

Duke OHNS Residency Program Handbook

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Compact Between Resident Physicians and Their Teachers

Residency is an integral component of the formal education of physicians. In order to practice medicine independently, physicians must receive a medical degree and complete a supervised period of residency training in a specialty area. To meet their educational goals, Resident physicians must participate actively in the care of patients and must assume progressively more responsibility for that care as they advance through their training. In supervising Resident education, Faculty must ensure that trainees acquire the knowledge and special skills of their respective disciplines while adhering to the highest standards of quality and safety in the delivery of patient care services. In addition, Faculty is charged with nurturing those values and behaviors that strengthen the doctor-patient relationship and that sustain the profession of medicine as an ethical enterprise.

Core Tenets of Residency Education

Excellence in Medical Education

Institutional sponsors of residency programs and program Faculty must be committed to maintaining high standards of educational quality. Resident physicians are first and foremost learners. Accordingly, a Resident's educational needs should be the primary determinant of any assigned patient care services. Residents must, however, remain mindful of their oath as physicians and recognize that their responsibilities to patients always take priority over purely educational considerations.

Highest Quality Patient Care and Safety

Preparing future physicians to meet patients' expectations for optimal care requires that Residents learn in clinical settings epitomizing the highest standards of medical practice. Indeed, the primary obligation of institutions and individuals providing Resident education is the provision of high quality, safe patient care. By allowing Resident physicians to participate in the care of their patients, Faculty accepts an obligation to ensure high quality medical care in all learning environments.

Respect for Residents' Well-Being

Fundamental to the ethic of medicine is respect for every individual. In keeping with their status as trainees, Resident physicians are especially vulnerable and their well-being must be accorded the highest priority. Given the uncommon stresses inherent in fulfilling the demands of their training program, Residents must be allowed sufficient opportunities to meet personal and family obligations, to pursue recreational activities and to obtain adequate rest.

Commitments of Faculty

1. As role models for our Residents, we will maintain the highest standards of care, respect the needs and expectations of patients, and embrace the contributions of all members of the healthcare team.
2. We pledge our utmost effort to ensure that all components of the educational program for Resident physicians are of high quality, including our own contributions as teachers.

3. In fulfilling our responsibility to nurture both the intellectual and the personal development of Residents, we commit to fostering academic excellence, exemplary professionalism, cultural sensitivity, and a commitment to maintaining competence through life-long learning.
4. We will demonstrate respect for all Residents as individuals, without regard to gender, race, national origin, religion, disability or sexual orientation.
5. We will do our utmost to ensure that Resident physicians have opportunities to participate in patient care activities of sufficient variety and with sufficient frequency to achieve the competencies required by their chosen discipline. We also will do our utmost to ensure that Residents are not assigned excessive clinical responsibilities and are not overburdened with services of little or no educational value.
6. We will provide Resident physicians with opportunities to exercise graded, progressive responsibility for the care of patients, so that they can learn how to practice their specialty and recognize when, and under what circumstances, they should seek assistance from colleagues. We will do our utmost to prepare Residents to function effectively as members of healthcare teams.
7. In fulfilling the essential responsibility we have to our patients, we will ensure that Residents receive appropriate supervision for all of the care they provide during their training.
8. We will evaluate each Resident's performance on a regular basis, provide appropriate verbal and written feedback, and document achievement of the competencies required to meet all educational objectives.
9. We will ensure that Resident physicians have opportunities to partake in required conferences, seminars and other non-patient care learning experiences, and that they have sufficient time to pursue the independent, self-directed learning essential for acquiring the knowledge, skills, attitudes, and behaviors required for practice.
10. We will nurture and support Residents in their role as teachers of other Residents and of medical students.

Commitment of Residents

1. We acknowledge our fundamental obligation as physicians is to place our patients' welfare uppermost; quality health care and patient safety will always be our prime objectives.
2. We pledge our utmost effort to acquire the knowledge, clinical skills, attitudes and behaviors required to fulfill all objectives of the educational program and to achieve the competencies deemed appropriate for our chosen discipline.
3. We embrace the professional values of honesty, compassion, integrity, and dependability.
4. We will adhere to the highest standards of the medical profession and pledge to conduct ourselves accordingly in all of our interactions. We will demonstrate respect for all patients and members of the health care team without regard to gender, race, national origin, religion, economic status, disability or sexual orientation.
5. As physicians in training, we learn most from being involved in the direct care of patients and from the guidance of Faculty and other members of the healthcare team. We understand the need for Faculty to supervise all of our interactions with patients.
6. We accept our obligation to secure direct assistance from Faculty or appropriately experienced Residents whenever we are confronted with high-risk situations or with clinical decisions that exceed our confidence or skill to handle alone.
7. We welcome candid and constructive feedback from Faculty and all others who observe our performance, recognizing that objective assessments are indispensable guides to improving our skills as physicians.

8. We also will provide candid and constructive feedback on the performance of our fellow Residents, students, and Faculty, recognizing our life-long obligation as physicians to participate in peer evaluation and quality improvement.
9. We recognize the rapid pace of change in medical knowledge and the consequent need to prepare ourselves to maintain our expertise and competency throughout our professional lifetimes.
10. In fulfilling our own obligations as professionals, we pledge to assist both medical students and fellow Residents in meeting their professional obligations by serving as their teachers and role models.

This compact serves as both a pledge and a reminder to Resident physicians and their teachers that their conduct in fulfilling their obligations to one another is the medium through which the profession perpetuates its standards and inculcates its ethical values. This compact was established by the AAMC (www.aamc.org/residentcompact).

Faculty Supervision Policy

The goal of our educational program is to provide an environment that allows for the full development of skills. This requires a balance between observation and performance both in the operating room, on the ward, and in the out-patient setting. This balance is determined by the individual attending, Resident's skills and patient preferences. It is expected that during this program a graduated process of supervised performance will occur in accordance with the Resident's PGY level, experience and abilities.

The OHNS Resident is responsible for the medical, preoperative, intra-operative and post-operative management of the patients under the supervision of the Attending surgeon. The Resident's role in the surgical and non-surgical management of the patient is commensurate with his/her experience and abilities. The Resident will have first seen the patient in the outpatient clinic, Emergency Room, in-patient ward or upon admission to the preoperative unit. Preoperatively, a dialogue is established between the Resident involved and the responsible Faculty member to determine the specifics of therapy and the options for management. No patient can be taken to the operating room for any surgical procedure without the Faculty member present in the operating room. Anesthesia cannot be induced until the Faculty member has related to the patient. The Attending and Resident surgeon will perform the operation in keeping with the complexity of the case, the Resident's ability, and the patient's preference. All attestation sheets are signed by the Faculty member of record, as are the operative notes. Under the supervision of the attending surgeon, the Resident is responsible for the postoperative in-hospital management of the patient. Please see the document entitled "Duke University Hospital Graduate Medical Trainees and Attending Physicians Patient Care Activities and Supervision Responsibilities" which can be found at the following website: http://www.gme.duke.edu/program_coordinators/forms/Supervision_10-21-2002.pdf.

Supervisory Lines of Responsibility

The Duke University OHNS Residency Program is designed to provide consistent and outstanding didactic, clinical, and technical education, along with research training to the OHNS Resident. Attaining the goals and objectives of the residency program enables the Resident to independently manage the medical, preoperative, operative, and postoperative care of patients so that he/she can effectively provide superior health care to patients in need. In addition, the Resident will develop the framework to pursue necessary scientific investigation into his/her patients' disease processes. Achieving the goals of each residency year will also result in the Resident achieving a progressive

level of responsibility commensurate with the Resident's PGY level and performance. These goals are explicitly delineated later in the Handbook under the Policy on Resident progression and the Goals and Objectives. PGY-1 residents do not take home call and are therefore subject to indirect supervision with direct supervision immediately available.

The general lines of supervision progress from intern to resident working with the patient's attending or junior resident on call, to the senior resident on call or senior resident who leads the service, and finally, to the patient's attending or attending on call. In keeping with ACGME policy that programs must set guidelines for circumstances and events in which Residents must communicate with appropriate supervising Faculty members, OHNS Residents must use the general lines of supervision outlined above to notify the Attending of the transfer of a patient to an intensive care unit, DNR or end-of-life decisions taken by the patient or patient's family member, a post-operative complication (especially one that needs surgical treatment) or any other significant change in the patient's condition. In the case of a significant change in the patient's condition, both the patient's Attending and the Attending on call must be notified. As always, a Resident should go up the chain of command (supervisory line of responsibility) whenever he/she has a question regarding patient management or when a patient's course differs from the expected course or when a patient is not doing well. When in doubt, ask. Always.

Resident Appointment, Reappointment, Promotion, Dismissal

Commencement of Residency is based on several factors including successful completion of medical school, passage of USMLE Step 2 and obtaining a NC training license. All Employment Agreement letters are for one year, renewable each Spring. Contracts are prepared by the GME Office and signed by the Program Director, Resident, and Designated Institutional Officer (DIO).

Promotion and Graduation are based on the Resident's ongoing clinical skills evaluation, evidence of ethical behavior, and the professional characteristics of an individual capable of practice without supervision in Otolaryngology – Head & Neck Surgery. These factors include:

- a. Outcome assessment through various formats
- b. Operative case experience
- c. Formal and informal evaluations in clinical and research settings from the Program Director, Faculty and others involved in patient care
- d. Commitment and interest in scholarly activities
- e. Fulfillment of professional obligations (compliance with institutional and regulatory agency requirements, ethical behavior, interpersonal skills, etc.)

In addition, at any time during the Resident's training, written or verbal reports to the Program Director of inappropriate behavior or actions of the Resident are discussed with him/her. After investigation and evaluation of the allegations, appropriate actions may be taken. These may include but are not limited to advice, warnings, counseling, psychological support, change in rotations, corrective action, or recommendation to the institution that the Resident be given a leave of absence or be dismissed using the appropriate due process policies of Duke University Hospital.

If it is decided that a Resident should take a leave of absence or be dismissed, the Program Director will notify the Resident, Division Chief, Chairman of the Department and the DIO in writing. Final decisions are subject to Duke University GME House Staff policies and shall always be in writing.

Extended Leave of Absence Policy

Maternity and paternity leave will be granted based on Duke University and Federal Government FMLA Policies. Maternity and Paternity leave must be coordinated through the Program Director and the GME Office. Paid FMLA leave may be granted for up to 84 days (7 days a week including weekends and holidays) in a rolling calendar year for a qualifying FMLA condition. A Resident is also entitled to military leave and military family leave as per federal regulations. Leave of any type may result in the extension of the Resident's training in order to meet RRC and ABOto guidelines. Leave policy is subject to change without notice.

