describe the benefits and relative risks of roloxifen (Evista) and toremefin (Fareston) as they relate to the above noted risks of uterine cancer and thromboembolic episodes.
6. Describe which patients are candidates for BRCA 1-2 genetic screening and be prepared to discuss the problems associated with the screening, insurability, and potential for follow-up, prevention methods, and possible prophylactic mastectomy.
7. Describe the use of natural remedies such as flaxseed, soy products, (Genestine) for use in patients with breast cancer or high-risk populations. Describe the use of Estramet testing for management of patients with HRT with and without breast cancer.
8. Describe the key factors of a breast exam and be able to teach the patient the key findings as they relate to texture consistency and size of palpable lumps in the breast as well as proper timing of the breast exam relative to the menstrual cycle.

9. Describe the physical signs and symptoms of breast cancer including the mammographic signs of breast cancer.
10. Describe the mammographic findings that necessitate breast biopsy and the preferred biopsy technique depending on the size location and nature of the lesion.
11. Describe the differences pathologically and the treatment for: Phylloides tumor vs. Cystosarcoma Phylloides, Fibroadenoma vs. Lactating Adenoma vs. Juvenile Adenoma
12. Describe the significance of nipple discharge as it relates to a breast cancer diagnosis. Be able to differentiate between benign, physiologic bloody nipple discharge, physiologic milky nipple discharge and abnormal milky nipple discharge and fibrocystic nipple discharge and the work-up of each.
13. Describe the surgical indications and contraindications for lumpectomy and mastectomy in the following: DCIS, T1, T2 and T3 invasive breast cancer
14. Describe the recommended chemotherapy as primary adjuvant therapy: Stage I, Stage IIA, Stage IIB, Stage IIIA, and Stage IIIB breast cancer
15. Describe when and how to operate on Stage III breast cancer.
16. Describe when and how to operate on Stage IV breast cancer.
17. What are the following prognostic indicators and the significance of each of breast cancer: Lymph Node status [a) H&E Positive b) Cytokeratin Positive c) extra capsular extension], S-Phase, DNA Ploidy, Estrogen/Progesterone Receptors, Her 2 Nu
18. Describe when radiation is indicated and not indicated: a) following lumpectomy b) following mastectomy.
19. Describe the method and standard dosage, time required, number of treatments and a description of the treatment plan for radiation therapy along with the potential complications. Describe how to manage DCIS a) less than 1cm b) >4cm c) EIC.
20. Describe what is the incidence of lymphedema following axillary lymph node dissection and following sentinel node biopsy without axillary lymph node biopsy.
21. Describe the incidence of positive nodes in the following breast lesions: DCIS, T1A, T1B, T1C, T2, T3
22. Describe the psychosocial impact of breast cancer: Severity of Disease, Life Change, and Time to Psychological Recovery.
23. Describe the long term effects of the surgical diagnostic interview (telling the patient that they have cancer for the first time) What two things does the patient remember?
24. Describe the three keys to decision making for a woman contemplating Lumpectomy vs. Mastectomy.
25. Describe the literature that would indicate whether a patient should be given an open ended decision making capacity with facts or a specific recommendation.
26. Understand the current research protocols for the treatment and staging of breast cancer being done at the Moffitt cancer center: Seed Vs Wire Localization study MCC# 14112, Dual Isotope scanning Seed Localization Trial, Z0010 American College of Surgeons Oncology Group Trial (Micromets), Z0011 American College of Surgeons Oncology Group Trial (Node Dissection), Stage III protocol (Dr. Minton and Dr. Jove STAT 3 evaluation), STAR Prevention Trial (Postmenopausal Tamoxifen vs. Roloxifen).

Breast biopsy:
1. Describe the epidemiology and statistics surrounding the current and future increase in incidence of breast biopsy procedures.
2. Describe the technical method, indications for, relative cost of and limitations or contraindications for the following types of breast biopsy: Fine needle aspiration breast biopsy (FNA), Core needle biopsy (palpable, ultrasound, or stereotactically guided), Vacuum assisted core needle biopsy (MIBB, Biopsys), Advanced breast biopsy instrumentation (ABBI stereotactic large core biopsy), Surcore biopsy (ultrasound directed large core biopsy), Needle

localized breast biopsy (mammographically or ultrasound guided), Radioactive seed localized breast biopsy (RASLO) (mammographically or ultrasound guided), Open breast biopsy (palpable mass).
3. Describe in detail the closure of an open breast biopsy incision to avoid dehiscence and subsequent wound infection.
4. Describe the preferred method of the author for wound dressing of breast incisions and the relative merits of the technique.
5. Describe where and how to make the incision for an open or needle localized biopsy in various locations of the breast.
6. Describe the techniques to achieve hemostasis of a breast biopsy incision and the relative merits and problems associated with each.
7. Describe the signs symptoms, clinical course and treatment of a breast wound hematoma , and a seroma.
8. Describe in what circumstance one would consider packing a breast incision.
9. There are three benign pathologic entities that require a specific approach for biopsy and treatment: Fibroadenoma, Keratin Plugging, Intraductal Papilloma
10. Discuss the pathophysiology of each and their therapeutic management.
11. Name three entities that result in bloody nipple discharge one physiologic and two pathologic. Describe the pathophysiology, biopsy method, treatment and prognosis of each.

Lymphatic mapping for Breast Cancer:
1. Discuss the epidemiology and biostatistics of breast cancer and the projected need for future treatment strategies that will provide more efficient and cost effective means of treating breast cancer.
2. Describe the basic technique of breast cancer lymphatic mapping: Dose, route of administration, location and timing of the radio colloid (Tc^{99m} sulfur colloid) and Lymphazurin (Blue dye) injections.
Is there statistical improvement of breast lymphatic mapping with the use of manual massage of the breast after injection with a) radio colloid b) Lymphazurin?
4. Describe Dr. Cox's anatomic pearls for locating the majority of sentinel nodes in breast cancer lymphatic mapping. Also, describe how to scan for and find the nodes not in their usual location.
5. Describe the advantages and disadvantages of Lymphazurin mapping for breast cancer.
6. What is the primary route of excretion of Lymphazurin and how do you need to advise the patient.
7. Describe the pharmacological interactions of Lymphazurin with: a) Lidocaine b) Tc^{99m} Sulfur Colloid .
8. Describe the advantages and disadvantages of Tc^{99m} Sulfur Colloid mapping for breast cancer.
9. Describe the method for locating and complications for the removal of an internal mammary node and the incidence of solitary metastases to the internal mammary chain.
10. Qualify the relative importance of finding an internal mammary node located by pre or intra operative scanning for the total population of breast cancer patients and for the individual breast cancer patient.
11. Describe which breast cancer patients may benefit from the preoperative assessment of a lymphoscintogram.
12. Describe the general principles of radioisotope scanning: Compton effect, Shine through, KeV of an isotope and the importance of calibration and windowing as they apply to mapping, Half life and KeV of the isotopes a) Tc^{99m} b) Palladium c) I^{125}
13. Be able to discuss the current controversies in mapping : Route of injection a) intra parenchymal b) intradermal radio colloid with intraparenchymal Lymphazurin c) peri-areolar sub dermal injection of either or both agents

Method of preparation of the Tc99m Sulfur colloid a) 0.22 micron filtered b) Unfiltered
Mapping in DCIS, c) Mapping in advanced (Stage III) breast cancer
14. Describe the differences between breast cancer mapping and melanoma mapping.
15. Describe the necessity for adequate training and monitoring of outcomes as they relate to false negative rates and overall success of mapping a sentinel node.
16. Describe the minimum number of monitored breast cancer cases (sentinel node biopsy followed by complete axillary dissection) by the individual surgeon and the institution that should be performed prior to proceeding with sentinel node biopsy without complete node dissection in patients with negative sentinel nodes. (Learning Curves)
17. Describe the minimum number of cases required to achieve 90% success in mapping and 95% success in breast cancer lymphatic mapping.
18. Describe the causes for failure of breast cancer lymphatic mapping.
19. Describe the impact of diagnostic biopsy method (FNA, core, excisional) on the successful outcome of breast cancer lymphatic mapping.
20. Describe the level of scrutiny that the pathologist should apply to the sentinel lymph node to determine that it is negative and why is it of importance to evaluate the lymph node with immunohistochemical methods.
21. Describe the importance of micro metastases in a sentinel node regarding: False negative rates and Prognostic impact for long term survival.
22. Describe the implication of micro metastases seen by cytokeratin analysis alone regarding:
Completion axillary node dissection in: a) invasive breast carcinoma b) DCIS
Long term prognosis for a patient with a) invasive breast carcinoma b) DCIS
Need for adjuvant chemo or hormonal therapy in a) invasive breast carcinoma b) DCIS
23. Describe the role of lymphatic mapping in prophylactic mastectomy. What are the differences in how the mapping is performed?
24. Describe the value of Sentinel Node Biopsy to the patient in combination with or without an axillary node dissection.
25. Describe the indications and contraindications for sentinel node mapping in breast cancer.

Vascular Surgery (Tampa General Hospital and James A Haley VA)

PGY 1
Knowledge Objectives
1. Describe human arterial and venous anatomy; lower limb (arterial and venous), upper limb (arterial and venous), extracranial carotid, intracranial arterial, mesenteric and renal
2. Describe basic "normal" arterial (carotid, visceral, peripheral) and venous (saphenous, deep venous system) hemodynamics, and the abnormalities associated with: "critical" stenosis, intermittent claudication of the lower limb, subclavian steal syndrome, chronic mesenteric angina, renovascular hypertension, acute deep venous thrombosis, chronic venous insufficiency, arteriovenous (AV) fistula
3. Discuss the anatomy, pathology, and pathophysiology of the arterial wall; intima, media, adventitia
4. Discuss the clinical manifestations of the following vascular disorders: atherosclerosis obliterans of the lower limb, aneurysmal arterial disease, thromboembolic disease, arterial and venous
5. Describe invasive and noninvasive techniques for measurement of limb blood pressure and their use in the evaluation of vascular disease, including the arterial pressure criteria of a "hemodynamically significant" stenosis, ankle systolic pressure, ankle-brachial systolic pressure index (ABI), digit systolic pressure and pulse volume recordings, doppler waveform analysis, exercise treadmill testing

6. Describe the relationship of the following disorders/risk factors to atherosclerotic arterial occlusive/aneurysmal disease: diabetes mellitus, hypertension, renal failure, congestive heart failure, hyperlipidemia, smoking
7. Describe the clinical manifestation and intervention for: ruptured abdominal aortic aneurysm, embolus to the brachial artery, acute lower limb deep venous thrombosis, acute superior mesenteric artery thrombosis, acute lower limb graft thrombosis
8. Differentiate between the following diagnostic techniques for assessment of vascular disease: angiography, computed axial tomographic (CAT) scanning, magnetic resonance imaging (MRI) and MR angiography, duplex scanning (ultrasonography)
9. Explain the concept of "silent" vascular disease and cite examples when it represents a major threat to the patient.
10. Summarize the etiology, pathophysiology, and therapeutic options of specific venous disorders: varicose veins involving the greater saphenous system, post-phlebitic (chronic venous insufficiency) syndrome, pulmonary embolus, superficial thrombophlebitis of the greater saphenous vein, iliofemoral venous thrombosis
11. Summarize the etiology, pathophysiology, and therapeutic options of specific lymphatic disorders: lymphedema praecox, lymphedema tarda, postoperative lymphedema
12. Summarize the etiology, pathophysiology, and therapeutic options of specific arterial disorders: aortoiliac occlusive disease, abdominal aortic aneurysm, arterial embolic disease, extracranial carotid stenosis, thoracic outlet syndrome, visceral ischemic syndromes, trauma, arteriovenous malformations
13. Describe the type of the non-invasive vascular laboratory testing used to evaluate: arterial occlusive disease, venous disease, arterial aneurysmal disease, digit ischemia, vascular trauma, thoracic outlet syndrome, extracranial carotid stenosis
14. Describe the bedside technique of Doppler ultrasound arterial and venous testing.
15. Outline the patient care principles for lower limb ischemia.
16. Describe the natural history of the following vascular disorders: carotid bifurcation atherosclerotic stenosis, abdominal aortic aneurysm, superficial femoral artery stenosis/occlusion – intermittent claudication, ileofemoral deep venous thrombosis, calf vein thrombosis
17. Summarize principles for the preoperative assessment and postoperative care of patients undergoing: carotid endarterectomy, lower limb arterial bypass, abdominal aortic aneurysm repair, thromboembolectomy of the femoral artery, placement of hemoaccess for dialysis in the upper limb, varicose vein excision, placement of an inferior vena cava filter, repair of femoral artery false aneurysm, blunt popliteal artery trauma, catheter-directed thrombolysis of acute graft thrombosis, femoropoliteal PTFE graft infection, STSG of venous ulcer
18. Discuss the principles of and contraindications for anticoagulation and thrombolytic therapy.
19. Describe the evaluation and treatment of the sequelae of vascular intervention including: groin lymphocele/fistula, lower limb swelling, stroke after carotid endarterectomy, infrainguinal vein graft stenosis, graft-enteric erosion/fistula, arterial steal syndrome following AV bridge graft placement for dialysis
20. Discuss the technique of: pulmonary catheter placement, perma-cath insertion for hemodialysis, digit amputation, below-knee amputation, I&D of diabetic foot infection, varicose vein excision (microphlebectomy), high ligation of the greater saphenous vein, stent-assisted angioplasty, arterial suturing, vena cava filter insertion
21. Describe measures to reduce the progression of vascular disease
22. Determine a plan for assessment of operative risk in these categories: coronary artery disease, congestive heart failure, chronic obstructive lung disease (COPD), renal insufficiency, level of anesthetic risk
23. Demonstrative ability to prepare patients for definitive operative and endovascular interventions, rehabilitation, and discharge planning.

24. Discuss the diagnosis and management of non-atherosclerotic vascular diseases: systemic vasculitis, giant cell arteritis, Takayasu's disease, radiation induced arterial disease, arterial infection, adventitial cystic disease, popliteal entrapment syndrome, Buerger's disease, coarctation of the abdominal aorta, persistent sciatic artery aberrant subclavian artery, arteriopathies, Marfan's syndrome, Ehlers-Danlos syndrome, arterial magna syndrome, Behçet's disease, homocystinuria.

PERFORMANCE OBJECTIVES

1. EVALUATE PATIENTS FOR ARTERIAL, VENOUS, AND LYMPHATIC DISORDERS.
2. DEMONSTRATE SKILL IN BASIC VASCULAR SURGICAL TECHNIQUES, INCLUDING: SUTURING AN ANASTOMOSIS, BALLOON CATHETER THROMBECTOMY, HANDLING OF AUTOGENOUS VEIN AND PROSTHETIC GRAFT MATERIAL, CLOSURE OF VASCULAR INCISIONS (IN SITU BYPASS, FEMORAL INCISIONS, CAROTID SURGERY)
3. PARTICIPATE IN SURGERY FOR VARICOSE VEIN DISEASE, INCLUDING: LIGATION AND STRIPPING, MICROPHLEBECTOMY, MANAGEMENT OF VENOUS ULCERS, MANAGEMENT OF SUPERFICIAL THROMBOPHLEBITIS
4. PARTICIPATE IN AMPUTATIONS WITH SPECIFIC ATTENTION TO: SELECTION OF LEVEL REQUIRED FOR HEALING, INDICATIONS FOR PRIMARY AMPUTATION, TECHNIQUE OF DIGIT, METATARSAL, AND MIDFOOT AMPUTATIONS, TECHNIQUE OF BELOW- AND ABOVE-KNEE AMPUTATION
5. DEMONSTRATE PROFICIENCY IN HEMOACCESS PROCEDURES FOR DIALYSIS.
6. PARTICIPATE IN THROMBOENDARTECTOMY AND THROMBECTOMY PROCEDURES.
7. EVALUATE INDICATIONS FOR AND MANAGEMENT OF PATIENTS UNDERGOING SYMPATHECTOMY PROCEDURES.
8. Perform the preoperative assessment and postoperative care of patients undergoing major vascular surgical procedures**.**

KNOWLEDGE OBJECTIVES

1.Identify and describe vascular anatomy and regional anatomy related to arterial/venous vascular disorders for: extracranial carotid occlusive, aneurysmal disease, aortoiliac occlusive, aneurysmal disease, lower/upper limb occlusive disease, visceral/renal occlusive and aneurysmal disease.
2.Discuss the broad range of vascular illness, including congenital vascular disease and diseases of the venous and lymphatic systems
3. Outline the indications for intervention for intermittent claudication, abdominal aortic aneurysm, extracranial carotid stenosis, renal artery stenosis, and visceral artery occlusive disease.
4. Describe the pathogenesis and complications of renovascular hypertension, aneurysmal disease, atherosclerosis obliterans of the lower limb.
5. Illustrate the operative exposure of the major vessels, including: aortic arch, proximal subclavian artery, carotid artery, suprarenal aorta, infrarenal aorta, femoral artery, popliteal artery (above-, below-knee), tibial arteries (anterior, posterior, peroneal)
6. Discuss the operative principles/approaches to: bypass grafting (types of grafts and suture material), emergency vascular surgery, reoperative vascular surgery, principles/technique of endarterectomy, anastomotic construction
7. Summarize the etiology, microbiology, and treatment of diabetic foot infection.
8. Analyze the options for treatment of patients with chronic venous insufficiency and venous ulceration.

9. Categorize the prevention and management of operative and postoperative complications, including: graft infections, ischemic bowel, graft thrombosis, atheroembolic ("trash" leg syndrome), white clot syndrome
10. Summarize the open surgical and endovascular techniques available for managing the following vascular disorders: abdominal aortic aneurysms, internal carotid stenosis, subclavian steal syndrome, femoral popliteal occlusion, tibial artery occlusion
11. Review critical factors for decision making in vascular surgery: risk:reward ratio, morbidity and mortality probability, preoperative and postoperative assessment, intraoperative assessment, noninvasive vascular testing, role of CT scans, MRI, MRA, angioplasty.

Performance Objectives:
1. Demonstrate the appropriate incisions and exposure of: abdominal aorta and its branches, portal venous system, peripheral arterial system, extracranial carotid system, arteriovenous fistula.
2. Obtain vascular control of major vessels, including: ruptured abdominal aortic aneurysm, inferior vena cava, popliteal artery, internal carotid artery, subclavian artery, vertebral artery.
3. Perform selected "open" procedures or parts of the following procedures under supervision: aortic aneurysm repair, carotid endarterectomy, aortoiliac occlusive disease, femoral popliteal occlusive disease, peripheral vascular trauma, inferior vena cava filter placement, arteriovenous bridge graft foe hemodialysis

4. DISCUSS AND DEMONSTRATE THE ROLE OF ADJUNCTIVE MEASURES IN OPERATIVE PROCEDURES INCLUDING ARTERIOGRAPHY, ANGIOSCOPY, AND THROMBOLYTIC THERAPY.
5. PERFORM ALTERNATIVE METHODS OF BYPASS GRAFTING SUCH AS: EXTRA-ANATOMIC BYPASS, IN SITU BYPASS TECHNIQUES, SEQUENTIAL AND COMPOSITE BYPASS GRAFTING TECHNIQUES.
6. MANAGEMENT OF VASCULAR GRAFT INFECTIONS INCLUDING: AORTOFEMORAL GRAFT INFECTION, PRIMARY/SECONDARY AORTODUODENAL FISTULA, AV BRIDGE GRAFT INFECTION, EXPOSED INFRAINGUINAL BYPASS GRAFT
7. MANAGE COMPLICATIONS OF COMMON MAJOR VASCULAR PROCEDURES (CAROTID ENDARTERECTOMY, AORTIC RECONSTRUCTION, LOWER EXTREMITY BYPASS, DIALYSIS ACCESS THROMBOSIS).

B. ACGME Competencies

In 2002, the ACGME began to monitor the implementation of general competencies and assessment for all existing core programs by using a common data collection tool. Log onto the Web Accreditation Data System and proceed to the Site Visit Information section and select *Update/Verify General Competency Addendum* to enter your information. Once the information has been entered and saved, select *Print PIF Competencies Addendum* to generate a printed copy of the General Competencies Addendum and attach it to the end of PIF.

Education Objectives for Anesthesiology

Rotation: Introduction to Anesthesiology

Duration: One-month

Faculty: Hans W. Schweiger, M.D., (Director of Eduction)
Dev Mangar, M.D., (Vice Chair of Clinical Affairs)
Enrico Camporesi, M.D. (Chairman)
Gulf-to-Bay / USF Anesthesiology Faculty Members

Residents will be evaluated using framework established by Six General Competencies of Accreditation Council for Graduate Medical Education (ACGME) Outcomes Project.

General Goals of Rotation

The Introduction to Anesthesia rotation is designed to expose new residents to the basic concepts of physiology and pharmacology as applied to the practice of anesthesiology. Didactic lectures, simulator-based sessions, and reading lists are included to give the residents a strong background in the specialty.

Specific Competencies

Patient Care Skills

Anesthesiology residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and promotion of health. Consequently, by the end of the Introductory rotation in the anesthesiology resident will be able to:

1. Appropriately prepare an ASA 1 or 2 patient for anesthesia with consideration of both the patient and procedure-make sure all appropriate preoperative evaluations, lab tests, medication, and blood orders are appropriately completed. Obtain appropriate consent for anesthesia.
2. Appropriately organize the anesthesia work station for care of ASA 1 and 2 patients.
3. Obtain peripheral IV access for patients in or destined for the operating room.
4. Place all usual practice non-invasive monitoring devices on patients in the operating room.
5. After induction of anesthesia, be able to ventilate the patient by mask prior to placement of the tracheal tube.
6. Properly place and verify placement of airway devices (oral and nasal airways, endotracheal tube, and laryngeal mask airway) and be able to use both Miller and MAC blades for tracheal intubation.
7. Establish appropriate mechanical ventilation settings for patient sin the operating room.

Rotation: Introduction to Anesthesiology (con't)

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8. Appropriately titrate anesthetic agents during different phases of surgery
9. Define and compute the following:
    a. Estimated blood volume
    b. Allowable blood loss
    c. Estimated blood loss
10. Accurately complete an anesthetic record that is fully medicare-compliant

11. Assess patients for readiness for extubation and extubate patients safely.
12. Safely transport patients to the appropriate post anesthesia care unit following the operative procedure and provide a proper report the caregiver.

Medical Knowledge

Anesthesiology residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Consequently, by the end of the Introductory rotation the anesthesiology resident is expected to be able to answer the following questions and discuss the following topics. A test will be given at the end of the four months, and performance on the test will be used in conjunction with evaluations, AKT-0 and AKT-1 performances to help assess your progress early in your training.

1. What is the definition of MAC?
2. What is the ASA physical status classification system in detail?
3. What are the indications for a rapid sequence induction?
4. What is a rapid sequence induction in detail?
5. What are the contraindications for LMA placement?
6. What are the advantages and disadvantages of spinal and epidural analgesia?
7. What are the doses, advantages, disadvantages, pharmacodynamic properties, and pharmacokinetic properties of the most commonly used drugs, including:
    a. Pentothal
    b. Propofol
    c. Etomidate
    d. Ketamine
    e. Succinylcholine
    f. Cisatracurium
    g. Rocuronium
    h. Vecuronium
    i. Mivacurium
    j. Pancuronium
    k. Fentanyl
    l. Morphine
    m. Neostigmine
    n. Glycopyrrolate
    o. Atropine
    p. Ephedrine
    q. Phenylephrine

    r. Epinephrine
    s. Emsolol
    t. Labetalol
    u. Midazolam
    v. Metoclopramide
    w. Ranitidine
    x. Ondansetron
    y. Droperidol

8. What is the Mallampati classification system?

9. What are the physical examination findings of a patient with potentially difficult airway?
10. Which medications should a patient take or not take on the morning of surgery?
11. What are NPO guidelines for an adult?
12. What is compound A and why is it an issue?
13. How are local anesthetics metabolized?
14. How, in detail, do you do a machine check?
15. Explain the advantages and disadvantages of the circle system.
16. What are the "standard ASA monitors?"
17. What are the indications for an arterial line?
18. What are the indications of a central line?
19. How does a pulse oximeter work?
20. How does an automatic noninvasive blood pressure cuff work?
21. Discuss common capnographic findings.
22. What are extubation criteria (at the end of a case)?
23. How can you blunt the hypertensive/tachycardic response to extubation?
24. In which patient should you blunt the response?
25. What is the advantage of neuromusclular monitoring on the arm vs. the face?
26. Explain in detail train-of four monitoring, sustained tetanus, post-tetanic potentiation, and phase 1 and 2 blockade.

<u>Practice-based Learning & Improvement</u>

Anesthesiology residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Consequently, by the end of the Introductory rotation, the anesthesiology resident is expected to demonstrate ability to:

1. Assimilate knowledge from the new resident reading list, and answer basic written questions accordingly.
2. Synthesize the knowledge from the text reading and apply it to simulator-based sessions as well as to clinical practice.

<u>Interpersonal & Communication Skills</u>

Anesthesiology residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patient's families, and professional associates. Consequently, by the end of the Introductory rotation the anesthesiology resident is expected to demonstrate ability to:

1. Communicate with a surgeon and circulation nurse effectively in order to:
    a. Be aware of important surgical activities that impact on anesthetic management.
    b. Communicate needs of the anesthesia team to the OR team.

2. Exhibit appropriate respect for OR team personnel members.
3. Communicate effectively with patients in order to:
    a. Elicit historical information important to anesthetic care.
    b. Reassure patients and their families regarding the pending anesthetic/surgical experience.
4. Communicate effectively with attending physicians in order to:
    a. Discuss preoperative evaluation and develop an anesthetic plan.
    b. Inform the attending physicians of important intraoperative events that require his/her input or attention.

5. Develop appropriate flexibility to negotiate the differential professional styles, techniques, attitudes, and approaches to the safe administration of anesthesia encountered when teaming with varied senior residents and attendings.

Professionalism

Anesthesiology residents must demonstrate a commitment to implementing professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Consequently, by the end of the Introductory rotation the anesthesiology resident is expected to demonstrate:

1. Appropriate interactions with surgeons, nursing staff, and fellow anesthesia practitioners.
2. Respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and medical profession in general and anesthesiology professional development.
3. Commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices.
4. Sensitivity and responsiveness to patients' culture, age, gender, and disabilities.
5. Exhibit high standards of ethical/moral behavior.
6. Exhibits honesty/integrity.
7. Exhibits reliability/responsibility.
8. Optimizes learning from experience.
9. Appropriately reacts to stressful/emotional situations.
10. Respects dignity of patients and colleagues.

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 call on system resources to provide care that is of optimal value. Consequently, by the end of the Introductory rotation the anesthesiology residents is expected to:

1. Understand how their patients care and other professional practices affect other health care professionals, the health care organization, and society as a whole and how these elements of the system affect their own practice.
    a. Appropriately utilize consultants and diagnostic testing information to appropriately prepare patients for surgery.
2. Practice cost-effective health care and resources allocation that does not compromise quality of care.
3. Advocate for quality patient care and assist patients in dealing with system complexities.
4. Recognize the need and appropriately plan for needed postoperative recovery care including recognizing when a patient is an appropriate candidate for ambulatory surgery.
5. Exhibit adequate record keeping skills to insure:
    a. Documentation of anesthetic management completely and accurately.
    b. Appropriate documentation of effort for reimbursement and demonstrates knowledge of and behavior consistent with strict Medicare compliance.

Rotation: Introduction to Anesthesiology (con't)

Evaluation of Goals Achievement

Evaluation of competencies for Anesthesiology Residents in the Introductory rotation will be applied in the following manners:

1. Patient Care Skills will be evaluated case-by-case by attending (oral formative evaluation) and during weekly (6-consecutive weeks) Anesthesia Human Patient Simulator challenges. Evaluations will specifically address residents' communication skills, perioperative assessment, decision making and clinical skills.
2. Medical Knowledge will be evaluated case-by-case with attending (oral formative evaluation) and by utilization of the Anesthesia Knowledge Test (AKT-0, AKT-1; AKT-1 is considered a summative evaluation for the first of intensive anesthesiology training) and during weekly Anesthesia Human Patient Simulator challenges.
3. Practice-based Learning & Improvement skills will be demonstrated via interaction with a supervisory faculty (case-by-case formative evaluation), journal clubs, case conferences, and during weekly Anesthesia Human Patient Simulator challenges.
4. Interpersonal & Communication Skills are directly assessed in daily evaluations, during weekly Anesthesia Human Patient Simulator challenges.
5. Professionalism is assessed via observed interactions with patients and health care team members.

6. Systems-based Practice is addressed via Departmental seminars/workshops regarding medical record documentation compliance, medical quality improvement, and medical risk management.
7. Systematic weaknesses in areas considered core to Introductory Anesthesia may precipitate modification to goals & objectives listed herein.

Teaching & learning resources to accomplish objectives

1. Patient population: Main OR at Tampa General Hospital
2. Reading resources:
    a. Stoelting and Miller; Basics of Anesthesia
    i. Supplemented with primary anesthesiology texts located in Department Library.
    ii. Supplemented with CD-ROM's available in Departmental Library.
    iii. Supplemented with Anesthesiology journals available in Departmental Library.

3. Didactic Lecture (Core lectures for Introduction to Anesthesiology)
4. Anesthesia Patient Simulator workshops (Core clinical challenges for Introduction to Anesthesiology)
5. Faculty resources: All TGH-main OR Anesthesiology attendings
6. Inernet Resources:
    a. USF-Department of Anesthesiology
        i. Links to PubMed and Anesthesiology, Critical Care, and Pain Medicine Web sites.
    b. American Society for Anesthesiologists
    c. International Anesthesia Research Society
    d. Anesthesiology GASNet

Emergency Medicine Rotation

Educational Objectives:
The emergency medicine resident will gain knowledge in al areas of emergency medicine, as outlined in the Model for the Clinical Practice of Emergency Medicine.

The resident will become proficient in the performance of history taking and physical examination of the ED patient.

The resident will be able to form a differential diagnosis, order diagnostic tests, interpret them accurately, form a treatment plan, and make appropriate referrals for the full range of patients presenting to the ED.

The resident will become proficient at recognizing and treating life and limb threatening emergencies.

The resident will become proficient at a broad variety of emergency procedures necessary for the treatment of ED patients, as outlined in the Model for the Clinical Practice of Emergency Medicine.

Description of clinical experiences:
The rotation will consist of a month long experience in the adult emergency care center, under the direct supervision of the attending physicians.

Evaluation process:
The resident will be evaluated by the faculty of Emergency Medicine using the standard resident evaluation form. The resident will provide a written evaluation of the rotation upon its completion to the program director, who will review collected evaluations with the departmental chair and staff physicians twice annually. The resident will also complete a written test based upon assigned reading.

Feedback mechanisms:
The resident will receive both verbal and written feedback from the faculty overseeing the experience. Performance will be reviewed with the resident at a biannual conference between the resident and program director. The written test score will be returned to the resident. The resident will provide feedback of the rotation in an anonymous fashion utilizing the standard written evaluation form.

Resident Curriculum Guidelines for Department of Neurosurgery

TGH Rotation: Junior Level

Neuroanatomy

Unit Objectives
Demonstrate knowledge of anatomy that is pertinent to the diagnosis of diseases of the nervous system and practice of neurological surgery.

Competency-Based knowledge Objectives:

General

1. Review the embryological development of the brain, cerebellum, brain stem, glial elements, spinal cord, conus medullaris, cauda equine, sympathetic and parasympathetic systems and the peripheral nervous system.
2. Discuss the embryologic development of the skull, craniovertebral junction, and spine.
3. Describe and differentiate the different types of neurons.
4. Discuss the microanatomy of the neuron including the:
    a. Cell body
    b. Dendritic process
    c. Axonal process
5. Diagram and describe the microanatomy of the synapse.
6. List the microglial elements and review their microanatomy:
    a. astrocytes
    b. oligodendrocytes
    c. microglia
    d. ependyma
    e. choroids epithelium
7. Diagram and describe in detail the carotid and vertebral arteries and their branches which provide blood supply to the face, scalp, skull, meninges, brain, brain stem, cerebellum, and rostral spinal cord.
8. Discuss in detail the arterial blood supply to the spinal cord. Include in the discussion the spinal and radicular arteries and the concept of watershed ischemia.
9. Identify and review the venous drainage of the central nervous system.
10. List and identify the bones of the skull.
11. Describe each of the sutures of the skull.
12. Identify each named foramen of the skull and list its contents.
13. Describe the anatomy of the meninges including the:
    a. dura mater
    b. arachnoid mater
    c. pia mater
14. Describe the anatomy of the dura including the falx cerebri and tentorium.
15. Review the layers of the scalp and discuss its innervation.
16. Diagram the cerebral ventricles.
17. Discuss the major arachnoid cisterns.
18. Review the anatomy of the arachnoid villi.

19. Discuss the anatomic correlates pertinent to the production, flow, and reabsorption of cerebrospinal fluid.
20. Identify and describe the gross anatomy of the spine including:
    a. atlas
    b. axis
    c. subaxial cervical vertebrae
    d. thoracic vertebrae
    e. lumbar vertebrae
    f. sacrum
    g. coccyx
    h. intervertebral disc complex
    i. supporting ligaments of the spine
21. List the muscles related to the skull and spine
22. Describe the gross anatomy of the neck.
23. Discuss the anatomical basis for the blood-brain barrier in detail

Central Nervous System

1. Describe the gross anatomy of the brain, brain stem, cerebellum, cranial nerves, and spinal cord in detail.
2. Describe the anatomy of the cerebral cortex in detail including:
    a. cortical layers
    b. sensory areas
    c. motor areas
    d. prefrontal cortex
    e. fiber tracts
    f. calcarine cortex
3. Describe the anatomy of the olfactory pathways, hippocampal formation and amygdale in detail including:
    a. rhinencephalon
    b. olfactory pathways
    c. anterior commissure
    d. hippacampal formation (including cytoarchitecture)
    e. amygdale
    f. limbic system
4. Describe the anatomy of the corpus striatum in detail including:
    a. striatum
    b. globus pallidus
    c. claustrum
    d. subthalamic region
    e. striatal afferent and efferent connections
    f. pallidal afferent and efferent connections
    g. pallidofugal fiber systems
5. Describe the anatomy of the hypothalamus and pituitary in detail including:
    a. cytoarchitecture of the hypothalmus
    b. afferent and efferent connections of the hypothalamus
    c. supraoptic nuclei and tracts
    d. hypophysial portal system
    e. anatomy of the pituitary stalk
    f. anterior and posterior pituitary
    g. cellular organization of the anterior pituitary
    h. hormonally active cells of the hypothalamus and pituitary

6. Describe the anatomy of the diencephalons in detail including:
    a. midbrain-dienencephalon junction
    b. caudal diencephalons
    c. epithalamus
    d. thalamus (including nuclei)
    e. thalamic radiations
    f. internal capsule
    g. visual pathways
7. Describe the anatomy of the cerebellum in detail including:
    a. cerebellar cortex including organization
    b. deep cerebellar nuclei
    c. cerebellar connections
    d. cerebellar peduncles
8. Describe the anatomy of the mesencephalon in detail including:
    a. superior colliculus
    b. inferior colliculus
    c. pretectal region
    d. posterior commissure
    e. mesencephalic nuclei
    f. oculomotor nerve
    g. tegmentum
    h. mesencephalic reticular formation
    i. substantia nigra
    j. crus cerebri
    k. ascending and descending tracts
9. Describe the anatomy of the pons in detail including:
    a. vestibulocochlear nerve
    b. facial nerve
    c. abducens nerve
    d. trigeminal nerve
    e. ascending and descending tracts
10. Describe the anatomy of the medulla in detail including:
    a. olivary nucleus
    b. medullary reticular formation
    c. cranial nerves of the medulla
    d. ascending and descending tracts
11. Review the location and connections of each cranial nerve nuclei. Trace the course of each cranial nerve from nucleus to end organ termination.
12. Describe the external topography and landmarks of the fourth ventricle.
13. Describe the anatomy of the spinal cord in detail including:
    a. nuclei and cell groups
    b. cytoacrchitectural lamination (Rexed Laminae)
    c. somatic and visceral efferent neurons
    d. posterior horn neurons
    e. descending tracts
    f. ascending tracts
    g. upper and lower motor neurons
    h. somatotopic organization

Autonomic Nervous System

1. Distinguish pre and postganglionic neurons.

2. Describe the sympathetic nervous system
3. Describe the parasympathitic nervous system
4. Review the visceral afferent fibers
5. Describe the structure of the autonomic ganglia
6. Discuss the central autonomic patheways

Peripheral Nervous System

1. Differentiate between segmental and peripheral innervation
2. Diagram the anatomy of the spinal nerve root
3. Diagram and discuss the cervical, brachial, and lumbosacral plexi
4. Outline the anatomy of the major peripheral nerves of the upper and lower extremity including:
    a. axillary
    b. suprascapular
    c. median
    d. ulnar
    e. radial
    f. long thoracic
    g. musculocutaneous
    h. lateral femoral cutaneous
    i. femoral
    j. obturator
    k. sciatic
    l. saphenous
    m. peroneal
    n. tibial
5. Describe the microanatomy of the peripheral nerves in detail
6. Explain the difference between myelinated and unmyelinated nerves
7. Review the anatomy of the Schwann cell
8. List the peripheral afferent receptors and describe the anatomy of each
9. Segregate peripheral neurons by size and explain the rationale for such a classification scheme.

Muscle

1. Explain the concept of the motor unit
2. Describe the anatomy of the motor end plate
3. Describe the microscopic anatomy of striated and smooth muscle
4. Discuss the subcellular components of muscle

NEUROPHYSIOLOGY
UNIT OBJECTIVES
Demonstrate knowledge of physiology that is pertinent to the understanding of neurological disease.

COMPETENCY-BASED KNOWLEDGE OBJECTIVES:

1. Review the basic biology of the nerves including:
    a. synthesis and movement of proteins in the nerve
    b. membrane potential and membrane properties
    c. ion channels
    d. generation and conduction of an action potential
2. Discuss synaptic transmission including:

a. types of synaptic transmission
b. transmitter release
c. nerve-muscle transmission
d. chemical messengers
e. direct gated receptors
f. second messenger linked receptors

3. Describe the physiology of the sensory systems including:
    a. sensory receptor physiology
    b. anatomy of somatic sensory system
    c. coding of modality specific sensory information
    d. pain and analgesia
    e. cortical integration of sensory perception
    f. visual system
    1. processing of information in the retina
    2. processing of vision in the central visual pathways
    3. columnar units of visual cortex
    4. processing in the geniculate nucleus
    5. visual perception of motion and form
    g. auditory system. Within this description review the processing of hearing in the cochlea and the central auditory pathways.
    h. olfaction and taste
4. Discuss the physiology of the motor system including:
    a. mechanisms of muscle contraction
    b. muscle receptors, spinal reflexes
    c. spinal reflexes concerned with position
    d. brain stem reflexes controlling motion
    e. vestibular nuclei control of movement and posture
    f. red nucleus control of movement
    g. cortical control of movement
    h. cerebellar control of movement
        1. regional and cellular organization of the cerebellum
        2. functional divisions of the cerebellum
        3. the role of the cerebellum in planning movement
    i. basal ganglia
        1. the anatomy of basal ganglia pathways
        2. neural transmitters in the circuits within the basal ganglia
    j. thalamus
5. Describe the attributes of the autonomic nervous system including both the sympathetic and parasympathetic systems.
6. Review the physiological basis of arousal and emotion. Include with this view the:
    a. noradrenergic systems
    b. limbic system. Include within this view the physiologic basis for emotion and memory
    c. sleeping and sleep states
    d. reticular activating system
7. Describe the higher cortical functions including:
    a. Anatomy of language
    b. Function of association cortex
8. Describe the physiological basis for cerebrospinal fluid production and reabsorption.
9. Review the physiological control of the cerebral vasculature.