Overall Policies for Duke University Hospital and Medical Center (Please see the Duke University Hospital GME Policy Manual and Benefits Guide for Further Details)

All Duke University Hospital graduate medical trainees will receive compensation according to the Graduate Medical Education training level. Additionally, Residents are required to comply with the Federal Drug Free Workplace Act – for more information please refer to this website:

<http://www.dol.gov/elaws/drugfree.htm>.

Also outlined in the benefit guide is the Duke University Policy for House Staff Grievance and the Duke University Harassment Policy.

Licensure Requirements

All trainees in the OHNS Residency Program are required to have a Resident Training License through the North Carolina Medical Board. It is the Resident's responsibility to maintain this license in good standing. Licenses are renewed annually on the licensee's birthday. A condition of obtaining a full NC License is passing each step of the USMLE within 3 tries.

Harassment Policy

Duke University is committed to maintaining a bias-free environment for all members of the University community including freedom from harassment. Harassment is defined as the creation of a hostile or intimidating environment in which verbal or physical conduct because of its severity and/or persistence is likely to interfere significantly with an individual's work.

Sexual coercion consists of unwelcome sexual advances, request for sexual favors, or other verbal or physical conduct of a sexual nature when submission to such conduct is made explicitly or implicitly a term or condition of an individual's employment or submission to or rejection of such conduct is used as a basis for employment decisions affecting an individual.

Such conduct has the purpose of substantially interfering with an individual's work performance or environment. The conduct alleged to constitute harassment under this policy should be evaluated from the perspective of a reasonable person similarly situated to the complainant and considering all the circumstances.

Conflict Resolution Process

Recognizing that there is an inherent hierarchy and power differential in any training program, there is a need to explicitly state a process for resolving personal differences, conflicts, or concerns. This is based on the fact that regardless of the position one holds within the OHNS division, all persons are afforded respect and expected to treat others in a similar fashion. Thus, the purpose of the following conflict resolution process is to address these personal differences, conflicts, or concerns with the goal of reconciliation through mutual respect and understanding.

If a conflict situation arises in which there is a significant disagreement or concern, that person should bring the matter to the attention of another trusted faculty member, mentor, or senior resident as appropriate. Upon hearing and discussing the concern, the trusted individual should

then make a judgment regarding the validity and extent of the problem. If needed, the trusted individual should offer to either speak to the other party or accompany the offended person if he/she does not feel comfortable discussing the issue one on one with the other person involved. If reconciliation cannot be achieved in this manner, then the concern is brought to Divisional and/or Program leadership who will then discuss the issue with both parties. If it is not possible to achieve resolution within the Division, then Duke resources such as the GME office or the Office of Institutional Equity will be utilized.

Grievance Policy for Housestaff

The purpose of the Grievance Policy is to provide an additional, nonexclusive system of communication, exchange of information, and confidential concerns of individual Graduate Medical Trainees regarding their educational programs. Graduate Medical Trainees may contact their Fellow or Faculty representative on the Institutional Committee for Graduate Medical Education, who has full access to the committee and any ad hoc committees necessary to explore and address a Trainee's concerns, complaints, or grievances not covered under the "Corrective Action and Hearing Procedures for Associate Medical Staff of Duke University Hospital." The names of the Graduate Medical Trainee and Faculty representatives will be made available to all Graduate Medical Trainees on an annual basis. Any records regarding these issues will have protected status of peer review. Please see the document entitled "Corrective Action and Hearing Procedures for Associate Medical Staff of Duke University Hospital," found on the Duke GME website.

Professionalism

It is important to remember that we are professionals at all times, even when on personal time outside of work. In our interactions with others, be they in person or online, we still represent our institution, division and program in addition to our profession. Social media should be used responsibly and should maintain patient confidentiality.

Impairment Policy

I. Background

Graduate Medical Trainees are at risk for all the health problems seen in the general population and are expected to function at a superior level as Trainees in medicine and as health care providers. The supervision of their provision of care and evaluation of their learning is complicated by the fact that their supervisors and evaluators are health care providers. Role confusion can occur which interferes with both clear evaluation of performance and appropriate health care intervention for the trainee.

The policy, procedure and training program below are designed to enhance the quality of the Duke Graduate Medical Education program by providing guidance for handling issues of impairment of performance.

II. Policy

The Duke Office of Graduate Medical Education will address all cases of impaired performance among Trainees in order to assure the safety of Trainees and the safety of patients and co-workers. Impairment may result from physical and mental/behavioral health problems. Services to support confidential and constructive intervention to resolve impairments will be made available.

III. Procedure

Supervisors of Trainees will utilize the impairment checklist to evaluate Trainees as appropriate. Concerns arising out of the evaluation will be brought to the attention of the Office of Graduate Medical Education and the Program Director. Performance and/or behavioral concerns will be addressed with the Trainee. Trainees will be encouraged to utilize the Personal Assistance Service (PAS) or the Dean of Medical Education Counseling on a voluntary basis. PAS is a free and confidential resource available to house staff and immediate family members. PAS provides assessment, short-term counseling and referral. Clear expectations for improvement will be established in writing and evaluation will occur periodically.

Impairment concerns will be reviewed with Duke Employee Occupational Health (EOH) and/or the NC Physicians Health Program (NCPHP). With the concurrence of EOH and/or NCPHP the Trainee will be referred by the Program Director for mandatory evaluation and removed from patient care responsibilities. EOH and/or NCPHP will evaluate the Trainee and make recommendations for return to work to the Program Director and the Office of Graduate Medical Education. Any Trainee removed from any aspect of their training program for any reason must be returned to work through EOH and the Office of Graduate Medical Education must be notified.

IV. Guidelines

Most Trainees are eager, productive learners and colleagues; however, some experience difficulties in learning and/or performance and may demonstrate behaviors that are inappropriate. How these issues are addressed can have a substantial effect on a Trainee's career and Duke's mission as an educational institution. The following suggestions can enhance successful resolution:

- Consult with PAS. PAS is also a consultative resource for supervisors of Trainees regarding how concern might be addressed.
- Do not ignore, "push under the rug", or dismiss as a "bad day," inappropriate behavior. Address issues promptly to improve the outcome.
- Document behaviors and incidents that create concern. Request co-observation with a colleague when possible.
- Do not try to diagnose, do not argue. Rather, discuss concerns using specific behavioral terms and expectations for improvement.
- Offer and encourage Trainee to use available resources.
- Establish clear, written expectations for improvement and an evaluation plan.

V. Manifestations of Impairment

- Dramatic decrease in performance
- Persistent or repetitive absenteeism/lateness
- Mood swings
- Interaction difficulties
- Patient/colleague complaints
- Disruptive behaviors
- Medications missing from work area
- Disappearances from work
- Disordered thought
- Alcohol on breath, other stigmata of drug use
- Diminished physical appearance

VI. Resources

Personal Assistance Service

2200 West Main Street, Ste 400A

Erwin Square Tower

Durham NC 27705

919-416-1PAS (416-1727)

Personal Assistance Service (PAS) is the Faculty/staff assistance program of Duke University. The staff of licensed professionals offers assessment, short-term counseling, and referrals to help resolve a broad range of personal, work, and family problems. There are no charges for any service provided by the PAS staff.

Employee Occupational Health and Wellness Services

Duke South Basement

DUMC Box 3148

Red Zone Room 04290

Durham NC 27710

(919) 684-3136

Employee Occupational Health (EOH) provides evaluation of health issues that involve the safety of the work force and the safety of patients, visitors, and products of Duke University.

The North Carolina Physicians Health Program

The North Carolina Physicians Health Program (NCPHP) was established in 1988 by a collaborative effort of the North Carolina Medical Society and the North Carolina Medical Board to help impaired physicians. The NCPHP is set up to identify troubled physicians, get them the appropriate treatment and return them to the productive practice of medicine. Impairment can be caused by alcoholism/chemical dependency, psychiatric disorders, disruptive behavior, professional sexual misconduct and severe stress. Anyone who feels that they themselves or a colleague possibly has an impairment problem can seek assistance anonymously and confidentially by calling the NCPHP at 1-800-783-6792.

Moonlighting

Because graduate medical education is a full-time endeavor, there will be **NO** external moonlighting. Internal moonlighting within Duke University (Temporary Special Medical Activity) must be counted toward the 80-hour weekly limit on duty hours and may only be approved on a case-by-case basis by the Program Director. Requests for TSMA activity must include documentation of duty hours.

Resident Mentor Program

Upon arrival at Duke, each Resident will be asked to select a Mentor from among the OHNS Faculty. The Mentor will guide the Resident through his/her training and, in particular, advise the Resident with regard to his/her investigative choices. Moreover, the Mentor will meet with the Resident at least semi-annually to review the Resident's performance, goals and progression within the residency program and will meet with the Resident as needed for his/her research projects. The Resident is free to select a different Mentor at any time, especially if career goals develop in a direction in which the Mentor is not best qualified to direct. Due to their roles in Program administration, the Program Director, Assistant Program Director and the Division Chief cannot be formal mentors to individual residents.

Mailbox & Messages

At the start of the PGY-1 year every Resident will be assigned an individual mailbox in the OHNS Resident Office in the HAFS Building, 7th floor. All mail received for Residents at DUMC Box 3805 will be placed in this mailbox. Residents are expected to keep up with their mail. As professionals, it is the responsibility of the Residents to go through their mail at least weekly, and attend to any patient care related correspondence as a first priority. Non-urgent phone messages for Residents will be e-mailed or written and placed in the Resident's mailbox.

Lab Coats/Prescription Pads

Lab coats are distributed annually through the GME Office. Name embroidery on lab coats is an acceptable expense covered by the Department. The embroidery logo, color, and script are standardized for the Residents and Faculty, and are on file at the Medical Bookstore. Prescription pads may be reordered by contacting the Program Coordinator. Do not leave the prescription pads unsecured!! DEA#s are not to be preprinted on the prescription pad!!

Copier/Fax/Supplies

The Resident's badge gives access to the Division digital copier which also has scanning capability. Please ask the administrative staff for a brief orientation to these machines. Residents may use 919-668-3103 to receive facsimiles, which will be placed in the Resident's mailbox unless other arrangements are made. Faxes must be sent during business hours with the help of administrative staff.

Society Memberships

During residency, the Division actively supports membership in the following professional societies:

- **American Academy of Otolaryngology-HNS**
- **Triological Society**
- **American Academy of Otolaryngic Allergy**
- **American Academy of Facial Plastic and Reconstructive Surgery**
- **North Carolina Society of OHNS**

Divisional funds will pay for Resident membership fees for these professional societies for the duration of residency. Application forms are available on-line or from the Program Coordinator. The Resident is responsible for the initial application and maintenance of the membership. Membership in the American Medical Association and the NC Medical Society is also encouraged.

Otolaryngology In-Training Exam

The Otolaryngology Training Exam is always held on the first Saturday in March. Resident scores on this exam are used to evaluate individual and group performance and knowledge base, plus the residency curriculum. Residents who fail to achieve the 25th percentile (those who score in stanines 1-3) nationally for their PGY level in any section of the exam, will be assigned additional reading, grand rounds presentations and/or study courses in preparation for the next training exam. Research has shown a correlation between performance on the in-training exam and the written board examination. Residents who do poorly on the in-service run the risk of failing the boards, and, therefore, this poor performance must be remediated.

Required Reading

Home Study Course

As an additional training tool, the Division will pay the registration fee for the Home Study Course. This is a required course that is available in a soft cover book or online format and can be mailed to the Resident's preferred address. Every Resident at the PGY-2 level and above is required to complete each course section by submitting the exam to the AAO-HNS within the specified time frame. The Division will not pay any late fees associated with late submissions. All Residents are expected to complete the home study sections by the first deadline for that section. Any sections remaining outstanding after the second deadline will result in negative performance evaluations. ALL sections must be completed every year.

ABOto Self Assessment Modules

Beginning at the PGY1 level residents are required to complete 5 SAMs per year. Completion of these modules will allow residents to assess their knowledge regarding a topic and will direct learning regarding that topic. Residents must achieve a passing score of 80% for successful completion of the modules. Residents must submit to the program coordinator documentation of successful completion of the modules. To ensure comprehensive learning residents must submit 25 unique modules.

Record Keeping

Attendance Records

Residents are required to attend and sign in *legibly* at all Grand Rounds, Conferences and Journal Clubs. Attendance of 75% of Grand Rounds, Conferences and Journal Clubs will be considered as part of the promotion/graduation process.

Operative Cases

An operative report for a Duke operative case in which the Resident was the primary surgeon (or any case upon discussion with the Attending) must be entered within 12 hours of completion of the case. Duke Clinic and Emergency Department notes must be entered immediately upon finishing the patient evaluation. At the VA, operative notes must be dictated prior to the patient leaving the OR and the dictation code written in the brief operative note and entered on the nursing OR sheet. VA clinic notes and visit coding must be entered at the time of the patient encounter, and operative notes must be edited and signed within 3 business days.

Discharge Summaries

The complexity of some OHNS patients requires that someone more experienced than the intern dictate the discharge summary to ensure completeness and accuracy. Residents should check with their respective Faculty to determine if a discharge summary dictated by the intern is acceptable, or if the Faculty member wishes that the Resident on the rotation dictate it. All discharge summaries must contain an accurate listing of the procedures performed, an appropriate summary of the hospital course and a detailed discharge plan.

Unassigned Patient Follow-Up

Unassigned patients, whether postoperative, having a complication or other urgent issue, are to be discussed with, and the notes sent to, the patient's attending MD. If that MD is not in town, the patient must be staffed with the attending on call. If there is an urgent issue, and the

patient's attending or on call MD is not physically able to see the patient, an attending in the clinic must evaluate the patient for proper patient disposition.

Residents and PAs should email or call the attending to alert him/her so that the note on an unassigned patient can be signed within 24 hours.

Unassigned patients and ED follow ups should be placed preferentially on the PAs schedules if they are general OHNS follow ups (obvious H&N or laryngology, etc. patients will go to those attendings if known surgical intervention or cancer workup is needed). The PA will call upon any available clinic resident to double check the patient.

The consult resident will be the first resident called to see unassigned patients if the PA is unavailable.

Operative Case Logs

Operative cases must be submitted on-line to the ACGME using the Resident Case Log System. Timely submission of these cases is imperative as it documents both the Resident's and the Program's surgical case experience. The Program Director will carefully monitor this data, and if a Resident falls behind the minimum RRC requirements, the Program Director and the OHNS Faculty will identify appropriate cases for the Resident to perform in order to bring the number of surgical cases in-line. Residents receive a weekly reminder to log cases. Failure of the Resident to enter cases in a timely fashion may result in disciplinary measures.

CASE CODING GUIDELINES (also found on the Q drive)

Guiding Principles

- Keep current with your case logs. Best to do this after every case. Code at least every week. You will receive a reminder every Friday afternoon to help with this.
- Code ALL your surgical procedures. Every last one – including ED and clinic procedures except for fiberoptic exam of the nose or larynx. This includes lacerations, biopsies, control of epistaxis, closed nasal reductions, PTA's, etc.
- The three T's (turbinates, tonsils and tubes) are to be counted per patient. Input only one code even if you do them on both sides. Everything else is per side/component. EVERYTHING.
- Unbundle, unbundle, unbundle. Break down the operation into component parts. Do not code only the main operation (TL) and forget the smaller components (CP myotomy and thyroid lobectomy). Do not forget about the reconstruction.
- Do not shortchange yourself on primary surgeon or teaching resident status. Wherever possible, the senior should be the teaching surgeon and the junior the primary surgeon.
 - If you are the only resident in the case, you are the resident surgeon unless all you did was hold hooks and suction and close the wound. If in doubt, ask the attending if it's OK to code as primary.
 - Even if you are the assistant for the larger procedure(s), give yourself credit as primary surgeon for closure of a complex wound or any of the smaller components of the case that you did as primary (e.g. cricopharyngeal myotomy in a TL case).
- You must participate in the case to count as assistant.
- Use codes that will count toward your overall case numbers. Non-tracked codes do NOT count toward your or the program's procedure logs.
 - You need to pick a code that is close, but not as specific, if the specific code is a non-tracked code (e.g. if the code for substernal goiter is a non-tracked code, then use the regular thyroid code). This usually means having to use a more general code.
 - You are not lying when you do this. CPT codes are for billing purposes, not for resident case log purposes.

- Think outside the box. If you repair a complex laceration on a nose in which you have to suture the cartilage, code it as a rhinoplasty (and code a septoplasty in addition if you had to fix the septum).
- Keep track of your laser and robotic cases. Best thing is to place a comment in the comments section re what type of laser you used and use the laser code (if available) in addition to the code for the regular case. **IT IS YOUR RESPONSIBILITY TO KEEP TRACK OF YOUR LASER CASES.**
- Upon graduation, you have to use the correct, specific CPT code (which is often a bundled code) when you start to bill.

Examples

- CMF
 - Pt with left angle and right body fracture: two mandible fracture ORIFs and one MMF.
 - Right angle and right subcondylar: one ORIF for the angle, one MMF for the subcondylar
 - ZMC with involvement of orbit and arch fracture: ORIF of the ZMC, orbital floor exploration or repair, reduction of arch
 - Bilateral fractures: code each component of each side
- Thyroid
 - Total thyroid in which you did one lobe and the attending did the other: code one as resident surgeon and one as assistant.
 - Total thyroid where you did both sides: one code (primary surgeon for a total thyroidectomy).
- Otology
 - Tympanoplasty/Mastoidectomy/OCR case: code 3 separate procedures, one for each component.
- Large cases
 - TL with neck dissection: one code the laryngectomy and one for the ND. If it was a bilateral ND, then you code the neck twice. Don't forget the CP myotomy, thyroid lobectomy and central compartment neck dissection if done.
 - Cochlear implant: one code for mastoidectomy and one for the CI.
 - Free flap in which you assisted in the harvest, performed the inset, assisted with the vessels and performed the harvest of the skin graft and the closure of the donor site: 4 codes (one code as assistant for the harvest & vessels, second code for recon of the defect, third code for the harvest of the graft and fourth code for the donor site closure).
 - Do not code the closure of the wound if you did the main case (e.g. do not code complex closure of the neck if you did the neck dissection).
 - Do code the closure if you did not participate in the main case
- Non-tracked codes
 - CPT 42950 Pharyngoplasty (plastic or reconstructive operation on pharynx) – this should be coded as a flap of some kind (rotational, advancement, etc.)
 - All of these more specific codes, non-tracked codes need to be recoded as 42890 which is partial pharyngectomy.
 - CPT 42120 Resection of palate or extensive resection of lesion
 - CPT 42808 Excision or destruction of lesion of pharynx, any method
 - CPT 42842 Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; without closure
 - CPT 42845 Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; closure with other flap

CPT 42870 Excision or destruction lingual tonsil, any method
CPT 42894 Resection of pharyngeal wall requiring closure with myocutaneous or fasciocutaneous flap or free muscle, skin, or fascial flap with microvascular anastomosis

Bottom line: breakdown cases into their component parts and code everything using codes that are tracked not being shy to code as primary surgeon.

USMLE STEP 3

USMLE Step 3 must be taken as an intern (PGY-1). Once the exam is passed, the Resident must provide the certificate to the Program Coordinator.

Duty Hour/Fatigue Policy

All PGY-2 Residents and above in the Duke OHNS program take home call. In order to maintain patient safety, Residents will live within 20 minutes of the Duke Medical Center and the Durham VA Medical Center.

All Residents will keep a log of their daily duty hours. At least every week, the Resident will enter his/her data via MedHub. The Program Director and Coordinator will review and monitor the data submitted. A monthly calculation will be tabulated and tracked to ensure ACGME compliance as follows:

1. Duty hours are defined as clinical and academic activities related to the residency program performed while physically at the duty site; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and participation in scheduled activities such as Teaching Conferences. Duty hours do *not* include preparation for operative cases or patient care, preparation for Conferences and Journal Clubs, etc.
2. Duty hours must be limited to 80 hours per week, averaged over a four week period, inclusive of all in-house call activities.
3. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a four week period, inclusive of call. *One day* is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties.
4. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period, and must consist of an 8-hour time period, provided between all daily duty periods and after in-house call.
6. To address the issue of 10 hours off between duty periods, it is the policy of this Program that on-call Residents come to the OR to relieve Residents in that OR case if that case is expected to end late thereby placing non-call Residents in violation of the 10 hours off rule. For the on-call Residents, this is not a violation of the rule because this is part of the on-call duty period.
7. Interns are limited to 16 hours of continuous in-house duties. After a 16 hour period of in-house duties, the intern must have 14 hours free of any duties prior to returning to work.

Residents who fail to comply with the ACGME rules place the patient, themselves and the Program at risk.

If a Resident has failed to obtain at least four (4) hours of sleep due to call responsibilities the night before, the Resident will be required to leave no later than 12:00 p.m. (noon) the following day. Residents exhibiting signs of fatigue (e.g. somnolence, lack of alertness, cloudy thinking,

inappropriate behavior) should be questioned by their peers and Faculty regarding recent sleep. It is the Resident's responsibility to alert the supervising Attending and Chief Resident about the extent of hours worked during a call period so that arrangements can be made to provide for alternative coverage of clinical responsibilities. If a Resident is too tired to drive home, taxi service is available through the institution and call rooms are available as well.