10. Discuss, in detail, the physiology of the hypothalamus and pituitary, particularly as related to endocrinology.

NEUROPHRMACOLOGY

UNIT OBJECTIVES

Demonstrate knowledge of pharmacology that is pertinent to the treatment of neurological disorders and diseases which affect the nervous system.

COMPETENCY-BASED KNOWLEDGE OBJECTIVES:

1. Review basic cellular neurotransmission. In the course of this review discuss:
    a. the synapse
    b. membrane potentials
    c. ion pumps
    d. ion channels
    e. transmitter secretion
    f. transmitter identification
2. Define and discuss receptors and receptor pharmacodynamics including:
    a. receptor classification
    b. receptor identification
    c. dose response curves
    d. agonists and antagonists
    e. receptor modulation
3. Discuss the neurotransmitter acetylcholine in detail. Include within the context of the discussion:
    a. cholinergic receptor classification
    b. functional aspects of cholinergic receptors
    c. synthesis, storage, and release of acetylcholine
4. Discuss the catecholamine neurotransmitters (norepinephrine and dopamine) in detail. Including within the context of the discussion:
    a. biosynthesis of catecholamines
    b. storage and release of catecholamines
    c. anatomy of catecholamine receptors
    d. adrenergic receptors
    e. dopaminergic receptors
5. Discuss the neurotransmitter serotonin in detail. Include within the context of the discussion:
    a. Anatomy of serotonin receptors
    b. Biosynthesis, storage and release of serotonin
    c. Sub-types of serotonin receptors
6. Discuss the neurotransmitter glutamate in detail. Include within the context of the discussion:
    a. biosynthesis, storage and release of glutamate
    b. ionotropic glutamate receptors
        1. NMDA receptors and subunits
        2. non-NMDA receptors and subunits
    c. metabotropic glutamate receptors
        1. Group I metabotropic receptors and subunits
        2. Group II metabotropic receptors and subunits
        3. Group III metabotropic receptors and subunits
    d. role in neurological disorders

7. Discuss the neurotransmitters GABA and glycine in detail.
    a. syunthesis, uptake, and release
    b. physiology and pharmacology
    c. clinically relevant agonists and antagonists of GABA and glycine receptors
8. Discuss the peptide neurotransmitters
9. Describe the pharmacology of each of the drugs used to treat neurological disorders.

FLUIDS, ELECTROLYTES, AND NUTRITION

UNIT OBJECTIVES

Demonstrate an understanding of normal and pathologic fluid and electrolyte homeostasis. Demonstrate an ability to maintain normal electrolyte balance. Demonstrate an understanding of the basics of nutritional management in neurosurgical patients.

1. Discuss the normal distribution of intracellular and extracellular fluid and electrolytes including:
    a. Sodium and water distribution and metabolism
    b. Clinical assessment of water and sodium balance and the concept of osmolality
    c. Normal maintenance requirements
    d. Management of pathologic conditions such as diabetes insipidus and the syndrome of inappropriate antidiuretic hormone secretion
    e. Cerebral salt wasting
2. Review the potential implications of diuresis and fluid restriction on water and electrolyte balance
3. Briefly review the potential clinical implications of calcium, phosphorous, and magnesium excesses and deficiencies and the treatment of same.
4. Review the criteria for nutritional assessment including:
    a. history of significant weight loss
    b. hypoalbuminemia
    c. impaired immune response including diminished total lymphocyte count and anergy
    d. physical signs of malnutrition
5. Briefly describe the metabolic responses to starvation and stress
6. Describe and contrast the indications, contraindications, complications, and benefits of enteral and parenteral nutrition.
7. Analyze the implications of specific nutritional deficiencies as they relate to neurological and neurosurgical disease,
8. Briefly review swallowing disorders
9. Describe the common changes of metabolism and nutritional requirements of trauma patients and their evaluation.

COMPETENCY-BASED KNOWLEDGE OBJECTIVES:

1. Demonstrate an ability to mange the fluid and electrolyte requirements of neonatal, pediatric, and adult neurosurgical patients.
2. Demonstrate the ability to place central venous catheters
3. Demonstrate the ability to place enteral feeding tubes
4. Demonstrate an ability to prescribe appropriate parenteral and enteral nutrition.
5. Recognize and treat the complications of parenteral and enteral feeding including:
    a. line sepsis
    b. glucose intolerance
    c. diarrhea

    d. dehydration
6. Recognize swallowing disorders and manage same.

GENERAL CRITICAL CARE
UNIT OBJECTIVES
Demonstrate an ability to triage neurosurgical patients to and from a critical care setting.
Demonstrate knowledge of and the ability to manage neurosurgical patients in the critical care setting.
COMPETENCY-BASED KNOWLEDGE OBJECTIVES:

1. Define the adult and pediatric patient who would be best served in a critical care setting; including both medical and neurosurgical issues within the context of this discussion.
2. Review general medical issues pertinent to the management of neurosurgical patients in a critical care setting including:
    a. prophylaxis of gastrointestinal hemorrhage
    b. prophylaxis of pulmonary morbidity
    c. prophylaxis, diagnosis, and treatment of venous thrombosis and pulmonary embolism
    d. skin care
    e. eye care
    f. physical therapy to maintain strength and joint range of motion
    g. universal precautions
    h. workup and treatment of sepsis
3. Describe the indications and pharmacokinetics for medications commonly used in the management of critically ill neurosurgical patients including:
    a. vasoactive drugs
    b. ionotropic drugs
    c. bronchodilators
    d. diuretics
    e. antiarrhythmics
    f. antihypertensives
    g. antimicrobials
    h. anticonvulsants
4. Describe the clinical presentation, evaluation, and treatment of infections which commonly occur in critical care neurosurgical patients.
5. Review the indications for intubation including:
    a. loss of patient airway
    b. respiratory insufficiency
    c. inability to protect airway
6. Discuss commonly used pulmonary values including:
    a. measured pulmonary functions
        i. rate
        ii. minute ventilation
        iii. spontaneous tidal volume
        iv. forced vital capacity (FVC)
        v. functional residual capacity (FRC)
        vi. maximum ventilatory volume (MVV)
    b. ventilator mode and settings
        i. pressure versus volume ventilation
        ii. continuous positive airway pressure (CPAP)
        iii. intermittent positive airway pressure (IPAP)

iv. pressure support
v. assist control
vi. intermittent mandatory ventilation (IMV)
vii. positive end expiratory pressure (PEEP)
viii. rate
ix. tidal volume

7. Review the indications for weaning patients from ventilatory support. Describe the methods by which this is accomplished and the general pulmonary parameters a patient must demonstrate prior to extubation.
8. Discuss the medications used to improve pulmonary function.
9. Briefly review the following cardiac function parameters:
    a. preload
    b. afterload
    c. contractility
10. Review the indications for implementing the following monitoring devices. Briefly describe how the information obtained is utilized to optimize patient management.
    a. arterial catherters
    b. central venous catheters
    c. Swan-Ganz catheters
    d. pulse oximetry
    e. electrocardiographic monitoring
    f. end-tidal CO2 monitors
11. List the signs of acute myocardial ischemia and briefly discuss the emergent treatment of this condition.
12. Review the impact of renal insufficiency as it pertains to the management of neurosurgical patients.
13. Briefly discuss the diagnosis and management of acute renal insufficiency.
14. Describe the diagnosis and management of an ileus. List the differential diagnosis for an ileus.
15. Review the diagnosis and management principles of the following endocrine disorders:
    a. hypo/hyperthyroidism
    b. hypo/hyperparathyroidism
    c. adrenal cortical excess and deficiency
    d. diabetes mellitus
    e. diabetes insipidus
16. Review the medical and legal definitions of brain death.
17. Discuss moral and ethical issues pertaining to critically ill neurosurgical patients including:
    a. patient or family request to withhold or withdraw treatment
    b. organ donation
18. Summarize the physiology of hydrogen ion production and excretion.
19. Briefly discuss acute and chronic buffering systems
20. Discuss metabolic acidosis and alkalosis
21. Discuss respiratory acidosis and alkalosis
22. Review the effects of acid-based disturbances on the central nervous system and intracranial pressure.

COMPETENCY-BASED KNOWLEDGE OBJECTIVES:

1. Obtain ACLS and ATLS certification
2. Demonstrate the ability to perform an initial evaluation and management of critically ill neurosurgical patients.
3. Perform the following procedures:
    a. orotracheal intubation
    b. nasogastric intubation
    c. bladder intubation
4. Serve on a trauma team
5. Demonstrate an ability to manage neurosurgical patients in a critical care setting.
6. Diagnose and treat acid-base abnormalities in neurosurgical patients.
7. Demonstrate an understanding of the management of complex-acid base disturbances in the critical care setting.

INFECTION

UNIT OBJECTIVES

Demonstrate an understanding of the factors related to the acquisition, diagnosis, and treatment of infections as they pertain to neurosurgical patients. Describe the typical presentation and treatment of common neurosurgical infections. Review the methods used to minimize infectious complications in neurosurgical patients. Demonstrate an understanding of the techniques to minimize the risk of spread of viral infections, including hepatitis and human immunodeficiency virus (HIV)

COMPETENCY-BASED KNOWLEDGE OBJECTIVES:

1. List the common organisms responsible for meningitis in an age related fashion.
2. List the common CNS infections and describe the populations which are most at risk for each.
3. List the common opportunistic CNS infections and describe the populations which are most at risk for each.
4. Describe in detail the clinical and pathological symptoms and findings associated with CNS infections.
5. Discuss the radiological evaluation of patients with suspected and known CNS infections.
6. Review the indications for alerting individuals at risk for infections based on exposure to a patient with a known CNS infectious process.
7. Review each major class of antimicrobial drugs:
    a. describe the potential of resistance of each drug
    b. list the potential complications of each agent
    c. review the serological monitoring of each antimicrobial agent including the need for monitoring renal, hepatic, and hemopoietic function
    d. indicate which drugs will traverse the blood-brain barrier and which will not
    e. demonstrate a knowledge of the pharmacokinetics of each antimicrobial agent
    f. describe the potential complications of each antimicrobial drug and explain how to monitor for and detect same.
    g. Review the rationale for monitoring drug levels and list the therapeutic levels of antimicrobials commonly used to treat neurosurgical infections.
8. Discuss the advantages and disadvantages of treatment of CNS infections with corticosteroids.
9. Review the role of anticonvulsant therapy in the management of CNS infections.
10. List the universal precautions for prevention of infection as they pertain to health care workers in general and neurosurgeons in particular.

11. Discuss the role of hand washing as the most important method of preventing infection.
12. Describe the role of the clinical epidemiologist in tracking infectious disease incidence and potential sources of infection within the hospital and community setting.
13. Review the mode of transmission, diagnosis, and treatment of non-CNS infections which may commonly arise in neurosurgical patients such as:
    a. respiratory infections
    b. urinary tract infections
    c. wound infections
14. Review the prevention, diagnosis and management of sepsis
15. List the common sources of a postoperative fever
16. Describe the workup for a febrile patient
17. Discuss the use of prophylactic antibiotics
18. Review the symptoms, clinical evaluation and management of patients with shunt infections.
19. Discuss prior disease and precautions to be taken when it is suspected.

COMPETENCY-BASED KNOWLEDGE OBJECTIVES:

1. Demonstrate the ability to use universal precautions.
2. Demonstrate the ability to use sterile technique.
3. Appropriately diagnose and treat non-CNS infections in neurosurgical patients
4. Appropriately diagnose and treat CNS infections in neurosurgical patients.

PRACTICE MANGEMENT, LEGAL AND SOCIOECONOMIC ISSUES

UNIT OBJECTIVES

Demonstrate an understanding of the principles of practice management and the business aspects associated with the delivery of health care.

COMPETENCY-BASED KNOWLEDGE OBJECTIVES:

1. Discuss the ethical and moral factors associated with the practice of neurosurgery.
2. Review the role of the neurosurgical leadership in the community and hospital setting.
3. Explain the neurosurgeon's responsibilities in terms of health care cost containment.
4. Review the features relationships of the healthcare system including:
    a. treatment facilities
    b. third party payment systems
        1. Medicare
        2. Medicaid
        3. employer-provided insurance
        4. private insurance
    c. physician practice organizations
    d. medical equipment manufactures
    e. pharmaceutical companies
5. Recite the rules and regulations of the training hospital(s) as they pertain to the practice of neurosurgery in which the residency is performed.
6. Name the institutional and social service agencies in your community and review their role in the overall management of neurosurgical patients.
7. Demonstrate a knowledge of the rules and regulations of your State Medical Board
8. Discuss the concept of informed consent
9. Discuss mandatory reporting laws

10. Discuss issues pertinent to the topic of the impaired physician
11. Name and describe the local, regional, and national neurosurgical organizations including their purposes, roles, activities, and interactions.
12. Discuss the importance of tracking morbidity, mortality, and patient outcomes.
13. Review the career options available at the completion of neurosurgical residency in detail including:
    a. Private practice
    b. Academic practice
    c. Subspecialty fellowship
    d. Research
    e. Administration
    f. Military
14. Discuss post-residency fellowship training program availability, application process, and career usefulness.
15. Describe the types and characteristics of surgical practice organizations including:
    a. Solo practice
    b. Group practice
        1. partnership
        2. professional association
        3. corporation
    c. academic practice
    d. Health Maintenance Organizations (HMO)
        1. Preferred Provider Organizations (PPO)
        2. Individual Practice Associations (IPA)
        3. staff model (Kaiser-Permanente type)
    e. Federal
    1. Department of Veterans Affairs
    2. Military
    3. Public Health Service
16. Discuss hospital payment systems (e.g., DRGs, per diem rates) and describe their incentives and how they affect hospital profitability.
17. Discuss the role and influence of national quality oversight and review organizations for hospitals and health plans (JCAHO, NCQA).
18. Discuss the history, changes, eligibility, funding, and problems associated with the Medicare program.
19. Describe the Medicare program features, such as eligibility, funding, administration, federal-state relationship, benefits, and payment methods.
20. Discuss federal funding of graduate medical education and how current federal budget allocations and proposals for changes in funding affect or will affect neurosurgical training programs.
21. Discuss the significance of the following issues as they relate to the practice of neurosurgery:
    a. Legislative/regulatory requirements
        1. Americans with Disabilities Act
        2. Clinical Laboratory Improvement Amendments (CLIA)
    b. Federal/professional regulatory requirements
        1. Health Care Financing Administration (HFCA)
        2. Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
        3. Occupational Safety and Health Administration (OSHA)
    c. miscellaneous

1. affirmative action
2. equal opportunity
3. sexual harassment

22. Discuss the common causes of malpractice actions and effective measures to reduce the risk of malpractice complaints
23. Describe the ways, means, and reasons physicians influence the political process at the national, state, and local levels.
24. Discuss the demographics of neurosurgeon distribution, numbers, workload studies, and workforce needs.
25. Outline the requirements for certification by the American Board of Neurological Surgery.
26. Formulate a strategy to evaluate personal and professional considerations in making a career choice.
27. Appraise the importance of family involvement in making career choices, including geographic location.

COMPETENCY-BASED KNOWLEDGE OBJECTIVES:

1. Demonstrate an ability to interact effectively, professionally, and respectfully with:
    a. patients and their families
    b. fellow residents
    c. allied health care personnel
    d. hospital staff
    e. medical students
    f. faculty physicians
    g. referring physicians
2. Demonstrate the ability to maintain accurate and current medical records.
3. Discuss neurosurgical career options with
    a. faculty
    b. peers
    c. family
    d. non-faculty neurosurgeon and other mentors
4. Accumulate information about post-residency career options
5. Create and keep current a resume/curriculum vitae
6. Record CPT codes for office visits and procedures performed on service
7. Accurately document H&P and consultations according to the AMA-CPT E&M documentation guidelines

CEREBROVASCULAR SURGERY

UNIT OBJECTIVES

Demonstrate an understanding of the anatomy, physiology, pathophysiology and presentation of cerebrovascular diseases, including ischemic and hemorrhagic stroke, and other diseases and malformations of intracranial, extracranial, and spinal vasculature. Demonstrate the ability to formulate and implement a diagnostic and treatment plan for cerebrovascular diseases, including medical and surgical management.

COMPETENCY-BASED KNOWLEDGE OBJECTIVES:

1. Describe the anatomy of the extracranial and intracranial vessels, including the carotid, vertebral, and spinal arteries.
2. Describe the location of key perforating arteries involving the anterior and posterior circulation, their target distribution, and the consequence of occlusion or injury.

3. Review the anatomy of the venous circulation as it pertains to the central nervous system.
4. Identify the classic syndromes of vessel occlusion of the following:
    a. internal carotid artery
    b. middle cerebral artery
    c. anterior cerebral artery
    d. recurrent artery of Heubner
    e. anterior choroidal artery
    f. vertebral artery
    g. posterior inferior cerebellar artery (PICA)
    h. lower and upper basilar trunk
5. Identify the classic brain stem ischemic syndromes.
6. Explain the concepts of cerebral blood flow, cerebral autoregulation (hemodynamic and metabolic), ischemic thresholds, intracranial pressure, and cerebral perfusion pressure. Describe the impact of intracranial hypertension with and without mass lesion on cerebral blood flow.
7. Recognize the common causes of brain ischemic states including:
    a. cardiac embolism
    b. embolism from proximal vasculature
    c. large vessel occlusion
    d. intracranial conducting vessel occlusion
    e. small vessel disease
8. Associate computed tomography (CT) and magnetic resonance (MR) evidence of ischemic injury with likely anatomic substrate.
9. Describe the epidemiology, physiology, and underlying pathophysiology of ischemic brain
10. Recognize the common causes of intracranial and intraspinal hemorrhage including:
    a. aneurismal disease
    b. vascular malformations
    c. hypertension
    d. vasculopathies
    e. degenerative diseases
    f. hemorrhagic arterial infarction
    g. venous infarction
11. Relate typical imaging characteristics of central nervous system hemorrhagic lesions to probable causes.
12. Categorize common causes of intracranial hemorrhage, subarachnoid hemorrhage, and ischemic stroke.
13. Explain the principles of fluid and electrolyte resuscitation and maintenance, respiratory physiology, cardiac physiology, and nutritional physiology, as applied to the neurological patient following ischemic or hemorrhagic stroke. Integrate this knowledge with the specific issues of the perioperative period.
14. Recognize the need for laboratory evaluation for systemic illness.
15. List the appropriate diagnostic neuro-imaging studies utilized to evaluate ischemic and hemorrhagic stroke.
16. Recognize the typical clinical course of patients with ischemic and hemorrhagic stroke, including peak risk intervals for edema, vasospasm, re-bleeding, etc.
17. Identify the periods of high vulnerability to systemic complications of cerebrovascular illness, including deep venous thrombosis, pulmonary embolism, bacterial pneumonia, aspiration, congestive heart failure, etc.
18. Explain the principles of augmentation of cerebral blood flow during cerebral vasospasm.

19. Discuss the principles and indications for medical, endovascular, and surgical interventions for ischemic and hemorrhagic stroke.
20. Relate the principle of timing of medial, endovascular, and surgical intervention in these same disease states.
21. Explain the principles, indications for, and complications of barbiturate coma.
22. Recognize the principles and interpretation of normal and common abnormal findings on skull, chest, and abdominal e-rays in the Critical Care Unit.
23. Describe the fundamentals of CT scanning, including the typical appearance of acute, subacute, and chronic blood, calcification, ventricular anatomy, and mass effect.
24. Describe the typical CT appearance of hemorrhagic and ischemic stroke. Provide a detailed explanation for the typical delay between the onset of stroke and appearance of confirmatory CT findings.
25. Explain the fundamentals of MR imaging. Distinguish between normal abnormal findings within the realm of cerebrovascular disease. Recognize the classic MR appearance for:
    a. arteriovenous malformations
    b. venous angiomas
    c. cavernous malformations
    d. aneurysms
26. List the indications for non-invasive vascular imaging, including ultrasound, magnetic resonance angiography (MRA) and CT angiography. Recite the limitations of non-invasive studies.
27. Describe the practical application of commonly employed non-invasive studies, such as transcranial Doppler, in the setting of cerebral vasospasm.
28. List the indications for catheter angiography. Interpret the findings of angiography in ischemic and hemorrhagic cerebrovascular conditions. Identify the key segments of the internal carotid artery including the upper cervical, petrous, cavernous, and supraclinoid components.
29. Recite the principles of localizing focal intracranial and spinal vacular pathology by the use of traditional topographic measurements and the application of stereotactic guidance.
30. Describe the surgical anatomy and the principles of exposure of the cervical carotid artery.
31. Describe the principles of pterional craniotomy, including scalp and bony anatomy, as well as the anatomy of the sphenoid ridge.
32. Explain the principles of cerebrovascular surgery detailed in the previous objectives to medical students and allied health personnel during conferences.

COMPETENCY-BASED KNOWLEDGE OBJECTIVES:

1. Perform a comprehensive neurological history and clinical examination.
2. Perform a comprehensive systemic evaluation.
3. Adapt comprehensive evaluation to specific pertinent positive and negatives with regard to ischemic and hemorrhagic stroke.
4. Demonstrate an understanding of urgency and the ability to prioritize during emergent aspects of hemorrhagic and ischemic disease states.
5. Demonstrate the ability to manage cardiac and pulmonary complications following cerebrovascular illness and therapy, and review the need for specialty and subspecialty consultations.
6. Apply the principles of perioperative care following common endovascular and surgical procedures directed at cerebrovascular disease.
7. Demonstrate the ability to be vigilant in the clinical detection of subtle neurological changes during the acute and subacute phases of illness.

8. Demonstrate the ability to place an arterial catheter, central venous catheter and pulmonary artery catheter. Perform placement of a ventricular catheter via a burr hole or twist-drill craniostomy.
9. Perform lumbar puncture and cerebrospinal fluid (CSF) reservoir tapping.
10. Define the proper placement of a craniotomy flap in the planned surgical evacuation of hematoma. This should be performed using both topographical as well as stereotatic-assisted navigation techniques.
11. Assist in the opening, exposure, and closure of cervical carotid procedures.
12. Assist during pterional craniotomy for vascular disease.
13. Assist in the performance of intracranial hematoma evacuation
14. Demonstrate the ability to keep accurate and timely records.

NEUROSURGICAL ONCOLOGY
UNIT OBJECTIVES

Demonstrate an understanding of the anatomy, physiology, pathophysiology, and presentation of tumor-related diseases of the cranium. Demonstrate the ability to formulate and implement a diagnostic and treatment plan for tumor-related diseases of the cranium that are amendable to surgical intervention.

COMPETENCY-BASED KNOWLEDGE OBJECTIVES:

1. Summarize the epidemiology, incidence, and risk factors for intracranial neoplasms.
2. Summarize the tenets of tumor biology including genetic factors and biochemical processes associated with invasion. Describe the natural history of intracranial neoplasms.
3. List a differential diagnosis of lesions requiring biopsy and describe their pathophysiology.
4. List the various types of bone tumors involving eh calvarium.
5. Describe and differentiate:
    a. Astrocytomas, including the accepted Wourld Health Organization (WHO) grading scheme
    b. Gliomas other than astrocytomas
    c. Infectiousm granulomatous, and cystic lesions that may present in a tumor-like manner
    d. Infectiousm granulomatousm and systic lesions that may present in a tumor-like manner
6. Define the cell or origin of meningioma, its common intracranial locations, and expected presentation for each location.
7. Define the embryological origin of arachnoid cysts and their natural history; list the etiologies of other cystic lesions of the brain, including tumoral and infectious.
8. Describe the anatomic location, cell of origin, clinical presentation, age at presentation, and natural history of common intrinsic posterior fossa neoplasms, including cerebellar astrocytoma, medulloblastoma, and ependymoma.
9. Describe the anatomy of the posterior fossa and the relateion of the cranial nerves to the brain stem and skull.
10. Illustrate the relationship of the facial, vetibular, and cochlear components of the acoustic nerve at the internal auditory meatus.
11. Describe the various tumors that may arise in the cerebellopontine angle (CPA).
12. Describe the management of a patient with a brain abscess, including the role of sterotactic drainage or open drainage.
13. Explain the medical workup of a patient with a diagnosed brain abscess.

14. Specify the follow-up and evaluation of the patient with a brain abscess following surgical treatment.
15. Describe the embryological origin of craniopharyngioma. List the common locations of the tumor.
16. Describe the common presentations of pituitary tumors, the cell of origin, and endocrinopathies associated with:
    a. Null cell adenomas
    b. Somatotrophic adenomas
    c. Prolactinomas
    d. Corticotropic secreting adenomas
    e. Thyrotrophic-secreting adenoma
17. Define the medical management of the secreting pituitary tumors. Explain the role of surgery in each of the tumors above.
18. Describe the etiology of fibrous dysplasia, its presentation and general management. List the indications for surgery for benign tumors of bone at the base of the skull, and potential adjuvant therapy.
19. List the tumors that may be routinely approached through a transtemporal route.
20. Describe the indications for use of lumbar spinal drainage in skull base surgery, and its implementation. List all complications associated with continuous lumbar spinal drainage.
21. Illustrate the general principles of stereotaxis and the underlying localization techniques.

COMPETENCY-BASED KNOWLEDGE OBJECTIVES:

1. Perform a complete history and physical examination on patients with intracranial neoplasms.
2. Review appropriate radiographic studies with a radiologist and formulate a differential diagnosis for patients with intracranial neoplasms.
3. Prepare patients for cranial tumor surgery.
4. Understand the positioning of patients for craniotomy and craniectomy.
5. Assist in the opening and closing of craniotomies and craniectomies for neoplasms.
6. Place lumbar drains
7. Demonstrate the ability to open and close scalp incisions.
8. Perform ventriculostomies
9. Demonstrate proper postoperative wound care.

NEUROTRAUMA AND NEUROSURGICAL CRITICAL CARE

UNIT OBJETIVES

Demonstrate an understanding of the anatomy, physiology, pathophysiology, and presentation of traumatic injuries of the brain, spinal cord, and peripheral nervous system, including their supporting structures. Demonstrate the ability to formulate and implement appropriate diagnostic and treatment plans for traumatic injuries to the nervous system, including both surgical and nonsurgical management.

COMPATENCY-BASED KNOWLEDGE OBJECTIVES:

1. Describe the systematic assessment of polytrauma patients.
2. Rank management priorities in polytrauma patients appropriately.
3. Discuss principles of resuscitation of polytrauma patients including appropriate fluid resuscitation, and explain the anticipated effects of shock and resuscitationon fluid shifts and on electrolyte balance.
4. Name an initial choice for intravenous fluids for a newly admitted Intensive Care Unit (ICU) patients with the following diagnoses and explain changes in that choice

based upon specific changes in the patient's diagnosis, clinical condition, electrolyte and volume status:
    a. Head injury
    b. Stroke
    c. Tumor
    d. Infection
    e. Hydrocephalic
5. Propose appropriate initial ventilator settings for patients with different types of common neurosurgical conditions and explain changes in that choice based upon specific changes in the patient's metabolic or pulmonary status.
6. List the mechanisms of action and potential complications of commonly used pressors and hypotensive agents.
7. Discuss indications, pharmacologic mechanism, duration of action, and effect on the neurologic examination for sedative, paralytic, and analgesic agents commonly used in the ICU.
8. Explain the indications, advantages, and risks for various hemodynamic monitoring tools (e.g., pulmonary artery catheters, indwelling arterial lines) used in critically ill patients.
9. Discuss the pathophysiology and management of coagulopathy after head injury.
10. Describe basic principles of ICU management in neurosurgical critical care.
11. Explain the treatment of posttraumatic seizures.
12. Outline basic principles of ICU management of patients with spinal cord injury
13. Name the major structures supplied by the major vessels of the brain and spinal cord.
14. Discuss the evaluation, treatment, and prognosis of subarachnoid hemorrhage both traumatic and spontaneous.
15. Explain the pathophysiology and treatment of cerebral vasospasm.
16. Formulate a diagnostic and treatment plan for patients with cerebral ischemia.
17. Explain the pathophysiology and treatment of cerebral vasoplasm.
18. Describe a systematic approach to the examination of the peripheral nervous system.
19. Describe the basic principles of management of peripheral nerve injuries.
20. List principles of rehabilitation of different types of neurosurgical patients.
21. Define brain death and discuss methods of making such a diagnosis.
22. Describe the pathophysiology of electrical injuries to the nervous system and review treatment of same.

COMPETENCY-BASED KNOWLEDGE OBJECTIVES:

1. Perform and document pertinent history, physical findings, and radiologic findins in a polytrauma patient
2. Differentiate central from peripheral nervous system injuries
3. Insert intravascular monitoring devices for use in the hemodynamic management of critically ill patients, including central venous line, pulmonary artery catheters, and arterial catheters.
4. Insert intracranial pressure monitoring devices, including ventriculostomy catheters and electronic (fiberopetic or miniaturized strain gauge) devices.
5. Perform twist-drill or burr-hole drainage of subdural fluid collections.
6. Decide appropriately which patients require emergency craniotomy and other procedures.
7. Position patients appropriately for procuraes/surgery and begin emergency procedures if more experienced neurosurgeons have not yet arrived.
8. Assist with opening and closure of craniotomies.
9. Perform elective tracheotomies and be able to perform emergency tracheotomies.
10. Be able to intubate patients in both emergency and elective situations.

PAIN MANGEMENT
UNIT OBJECTIVES
Illustrate an understanding of the anatomical and physiological substrates of pain and pain disorders. Demonstrate an ability to formulate and execute diagnostic and therapeutic plans for management of pain and disorders giving rise to pain.

COMPETENCY-BASED KNOWLEDGE OBJECTIVES:

1. Describe the anatomy and physiology of nociception within the peripheral and central nervous system.
2. Differentiate the basic categories of pain syndromes:
    a. Acute
    b. Chronic
    c. Nociceptive
    d. Neuropathic (including complex regional syndromes)
    e. Myofascial
    f. Cancer-related
    g. Postoperative
3. Explain the concept of pain as a biopsychosocial disorder.
4. Discuss the role of rehabilitation in pain management.
5. Describe methods for assessing pain in pediatric patients
6. Discuss ethical standers in pain management and research
7. Discuss methods of assessing outcomes of pain tratmetn and describe common assessment tools.
8. Describe a typical history of a patient with trigeminal neuralgia, trigeminal neuropathic pain, and atypical facial pain.
9. Diagram the anatomy of the following: Trigeminal nerve divisions (ophthalmic, maxillary and mandibular nerves), foramen ovale, Meckel's cave, trigeminal (gasserian) ganglion, cistern of Meckel's cave, retrogasserian root, descending tract and nuclei, nervus intermedius, glosssopharyngeal nerve.
10. Illustrate the appropriate medical management of patients with trigeminal neuralgia, trigeminal neuropathic pain, and atypical facial pain.
11. Discuss the potential complications of percutaneous procedures for trigeminal neuralgia.
12. Describe the pain stem anatomy and physiology of the spinothalamic and trigeminothalamic systems.
13. Describe the anatomy of the primary sensory cortex (S1), Rolandic fissure, and the relationship of S1 to the primary motor cortex.
14. Describe the functional anatomy of the following thalamic nuclei: ventral posterolateral (VPL), ventralis caudalis externus (Vce), ventral posteromedial (VPM), and ventralis caudalis internus (Vci). Review the functional anatomy of the medial thalamic nuclei (e.g.,n. parafascicularis).
15. Indentify the primary indications for spinal cord stimulation, peripheral nerve stimulation, and intraspinal (epidural, intrathecal) drug infusion therapy.
16. Diagram the spine anatomy pertinent to SCS and intraspinal drug administration, including the spinous process/interspinal ligament/spinous process complex, ligamentum flavum and dorsal epidural space. Review the different degrees of angulation of the spinous processes at various spine levels in the cervical and thoracic area.
17. Diagram the spinal cord anatomy pertinent to spinal ablative procedures for pain management.
18. Recognize complications arising from implantation of pulse generators/receivers and infusion pumps.

19. Describe the anatomy of the major peripheral nerves, branchial plexus, and lumbosacral plexus.
20. Describe the anatomy of the sympathetic nervous system and explain its role in pain.
21. List the common mechanisms of peripheral nerve injury and describe the changes which occur in an injured nerve at both the microscopic and macroscopic level. Explain the theories of pain generation in peripheral nerve injury.
22. Describe the pharmacology of local anesthetic agents (e.g., lidocaine, procaine, tetracaine, bupivacaine) and the use of epinephrine and local anesthetic agents.
23. Discuss the indications for peripheral neural blockade. Explain the principles of blocking procedures including the techniques and expected outcomes. Cite the complications of peripheral neural blockage (including anaphylaxis, neural injury, intravascular or intrathecal administration). List the alternatives to temporary blockade including neurolytic blocks, ablative neurosurgical procedures, augmentative neurosurgical procedures, alternative traditional pain management procedures, and alternative medicine approaches.
24. Review the indications for radiofrequency facet rhizolysis.
25. Discuss the anatomy and biomechanics of the facet complex with emphasis on bone, cartilage, fibrous camsule, synovial fluid, ad innervation of this structure.

COMPETENCY-BASED KNOWLEDGE OBJECTIVES:

1. Obtain a pertinent history and perform an appropriate physical examination for a patient with a primary complaint of pain.
2. Formulate and implement treatment plans for simple pain syndromes (e.g., acute postoperative pain, acute low back pain).
3. Evaluate and diagnose a patient with trigeminal neuralgia, trigeminal neuropathic pain, an atypical facial pain.
4. Assist with radiofrequency, glycerol or balloon compression neurolysis of the trigeminal nerve in patients with trigeminal neuralgia.
5. Assist with surgical exploration of the trigeminal nerve, nervus intermedius, or glossopharyngeal nerve for MVD or rhizotomy.
6. Illustrate appropriate patient selection for spinal ablative or augmentative procedures for pain management.
7. Locate the spinal epidural space and place a percutaneous spinal cord stimulation electrode with supervision.
8. Assist with implantation of a plate electrode for spinal cord stimulation.
9. Insert with supervision a spinal catheter for drug administration.
10. Implant with supervision a spinal cord stimulation system pulse generator/receiver and extension wire.
11. Implant with supervision an intraspinal drug infusion pump.
12. Assist with spinal ablative procedures for pain management (cordotomy, myelotomy, DREZ).
13. For peripheral nerve repair, neurectomy, and neurolysis perform, record, and report complete patient evaluation and assessment, including comprehensive neuromuscular examination of affection nerve distribution.
14. Evaluate electrodiagnostic studies pertaining to peripheral nerve injury.
15. Recognize and treat the potential complications of peripheral nerve repair, neurectomy, and neurolysis including hematoma formation, infection, and local wound problems.
16. Assist in surgical treatment of peripheral nerves.
17. Assist with implantation of peripheral nerve stimulation system.
18. Perform, record and report complete patient evaluation and assessment for dorsal root ganglionectomy.

19. Recognize and treat the potential complications of dorsal root ganglionectomy including cerebrospinal fluid leak, infection, and local wound problems.
20. Assist in foraminotomy and exposure of dorsal root ganglion.
21. Assess patients for appropriateness of local anesthetic block(s).
22. Perform simple superficial blocks with supervision and assist in complicated procedures. Following such procedures:
    a. Assess outcome of nerve block
    b. Recognize and treat complications
    c. Record and monitor effects of block over a specified time interval
    d. Assess need for repeat blocks
23. Assess patient for appropriateness of ablative neurolysis. Perform simple superficial neurolysis with supervision and assist in complicated procedures. Following ablative neurolysis:
    a. Assess outcome of procedure
    b. Recognize and treat complications
    c. Record and monitor effects of neurolysis over a specified time interval

Resident Curriculum Guidelines Otolaryngology/Head and Neck Surgery for PGY-1

General guidelines: The resident will learn the basic evaluative and therapeutic processes for head and neck disorders.

1. Care of surgical patient on the ward; including preoperative evaluation, writing preoperative and postoperative orders, postoperative care. Assessment: faculty evaluations
2. Provide oversight of all aspects of pre-, peri- and post-operative care. Coordinate evaluation, input, and care from consultants and other health care professionals. Assessment: faculty evaluations, colleague (i.e. other residents).
3. Basic pathophysiology of disease. Assessment: In-service exam
4. Basic procedures: tonsillectomy, adenoidectomy, myringotomy with/without tube placement, tracheotomy, wound closure, laceration repair, epistaxis control (packing, cauterization), endoscopic nasal, sinus, laryngeal, and hypopharyngeal examination, direct laryngoscopy, tracheoscopy, bronchoscopy, and esophagoscopy, facial fracture reduction and fixation Assessment: faculty/ senior resident supervision, log book
5. Surgery: basic techniques, sterile technique, surgeon in simple procedures. First assist on larger procedures. Assessment: Observation in OR, faculty evaluation
6. Communicate as a professional with patients, hospital staff, students, fellow residents and attending staff. Assessment: self, colleague (i.e. other residents), and faculty evaluation. Clinic nursing evaluation.
7. Develop an understanding of clinical tests including radiography, laboratory studies, pulmonary function tests, swallowing evaluation, balance testing, audiologic tests, smell and taste tests, nasal airway tests, allergy tests. Assessment: self, faculty evalutions, in-service.
8. Develop basic skills in clinical evaluation of disease and medical and surgical therapeutic options. Assessment: faculty evaluation, in-service.