Surgical Case Review/Morbidity and Mortality/Quality Assurance Conference

All cases meeting criteria for monthly Surgical Case Review/M&M must be recorded and submitted to the Division Chief's Office. Criteria include:

- Reason to discuss decision to operate or selection of procedure
- Significant intraoperative departure from preoperative plan
- Inconsistent pathological findings
- Intra- or post-operative complication
- Intra- or post-operative death

Residents will use the form "Surgical Case Review – Dataset" for every reported case presented at Surgical Case Review. Before each Surgical Case Review/M&M Conference, the Residents will prepare those cases and related topics. All deaths, airway complications, major complications, and cases that raise questions regarding quality improvement and systems based practice must be presented. Surgical Case Review information and attendance sheets must be submitted to the Program Coordinator immediately following the conference. The Resident most involved with the case will present the patient and the Surgical Case Review/M&M. Preparation includes doing a literature search and reading on that morbidity/mortality so that the Resident may be prepared to answer questions regarding the case as well as discuss personal, team or system changes that might prevent such an issue in the future.

Institutional Compliance Modules

Institutional compliance modules include Patient Safety, Laser Safety, Time Out Training, etc. These modules must be updated annually. Emergency Response Training (BLS, ACLS) must be updated biannually. Reminders will be sent via email by the GME Office. Every Resident is required to maintain compliance at all times. Failure to comply includes unpaid, DUH mandated, administrative leave and temporary loss of training privileges. This can result in a negative listing with the Physician Central Data Computer. In addition, disciplinary measures will be taken by the Division if a Resident is out of compliance with the professional requirements.

Evaluations

As an OHNS Resident, every Resident is required to participate in the Division's evaluation requirements.

1. Resident of Faculty Evaluation – to provide the Faculty with valuable feedback concerning teaching abilities, commitment to the educational program, research/scholarly activity and clinical acumen/knowledge among other domains.

2. Faculty of Resident Evaluation – performed mid-rotation and at the end of the rotation – to provide the Resident with appropriate feedback concerning his/her abilities related to the six ACGME General Competencies:

- a. Medical Knowledge
- b. Patient Care
- c. Interpersonal & Communication Skills
- d. Professionalism
- e. Practice-Based Learning & Improvement

f. **Systems-Based Practice**

Each rotation evaluation form measures the Resident's performance in several areas.

3. Resident Semi-Annual Summative Evaluation Form – to provide the Resident with a semi-annual review for promotion/graduation purposes and an overall sense of progression in his/her training. This summative evaluation is discussed in an individual meeting with the Program Director.

4. Program Evaluation – completed by Faculty and Residents annually to provide the Program Evaluation Committee with feedback related to continual improvement. Input from this evaluation helps inform the Program Evaluation Committee regarding the Annual Program Evaluation and Improvement process.

5. 360 Degree Evaluation – distributed to peers, medical students, nursing staff and patients. The results of the evaluation will be anonymously tabulated and discussed by the Program Director with every Resident individually.

6. Resident Grand Rounds Evaluation – to provide the Resident with feedback concerning his/her didactic delivery related to the content, style and delivery of the Grand Rounds which helps Residents prepare for regional and national presentations.

7. ROPE (Resident Operative Performance Evaluation) – to provide the Resident with feedback concerning clinical effectiveness and operative performance in keeping with the semi-annual ACGME Milestone reporting requirement and the annual ABOto resident operative competency report.

8. Self-Evaluation – an opportunity for Residents to engage in self-reflection and performance based learning and improvement; this is performed semiannually on a formal basis, but Residents are encouraged to engage in this throughout their training.

The **Clinical Competency Committee (CCC)** is comprised of all Core Faculty and chaired by the Division Director. In keeping with section V.A.1 of the Common Program Requirements, the purpose of the Clinical Competency Committee is to provide broad input from the Faculty to advise the Program Director regarding resident progress, including promotion, remediation, and dismissal. The CCC assists the Program Director in completing the Resident Semi-Annual Summative Evaluation, the ROPEs, Milestones, etc.

The **Program Evaluation Committee (PEC)** is chaired by the Program Director and comprised of the Core Faculty, the Program Coordinator and at least one senior Resident who is peer selected and meets at least annually. The purpose of the PEC is plan the educational activities of the program in accordance with sections V.C.1 of the Common Program Requirements, and to document formal, systematic evaluation of the curriculum, educational activities and compliance with ACGME standards and to render a written Annual Program Evaluation (APE) in accordance with sections V.C.2 and V.C.3 of the Common Program Requirements.

Conference Travel Policy

If a Resident is first-author or oral presenter of an accepted paper or poster at a national or sectional society meeting for Duke related work, the Division will support the Resident's attendance at that meeting. All manuscript/poster submissions must be reviewed and pre-approved by the Resident Mentor/Advisor **and** the Resident Research Director (Dr. Lee) **prior** to submission to a journal or conference selection committee.

Residents requesting time away to attend a meeting must request the travel time with the Administrative Chief Resident and have the meeting attendance requested and approved through MedHub by the Program Coordinator/Director at least two months before travel commences.

Resident travel permission will be granted only after ensuring that there is appropriate call coverage. Time away for professional meetings or courses is in addition to allotted vacation time.

The Division will only pay travel expenses for the Resident (i.e. Residents of the same gender will share rooms, spousal travel and meals will not be reimbursed, etc.). Alcohol will not be reimbursed. Once approval is granted, the Resident is to use his/her own funds and submit original, itemized receipts to the Residency Coordinator for reimbursement upon return.

Residents may attend one conference without presenting or one course of the Resident's choosing that will be financially supported by the Program up to a cost of \$2000. The Program will fully support resident attendance at the American Academy of Otolaryngic Allergy (AAOA) Basic Allergy Course. This course is attended by every resident once at the PGY-2 or PGY-3 level.

In general, courses in which Duke Faculty are course faculty are also supported by the Program. The Carolinas Airway Course is usually attended by PGY-3 residents, the Duke CMF course is attended by all residents and temporal bone courses and skull base courses sponsored by Carolina programs are attended by senior residents. PGY-1 and PGY-2 residents attend the Duke Emergency Skills Bootcamp held every July.

Any travel grants monies **MUST** be submitted to the Division (not awarded to you personally), and you **MUST** notify the Program Director that you are applying for any such grant.

Resident Education Fund

Every Resident will receive a one-time monetary gift of \$1000 upon successful completion of the PGY-2 year. This money is to be used for educational purposes only, and purchases or expenditures **must** be pre-approved by the Program Director. Receipt of this money is dependent upon a consistently good performance. Lapses in academic, clinical or professional performance will result in the withholding of these funds.

All Resident education fund expenses must receive prior approval from the Program Director and must be coordinated through the Program Coordinator. Allowable expenditures using the Resident Education Fund:

- Expenses to attend a course or meeting beyond the \$2000 supported by the Division
- Textbooks

Digital or computing devices are not allowable expenditures. These should be purchased with personal funds and deducted from income taxes.

Reimbursement Policy

To receive reimbursement, a Resident must submit **itemized, original** receipts to the Residency Coordinator (with a note if they are not self-evident). Do keep a photocopy of the submission and keep in mind that the process can take upwards of 30 – 45 days to process. Credit card statements are **not** acceptable receipts. Alcohol will not be reimbursed. At the time of submission of the receipts for a conference at which the resident presented, proof of submission of the associated manuscript **MUST** also be submitted. As the goal of research projects presented at meetings is still ultimately publication in a peer reviewed journal, this requirement will help make sure that manuscripts are submitted in a timely manner.

Per Duke University policy:

1. Meals should not exceed \$50/day with no single meal exceeding \$25 (these amounts

- exclude tax and gratuities).
2. The title of the presentation (oral/poster) must also be included with the submitted reimbursement form.
 3. In lieu of airfare, mileage by personal vehicle will be reimbursed at IRS rates not to exceed the cost of a comparable super-saver airline fare.
 4. The hotel room rates are not to exceed the conference's standard hotel room rate.
 5. Rental cars must be preapproved by the Program Director.

Call Schedules

The junior call schedule is compiled by the junior resident rotating at the VA. This call schedule must be vetted by the senior resident at the VA who also compiles the senior resident call schedule, and these call schedules need to be submitted to the Associate Program Director at least two weeks before the end of the prior month in order to allow for review and approval. Call schedules must be in keeping with ACGME Duty Hour Policies of at-home call not being so frequent as to preclude rest and reasonable personal time.

Vacation Policy

- Residents may receive to 20 days Monday through Friday of vacation time during one academic year. This time is provided at the discretion of the HNSCS faculty and is subject to review and change.
- Only one clinical Resident may be gone from one hospital at a time on elective vacation.
- At the PGY-2 – PGY-5 levels:
 - One vacation per rotation must be taken in a one week block. A week's vacation refers to five weekdays (M-F).
 - If a Resident's schedule is such that it consists of three 4-month blocks, 7 days may be taken in two blocks and 6 days in the third block. If the schedule includes the VA, six days are to be taken at the VA. When more than 5 days are taken in one 4-month block, only the extra 1-2 days may be taken as a three to four day weekend.
- At the PGY-1 level:
 - Two weeks are taken during the ED rotation.
 - Two additional weeks can be taken in 1 week blocks during the 6 months of OHNS rotation (one per 3 month block)
- NO vacation is allowed by anyone the first two weeks of July.
- PGY-1 and 2s are not allowed to take vacation the entire month of July.
- PGY-5s are not allowed to formally leave the Program prior to June 30. Therefore, if a resident needs to leave for fellowship, vacation days must be saved to allow for time away days at the end of the year.
- No vacation is allowed the week prior to the in-service exam (the first weekend of March), during COSM or the AAO-HNS meeting.
- If a Resident "accidentally" forgets to take vacation during a rotation (including Research), the Resident will lose the opportunity for vacation. Residents are not allowed "make-up" vacation.
- Flexibility in vacation days is given to Residents who are pursuing fellowships while still adhering to the basic principles stated above. E.g. if a resident expects to utilize 10 interview days during his/her Spring rotation, the initial 10 time away days must be taken in two one-week blocks in two prior rotations. Residents must not plan elective vacation during their interview season.
- In addition residents receive 2 days of personal health time that may be used for illness or doctor's appointments. (There is a special consideration for residents pursuing a

fellowship. If these days have not previously been used for personal health issues, then they may be used for interview purposes.) If more than 2 personal health days are used for illness, then vacation days must be used. Personal health days may not be used at the VA on Mondays and Fridays and the first Tuesday of the month. Personal health days used for doctor's or dentist's appointments are to be used in ½ day increments. This time must be tracked and is not to be stored up for more "regular" days off at the end of the year.

- VA vacations must be scheduled at LEAST six weeks in advance (the earlier the better). Residents due to rotate at the VA must advise the current VA chief of a scheduled vacation even if not already on the VA service.
- Time away for professional meetings is in addition to allotted vacation time. Prior approvals, by the Administrative Chief Resident, Director of Resident Research and the Associate Program Director, are required for professional meetings. These requests must be submitted as soon as you receive notice of abstract acceptance from the meeting. If a Resident takes time off for a meeting without prior approval, there will be NO reimbursement of expenses.
- Residents are not allowed to take more than 5-7 days of vacation on a given rotation, unless one is going to have elective surgery, or would like to use vacation time as maternity or paternity leave.
- If a Resident uses up all of the 20 time away days, and two personal health days and still requires time away from the program for his/her health issues, or a family member's illness, FMLA leave must be used. A Resident using sick leave must notify the Administrative Chief Resident and the Program Coordinator by phone and email, and upon return to work, he/she must indicate in MedHub that sick days were used.
- Vacation days include interviews for fellowship and/or job interviews.
- At all times, there must be an appropriate number of senior and junior level Residents to provide the necessary call coverage while keeping the Program compliant with ACGME duty hour restrictions (e.g. all senior residents cannot be gone to an academic meeting at the same time).
- The Administrative Chief Resident will make the tentative vacation schedule according to the rules as stated above and submit it to the Associate Program Director by May 15 for the following July-December time frame and by November 15 for the following January-June time frame.

Please note that the American Board of Otolaryngology allows a Resident only six weeks off during one academic year no matter the reason. If a Resident takes more than six weeks off, the additional time will need to be made up and may delay graduation from the Program.

Conference Schedule

The OHNS Conference Schedule includes Grand Rounds on Wednesday morning from 0730-0830 and Resident Teaching Conference on Friday from 0700-0800. These conferences may start earlier to accommodate educational or administrative needs. As additions or changes to speakers or sessions are made, the conference schedule will be updated by the Senior Resident in charge of the Conference Schedule. The conference schedule may be viewed by looking on the Duke shared Q Drive for the OHNS folder. Access to this folder is limited to the OHNS Division. Please make sure that all changes are submitted to the Program Coordinator so that the data is recorded for reporting purposes. In addition, journal clubs and other educational forums will be announced as they are scheduled. These conferences will vary in their time and setting so be sure to keep emails/text messages which detail the time and place of these conferences.

Corrective Action and Hearing Procedures

The Division of OHNS uses the Corrective Action and Hearing Procedures implemented by the Duke Graduate Medical Education office. Please see the document entitled “Corrective Action and Hearing Procedures for Associate Medical Staff of Duke University Hospital.” (<http://www.gme.duke.edu/hsmanual/Corrective%20Action%20approved%208.20.07.pdf>).

Failure to adhere to Program requirements may include administrative leave or a corrective action plan. If a Resident fails to adhere to the corrective action plan, as a last resort, termination from the program will be considered.

Handoff Policy

All Residents will review the educational material developed by the GME office and the Duke GME Patient Safety and Quality Council Handoffs Task Force. These are available on the Q shared drive under the OHNS folder. Every resident receives this information as part of the GME orientation. All Residents will use the “Physician Handoff” form in Maestro as the written component of the information conveyed during sign-out from one Resident to another. Residents will be evaluated and certified by the Faculty regarding their competency in performing appropriate, meaningful patient care sign-out/handoff. Faculty members will individually contact the Attending on call to sign out their patients as well.

Duke Raleigh Hospital (DRAH) Resident Responsibilities and Procedures

I. Rounding/Inpatient Calls

A. Weekdays

Rounding on and management of OHNS inpatients (questions from nurses, placing of consults, etc.) will be per discussion between the DRAH resident and the DRAH attendings.

B. Weekends and holidays

1. If there are DRAH inpatients over the weekend or on holidays, the DRAH resident will sign-out the patient(s) (phone call at minimum) to the Duke Junior and Senior residents on call.

i. Dr. Cunningham will often round on his own inpatients over the weekend. The resident on the DRAH rotation will confirm whether the DUH Junior resident should round on his patients.

2. Rounding on OHNS inpatients at DRAH on weekends and holidays will be the responsibility of the post call DUH junior resident. The DUH junior resident rounding at DRAH will discuss the patients directly with the patient’s DRAH attending.

3. On weekends and holidays, questions about the management of inpatients (i.e. pages from nurses) will be directed to (919) 970-1320.

II. Consults

A. Weekdays

The resident on the DRAH rotation is expected to see weekday daytime ED and inpatient consults. Consults will be received by the DRAH attending on call and routed to DRAH resident.

B. Weekends and Holidays

The DRAH attending on-call will manage ED and inpatient consults at DRAH on weekends and holidays.

III. Practice Coverage

A. The DUH Resident on call will provide practice call coverage for the Duke Otolaryngology of Raleigh practice overnight on weekdays and all day on weekends and holidays

documenting patient interactions in the patient's chart notifying the attending by Epic inbasket or email.

- B. If there is a question about management, the DUH Junior Resident will discuss the patient with the DUH Senior Resident on call. If the DUH Senior Resident on call needs to discuss the patient with an attending, the DUH Senior Resident on call will discuss the case with the patient's DRAH attending.

Duke Regional Hospital (DRH) and Duke Otolaryngology of Durham (DOD) Resident Call Responsibilities and Procedures

I. Scope of Coverage

- A. The DUH Senior Resident on call will provide weekend coverage for all DRH ED and inpatient consults with DUH faculty back-up. Weekend coverage is from 5pm Friday to 7am Monday and call pay is for three full days.
- B. The DUH Senior Resident on call will provide coverage for all DRH ED and inpatient consults with DUH faculty back-up on Duke Health System designated holidays. Holiday coverage starts at 5p Friday on a holiday weekend and ends at 7am on the next normal business day. Call pay will include the weekend and the holiday.
- C. The DUH Residents on call will provide practice call coverage with DUH faculty back-up for all Duke Otolaryngology of Durham patients Monday to Thursday from 5p-7a, weekends Friday 5p to Monday 7am and Duke Health System holidays. See III below for details on Duke Otolaryngology of Durham practice call coverage. Practice call coverage includes the following:
 - 1. Fielding phone calls from Duke Otolaryngology of Durham patients and triaging/managing as appropriate
 - 2. Triaging/managing otolaryngology issues for Duke Otolaryngology of Durham patients who are either sent to the ED by the DUH Resident on call or who arrive in the DRH ED independently
- D. Consults will be placed in Epic and will be routed to the on call Senior Resident via the functional pager, (919) 470-4636 pager 8270. Consults are for general otolaryngology calls (non-CMF and non-pediatric – except for practice pediatric patients who are covered under this system).

II. Patient Follow Up

- A. For DRH ED and inpatient consults triaged to clinic, or seen at DRH but in need of outpatient follow up, follow up will occur in the on-call attending's clinic at DUH or a suitable attending clinic at DUH if the on-call attending's clinic is not appropriate for the patient's complaint.
- B. If the patient is an established patient at Duke Otolaryngology of Durham, follow up will occur at the Duke Otolaryngology of Durham location. If specialist care is needed, the patient will follow up at DUH with an appropriate attending pending approval by the Duke Otolaryngology of Durham attending.

III. Practice Call Coverage

- A. Duke Otolaryngology of Durham practice coverage will be provided by DUH on call residents via the functional pager, (919) 470-4626 pager 8270, as described above in I.C.
- B. Practice Phone calls
 - 1. The DUH Junior Resident on call will cover Duke Otolaryngology of Durham practice phone calls Monday through Thursday nights from 5p-7a. If a weeknight happens to fall on a holiday (ex. Thanksgiving Thursday), the DUH Senior Resident on call will cover patient phone calls.

2. The DUH Senior Resident on call will cover Duke Otolaryngology of Durham practice phone calls on weekends and holidays.
3. The DUH Residents on call will not cover patient phone calls for Dr. Yu's practice. All calls from Dr. Yu's patients will be forwarded to her via the contact information below.
4. If there is a question about management when the DUH Junior Resident on call is covering practice phone calls, he/she will discuss the patient with the DUH Senior Resident on call. If the DUH Senior Resident on call needs to discuss the patient with an attending, the DUH Senior Resident on call will contact the DUH attending on call.
5. If a Duke Otolaryngology of Durham practice needs further evaluation in an ED, the DUH Senior Resident on call will coordinate care as described below in III.C.
6. All phone calls will be documented in the patient's chart (Epic). The appropriate Duke Otolaryngology of Durham attending will be notified via email or Epic in-basket.

C. ED Visits for Practice Patients

1. If a practice patient calls and requires evaluation in the ED for ENT complaints and a Duke Otolaryngology of Durham attending is on call at DRH ED, the DUH Senior Resident on call will notify the Duke Otolaryngology of Durham faculty member of the patient's impending arrival at the DRH ED.
2. If a practice patient calls and requires evaluation in the ED for ENT complaints and Dr. Yu is on call at DRH ED, management will be per discussion between the DUH Senior Resident on call and the DUH attending on call.
3. If a practice patient calls and requires evaluation in the ED for ENT complaints and a DUH faculty member is on call at DRH ED, management will be per discussion between the DUH Senior Resident on call and the DUH attending on call.
4. If a practice patient arrives independently in the DRH ED for ENT complaints when the DRH ED is not being covered by a Duke Otolaryngology of Durham faculty member, the DUH Senior Resident on call will manage the patient with DUH faculty backup.

IV. Inpatient Rounding

- A. In the event a patient is admitted to a Duke Otolaryngology of Durham attending prior to the start of the DUH Senior Resident's call (5p Friday or holiday call) and that patient needs to be seen over the weekend, the Duke Otolaryngology of Durham attending will contact the DUH Senior Resident on call to sign the patient out. The patient will be seen by the DUH Senior Resident on call and staffed with the DUH attending on call.
- B. In the event a patient admitted to a Duke Otolaryngology of Durham attending prior to the start of DUH Senior Resident call (5p Friday or holiday call) and that patient remains in house through 7a Monday, the DUH Senior Resident on call will contact the appropriate Duke Otolaryngology of Durham attending to sign the patient out.
- C. In the event a patient admitted to DRH for whom a Duke Otolaryngology of Durham attending is consulting needs to be seen over the weekend, the process will be the same as detailed above in IVA and IVB for primary patients admitted to DRH.
- D. New consultation patients seen at DRH when a DUH attending is on call that require surgery and/or prolonged hospitalization, will be transferred to DUH. In the event the patient is unstable and needs surgery at DRH or cannot be transferred due to DUH bed availability, one of the Duke Otolaryngology of Durham attendings will round on the patient until the patient can be transferred to DUH. Sign out for the patient will be the same as described above in IV.B.