Specific Goals

1. Anatomy

A. General patient overview
B. Head
    1. scalp
    2. cranial bones
    3. neuro-anatomy
C. Facial
        1. forehead
        2. eyebrow
        3. facial muscles
        4. cranial nerves
        5. major salivary glands
        6. facial bones
        7. superficial musculo-aponeurotic system (SMAS)
        8. skin
D. Ear
        1. external
        2. middle
        3. inner
E. Orbital

1. bony orbit
2. globe
3. extra-ocular muscles
4. eyelid
5. lacrimal system

F. Nose/sinus
1. bony and cartilaginous structure
2. septum
3. maxillary, frontal, ethmoid, sphenoid sinuses

G. Oral cavity
1. lips
2. gingival
3. teeth
4. oral mucosa
5. tongue

H. Oro-pharynx
1. palate
2. tonsils
3. pharynx
4. tongue base
5. valleculae

I. Larynx
1. supraglottis
2. glottis
3. subglottis

J. Hypopharynx
1. post-cricoid
2. piriform sinuses

K. Neck
1. lymphatics
2. cartilaginous structures
3. musculature
4. thyroid, parathyroid glands
5. trachea
6. vasculature
7. neuro-anatomy

2. Physiology

A. Otologic
B. Ocular
C. Glutition
D. Speech
E. Respiratory
F. Endocrine
G. Nasal
H. Sinus
I. Lacrimal
J. Salivary
K. Wound healing
L. Neurologic
M. Skin

3. Pathophysiology

A. Otologic
B. Ocular
C. Glutition
D. Speech
E. Respiratory
F. Endocrine
G. Nasal
H. Sinus
I. Lacrimal
J. Salivary
K. Wound healing
L. Neurologic
M. Skin
N. Neoplasia
O. Allergy

Critical Care Medicine Goal of the Rotation for PGY-1

The goal of the education of residents rotating with Critical Care Service is to expose the resident to the management of the critical care patient. This rotation is for residents at the PGY-1 level. The resident should become proficient in procedures appropriate for their level of training as well as gaining an understanding of the risks, complications and expected outcomes for patients treated by the service.

H&P

Learning Objective
Access status of ICU Patient

Evaluation Method
Personal Observation, record review

Information gathering
Assess laboratory, hemodynamic and imaging results.

Evaluation Method
Direct observation, record review.

Documentation
Write focused and specific progress notes on ICU Patients

Evaluation Method
Direct observation, record review.

Patient Management
Assess patients, manage fluid and electrolytes, utilize hemodynamic data, and manage cardiac, pulmonary venal physiology.

Practice Based Learning and Improvement
Medline Search

Interpersonal and Communication Skills
Present succinct summary of patient status and events.

Professionalism
Treat colleagues, nurses, patients and families with respect. Hand off information efficiently.

Systems Based Practice
PACS system, electronic medical record, ICU bed utilization.

II. A. PGY-2 OTOLARYNGOLOGY RESIDENTS RESPONSIBILITIES & REQUIREMENTS

1. Complete reading assignment from *Baileys Textbook* and take written examination during July. **Date: TBA** Reading assignments given in March of PGY-1 year for completion by start of PGY-2 otolaryngology residency training.

2. Read *Educational Objectives for Residents in Otolaryngology-Head and Neck Surgery*. This is published by the American Academy of Otolaryngology-Head and Neck Surgery and will serve as a study guide throughout your training.

4. Attend all conferences scheduled in the teaching program.

5. Attend all assigned clinics.

6. Scrubbed and in OR **on time** for all assigned cases. All assigned cases must be followed. Communication with the attending is important to avoid confusion concerning post-op care.

7. Work-up all private and/or service cases as assigned.

8. Assist more senior residents with duties as designated.

9. Knowledge of appropriate counting procedures for operative cases; operative logs to Program Director on time; maintenance of back-up data for operative logs.

10. **Home Study Course** Complete all four sections on time. Payment of the two-year subscription will be made by the department at the beginning of each 2 year cycle, currently $390.00. Section scores are reported to the Program Director on a quarterly basis from the Academy. Residents not completing the sections, or not obtaining a passing grade, will be subject to disciplinary action.

11. **ACLS**: must be kept current and copy on file in the program office.

12. **Communicable Disease Prevention**: must be current on all immunizations.

13. **Medical Licensure:** Must have current license or UL#. *PGY-2 year residents should have completed step III of USMLE. Failure to keep license current will result in suspension from ALL patient care duties, without pay, until rectified.

II. A. PGY-3 OTOLARYNGOLOGY RESIDENTS RESPONSIBILITIES & REQUIREMENTS

1. Attend all conferences scheduled in the teaching program.

2. Attend all assigned clinics.

3. Scrubbed and in OR **on time** for all assigned cases. All assigned cases must be followed. Communication with the attending is important to avoid confusion concerning post-op care.

4. Knowledge of appropriate counting procedures for operative cases; operative logs to Program Director on time; maintenance of back-up data for operative logs.

5. Work-up all private and/or service cases as assigned.

6. Assist the PGY-4 residents and Chief Residents with their responsibilities as designated.

7. Demonstrate ability to teach Medical Students.

8. When rotating at Moffitt, responsible for turning in all sign-in sheets for Moffitt Teaching Rounds, Videostroboscopy Conferences, M&M patient forms, etc.

9. **Home Study Course** Complete all four sections on time. Payment of the two-year subscription will be made by the department at the beginning of each 2 year cycle, currently $390.00. Section scores are reported to the Program Director on a quarterly basis from the Academy. Residents not completing the sections, or not obtaining a passing grade, will be subject to disciplinary action.

10. **ACLS**: must be kept current and copy on file in the Program Office.

11. **Communicable Disease Prevention**: must be current on all immunizations.

12. **Medical Licensure:** must have current license or UL#. Failure to keep license current will result in suspension from ALL patient care duties, without pay, until rectified.

II.A. PGY-4 OTOLARYNGOLOGY RESIDENTS RESPONSIBILITIES & REQUIREMENTS

1. Attend all conferences scheduled in the teaching program.

2. Attend all assigned clinics.

3. Scrubbed and in OR **on time** for all assigned cases. All assigned cases must be followed. Communication with the attending is important to avoid confusion concerning post-op care.

4. Work-up all private and/or service cases as assigned.

5. Preparation of call schedule to be delivered to Program Coordinator **by the 12th** of each month.

6. Knowledge of appropriate counting procedures for operative cases; operative logs to Program Director on time; maintenance of back-up data for operative logs.

7. Assist Chief Resident with his/her responsibilities as designated.

8. Demonstrate ability to train junior residents and medical students.

9. When rotating at Moffitt responsible for turning in sign-in sheets for Moffitt Teaching Rounds, Videostroboscopy Conferences, M&M patient forms, etc.

10. **Home Study Course** Complete all four sections on time. Payment of the two-year subscription will be made by the department at the beginning of each 2 year cycle, currently $390.00. Section scores are reported to the Program Director on a quarterly basis from the Academy. Residents not completing the sections, or not obtaining a passing grade, will be subject to disciplinary action.

11. **ACLS**: must be kept current and copy on file in the Program Office.

12. **Communicable Disease Prevention**: must be current on all immunizations.

13. **Medical Licensure:** must have current license or UL#. Failure to keep license current will result in suspension from ALL patient care duties, without pay, until rectified.

II.A. PGY-5 OTOLARYNGOLOGY RESIDENTS (CHIEF) RESPONSIBILITIES & REQUIREMENTS

Supervise the day-to-day care and surgery of the patients on the Otolaryngology Service.

Attend all ENT clinic sessions unless precluded by surgery. Clinic responsibilities include: seeing patients; assisting the junior residents and students in evaluation and treatment of all cases; obtain staffing on all patients; perform minor surgery; correlate admissions with nursing personnel; review all cases scheduled for surgery by junior residents and assure that these cases have been reviewed by the attending and approved for surgery.

Perform surgery or assist the junior residents in surgery on all TGH service cases and all VAH cases. Assure that such cases have been properly scheduled with OR booking. Arrange appropriate attending coverage for OR cases and perform or assist in surgery on attending cases as designated by attending.

Assure appropriate follow-up for all patients (service or private) seen in clinics or surgical cases for surgical patients this includes daily rounds, dressing changes, etc.

Supervise day-to-day teaching of medical students assigned to the service.

Interpret ENG's.

Take second or back-up call as arranged between Chiefs. In this capacity, he/she will render appropriate consultation and assistance to the junior resident or attending. **Advise Tampa General and VAH operators of any change in call schedule, only when change is made in short notice and can not be communicated through the Program Coordinator.**

Review and countersign all consultations done by junior/senior residents to the private service at TGH and for all VAH consults. Review these consults with an attending surgeon who will examine the patient and countersign the consult.

Attend all conferences unless precluded by **urgent** surgery. Additionally, he/she will assure that the day's work is so organized so that the maximum number of junior residents are free to attend the conferences.

Sign-in sheets for teaching conferences held at site of rotation, site chief responsible for gathering signatures and returning forms, which are to include topic covered, to the residency coordinator.

Morbidity and mortality paperwork for site of rotation (TGH/VAH) to be turned in to the Program Coordinator no later than one week after presentation at Wednesday conference.

Coordinate TGH Trauma, Facial Plastic, and Skull Base conferences.

*VAH- All head and neck cancer patients will have staging form filled out in duplicate. One copy to patients chart, one copy to Dr. Judith McCaffrey for Cancer Registry.

Approval/Disapproval, by signature, on leave form of all junior residents **and verify necessary clinic reductions with Program Coordinator.**

TGH: Attend monthly Chief Resident Meetings

VAH: Attend Surgical Service meetings the 1st Thursday of each quarter.
Attend 4-North discharge planning conference.

TGH : Notify attending of the day of all hospital consults for review and billing.
Keep copies of TGH attending confirmation consult forms and billing forms for consult rounds

Knowledge of appropriate counting procedures for operative cases; operative logs to Program Director on time; maintenance of back-up data for operative logs.

Coordinate harvesting of bones in December for use in the Temporal Bone Course.

Home Study Course Complete all four sections on time. Payment of the two-year subscription will be made by the department at the beginning of each 2 year cycle, currently $390.00. Section scores are reported to the Program Director on a quarterly basis from the Academy. Residents not completing the sections, or not obtaining a passing grade, will be subject to disciplinary action.

ACLS: must be kept current and copy on file in the Program Office.

Communicable Disease Prevention: must be current on all immunizations.

Medical Licensure: must have current license or UL#. Failure to keep license current will result in suspension from ALL patient care duties, without pay, until rectified.

PRIOR TO DEPARTURE:

A copy of Operative Log and ABO print-out to the Program Director's office

All chart work completed at all institutions

End-of-year paperwork completed at TGH, VAH, HLM and the Personnel Office at the College of Medicine

Return of pagers, all keys, department orientation book, and TGH parking cards to Program Coordinator and/or House Staff Coordinator at Tampa General. FAILURE TO COMPLY WITH DEPARTURE POLICIES WILL RESULT IN THE DEPARTMENT HOLDING YOUR CERTIFICATE OF COMPLETION UNTIL ALL REQUIREMENTS HAVE BEEN MET.

II. B. NIGHT CALL

The PGY-4 resident is responsible for completing and delivering the night call schedule to the Program Coordinator's office **by the 12th of each month.** *(Form: See SCHEDULES section).* **In assigning call responsibilities, the following work hour limitations MUST be met. If a resident works in excess of the below guidelines, this MUST immediately be reported to an attending or the Program Director so scheduling changes can be made.**

- Residents are limited to a maximum of 80 duty hours per week, including in-house call, averaged over four weeks.
- Residents must be given one day out of seven free from all clinical and educational responsibilities, averaged over four weeks.
- Residents cannot be scheduled for in-house call more than once every three nights, averaged over four weeks.
- Duty periods cannot last for more than 24 hours, although residents may remain on duty for six additional hours to transfer patients, maintain continuity of care or participate in educational activities.
- Residents should be given at least 10 hours for rest and personal activities between daily duty periods and after in-house call.
- In-house moonlight counts toward the weekly limit. In addition, program directors must ensure that external and internal moonlighting does not interfere with the resident's achievement of the program's educational goals and objectives.

James A. Haley VA Hospital
A resident is required to stay in-house whenever a patient is determined to be at risk. The PGY-5 year resident (Chief) will take 2nd call from home. When in-house night call is not required, the assigned resident must be available at home or on pager. The Attending on-call is listed on the monthly call schedule and will be available for consultation. The Chief Resident must notify the operators, through the Program Coordinator, of any immediate changes in the call schedule.

Tampa General Hospital
The resident on trauma call will not cover any other hospital. The PGY-5 year (Chief) resident will take 2nd call from home at night, and must be available at all times. Night call may be taken from home by the 1st call resident, who must be available by pager. The Chief Resident is responsible for notifying the TGH operators of changes in the call schedule. Ward nurses should also be notified. This should be done through the Program Coordinator, if not a last minute change.

H. Lee Moffitt Cancer Center & Research Institute
The resident assigned to the Moffitt rotation will take the majority of the call coverage responsibility. Another senior level resident will be assigned to take night call the remaining nights. Call is taken in-house when a patient is determined to be at risk. Otherwise call is taken from home, where the resident is available by pager at all times. The resident on rotation is responsible for notifying the Program Coordinator, in order for the operator and the ward nurses to be made aware of any change in the call schedule.

All Children's Hospital

The resident assigned will take call Monday through Friday of every other week and two weekends a month. Call is taken from home, where the resident is available by pager at all times.

II.C. LEAVE POLICY

All annual leave (vacation) must be scheduled through the Program Coordinator **at least two months in advance**. To schedule annual leave, a completed leave request form (sample following) must be submitted to the Program Coordinator. The leave request form must have the signatures of the Chief Residents indicating approval of the leave. The Program Coordinator will then submit the leave request to the Program Director for final approval. Once signed by the Program Director, you will be notified of the status your leave request. Approval for leave will be on a first-come, first-serve basis. **Requests for annual leave less than two months in advance will not be granted**.

PGY-2 & PGY-4 year residents **must** take one week of vacation during the first six months and two weeks during the second six months. PGY-3 & PGY-5 year residents **must** take two weeks of vacation during the first six months and one week during the second six months. **No vacation will be granted during a Moffitt rotation.** The following schedule will assist you in planning your annual leave.

Annual leave may not be taken during the Head and Neck Anatomy Course, Academy Meeting, Temporal Bone Course, Standardized Oral Examinations, any other special courses or meetings, if visiting professors are scheduled or during the month of July.

Annual leave consists of 3 weeks yearly and will be taken one week at a time (seven consecutive days). Weeks may not be consecutive. VAH residents must begin their leave on Sunday.

Chief residents will be granted a maximum of three days in their chief year for interviews. A leave authorization form should be submitted to the Program Coordinator for Dr. McCaffrey's approval and will be tracked the same as annual leave.

No more than one resident should be on annual leave at any given time, unless approved in advance by the Program Director.

Prior to the start of Authorized Leave:

- 1st & 2nd Call Coverage Must Be Arranged
- All medical records must be completed
- Wednesday morning conference and resident lecture obligations must be covered
- Attendings on your rotation notified by you of your planned absence

Annual leave and other approved leave affect staffing at all clinics. The clinics must be adjusted or covered by another resident. **Chief Residents must verify with the Program Coordinator or the clinic that clinic(s) have been adjusted.**

All absences from duties for health reasons, i.e. illness, doctor or dentist appointments, emergencies, etc. should be reported immediately to the Chief Resident. Residents who have taken unexpected sick leave must notify the Program Coordinator following return to work. All leave must be recorded, as residents may not graduate with an excess of 6 weeks leave in any given academic year. **Residents are assumed to**

either be at their duty stations from 7:00 am - 5:00 pm or have approved leave. **ALL LEAVE** (annual, educational, administrative, family, etc,) **MUST BE APPROVED BY THE PROGRAM DIRECTOR.**

2005-2006

Otolaryngology House Officer Leave Request

NAME

DATE SUBMITTED

Vacation-Sick Leave-Meeting
(circle one)

Other:

(explain)

DATES REQUESTED

From:

To:

CHIEF RESIDENT-TGH

Approved ☐ Not Approved ☐

& DATE SIGNED

CHIEF RESIDENT-VAH

Approved ☐ Not Approved ☐

& DATE SIGNED

PROGRAM DIRECTOR

Approved ☐ Not Approved ☐

Thomas V. McCaffrey, M.D., Ph.D.
Program Director

DATE APPROVED

JULY 2005

S	M	T	W	T	F	S
					1	2
3	**4**	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

AUGUST 2005

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28	29	30	31			

September 2005

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18	19	20	21	22	23	24
25	26	27	28	29	30	

October 2005

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16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

November 2005

S	M	T	W	T	F	S
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13	**14**	15	16	17	18	19
20	21	22	23	**24**	**25**	26
27	28	29	30			

December 2005

S	M	T	W	T	F	S
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18	19	20	21	22	**23**	24
25	26	27	28	29	**30**	31

JANUARY 2006

S	M	T	W	T	F	S
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8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	**23**	24	25	26	27	28
29	30	31				

February 2006

S	M	T	W	T	F	S
			1	2	3	4
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12	13	14	15	16	17	18
19	**20**	21	22	23	24	25
26	27	28				

March 2006

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

April 2006

S	M	T	W	T	F	S
						1
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9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

May 2006

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	**29**	30	31			

June 2006

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

***note: Holidays are shaded, however they may not be observed by all**

insttitutions. See section VIII E, Holidays.

II.C. RESIDENT ANNUAL LEAVE (VACATION) SCHEDULE:

Per Academic Year

	FIRST SIX MONTHS	SECONDSIX MONTHS
PGY-1		
PGY-2 & PGY-4	take 1 wk vacation	take 2 wks vacation
PGY-3 & PGY-5	take 2 wks vacation	take 1 wk vacation

No vacations in July or during special courses
No vacations approved while resident rotates at HLM
No vacations approved for two consecutive weeks
One vacation week per 3 month rotation (2 month rotation for OTO 1's), unless approved by Program Director.

	7/03-8/03	9/03-10/03	11/03-12/03	1/04-2/04	3/04-4/04	5/04-6/04
PGY-1						
PGY-2	(1 wk during any separate block)			(2 wks during any separate block)		
Rogers	**VAH**	**TGH**	**VAH**	**TGH**	**VAH**	**TGH**
Stavinoha	**TGH**	**VAH**	**TGH**	**VAH**	**TGH**	**VAH**

	7/03-9/03	10/03-12/03	1/04-3/04	4/04-6/04
PGY-3	1 wk here	1 wk here	NO VACATION	1 wk here
Kang	**VAH**	**ACH**	**HLM**	**TGH/Otology**
Tucker	1 wk here	1 wk here	1 wk here	NO VACATION
	ACH	**VAH**	**TGH/Otology**	**HLM**
PGY-4	NO VACATION	1 wk here	1 wk here	1 wk here
Faisal	**HLM**	**TGH/Otology**	**VAH/research**	**ACH**
Powell	1 wk here	NO VACATION	1 wk here	1 wk here
	TGH/Otology	**HLM**	**ACH**	**VAH/research**
PGY-5	1 wk here	1 wk here	1 wk here or	1 wk here
Meigs	**VAH**	**TGH**	**VAH**	**TGH**
Zeiders	**TGH**	**VAH**	**TGH**	**VAH**

II.C. INSTITUTIONAL COVERAGE

ALL RESIDENTS/ALL INSTITUTIONS

7:00 am - 5:00 pm Monday - Friday: basic clinical, hospital and OR duties.

All residents are assumed to be at their assigned institutions unless an approved leave form is on file in the program office.

II.D. MEDICAL STUDENTS

Teaching medical students is an important aspect of this training program for which each resident is accountable. This Service has an excellent reputation for assuming this responsibility. Second year medical students are taught Physical Diagnosis by faculty and residents each year. On occasion, Third year students rotate on surgical clerkships and Fourth year students rotate with the department as electives. The teaching skills of both residents and faculty are evaluated by the medical students.

- **Please see the RESIDENTS AS TEACHERS section of the orientation manual for additional important information.**

II.E. PROFESSIONAL LIABILITY PROTECTION & INCIDENT REPORTING

As a member of the University of South Florida College of Medicine, you are provided professional liability protection by the University of South Florida Health Sciences Center Self Insurance Program. It is essential to the proper operation of the Self-Insurance Program that residents give immediate notice upon their becoming aware of any incident that may expose them & the Self-Insurance Program to any loss. The Program Director should also be notified immediately of any incident.

In general, reportable incidents fall into three broad categories:

1. Any incident in which a patient has sustained an iatrogenic injury that was not anticipated by the physician or patient.

2. Any of the injuries listed below. Although there appears to be no departure from accepted standard of practice, these cases should be reported:

    a. Death - unexpected or unexplained
    b. Paralysis, paraplegia or quadriplegia
    c. Spinal cord injury
    d. Nerve injury or neurological deficit
    e. Brain damage
    f. Total or partial loss of limb, or loss of the use of limb
    g. Sensory organ or reproduction organ loss or impairment
    h. Injury which results in disability or disfigurement

3. All incidents in the broad categories listed below should be reported:

    a. Any injury to the mother or baby associated with birth
    b. Any patient injury resulting from defective or nonfunctioning medical equipment
    c. Any injury to parts of the anatomy not undergoing treatment
    d. Any charge by a patient or family member that a patient has been medically injured
    e. Any assertion by the patient or family that no consent for treatment was given
    f. Any increase in morbidity due to misdiagnosis

The standard practice should be, when in doubt, always report, and do so promptly!

Following notification to the Program Director, the Self-Insurance Program office @ 974-8008 should be notified in each of the following situations:

1. Receipt of any correspondence from any source, attorney, patient, or third party making an inquiry in connection with a claim or intent to initiate malpractice action.
2. Receipt of a Summons, Complaint or legal papers in connection with a claim.

3. Inquiry about any case by the Florida Department of Professional Regulation.

Do not discuss a risk management case with anyone, except under the guidance of the Self-Insurance Program.

II.F. ADDITIONAL REQUIREMENTS

- The State of Florida requires that **all residents MUST** be licensed in the state or registered with the state as an unlicensed physician in order to see patients. Our Self-Insurance Program **does not** cover residents who are not licensed or registered. Both licensure and registration are renewed every two years. The Program Coordinator will assist you in obtaining paperwork for licensure or renewing your registration, however, **this is your responsibility and failure to maintain a current license or UL registration with the state will result in being suspended from ALL patient care duties, without pay, until rectified.**

- For inquires regarding all resident benefits; health, life, dental and disability insurance, please contact Muniz and Associates, Inc., 813/258-0033.

- Individual salary information can be obtained and verified through the Program Coordinator.

- All residents are fully covered under the University Self Insurance Program. **Residents are only covered for activities which are conducted in the course of their training activities under the direct or indirect supervision of designated faculty of the college of medicine or their designees.** House officers may not accept outside employment or engage in other outside activity which may interfere with the full and faithful performance of clinical responsibilities without first getting written approval from both the Program Director and the Associate Dean of Clinical Affairs. *(sample form enclosed)* Violation of this policy may lead to disciplinary action up to and including termination of training. **NOTE: The hours worked for outside activities, if conducted at a participating institution of the otolaryngology service, MUST be included in your work hour reporting.**

- Report any injury to the Program Director's office immediately and to the employee health unit at whichever hospital or facility the injury occurred. The injury must be reported to the USFCOM employee health unit (974-3163) within 5 days of the injury. Please refer to the USFCOM Resident Policies and Procedures Manual for more detailed information on reporting injuries. Remember that incident reports must be filed. Many subsequent benefits, including long-term hospitalization and disability compensation depend upon prompt reporting.

- Advanced Cardiac Life Support (ACLS) is a requirement for all residents. The Program Coordinator, in conjunction with the Graduate Medical Education Office, will notify you of your status and classes offered. **If you have not received certification within an appropriate period of time, you will not be reappointed.**

- A log of your operations must be kept up-to-date with the ACGME and American Board of Otolaryngology. An accounting of your operations from the beginning of your otolaryngology residency to the completion of your otolaryngology residency is required for Board application/certification. **A printout of your operative**

data is due in the Program Director's office once a month and also a week prior to the ABO's annual July 10th deadline.

- Residents must turn in to the Program Director monthly their operative logs and an operative log verification form showing a count of procedures for that month. The Program Coordinator (See OPERATIVE LOG section). **Failure to turn logs in by the given due dates will result in disciplinary action at the time of your quarterly evaluation, which will become a part of your permanent residency file.**

- Residents **must** formally evaluate the otolaryngology training program once each year. This evaluation is confidential and must not be hand written (form will be provided). A typewriter and a computer/printer are available through the Program Coordinator, or the ENT offices for resident use. **Residents, however, may meet with the Program Director at any time to discuss any concerns regarding the program.**

- Residents **must** also formally evaluate full-time and clinical faculty once each year. This evaluation is confidential and may not be handwritten (form will be provided). A typewriter and a computer/printer are available through the Program Coordinator, or the ENT offices for resident use.

- Registration fees for membership in the American Academy of Otolaryngology-Head and Neck Surgery Foundation are paid for residents annually by the Department. Included in this membership are subscriptions to the Academy *Bulletin* and to the journal, *Otolaryngology-Head and Neck Surgery*. AM lecture slides, photographs of x-rays, and graphics work should be obtained through the VA Medical Media. This usually requires two (2) weeks lead time, so advance, long range planning is important.

- Charges for photography work, slides, etc, for presentations must be pre-approved. Charges for a RUSH slide preparation will not be approved, and will be the responsibility of the resident. Residents are required to get approval from the Department Administrator, before ordering.

- Software is available at Moffitt, the HSC Library and in the resident work area at the ENT Center for you to prepare your assigned presentations.

- Professional relations are very important. You are expected to treat medical students, nursing staff, paramedical personnel, and administrative staff in a courteous and professional manner at all times.

- House officers are to be appropriately attired at all times during duty hours. Male house officers are expected to be in a dress shirt and tie; female house officers, an appropriate dress or dress slacks and shirt. Clogs, tennis shoes, flip flops, and sandals are not appropriate footwear. Appropriate and neat grooming is expected. **White, full-length clinical coats, which have been provided to you, are to be worn in all patient contact areas by all house officers and should be neat AND clean!**

- The otolaryngology support staff will gladly assist you throughout your training program. Secretarial support is available from the Program Coordinator or faculty offices depending upon the type of project, i.e. manuscripts, research, or program related. Your requests will be handled in a professional manner and you are expected to treat all support staff with courtesy. While available to assist you, support staff will not perform tasks for which you are responsible or be expected to alter their work schedules to accommodate your deadline needs because of lack of planning on your part.

- Residents shall have taken part III of USMLE by the end of their general surgery year.

- **Residents are required to submit for licensure by their Chief Year.**

- Do not conduct personal business during clinic hours.

- Orientation Books must be returned to the Program Coordinator **by June 1.**

- Address and home phone number changes **must** be reported to Program Coordinator, at which time you will be required to complete a change of address form for your health insurance carrier and a revised W4 that will be forwarded to Human Resources Office.

II.G. **Disclosure**
Request for Activities Outside of Residency

Name of Resident: _____, MD

Date of Request: _____

I am requesting approval for acceptance for outside employment, either compensated or uncompensated, which at the present time, will not interfere with my full and faithful performance of clinical responsibilities for the Department of Otolaryngology-Head and Neck Surgery at the University of South Florida, as explained in the Departments' Orientation Manual.

I further understand that if outside the requested outside activities occur a participating institution at which I would normally be assigned during my residency tenure in the otolaryngology program, that I must also include the hours worked, either compensated or uncompensated, in my work hour reporting, as required by the Office of Graduate Medical Education.

I have fully disclosed the dates and location of my requested outside activity and have discussed this in full with the Program Director. Furthermore, I understand that I am held to the policy on professional activities outside of the training program as listed in section 4-E of the University of South Florida House Officer Contract and understand that I will not be covered for liability in the event of incidences occurring in the course of any outside activity.

I understand that this form will become a permanent part of my residency file. If at any time this outside activity interferes with my clinical duties for the Department of Otolaryngology I will be denied the privilege of continuing these tasks.

_____

Resident **Date**

_____

Thomas V. McCaffrey, M.D., Ph. D. **Date**
Program Director and Chair
Department of Otolaryngology-HNS

_____

Peter J. Fabri, M.D. **Date**
Associate Dean, Graduate Medical Education
University of South Florida College of Medicine

II.H.

UNIVERSITY OF SOUTH FLORIDA
COLLEGE OF MEDICINE
HOUSE OFFICER CONTRACT
2005- 2006

This House Officer Contract is made and entered into by and between the University of South Florida (for the University of South Florida College of Medicine), acting for and on behalf of the Board of Regents, a public corporation of the State of Florida (hereinafter "University"), and **«FirstName» «LastName», «Degree»**, (hereinafter "House Officer"). In consideration of the mutual promises and conditions set forth in this Contract, University and House Officer, agree as follows:

I. House Officer accepts appointment to the University's Affiliated Hospitals' House Officer Training Program (hereinafter "Program"), which is approved by the Accreditation Council for Graduate Medical Education, as **PGY** in the Department of **«Program»**, Subspecialty: **N/A,** from **July 1, 2005 through June 30, 2006**

A. Duration of Appointment: While it is generally understood that efforts will be taken to assure that an individual who has met all requirements of his/her training program and conducted himself/herself appropriately will be allowed to complete the training program to which he/she was accepted, this Contract is for one year only and is subject to renewal prior to each academic year. In addition, acceptance into an initial residency at the University does not assure acceptance into subsequent advanced training programs nor does it guarantee transfer into another training program at the University.

B. Conditions for Re-appointment: In order to be re-appointed for the next year of residency training, an individual must be in good standing with the University and with the University's College of Medicine. Re-appointment requires satisfactory participation in educational and continuing education as well as ACLS/PALS registration. Re-appointment is subject to approval of the Program Director. Individuals who are not re-appointed have full rights of appeal as described in the House Staff Handbook.

II. The University agrees to compensate the House Officer during the above appointment period under this Contract at the rate of **$«Salary».00** per annum. All residents will receive financial support from the University as stipulated in their applicable House Officer Contract. All residents at comparable levels will be compensated according to the same schedule. Any exception to this policy must be approved in writing by the University's College of Medicine Dean or his designate. All residents will receive the same benefits package.

III. University agrees to provide:

A. Professional Liability Protection: Professional liability protection equivalent to that provided to the clinical faculty physicians through the University of South Florida Health Sciences Center Self Insurance Program ("SIP"). All residents are provided legal defense and protection against awards by the SIP and Florida Statutes Section 768.28 during the course of their training as well as afterward (tail coverage) for alleged acts or omissions of the residents occurring during and

SAMPLE

within the scope of their University appointment and educational program. The SIP and Florida Statutes Section 768.28 do not provide professional liability protection to residents for incidents occurring outside the scope of their University employment or function.

B. Leave Policies:

1. Annual Leave: Paid vacation leave with use and accrual subject to provisions set forth in the Resident Handbook. All residents are entitled to have and are required to use paid vacation leave as described in this Contract and the Resident Handbook. PGY-I Residents are entitled to two weeks of annual leave composed of seven consecutive days each. Residents in PGY-II and above are entitled to three weeks of annual leave composed of seven consecutive days each. Annual leave must be used during the Contract year in which it is accrued. The only exception is for planned and approved Parental Leave of Absence (see subsection III. B.3. below) in which case one week of leave can be carried over for one year only.

2. Sick Leave: Paid sick leave during each year of residency and participation in the sick leave pool subject to the provisions set forth in the Resident Handbook. Each resident is allocated five (5) days of sick leave per Contract year. In addition, each resident contributes five (5) days of sick leave to the sick leave pool. Use of the sick leave pool is limited to a maximum of 90 days per individual.

3. Parental Leave of Absence: Each resident is allowed up to twelve (12) weeks of uncompensated parental leave. Individuals must apply for parental leave in advance and obtain approval from their Program Director. Individuals may utilize accumulated leave (sick leave and annual leave) as continued compensation during parental leave. No other compensation is available for parental leave. In addition, residents are advised to familiarize themselves with the applicable board requirements for their particular specialty to determine if extensive absence will jeopardize board eligibility. Individuals enrolled in training programs at the University are not automatically entitled to additional training beyond the prescribed number of years, in order to complete board requirements. Any such extension of the training program must be approved by the Program Director and the University's College of Medicine Office of Graduate Medical Education and may not be compensated.

Note: Individuals who are required to discontinue work because of the medical needs of the mother or unborn child may be authorized to use leave from the sick leave pool. The use of the sick leave pool is not available for uncomplicated maternity.

4. Professional Leave of Absence: Professional (Administrative) Leave is available to residents for professional activities with the prior approval of the Program Director and the Graduate Medical Education Office.

5. Leave of Absence: Individuals wishing to take a leave of absence from their training program must obtain approval from both their Program Director and the University's College of Medicine Office of Graduate Medical Education. Individuals are not automatically guaranteed re-entry into the training program and therefore should discuss future arrangements with their Program Director prior to commencing a leave of absence. Leave of absence is uncompensated leave.

6. Effect of Leave on Program Completion: Most training programs have specified requirements for the number of weeks of training completed per year and over the course of the residency. Approved annual leave and sick leave are within the current requirements of all certifying agencies. Individuals anticipating the need to request additional leave, compensated or uncompensated, should discuss the impact on their program completion prior to commencing the additional leave.

C. Health, Disability, and Life Insurance: Health, disability, and life insurance benefits are described in the House Officer Policies and Procedures Manual. As a component of their benefits, all residents participate in the comprehensive health insurance plan obtained for the University's College of Medicine graduate medical education program. Residents should refer to the House Officer Policies and Procedures Manual to familiarize themselves with the conditions of the plan, including but not limited to deductibles, co-payments for non-participating physicians/institutions, and benefits for dependents. The health insurance policy is continuous for 18 months after completing training at the resident's expense under the provisions of COBRA. All residents receive disability benefits as follows: Upon receipt by the University's College of Medicine Office of Graduate Medical Education from the chairperson of the respective department, of a written request to place a resident on extended sick utilizing the "sick leave pool", the resident will be eligible to draw from the "sick leave pool" for salary and benefits coverage for up to ninety (90) days. From ninety (90) to one hundred eighty (180) days the resident will be eligible for a short-term disability policy that will continue the salary and benefit coverage. After one hundred eighty (180) days the resident will be covered by a long-term disability policy which provides $2000.00 (two thousand dollars) per month to the age of 65 as long as the resident is unable to practice. Individuals are encouraged to refer the Resident Handbook and/or to contact the Office of Graduate Medical Education to obtain specific information regarding these policies. The permanent disability policy can be converted at individual expense to an individual policy at completion of training.

Note: Dental insurance is not provided by the University. Individuals wishing to purchase dental insurance should contact the Office of Graduate Medical Education.

Effective July 1, 2000, the University will charge residents who enroll for health insurance dependent coverage at the following rates: $50.00 per month for spouse only, and $100 per month for spouse and child(ren) or child(ren) only. Residents will be billed the applicable amount on a monthly basis and are responsible to make prompt payment. Failure to make timely payments will result in termination of the resident's health insurance dependent coverage.

D. Conditions For Living Quarters, Meals and Laundry: Neither the University nor the Affiliated Hospitals provide housing, meals, or laundry for residents. Residents who are assigned to take in-house call will receive suitable quarters for sleep and study and will receive dinner before and breakfast after the assigned in-house call tour. Neither the University nor the Affiliated Hospitals provide sleeping facilities or food for family members during call tours.

E. Counseling and Psychological Support Services: A "Resident Assistance Program (RAP)" is provided to all residents as a benefit of their employment by the University. Services include counseling, rehabilitation, alcohol and drug abuse, grief and loss, financial counseling, and others. Residents are advised to consult the Resident Handbook for a full description of this benefit. Currently, three (3) visits per year are prepaid. Additional visits and/or treatment may be covered by health or disability insurance programs. The RAP is a confidential service which utilizes health care providers outside of the normal house staff experiences to assure privacy and freedom from interaction with colleagues or supervisors.

IV. House Officer agrees to accept responsibility for:

Residents' Responsibilities - Residents are expected to conduct themselves as professionals in all situations. As such, residents are expected to dress appropriately, use appropriate language, refrain from actual or perceived harassment and interact with patients, families, and co-workers in a congenial and constructive manner. As mature adults with professional responsibility and standing, residents must be committed to quality excellence in all aspects of their activities and are expected to positively represent the University and the Affiliated Hospitals in all activities, both within and outside of the workplace.

Residents' responsibilities include:

1. Developing a personal program of self-study and professional growth with guidance from the teaching staff.

2. Participation in safe, compassionate and cost efficient patient care under supervision, commensurate with level of advancement and responsibility and advising all patients at an appropriate time of their status as University-employed residents.

3. Participating fully in all the educational activities of the Program and, as required, assuming responsibility for teaching and supervising other house staff and residents.

4. Participation in all required orientations, continuing education and safety seminars.

5. Maintenance of current ACLS/PALS registration.

6. Participating in institutional programs and activities involving the medical staff and adhering to established practices, procedures, policies and

medical staff by-laws of the university and of the relevant Affiliated Hospital.

7. Participation in institutional committees and councils, especially those that relate to patient care review activities.

8. Assuring State licensure or registration as required by the Florida Department of Professional Regulation as described in the Resident Handbook.

9. Complying with the scope of practice documents pertinent to the training program and obtaining an appropriate level of supervision for all patient care activities.

10. Timely Payment of all financial obligations to the University. The resident agrees that, in the event he/she has any unpaid financial obligation(s) to the University, the University is authorized to withhold issuance of the certificate of program completion until all such financial obligations are paid in full.

B. Physician Impairment and Substance Abuse: The University and the Affiliated Hospitals are each Drug Free Workplaces. As such, strict rules will affect individuals who report for duty while under the influence of alcohol or drugs or are suspected of being intoxicated.

Residents identified as being intoxicated will be referred to the Physician Recovery Network (PRN), an independent agency sanctioned by the State of Florida. Individuals declining referral to the PRN will be reported to the Board of Medicine and may be subject to adverse consideration by the University's College of Medicine. In addition, individuals are subject to Federal, state, and local laws. Individuals forging prescriptions or otherwise illegally obtaining controlled substances will be subject to severe disciplinary measures as well as formal criminal prosecution. Individuals who recognize the presence of a drug or alcohol problem or other impairment are encouraged to use the RAP or other support mechanisms within the University community. The University will provide an educational program for residents regarding physician impairment, including substance abuse.

C. Policy on Professional Activities Outside of the Training Program: House Officers may not accept outside employment or engage in other outside activity, compensated or uncompensated, which may interfere with the full and faithful performance of clinical responsibilities. Any proposed outside professional activities must be reported in writing to and approved in advance by the Program Director and the University's College of Medicine Associate Dean for Graduate Medical Education. The SIP does not provide liability protection for residents for incidents occurring in the course of outside professional activity. Residents should refer to the Resident Handbook or contact the Office of Graduate Medical Education for additional information regarding the approval of outside activity.

D. Grievance Procedures: Residents are provided full protection against unfair treatment through a formal grievance procedure. Specific directions for filing a

grievance are found in the Resident Handbook. Residents are advised that defined time intervals apply to most grievances and delay beyond these prescribed times may exclude the possibility of filing a grievance. Grievances should be filed with the Office of Graduate Medical Education at which time assistance will be provided in a fair and impartial manner.

E. Policies on Gender or Other Forms of Harassment: The University's College of Medicine published specific guidelines regarding all forms of harassment, which are consonant with the rules and policies of the University as well as laws and rules of the state of Florida. Sexual harassment, in particular, as well as all other forms of harassment, is inconsistent with the role of a professional and is not tolerated by the University. Individuals with knowledge of harassment are encouraged to promptly report such activity to the Office of the Dean of the University's College of Medicine.

F. Residency Closure/Reduction: Recent changes in public policy as well as changes in federal funding may, in the future, require adjustments in the number of residents in existing programs or could even result in the closure of a program. In the event the University intends to reduce the size of or close a residency program, the University will inform affected Residents as soon as possible and make every effort to allow residents already in the program to complete their education. If any residents are displaced by the closure of a program or a reduction in the number of residents, the University will make every effort to assist the residents in identifying a program in which they can continue their education.

G. Discipline and Discontinuation: House Officer agrees and understands that his/her continuation in the Program is dependent upon his/her satisfactory performance in accordance with professional patient care standards and the criteria of his/her Program, and compliance with the conditions and requirements of this Contract and the Resident Handbook. The University endorses the principle of progressive discipline and seeks to address substandard performance and/or conduct with the least severe action necessary to effect the desired change.

The University agrees that any academic or other disciplinary action, including dismissal, which may be taken against House Officer, will be in accordance with fair institutional policies and procedures as described in the Resident Handbook. The University agrees that the adjudication of any House Officer complaints and grievances related to actions which could result in dismissal or could significantly threaten the House Officer's intended career development will be in accordance with fair institutional policies and procedures as described in the Resident Handbook.

_____

House Officer Date

_____

Program Director Date

_____

Associate Dean of Clinical Affairs Date
Graduate Medical Education

II. I. RESIDENT WORK HOURS

Residents at all levels shall have the opportunity to spend on average at least one full day out of 7 free of hospital duties and will be on call in the institution not in excess of every third night except when continuity of care in patient management is required. Residents whose responsibilities include preparing the on-call schedule *(the PGY-4 year resident who is on the Otology or Research block)* should abide by these rules which will be monitored closely by the Residency Coordinator and reported to the Program Director to ensure that the resident work hours are appropriate. On-call facilities are provided at each of the institutions, should overnight stay be necessary.

If a resident works in excess of the below guidelines which are established and enforced by the ACGME, this MUST immediately be reported to an attending or the Program Director so scheduling changes can be made.

- Residents are limited to a maximum of 80 duty hours per week, including in-house call, averaged over four weeks.
- Residents must be given one day out of seven free from all clinical and educational responsibilities, averaged over four weeks.
- Residents cannot be scheduled for in-house call more than once every three nights, averaged over four weeks.
- Duty periods cannot last for more than 24 hours, although residents may remain on duty for six additional hours to transfer patients, maintain continuity of care or participate in educational activities.
- Residents should be given at least 10 hours for rest and personal activities between daily duty periods and after in-house call.
- In-house moonlight counts toward the weekly limit. In addition, program directors must ensure that external and internal moonlighting does not interfere with the resident's achievement of the program's educational goals and objectives.

III. A. OTOLARYNGOLOGY CONFERENCES
FACULTY LECTURES
(Tuesdays @ 5:00pm)

GOAL

The goal of the Otolaryngology Faculty Lectures is to provide a core didactic curriculum covering the entire specialty of Otolaryngology-Head and Neck Surgery every two years. Each resident is expected to have a general knowledge and understanding of the basic and clinical sciences related to the specialty following the first two years of the curriculum and a broad knowledge and understanding at the completion of the four-year training program.

OBJECTIVES

Upon completion of a five-year series of Faculty Lectures, each resident should:

- Possess in-depth knowledge of the basic sciences related to the specialty of Otolaryngology-Head and Neck Surgery, including anatomy, embryology, physiology, biochemistry, pathology, microbiology, immunology, and pharmacology.

- Possess in-depth knowledge of the clinical science of the specialty of Otolaryngology-Head and Neck Surgery, including surgical pre- and postoperative care, surgical techniques necessary to perform procedures of the head and neck, indications for surgical procedures within the specialty, office diagnostic techniques, and management of patients with diseases of the head and neck.

- Be familiar with the clinical sciences closely related to the specialty of Otolaryngology-Head and Neck Surgery, including pathology, radiology, radiation oncology, audiology, and speech pathology.

- Be able to develop a comprehensive differential diagnosis for any patient presenting with a complaint referable to the head and neck.

- Be able to plan a course of diagnosis and management for any patient presenting with a head and neck complaint.

- Be able to choose the most appropriate and cost-effective approach for diagnosis and treatment of head and neck complaints.

III. A OTOLARYNGOLOGY MONDAY/FRIDAY AM CONFERENCES
RESIDENT FORMAL CASE PRESENTATIONS AND FACULTY/RESIDENT ASSIGNED CASE REVIEWS

(Monday: USF and Friday: TGH, 7:30am)

GOAL

The goal of the Otolaryngology Resident Formal Presentations and Case Review Conferences is to provide a forum for residents to share experience and knowledge gained through clinical experience and research with other members of the department. . As a result of these conferences, each resident should gain an in-depth understanding of a broad spectrum of disease processes within the specialty of Otolaryngology-Head and Neck Surgery.

OBJECTIVES

At the completion of five years of attendance at the weekly Resident Presentations, each resident should:

- Be able to formulate a comprehensive differential diagnosis for any complaint referable to the head and neck.
- Know the presenting signs and symptoms of diseases of the head and neck.
- Be able to choose an efficient and cost-effective approach for the diagnosis and treatment of diseases of the head and neck.
- Know the medical and surgical options available for treatment of disease processes of the head and neck.
- Be able to interpret laboratory, office and surgical diagnostic tests in the context of the overall patient presentation.
- Be able to locate current literature relevant to the diagnosis and treatment of any head and neck disease.
- Be able to critically assess the information available in the medical literature as applicable to individual patient needs.
- Be able to present patient, medical, and research information to colleagues in a coherent, organized, efficient, and understandable manner using various modalities of audiovisual assistance.

NOTE: Formal presentation topics and learning objectives should be turned into the program coordinator one month prior to your scheduled lecture.

III. A. Morbidity and Mortality Conference

(Wednesdays monthly @ 7:00am)

A Morbidity and Mortality Conference is held on Wednesdays of every month at Tampa General Hospital, room B-301. The Chief Residents at each hospital (Tampa General Hospital & James A. Haley Veterans' Hospital) and the resident rotating at H. Lee Moffitt are responsible for the presentation and discussion of all morbidity and mortality patients arising at each hospital service. Participants in this conference include all full-time faculty and residents, as well as the medical student(s) rotating with our service. On occasion there may be other disciplines represented for discussion on particular cases. The objective of this conference is to discuss the morbidities as well as mortalities in the context of continuity of care in order to learn from experience and use the experiences to tailor one's approach in the management of otolaryngology patients. In addition to oral presentations, the chief residents and the rotating Moffitt resident are responsible for filling out M&M forms that present patient data and clinical data as well as the description of the morbidity or mortality for departmental records and must be turned into the Program Coordinator in a timely basis.

Trauma Conference

(Wednesdays quarterly @ 7:00am)

Trauma Conference is held quarterly on Wednesday mornings at Tampa General Hospital, room B-301. Participants in this conference include all full-time faculty as well as all residents and medical students rotating on the Otolaryngology Service. The conference is coordinated and organized by the chief resident at Tampa General Hospital, in that he/she chooses appropriate cases for presentation. The Chief Resident gives a brief overview to the attending faculty and residents on a particular topic pertinent to maxillofacial trauma and select cases are presented for discussion. The cases presented are patients that have been treated at Tampa General for maxillofacial trauma. The discussion is lead by the chief resident who will often question the more junior residents prompting them for appropriate history as well as correlation of physical findings with radiographic studies. More senior level residents will learn to discuss the management treatment options of maxillofacial trauma. The objectives of this conference entails the learning of appropriate history taking skills as well as physical examination and interpretation of imaging studies in the evaluation and management of trauma patients. Faculty add commentary and appropriate guidance in directing residents to appropriate surgical, as well as non-surgical management.

III. A. CONT.

Otology Conference
(Wednesdays quarterly @ 7:00am)

The Otology Conference is held on Wednesdays quarterly at Tampa General Hospital, room B-301. Participants include all residents, the Departments' Neurotologist, Dr. K. Paul Boyev and Dr. Loren J. Bartels, Clinical Associate Professor and fellowship trained neurotologist as well as the medical students rotating on our service. During this conference, residents who have been previously selected by Dr. Boyev or Bartels will discuss topics pertinent to otology. The resident is asked to present a case based conference centered around an interesting case that he/she has seen in the otology clinic. A broad discussion is then undertaken by the resident to thoroughly cover the topic with an appropriate literature search and distribution of articles for faculty and resident review. The objective of this conference is to teach the resident to use history and physical exam findings to reach an appropriate differential diagnosis of otologic diseases and to arrive at an appropriate treatment plan and to support that plan with review of updated literature.

Facial Plastic Conference
(Wednesdays quarterly @ 7:00am)

A Facial Plastic Conference is held quarterly on Wednesday mornings at Tampa General Hospital, room B-301. Participants in this conference include full-time faculty, residents and any medical students on rotation with our service. The Director of the Facial Plastic Section will choose and present relevant cases for discussion. He/she will review the history and physical findings as well as adjuvant studies that are required to fully assess facial plastic and reconstructive patients. The objective of this conference is for the residents to learn how to appropriately assimilate history and physical findings with the appropriate diagnosis and management strategies for facial plastics and reconstructive patients. In addition to management strategies, complications are also discussed and management of these complications will be learned.

Skull Base Conference

Skull Base Conferences are periodically held on Wednesday mornings at H. Lee Moffitt Cancer Center and Research Institute, room 3162. Participants include full-time faculty, residents, and any medical students rotating our service in addition to members of other disciplines when deemed necessary. Either Faculty of the Department of Neurosurgery or our Otolaryngology Faculty with expertise in Skull Base Surgery will provide lectures. The lectures are followed by discussions amongst the faculty and residents, including management strategies and complications related to the management of patients with skull base tumors.

Journal Club
(Thursday evenings-monthly)

Journal Clubs are held once a month during the academic year in either the USF ENT Conference Room (#1072) or at a local restaurant. The goal of Journal Club is to keep current with the otolaryngology literature and to learn to critically evaluate the peer-reviewed literature. Each Journal Club is centered around a specific topic, which is addressed by several different authors. Residents are responsible for reading all distributed articles (usually 6-7) for each Journal Club. They will be asked to present the pertinent aspects of the article, to evaluate the methods, including the statistical analytical methods used in the articles, and critique the paper.

H. Lee Moffitt Cancer Center Multidisciplinary Tumor Board
(Tuesdays weekly @ 8:00am)

The resident on the head and neck oncology service at H. Lee Moffitt Cancer Center will participate in the multidisciplinary tumor board on Tuesday mornings at 8 a.m. During this conference, the resident will present all new head and neck oncology cases in an organized fashion. He or she will present an abbreviated history and all pertinent physical exam findings as well as deliver pertinent x-rays and histopathologic specimens to the radiologist and pathologist respectively. The resident will learn to appropriately stage tumors and learn the implications staging in the choice of management options. In addition to providing this information, the resident is encouraged to actively participate in the treatment decision-making process for each new patient. The goal of this conference is for the resident to learn the importance of a multidisciplinary approach in the care of complicated head and neck cancer patients and to learn about the controversies that may arise with regard to treatment options. Novel protocols as well as novel therapies are discussed and the resident will learn about the appropriate candidacy of patients for currently active protocols.

H. Lee Moffitt Cancer Center & Research Institute Teaching Rounds
(Tuesdays and Thursdays, weekly)
(Tuesdays weekly @ 7:30am / Thursdays weekly @ 8:00am)

The resident rotating at H. Lee Moffitt Cancer Center will participate in the Tuesday and Thursday morning Teaching Rounds. Participants of these rounds include the multidisciplinary specialties such as Head and Neck Surgery, Speech and Language Pathology, Otolaryngology Nursing and Social Work. In addition, on occasion, other disciplines may be represented on these rounds. All head and neck oncology inpatients are reviewed with the group at bedside and specific issues are addressed, including post operative management as well as general discussions surrounding the patients on the ward. These rounds are under the direction of the Moffitt attendings on both Tuesday and Thursday mornings. The resident participating in these rounds will learn to discuss pertinent operative findings, particular details regarding the surgical procedure and the expected post-operative course of all the post operative in-house patients. The resident will learn to justify his/her choice of treatment as well as the choice of management strategies. In addition, this resident, under the guidance of the attending physician, will coordinate the rehabilitation of the head and neck cancer

patient and he/she will learn to discuss rehabilitation efforts at length with the multidisciplinary group. The objective is to learn to correlate preoperative counseling and intraoperative findings with postoperative outcome and continuity of follow-up in the comprehensive management of head and neck cancer patients.

James A. Haley Veterans' Hospital Teaching Rounds
(Wednesday mornings 8:30-9:10am)

PGY II: The resident at this level will learn the correct manner of presenting a brief history and physical on all hospital ward inpatients as well as an update on the status of the patient's hospital course for those members of the multidisciplinary team participating in ward rounds. The objective is to learn to organize pertinent facts in the day to day management of hospital inpatients.

PGY III: The resident at this level will learn to discuss any pertinent operative findings, particular details regarding the surgical procedure, and the expected postoperative course of all post-op hospital patients. In addition, the resident will learn to justify his or her choice of treatment as well as choice of management strategies in an effective manner. The objective is to learn to correlate intraoperative findings with postoperative course of patients undergoing otolaryngology surgery.

PGY IV: The resident at this level will learn to discuss any significant postoperative complications, management strategies for complications, and long term plans for the inpatients. In addition, he or she will be expected to present any pathology reports and will learn how these reports alter further management. Any rehabilitation for the head and neck cancer patients will also be coordinated by the chief resident and he or she will learn to discuss the rehabilitation efforts at length with the multidisciplinary group. The objective is to learn to correlate preoperative counseling and intraoperative findings with postoperative outcome and follow-up in the comprehensive management of otolaryngology patients.

James A. Haley Veterans' Hospital Multidisciplinary Head and Neck Tumor Board
(Wednesday morning 9:15-10:00am, Room: 101)

PGY II: The resident at this level will learn to present, to all involved members of the tumor board, complete history and physical data gathered on all new head and neck cancer patients presenting to the head and neck clinic during the previous week. He or she will learn to correlate physical exam findings with pertinent imaging studies and will participate in discussion regarding appropriate management of patients presented.

PGY III: The resident at this level will learn to discuss standard treatment options for the various cases discussed. He or she will assist in determining the recommended course of action with direct guidance from the chief resident and attending physicians. He or she will learn to read any imaging studies presented by the attending radiologist and otolaryngologist.

PGY IV: The chief resident will lead the discussion at this conference. In his or her absence, the discussion will be led by the senior resident. The chief resident will learn to formulate a treatment plan in the management of head and neck cancer patients that

is based upon experience and supported by literature. He or she will learn about various cancer treatment protocols and if and when it is appropriate to consider a protocol in the management of a particular case. The final decision regarding treatment will be made by the chief resident and attending physicians. The chief resident will be expected to coordinate the efforts of the multidisciplinary tumor board members as the team leader (with the attending physician) in order to provide comprehensive head and neck cancer care.

Videostroboscopy Conference:

Held monthly, this hour-long conference will review interesting videostroboscopy teaching cases. The basics of videostroboscopy, including definitions, indications, and mechanics involved in performing the test will be reviewed in the first session. Interesting teaching cases will be reviewed to emphasize particular points. Participants included speech and language pathologists from HLMCC and JAHVAH, attending otolaryngologists, and residents rotating at both JAHVA and HLMCC. The goal of this conference is to expose the residents to videostroboscopy and the appropriate indications for use of videostroboscopy in the evaluation of voice disorders. The Moffitt Resident is responsible for returning the sign-in sheet to the Program Coordinator for departmental record.

Thyroid Conference:

Held monthly at H. Lee Moffitt Cancer Center and Research Institute, this conference discusses all thyroid cases seen by the faculty at H. Lee Moffitt Center, James A. Haley Veterans' Hospital, and the USF Ear Nose and Throat Center. Residents on rotation at the H. Lee Moffitt Cancer Center and James A. Haley Veterans' Hospital participate in this conference to learn the comprehensive care of patients with thyroid disease.

III. B. Speech and Language/Audiology Rotations

JAHVA rotation:

During the PGY II rotation at the VAH, the resident will participate in practicums with the speech and language pathologists who work with our head and neck patients. A schedule will be made wherein the resident will spend approximately 3 half-day sessions during each two month rotation for a total of approximately six half-day sessions with a speech pathologist. During the rotation, the resident will participate in several speech and swallowing assessments including but not limited to:

1. initial and follow-up tracheoesophageal (TEP) fitting sessions
2. TEP evaluation/esophageal insufflation session
3. Tracheostoma valve fitting
4. Passy Muir valve evaluation
5. dynamic videoesophagram swallow study and tape analysis
6. voice evaluation with visipitch analysis
7. augmentative /alternative communication evaluation or treatment

The goal is to provide practical experience in the rehabilitation of head and neck patients with appropriate guidance by professional speech and language pathologists. A sign off sheet will be distributed to residents for attendance record and MUST be returned to the Program Coordinator for your permanent file.

During the PGY II rotation at the VAH, the resident will participate in practicums with the audiologists to learn appropriate audiometric assessment techniques on otolaryngology patients. A schedule will be made wherein the resident will spend approximately 2 half-day sessions per three month rotation at the VAH for a total of 4 half-day sessions with an audiologist. The resident will participate in hearing and balance assessments including, but not limited to:

1. pure tone air audiometry
2. bone conduction audiometry
3. speech recognition assessment
4. auditory brainstem response assessment
5. electronystagmography
6. hearing aid evaluation

The goal is to provide the resident with the skills necessary to complete audiometric testing in effort to better understand hearing loss and its rehabilitation. A sign off sheet will be distributed to residents for attendance record and MUST be returned to the Program Coordinator for your permanent file.

In addition to the practicums in speech pathology and audiology, general lectures on related topics will be given during the academic year during the core lecture series. Also, made available to residents are CD-ROM self-guided audiology primers at the VAH library for those who wish additional exposure.

III. C. Home Study Course

Residents are required by the Department to participate in the AAO-HNS Home Study Course during the entire four years of otolaryngology training. Payment of the two-year subscription will be paid by the department for each resident at the beginning of each two year cycle, currently $390.00.

The Home Study Course covers four different sections of study each year. Residents are expected to read each section and return the exams for grading to the Academy in a timely manner. Late fees, if accrued, for grading will be the responsibility of the resident. Residents are required to complete all sections and obtain passing grades. Failure to do so will result in disciplinary action at the time of your quarterly review with the Program Director. Exam scores become a permanent part of each resident's file.

III. E. Meetings & Courses

All residents are encouraged to attend regional and national meetings. Plane fare and per diem depend on available funds for meetings and courses outside the established curriculum. Residents are expected to attend the meetings of the Florida Gulf Coast ENT Society which is an educational conference; dinner is provided for the resident and their guest. Second-year otolaryngology residents attend the annual meeting of the American Academy of Otolaryngology-Head and Neck Surgery. A third or fourth year resident is expected to present their research project at the annual meeting of the Florida Society of Otolaryngology-Head and Neck Surgery; expenses are paid by the Society for the presenting resident. Attendance at national meetings and courses such as the Combined Otolaryngological Spring Meeting (COSM), the Southern Section of the Triologic Society Meeting and the AAOA Basic Course in Otolaryngic Allergy is supported by the Department. Attendance will depend on available funds and coverage issues.

Paper presentations at meetings will be subsidized. Each resident is entitled to five (5) days of compensated professional (administrative) leave per year. In state travel will be compensated, with prior approval, at $65.00 per day per diem. . **Written approval MUST be obtained from the Program Director prior to ANY leave being planned.**

Bronchoscopy Training Course for Otolaryngology Residents:

Goal:
To provide a foundation upon which to build and establish clinical competence in rigid bronchoscopy and foreign removal from the airway.

Objectives:

1. Know the human endobronchial anatomy and the segments of the lungs.
2. Recognize common endobronchial pathology.
3. Be familiar with the various techniques for foreign body removal from the airway.
4. Be able to choose appropriate rigid instrumentation for a given airway.
5. Be able to pass a bronchoscope atraumatically into the mainstream bronchi.
6. Be able to remove a foreign body from the airway of a laboratory animal.

Temporal Bone Course:

Goal:
To provide intense exposure to temporal bone anatomy, histology, pathology and surgical procedures in effort to establish clinical competence in diagnosis and management of otologic disorders.

Objectives:

1. Know detailed anatomy of the temporal bone.
2. Understand the histopathology of the temporal bone in paraffin embedded sections.
3. Be able to perform numerous operative procedures in the temporal bone such as; mastoidectomy, labyrintheetomy, translabyrinthine approach to intural auditory canal
4. Become familiar with the operating microscope and it's applications in otologic surgery.
5. Become familiar with the micro instruments used in otologic surgery, including the drills, various drill bits and indications for their use.

Head and Neck Anatomy Course:

Goal: to provide a foundation upon which to build and establish clinical competence in the surgical anatomy of the head, neck and skull base.

Objectives:

1. Know the human head and neck anatomy via assigned readings, interactive lectures, and dissection sessions
2. Recognize common anatomic variants in the head and neck anatomy
3. Be familiar with various surgical techniques used in head, neck and skull base surgery
4. Be able to choose appropriate instrumentation for an appropriate head and neck surgical procedure
5. Be familiar with intracranial and extracranial skull base anatomy

ALL residents are responsible for procuring temporal bones at the completion of the dissection course, which will then be used in temporal bone dissection course(s).

III. F. Required and Recommended Reading

The following is a list of **required** texts and journals. All residents receive these through the Department or through medical association/society memberships. Please contact the Program Coordinator for society membership information.

Text

Otolaryngology- Head and Neck Surgery
Bailey (editor) 2nd or 3rd Edition
Lippincott Williams and Wilkins

Journals

Annals of Otology, Rhinology & Laryngology
Archives of Otolaryngology- Head and Neck Surgery
Otolaryngology – Head and Neck Surgery *(free with AAO-HNSF membership)*
Archives of Facial Plastic and Reconstructive Surgery *(free with membership to AAFPRS)*

The following is a list of **recommended** texts and journals. These have also been made available to the residents at the following locations: James A. Haley Veterans' Hospital clinic conference room and library, USF conference room and library, and TGH library.

TEXT

RHINOLOGIC DIAGNOSIS AND TREATMENT
McCaffrey,TV (editor)
Thieme 1997

OTOLARYNGOLOGY-A CASE STUDY APPROACH
Tami, TA (editor)
Thieme 1998

OTOLARYNGOLOGY- HEAD AND NECK SURGERY
Cummings (editor) (5 vol)
Mosby 1998

PEDIATRIC OTOLARYNGOLOGY
Bluestone (editor) 3rd edition
W.B. Saunders

AN ATLAS OF HEAD AND NECK SURGERY
Lore (editor)
W.B. Saunders 1989

OTOLOGIC SURGERY
Brachman (editor) 1st edition
W.B. Saunders

OPERATIVE OTOLARYNGOLOGY HEAD AND NECK SURGERY
Myers (editor)

COMPREHENSIVE MANAGEMENT OF HEAD AND NECK TUMORS
Thawley, Panje, Batsakis, Lindburg (editors) 1999 ed

ESSENTIAL AUDIOLOGY FOR PHYSICIANS
Campbell (editor) 1997
Singular Publishing Group

Journals

Laryngoscope
The Otolaryngology Clinics of North America
ENT Journal
Head and Neck

To Order Journals and Books (see next page)

III. G. TO ORDER JOURNALS AND BOOKS

Archives of Otolaryngology-Head and Neck Surgery $55.00/yr
c/o Subscriber Services, American Medical Association
515 North State Street
Chicago, IL 60610-0946 (800) 262-2350 www.ama-assn.org

Laryngoscope $64.00/yr
(Must call to order, resident rate not available on line)
Lippincott William & Wilkins
12107 Insurance Way
Hagerstown, MD 21740 (800) 638-3030 www.laryngoscope.com
Fax: 301/824-7390

Annals of Otology, Rhinology & Laryngology $112.00/yr
4507 Laclede Avenue
St. Louis, Missouri 63108 (314) 367-4987 www.annals.com

The Otolaryngology Clinics of North America $90.00/yr (6 issues)
W.B. Saunders Company/Publishing
6277 Sea Harbor Drive
Orlando, Florida 32887 (800) 654-2452 www.wbsaunders.com

Otolaryngology-Head and Neck Surgery $99.00/yr
Mosby Yearbook, Inc.
11830 Westline Industrial Drive
St. Louis, Missouri 63146-3318 (800) 453-4351

The C.V. Mosby Co. -Local Representative: John Kenyon (727) 726-0225
11830 Westline Industrial Drive
St. Louis, Missouri 63141 (314) 872-8370

W. B. Saunders Co. -Local Representative: John Kenyon
6277 Sea Harbor Drive
Orlando, Fl 32887

Brian C. Decker, A Division of Thieme-Stratton, Inc.
381 Park Avenue South
New York, New York 10010

Singular Publishing Group, Inc.
401 W. “A” Street, suite 325
Dan Diego, California 92101-7904 (619) 238-6777 www.singpub.com

III. H. Additional Book/Journal Ordering Information:

Tony Norton is the local representative for the following publishers:

W. B. Saunders

Mr. Norton can be reached by telephone, FAX, or mail:
Telephone: 800/543-6775
FAX: (727) 785-2328
Address: PO Box 1701
Palm Harbor, FL 34682

Per Mr. Norton, an easy payment plan is available for residents. Any order over $100 qualifies. Payments can be made monthly with no interest and the base price is the publishers price without mark-up. Please call Tony for more information.

Richard Settle is the local representative for the following publishers:
(727) 781-1086

Lippincott-Raven	Springer-Verlog
Blackwell Science	

John Kenyon is the local representative for the following publishers:
(727) 726-0225

C. V. Mosby	Thieme
Williams & Wilkins	Magraw Hill

Per Mr. Kenyon, resident discounts and payment plans are available.

III. I. Library Services

University of South Florida Health Sciences Center 974-2243

Hours:	Monday - Friday	7:30 am - 11:00 pm
	Saturday	10:00 am - 11:00 pm
	Sunday	Noon - 11:00 pm
	Holidays	Check with library.

Full staff of librarians to assist. Computers available. Internet access available. Classes available for Netscape, PowerPoint and Excel; check with the library for schedules.

USF Main Campus 974-2729

Full service library (staff, computers, copiers)

Hours:	Monday -Thursday	8:00 am - 1:00 am
	Friday	8:00 am - 9:00 pm
	Saturday	8:00 am - 8:00 pm
	Sunday	Noon - 1:00 am

Tampa General Hospital 251-7066

Hours: Monday – Friday, 8:00 am - 5:00 pm

Self check-out of test and tapes is provided. A copier and phone are on site. Internet access is available and to be used for those items that specifically relate to the mission of the hospital, i.e. medical only. Journals published before 1995 are stored in the basement.

For after hours access, please call security (251-7363).

H. Lee Moffitt Cancer Center 979-7295

Hours: Monday – Friday, 8:00 am - 4:30 pm

Located on the second floor of the Research Center building. Houses a current book and journal collection, with an emphasis on cancer (see web page for complete listing). Mednet (must have USF Mednet password) and Internet access available. Two librarians to assist with computer searches.

For after hours access, contact Moffitt Security at x3000. (HLM ID badge required)

James A. Haley Veterans' Hospital 972-7531

Hours: Monday – Friday, 8:00 am - 4:30 pm

Located on the second floor in rooms A237 and A239. Printed index Medicus, Hospital Literature Index, and Cumulative Index to Nursing and Allied Health Literature are available. Internet access available. Librarians will assist with computer searches. Copier available 8:00 am - 4:30 pm only.

For after hours access, request key from the Administrative Officer of the Day (AOD).

All Children's Hospital (727) 892-4278

Hours: Monday – Friday, 8:30 am - 5:30 pm

Librarian available to assist with searches, etc. Computer and copier are available.

For after hours access, use ACH ID badge bar code (on back of badge). Bar code slide is on right side of library entry door. Security can assist (x3300) if bar code does not allow entry.

Department of Otolaryngology Resident Library 974-6924
(CONTACT RESIDENT COORDINATOR W/QUESTIONS)

Hours: Monday – Friday, 8:00 am – 5:00 pm
(as long as Ophthalmology or Otolaryngology is not using the room for conferences or meetings)

Located at the USF Eye/ENT Institute, Room 1072.
For after hours access, use *(your)* key card or contact Moffitt Security at ext. 3000. (Moffitt ID badge required)

IV. A. Resident Research Protocol

Objective

Each resident should be able to design and execute one research project per academic year (This is in addition to the assigned research block in the PGY-4 year).

Goals

The three-month rotation is designed to promote an understanding and an appreciation of the research process and its role in medicine. The goals include development of a hypothesis, model, methodology, and system of statistical evaluation such that conclusions will allow a paper worthy of publication to be produced. Each resident will learn the process of research design and will finish the program with 2-4 projects that are journal quality/1st author papers.

Projects that are completed at any other time during your residency will fulfill your requirement for research. Failure to complete any portion of your research will result in a failure to complete the research rotation that is a requirement of this residency program.

Project types:

1. retrospective
2. case study or case series
3. new technique or new product design
4. basic science
5. prospective (can span from 1-3 years with prior approval)

Consequences for not following research procedures/timeline:

A resident's inability to adhere to the schedule with prior approval of their advisor will result in:

1. suspension of all operating privileges
2. and/or suspension of all operating privileges
3. and/or placement on probationary status

Benefit to resident:

1. contribution to scientific literature
2. possible trip to a national meeting with a verbal presentation with Chairman's approval
3. help bolster a possible future academic career

Upcoming otolaryngology meeting dates/abstract deadlines:

MEETING /YEAR:	LOCATION	DATES	ABSTRACT DATE
	2005		
2005 Triologic Southern Section Meeting	**Miami, FL**	**Jan. 13-15**	**Aug. 1, 2004**
2005 Association for Research in Otolaryngology	**Daytona, FL**	**Feb. 27-Mar. 3**	**Aug. 2004**
2005 COSM Meeting	Boca Raton, FL	May 12-17	Oct. 2004
2005 AAO-HNS Meeting	Los Angeles, CA	Sept. 25-28	Jan.7, 2005
2005 Florida Society of OTO-HNS	**Orlando, FL.**	**Nov. 11-13**	**TBA**
	2006		
2006 Triologic Southern Section Meeting	**Naples, FL**	**Jan. 12-14**	
2006 Association for Research in Otolaryngology	**New Orleans, LA**	**Feb. 10-15**	**Sept 1-Oct 1, 2005**
2006 COSM Meeting	Chicago, IL.	May 19-22	Online July 1, 2005
2006 AAO-HNS Meeting	Toronto, Canada	Sept. 17-20	Jan.7, 2006
2006 Florida Society of OTO-HNS	**TBA**	**Nov. 2006**	**TBA**
	2007		
2007 Triologic Southern Section Meeting	**TBA**		
2007 Association for Research in Otolaryngology	**TBA**		
2007 NASBS	TBA		
2007 COSM Meeting	San Diego, CA	April 26-29	
2007 AHNS	San Diego, CA	April 26-29	
2007 AAO-HNS Meeting	Washington, DC	Sept 16-19	Jan. 7, 2007
2007 Florida Society of OTO-HNS			
2008 AAO-HNS Meeting	Chicago, IL	Sept. 21-24	Jan.7, 2008
2009 AAO-HNS Meeting	San Diego, CA	Sept. 13-16	Jan.7, 2009

* Meetings in Bold =meetings that we should have at least 1-3 residents presenting

Resident Research Advisory Board

It is required that a faculty member serves as your advisor for research. You may select anyone as an advisor who is willing to serve as a mentor for the rotation.

Resident Research Director	**Otolaryngology Research Committee**
Bernd Sokolowski, Ph.D.	Bernd Sokolowski, PhD, Chairman Thomas V. McCaffrey, MD, PhD Paul Boyev, MD Marion B. Ridley, MD

The advisor will be available to assist you in development of your project. They are also willing to provide projects within their specific areas of interest, which you may choose to participate in during your research rotation.

Resident Research Evaluations

After completion of the three-month research rotation, an evaluation form will be distributed to your advisor and co-investigators. (Appendix A) This form is then entered into a database containing information regarding your research project, and the information will be available for future reference when recommendations are needed. You will also receive an evaluation form to complete. Your comments and suggestions regarding ways that the research program could be improved are appreciated.

Research Deadlines

1. During the spring of your first year in residency you are asked to meet with the research director to discuss the research program including funding opportunities, IRB and IACUC guidelines. Copies of the guidelines are available through Mrs. Marge Kuligofski in the research office. In addition, before undertaking any project each resident is required to view the USF training video on ethics and compliance in research. This training is an absolute must since no research can be started prior to viewing these videos. This restriction includes access to patient charts for data collection.

2. Nine months prior to commencement of your research project, you are asked to submit the project title and the name of the supervisory faculty member. The supervisor must indicate acceptance of the title by signature of a proposal memo to the program director.

3. Six months prior to commencing research, an outline must be submitted to and approved by the supervisory faculty to be submitted to the program director. In addition, a preliminary budget and indication of acceptance by the laboratory supervisor where the project will take place must be submitted to the program director.

4. Three months prior to your scheduled research rotation, you will be required to submit a copy of your research proposal (see part III), to the research director and program

director. You will then be asked to attend a meeting of the department research committee to present your project and discuss it. Recommended changes can then be made in plenty of time to commence the project on day one of the research rotation. All IRB and IACUC approvals must be completed or pending (submitted to the respective committees) by the date of the meeting with the research committee.

5. Approximately 1 to 2 months prior to beginning the project, you will be required to present your project to the residents and faculty.

6. The summary of the statistical analysis with completed statistical evaluation should be submitted approximately three months following completion of the research rotation to the research director and the program director. Each resident will be sent one reminder of this date by the residency program coordinator.

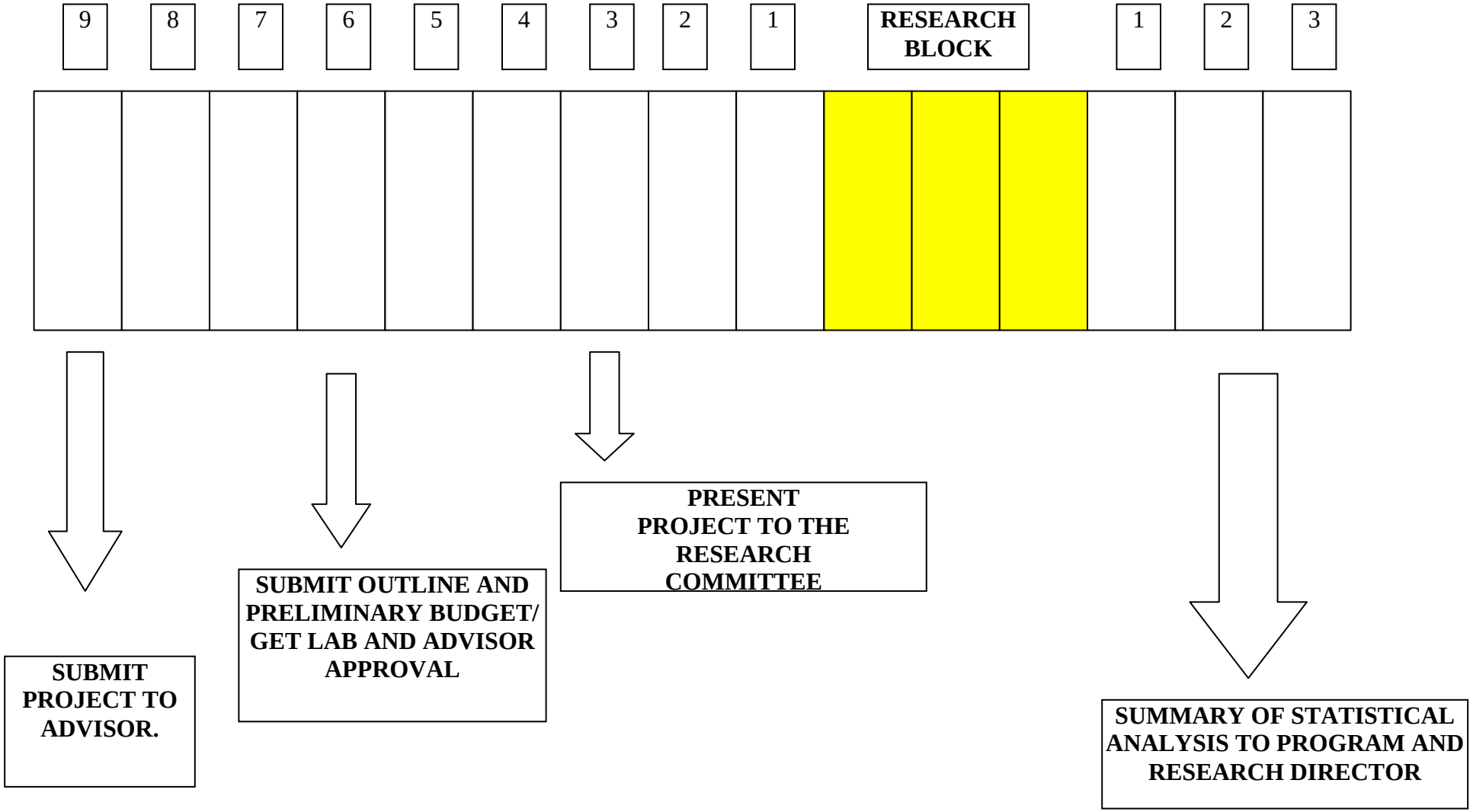
Publications for Resident Research

It is expected that publications of the research project will be pursued in an appropriate journal with the guidance from the supervisory faculty.

FAILURE TO MEET THE ABOVE DEADLINES WILL RESULT IN THE RESIDENT BEING UNABLE TO HAVE PROTECTED RESEARCH TIME.

IV. B. RESIDENT RESEARCH TIMELINE/ (For Research Block):

MONTHS PRIOR TO PROJECT **MONTHS AFTER RESEARCH**



IV. C. RESEARCH REOUIREMENTS

A. Research Proposal

The research proposal, which is to be compiled and written by the resident, follows a standard NIH grant format, and will consist of an abstract and the following four sections:

Section 1. Specific Aims:

What do you intend to do?
State the broad objectives. These should be realistic. State whether this is a pilot study or a study designed to test previously generated hypotheses.

e.g. The specific aim is ___. This will be accomplished by ____. The result of this experiment will tell us ____.

Section 2. Background and Significance:

Why is the work important?
Sketch the background to the present proposal. Critically evaluate existing knowledge and identify the gaps that this project is designed to fill. Do not limit your discussion to studies that support your ideas. Present both sides.

(Include copies of your references when you submit your proposal)

Section 3. Experimental Design and Methods:

How are you going to do the work?
Outline the experimental design and procedures to be used to accomplish the specific aims of the project. Include the means by which the data will be collected, analyzed and interpreted.

Section 4. Budget:

You must provide a detailed budget delineating any and all costs which will be incurred by your project. Costs include: materials, explanation of required and available facilities, overhead costs (if applicable), animal subject costs (purchase price, per diem, disposal), human subject costs (accurate price quotes from participating institutions). Early submission of budget is necessary to facilitate funding. There is limited funding available for projects from the Department. You are strongly encouraged and it is recommended that you apply for external funding. There are resident research grants available from several sources. (See Appendix B). These are discussed with the research director in the first meeting.