V. Extenuating Circumstances

- A. In the event the DUH Senior Resident on call is managing a patient at DRH and there is an emergency at DUH, the DUH Junior Resident on call will contact the DUH attending on call directly.

VI. Contact Information

Duke Regional Contact Information	
DRH Main Hospital	919-470-4000
DRH ED	919-470-5345
ED Charge RN	919-470-6663
Radiology	919-470-5295
Reading Room	919-470-5277
	919-470-5275

VI. Paging Information

- A. DRH OHN Functional Pager- (919) 470-4636 pager 8270
- B. Rolling the pager to yourself is the same as DUH.

Policy on Resident Educational Progression and Goals and Objectives

PGY-1 Training Objectives

The PGY-1 OHNS Resident experience includes six months of OHNS; one month in each of the following: Emergency Department, Surgical Intensive Care Unit, Neurosurgery, Anesthesiology; two months of general surgery, at least one of which is at the VA.

Patient Care

The PGY-1 Resident should demonstrate the ability to:

OHNS:

- Evaluate pre-operative patients.
- Manage ward/post-operative patients.
- Prioritize patient acuity.
- Manage ward emergencies (e.g. acute airway obstruction, hematoma).
- Prioritize clinical responsibilities.
- Discharge planning.
- Perform the following procedures:
 - Arterial line/ABG

- Peripheral line/Phlebotomy
- Post-op drain care
- Tracheostomy care
- Tracheostomy tube exchange
- Post-op flap care
- Direct laryngoscopy
- Femoral, IJ, SC line placement
- Nasopharyngoscopy
- Flexible fiberoptic nasolaryngoscopy
- Dobhoff/NGT placement
- Tracheostomy removal
- Laceration repair, simple and complex
- Closure of incisions in the OR

Neurosurgery:

- Evaluate pre-operative patients.
- Manage ward/post-operative patients.
- Priority patient acuity.
- Manage ward emergencies (e.g. hypo/hypermnatremia, hydrocephalus, etc.).
- Prioritize clinical responsibilities.
- Discharge planning.
- Perform the following procedures:
 - Arterial line/ABG
 - Peripheral line/Phlebotomy
 - Post-op drain care
 - Lumbar drain management
 - Ventriculostomy management
 - Burr hole placement
 - Halo placement
 - Femoral, IJ, SC line placement
 - Lumbar puncture/drain
 - Laceration repair, cranial

Anesthesiology:

- Evaluate preoperative patients for IV sedation or general anesthesia.
- Assess a patient's ability to tolerate anesthesia/surgical stress.
- Classify the physical status of patients.
- Use monitoring systems to continually evaluate patients' vital signs (cardiac monitoring, blood gases, ventilators, etc.).
- Perform CPR and advanced cardiac life support procedures.
- Develop technical skills in airway control, endotracheal intubation, intravenous techniques, continuous intravenous drug therapy.
- Gain knowledge in drug pharmacology, pharmacodynamics, interactions and specific effects of anesthetic agents on patients.
- Gain knowledge in the prevention of anesthetic emergencies.
- Assist in supervision of patient recovery from anesthesia.
- Knowledge of rapid sequence induction as well as standard induction and intubation techniques.

- Evaluate laboratory data as it specifically relates to the anesthesia/surgical patient.
- Interpret chest x-rays for anesthesia purposes.
- Review of basic pulmonary and cardiovascular physiology in dynamic situations.
- Understand and utilize the different techniques available to secure a patient's airway (ETT, LMA, Fast Track intubation, fiberoptic intubation, etc.)

General Surgery (VA or Duke Raleigh)

- Evaluate pre-operative patients.
- Manage general surgery ward/post-operative patients.
- Manage ICU patients.
- Manage ED/Trauma patients.
- Assess surgical consult patients.
- Prioritize patient acuity.
- Manage ward emergencies (e.g. arrhythmia, hypoxia, myocardial infarct, shock, etc.).
- Prioritize clinical responsibilities.
- Discharge planning.
- Perform the following procedures:
 - Arterial line/ABG
 - IV placement/Phlebotomy
 - NG tube placement
 - Dobhoff placement
 - Chest tube placement
 - Femoral, IJ, SC line placement
 - Laceration repair, simple
- Assist in the following procedures:
 - Amputation (AKA, BKA)
 - Appendectomy
 - Arteriovenous fistula
 - Breast: axillary and sentinel LND
 - Breast: lumpectomy
 - Breast: mastectomy
 - Cholecystectomy, laparoscopic and open
 - Hemorrhoidectomy
 - Hernia repair, inguinal and ventral
 - Hickman catheter
 - Laceration repair, complex
 - Open G-tube, J-tube
 - Open/close laparotomy
 - PEG
 - Tracheostomy
 - Wide local excision

Emergency Department:

- Efficiently evaluate patients.
- Develop differential diagnosis.
- Prioritize patient acuity.
- Recognize ED emergencies (e.g. airway, arrhythmia, hypoxia, shock, etc.).
- Prioritize clinical responsibilities.

- Understand role and timing of subspecialty consultants.
- Discharge planning.
- Perform the following procedures:
 - Arterial line/ABG.
 - Peripheral line/Phlebotomy.
 - Chest tube placement.
 - Femoral IJ/SC line placement.
 - Thoracentesis.
 - Paracentesis.
 - Lumbar puncture.
 - I and D of wound/abscess.
 - Laceration repair, simple.
 - Laceration repair, complex.
 - Intubation, orotracheal.
 - Intubation, nasotracheal.
 - Foley catheter placement.
 - Proctoscopy.
 - Shoulder relocation.
 - Extremity splint placement.
 - Extremity traction placement.
 - Chest tube removal.
 - Dobhuff/NGT placement.
 - Central line removal.
 - Tracheostomy exchange.
 - Chest tube management.
 - External pacing.

Surgical Intensive Care Unit (Duke):

- Organize patient data by systems.
- Develop complex differential diagnoses.
- Formulate comprehensive assessment and plan.
- Prioritize patient acuity and tasks
- Manage ICU Emergencies (e.g. arrhythmia, hypotension, hemorrhage, codes).
- Perform the following procedures:
 - Arterial lines
 - Bronchoscopy
 - Chest tube placement
 - Dobhuff/ NGT placement
 - Femoral line
 - Internal jugular line
 - Subclavian line
 - Tracheostomy tube exchange

Medical Knowledge

The PGY-1 Resident should understand:

- Basic science principles (e.g. metabolism, wound healing, electrolyte imbalances).
- OHNS principles (e.g. evaluation and management of neck mass).
- Cardiology principles (e.g. cardiac physiology).
- ACLS protocols (e.g. management of atrial fibrillation).

- Reconstructive Surgery principles (e.g. skin graft, wound VAC, rotation and vascularized free tissue flaps).
- Pharmacologic protocols (e.g. anticoagulation).
- Critical Care subjects (e.g. ARDS, SIRS, acid/base disturbances).
- General Medicine principles (e.g. ESRD, diabetes, respiratory failure, soft tissue infection).
- General OHNS principles (e.g. airway obstruction, epistaxis treatment).
- General Surgery principles (e.g. acute abdomen).
- Trauma Surgery principles (e.g. basic resuscitation and airway management).
- The indications and contra-indications for the placement of central venous lines.
- Neurosurgical principles (e.g. ICP, peripheral and central nervous systems exam, Glasgow coma scale, recognition of closed head injury).
- Hepatobiliary principles (e.g. bilirubin levels, bilirubin pathway, hepatic function)
- Colorectal principles (e.g. indications for colonoscopy, management of colon cancer)
- Radiographic studies: indications and interpretation.

Practice Based Learning and Improvement

The PGY-1 Resident should demonstrate the ability to:

- Evaluate published literature in critically acclaimed journals and texts.
- Apply clinical trials data to patient management.
- Participate in academic and clinical discussions.
- Teach medical students and physician assistant students.
- Regularly attend teaching conferences.
- Demonstrate insight into own performance and identify areas and means for improvement

Interpersonal and Communication Skills

The PGY-1 Resident should:

- Interact well with Patients/Family Members.
- Interact well with Nursing Staff.
- Interact well with Patient Resource Managers/Social Workers.
- Interact well with Attendings.
- Interact well with other Residents.
- Effectively and accurately record daily progress notes on each patient.
- Write/Dictate concise history and physical exams, admission notes, transfer notes, discharge summaries and procedure notes in a timely manner.
- Demonstrate behaviors that reflect an ongoing commitment to continuous professional development, ethical practice, sensitivity to diversity
- Demonstrate a responsible attitude toward patient care.

Professionalism and Ethics

The PGY-1 Resident should:

- Be receptive to feedback on performance.
- Be attentive to ethical issues.
- Be involved in end-of-life discussions and decisions.
- Be sensitive to gender, age, race, and cultural issues.
- Demonstrate leadership.
- Demonstrate insight into own performance and identify areas and means for improvement.
- Fulfill all professional responsibilities (e.g. compliance modules, licensing requirements, etc)

Systems Based Practice

The PGY-1 Resident should:

- Be aware of cost-effective care issues.
- Be sensitive to medical-legal issues.
- Utilize technology/computer resources to provide effective patient care
- Know how to properly code clinic visits, ED visits, ED treatments, inpatient care
- Learn and incorporate health system resources to provide effective patient care

PGY-2 OHNS Training Objectives

The PGY-2 Resident is assigned to Duke University Hospital and Clinics for the entire year. Rotations include exposure to Head and Neck, CMF Trauma, Pediatrics, Facial Plastics, Otolaryngology, Rhinology, and Laryngology. Rotations are set up in a team approach with a senior resident leading each of the teams at Duke and the VA.