An abbreviated example of a research proposal has been included, see Appendix C.

IV. D. RESEARCH CONSIDERATIONS

Prior to starting your research project you need to give some considerable thought to the types of subjects and agents you will be working with. This takes planning because there are certain guidelines that must be followed, prior to beginning the project. Guidelines and web sites for using Human subjects, Animal subjects, Recombinant DNA, and Toxic/Infectious agents are available by contacting Mrs. Marge Kuligofski in the Otolaryngology Research Office.

A. Human Studies

If you are planning to use human subjects in your research, **INCLUDING CHART REVIEWS**, you must be prepared to complete IRB applications and Informed Consent forms. These are required at the same time as your proposal meeting. Most grant applications require that a letter of approval from the institution be included with any applications for funding for projects utilizing human subjects. Please be aware that processing of IRB applications can take 1-2 months. For more information regarding this application process, please contact the head of the research committee and/or check the USF Research Compliance web site at http://www.research.usf.edu/cs/. **VIEWING OF THE USF VIDEO ON RESEARCH ETHICS AND COMPLIANCE IS MANDATORY BEFORE PROCEEDING WITH ANY RESEARCH!!!** ***Furthermore, human subject research will be reviewed by the departmental research committee prior to presenting an application to the IRB.***

B. Animal Studies

If you are planning to use animal subjects in your research, you must be prepared to complete IACUC applications. These are required at the same time as your proposal. Most grant applications require that a letter of approval from the institution be included with any applications for funding for projects utilizing animals. Please be aware that the IACUC committee has specific deadlines for submission of applications. For more information regarding this application process, contact the head of the research committee and/or check the USF Research Compliance web site at http://www.research.usf.edu/cb/. **VIEWING OF THE USF VIDEO ON RESEARCH ETHICS AND COMPLIANCE IS MANDATORY BEFORE PROCEEDING WITH ANY RESEARCH!!!** ***Furthermore, all animal research will be reviewed by the departmental research committee prior to presenting an application to the IACUC.***

C. Radioisotopes

If you are planning to use radioisotopes in your research you will be required to attend a radiation biosafety class. This class will provide you with the necessary forms, approvals, and information regarding the possible hazards involved. Consult with the Radiation Safety Officer at the participating institution for class schedules.

D. Recombinant DNA and Infectious/Toxic Agents

If you are planning to use either recombinant DNA or infectious and /or toxic agents, you will be required to attend a biosafety class. In addition, requests to use recombinant DNA and certain toxic agents requires filling out forms for these agents. To determine the risk group or biosafety level of the recombinant DNA or toxic/infectious agent and to obtain the necessary forms, you can check the USF Research Compliance web site at http://www.research.usf.edu/cs/biosafety.htm. Completed and signed forms are to be returned to Dennis Freeman, Institutional Biosafety Officer, Compliance Services, MDC35. Completion of these forms is a must before beginning your research.

IV. E. APPENDIX A

RESIDENT RESEARCH REGISTRY

Resident:_____

Advisor: _____

Project
Title:_____
_____

Abstract:_____
_____
_____
_____
_____
_____
_____

Proposal Deadline:_____ Final Draft Date:_____

Publication Date:_____ Journal:_____

Funding Source:_____ Total Project Cost:_____

Resident
Comments:_____
_____
_____

Resident
Suggestions:_____
_____
_____

Advisor -
Comments:_____
_____

Advisor - Recommendation of Resident:_____

IV. F. APPENDIX B

FUNDING SOURCES

This is a partial listing of funding sources. Grant searches can be requested from the Division of Sponsored Research. Grant announcements are frequently presented in your professional journals. Please watch for these announcements.

Funding Deadlines: January - Letter of Intent
February - Grant Proposal
Deadlines subject to change and vary according to sponsor

1. American Academy of Otolaryngology - Head and Neck Surgery Foundation
   - A. AAO-HNS Foundation Resident Research Grant
     - project related to any area of Otolaryngology - H & N Surgery
     - $10,000.00 maximum award
     - $ 1,000.00 travel allowance
   - B. AAO-HNS Research Training Award
     - project related to any area of Otolaryngology - H & N Surgery
     - designed to provide Research Training
     - $15,000.00 maximum award
   - C. Combined PSEF/AAO-HNSF Award
     - collaborative effort between two surgical specialties
     - $10,000.00 maximum award
   - D. Combined AAOA/AAO-HNSF Award
     - project related to otolaryngic allergy, either clinical or basic research
     - $10,000.00 maximum award

H. American Society for Head and Neck Surgery
   - A. Clinical Research Award
     - $10,000.00 maximum award
   - B. Basic Science Research Award
     - $10,000.00 maximum award

Funding Deadlines: By July 1 - Request for Applications
August 1 - Grant Proposal
Deadlines subject to change and vary according to sponsor

III. American College of Surgeons

- **A.** Ethicon Scholarship of the ACS for the Study of Surgical Wound Healing
  - $20,000 per year/ 2 year award
- **B.** Pharmacia & Upjohn Research Scholarship of the ACS
  - $20,000 per year/ 2 year award

**For more information regarding funding sources, applications, or deadlines please contact Dr. Sokolowski's office.

IV. G. APPENDIX C

RESEARCH PROPOSAL EXAMPLE

TITLE: A Pilot Study to Evaluate the Use of Lymphoscintigraphy in the Staging of Clinical T2-T4, NO Squamous Cell Carcinomas of the Floor of Mouth

Principal Investigator: _____, M.D.
Advisor: _____, M.D.
Co-Investigators: _____, M.D., _____ M.D.

ABSTRACT: (self explanatory)

SPECIFIC AIM: (one page or less is recommended)

The specific aim of this project is to evaluate the use of lymphoscintigraphy as a predictor of regional metastases in head and neck squamous cell carcinoma. This will be accomplished by identification of patients with clinically negative necks and histologic examination of nodes that are identified as positive by lymphoscintigraphy for the presence of occult metastasis. RT-PCR with keratin primers will be performed on nodes that are positive by lymphoscintigraphy to determine if this is a more sensitive means to assess the presence of metastatic disease. A secondary aim will be to assess the incidence of skip metastases in neck dissection specimens. The result of this experiment will determine the utility of lymphoscintigraphy as a staging procedure.

BACKGROUND AND SIGNIFICANCE: (two to three pages are recommended)

Malignancies of the oral cavity account for 4% of all cancers occurring in men and 2% in women. Control of the primary lesion has great prognostic significance. However, the status of the regional lymph nodes play a major role. A review of the literature reveals the incidence of cervical metastasis after initial treatment to vary from 15-38%. A consistent prognostic factor, (e.g. T-stage, histologic grade of the tumor) contributing to cervical metastases has not been delineated.

Lindberg has demonstrated in a review of 258 carcinomas of the floor of mouth that the nodal groups most often involved by metastatic disease include the submandibular, jugulodigastric and midjugular nodes. The tumors frequently metastasize to both ipsilateral and contralateral nodes. The possibility of skip metastases as well as involvement of the posterior triangle remains controversial. Harrold reported a 10% incidence of metastases in the middle and lower necks unassociated with metastases in the upper levels. Shaha found a 5% incidence of posterior triangle metastases but only in conjunction with disease higher in the neck. Skolnik found no metastases in the nodes of the posterior triangle of radical neck dissection specimens. Lindberg reports a 3% incidence of lower jugular and posterior cervical nodes in floor of mouth (FOM) cancer. Their association with upper echelon nodes is not detailed.

The method of pathologic evaluation of the surgical specimens may have served as a source of the discrepancies. The specimen is evaluated visually, occasionally with the aid of an illumination board or defatting procedure, as well as by palpation. This is dependent on the skill and diligence of the pathologist. The lymph nodes identified are then sectioned with variable number of slides prepared for histological evaluation, the number depending on the size of the lymph node. This method contributes to the lack of recovery of nodes as well as sampling error from those obtained. Further errors may occur when lymph node levels are arbitrarily assigned by the pathologist rather than being specifically indicated by the surgeon.

The nodal status of the neck is important in patients who have a primary tumor which is amenable to surgery alone, but have a likelihood of producing nodal metastasis. Excellent examples of this include patients with large T2NO and T3NO squamous cell carcinomas (SqCCa) of the FOM. the incidence of occult metastases is reported to be 10-30%. Expectant observation, radiotherapy and elective nodal dissections are used to manage the clinically negative neck in FOM carcinoma. Neck dissection in the NO neck when all nodes are found to be histologically negative serves only as staging procedure. For this staging to be accurate, all nodes at risk of containing metastases must be removed. This requires bilateral neck dissection in patients with anterior FOM cancer. The morbidity, time and cost of elective neck dissections must be weighed against the risk of development of future cervical metastases. This risk is compounded by the poor rate of disease control with salvage surgery as compared to initial surgery.

A means of evaluations which provides an assessment of the actual presence of metastatic disease for preoperative planing and staging is desirable. Lymphoscintigraphy has been used to successfully manage patients with lymphoma, breast cancer and melanoma. Lymphoscintigraphy studies conducted to evaluate SqCCa of the head and neck have included variations in the method of injection of the radioactive colloid and the timing of the scanning. The results of its application to date have been inconsistent and disappointing.

EXPERIMENTAL DESIGN AND METHODS: (less than four pages)

The subjects for this project will include the first ten consecutive patients to present to the H. Lee Moffitt Cancer Center Head and Neck Clinic who give informed consent to participate and meet the following inclusion criteria: a diagnosis of T2, T3, or T4 SqCCa of the floor of mouth with a clinically negative neck (NO); medical clearance for surgical intervention. Exclusion criteria include: previous diagnosis of SqCCa for this anatomical site; previous surgical intervention or radiotherapy to the neck.

The patients will be evaluated in the routine manner in the head and neck clinic and surgical treatment plan will be determined according to current standards. Lymphoscintigraphy shall be performed on the morning the patient is scheduled for surgery. An ENT physician will identify the floor of mouth tumor and place a butterfly needle into the tissue. A licensed nuclear medical technologist or a physician who is an authorized user on H. Lee Moffitt's Radioactive Material License will inject 25OuCi of 99m Tc-sulfur Colloid through an adapter. Injections will be made approximately I cm from the outer edge of the tumor at 12:00, 3:00, 6:00, and 9:00 positions. Immediately following the injection, a Sentinel Flow Scan will be acquired using the Gamma Camera. If the sentinel node is identified it will be tattooed.

The patient shall undergo his/her planned surgical procedure in the afternoon. The initial portion of the procedure shall involve the resection of the primary tumor. Following resection, the primary specimen will be removed from the operative field, and stored appropriately for later transport to the pathology specimen holding room (Room 2175). Frozen section margins will then be obtained from the oral cavity. Each margin will be scanned for radioactivity level to ensure that the margin is below background prior to transport for frozen section analysis. In the event that the margin is above background level, a second margin will be obtained and scanned.

The neck dissection(s) will then be addressed. Palpation as well as the portable neoprobe detector will be used intra-operatively to identify any nodes which have been visualized by lymphoscintigraphy. Identified nodes will be tagged with suture material. the surgical neck specimen will be tagged during the dissection to indicate specific nodal levels and will be placed on the specimen board at the completion of the dissection. A portion of the identified lymph nodes, as well as a random sampling of nodes from each level will be dissected from the neck specimen and stored appropriately in liquid N_2 for later RNA extraction. The remainder of the specimen will be transported in an appropriate container to the pathology holding room (Room 2175) by a nuclear medicine technologist.

After 60 hours of decay, the specimens will be dissected and lymph nodes isolated. Each node shall be sectioned with a minimum of two slides and evaluated histopathologically. Portions of nodes previously stored for RNA extraction shall be lysed and RT-PCR with keratin primer (K19) will be performed. **The methods section would continue with an explanation of the RT-PCR analysis .....**

IV. H. BUDGET:

Lymphoscintigraphy

Technical Component	HLM Research Admin.	
Sentinel Flow		$144.00
Intraoperative Component		$459.00
Sulfur Colloid		$ 40.00
Total Technical Cost		$643.00
Professional Component	HLM Research Admin.	$ 57.00
Total Per Patient Cost		$700.00

Total Cost: 10 patients x $700.00/patient $7000.00

Lymph Node Testing

RNA Extraction		
Trizol 100ml	Gibco	$ 76.00
Buffer Reagents	Gibco	$100.00
Eppendorff Tubes	Fisher Scientific	$ 75.00
Pipet Tips	Fisher Scientific	$ 75.00
PCR Analysis		
PCR Amplification Kit	Perkin Elmer	$200.00
Taq Polymerase (x5)	Perkin Elmer	$250.00
Primers (4-6 x 20 bases each at $1.65/base)	IDT Technologies	$297.00
Electrophoresis		
Agarose		$200.00
Buffer Reagents		$200.00

Total Cost Lymph Node Testing: $1473.00

Total Project Costs: $8473.00

IV. I. APPENDIX D

EXAMPLE OF INSTITUTIONAL APPROVAL INFORMATION/SCHEDULE

Moffitt Project Review Deadline	**Moffitt Scientific Review Meeting**	**IRB Meeting**
09-30-98	10-19-98	12-07-98 12-15-98
10 -28-98	11-16-98	01-04-99 01-19-99
12-02-98	12-21-98	02- ? -99

* This is an **example** of an application deadline for a project that will be conducted at H.Lee Moffitt Cancer Center. IRB deadlines involve studies which will include human subjects.

** Projects which will be conducted at the H. Lee Moffitt Cancer Center must receive Scientific approval from the Moffitt committee before applications can be submitted to the IRB. Moffitt requires completion of all IRB application components as well as their own two page application form. The IRB will require all necessary forms as well as the approval letter from the Moffitt Scientific Review Committee.

Behavioral Science Deadline (IACUC)	**Behavioral Science Meeting (IACUC)**
09-14-98	09-25-98
10-12-98	10-23-98
11-09-98	11-20-98
12-07-98	12-18-98

* This is an **example** of an application deadline for a project that must be submitted to the IACUC. An IACUC application requests approval for studies which will include animal subjects.

** A project cannot include both human and animal subjects.

*** Please note that the James A. Haley VA also has a separate approval and review process. This is required for all studies that are to be conducted using VA facilities. IRB or IACUC approval must be received prior to application for VA approval.

IV. J. **SAMPLE IRB/MEDICAL STUDY APPLICATION**

IRB #:
Contact Person for IRB:
Address:
Telephone:
Fax:
E-Mail:

Note: The above will be used by the IRB for all outgoing IRB-related correspondence.

Institutional Review Board

University of South Florida
Medical Studies
Assurance No. M 1284

APPLICATION FOR IRB REVIEW OF RESEARCH INVOLVING THE USE OF HUMAN SUBJECTS

Type all answers

Check applicable boxes:
- ☐ New IRB Protocol (not previously reviewed)
- ☐ Revision(s) to Previously Submitted Application, IRB # _____.
- ☐ Requesting Exempt Category No. _____
- ☐ Requesting Expedited Category No. _____

1. General Personnel Information

Principal Investigator:
Social security number :
☐ Non-USF ☐ USF College/Department: Tel#:
Fax#:
E-mail:
Address:
Co-Investigator(s):

Study coordinator(s), degree(s): Tel#:
Fax#:
E-mail:

2. General Protocol Information

Title:
Protocol/Clinical ID No. Multi-Center Study? ☐ Yes # Ctrs.: ☐ No
Total project approval period being sought is: From: To:
Local number of subjects: ☐ Male ☐ Female Age range:
Sponsor/
Funding source:
Are you requesting dual enrollment exemption? ☐ Yes ☐ No If yes, list all IRB study numbers for which dual enrollment is being requested:

3. Institutions and/or Facilities Used in this Research (Attach Institution approval letter.)

☐ Tampa General	☐ All Children's	☐ USF Medical Clinics	☐ USF College of Nursing
☐ Moffitt Cancer Center	☐ Bay Pines VA	☐ JA Haley VA Hosp.	☐ USF College of Public Health
☐ Dept. of Health Clinics	☐ FMHI	☐ Other:	

4. Special or Vulnerable Study Subjects Involved in this Research: ☐ **N/A**

(Attach the appropriate informed consent document for each subject population checked)

☐ USF Medical Students (Attach approval letter from COM Medical Student Affairs Committee)
☐ USF Medical Residents (Attach approval letter from COM Graduate Medical Education Committee)
☐ Pregnant Women ☐ Children ☐ Embryos/fetuses ☐ Juvenile offenders ☐ Prisoners
☐ Persons with acute and/or severe mental/physical disabilities ☐ Elderly persons ≥ 65
☐ Non-English speaking persons-identify language: _____ (Attach translated consent.)

5. Drugs, Devices, and Procedures ☐ **N/A**

Indicate all of the items that apply to your research.

☐ Investigational New Drug—If IND issued, indicate name and no.: _____
☐ Investigational New Devices—If IDE issued, indicate name and no.: _____
Is this device Significant Risk or Non-Significant Risk? _____
☐ FDA approved drug(s) for unapproved use - if IND issued, name, #: _____
☐ FDA approved drug(s) ☐ Approved device for new use.
☐ Approved procedure that is not approved for indication.

6. Pharmacy and Laboratory Considerations ☐ **N/A**

Will a ***pharmacy*** be used in this study? ☐ Yes ☐ No
If yes, indicate the name and address: _____
If no, where and how will drug(s) be dispensed? _____
Drug administration mode: IV: ☐ IM: ☐ IP: ☐ PO: ☐ SC: ☐ PR: ☐ Other: _____
Please indicate the name(s) and degree(s) of each person who may be administering the drug(s).

_____

_____

Will a ***laboratory*** be used in this study? ☐ Yes ☐ No
☐ central lab ☐ local lab (provide name, address, and laboratory license no.)

_____

7. Radiation Considerations ☐ **N/A**

Approval of Human-Use Radiation Committee: ☐ Pending ☐ Approval date: _____
Approval of Radioactive Drug Research Committee: ☐ Pending ☐ Approval date: _____

8. Genetic Testing Considerations

Will anyone (local or otherwise) be doing any analyses of human genetic material obtained from subjects enrolled in this study? ☐ Yes ☐ No

If the answer to this question is yes, appropriate genetic consent language must be included in the consent form(s) used in this study.

Specify here what you will be testing for:

9. Biosafety Considerations ☐ **N/A**

Does this research involve use of any of the following?

Infectious agents (e.g., hepatitis-causing organisms)? ☐ Yes ☐ No
Regulated toxins (e.g., botulinum toxin)? ☐ Yes ☐ No

Xenotransplantation (cells/tissues/organs from other species into humans)?	☐ Yes	☐ No
Any recombinant DNA technology?	☐ Yes	☐ No
Human Gene Therapy procedures?	☐ Yes	☐ No

If the answer to any of the questions above is yes, this project must be approved by the USF Institutional Biosafety Committee and have IRB approval before the project can begin. Contact Dennis Freeman at (813) 974-7104 for more information.

10. Protocol Design and Subject Specifications

- State either the hypothesis to be tested or the objectives of the proposed research.

- Provide the relevant background pertinent to the hypothesis including the rationale for the experimental procedure, drug, biologic and/or device (limit your answer to 150 words or less).

- Provide a summary of the clinical procedure: standard vs. protocol.

- Describe the source and selection method of the experimental and control subjects. If you are advertising for research subjects, indicate the type of advertising and attach a copy of your advertisement for review. *All advertising must be approved by the IRB before use.*

- Describe the inclusion/exclusion criteria of each subject population.

- Describe the anticipated benefits to subjects in this research.

- Describe the risks and side effects (physical, psychological, and social) to subjects in this research. **List any precautions you are taking to minimize these risks.**

- Describe your consent process: How you will obtain informed consent and how you will ensure confidentiality of the subject.

- List any cost/financial remuneration to the subject as a result of participating in this research.

11. Principal Investigator's Statement of Assurance

The proposed investigation involves the use of human subjects. I am submitting this form with a description of my project prepared in accordance with the University of South Florida's and its affiliates' policies for the protection of human subjects participating in research. I certify that I have either read “The Belmont Report” or viewed the IRB instructional videotapes, and have read USF's Multiple Project Assurance. I understand the University’s policies concerning research involving human subjects and agree to:

a. obtain voluntary informed consent of subjects capable of providing consent who are requested to participate in this project;
b. report to the IRB any serious or unexpected on-site or off-site adverse events within the appropriate reporting period;
c. cooperate with the IRB in the continuing review of this project (submit Research Progress Reports);

d. obtain prior approval from the IRB before amending or altering the scope of the project or implementing changes in the approved informed consent form (submit Change in Procedure Application);
e. maintain documentation of informed consent forms and progress reports as required by institutional and federal policies (see IRB handbook or our Web site for more information);
f. accept the responsibility for the conduct of this research and the supervision of human subjects as required by law and as documented in the USF Multiple Project Assurance guidelines and USF policies and procedures.

_____ _____

Signature of Principal Investigator Date

12. Signature Requirements

A. Scientific Review

Scientific Review must be conducted by a member of the principal investigator's department or centrally by an affiliate's research administration branch.

This application and protocol have been reviewed for scientific merit and meet departmental/affiliate standards.

_____ _____ _____ _____

Signature of Scientific Reviewer Title Department Date

Scientific Reviewer's name (typed or printed): _____

B. Approval of Department Chairperson

_____ _____

Signature of Chairperson Date

Chairperson's name (typed or printed): _____

C. Co-Investigator(s) and Study Personnel Agreement

By this signature, I acknowledge my role in this research study, and will abide by policies of the University of South Florida and its affiliates.

Name	**Degree(s)**	**Role in Study**	**Signature**

To qualify for protocol submission process, you must submit the following:

1. four copies of the research protocol;
2. four copies of any investigator's brochure relating to the protocol.;
3. one copy of the informed consent form(s) for adults, children, or both, as applicable, along with one copy of any necessary informed consent form translations;
4. any documents, certifications, or licensure requested above;
5. if this is a federally funded project you **must** submit a full and complete copy of the appropriate grant application;
6. The original IRB application, the text of any advertisements, physician's letters, affiliate approval letters, etc.

Incomplete submissions *will* be returned without being processed.

Please return this application and any of the above attachments to:

USF Campus:	MDC 035
Off-campus mailing:	Division of Research Compliance 12901 Bruce B. Downs Blvd. MDC 35 Tampa, FL 33612
To hand-deliver:	University Professional Center 3500 E. Fletcher Ave., Suite 518 Tampa, FL 33613
Our phone number:	813-974-5638

IV.K. SAMPLE IRB/CHART REVIEW APPLICATION

Institutional Review Board

University of South Florida--Medical Studies--Assurance No. MPA 1284

Application for IRB Review of Research Involving Human Subjects
Chart Review

TYPE ALL ANSWERS

DO NOT WRITE IN SHADED AREAS
USE MOST RECENT VERSION LOCATED At www.research.usf.edu/cs/download.htm

IRB#_____ Review Category _____ Protocol Status_____
Submission Date _____ Approval Date _____
Approval Period from:_____
to:_____

1. GENERAL INFORMATION
PRINCIPAL INVESTIGATOR:

AFFILIATION: (circle one) USF OR NonUSF	**DEPARTMENT:**
ADDRESS:	**TEL#/FAX:**
CO-INVESTIGATORS/CONTACT PERSON	**TEL#/FAX:**

2. TITLE OF PROTOCOL:

3. WHAT IS THE OBJECTIVE/PURPOSE OF STUDY?

4. NUMBER OF CHARTS TO BE REVIEWED?

5. SOURCE (LOCATION) OF CHARTS?

6. DATA TO BE COLLECTED FROM CHARTS?

7. PLEASE DON'T FORGET TO ATTACH PROTOCOL. (The title of the protocol must match the title on this application.)

8. CONFIDENTIALITY (check appropriate box(es):

	Unlinked data - Data will be recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subject (no codes or links of any sort will be maintained)
	Linked data -Subject names and other unique identifying information will not be published but a list will be maintained that links subject to data recorded (a consent form is attached or a waiver has been requested that meets criteria listed below)
	Requesting a waiver of consent because research meets all of the following criteria: **The research will not involve greater than "minimal risk" to the subject** **It is not practicable to conduct research without waiver** **Waiving will not adversely affect subject's rights** **If appropriate, information will be provided to subject later**

9. STATEMENT OF ASSURANCE

The proposed investigation involves the use of human subjects. I am submitting this form with a description of my project prepared in accordance with the University of South Florida and its affiliates policies for the protection of human subjects participating in research. I certify that I have either read "The Belmont Report" or viewed the IRB instructional videotapes, and have read the Assurance. I understand the University's policies concerning research involving human subjects and agree to:

a. obtain voluntary and knowing informed consent of subjects capable of providing consent who are requested to participate in this project (if applicable);
b. report to the IRB any unanticipated effects on subjects which become apparent during the course or as a result of experimentation and the actions taken as a result;
c. cooperate with the IRB with the continuing review of this project (IRB form 2) (if applicable),
d. obtain prior approval from the IRB before amending or altering the scope of the project or implementing changes in approved consent form (IRB Form 3);
e. maintain documentation of consent forms and progress reports as required by institutional and Federal policies (IRB handbook);
f. accept the responsibility for the conduct of this research and the supervision of human subjects as required by law and as documented in the USF Multiple Project Assurance.

10. SIGNATURE REQUIREMENTS

_____ _____

Signature of Principal Investigator Date

_____ _____

Reviewer Signature/Printed Name Date

(The application and related protocol described above have been reviewed by department chairperson, faculty member, or supervisor.)

_____ _____

Signature of Co-Investigator/Study Personnel Signature of Co-Investigator/Study Personnel

Please return this application and protocol to: 12901 N. Bruce B. Downs MDC Box 35
Division of Research Compliance Tampa, FL 33612

VI. A. <u>Causes for Immediate Dismissal</u>

1. Failure to be present during duty hours or when on call.

2. Intoxication or imbibing of alcohol or use of illicit drugs while on duty or on call.

3. Conviction of a felony or violation of federal, state, or local narcotics law.

4. Falsification of medical records.

5. Patient neglect resulting in injury or harm to the patient.

6. Performance of invasive procedures without appropriate authorization, except in definite life-threatening situations.

7. Failure to maintain academic standards and educational requirements of the program.

8. Falsification of data on your application.

9. Performing operating room procedures without proper attending supervision.

10. Failure to give emergency help to all patients at all times throughout the hospital, regardless of whether the patient is on the service or not.

11. Repeated violation of Program rules after counseling, warning, and a probation period.

Failure of the resident to perform in a timely manner those items which are deemed necessary for the required accreditation of this program (operative logs; faculty appraisals; research block preparation & completion) and those items specifically requested for the necessary administration of this program may result in disciplinary action for that resident.

VI. B. Evaluation

There is no guarantee that a resident will successfully complete his/her specialty training at the University of South Florida College of Medicine. Each resident is evaluated four times per year by attending faculty. In addition, the nursing staff also evaluates all residents. The forms, located in the EVALUATIONS section of the orientation manual, should aid you in understanding the qualities expected of a resident.

All residents will take the annual Otolaryngology Training Examination (In-Service) and Standardized Oral Examination. **The following scores are the minimum requirement to avoid the disciplinary and remedial process:**

Otolaryngology Year	In-Service Composite Score	Standardized Oral Exam Score	Clinical Composite Evaluation Score
PGY -1	Z score > -1 *(using the mean for you year of training)*	7.0	7
PGY-2	Z score > -1 *(using the mean for you year of training)*	7.0	7
PGY-3	Z score > -1 *(using the mean for you year of training)*	8.0	7
PGY-4	Z score > -1 *(using the mean for you year of training)*	9.0	7
PGY-5	Z score > -1 *(using the mean for you year of training)*	9.0	7

***Z-score is arrived at by: score – mean ÷ Standard Deviation = Z Score**

Performance on the Otolaryngology Training Examinations, the Standardized Oral Examinations and quarterly evaluations by faculty and nursing staff will be used to determine whether or not a resident will continue in the residency program. The Program Director will meet with each resident individually, on a quarterly basis, to review these evaluations, Home Study Course Scores and your quarterly operative logs.

Residents who do not meet expected standards at any time during the academic year will receive oral and written communication from the Program Director. Progressive disciplinary status will be addressed using the following guidelines, which will always be in writing and will become a part of your permanent file:

1. Counseling: The resident is told of deficiencies that must be corrected.

2. Warning: A warning is issued if the problem persists or additional problems arise.

3. Probation: Continued deficiencies.

4. Discontinuation (Termination or Suspension): See this Section in the University of South Florida, College of Medicine, Resident Policies and Procedures.

Completion of any year of residency requires a core of operating experience. Any resident who misses 10% of his/her operating time may not be eligible for promotion.

VI. C. Standardized Oral Examination

Given annually, near the time of the Otolaryngology In-training Examination, the Department conducts a Standardized Oral Examination (Miniboards). Miniboards are given on an annual basis to assess your ability to appropriately process information given in oral format. The examination is structured to parallel the Oral Board Examination given by the American Board of Otolaryngology. Miniboards will consist of eight ½ hour discussions of case presentations. The topics include Facial Plastic & Reconstructive Surgery, Head and Neck Surgery, Otology and General Otolaryngology. You will be given a case presentation and asked a series of questions that will test your skills in history taking, physical examination skills, the ordering of appropriate tests, the interpretation of these tests, the formulation of a differential diagnosis, the correlation of pathological findings and medical and/or surgical management of these cases.

The examination will be graded on a scale of 12 points total per question. A total of 4 points can be obtained for each of the following categories: data gathering and interpretation, differential diagnosis/working diagnosis, management and treatment. There are minimum requirements for scores based on PGY level that have been deemed acceptable by the Residency Education Committee in the Department of Otolaryngology. These can be found in the table included in this section. Final scores will be discussed with the residents on a one-to-one basis with the Program Director at their quarterly evaluation following the exam.

VI. D.

Faculty Evaluation of Resident Presentations
Grand Rounds

Presenter:

Title:

Date of Presentation:

Objectives: 1)
2)
3)

	Outstanding	Very Good	Average	Marginal	Poor
1. Degree to which presentation met stated objectives	☐	☐	☐	☐	☐
2. Review of relevant literature	☐	☐	☐	☐	☐
3. Presenter's knowledge of subject	☐	☐	☐	☐	☐
4.Presenter's delivery (speaking style, clarity, communication skills, ability to maintain interest)	☐	☐	☐	☐	☐
5. Content of presentation	☐	☐	☐	☐	☐
6. Organization of presentation	☐	☐	☐	☐	☐
7. Presenter's ability to respond to questions	☐	☐	☐	☐	☐
8.Quality/effectiveness of audio-visual aids	☐	☐	☐	☐	☐
9. Overall evaluation of presentation	☐	☐	☐	☐	☐

KEY:

Outstanding	5
Very Good	4
Average	3
Marginal	2
Poor	1

AVERAGE:_____

Evaluated by:_____

VI. E.

DEPARTMENT OF OTOLARYNGOLOGY-HEAD AND NECK SURGERY
UNIVERSITY OF SOUTH FLORIDA

RESIDENT EVALUATION FORM
xxxx - xxxx

RESIDENT: _____, M.D. July – Sept. / Quarter 1
PGY-__ / OTO-__

A. Your relationship to Resident

___ Director of Otolaryngology Residency Program
___ Full-time Faculty
___ Clinical or Voluntary Faculty

B. Familiarity with resident's practice

___ Not familiar
___ Slightly familiar
___ Moderately familiar
___ Very familiar

C. Contact with resident

___ Surgery
___ Clinical
___ Surgery & Clinical
___ None

PLEASE MAKE COMMENTS SO THAT WE MAY GIVE ANONYMOUS FEEDBACK TO THE RESIDENT. ANY NUMERIC SCORE OF LESS THAN 7, PLACING THE RESIDENT IN A CATERGORY OF MARGINAL OR POOR, **MUST** HAVE COMMENTS OR THEY WILL BE RETURNED.

Factor 1. ***INFORMATION GATHERING***: This factor is concerned with Resident's willingness, ability and skill in gathering information necessary for diagnosis.

The **INEFFECTIVE** Resident limits his interview and physical examination to the area of complaint and fails to pursue alternative hypotheses. Resident frequently uses therapy to substantiate clinical impressions.

The **EFFECTIVE** Resident routinely takes a comprehensive initial history and physical examination. he/she records the information received in a systematic fashion, and pays careful attention to progress notes. Resident is aware of information other than the medical and indicates this by initiating further procedures and questions.

___	___ ___ ___	___ ___ ___	___ ___ ___	___ ___ ___
00	01 02 03	04 05 06	07 08 09	10 11 12
	POOR	MARGINAL	GOOD	EXCELLENT

Factor 2. ***PROBLEM SOLVING***: This factor is concerned with the Resident's ability and skill in using information gained to develop a diagnosis and support clinical activity.

The **INEFFECTIVE** Resident has an incomplete comprehension of the implications of the data he/she has collected. Resident is unable to interpret unexpected results and often ignores them. Resident makes decisions on the basis of experience, disregarding the context in which that experience was gained. His/her thinking is rigid and unimaginative, impeding his/her recognition of associated problems.

The **EFFECTIVE** Resident realizes the importance of unexpected findings and seeks to determine their implications. Resident understands the nature of probability and uses this to illuminate his/her experience. Resident takes all the data into account before reaching a decision, and routinely tests alternative hypotheses.

___	___ ___ ___	___ ___ ___	___ ___ ___	___ ___ ___
00	01 02 03	04 05 06	07 08 09	10 11 12
	POOR	MARGINAL	GOOD	EXCELLENT

Factor 3. ***CLINICAL JUDGEMENT***: This factor is concerned with the Resident's ability to use sound judgement in planning for and carrying out treatment.

The **INEFFECTIVE** Resident is overly concerned with treatment techniques at the expense of overall goals. Resident often delegates pre- and postoperative care to others. Resident plans treatment without sufficient familiarity with the procedures he/she selects. His/her treatment choice is rigid - using a set formula for treating each clinical problem or using a favorite technique when more effective ones are available.

The **EFFECTIVE** Resident is familiar with the uses and limitations of the procedures he/she attempts. Resident recognizes his/her own capabilities and uses procedures which correspond to them. Resident considers simple procedures first. His/her clinical judgement encompasses information beyond the pathologic. Resident demonstrates regard for patients' needs, desires and life conditions. Resident is flexible enough to modify his/her treatment plans when the situation warrants doing so.

___	___ ___ ___	___ ___ ___	___ ___ ___	___ ___ ___
00	01 02 03	04 05 06	07 08 09	10 11 12
	POOR	MARGINAL	GOOD	EXCELLENT

Factor 4. ***SURGICAL TECHNIQUE***: This factor is concerned with the Resident's ability and skill in carrying out operative procedures.

The **INEFFECTIVE** Resident has insufficient skill for the procedures he/she attempts. His/her overall handling of instruments and tissue lacks finesse. His/her operating time is often prolonged through unfamiliarity with procedures or inadequate planning. Resident takes unnecessary operative risks or terminates operation before maximum results are achieved.

The **EFFECTIVE** Resident handles tissues gently, uses careful hemostasis, and makes a proper and adequate exposure of the operating field. Resident carefully attends to details such as sterilization of instruments and proper choice of same. Resident carefully monitors his/her patient during operative procedure. Resident applies appropriate dressings and other postoperative devices.

___	___ ___ ___	___ ___ ___	___ ___ ___	___ ___ ___
00	01 02 03	04 05 06	07 08 09	10 11 12
	POOR	MARGINAL	GOOD	EXCELLENT

Factor 5. ***RELATING TO PATIENT***: This factor is concerned with the Resident's effectiveness in working with patients.

The **INEFFECTIVE** Resident does not communicate with his/her patients, either through aloofness, indifference or the pressure of time. Resident has difficulty understanding patient needs. Resident is unable to evoke patient confidence, tending even to alarm them. Resident reacts negatively to hostility or other emotional displays.

The **EFFECTIVE** Resident's manner elicits patient confidence and cooperation and relieves anxiety. Resident is interested in his/her patient's well-being and demonstrates this without becoming emotionally involved. Resident is honest with the patient and patient□s family. Patients like him/her and readily feel they can ask questions and discuss problems with him/her.

___	___ ___ ___	___ ___ ___	___ ___ ___	___ ___ ___
00	01 02 03	04 05 06	07 08 09	10 11 12
	POOR	MARGINAL	GOOD	EXCELLENT

Factor 6. ***CONTINUING RESPONSIBILITY***: This factor is concerned with the Resident's willingness to accept the responsibility for long-term patient care.

The **INEFFECTIVE** Resident either losses interest after initial treatment or does not take the time for adequate follow-up. Resident becomes discouraged with slow progress and cannot cope with a poor prognosis. Resident is unable to communicate realistic expectations to the patient. His/her utilization of support personnel is either inadequate or Resident expects assistance beyond their capabilities and training.

The **EFFECTIVE** Resident is able and willing to work with the patient to achieve maximum rehabilitation. Resident monitors patient's progress, altering therapy or treatment as indicated. Resident understands the roles of various allied health professions and makes maximum use of their assistance. Resident maintains a positive and persistent attitude toward recovery.

___	___ ___ ___	___ ___ ___	___ ___ ___	___ ___ ___
00	01 02 03	04 05 06	07 08 09	10 11 12
	POOR	MARGINAL	GOOD	EXCELLENT

Factor 7. ***EMERGENCY CARE***: This factor is concerned with the Resident's ability to act effectively in emergency situations, in the operating theater or the emergency room.

The **INEFFECTIVE** Resident panics easily and makes inappropriate use of time available. Resident becomes confused under pressure and has difficulty establishing priorities. Resident is unable to delegate aspects of care to others. Resident is careless about applying protective measures. Resident is unable to make decision alone.

The **EFFECTIVE** Resident quickly assesses the situation, pays attention to lifesaving procedures and demonstrates understanding of triage concepts. Resident is able to obtain and organize assistance of others. Resident is able and willing to make decisions alone if necessary. Resident is aware of the consequences of delay.

___	___ ___ ___	___ ___ ___	___ ___ ___	___ ___ ___
00	01 02 03	04 05 06	07 08 09	10 11 12
	POOR	MARGINAL	GOOD	EXCELLENT

Factor 8. ***RELATING TO COLLEAGUES***: This factor is concerned with the Resident's ability to work effectively with his colleagues and other members of the health team.

The **INEFFECTIVE** Resident has difficulty relating to others and lacks the ability either to give or take instruction gracefully. Resident tends to be tactless and inconsiderate and does not evoke the confidence and cooperation of those with whom he/she works. Resident habitually gives unsolicited advice, and in an offensive manner. Resident is unwilling to make referrals or seek consultation and fails to support his colleagues in their contacts with his patients.

The **EFFECTIVE** Resident relates well to others and communicates easily, working well in a team situation. Resident seeks consultation when appropriate and respects other's views. Resident demonstrates self-control. Resident gives credit to others for their contributions and creates an atmosphere of working together - not working for.

___	___ ___ ___	___ ___ ___	___ ___ ___	___ ___ ___
00	01 02 03	04 05 06	07 08 09	10 11 12
	POOR	MARGINAL	GOOD	EXCELLENT

Factor 9. ***MORAL AND ETHICAL VALUES***: This factor is concerned with the Resident's attitude and standards as an individual.