Patient Care

The PGY-2 Resident should demonstrate the ability to:

- Conduct a complete office-based physical exam of the head and neck, including performing indirect mirror and flexible laryngoscopy.
- Progress through outpatient clinic or emergency procedures under direct supervision of Faculty and/or senior Residents.
- Evaluate risk factors in the preoperative assessment of surgical patients.
- Perform ambulatory and inpatient surgical procedures.
- Function as first assistant on major head and neck surgical procedures.
- Maintain appropriate fluid and electrolyte balance in the perioperative care of the head and neck surgical patient.
- Demonstrate knowledge of the hematologic coagulation cascade as applied to the perioperative care of the head and neck surgical patient.
- Perform pre-operative and post-operative assessment and management of the patient undergoing pediatric, otologic, rhinologic, laryngologic, general, trauma and head and neck surgical procedures.
- Describe the classification and anatomy of the cervical lymph nodes
- Describe the histology of cervical lymph nodes including histopathologic changes associated with inflammatory diseases.
- Develop a differential diagnosis of patient presenting with inflammatory diseases of the cervical lymph nodes.
- Develop a differential diagnosis for common presenting signs and symptoms of connective tissue and granulomatous diseases of the head and neck.
- Develop a differential diagnosis and evaluation plan for abnormal enlargement of the salivary glands.
- Identify the clinical presenting signs and symptoms and understand the physiologic and anatomic basis for the presenting condition, in patients with cancer of the oral cavity, nasopharynx, oropharynx, hypopharynx, larynx, thyroid, and salivary glands.
- Assess cranial nerve deficits related to each of the above site-specific head and neck cancers as well as facial trauma injuries.

- Conduct a differential diagnosis of clinically-identified lesions of the head and neck including nasopharynx, nasal cavity and paranasal sinuses, oral cavity, pharynx, and larynx.
- Conduct a comprehensive assessment of esophageal physiology and esophageal disease.
- Identify and manage OHNS emergencies – e.g. epistaxis; potential and actual airway emergencies; foreign bodies in the ear, airway and esophagus; infectious disease processes (neck abscess, invasive fungal disease)
- Perform and interpret allergy testing
- Perform facial analysis
- Appropriately evaluate and interpret basic findings on facial, neck and sinus CT scans
- Based upon the American Board of Otolaryngology Scope of Knowledge Report (2003), PGY2's will become proficient in the following surgical procedures:

Head & Neck:

Excision of skin lesion
 I & D of abscess
 Cervical node biopsy
 Tracheostomy
 Intraoral biopsy
 Fine needle aspiration
 Arterial Ligation

Otology:

Myringotomy; Myringotomy with tube insertion
 Microscopic external auditory canal cleaning and otologic examination
 Harvesting of fascia grafts
 I & D of pinna hematoma
 Pneumatic otoscopy
 Performing and interpreting an audiogram

Plastics/Head & Neck Reconstruction/CMF Trauma:

Closed reduction of nasal fracture
 Split thickness skin graft
 Full thickness skin graft
 Repair of facial laceration
 Excision of skin lesion with simple flap closure
 Closure of simple and complex wounds and incisions
 Exposure of facial fractures
 ORIF facial fractures
 Mandibulomaxillary fixation
 Injectable fillers and Botox
 Facial analysis

Laryngology:

Flexible fiberoptic laryngoscopy
 Direct Laryngoscopy
 Microlaryngoscopy
 Rigid and Flexible nasal endoscopy

Rigid and flexible esophagoscopy
Rigid bronchoscopy

General/Rhinology/Sleep Medicine:

Adenoidectomy
Tonsillectomy
Uvulopalatopharyngoplasty
Nasal anesthesia
Dental anesthesia
Local anesthesia for OHNS surgeries
Maxillary sinus surgery including endoscopic antrostomy and sublabial antrostomy
(Caldwell-Luc)
Septoplasty
Turbinate surgery – SMR, reduction and removal
Epistaxis management
Esophagoscopy (with foreign body removal)

Pediatrics:

Adenoidectomy
Tonsillectomy
Direct Laryngoscopy
Bronchoscopy
Flexible Laryngoscopy of the pediatric patient
Myringotomy and tube placement
Esophagoscopy (with foreign body removal)
Supraglottoplasty
Laryngotracheal Reconstruction
Pediatric Head and Neck procedures (branchial cleft sinus/cyst excision, etc)
Choanal Atresia
Pyiform Aperture Stenosis

Medical Knowledge

The PGY-2 Resident should:

- Understand Basic Science principles including embryology and physiology of the upper aerodigestive tract as derived from the Basic Science Conferences, Journal Clubs, Grand Rounds, Tumor Boards, specialty lectures, assigned and independent journal and textbook reading.
- Explain surgical anatomy of the head and neck with a focus on the clinical relevance of anatomical structures and their relationship to disease management.
- Explain surgical considerations of otolaryngologic surgery including:
 - Body composition of fluids and electrolytes in the resting state including insensible losses.
 - The intrinsic and extrinsic coagulation cascades.
 - Pulmonary function testing in the head and neck surgical patient.
 - Common pulmonary function abnormalities in the head and neck patient and pulmonary support mechanisms.
 - Principles and practice of diagnostic radiology. Be capable of understanding the principles and rationale including limitations of various radiographic assessments including CT scan, MRI, ultrasonography, and radionuclide studies.

- Principles of surgical pathology. Be capable of identifying common pathologic entities of the head and neck including but not limited to: intraepithelial neoplasia, squamous cell cancer; benign laryngeal lesions, congenital cystic lesions of the head and neck, pathologic entities of the exocrine and endocrine glands.
- Historical evolution and principles of upper aerodigestive and pulmonary endoscopy.
- Common agents used in anesthesiology including both local and general anesthetic agents. Knowledge of both contraindications and complications associated with these agents.
- Preoperative risk assessment for specific organ systems in patients undergoing head and neck surgery.
- Explain antimicrobial therapy and recent advances in therapy for otolaryngologic diseases.
- Understand the principles of diagnosis and surgical/non-surgical management of laryngomalacia.
- Understand the principles of the diagnosis, evaluation and management of facial trauma including the assessment of the patient, the surgical approaches and the principles of fixation.
- Explain surgical treatment plans, results, and their complications for cancers of the oral cavity, oropharynx, nasopharynx, hypopharynx, larynx, nose, neck and skull base.
- Explain the rationale and implications of AJCC staging in the treatment of these diseases.
- Explain the epidemiology of neoplasms and the role of carcinogenic agents in the development of pre-malignant and malignant disease.
- Explain the application of multimodality therapy for cancers of the oral cavity, oropharynx, nasopharynx, hypopharynx, larynx, nose, neck and skull base, including:
 - Indications and rationale for radiation therapy and/or chemotherapy of cancers of the larynx and hypopharynx.
 - Principles of radiobiology, dosimetry and fractionation schemes in radiation oncology.
 - Management of the head and neck cancer patient undergoing radiation therapy.
 - Limitations and complications of radiation therapy.
- Describe the natural history, histopathology, and treatment of non-squamous cell cancers of the pharynx, nose, salivary glands, skin and larynx.
- Define the various types of free tissue transfer and their application to reconstruction of head and neck defects, including:
 - Explaining various donor site considerations.
 - Explaining the post-operative management of the patient undergoing free tissue transfer.
 - Understanding the anatomy of the various local and free tissue flaps
- Describe the natural history, histopathology, and treatment of thyroid, parathyroid and major and minor salivary glands neoplasms.
- Explain the pathophysiology of laryngeal squamous cell carcinoma, including:
 - Local spread of tumor in the larynx, according to site of origin, with special emphasis on ligamentous and fascial barriers, as well as paths of extralaryngeal escape.
 - Lymphatic drainage of tumor, both intralaryngeal and extralaryngeal, with implications for treatment.
 - Diagnostic evaluation and plan of investigation.
 - Vocal consequences of the disease and its surgical and radiotherapy management. Compare voice outcomes for various treatment strategies for any given tumor.
 - The indications, contraindications, and risks of the conservation laryngeal surgery, including supraglottic, vertical hemi- and supra- cricoid laryngectomies.
- Describe strategies for voice and swallowing rehabilitation of patients' status post treatment for carcinoma.

- Explain the etiology, histologic and gross appearance, consequences to laryngeal function, and management for granulomas and contact ulcers, cysts, Reinke's edema, and vocal fold immobility.
- Explain the rationale for and basic techniques of voice therapy, including voice therapy evaluation and treatment plan formulation.
- Explain head and neck manifestations of systemic disease, including sarcoid, pemphigus, pemphigoid, AIDS, Wegener's granulomatosis, tuberculosis, rheumatoid arthritis, Sjogren syndrome, and relapsing polychondritis.
- Describe the indications, success rates, complications and surgical options for sleep apnea surgical procedures, including the role of office-based procedures, pharyngoplasties, and maxillofacial procedures.
- Explain the terminology of and differentiate types of otitis media, including:
 - Pathogenesis and pathophysiology.
 - Natural history of otitis media.
 - Signs and symptoms.
 - Diagnostic tools.
 - Treatment options.
- Use the appropriate terminology to differentiate types of sinusitis (rhinosinusitis) in both adults and children, including:
 - Pathogenesis and pathophysiology.
 - Developmental anatomy.
 - Signs and symptoms.
 - Diagnostic tools, endoscopic and radiographic staging.
 - Treatment options.
- Explain the pathophysiology of various types of adenoid and tonsil disease, including:
 - Signs, symptoms and related airway problems.
 - Diagnostic tools.
 - Treatment options.
- Describe etiologies and evaluation of pediatric hearing disorders, including:
 - Serous otitis media.
 - Congenital hearing loss.
 - Acquired hearing loss.
- Describe appropriate pediatric audiologic interventions (hearing aids, etc.) based on the patient's age and audiologic situation.
- Describe the evaluation and management of pediatric patients with airway disorders, including:
 - Laryngeal papillomatosis.
 - Epiglottitis.
 - Subglottic stenosis.
 - Laryngomalacia
 - Vocal fold paresis/paralysis.
- Discuss congenital airway disorders in relation to the embryology and development of the larynx and trachea.
- Discuss the physiology of the larynx with respect to its role in respiration, airway protection, and phonation, including:
 - The mechanism of the normal swallow.
 - The mechanism of quiet and effortless respiration.
- Discuss the etiology, diagnostic considerations, histopathology, and clinical characteristics of vascular and congenital anomalies of the head and neck.

- Discuss the pathogenesis and treatment of neuroendocrine lesions of the head and neck, including glomus and carotid body tumors.
- Discuss the pathogenesis and treatment of allergy, and its manifestations in the upper aerodigestive tract.
- Discuss the pathogenesis and treatment of reflux, and its manifestations in the upper aerodigestive tract.
- Discuss the principles of facial analysis and facial rejuvenation
- Understand the different facial rejuvenation techniques including the use of fillers, facelifts, laser resurfacing and chemical peels.
- Describe the use of local flaps and incision planning for facial skin cancer resection and reconstruction.