The **INEFFECTIVE** Resident attempts to cover up his/her errors. Resident is frequently absent from assigned duty or unavailable when needed. Resident has unethical contacts with nonmedical professions and allows his personal finances to unduly influence treatment. Resident discusses medical mismanagement with patients.

The **EFFECTIVE** Resident's conduct reflects kindness, respect, honesty and humility. Resident reports facts accurately, including his own errors. Resident respects the confidence of colleagues and patients. Resident places patient care above personal considerations. Resident respects the property of others. Resident recognizes his own professional capabilities and limitations.

___	___ ___ ___	___ ___ ___	___ ___ ___	___ ___ ___
00	01 02 03	04 05 06	07 08 09	10 11 12
	POOR	MARGINAL	GOOD	EXCELLENT

Factor 10. ***OVERALL COMPETENCE***: This factor is concerned with your judgment of the Resident's overall competence, taking into account Factors 1 through 9.

00	01 02 03	04 05 06	07 08 09	10 11 12
	POOR	MARGINAL	GOOD	EXCELLENT

Did the resident meet the required goals and objectives for their level of training for this rotation?

☐ **YES** ☐ **NO**

ADDITIONAL COMMENTS: **You are encouraged to comment below on any or all of resident factors in this evaluation form or to bring additional information to our attention. Please attach extra sheets if necessary.**

V.F. Quarterly Summary

Evaluation Summary

QUARTER:_____ **RESIDENT:_____**

FACULTY #	1	2	3	4	5	6	7	8	9	10	11	12	AVERAGE
Information Gathering													
Problem Solving													
Clinical Judgment													
Surgical Technique													
Relating to Patient													
Continuing Responsibility													
Emergency Care													
Relating to Colleagues													
Moral and ethical Values													

COMMENTS: SEE NEXT PAGE

KEY
Poor: 1,2,3
Marginal: 4,5,6
Good: 7,8,9
Excellent: 10,11,12
* : Not evaluated or insufficient Information to judge

VI. G. DEPARTMENT OF OTOLARYNGOLOGY-HEAD AND NECK SURGERY
UNIVERSITY OF SOUTH FLORIDA
FACULTY EVALUATION FORM / ACADEMIC YEAR XXXX-XXXX

Faculty Member: _____, M.D.

1=ineffective 5=very effective

1. Teaching ability and commitment. *(Click choice and write comments)*

1☐ 2☐ 3☐ 4☐ 5☐

Comments:

---

2. Clinical Knowledge.

1☐ 2☐ 3☐ 4☐ 5☐

Comments:

---

3. Scholarly Contributions.

1☐ 2☐ 3☐ 4☐ 5☐

Comments:

---

4. Overall

1☐ 2☐ 3☐ 4☐ 5☐

Comments:

Faculty: 1= poor educator or resource 5= Excellent educator or resource

(Please click in your selection)

Also evaluate full-time faculty on previous individual forms.

PHYSICIAN	TEACHING	KNOWLEDGE	CONTRIBUTIONS
Full-time Faculty	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Dr. Thomas McCaffrey	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Dr. Paul Boyev	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Dr. Matthew Kienstra	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Dr. Judith McCaffrey	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Dr. Tapan Padhya	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Dr. Yash Patil	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Dr. Marion Ridley	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Dr. Jonathan Morgan	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Clinical Faculty			
Dr. William Alonso	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Dr. Thomas Andrews	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Dr. Loren Bartels	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Dr. Nelson Castellano	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Dr. Wade Cressman	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Dr. Edward Farrior	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Dr. Jay Farrior	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Dr. Richard Farrior	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
Dr. Peter Orobello	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐

VI. H. DEPARTMENT OF OTOLARYNGOLOGY-HEAD AND NECK SURGERY
UNIVERSITY OF SOUTH FLORIDA
PROGRAM EVALUATION FORM / ACADEMIC YEAR XXXX-XXXX

Please answer these questions 1-5, 1=not valuable 5=very valuable

Curriculum: *(Click choice)*	**1**	**2**	**3**	**4**	**5**
Tuesday Core Lecture	☐	☐	☐	☐	☐
Wednesday am Conference	☐	☐	☐	☐	☐
Tumor Board / Moffitt	☐	☐	☐	☐	☐
Tumor Board / VA	☐	☐	☐	☐	☐
Mon/Fri AM Conferences	☐	☐	☐	☐	☐
Temporal Bone Course	☐	☐	☐	☐	☐
Anatomy/Bronch Course	☐	☐	☐	☐	☐
Mini Boards	☐	☐	☐	☐	☐
Videostroboscopy Conference	☐	☐	☐	☐	☐

Comments: *(what changes would you suggest?)*

Rotations:	**1**	**2**	**3**	**4**	**5**
VA	☐	☐	☐	☐	☐
MOFFITT	☐	☐	☐	☐	☐
TGH	☐	☐	☐	☐	☐
ACH	☐	☐	☐	☐	☐
OTO/FPS	☐	☐	☐	☐	☐

Comments: *(what changes would you suggest?)*

Facilities: (1=poor / 5=outstanding)	**1**	**2**	**3**	**4**	**5**
Temporal Bone lab	☐	☐	☐	☐	☐
Library	☐	☐	☐	☐	☐
Computer Network	☐	☐	☐	☐	☐
Teaching resources availability					
-Journals	☐	☐	☐	☐	☐
-Videos	☐	☐	☐	☐	☐
Audio Visual	☐	☐	☐	☐	☐
Research Laboratories	☐	☐	☐	☐	☐

Learning Opportunities:	**1**	**2**	**3**	**4**	**5**
Practice Management	☐	☐	☐	☐	☐
Medical Ethics	☐	☐	☐	☐	☐
Teaching Techniques	☐	☐	☐	☐	☐
Research Techniques	☐	☐	☐	☐	☐

What do you feel can be done differently to make this a better training program?

Other Comments re: call, scheduling, staffing, or assignments?

VII. A. INTRODUCTION TO OPERATIVE LOG

Yearly reports are required for residents in the Otolaryngology Training Program by the American Board of Otolaryngology. This report includes the Resident Operative Experience Report. A log of your operative experience must be kept up-to-date and input into the American Board of Otolaryngology website on a yearly basis. In addition, residents are now also required to input cases on a monthly basis to ACGME Resident Case Log System, which will be monitored for compliance by the Program Director. This log should include every case performed from the first day of Otolaryngology training until the last.

Residents must turn into the Program Director an operative log on a monthly basis. Backup for the numbers reported should be kept by the resident, such as imprints of the patients hospital plate, including the medical record number, the date of procedure, and the procedure performed.

Procedures are counted as listed on the Operative Experience Report by CPT code. The number of other procedures should be kept to a minimum, and procedures should be counted within a designated category if it is feasible to do so. Procedures should not be unbundled, e.g. if a partial glossectomy is performed in conjunction with a neck dissection, this should be counted as one procedure on the Operative Log under CPT code #41135. There are numerous explanatory notes on the actual Operative Log instructing you on how to count procedures. For example following mandibular resection are the words independent procedure in parentheses. This means that this procedure would be used only for a separately performed mandibular resection, and not for a mandibular resection as part of a larger composite resection of the tongue, jaw and neck. Neck dissections are to be counted only when they are not specifically described with a procedure. In the event that a total laryngectomy and bilateral neck dissections were performed, the procedure would be coded as one CPT #31365 and one CPT #38724 or 38720. There are specific instructions to count patients (not procedures) undergoing myringotomy and tube, tonsillectomy, turbinate resection, Caldwell-Luc and endoscopic sinus surgery. A typical panendoscopy would count as three procedures, i.e. laryngoscopy, bronchoscopy and esophagoscopy.

It is of the utmost importance to report accurate and verifiable information concerning your operative experience. You will be required to sign your Operative Experience Report attesting to its veracity. All reports are subject to audit with the requirement that you provide verifiable documentation of your experience. Any misrepresentation of your operative experience, either intentional or inadvertent, is grounds for disciplinary action including termination.

Questions regarding how a specific procedure should be counted may be directed to the attending physician directly responsible for the case.

Keeping a “running count” of your cases in a notebook, for example, on a daily basis is the best way to avoid any “last minute” furious data collection.

VII. B. DEFINITION OF SURGEON

As Defined by the Accreditation Council for Graduate Medical Education Residency Review Committee for Otolaryngology.

I. Definitions of the 3 Levels of Resident Involvement in Surgical Procedures

Resident Supervisor
A resident supervisor instructs, and assists as needed, a more junior resident during a procedure during which the junior resident performs greater than or equal to 50% of the operation, including the key portion(s) of the procedure. The attending functions as an assistant or observer.

Resident Surgeon
A resident surgeon performs greater than or equal to 50% of the operation with the attending surgeon (and resident supervisor, if applicable), including the key portion(s) of the procedure.

Assistant Surgeon*
An assistant surgeon performs less than 50% of the operation, or greater than or equal to 50% of the operation but not the key portion(s) of the procedure.
* =it is expected that a resident will observe and/or assist with a procedure (with a complex procedure, probably as assistant/observer on multiple occasions) before performing the procedure as resident surgeon

Examples of the Classification of Resident Involvement in Surgical Procedures

Scenario 1
A patient undergoes a total laryngectomy and radical neck dissection performed by an attending, a chief resident and a junior resident. The chief resident guides and assists the junior resident who performs over 50% of the key components of the radical neck dissection. The attending and the chief resident perform the total laryngectomy with the chief resident performing over 50% of the key portions of the laryngectomy.

	Neck dissection	**Laryngectomy**
Chief resident	Resident Supervisor	Resident Surgeon
Junior resident	Resident Surgeon	Resident Assistant

Scenario 2
A patient undergoes a hemiglossectomy, ipsilateral selective neck dissection, tracheotomy and radial forearm free flap. The senior resident supervises and assists the junior resident while the junior resident performs over 50% of the tracheotomy and the neck dissection, including the key portions of those procedures. The attending supervises the senior resident in the hemiglossectomy, of which the senior resident performs over 50%, including the key portion of that procedure. The junior resident assists during this part of the procedure, then leaves. The attending then harvests the radial forearm free flap and does the vessel work with the assistance of the senior resident, and the senior resident then performs the closure of the oral defect with the flap.

	Neck Dissection / Tracheotomy	**Hemiglossectomy**	**Radial Forearm Free Flap**
Senior resident	Resident Supervisor	Resident Surgeon	Resident Assistant
Junior resident	Resident Surgeon	Resident Assistant	

Scenario 3
A chief resident performs, under the attending's supervision, a mastoidectomy. The junior resident observes the procedure in the OR.

	Mastoidectomy
Chief resident	Resident Surgeon
Junior resident	Resident Assistant

Scenario 4
A patient undergoes a parotidectomy for a tumor. The resident makes the skin incision and does the bulk of the dissection approaching the facial nerve. The attending then identifies the facial nerve, removing the tumor with the resident making the cuts in the parotid while the attending traces the nerve with a hemostat.

	Parotidectomy
Resident	Resident Assistant

Scenario 5
A patient undergoes bilateral endoscopic ethmoidectomy. The chief resident does the left side with the junior resident observing in the OR. The junior resident performs the procedure on the right side under chief resident.

	Left ethmoidectomy	Right ethmoidectomy
Chief resident	Resident Surgeon	Resident Supervisor
Junior resident	Resident Assistant	Resident Surgeon

Scenario 6
A patient undergoes a total thyroidectomy with a single selective neck dissection. The attending assists the senior resident during one thyroid lobectomy, and then the senior resident supervises the junior resident during the contralateral lobectomy. Both residents remain scrubbed the entire time. The senior resident then performs the entire neck disection with the attending and junior resident assisting.

	Thyroid Lobectomy 1	Thyroid Lobectomy 2	Neck Dissection
Senior resident	Resident Surgeon	Resident Supervisor	Resident Surgeon
Junior resident	Resident Assistant	Resident Surgeon	Resident Assistant

II. "Unbundling" of CPT codes for the Purpose of Reporting Resident Case Experiences

Case Experiences Current Procedural Terminology (CPT) codes are assembled by the American Medical Association, with specialty society input, and are updated yearly. These codes form the basis on which physician charges are enumerated, and there is a detailed set of rules regarding what services/procedures can be reported separately, and which are "bundled", i.e., reported under 1 code. For example, there is a code for total laryngectomy (#31360), and for modified neck dissection (#38724), but if the total laryngectomy and the neck dissection are performed during the same operative session, the combination is "bundled" under one code, namely #31365 (total laryngectomy with neck dissection).

The Residency Review Committee for Otolaryngology and the American Board of Otolaryngology seek to capture all procedures done by each resident. Therefore, for the purposes of reporting your operative experiences on the ACGME site, "unbundling" is allowed under a variety of circumstances. In addition, all bilateral procedures, except myringotomy and insertion of pressure equalization tubes, or tonsillectomy, are reported as two separate procedures (e.g., bilateral ethmoidectomy reported as right ethmoidectomy as one procedure and left ethmoidectomy as another procedure).

Please remember that "unbundling" of procedures, and the examples that follow, are for resident case reporting purposes ONLY, and it is illegal (fraud) to "unbundle" for billing purposes.

Examples of "Unbundling" Acceptable in Reporting Resident Operative Experience (consult your faculty if questions on how to code any particular procedure.)

Examples in Reporting "Thyroidectomy, total or complete"

1. "Thyroidectomy, total or complete" (#60240 if done by one resident as surgeon)

2. "Total Thyroid Lobectomy, unilateral" (#60220 if each side done by a different resident as surgeon)

Examples in Reporting "Thyroidectomy, total or subtotal, with Limited Neck Dissection"

1. "Thyroidectomy, total or subtotal for malignancy; with limited n dissection" (#60252 if reported by one resident as surgeon)

2. "Thyroidectomy, total or complete" (#60240 if one resident performs the thyroidectomy as surgeon, and "Cervical Lymphadenectomy" (#38720 or #38724, depending on extent of neck dissection, if another resident performs the lymphadenectomy as surgeon)

Examples in Reporting "Composite Procedure with Resection of Floor of Mouth Mandibular Resection, and Radical Neck Dissection"; plus "Tracheostomy"

1. "Composite Procedure with Resection of Floor of Mouth, Mandibular Resection, and Radical Neck Dissection" (#41155 if reported by one resident as surgeon);"Tracheostomy" (#31600 if reported by same or different resident as surgeon)

2. "Composite Procedure with Resection of Floor of Mouth and Mandibular Resection (#41145 if reported by 1 resident as surgeon); "Cervical Lymphadenectomy, complete" (#38720 if reported by another resident as surgeon); "Tracheostomy" (#31600 if reported by either resident above or a third resident as surgeon)

Examples in Reporting "Craniectomy, Bone Flap Craniotomy, Transtemporal (mastoid) for Excision of Cerebellopontine Angle Tumor"

1. "Craniectomy, Bone Flap Craniotomy, Transtemporal (mastoid) for excision of Cerebellopontine Angle Tumor" (#61526 if reported by one resident as surgeon)

2."Craniectomy, Bone Flap Craniotomy, Transtemporal (mastoid) for Excision of Cerebellopontine Angle Tumor" (#61526 if one resident as surgeon removes acoustic neuroma);

3. "Labyrinthectomy with Mastoidectomy" (#69910 if mastoidectomy and labyrinthectomy reported by another resident as surgeon)

Examples in Reporting"Tympanoplasty with Mastoidectomy, with Ossicular Reconstruction"

1. "Tympanoplasty with Mastoidectomy, with Ossicular Reconstruction" (#69642 if reported by one resident as surgeon)

2. "Mastoidectomy, Complete" (#69502 if reported by one resident as surgeon); "Tympanoplasty without Mastoidectomy, with Ossicular Chain Reconstruction" (#69632 if reported by another resident as surgeon)

Examples in Reporting "Rhinoplasty, complete, including Major Septal Repair"

1. "Rhinoplasty, complete, including Major Septal Repair" (#30420 if reported by 1 resident as surgeon)

2. “Rhinoplasty, complete” (#30410 if reported by one resident as surgeon); “Septoplasty” (#30520 if reported by another resident as surgeon)

Examples in Reporting ”Ligation Arteries: Internal Maxillary Artery Ligation, Transantral”

1. ‘Ligation Arteries: Internal Maxillary Artery Ligation, Transantral” (#30920 if reported by one resident as surgeon)

2. “Ligation Arteries: Internal Maxillary Artery Ligation, Transantral”(#30920 if 1 resident does artery identification and ligation/clipping in pterygomaxillary area as surgeon); “Sinusotomy, maxillary, radical (Caldwell-Luc) without removal of antrochoanal polyp” (#31030 if another resident performs Caldwell-Luc)

Examples in Reporting “Nasal/Sinus Endoscopy, Surgical, with Repair of CSF Leak; Sphenoid Region”

1. “Nasal/Sinus Endoscopy, Surgical, with Repair of CSF Leak; Sphenoid Region” (#31291 if reported by one resident as surgeon)

2. “Nasal/Sinus Endoscopy, Surgical, with Repair of CSF Leak; Sphenoid Region” (#31291 if one resident repairs CSF leak as surgeon); “Nasal/Sinus Endoscopy, Surgical, with sphenoidotomy” (#31288 if another resident performs sphenoid sinusotomy)

VII. C. RESIDENT OPERATIVE EXPERIENCE REPORT BY INSTITUTION

Resident: _____, **M.D.**

Time Period: **July 1, - Sept. 31, XXXX (1st Quarter)**

Note: The "OTHER" categories should be used sparingly and the operative procedures should be tallied into the closest grouping. **DO NOT** artificially separate closely related procedures.

S = Surgeon A = Assistant

PROCEDURES		TGH		VAH		HLM		ACH		ST. JOE		TOTALS	
		S	A	S	A	S	A	S	A	S	A	S	A
HEAD & NECK													
SALIVARY GLANDS													
Superficial Parotidectomy	42415												
Total Parotidectomy, VII Preserved	42420												
Parotidectomy with Nerve Graft	42425												
Submandibular Gland Excision	42440												
Peripharyngeal Space Tumor	42699												
Other													
NOSE & MAXILLA													
Rhinectomy, Partial	30150												
Rhinectomy, Total	30160												
Lateral Rhinectomy	30118												
Maxillectomy	31225												
Maxillectomy w/ Orbital Exenteration	31230												

PROCEDURES		TGH		VAH		HLM		ACH		ST. JOE		TOTALS	
		S	A	S	A	S	A	S	A	S	A	S	A
Excision Angiofibroma	42880												
Excision other Nasopharyngeal Tumor	42880												
Excision Tumor Ethmoid Cribriform Plate	31299												
Other													
LIPS													
Lip Shave	40500												
Wedge Resection Primary Closure	40520												
Excision with Flap Reconstruction	40525												
Other													
ORAL CAVITY													
Local Resection, Tumor of Oral Cavity	41116												
Hemiglossectomy	41130												
Partial Glossectomy w/o Neck Dissection	41120												
Partial Glossectomy w/ Neck Dissection	41135												
Composite Resection of Primary in Floor of Mouth, Alveolus, Tongue, Buccal Region, Tonsil or any combination	41155												
Mandibular Resection (independent procedure)	21044												

PROCEDURES		TGH		VAH		HLM		ACH		ST. JOE		TOTALS	
		S	A	S	A	S	A	S	A	S	A	S	A
Other													
EAR													
Excision Pinna	69120												
Temporal Bone Resection	69535												
Other													
NECK													
I & D Neck Abscess	21501												
Neck Dissections (count each side) -Complete	38720												
-Modified	38724												
Transsternal Mediastinal Dissection	21632												
Cervical Node Biopsy	38510												
Other													
LARYNX													
Thyrotomy (Laryngofissure)	31300												
Hemilaryngectomy	31370/75 or 31380/82												
Supraglottic Laryngectomy	31367												

PROCEDURES		TGH		VAH		HLM		ACH		ST. JOE		TOTALS	
		S	A	S	A	S	A	S	A	S	A	S	A
-with Neck Dissection	31368												
Total Laryngectomy	31360												
-with Neck Dissection	31365												
Laryngopharyngectomy	31390												
Surgical Speech Fistula	31611												
Repair Laryngeal Fracture	31584												
Laryngoplasty (includes laryngotracheoplasty)	31582												
Arytenoidectomy, Arytenoidpexy	31400												
Other													
OTHER													
Thyroid Lobectomy	60220												
Subtotal Thyroidectomy	60245												
Total Thyroidectomy	60240												
Parathyroidectomy	60500												
Cricopharyngeal Myotomy	43030												
Pharyngoesophagectomy	43105												
Cervical Esophagostomy for Feeding	43352												

PROCEDURES		TGH		VAH		HLM		ACH		ST. JOE		TOTALS	
		S	A	S	A	S	A	S	A	S	A	S	A
Pharyngeal Diverticulectomy/Pexy	43130												
Tracheotomy	31600												
Tracheal Resection with Repair	31780												
Major Vessel Ligation	35201												
Major Vessel Repair	37400												
Other													
CONGENITAL ANOMALIES													
Branchial Cleft Anomaly	42815												
Thyroglossal Duct Cyst	60280/81												
Dermoid	11420												
Lymphatic Vascular Malformation	38550/55												
Anterior Skull Base Surgery	61580/85 61600/01												
Other (congenital)													
Sub-total Head & Neck													
OTOLOGIC													
Myringotomy and Tube (count patients)	69436												
Tympanoplasty I	69620/31												
Tympanoplasty II-IV (w/ Ossicular	69632/33												

PROCEDURES		TGH		VAH		HLM		ACH		ST. JOE		TOTALS	
		S	A	S	A	S	A	S	A	S	A	S	A
Reconstruction)													
Tympanoplasty w/ Mastoidectomy	69635/37 69641/42												
Simple Mastoidectomy	69502												
Modified Radical Mastoidectomy	69505												
Radical Mastoidectomy	69511												
Stapedectomy	69660												
Facial Nerve Decompression	69720/25												
Facial Nerve Graft/Repair/Substitution	69740/45												
Repair Fistula (OW,RW)	69666/67												
Labyrinthectomy	69905, 69910												
Decompression Membranous Labyrinth -Cochleosacculotomy	69801												
-Endolymphatic Sac Operations	69805/06												
Resection Cerebellopontine Angle Tumor	61526												
VIII Nerve Section	69915												
Excision Glomus Tumor	69550												
Reconstruction Congenital Aural Atresia	69320												
Middle Ear Exploration	69440												
Petrous Apicectomy, includes Radical Mastoidectomy	69530												

PROCEDURES		TGH		VAH		HLM		ACH		ST. JOE		TOTALS	
		S	A	S	A	S	A	S	A	S	A	S	A
Middle & Posterior Fossa Skull Base Surgery	61590/98 ,61605/16												
Cochlear Implantation	69930												
Meatoplasty (for stenosis due to trauma, infection)	69310												
Other (Otology)													
Sub-total Otology													
PLASTIC & RECONSTRUCTIVE													
Otoplasty (includes auricular reconstruction)	69300												
Rhinoplasty	30400/62												
Mentoplasty	21120/23												
Rhytidectomy (count patients)	15824/29												
Blepharoplasty (count patients)	15820/23												
Liposuction	15876												
Chemical Peel	15788/89												
Dermabrasion	15780/81												
Repair Complex Facial Lacerations	13131/52												
Reduction Facial Fractures -Frontal	21343/44												

PROCEDURES		TGH		VAH		HLM		ACH		ST. JOE		TOTALS	
		S	A	S	A	S	A	S	A	S	A	S	A
-Nasal	21310/35												
-Maxilla-LeFort	21421/36												
-Malar (zygomatic)	21356/66												
-Orbital Blowout	21385/95												
-Mandibular-closed	21453												
-open	21454/70												
-Other (fractures)													
Pedicle Flap Procedures -Local	14040/61												
-Regional	15570/76												
-Myocutaneous	15732/34												
-Microsurgical Free Flap	15755												
-Other (pedicle flaps)													
Grafts -Split Thickness Skin	15120												
-Full Thickness Skin	15240												
-Composite Graft	15760												
-Dermal-Fat-Fascia	15770												
-Other (grafts)													
Facial Sling Procedures	15840												
Oroantral Fistula Repair	30580												

PROCEDURES		TGH		VAH		HLM		ACH		ST. JOE		TOTALS	
		S	A	S	A	S	A	S	A	S	A	S	A
Choanal Atresia Repair	30540/45												
Cleft Lip Repair	40700/61												
Cleft Palate Repair	42200/10												
Pharyngeal Flap	42226												
Excision Skin Lesions, Primary Closure (count patients)	11440/46 11620/46												
Other (Plastic & Reconstructive)													
Sub-total Plastic & Reconstructive													
ENDOSCOPY													
Direct Laryngoscopy													
-Diagnostic, Newborn	31520												
-Diagnostic, Excerpt Newborn	31525												
-Diagnostic, with Operating Microscope	31526												
-With Dilatation	31528/29												
-With Foreign Body Removal	31530/31												
-With Biopsy	31535/36												
-Operative, w/Excision of Tumor and/or Stripping of Vocal Folds or Epiglottis	31540/41												
-With Arytenoidectomy	31560/61												
-With Injection into Vocal Folds	31570/71												

PROCEDURES		TGH		VAH		HLM		ACH		ST. JOE		TOTALS	
		S	A	S	A	S	A	S	A	S	A	S	A
Esophagoscopy -Diagnostic	43200												
-With Foreign Body Removal	43215												
-With Stricture Dilatation	43220												
Bronchoscopy -Diagnostic	31622												
-with Foreign Body Removal	31635												
-With Stricture Dilatation	31630												
Other (Endoscopy)													
Sub-totals Endoscopy													
GENERAL													
Adenoidectomy	42830												
Tonsillectomy (count patients)	42825												
Tonsillectomy & Adenoidectomy	42820												
Uvulopalatopharyngoplasty	42299												
Nasal Septoplasty	30520												
Turbinate Reduction (count patients)	30130												
Caldwell Luc (count patients)	31030												
Endoscopic Sinus Surgery (count patients) -Ethmoidectomy	31254/55												

PROCEDURES		TGH		VAH		HLM		ACH		ST. JOE		TOTALS	
		S	A	S	A	S	A	S	A	S	A	S	A
-Maxillary Sinusotomy	31256/57												
-Sphenoid Sinusotomy	31287/88												
-Frontal Sinusotomy	31276												
Ligation Ethmoid Arteries	30915												
Transantral Ligation of Vessels	30920												
Intranasal Ethmoidectomy (count patients)	31200												
External Ethmoidectomy (count patients)	31205												
Frontoethmoidectomy	31075												
Frontal Sinus Trephine	31070												
Osteoplastic Frontal Sinusectomy w/ Obliteration	31084/85												
Hypophysectomy (transnasal approach)	61584												
Other (General)													
Sub-total General													

		As Surgeon	As Assistant
CATEGORY TOTALS:	**HEAD & NECK**	_____	_____
	OTOLOGIC	_____	_____
	PLASTIC & RECONSTRUCTIVE	_____	_____
	ENDOSCOPY	_____	_____
	GENERAL	_____	_____
	GRAND TOTALS:	_____	_____

SIGNATURE: _____

DATE: _____

University of South Florida
Department of Otolaryngology-HNS

Operative Verification Beginning: Ending: Resident:

Date	S / T / A	Attending	Hospital	Patient Name	CPT Code	Procedure/Description

VII. D.

Department of Otolaryngology-HNS
Resident Key Indicator Operative Experience Log
XXXX-XXXX

Resident: **_____, M.D.**

Quarter Ending: **September 31, XXXX**

Key Indicator Operative Procedures	As Surgeon
Parotidectomy	
Neck Dissection (all types)	
Laryngectomy (all types)	
Thyroid/Parathyroidectomy (all types)	
Tracheotomy	
Tympanoplasty (all types)	
Mastoidectomy (all types)	
Stapedectomy/Ossiculoplasty (all types)	
Rhinoplasty	
Blepharoplasty/Brow/Facelift	
Complex Lacerations	
Midface Fracture (exclude nasal)	
Mandibular Fracture (CI & open)	
Flaps	
Operative microlaryngoscopy (CPT 31541)	
Esophagoscopy (all types)	
Bronchoscopy (all types)	
Sinus surgery/endoscopic & non endoscopic	
TOTAL OPERATIONS AS SURGEON	

- **This form <u>must</u> be completed and turned in with your operative log and verification log on or before OCTOBER** 15, XXXX.

VIII. A.

OTOLARYNGOLOGY RESIDENT ROTATION SCHEDULE

JULY 2005-JUNE 2006

OTOLARYNGOLOGY RESIDENT ROTATION SCHEDULE

JULY 2005 - JUNE 2006

	July	August	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	March	April	May	June
PGY-1/Pre-OTO												
Dr. May	General Surgery		Neuro-Surgery/TGH	Anes-thesia	General Surgery		Critical Care/VA	ER/TGH	General Surgery		Otolaryngology/VA	
Dr. Phommachanh	Neuro-Surgery/TGH	Critical Care/VA	General Surgery		Anesthesia TGH	ER/TGH	General Surgery		Otolaryngology/VA		General Surgery	

	7/1-8/31	9/1-10/31	11/1-12/31	1/1-2/28	3/1-4/30	5/1-6/30
PGY-2/OTO-1						
Dr. Rogers	VAH	*TGH	VAH	*TGH	VAH	*TGH
Dr. Stavinoha	*TGH	VAH	*TGH	VAH	*TGH	VAH

*TGH ROTATION: **Mon-**Dr. Bartels Clinic **Tues-**USF Clinic **Weds-**Plastics **Thurs-**Dr. Bartels OR/USF Clinic **Fri-**TGH OR

	7/1-9/30	10/1-12/31	1/1-3/31	4/1-6/30
PGY-3/OTO-2				
Dr. Tucker	VAH Allergy q Tues. AM & Fri. PM	ACH	HLM	TGH *Otology
Dr. Kang	ACH	VAH Allergy q Tues. AM & Fri. PM	TGH *Otology	HLM

*OTOLOGY ROTATION: **Mon-**Dr. Boyev OR **Tues-**Dr. Bartels OR/Clinic **Weds**-*AM* J. Farrior Pre-op *PM* Dr. Boyev USF Clinic **Thurs.** Dr. J Farrior OR **Fri-**TGH OR or T. Bone Ind. Drilling

PGY-4/OTO-3				
Dr. Powell	TGH *Otology	HLM	ACH	VAH Research
Dr. Merchant	HLM	TGH *Otology	VAH Research	ACH

*OTOLOGY ROTATION: **Mon-**Dr. Boyev OR **Tues-**Dr. Bartels OR/Clinic **Weds**-*AM* J. Farrior Pre-op *PM* Dr. Boyev USF Clinic **Thurs.** Dr. J Farrior OR **Fri-**TGH OR or T. Bone Ind. Drilling

C-PGY-5/OTO-4				
Dr. Zeiders	VAH	TGH	VAH	TGH
Dr. Meigs	TGH	VAH	TGH	VAH

ACH- All Children's Hospital **HLM-** H. Lee Moffitt Cancer Center **TGH-** Tampa General Hospital **VAH-** James A. Haley Veterans' Hospital

VIII. B. **SCHEDULE OF TEACHING CONFERENCES**
July 01, 2005 - June 30, 2006

DAY	TIME	LOCATION	TITLE OF SESSION
Monday-Weekly	7:30am	ENT Conf. Room	Resident and Attending Case Presentations
Tuesday-Weekly	7:30 am	HLM-4 South	Teaching Rounds/Drs. Padhya & J. McCaffrey
Tuesday-Weekly	8:00 am	HLM-Rm. 2051	Tumor Board
Tuesday-Weekly	5:00 pm	ENT Conference	*****Attending Presentations/Core lecture
Wednesday-weekly			
	7:00 am	TGH-Rm. B-301	M&M Conference
	7:00 am	TGH-Rm. B-301	Trauma Conference
	7:00 am	TGH-Rm. B-301	Otology Conference
	7:00 am	TGH-Rm. B-301	Facial Plastic
	7:00 am	**HLM-Rm. 3039**	Skull Base Conference (?)
(See master conference schedule, as the above conferences alternate)			
Wednesday-Weekly	8:50 am	VAH-4-North	Teaching Rounds/J. McCaffrey, Dr. Ridley
Wednesday-Weekly	9:15 am	VAH-101	Tumor Board/Dr. J. McCaffrey
Thursday-Weekly	8:00 am	HLM-4 South	Teaching Rounds/Drs. TV McCaffrey & Kienstra
Thursday-Monthly	5:30 pm	Various Locations	Journal Club
Thursday-1st	11:45am	HLM Clinic	Videostroboscopy Conference

***Starts the 1st week of September-ends beginning of June.**

ADDITIONAL COURSES, MEETINGS, EXAMS

Bronchoscopy Course (August 6th)
AAO-HNS (September 18-22)
Temporal Bone Course (w/o January 25th & February 15th)
Mini Boards (February 12th)
Inservice Exam (March 5th)
Head & Neck Anatomy Course (March-May, every other year, alternates w/Bronch Course)

VIII. C.

MASTER CALENDAR
JULY 2005 - JUNE 2006

JULY 5	Orientation 5:00pm **(mandatory for all faculty and residents)**
TBA	Bronchoscopy Course/Dr. Ridley **(mandatory for all residents)**
SEPT 25-28	AAO-HNS Annual Meeting Los Angeles, CA **(Drs. Kang & Tucker)**
NOV 11-13	Florida Society of Otolaryngology-H&N Surgery Orlando, FL. **(residents w/presentations)**
DEC	Harvest Temporal Bones **(chief residents)**
JAN 13-15	Triologic Southern Section Meeting Miami, FL **(residents w/presentations)**
JAN 25, 28, 29 15, 18, 19	Temporal Bone Course **(all residents)** **(also…9/7, 9/9, 11/16, 11/18, 3/8, 3/10, 5/24, 5/26)**
FEB 12	Miniboard Examination **(all residents)**
MARCH 5	Otolaryngology Training Examination **(all residents)**
APRIL 15	Program/Faculty evaluations due **(all residents and faculty)**
MAY 19-22	COSM-Combined Otolaryngologic Spring Meeting Chicago, IL. **(residents w/presentations)**
JULY 10	ABO printouts to be mailed *(last postmark date)*
***MONTHLY**	**No later than the 15th of each month**, all residents **must** have their operative data updated with the ACGME site. Printouts will be provided to the Program Director at this time. Residents not complying with this deadline will be subject to disciplinary action.

Residents at **Tampa General Hospital** will observe the following holidays:

Independence Day	Monday, July 5, 2005
Labor Day	Monday, September 5, 2005
Thanksgiving Day	Thursday, November 254 2005
Christmas Day	Sunday, December 24, 2005
Christmas Day	(observed)
New Year's Day	Sunday, January 1, 2006
Memorial Day	Monday, May 29, 2006

Residents at **James A. Haley Veterans' Hospital** will observe the following holidays:

Independence Day	Monday, July 5, 2005
Labor Day	Monday, September 5, 2005
Columbus Day	Monday, October 10, 2005
Veterans' Day	Friday, November 11, 2005
Thanksgiving Day	Thursday, November 24, 2005
Christmas Day	(observed) Sunday, December 24, 2005
New Year's Day	Sunday, January 1, 2006
Martin Luther King Day	Monday, January 16, 2005
Presidents' Day	Monday, February 20, 2006
Memorial Day	Monday, May 29, 2006

Residents of **H. Lee Moffitt Cancer Center & Research Institute** will observe the following holidays:

Independence Day	Monday, July 5, 2005
Labor Day	Monday, September 5, 2005
Thanksgiving Day	Thursday, November 24, 2005
Day after Thanksgiving	Friday, November 25, 2005
Christmas Day	Sunday, December 24, 2005
New Year's Day	Sunday, January 1, 2006
Martin Luther King Day	Monday, January 16, 2005
Memorial Day	Monday, May 29, 2006

VIII. E. Otolaryngology Resident Call Schedule

Date	Trauma	TGH 1st	TGH 2nd	VAH 1st	VAH 2nd	ACH	HLM

Attending @ VAH:

Authorized Absence: *(list resident, meeting or courses)*

Vacations: *(lists residents & dates of vacation)*

Trauma: *(list dates/attending on call)*

VIII. F. Otolaryngology Morbidity and Mortality Report

Surgery Date:_____ **Hospital:** **HLM**
VAH
TGH
ACH

Patient Name:_____

Clinical History:

_____
_____
_____
_____

Description of Complication:

_____
_____
_____
_____

Classification of Complication(s): *(Check all that apply)*

_____	Wound Infection	_____	Neuroligic
_____	Post-op hemorrhage	_____	Fistula formation
_____	Cardiac	_____	Respiratory
		_____	Other

Treatment of Complication:

_____
_____
_____
_____
_____

Conclusion: _____Disease _____Technical Error _____Judgment

Recommendations:

_____
_____
_____
_____

Resident: _____ **Attending:** _____

Date discussed: _____

VIII G.

DEPARTMENT OF OTOLARYNGOLOGY
CONFERENCE SIGN-IN

Conference:
Presenter:
Date:

PLEASE SIGN IN ATTENDINGS

Thomas V. McCaffrey, M.D. Ph.D _____

K. Paul Boyev, M.D. _____

Matthew A. Kienstra, M.D. _____

Judith Czaja McCaffrey, M.D. _____

Tapan A. Padhya, M.D. _____

Yash J. Patil, M.D. _____

Marion B. Ridley, M.D. _____

Jonathan Morgan, M.D. _____

Loren J. Bartels, M.D. _____

David Schenck, M.D. _____

_____ _____

Print Name

RESIDENTS

Barry Kang, M.D. _____

James T. May, M.D. _____

Matthew Meigs, M.D. _____

FAISAL MERCHANT, M.D. _____

Vien Phommachanh, M.D. _____

Scott Powell, M.D. _____

Jeremy Rogers, M.D. _____

Rose C. Stavinoha, M.D. _____

Anthony Tucker, M.D. _____ _____

Jacob Zeiders, M.D. _____

ROTATING MEDICAL STUDENTS

_____ _____

VIII. H.

INPATIENT BILLING
Consult & Admission

AFFIX LABEL

Staff Surgeon: _____ Date of Service: _____

Patient Name: _____ Date of Birth: _____

Hospital: _____ Admit Date: _____

Referring M.D.: _____
(Consult Only)

INPATIENT CONSULTATION
_____ 99255 High Complex
_____ 99254 Mod-High Complex
_____ 99253 Moderate Complex
_____ 99252 Low-Mod Complex
_____ 99251 Low Complex

OBSERVATION OR INPATIENT CARE
_____ 99236 High Complex
_____ 99235 Moderate Complex
_____ 99234 Low Complex

FOLLOW-UP INPATIENT CONSULT
_____ 99263 High Complex
_____ 99262 Mod-High Complex
_____ 99261 Moderate Complex

INITIAL-INPATIENT CARE
_____ 99223 High Complex
_____ 99222 Moderate Complex
_____ 99221 Low Complex

ESTABLISHED HOSPITAL CARE
_____ 99233 High Complex
_____ 99232 Moderate Complex
_____ 99231 Low Complex

EMERGENCY ROOM ONLY (ONLY MD)
_____ 99285 High Complex
_____ 99284 Mod-High Complex
_____ 99283 Moderate Complex
_____ 99282 Low-Mod Complex
_____ 99281 Low Complex

DECISION FOR SURGERY ___Yes
(Modifier 57) ___ No

DIAGNOSIS _____

_____

I personally performed or supervised the services indicated on this form, the medical record documentation supports the billing of these services, and I hereby approve billing of these services in my name.

By checking this box ☐, I attest that a resident participated in the services and my teaching physician supervision is documented in the medical records.

_____
USF Provider Signature Date

Return Original To Deanna Springer MRC-OTO

IX. A.

Department of Otolaryngology
Head & Neck Surgery

FULL -TIME FACULTY

Faculty Member	Office	Pager	Appointment
Thomas V. McCaffrey, M.D., Ph.D. *Residency Program Director*	972-8463	221-9240	Professor & Chair
K. Paul Boyev, M.D.	974-9320	201-3382	Assistant Professor
Matthew A. Kienstra, M.D. *Billing Integrity Officer*	974-6573	201-2209	Assistant Professor
Judith Czaja McCaffrey, M.D.	972-8463	227-1138	Assistant Professor Joint Appointment/IOP
Tapan A. Padhya, M.D. *Medical Director-USF Clinic*	972-8463	201-3314	Assistant Professor
Yash J. Patil, M.D.	972-8463	201-8805	Assistant Professor
Marion B. Ridley, M.D.	974-4706	222-2765	Associate Professor
Bernd Sokolowski, Ph.D. *Director of Research*	974-5988	n/a	Associate Professor
Jonathan Morgan, M.D.	974-7036	201-3039	Instructor

IX. B.

Department of Otolaryngology
Head & Neck Surgery

CLINICAL FACULTY

Faculty Member	Office	Pager	Appointment
William Alonso, M.D.	875-9002	227-6191	Professor
Thomas Andrews, M.D.	727/892-4305	529-1032	Associate Professor
Loren Bartels, M.D.	844-4900	201-0332	Professor
Nelson Castellano, M.D.	879-6207	800/483-4726	Associate Professor
Dewey Christmas, M.D.	386/255-1200	n/a	Assistant Professor
Wade Cressman, M.D.	727/892-4305	405-7625	Assistant Professor
James Endicott, M.D.	727/551-0800	727/553-0666	Professor
Edward Farrior, M.D.	875-3223	222-1905	Associate Professor
Jay B. Farrior, M.D.	253-0916	278-2963	Professor
Richard T. Farrior, M.D.	251-6756	n/a	Professor
Holly Haggerty, Ph.D.	n/a	n/a	Instructor
David Hill, M.D.	727/821-4784	n/a	Honorary
Terry Kelly, M.D.	979-3968	201-0221	Assistant Professor
Joseph Mirante, M.D.	386/677-8808	n/a	Assistant Professor
Peter Orobello, M.D.	727/892-4305	727/790-3975	Associate Professor
Harold Pine, M.D.	727/892-4305		Assistant Professor
Seth Rosenberg, M.D.			Assistant Professor
Miguel Rivera, M.D.	685-7761		Assistant Professor

Joint Appointments

John Arlington, M.D. *USF Dept. of Radiology*	972-3351		Associate Professor
Nancy Patterson, AUD *USF Dept. of Communication and Science Disorders*	974-8804	n/a	Instructor
Carlos Muro-Cacho, M.D., Ph.D. *USF Dept. of Pathology*	972-8400 (x2268)		Associate Professor
David Schenck, Ph.D. *USF Ethics Center*	974-7533		Professor
Frank Vrionis, M.D. *USF Dept. of Neurosurgery*	972-8400 (x4251)		Assistant Professor

IX. C.

Department of Otolaryngology-Head & Neck Surgery

Administrative Support Staff

Name/Support for	Office	Pager	Title
Karyn Aldridge	974-1366	222-1538	Dept. Administrator
Dianne Sullivan *(Dr. T. McCaffrey)*	979-3057	N/A	Administrative Assistant
Millie Corbo *(Residents & Students)*	974-7036	N/A	Program Coordinator
Chantel Diaz *(Drs. Boyev & Kienstra)*	974-6573	N/A	Administrative Assistant
Marge Kuligofski *(Drs. Ridley & Sokolowski)*	974-4706	N/A	Administrative Assistant
Sarah Farfan	974-7278	201-5006	Financial Specialist
Shirley Serovey	974-8385	N/A	Authorizations Specialist
Deanna Springer	*Home:* 621-7676	N/A	Coder/Billing Specialist
Madge Brown *(Drs. J. McCaffrey, Padhya & Patil)*	972-8363	N/A	Administrative Assistant
Monique Valenzuelo			

IX. D. **2005 – 2006 RESIDENT INFORMATION**

Matthew M. Meigs, M.D. PGY-5 16033 Westerham Drive Tampa, Florida 33647 **Telephone:** 971-6585 **Pager:** 332-6085 **E-Mail:** mmeigs@hsc.usf.edu **Date of Birth:** 4/30/74 **Graduates from Residency:** 6/30/2006 **Medical School:** Univ of TX Med Branch @ Galveston **M.D. Degree:** 5/26/01 **AO#:** 88761 **S.S.#:** 458-67-4240 **Spouse:** Sarah	**Jacob W. Zeiders, M.D. PGY-5** 505 Tampania Ave., #2 Tampa, Florida 33609 **Telephone:** 258-61-58 **Pager:**332-6086 **E-Mail:** jwzeiders@hsc.usf.edu **Date of Birth:** 1/22/72 **Graduates from Residency:** 6/30/2006 **Medical School:** Royal College of Surgeons Dublin, Ireland **M.D. Degree:** 5/25/01 **AO#:** 94041 **S.S.#:** 220-15-2110 **Spouse:** Nicole
Faisal Merchant, M.D. PGY-4 5307 Archstone Drive, #106 Tampa, Florida 33634 **Telephone:** 835-3451 **Pager:**332-6088 **E-Mail:** fmerchan@hsc.usf.edu **Date of Birth:** 9/14/75 **Graduates from Residency:** 6/30/2007 **Medical School:** University of Miami **M.D. Degree:** 5/02 **AO#:** 26752 **S.S.#:** 226-15-1938	**Scott A. Powell, M.D. PGY-4** 8525 Cantebury Lake Blvd. Tampa, Florida 33619 **Telephone:** 627-1925 **Pager:** 332-6087 **E-Mail:** spowell@hsc.usf.edu **Date of Birth:** 5/19/75 **Graduates from Residency:** 6/30/2007 **Medical School:** University of South Florida **M.D. Degree:** 5/02 **AO#:** 26756 **S.S.#:** 589-44-7984 **Spouse:** Beth
Barry S. Kang, M.D. PGY-3 3113 W. San Carlos Street Tampa, Florida 33629 **Telephone:** 857-8013 **Pager:** 332-6079 **E-Mail:** bkang@hsc.usf.edu **Date of Birth:** 5/25/73 **Graduates from Residency:** 6/30/2008 **Medical School:** Howard University **M.D. Degree:** 5/03 **AO#:** 104962 **S.S.#:** 541-88-5003 **Spouse:** Mari	**Anthony T. Tucker, M.D. PGY-3** 10130 Somersby Drive Riverview, Florida 33569 **Telephone:** 677-7520 **Pager:** 332-6080 **E-Mail:** aucker@hsc.usf.edu **Date of Birth:** 6/17/74 **Graduates from Residency:** 6/30/2008 **Medical School:** Medical College of Georgia **M.D. Degree:** 5/03 **AO#:** 104963 **S.S.#:** 400-02-8764

Jeremy B. Rogers, M.D. PGY-2 8639 North Himes Ave Apt.# 3117 Tampa, Florida 33614 **Telephone:** **Pager:** 332-6390 **E-Mail:** **Date of Birth:** 6/6/78 **Graduates from Residency:** 6/30/2009 **Medical School:** Medical College of Georgia **M.D. Degree:** 5/7/2004 **AO#:** Pending **S.S.#:** 254-35-2296	**Rose C. Stavinoha, M.D. PGY-2** 6804 N. Dixon Ave Tampa, Florida 33604 **Telephone:** 231-4853 **Pager:** 332-6082 **E-Mail:** rstavino@hsc.usf.edu **Date of Birth:** 5/28/76 **Graduates from Residency:** 6/30/2009 **Medical School:** University of Texas, San Antonio **M.D. Degree:** 5/22/2004 **AO#:** Pending **S.S.#:** 466-83-7999
James T. May, M.D. PGY-1 1022 East Mohawk Avenue Tampa, Florida 33604 **Telephone:** 232-9121 Cell 804 338-1179 **Pager:** 332-6352 **E-Mail:** **Date of Birth:** **Graduates from Residency:** 6/30/2010 **Medical School:** Virginia Commonwealth University **M.D. Degree:** 5/2005 **AO#:** Pending **S.S.#:** 223-29-8256	**Viengsouk Phommachanh, M.D. PGY-1** 9729 Cypress Harbor Drive Gibsonton, Florida 33534 **Telephone:** 672-0416 **Pager:** 332-6341 **E-Mail:** **Date of Birth:** 7/29/77 **Graduates from Residency:** 6/30/2010 **Medical School:** Tulane **M.D. Degree:** 5/21/2005 **AO#:** Pending **S.S.#:** 027-60-5811 **Spouse:** Alison

X. SUPERVISORY LINES BY SITE & COMMUNICATION DIRECTIONS

Day-to-day surgical and clinical supervision of residents at all levels within this program is site specific. Residents will report to and follow instructions from the supervising attending for the OR case, clinic, or on-call at the site to which the resident is assigned by rotation or on-call schedule. If a supervising attending is not immediately present and the resident requires direction, the attending is to be paged. If the attending does not respond within an acceptable period of time with respect to the urgency of the problem, the resident is to page the Program Director for that institution. If the Program Director for the institution does not respond, the resident is to page the Program Director for the training program.

A listing of pager numbers for all attendings can be found in the PERSONNEL section of the orientation manual.

Program Director for Training Program: Thomas V. McCaffrey, M.D., Ph.D.
Pager: 221-9240

X. A. JAMES A. HALEY VETERANS HOSPITAL

Program Director for Institution: Judith Czaja McCaffrey, M.D. (pgr: 227-1138)

	AM	PM
Monday	**Surgery 7:00** Dr. William Alonso (or) Dr. Yash Patil	
	Clinic 8:00 Dr. Matthew Kienstra (or) Dr. Yash Patil	**Clinic 1:00** Dr. Marion B. Ridley
Tuesday	**Surgery 7:00** Dr. Nelson Castellano (or) Dr. Yash Patil	**Clinic 1:00** Dr. Nelson Castellano (or) Dr. Yash Patil
Wednesday	**Clinic 10:00** Dr. Judith McCaffrey	**Clinic 1:00** Dr. Marion B. Ridley
Thursday	**Surgery (1) 7:00** Dr. Judith McCaffrey	**Surgery (1) 1:00** Dr. Judith McCaffrey
	Surgery (2) 7:00 Dr. Matthew Kienstra (or) Dr. Tapan Padhya	**Surgery (2) 1:00** Dr. Matthew Kienstra (or) Dr. Tapan Padhya
Friday	**Surgery (1) 7:00** Dr. K. Paul Boyev (or) Dr. Jay Farrior *(qow)*	**Clinic 1:00** Dr. K. Paul Boyev (or) Dr. Jay Farrior *(qow)* Dr. Edgemon (1st) Dr. Miguel Rivera (1st, 3rd, 5th)
	Surgery (2) 7:00 Dr. Thomas McCaffrey (2nd) Dr. Yash Patil (4th) Dr. Miguel Rivera (1st, 3rd, 5th)	

X. B. TAMPA GENERAL HOSPITAL

Program Director for Institution: Tapan A. Padhya, M.D. (pgr:201-3314)

	AM	PM
Monday	**Surgery** Dr. K. Paul Boyev **Clinic** Dr. Marion B. Ridley Dr. Matthew Kienstra *(qow)* **Private Clinic** *(Jr. Resident)* Dr. Loren Bartels	**Surgery** Dr. K. Paul Boyev **Clinic** Dr. Tapan Padhya Chief Resident Clinic **Private Clinic** *(Jr. Resident)* Dr. Loren Bartels
Tuesday	**Clinic** Dr. Thomas McCaffrey Resident Pre-op Clinic Dr. Yash Patil *(qow)*	**Clinic** Dr. Thomas McCaffrey Dr. K. Paul Boyev Dr. Yash Patil *(qow)* **Resident Clinic @ Health Park** Dr. Marion Ridley
Wednesday	**Clinic** Dr. Matthew Kienstra *(qow Plastics)* Dr. K. Paul Boyev **Surgery** *(Jr. & Sr. Resident)* Dr. Ed Farrior Dr. Yash Patil	**Clinic** Dr. Matthew Kienstra Dr. K. Paul Boyev Dr. Yash Patil
Thursday	**Clinic** None **Surgery** *(Jr. Resident)* Dr. Loren Bartels	**Clinic** Dr. K. Paul Boyev Dr. Marion B. Ridley Resident Clinic
Friday	**Clinic** Dr. Tapan Padhya (1^{st} & 3^{rd}) *(sleep clinic)* Dr. Matthew Kienstra (2^{nd} & 4^{th}) *(Plastics Clinic)* **Surgery** Dr. Thomas McCaffrey (1^{st} and 3^{rd}) Dr. Tapan Padhya (2^{nd} & 4^{th}) Dr. Matthew Kienstra (1^{st} and 3^{rd})	**Clinic** Dr. Tapan Padhya (1^{st} & 3^{rd}) *(sleep clinic)* Dr. Thomas McCaffrey (2^{nd} & 4^{th}) Dr. Matthew Kienstra (2^{nd} & 4^{th}) *(Plastics Clinic)* Dr. Yash Patil **Surgery** Dr. Thomas McCaffrey (1^{st} and 3^{rd}) Dr. Tapan Padhya (2^{nd} & 4^{th}) Dr. Matthew Kienstra (1^{st} and 3^{rd})

TAMPA GENERAL HOSPITAL (cont.)

Otology Rotation

Monday	**Surgery** Dr. K. Paul Boyev	**Surgery** Dr. K. Paul Boyev
Tuesday	**Surgery** Dr. Loren Bartels	**Clinic** *(private office)* Dr. Loren Bartels
Wednesday	**Pre-Op Clinic** *(private office)* Dr. Jay B. Farrior	**USF Clinic** Dr. K. Paul Boyev
Thursday	**Surgery** (*St. Joseph's Hosp.)* Dr. Jay B. Farrior	**Surgery** (*St. Joseph's Hosp.)* Dr. Jay B. Farrior
***Friday	**Surgery @ TGH** (or T. Bone Lab)	**Surgery @ TGH** (or T. Bone Lab)

***If VA Chief on leave, help cover at VAH, instead of TGH**

X. C. H. LEE MOFFITT CANCER CENTER & RESEARCH INSTITUTE

Program Director at Institution: Thomas V. McCaffrey, M.D., Ph.D. (pgr: 221-9240)

	AM	PM
Monday	**Surgery** Dr. Thomas McCaffrey **Clinic** Dr. Judith McCaffrey	**Surgery** Dr. Thomas McCaffrey **Clinic** Dr. Judith McCaffrey Dr. Matthew Kienstra
Tuesday	**Tumor Board** *(everyone)* **Clinic** Dr. Tapan Padhya Resident Pre-op Clinic	**Surgery** Dr. Thomas McCaffrey **Clinic** Dr. Tapan Padhya
Wednesday	**Clinic** Dr. Thomas McCaffrey **Surgery** Dr. Tapan Padhya	**Clinic** Dr. Judith McCaffrey **Surgery** Dr. Tapan Padhya
Thursday	**Clinic** Dr. Thomas McCaffrey **Surgery** Dr. Tapan Padhya Dr. Yash Patil	**Clinic** Dr. Thomas McCaffrey **Surgery** Dr. Matthew Kienstra Dr. Yash Patil
Friday	**Surgery** Dr. Judith McCaffrey **Clinic** Dr. Yash Patil (except 5th)	**Surgery** Dr. Judith McCaffrey **Clinic** Dr. Tapan Padhya (1st and 3rd)

X. D. ALL CHILDREN'S HOSPITAL

Program Director for Institution: Peter Orobello, M.D. (pgr: 338-0950)

	AM	PM
Monday	**Surgery/Clinic**-ACH Orobello/Andrews/Cressman	**Surgery/Clinic**-ACH Orobello/Andrews/Cressman
Tuesday	**Surgery/Clinic**-ACH Orobello/Andrews/Cressman	**Surgery/Clinic-**ACH Orobello/Andrews/Cressman
Wednesday	**Surgery/Clinic**/N. Tampa Orobello/Andrews/Cressman	**Clinic/N. Tampa Annex** Orobello/Andrews/Cressman
Thursday	**Surgery/Clinic-**ACH Orobello/Andrews/Cressman	**Surgery/Clinic**-ACH Orobello/Andrews/Cressman
Friday	**Surgery/Clinic**-ACH Orobello/Andrews/Cressman	**Surgery/Clinic**-ACH Orobello/Andrews/Cressman

X. E. GENERAL COMMENTS

+ Medical Records Departments at all hospitals are persistent about keeping records completed. If a record is not completed in a timely manner, the attending on the case may lose admitting and other hospital privileges.

+ Discharge summaries at all hospitals should be dictated at time of discharge and include the following to meet JCAHO specifications:

    Pre-admit dx
    Discharge dx
    Treatment plan to include diet, activity, follow-up and medications

+ All referring physicians will receive a copy of the discharge summary, so each patient should sign a release of information when admitted from an outpatient clinic.

+ Whenever a nurse requests assistance, whether by phone or in person, that request is to be honored promptly. Nurses' suggestions and opinions in patient care should be given respectful consideration.

+ You are expected to use good technique in the OR, in the clinics, and on the ward, where appropriate, i.e. Universal Precautions, hand-washing, dressing changes, adequate scrub/prep, etc.

+ Residents are expected to read about their assigned cases or they may not be allowed to actively participate.

+ Do no refill a patient's prescription for non-otolaryngologic disorders unless you are their primary care physician. On hospital discharge, the patient may be given up to a 30 day supply and should then be referred to primary doctor for follow-up where appropriate.

+ Do not add editorial comments to charts.

+ HIV antibody testing is performed with informed consent by a clearly specific physician progress note in the chart.

+ All entries in the medical record must have a date and time.

+ Scrubs are not to be worn outside the hospital to which they belong.

XI. A. **INSTITUTIONAL REPORT**
JAMES A. HALEY VETERANS HOSPITAL

SCHEDULE & STAFFING

	AM	PM
Monday	**Surgery 7:00** Dr. William Alonso (or) Dr. Yash Patil **Clinic 8:00** Dr. Matthew Kienstra (or) Dr. Yash Patil	**Clinic 1:00** Dr. Marion B. Ridley
Tuesday	**Surgery 7:00** Dr. Nelson Castellano (or) Dr. Yash Patil	**Clinic 1:00** Dr. Nelson Castellano (or) Dr. Yash Patil
Wednesday	**Clinic 10:00** Dr. Judith McCaffrey	**Clinic 1:00** Dr. Marion B. Ridley
Thursday	**Surgery (1) 7:00** Dr. Judith McCaffrey **Surgery (2) 7:00** Dr. Matthew Kienstra (or) Dr. Tapan Padhya	**Surgery (1) 1:00** Dr. Judith McCaffrey **Surgery (2) 1:00** Dr. Matthew Kienstra (or) Dr. Tapan Padhya
Friday	**Surgery (1) 7:00** Dr. K. Paul Boyev (or) Dr. Jay Farrior *(qow)* **Surgery (2) 7:00** Dr. Thomas McCaffrey (2nd) Dr. Yash Patil (4th) Dr. Miguel Rivera (1st, 3rd, 5th)	**Clinic 1:00** Dr. K. Paul Boyev (or) Dr. Jay Farrior *(qow)* Dr. Edgemon (1st) Dr. Miguel Rivera (1st, 3rd, 5th)

Clinic Staff	Howell (Jack) Smith, PA, Theresa Chumley,C.M.A. Shannon Smith, M.A.
Speech Therapy	Judith Chen, M.S.; Sue Studenek, M.S. **(mail stop-ASP-126)**
Audiology	Bettina Tucker, M.S.; Paula Myers, M.S.; John Berardino, M.S. **(972-7529)**
Social Service	Mary Ellen Phillips, LCSW
Dietary	Sherri Lewis, R.D.
Dental Service	Mark Tucker, D.D.S.
Radiation Therapy Service	Ismail Kazam, M.D., Barb Kobosky, Maria Morales
XRT Secretary	Juanita, Ana (x7667)
Secretary (ENT)	Amanda Horton (x6506)

IRMS (Information Resources Management Services - VAH Computer System) See the Housestaff Coordinator, Surgical Service: Nannette Decker (x1727) for access instructions.

XI. B. OTOLARYNGOLOGY SERVICE
JAMES A. HALEY VETERANS' HOSPITAL

VAH ROTATION: GOALS and OBJECTIVES

The Otolaryngology rotation at the James A. Haley Veterans' Affairs Hospital (JAHVA) is a clinical rotation for residents at the PGY 2, PGY 3, and PGY 5 level. The goal of the JAHVA rotation is to gain proficiency in the diagnosis, management, and treatment of otolaryngologic diseases both in an outpatient and inpatient setting.

Clinical Objectives

PGY II: (6 months)

During, and at the completion of, the rotation, the resident at the PGY II level will be able:

1. To perform complete history and physical exams on new patients in the clinic. He or she is expected to relay the information gathered by history and physical to the chief resident and attending physician in an organized and professional manner. Over the course of the rotation, gradual responsibility will be given (as deemed appropriate) to the PGY II resident and eventually, formulation and execution of organized plans for treatment are anticipated, under guidance of the chief resident and attending physician who see all new patients in the clinic. The objective is to gather the pertinent clinical information from otolaryngology patients in order to formulate a formal and practical differential diagnosis of common and not so common ENT problems.

2. To provide follow-up care for clinic outpatients by assessment of treatment outcome and reassessment of treatment plans under close guidance of the chief resident and attending physicians. The objective is to learn in what way otolaryngologic conditions are altered by treatment and how plans may require change to yield particular outcomes. It is anticipated that the follow-up will provide the continuity of care that will teach the resident the importance of a physician-patient relationship.

3. To provide postoperative follow-up care in the outpatient clinic with the assistance of the chief resident or attending physician in order to understand the long term outcomes (functional, cosmetic, psychosocial results) of postsurgical otolaryngology patients. The objectives are to provide continuity of care and to allow for resident recognition of both successful and complicated outcomes. This opportunity will provide for guidance and instruction in the management of complications in postoperative patients. This will also provide an opportunity to critique one's methods and "learn from mistakes".

4. To provide consultation for emergency room patients. The resident is expected to see all ER consultations and perform a complete history and physical exam. He or she will obtain appropriate tests to aid in diagnosis, discuss a rational and organized treatment plan with the chief resident or attending physician, seek direct assistance for technically challenging situations or situations with which the resident is not comfortable and execute a plan. He or she will discuss the problem, solution, and plans for follow-up with the patients and the family (to the patient's satisfaction), document the visit on

the ER record and provide adequate otolaryngology follow-up as needed. Examples of consultations for ER patients that the resident will learn to execute include, but are not limited to, epistaxis, foreign body aspiration, foreign body ingestion, deep neck infection, airway problems, facial trauma, sudden

hearing loss, acute ear infections (otitis media, otitis externa), acute vertigo, sinusitis and related complications, etc.

5. To provide assistance with inpatient hospital consultations. The resident is expected to see the inpatients consultations, perform a complete history and physical exam, order tests as indicated, discuss a rational organized plan for treatment with the chief resident or attending physician, and provide follow-up for the patient. Inpatient hospital consults at JAHVA are seen either in the clinic or at the patient's bedside, and a chief resident or attending physician will see and examine all consultation patients to assess the resident's workup and evaluation and to educate the junior resident regarding the patient's condition and care.

6. To assume a role in the operating room as a first or second assistant for all major head and neck oncology cases, otology cases, and other general otolaryngologic procedures. In this capacity, the resident will learn to master assistance in the OR with positioning, prepping, and draping patients in addition to assisting with other necessary preoperative preparations. The resident will scrub and assist the chief resident and attending physician in effort to learn a) appropriate placement of incisions, b) surgical approaches, c) pertinent surgical anatomy, d) management of intraoperative complications, e) intraoperative decision-making and evolution of surgical procedures as dictated by pertinent operative findings and f) appropriate wound closure techniques. He or she will also master the postoperative care of inpatients on the ENT ward and in the surgical intensive care unit under direct supervision of the chief resident AND attending physician. Residents at this level will make at least twice daily ward rounds on all ENT hospital inpatients under the guidance of the chief resident and attending physician. Daily patient responsibilities include writing of legible and organized progress notes, medical orders, following up on laboratory and other tests, dictation of discharge summaries, and bedside care of ENT patients including tracheotomy tube changes, feeding tube placement or adjustment, wound care, suture removal, and other special patient needs under supervision. In addition, the junior resident is expected to promptly assess any inpatient on the otolaryngology service when he or she is called by the floor nurses. Execution of any plan based on such calls will be discussed with the chief resident or attending physician prior to completion in order to ensure that the situation will be handled appropriately.

The junior resident will assume the role of primary surgeon only under direct supervision of the chief resident, attending physician, or a selected senior resident in order to learn the following procedures, including but not limited to (this is left to the discretion of the attending physician.):

a) tracheotomy-intubated or awake patients
b) panendoscopy, including apneic laryngoscopy
c) intubation in appropriately selected cases
d) nasal septal reconstruction
e) simple biopsies
f) cervical node excisional biopsy

g) wound closures
h) tympanostomy tube insertion
i) tonsillectomy/adenoidectomy
j) modified and radical neck dissection

At the completion of the JAHVA rotation, the resident is expected to have mastered those procedures listed above under guidance of the supervising resident and attending physician. He or she will demonstrate proficiency in the technique as well as an understanding of the indications, various methods of accomplishing the procedure, and complications related

to each procedure. Inability to demonstrate proficiency will be discussed with the individual and recorded in his or her evaluation. The objective is the successful mastery of level-appropriate motor skills necessary for advancement to the PGY 3 level.

PGY III: (3 months)

During, and at the completion of, the JAHVA rotation, the PGY III resident will be able:

1. To perform complete history and physical exams on new patients in the clinic. At this level, the focus will be on the workup of the more complicated and challenging new cases. The resident will have mastered the basic skills of history taking and physical exam in the lower years, and therefore will be expected to formulate a sophisticated treatment plan based on a well-organized differential diagnosis. The PGY III resident is expected to know enough detail about the patient's condition that he or she is able to comfortably communicate about the diagnosis and treatment plan with the patient and family under guidance and supervision of the chief resident or attending physician. The resident is expected to review and understand pertinent pathology as it relates to certain cases. He or she shall review, with attending physician and pathologist, at minimum the intraoperative frozen section biopsies taken at panendoscopy. He or she should understand the implications of certain histopathologies and how they relate to treatment planning. The objective is to prepare the resident for proficiency in recognizing common pathologies in otolaryngology. The resident will learn the various treatment options including any standard and variant surgical procedures available for patients requiring surgical management, should be able to communicate the options to the patient effectively and should be able to justify his or her selected treatment plan based on experience and literature under the guidance of the chief resident and attending physician. In addition, he or she will be expected to know risks, complications, and normal postoperative course and convalescence of patients on whom they are operating.

2. To provide direct follow-up care on patients whom he or she has operated in order to learn about problems, complications, and successes. In addition, the resident is expected to recognize problems and complications and execute a management algorithm to correct the problem under guidance of the chief resident and attending physician. The resident will learn to appropriately communicate about problems and complications with patients and their families, and will learn how to provide reassurance and ensure a strong physician-patient relationship under direct supervision of the attending physician.

3. To provide immediate guidance and assistance to the junior resident (PGY 2) for inpatient hospital consultation and ER patients. The resident is expected to participate in the care of the more complicated cases by assisting with formulation and execution of an organized treatment plan. The objective is to introduce and reinforce the concept of resident as educator to the specific PGY 3 resident. He or she should be able to appropriately instruct the junior resident about management plans for basic and higher level problems under supervision. This prepares the PGY 3 resident for greater teaching responsibility as a PGY 4 and 5.

4. To assume a role in the operating room as first assistant or surgeon for all major head and neck cases, otology cases, and other general otolaryngologic procedures. The PGY 3 resident will learn to have appropriate preoperative conversations with patients, obtain informed consent, participate in preparation of the patient in the operating room, and have a surgical plan worked out for the approach that is reviewed, critiqued, and approved by the attending physician. The PGY 3 resident will scrub and assist the chief resident and attending physician on complicated cases in order to understand how to formulate and

execute intraoperative decisions based on operative findings. In addition, the resident will have the opportunity to learn advanced surgical techniques by observation, and later by execution at the discretion and under the supervision of the attending surgeon. The PGY 3 resident will assume the role of primary surgeon under DIRECT supervision of the chief resident or attending physician in order to learn the following procedures, including but not limited to:

a) selective neck dissection
b) parotidectomy with or without CN 7 preservation
c) thyroidectomy-hemi, total, subtotal
d) laryngectomy-partial, total
e) tracheoesophageal puncture-primary or secondary
f) transoral endoscopic procedures
g) mandibulotomy, mandibulectomy
h) tongue resection
i) tympanoplasty
j) mastoidectomy
k) functional endoscopic sinus surgery
l) skin excision, local flap closure
m) septorhinoplasty
n) pectoralis major myocutaneous flap

The PGY 3 resident will learn to participate closely in the postoperative care of the ENT patients, particularly those on whom he or she has operated. The resident will be expected to understand the final pathology of any patients operated upon and the indications for further treatment. With particular attention to head and neck oncology patients, the resident will learn clinical and pathologic staging of malignancies and when it is appropriate to add adjuvant therapy. He or she will learn how these factors affect prognosis and will learn how to effectively, honestly, and compassionately relay the information to the patient and the family under direct supervision of the attending physician.

At the completion of the JAHVA rotation, the PGY 3 resident is expected to have been exposed to or mastered those procedures listed above under guidance by the chief resident and attending physician. He or she will demonstrate proficiency in as many techniques as possible as well as an understanding of indications, risks, complications, and expected outcomes. Inability to demonstrate proficiency will be discussed with the individual and recorded in his or her evaluation. The objective is mastery of level-appropriate motor skills necessary for advancing to the PGY 4 level.

5. To learn the appropriate use of consulting services in the management of multidisciplinary ENT patients. The resident is expected to be able to recognize which

patients may need referral for assistance in management and is expected to communicate with colleagues in an effective manner to obtain help. Examples include general surgery, thoracic surgery, vascular surgery, neurosurgery, speech and swallowing therapists, audiologists, medical oncologists, radiotherapists, and social workers. These consultations are to be obtained only under supervision by the attending physician. The objective is to begin to learn about the many specialties that are interrelated in the care of complex ENT patients and to learn to develop effective and professional communication skills.

6. To demonstrate mastery of all the expectations of the PGY 2 resident. The objective is to ensure the appropriate foundation upon which to build more sophisticated clinical skills.

7. To participate in a specialty rotation in allergy/immunology 2 half days a week during the entire 3 month rotation. The objectives of the allergy rotation are: to understand the diagnosis and

management of allergic diseases, including asthma, allergic rhinitis, atopic dermatitis, chronic urticaria; to understand the role of skin testing and RAST in the diagnosis of allergic rhinitis; and to understand the treatment of asthma and allergic rhinitis including immunotherapy. This exposure is primarily in an outpatient setting.

PGY IV: (3 months)

The Third-Year resident rotating at the James A. Haley Veterans' Hospital performs his/her research project (see RESEARCH section of orientation book), attends all division conferences, and attends one all-day clinic per week at the VAH on Wednesday. The one day of clinical experience each week during this rotation allows the resident to maintain and sharpen his/her clinical skills during a rotation devoted primarily to research. In general the goals and objectives of the PGY-4 resident rotating in the outpatient clinic are identical to those of the PGY-3 level.

PGY V: (6 months)

During, and at the completion of the rotation, the resident at the PGY V level will be able:

1. To oversee the performance of complete head and neck histories and physical examinations executed by the PGY II and III residents. He or she will review the significant findings and guide the PGY II and III resident in the formulation of appropriate differential diagnosis, decisions about tests, and development of an appropriate treatment plan. Over the course of the rotation, gradual responsibility will be given (as deemed appropriate) to the PGY V resident by the supervising attending physician in order to eventually accomplish the aforementioned tasks independently. The chief resident will be overseen and guided by the attending physician for all complicated patients and all patients who will be going to the operating room. It is the responsibility of the chief resident to discuss with the attending physician any patient for whom it is recommended that an operation be performed. The attending physician will meet and examine these patients to confirm findings and judge the chief resident's ability to diagnose, appropriately counsel and educate the patients.

2. To provide close follow-up care to all patients on whom he or she has operated, both while an inpatient as well as an outpatient after discharge. In addition, the chief resident will oversee the patient follow-up visits performed by the PGY III resident to ensure adequate care is delivered. The six month continuous rotation for the PGY V resident ensures that continuity of patient care by residents is not disrupted and close follow-up of outcomes can be used as a learning/teaching tool.

3. To provide immediate guidance in the management of emergency patients for whom surgery is necessary. The chief resident will examine all emergency patients to determine the need for emergent surgical intervention in the operating room, will consult the attending physician, present the case, formulate a reasonable treatment plan, and execute the plan under guidance of the attending physician. In the emergent situation, he or she will learn to function as the primary surgeon: making decisions, organizing a surgical team, executing a successful plan, and managing complications as they arise, all under the guidance of the attending physician. The chief resident will learn

   that his or her actions are an example from which the junior residents learn and, as a chief, will therefore be expected to manage such situations in a clear and effective professional manner. The objective is to teach the chief resident to develop self-confidence and skills necessary to manage the emergent situation.

4. To assume a role as primary surgeon or first assistant in the operating room for all major head and neck cases, otologic cases, and general otolaryngologic procedures. He or she will be expected to oversee the PGY III resident in the preparation of patients for surgery under guidance of the attending physician. The PGY V resident will scrub and function as primary surgeon on complicated and advanced cases, at the discretion of and under guidance of the attending physician. The chief resident is expected to know all surgical approaches, benefits, indications, risks, and complications that are to be considered in the formation of a treatment plan. In addition, he or she should be able to demonstrate rational intraoperative decision making based on operative findings. Advanced surgical techniques will be taught to the PGY V resident by the attending physician, who will act as first or second assistant in all major cases. The PGY V resident will assume role of primary surgeon under supervision of the attending physician in effort to learn the following procedures, including, but not limited to:

   a. excision of vascular and neural tumors of the head and neck
   b. advanced or revision thyroid surgery
   c. parapharyngeal space tumor excision: cervical or mandibulotomy approach
   d. selective partial laryngectomy: supracricoid and near total laryngectomy
   e. wide excision of tonsillar, base of tongue, palate tumors through mandibulotomy
   f. maxillectomy with or without orbital exenteration
   g. craniofacial resection
   h. stapectomy/stapedotomy
   i. middle ear ossicular reconstruction
   j. facial nerve decompression in the middle ear
   k. tympanomastoidectomy
   l. modified and radical mastoidectomy
   m. tracheal resection
   n. laryngotracheal reconstruction
   o. septorhinoplasty
   p. FESS and external sinus surgery

The PGY V resident will oversee and supervise the postoperative care of all ENT patients in the hospital. He or she is responsible for conducting ward rounds with the other residents twice daily. The chief resident will make decisions regarding postoperative care including adjuvant treatment and will be responsible for appropriate consultations. He or she will inform the ward attending daily of the status of each patient and will make rounds with the attending physician.

At the completion of the JAHVA rotation, the PGY V resident is expected to have been exposed to or mastered the procedures listed above under DIRECT guidance of the attending physician. He or she will demonstrate proficiency in as many techniques as possible, and will be able to discuss the advantages, indications, risks, and complications of each. Inability to demonstrate proficiency will be discussed with the individual and recorded in his or her evaluation. The objective is to teach appropriate motor skills and professional skills necessary for successful completion of American Board of Otolaryngology testing and the practice of otolaryngology-head and neck surgery.

5. To perform the administrative tasks necessary to keep the service well managed. The chief resident will be responsible to accurate organization of the operating room schedule with the assistance of the attending physician. He or she will be responsible for assuring adequate attending coverage and will not be permitted to schedule any surgery without the appropriate coverage. The chief resident will learn to be in direct communication with the operating room scheduler to determine order of cases, etc. He or she will be directly responsible for arranging any presurgical testing for patients and for communicating with patients regarding any schedule changes or to answer patient questions. The objective is to teach the chief resident the skills required to organize a busy operating room schedule.

6. To demonstrate mastery of all expectations of the PGY II and III resident. The objective is to ensure the resident has the appropriate foundation upon which to mature and develop clinical and professional skills necessary to complete his or her training.

7. To share the responsibility of teaching rotating medical students in the third and fourth year rotations. The chief resident will have the medical students “shadow” him or her until the student demonstrates a sufficient level of proficiency in history taking and physical exam. The rotating medical student will then be allowed to perform limited work ups on patients first in the presence of the chief resident, then alone (as deemed appropriate) with immediate presentation of the H and P to the chief resident. Critique of the student’s workup will be offered and the chief resident will then revisit with the patient, complete the physical exam with the student at his or her side, pointing out salient points. Brief discussions regarding final diagnoses, with brief explanations to the student, will be completed by the chief resident. The responsibility of medical student instruction is overseen and shared by the attending physician as well as the PGY II and III residents.

XI. C. VAH ROTATION: POLICIES and PROCEDURES

1. Attend formal teaching rounds with staff members weekly: Wednesday 8:50am led by Dr. Marion B. Ridley and Dr. Judith McCaffrey

2. Attend VA Tumor Board: Wednesday 9:15-10:00am

3. To satisfy JCAHO requirements, progress notes must reflect when a patient has been staffed with an attending. The attending staff must write progress notes on days he/she makes rounds.

4. Rounds every day by residents together except for Saturday and Sunday when one resident may make rounds. Time of rounds is decided by the chief resident. Rounds should be made before morning surgery and in afternoons when clinic is completed.

5. Dr. Judith McCaffrey will make ward rounds on Tuesdays between cases with residents.

6. **All** operative cases **must** be presented to the full-time staff prior to operation, and this should be noted in the chart on the pre-op assessment form, i.e., attending Dr. _____ agrees with treatment plan, diagnosis, consults, and plan of operation.

7. All residents booking cases must go through mandatory training by Martha Rice in PACM to learn the PAT system. Contact her to schedule an appointment at the beginning of rotation.

8. One resident to be in OR dressed at 6:45 am on morning of first cases.

9. Major surgery should be scheduled as first case

10. Nursing home patients who will be admitted for surgery must be transferred to the hospital the day before the surgery. Those having Ambulatory Surgery can be worked up the day of surgery.

11. Patient's signed consent must be obtained and witnessed on form, completed and signed by physician prior to ordering blood transfusions. The name of the attending staffing the case **must** be on the consent form.

12. Patient's History & Physical (See Medical Records Requirements also)

    ⇒ examination dictated within 24 hours of arrival in hospital - **must be on chart before operation done**.

    ⇒ must be done by a physician. Co-signing student's H&P's is not acceptable for this requirement.

    ⇒ if applicable, referring physician's name and address should be on H&P.

13. Surgery requests must be entered into the computer 48 hours in advance; make sure the name of the attending who will be staffing the case is included, and whether an SICU bed or Medical Media is needed. Surgery scheduling should describe the age, diagnosis, staging,

and general health where indicated on the computerized form. All procedures and **correct** CPT codes must be listed.

14. Request any topical narcotics i.e., cocaine, the night before and fill out pharmacy slip.

15. Operative permits should be signed prior to receiving the next dose of narcotic for patients receiving pain medication.

16. Photographs:

    ⇒ Pre-op photographs **should be obtained** on the following patients:

    a. Candidates for rhinoplasty and otoplasty (photos available in the OR)
    b. Patients with facial nerve paralysis (series of pictures)
    c. Patients with complications of disease

    ⇒ Obtain post-op photos in the clinic by scheduling with Medical Media (Ext 7606).

17. Informed consent for major surgery should be performed with a witness present and noted in the chart. A physician must obtain the patient's signature on the operative consent form.

18. All HIV positive patients requiring lymph node biopsies must have a Progress Note in the chart from the attending physician confirming that the surgical procedure is clinically warranted.

19. All new HIV positive patients must have an Infectious Disease consult.

20. Following surgery, the resident surgeon shall call up the "verify screen" in the Operation Menu in DHCP and verify that the procedure and CPT code information in the computer is accurate.

21. The operative dictation must be done immediately after the case is completed. Surgeons who do not dictate a case will be suspended from operating for a week.

22. When dictating the operative note, the resident should state if the attending was scrubbed, in the OR, or immediately available.

23. An operative note must be written at the conclusion of the procedure. Patient can not leave recovery room without a handwritten post-op note.

24. Dictate the discharge summary in this order:
    1. Patient identifying information
    2. Discharge diagnosis & a list of all diagnoses treated during stay
    3. Description of hospital stay

25. Discharge summary should be dictated before patient leaves the hospital and discharge orders should be written prior to 7:00 am on the day of discharge. Discharge prescriptions should be written on Thursday or Friday for weekend discharges.

26. For all tumor evaluations a tumor staging sheet is available from the ENT cart in the pod. This sheet **must** be filled out.

    1. The resident completing the case is responsible for filling out both sides of tumor staging sheet in duplicate in OR (be sure patients name is on the form). This must be

reviewed with Dr. Judith McCaffrey. Provide 1 copy to patient's chart and 1 copy to Dr. Judith McCaffrey for tumor registry.

a. Draw lesions and state size (2 dimensions in cm)
b. Stage lesion (T,N,M)
c. If laryngeal lesion, state mobility of true vocal cords
d. Note attending and treatment recommendation
e. Date
f. Signature of resident

2. Fill out neck sheet if adenopathy present. State size of nodes and location (two largest diameters)

a. Date
b. Be certain to verify that correct name is on these forms.

27. All Surgical Consults require completion of VA Form SF-513, signed and dated by the consulting physician.

28. Inter-ward transfer of patients cannot be performed on Saturday or Sunday or at night in non-acute areas.

29. Everyday (q.d.) lab work cannot be ordered on patients.

30. In the event of a patient death:

⇒ **Autopsy should be requested on any death in hospital**
⇒ Resident requesting autopsy should attempt to be at autopsy
⇒ Dictate M&M summary immediately upon expiration
⇒ Notify the nurse or clinic clerk whenever a H&N patient expires
⇒ Notify the attending physician responsible for the patient

31. ENT Clinic should begin on time with at least one resident present. Notify the clinic if there is a conflict (should be known one day in advance by 2:00 pm). If it is necessary to cancel or reduce clinic, only the Section Chief or Assistant can authorize.

32. Clinic cancellations require a minimum of one month's notice and must be originated in the office of the Chief of Otolaryngology (Dr. Marion B. Ridley) or acting chief (Dr. Judith McCaffrey).
33. List or register all pending biopsies in Clinical Book

34. When tumor patients with teeth are diagnosed in the Clinic, Oral Surgery should be notified immediately and the patient seen that day, if possible, to assess for extractions and determine denture eligibility. Endoscopy should be coordinated with the oral surgeon when extractions are indicated.

35. Outpatient notes should be completed, including age, weight, vital signs, a summary history and physical, impression, plan of treatment, and return appointment. Date of therapies should be documented. All medications in current use and all medications refilled should be noted.

36. Be sure to list the operative procedure in the outpatient chart when you schedule a patient for surgery.

37. Progress notes **must** be made on chart for procedures in clinic.

38. If a patient has a blood test performed for HIV and the result is positive, the patient **must** be notified of this result in person (not over the telephone).

39. If a patient has a biopsy for a presumed malignancy a follow-up appointment **must** be made for the patient and the diagnosis given in person. No diagnosis of cancer will be given to the patient over the phone.

40. On possible transfer or admission of private doctor's patients, notify the clinic and ask physicians office to contact the clinic for instructions. Referred patients must be cleared by the eligibility department.

41. If a patient's behavior or the behavior of a person accompanying the patient seems inappropriate in the clinic, a "REPORT of CONTACT FORM" (blue blazer) should be completed **immediately** and appended to the chart giving your version of the incident with witnesses noted. This is for your protection from later accusations. (See Example)

42. Consultations will be seen during the clinic hours or at the end of clinic depending on patient load.

43. Incidents that include possible cases of suicide, attempted suicide, serious allergic reactions to anesthesia or drugs, transfusion accidents, possible cases of rape, alleged patient abuse, permanent disability or disfigurement as a result of an incident, should be reported immediately to the Chief of Staff's office and the appropriate paperwork completed.

XI. D. MEDICAL RECORD REQUIREMENTS

1. History and Physical Exam

- on chart within 24 hours of admission
- must be performed by a physician
- must be signed by attending physician
- documents treatment plan

2. Progress Notes

- admission note
- pre-operative must include **all** items on overprint
- post-operative must include **all** items on overprint
- daily progress note for each patient
- attending, physician progress note documenting concurrence with the residents initial diagnosis and treatment plan within 24 hours after admission (pre-op note will serve if surgery performed within 24 hours of admission); attending name and nature of discussion (when supervision) is reflected in resident's progress note.
- progress note each time a significant change in condition occurs. This note must include the name of the attending with whom event was discussed and the date and nature of the discussion.

3. Informed Consent

- name of attending must appear on Consent Form SF 522

4. Operative Report

- dictated immediately following surgery
- countersigned by attending physician
- must contain description of findings, technical procedure used, specimens removed, and post op diagnosis

5. Problem List

- update at each hospitalization

XII. A.

INSTITUTIONAL REPORT
TAMPA GENERAL HOSPITAL

SCHEDULE & STAFFING

	AM	PM
Monday	**Surgery** Dr. K. Paul Boyev **Clinic** Dr. Marion B. Ridley Dr. Matthew Kienstra *(qow)* **Private Clinic** *(Jr. Resident)* Dr. Loren Bartels	**Surgery** Dr. K. Paul Boyev **Clinic** Dr. Tapan Padhya Chief Resident Clinic **Private Clinic** *(Jr. Resident)* Dr. Loren Bartels
Tuesday	**Clinic** Dr. Thomas McCaffrey Resident Pre-op Clinic Dr. Yash Patil *(qow)*	**Clinic** Dr. Thomas McCaffrey Dr. K. Paul Boyev Dr. Yash Patil *(qow)* **Resident Clinic @ Health Park** Dr. Marion Ridley
Wednesday	**Clinic** Dr. Matthew Kienstra *(qow Plastics)* Dr. K. Paul Boyev **Surgery** *(Jr. & Sr. Resident)* Dr. Ed Farrior Dr. Yash Patil	**Clinic** Dr. Matthew Kienstra Dr. K. Paul Boyev Dr. Yash Patil
Thursday	**Clinic** None **Surgery** *(Jr. Resident)* Dr. Loren Bartels	**Clinic** Dr. K. Paul Boyev Dr. Marion B. Ridley Resident Clinic
Friday	**Clinic** Dr. Tapan Padhya (1st & 3rd) *(sleep clinic)* Dr. Matthew Kienstra (2nd & 4th) *(Plastics Clinic)* **Surgery** Dr. Thomas McCaffrey (1st and 3rd) Dr. Tapan Padhya (2nd & 4th) Dr. Matthew Kienstra (1st and 3rd)	**Clinic** Dr. Tapan Padhya (1st & 3rd) *(sleep clinic)* Dr. Thomas McCaffrey (2nd & 4th) Dr. Matthew Kienstra (2nd & 4th) *(Plastics Clinic)* Dr. Yash Patil **Surgery** Dr. Thomas McCaffrey (1st and 3rd) Dr. Tapan Padhya (2nd & 4th) Dr. Matthew Kienstra (1st and 3rd)

XII. B. OTOLARYNGOLOGY SERVICE
TAMPA GENERAL HOSPITAL/USF ENT CLINIC

TGH ROTATION: GOALS and OBJECTIVES

The goal of the five-year period of education at this site is to train the resident in the prevention, diagnosis, and medical and surgical management of otolaryngologic disorders in patients of all ages and both sexes. It is designed to provide the resident with an academic and clinical education that allows for progressive responsibility for patient care.

This goal is achieved by the **PGY-2** through assisting the Chief Resident in patient care on ward rounds and in the intensive care unit, emergency room, outpatient clinic, and operating room. First-year otolaryngology residents may 1) evaluate and treat outpatients in the otolaryngology clinics, 2) provide immediate consultation and treatment in emergency departments, 3) provide immediate consultation and treatment for hospital inpatients, 4) perform admission history and physical examinations for hospital and surgical patients, 5) write all orders necessary for the care of patients on the Otolaryngology Service including orders for admission, medications, surgery, restraint (with indirect supervision), and discharge, 6) document the progress of care in patients charts, 7) obtain informed consent for operative procedures, 8) under supervision, perform minor procedures in the outpatient clinics, emergency departments and on the hospital floors, e.g. fiberoptic endoscopy, fine needle aspiration, biopsies of mucosa and skin, debridement of wounds, suture of complex facial lacerations, insertion of tympanostomy tubes, excision of skin lesions, incision and drainage of abscess, antral irrigation, 9) under supervision, perform minor surgery in the operating room, e.g. fiberoptic and rigid endoscopy, insertion of tympanostomy tubes, tonsillectomy, adenoidectomy, excision of lymph nodes, local skin flaps, tracheotomy, and intermaxillary fixation and 10) be the responsible surgeon present in the operating room for induction of anesthesia for all cases except those with difficult airways, and 11) prep, drape, and start operating room cases when the chief resident or attending is immediately available. The first-year resident will see and care for outpatients in the USF Resident's Clinic on Tuesday and Thursday during clinic hours and will assist in surgery Monday through Friday as directed by the Chief Resident.

The **PGY-3 Year Otolaryngology Resident** rotating at Tampa General Hospital is on the specialty rotation of Otology. The goal for the resident on the three-month otology rotation is to form a broad-based educational foundation in otology with experience in chronic ear surgery, neurotologic procedures, and exposure to a variety of otologic tests. The resident performs the H&P on all new patients and presents them to the otologist for discussion and treatment planning. The otology rotation involves five days each week, beginning the week with a surgical experience with Dr. K. Paul Boyev on Monday and assisting Dr. Bartels in the OR on Tuesday mornings and in clinic on Tuesday afternoons in his private office. Wednesday is an outpatient experience in Dr. Jay Farrior's private office followed by clinic with Dr. Boyev in the afternoon, and then in surgery on Thursdays at St. Joseph's Hospital assisting Dr. Jay B. Farrior. Friday, the entire day is spent either in the TGH OR or the resident may choose independent drilling in the Temporal Bone Lab, depending on case volume.

The **PGY-4-Year Otolaryngology Resident** at Tampa General Hospital completes the second three months of the six-month Otology Rotation. By the end of the third year of training, the resident should have a thorough knowledge of temporal bone anatomy, having participated in three temporal bone dissection courses. These include surgical as well as radiographic anatomy and didactic lectures on the management of chronic ear disease and otosclerosis.

The resident should be adept in obtaining a thorough neurotologic history and directing questions toward specific disease processes. The resident should have a thorough knowledge of the diagnostic skills that are needed for otology including a thorough otologic evaluation with or without microscopic examination, audiogram, auditory brainstem response (ABR), electronystagmography(ENG), electroneuronography(ENoG), and testing of facial nerve function.

The goal for the **PGY-5-Year Resident** (Chief) at Tampa General Hospital should be development of proficiency in clinical outpatient, inpatient, and operating room management and conference preparation and presentation. He/she is responsible for the coordination of the trauma conferences, radiology conferences, facial plastic, and skull base conferences held at Tampa General Hospital. The Chief Resident must assist the faculty in supervising the performance and training of the junior residents and the medical students, perform daily rounds, make daily surgical assignments on patients and be present in the outpatient clinic on Tuesday and Thursday afternoons. They are responsible for arranging attending supervision for all OR cases. By the end of the six- month rotation at Tampa General Hospital, the resident should be able to function independently and expertly in the prevention and management of diseases and disorders in the specialty of otolaryngology-head and neck surgery. The PGY V resident will assume the role of primary surgeon under supervision of the attending physician to learn the following procedures including, but not limited to:

A. excision of vascular and neural tumors of the head and neck advanced or revision thyroid surgery

B. parapharyngeal space tumor excision: cervical or mandibulotomy approach

C. selective partial laryngectomy: supracricoid and near total laryngectomy

D. wide excision of tonsillar, base of tongue, palate tumors through mandibulotomy

E. maxillectomy with or without orbital exenteration

F. craniofacial resection

G. stapectomy/stapedotomy

H. middle ear ossicular reconstruction

F. facial nerve decompression in the middle ear

G. tympanomastoidectomy

H. modified and radical mastoidectomy

I. tracheal resection

J. laryngotracheal reconstruction

K. septorhinoplasty

L. FESS and external sinus surgery

M. complex maxillofacial trauma

N. management of penetrating trauma

Tampa General is a Level I Trauma hospital with a large volume of maxillofacial injuries. All residents learn to evaluate the acutely injured patient and participate in the surgical management and perioperative care of trauma patients in the emergency department, the operating room, the intensive care units, and the inpatient floors.

XII. C. TGH ROTATION: POLICIES and PROCEDURES

1. Residents rotating at TGH will be responsible for all emergencies and consults during the day and work-ups prior to 5:00 pm. On Trauma Call weeks, at least one resident should remain at TGH until relieved by resident on Trauma Call. *(The call room assigned to otolaryngology is located on the fourth floor.)*

2. Do not leave the hospital uncovered; make sure ER knows who is on call during the day.

3. If it is necessary for the on-call resident to leave the hospital, the Chief Resident must be aware of the absence.

4. Rounds are to be made daily on all patients. Post-op rounds are made each afternoon.

5. The on-call resident should be familiar with all patients on the Service and should take care of needs if primary physician is not available.

6. Chief Resident is to maintain, on a daily basis, a complete patient list to include:
   - ⇒ all staff patients
   - ⇒ all attending private patients
   - ⇒ all staff consults
   - ⇒ specific attending consults

   A copy of this list is to be given to all residents and medical students at TGH.

7. Up-to-date patient list is to be given to resident on call at 5:00 pm, check-in. Any unit patients or problem patients and post-op patients are to be discussed and visited at bedside with notes on chart.

8. On-call resident is to leave list of new patients and consults (including room number and diagnosis). Any complications or difficulties should be made known to the Chief Resident in person or by phone and to the appropriate attending promptly.

9. Appropriate attending should be called for every emergency room admission and consult.

10. Outpatient private surgery cases should already have had their H&P performed before the patient arrives at TGH for surgery. Occasionally, a patient will forget their work-up and will require a short form H&P by the resident.

11. Cosmetic Surgery patients must be able to pay the hospital as an inpatient. Dr. Thomas McCaffrey is to be notified of all cases. Cosmetic Surgery cases may not be scheduled in June.

12. Precertification must be received for all procedures performed in clinic and for

surgical cases. Some procedures performed in the clinic have been cleared for our service without preauthorization. Please check the list for these procedures.

13. Surgical cases must have a booked OR date prior to requesting precertification.

14. Complete work-up in clinic should be done on all service cases prior to admission.

14. Chief Resident must staff all service cases.

All cases must be staffed either by Dr. McCaffrey, Dr. Boyev, Dr. Padhya, Dr. Kienstra, Dr. Patil, or the attending on call, depending on surgery date.

VIII. D. OTOLOGY ROTATION SCHEDULE & STAFFING

Otology Rotation

Monday	**Surgery** Dr. K. Paul Boyev	**Surgery** Dr. K. Paul Boyev
Tuesday	**Surgery** Dr. Loren Bartels	**Clinic** *(private office*)* Dr. Loren Bartels
Wednesday	**Pre-Op Clinic** *(private office)* Dr. Jay B. Farrior	**USF Clinic** Dr. K. Paul Boyev
Thursday	**Surgery** (*St. Joseph's Hosp.)* Dr. Jay B. Farrior	**Surgery** (*St. Joseph's Hosp.)* Dr. Jay B. Farrior
***Friday	**Surgery @ TGH** (or T. Bone Lab)	**Surgery @ TGH** (or T. Bone Lab)

* The resident will learn to assist with ENG and ABR testing.

If VA Chief on leave, the otology resident to assist to cover VAH clinic and OR, as needed, instead of TGH cases.

XII. E. OTOLOGY ROTATION POLICIES AND PROCEDURES

The goal of the otology rotation is for the resident to have progressively more responsibility in otologic surgery including myringotomy and ventilating tube insertion, reconstruction of the tympanic membrane, harvesting of temporalis fascia grafts, and tympanoplasty and mastoidectomy for chronic ear disease. The resident should also become knowledgeable in diagnosis, management, and treatment of otosclerosis, although the stapedectomy operation is generally performed by the residents during the fourth year of training. The resident should be able to assess and manage patients with acute, subacute and chronic otitis media and their complications including perforated tympanic membrane, acute and chronic mastoiditis, cholesteatoma, ossicular chain erosion, meningitis, brain abscess, and dural sinus thrombosis. The resident should be familiar with the treatment of mastoiditis, osteomyelitis of the skull base, and the diagnosis and evaluation of patients with congenital or acquired hearing loss, both conductive and sensorineural. The resident, at the end of the third year, should be familiar with the various inner ear disorders, including Meniere's disease, positional vertigo, labyrinthitis, syphilitic and auto-immune sensorineural hearing loss, and Cogan's syndrome. The resident should know the presenting symptoms, signs, and cost-effective evaluation of acoustic neuromas, glomus tumors, and cholesterol granulomas.

Leave/Attendings: If an otology attending is on leave, the resident should schedule time with the other attending.

If both otology attendings are on leave, resident is expected to participate at TGH.

Leave/Residents: The otology/plastic surgery resident may be pulled from routine rotation to TGH when other residents rotating at TGH are on leave. This will occur at the discretion of Dr. TV McCaffrey.

Scheduling Conflicts: Otology Rotation resident is expected to be present where assigned. Coordination of this rotation requires maturity and responsibility and ability to work out any conflicts in scheduling that may arise.

Should one otology attending schedule an unusual case on a day when the rotating resident is scheduled elsewhere, the resident's schedule may be adjusted to allow for attendance at the case. This will occur at the discretion of Dr. Boyev, Dr. Jay Farrior or Dr. Bartels.

Requirements/OR/Otology: The resident shall work-up all patients going to the OR on the day he is scheduled to be with the otologist, even if a schedule shift occurs, as indicated above. On days that the resident is not scheduled to be with the otologist, the patients will be worked-up through other usual channels.

TGH patient: usual mechanism for H&P's applies

St. Joseph's: Dr. J. Farrior will arrange for H&P's on patients scheduled for surgery outside assigned resident time

Requirements/Office/Otology: Resident will participate in office evaluation of patients at discretion of attending.

XII. F. RESPONSIBILITIES & DUTIES OF CHIEF RESIDENT @ TGH-HEALTH PARK & USF RESIDENT CLINICS

1. Assure that all in-patient, private and service cases are worked-up each day and assist in and coordinate this endeavor with the junior residents.

2. Round daily on all private and service cases and maintain a complete patient list to include:
   - ⇒ all staff patients
   - ⇒ all attending private patients
   - ⇒ all staff consults
   - ⇒ specific attending consults

3. Assure that weekend rounds are made on all TGH service and private cases.

4. Serve as the Otolaryngology Department's representative on all committee or other activities requested by the hospital administration.

5. Coordination of Trauma, Facial Plastic, and Otology conferences including selection of cases for Trauma conferences.

6. Responsible for sign-in sheets for any teaching conference conducted at TGH, i.e. M&M, Trauma, Otology, Facial Plastic, etc.

7. Staff all service cases from USF and Health Park Resident Clinics.

XIII. A.

INSTITUTIONAL REPORT
LEE MOFFITT CANCER CENTER & RESEARCH INSTITUTE

SCHEDULE & STAFFING

	AM	PM
Monday	**Surgery** Dr. Thomas McCaffrey **Clinic** Dr. Judith McCaffrey	**Surgery** Dr. Thomas McCaffrey **Clinic** Dr. Judith McCaffrey Dr. Matthew Kienstra
Tuesday	**Tumor Board** *(everyone)* **Clinic** Dr. Tapan Padhya Resident Pre-op Clinic	**Surgery** Dr. Thomas McCaffrey **Clinic** Dr. Tapan Padhya
Wednesday	**Clinic** Dr. Thomas McCaffrey **Surgery** Dr. Tapan Padhya	**Clinic** Dr. Judith McCaffrey **Surgery** Dr. Tapan Padhya
Thursday	**Clinic** Dr. Thomas McCaffrey **Surgery** Dr. Tapan Padhya Dr. Yash Patil	**Clinic** Dr. Thomas McCaffrey **Surgery** Dr. Matthew Kienstra Dr. Yash Patil
Friday	**Surgery** Dr. Judith McCaffrey **Clinic** Dr. Yash Patil (except 5th)	**Surgery** Dr. Judith McCaffrey **Clinic** Dr. Tapan Padhya (1st and 3rd)

Nursing Staff:	Gene Terkoski, RN, H&N Clinic Barb Wampler, RN, H&N Clinic Ellen Kokott, RN, H&N Clinic Susan Dato, Supervisor, Dental Clinic Theresa Papa-Rodriquez, RN, Head Nurse, 4 South	Dental: Terry Kelly, D.M.D. Speech: Joy Gaziano, M.S. Linda Stachowiak, M.S Social Service: Vicki Zambito
Dietary	Melissa Kiingery, RD	
Center Secretaries	Leah Sanders	

XIII. B. OTOLARYNGOLOGY SERVICE
H. LEE MOFFITT CANCER CENTER & RESEARCH INSTITUTE

HLM ROTATION: GOALS AND OBJECTIVES

The otolaryngology rotation at the H. Lee H. Lee Moffitt Cancer Center and Research Institute is a clinical rotation for resident at the PGY 3 and PGY 4 levels. The goal of the H. Lee Moffitt Cancer Center and Research Institute rotation is to gain proficiency in the diagnosis and treatment of head and neck cancer both in an outpatient as well as inpatient setting.

CLINICAL OBJECTIVES: PGY -3

During, and at the completion of, the H. Lee Moffitt Cancer Center rotation, the PGY III resident will be able:

1. To perform a complete and thorough history and physical examination on head and neck oncology patients. He or she will be participating in the work up and evaluation of the patients in the private clinic of the physicians participating in the head and neck program. The resident at this level will concentrate his or her efforts on more complicated and unusual tumor cases and will present new cases to the attending physicians. The resident should be able to formulate a well organized differential diagnosis and will learn to correlate to physical findings with radiographic and histopathologic findings in head and neck oncology patients.

2. To participate in the post operative care of patients on whom he or she has operated in effort
to learn about problems, complications, and successes. This includes follow-up of patients both in the hospital setting as well as in the outpatient clinic. The resident will attend to the needs of the patients in the postoperative period under the direct supervision of the attending physician.

3. To assume a role in the operating room as a first assistant on all major head and neck oncology cases being performed by the attending physicians in the head and neck program. He or she will be responsible for all preoperative history and physical examinations and the organization of paperwork, necessary to get the patient to the operating room. The resident will being active in the operative course of the patient, either assisting or functioning as the primary surgeon as deemed appropriate by the attending physician. The resident will learn basic and advanced surgical techniques by observation and later by execution of these techniques at the discretion and under the supervision of the attending physician. Procedures that the resident will be performing include, but are not limited to, the following:

a. selective neck dissection
b. parotidectomy
c. thyroidectomy
d. partial or total laryngectomy
e. tracheoesophageal puncture
f. transoral endoscopic procedures
g. mandibulotomy, mandibulectomy, tongue resection, tonsillar resection
h. pectoralis major myocutaneous flap
i. deltopectoral flaps

j. microvascular free tissue transfers

4. To participate in the multidisciplinary care of head and neck cancer patients both in the preoperative (tumor board) and postoperative (Ward rounds and daily maintenance of patients) settings. By active participation with the multidisciplinary team, the resident learns to communicate effectively with many disciplines that are required to care for complicated head

and neck oncology patients. At the completion of the H. Lee Moffitt Cancer Center rotation, the PGY III resident is expected to have been exposed to or master those procedures listed above under guidance of the attending physician. He or she will demonstrate proficiency in as many techniques as possible, as well as an understanding of the risks, complications, and expected outcomes. Inability to demonstrate proficiency will be discussed with the individual and recorded on his or her evaluation. The objective is mastery of appropriate motor skills necessary for advancement to the PGY IV level.

PGY 4

During, and at completion of the rotation, the resident at PGY IV level will be able:

1. To complete history and physical examinations on head and neck patients presenting to the head and neck oncology clinic under the direction of the attending physicians. The resident should be able to readily present pertinent findings and will learn to correlate radiographic and histopathologic findings with clinical scenarios in order to formulate management strategies.

2. To provide close follow-up, and care of those patients on whom the resident has operated. This includes both as the patient's primary physician while the patient is hospitalized as well as follow-up in the clinic during the postoperative period. The goal is for the resident to reinforce his or her ability to proficiently care for complicated head and neck patients more independently, with guidance and supervision from the attending physician. Close follow-up provides continuity of care for the patients as well as for the resident's education, where follow-up of outcomes can be used as a learning and teaching tool.

3. To assume a role as primary surgeon or first assistant in the operating room for all major head and neck oncologic cases under guidance of the attending physician. The PGY IV resident will scrub and function as the primary surgeon at the discretion of the attending physician on complicated and advanced head and neck cases. He or she will build upon the skills learned at the PGY III level in order to gain technical proficiency in major head and neck procedures. The procedures include, but are not limited to, the following:

a. parapharyngeal space and tumor excision
b. selective partial laryngectomy and
c. wide excision of tonsillar, tongue base, and palate tumors through mandibulotomy approaches
d. excision of vascular and neural tumors
e. advanced or revision thyroid surgery
f. craniofacial resection
g. tracheal resection
h. airway reconstruction

4. To share the responsibility of teaching rotating fourth year medical students during elective rotations at H. Lee Moffitt Cancer Center. The resident will share the responsibility of educating the medical students with the attending physician in effort to teach the student skills necessary for appropriate examination of head and neck oncology patients. The goal is to allow the resident to assume a role as an instructor to fine-tune his or her skills in teaching.

At the completion of the H. Lee Moffitt Cancer Center rotation, the PGY IV resident is expected to have been exposed to or have mastered the procedures listed above under the direct guidance of the attending physician. He or she will demonstrate proficiency in as many techniques as possible and will be able to discuss the advantages, indications, risks, and complications of each. Inability to demonstrate proficiency will be discussed with the individual and recorded in his or her evaluation. The objective is to teach appropriate motor skills and professional skills necessary for advancement to the chief resident year.

XIII. C. HLM ROTATION: POLICIES and PROCEDURES

1. Resident is to be in clinic immediately following Tumor Board each Tuesday morning for patient follow-up visits and pre-op clinic. Resident is responsible for H&P, consent, pre-op orders, and slide review forms.

2. Orders should be made using the TDS computer system. In-service training is available.

3. T & S blood crossmatch orders must be received in the Blood Bank before 8:00 pm on the day before surgery.

4. Resident will attend all inpatient and outpatient surgical cases.

5. Resident will be available in the OR 30 minutes prior to the first case.

6. The staging forms (See STAGING MANUAL AND FORMS section) must be completed on all cases to avoid a chart deficiency.

7. Charts will be kept current. Moffitt is extremely strict in enforcement of sanctions against attendings when residents have not completed their chart work.

8. Resident is responsible for sign-in sheets for all otolaryngology teaching conferences held at Moffitt (Videostroboscopy, Skullbase). Program Coordinator will provide sign-in sheets.

9. Moffitt provides, on a seven day a week basis, two meals to each resident required to take night call. These meals consist of an evening meal (provided on the day of the night call) and a breakfast meal (provided the morning following night call). The cashier maintains a copy of the call schedule and only those names listed for that particular day will be provided with a meal. If you pull call for someone on the list, you will be asked to print your name and sign the list. A $4.00 limit of food value items is established for breakfast; a $6.00 limit for the evening meal. Resident must pay for items over this amount. Lunches will be provided for a dollar value of $5.00 for residents on call on the weekend and Moffitt recognized holidays.

10. Otolaryngology resident mailbox for Moffitt is located in the hallway between medical records and nursing administration on the first floor.

First time rotation through Moffitt under Otolaryngology: Personal identifying Numbers and dictation codes are required for each resident. These are assigned during your first year of residency training and retained in Moffitt files until you rotate at Moffitt. Kathy McKinley, Resident/Fellowship Coordinator for Moffitt, will assist you in obtaining your number prior to your Moffitt rotation @ X-2069.

Call room: Room 3139 is the call room assigned to our service. This room is shared, but rarely used by the service with which we share. If a situation occurs in which a male

and female are on call simultaneously and assigned to this room, contact administrative coordinator through the operator. The resident coordinator has an extra key if needed during normal business hours. To gain access to the room you may also contact security at X-3000, at any time.

XIV. A.

INSTITUTIONAL REPORT
ALL CHILDREN'S HOSPITAL

SCHEDULE & STAFFING

	AM	PM
Monday	**Surgery/Clinic**-ACH Orobello/Andrews/Cressman	**Surgery/Clinic**-ACH Orobello/Andrews/Cressman
Tuesday	**Surgery/Clinic**-ACH Orobello/Andrews/Cressman	**Surgery/Clinic-**ACH Orobello/Andrews/Cressman
Wednesday	**Surgery/Clinic**/N. Tampa Orobello/Andrews/Cressman	**Clinic/**N. Tampa Orobello/Andrews/Cressman
Thursday	**Surgery/Clinic-**ACH Orobello/Andrews/Cressman	**Surgery/Clinic**-ACH Orobello/Andrews/Cressman
Friday	**Surgery/Clinic**-ACH Orobello/Andrews/Cressman	**Surgery/Clinic**-ACH Orobello/Andrews/Cressman

Debbie Miller ACH, University Teaching Service Director, 727-892-4106
ACH: 727-898-7451 (or) 800-456-4543
ACH Tampa Clinic: 813-631-5000
OR: 727-892-4300
ER: 727-892-8400
Office: 727-892-4305
Emergency Line to Nurses Station: 727-892-8361
Scheduling: 727-892-8586 (Linda Schuerman)

		Direct	Mobile	Home
Resident	664	727-516-3291		
Dr. Orobello	214	727-529-0329	727-420-3740	727-864-9977
Dr. Andrews	118	727-529-1032	727-420-5421	727-527-7637
Dr. Cressman	559	727-405-7625	727-410-9805	727-573-5320

XIV. B. OTOLARYNGOLOGY SERVICE
ALL CHILDREN'S HOSPITAL

ACH ROTATION: GOALS and OBJECTIVES

The **goal of the All Children's Hospital (ACH) rotation** is to train the resident in pediatric otolaryngology. The faculty at ACH consists of three, fellowship-trained pediatric otolaryngologist-head and neck surgeons. Under their supervision, the resident sees pediatric patients in a private office clinical setting approximately three days each week. He/she also has the opportunity to manage his/her own patients in the outpatient clinic and the operating room with attending supervision.

Second-Year Residents begin by observing the attending in order to: develop skills in examining a pediatric patient; diagnose pediatric problems; and develop treatment plans which provide suitable patient options. As the resident develops clinical skills with pediatric patients, he/she progresses to evaluation, diagnosis, and development of a treatment plan for operative and non-operative outpatients and consults which are presented to and reviewed by the attending. At the end of the second pediatric rotation, **the third year resident** should have a clear and concise understanding of the etiology, pathophysiology, diagnosis, and treatment, both medical and surgical of the following conditions:

1) Ear disease in children including otitis media with effusion, recurrent acute otitis media, perforation of the tympanic membrane, and cholesteatoma.

2) Diseases of the tonsils and adenoids including recurrent adenotonsillitis, upper airway obstruction, and peritonsillar abscess.

3) Congenital head and neck masses to include branchial cleft anomalies, thyroglossal duct anomalies, and hemangioma/cystic hygroma.

4) Vocal cord anomalies to include vocal cord paralysis and paresis, and lesions of the true vocal cord and larynx.
5) Diagnosis and management of subglottic stenosis.

6) Conditions of the palate and choana, including cleft palate, submucous clefting of the palate, choanal atresia, hypernasality, and velopharyngeal insufficiency.

Under the supervision of an attending, the resident participates in the management of pediatric patients in a private office setting approximately three days each week and in the OR approximately two days each week. The resident rotating at All Children's Hospital is responsible for the initial evaluation of inpatient consultations. The resident is responsible for assigned admission H&P's and discharge summaries, rounding twice daily on inpatients, and the

initial evaluation of emergency room patients during the week, Monday through Saturday. Additionally, during the second three-month rotation, the resident is strongly encouraged to write one paper which may be a case report, literature review, or clinical research under the direction of the attending staff with the intent of future presentation at a local or national meeting.

XIV. C. ACH ROTATION: POLICIES and PROCEDURES

1. **University Teaching Service:** Prior to start of rotation, resident must sign-in with Housestaff Office of the University Teaching Service, located in the Children's Health Center (CHC) 3rd Floor (Pediatric Residency Dept.) Hours: 8:00 am - 5:00 pm, Monday-Friday. Resident will review exposure control plan used by AHC and complete paperwork as required.

   The resident assigned to All Children's Hospital cannot begin the rotation until clearance is received from the University Teaching Service office at the Children's Health Center. Paperwork must be completed and immunizations must be up to date.

   The University Teaching Service office must also be advised of all leave taken by the resident rotating at ACH. The Pediatric Otolaryngology office must be informed of any planned leave/vacation **at least one month prior** to the start of leave, or as soon as approved by the Program Director.

2. Any resident assigned to the ACH rotation should directly notify Drs. Orobello, Andrews, Cressman and Linda Schuerman of leave dates at time of approval by Program Director. This rule applies to authorized leave as well as annual leave.

3. **Wards:**
   ENT resident will be responsible for all inpatient consultations. These should be seen **promptly** and **courteously**. These should be staffed with the appropriate attending.

   A. Have consult signed by attending. Place yellow copy in bin for Diane Hess.
   B. Resident is responsible for performing all H&P's and D/C summaries (use hospital dictation) for inpatient admissions.
   C. Residents will be on call for in-house consults and inpatients on the pediatric ENT service Monday 8:00 am to Friday 5:00 pm, and after hours according to the monthly call schedule, in which the resident alternates call with the PA. and NP.
   D. Residents will take call after hours from home for routine questions from **their own** surgical patients.

4. **Emergency Room (#8400)**
   ENT resident responsible for all consults and problems/complications related to service during the week and on specified weekend days. Notify attending early for airway or bleeding problems. Bring copy of ER note to office for billing and chart configuring. (Nurse/Diane Hess) Facial trauma call alternates with plastics weekly. A copy of that schedule is available for the entire year.

5. **Operating Room**

A. Resident will be supervised by attending.

B. Resident should bring office charts to OR and back to office every day. Resident is responsible for all charts.

C. Resident is responsible for dictation of all surgical resident cases performed.

D. Resident should check the OR schedule 1-2 weeks ahead for interesting or big cases to scrub. (Check schedule; discuss with Linda Schuerman)

E. Residents are not to remove office charts from the office except to go to the OR.

6. **Rounds**

Resident is responsible to round twice daily, **except Sundays**, and write notes every day on all inpatients. Resident will rotate with attending specified on call to see consults.

7. **Miscellaneous Clinical Duties**

A. Resident should strive to write one paper (case report, literature review, clinical research) while on rotation for the year. The attending will assist any resident wishing to present at a local, national meeting forum.

B. While rotating during office hours, resident will at first be expected to follow along with attending to appreciate how treatment plans are developed.

C. Resident will be particularly responsible for new patients he/she works up and schedules for surgery. Resident should make sure he/she is present for follow-up visits after surgery.

8. During the rotation, resident should complete a simple text on pediatric otolaryngology (supplied by Pediatric Otolaryngology).

9. By the end of the rotation, resident should be able to describe the appropriate history, physical exam, and treatment for:

Otitis media with effusion

Recurrent acute otitis media

Recurrent adenotonsillitis

Adenotonsillar hypertrophy with upper airway obstruction

Peritonsillar abscess

Congenital head and neck masses (including branchial cleft anomalies, thyroglossal duct cyst, dermoid hemangiomas, cystic hygromas)

Vocal cord paralysis

Subglottic stenosis

Cleft palate

Choanal atresia

Foreign bodies of the ear, nose, and airway

Laryngomalacia

Hearing loss: conductive/sensory neural

Stridor

XIV. D. MEDICAL PEARLS OF WISDOM

Tracheotomy

Post-op CXR checked by resident/noted in chart
Leave retention sutures until 1st trach change
No deaths reported for trach tied too tight; several reported for too loose
1st trach- Pod #3-5 (depending on attending)

Cricoid Split

Traction sutures always
Never close wound
Give steroids 24 hours prior to stent removal
Post-op CXR

Tonsillectomy

Under 3 years, 23 hour observation
Over 3 years, O.P.
Always write for meds on pre-printed R_x pads
If allergic to PCN, write for other appropriate antibiotics
Office post-op check in 2-3 weeks

Draining PET

No water in ears
Antibiotics ear or eye drops x 10 days
Systemic antibiotics based on severity x 10 days

FESS Surgery

1st surgery is 23 hour observation
2nd surgery (cavity suction) 2-3 weeks after 1st and is outpatient

IV Orders

1st 10 kg - 4 cc/kg/hr
2nd 10 kg - 2 cc/kg/hr
then after - 1 cc/kg/hr
if bolus needed - NS or LR at 10cc/kg over 30 to 60 minutes