Practice Based Learning and Improvement

The PGY-2 Resident should demonstrate the ability to:

- Evaluate published literature in specialty and critically acclaimed journals and texts.
- Apply clinical trials data to patient management.
- Participate in academic and clinical discussions including journal club and grand rounds.
- Teach medical students and physician assistant students.
- Regularly attend teaching conferences.
- Demonstrate insight into own performance and identify areas and means for improvement
- Use the inservice exam and home study course as well as performance evaluations and other feedback to identify areas of improvement and develop a plan to remediate any deficiencies in these areas
- Utilize resources to complete research project for presentation at end of the year

Interpersonal and Communication Skills

The PGY-2 Resident should:

- Establish and maintain professional and therapeutic relationships with patients and healthcare team members.
- Manage and maintain efficiency of the team.
- Demonstrate behaviors that reflect an ongoing commitment to continuous professional development, ethical practice, sensitivity to diversity
- Demonstrate a responsible attitude toward patient care
- Present clinical and analytical information in a logical, concise manner during grand rounds, tumor board and journal club presentations
- Discuss and explain to patients and their families the diagnosis, operative treatment and expected postoperative course

Professionalism and Ethics

The PGY-2 Resident should:

- Be receptive to feedback on performance.
- Be attentive to ethical issues.
- Be involved in end-of-life discussions and decisions.
- Be sensitive to gender, age, race, and cultural issues.
- Demonstrate leadership.
- Demonstrate insight into own performance and identify areas and means for improvement
- Fulfill all professional responsibilities (timely medical records, adherence to compliance modules, etc.)

Systems Based Practice

The PGY-2 Resident should:

- Be aware of cost-effective care issues.
- Be sensitive to medical-legal issues.
- Utilize technology/computer resources to provide effective patient care
- Know how to properly code clinic visits, ED visits, ED treatments, inpatient care
- Learn and incorporate health system resources to provide effective patient care
- Utilize resources to complete research project for presentation at end of the year

PGY-3 OHNS Training Objectives

During the PGY-3 year, Residents rotate at the Durham VA, Duke University Hospital (DUH) and Duke Raleigh (DRAH).

The VA rotation exposes the Resident to all areas of OHNS except pediatrics. There is a significant focus on head and neck surgery and oncology, with a weekly multidisciplinary tumor board where several patients a week are presented. Otology operative and clinic experiences are significant. Facial plastics cases at the Durham VA also allow hands-on operative training. Residents also perform a significant number of sinus surgeries as well as surgery for sleep apnea and nasal obstruction. The DRAH rotation is again a balanced experience in all aspects of OHNS with the exception of pediatrics. However, the PGY-3 will see pediatric consults while on call. The DUH experience is split between Team 1 (Head and Neck, CMF Trauma and Cancer Reconstruction) and Team 2 (Otology and Laryngology).

The PGY-3 Resident will build upon his/her knowledge gained during the PGY-2 experience and demonstrate the following:

Patient Care

The PGY-3 Resident should:

- Demonstrate expertise in the complete office-based physical exam of the head and neck, including assisting medical students in the clinic.
- Demonstrate advanced skills in the performance of indirect mirror and flexible laryngoscopy.
- Demonstrate development of medical and surgical management plans for diseases of the major and minor salivary glands.
- Demonstrate management of branchial cleft and vascular abnormalities, including treatment of therapeutic complications.
- Explain mechanisms of carcinogenesis of upper aerodigestive cancers in the context of abnormalities of the critical elements of cell cycle regulation.
- Discuss the measures of immune suppression in head and neck cancer and their biologic basis
- Demonstrate appropriate diagnostic assessment (e.g., staging endoscopy, CT and MRI imaging, and FNA) and apply staging parameters of squamous cell and non-squamous cell neoplasms of the head and neck in presentation of patients to Head and Neck Tumor Board, understanding of the relationship between clinical stage, treatment recommendation, and prognosis.
- Explain the use of diagnostic procedures for diseases of the esophagus including the identification of abnormalities involving manometry, ph monitoring, and esophagoscopy.

- Create a treatment plan including assessment and management for the patient with a thyroid nodule and goiter.
- Establish guidelines for the surgical and medical management of patients with hyperthyroidism.
- Describe criteria for the surgical management of Grave's ophthalmopathy, and the ocular complications.
- Apply knowledge of multi-organ system risk factors towards the management of postoperative complications in patients undergoing OHNS surgical treatment.
- Identify and Manage OHNS Emergencies especially airway and progressive infections
- Based the upon the American Board of Otolaryngology Scope of Knowledge Report (2003), the PGY-3 will become proficient in the following surgical procedures:

Head & Neck:

Pharyngotomy
 Excision of Congenital Cysts and Sinuses
 Laryngeal Fracture Management
 Laryngotracheoplasty
 Epiglottoplasty
 Management of Penetrating Head and Neck Trauma
 Zenker's Diverticulectomy
 Tracheoesophageal Pharyngotomy
 Laryngeal Pharyngotomy Surgery (TEP)
 Facial Fracture Management
 Ethmoidectomy, Frontoethmoidectomy
 Maxillary Sinus surgery
 Sphenoid Sinus Surgery
 Removal of Nasal Polyps
 Orbital Decompression
 Dacryocystorhinostomy
 Submandibular Gland Excision
 Excision of Thyroglossal Duct Cyst
 Local Excision of Cancer of the Oral Cavity
 Excision of Lip Cancer with Primary Closure

Otology/Neurotology:

Tympanoplasty/Myringoplasty
 Simple Mastoidectomy
 Transtympanic Drug Injection
 Excision of Pinna

Plastics/Reconstructive/CMF Trauma:

Scar Revision
 Repair Complex Facial Laceration
 Reconstruction of Tissue Defects with local flaps
 Management of Facial Fractures
 Repair Oroantral Fistula
 Rhinoplasty
 Blepharoplasty

Knowledge of free tissue transfer: indications, use of various flaps, postoperative management

Canthoplasty

Reconstruction of Eyelids after Tumor Resection or Trauma

Indications and applications of lasers in cosmetic settings

General/Laryngology/Rhinology:

Removal of Foreign Bodies from the Airway and Upper Digestive Tract

Bronchoscopy

Endoscopic Laser Surgery of the larynx

Functional endoscopic sinus surgery (ethmoidectomy, both anterior and posterior)

Medical Knowledge

The PGY-3 Resident should be able to:

- Describe the anatomy, embryology, and physiology of the aerodigestive tract
- Describe the surgical anatomy of the head and neck.
- Identify critical anatomical spaces of the head and neck as defined by the fascial compartments of the head and neck.
- Describe the vascular anatomy of the head and neck.
- Discuss the classification of various congenital disorders such as branchial cleft abnormalities.
- Discuss general considerations in head and neck surgery.
- Discuss blood volume and physiologic adaptations to blood loss.
- Describe tests of intrinsic and extrinsic coagulation cascade and the assessment of platelet function.
- Explain dosage schemes of various antibiotic regimens based on particular diseases
- Define side effects of the different antibiotics used in otolaryngology.
- Describe intra-operative complications involving respiratory, cardiac, renal, and hematologic systems including the definition and pathophysiology of shock.
- Describe characteristics and management of postoperative complications involving specific organ sites.
- Discuss advantages and limitations of current equipment used in endoscopy of the upper aerodigestive tract.
- Define critical anatomic landmarks in laryngoscopy, esophagoscopy, and bronchoscopy including relative distances from central incisors.
- Discuss principles of esophageal endoscopy, manometry, and pH monitoring.
- Discuss the role of lasers, including laser biology, appropriate application and safety precautions, in head and neck surgery.
- Define genetic basis of cell cycle dysregulation in cancers of the head and neck.
- Define critical cellular components in the metastatic process.
- Describe laboratory-based immunologic parameters associated with head and neck cancer.
- Describe factors associated with immune suppression and cell cycle escape by head and neck cancer.
- Define the AJCC staging parameters of cancers of the upper aerodigestive tract including cancers of the nasopharynx, paranasal sinuses, oral cavity, pharynx, and larynx, and associated cervical metastases.
- Describe the assessment and diagnostic evaluation of patients with diseases of the oral cavity.
- Explain the histopathologic classification systems of oral cavity cancer.
- Discuss the diagnostic evaluation and staging of oral cancers

- Describe the diagnostic characteristics, histopathologic characteristics, and natural history of benign lesions of the oral cavity including odontogenic tumors.
- Describe the histopathologic classification systems of oropharynx cancer.
- Discuss the current methodology for assessing speech and swallowing disorders.
- Describe the techniques for post-operative rehabilitation of swallowing function in the patient treated for head and neck cancer.
- Discuss the diagnostic considerations, histopathology, clinical course of acquired and congenital lesions of the larynx and hypopharynx.
- Explain the principles of medical and surgical treatment of gastroesophageal reflux disease.
- Explain sensitivity, specificity, and limitations relevant to the diagnostic tests for the thyroid nodule.
- Describe histopathologic conditions related to the thyroid nodule.
- Describe classification schemes for benign diseases of the major and minor salivary glands.
- Describe the differential diagnosis of enlargement of the parotid gland.
- Discuss the assessment and diagnostic evaluation of patients with diseases of the major and minor salivary glands.
- Explain the epidemiology of malignant diseases of the major and minor salivary glands.
- Describe the histopathologic characteristics of salivary gland neoplasia.
- Describe the histopathologic characterization, diagnostic, and radiographic characteristics of connective tissue and granulomatous diseases of the head and neck.
- Explain the diagnosis and management of deep space infections of the head and neck.
- Define the causes of lymphadenitis, both viral and non-viral.
- Describe the noninfectious causes of lymphadenopathy, including lymphadenopathy associated with systemic illness.
- Describe the diagnostic evaluation of obstructive sleep apnea including physiologic sleep studies, sleep disorder scales, and radiographic assessments.
- Discuss the role and characteristics of non-surgical management of sleep apnea.
- Discuss the etiology, diagnostic considerations, histopathology, and clinical characteristics of vascular anomalies of the head and neck.
- Discuss the pathogenesis and treatment of neuroendocrine lesions of the head and neck including glomus and carotid body tumors.

Practice Based Learning and Improvement

The PGY-3 Resident should demonstrate the ability to:

- Evaluate and critique published literature in OHNS and critically acclaimed journals and texts.
- Apply clinical trials data to patient management.
- Teach medical students and physician assistant students.
- Regularly attend teaching conferences.
- Demonstrate insight into own performance and identify areas and means for improvement
- Attend and actively participate in conferences including tumor board, journal club and grand rounds.
- Use the inservice exam and home study course as well as performance evaluations and other feedback to identify areas of improvement and develop a plan to remediate any deficiencies in these areas
- Utilize resources to complete research project for presentation at end of the year
- Utilize resources to develop research project for the dedicated research rotation

Interpersonal and Communication Skills

The PGY-3 Resident should:

- Establish and maintain professional and therapeutic relationships with patients and healthcare team members.
- Manage and maintain efficiency of the team.
- Demonstrate behaviors that reflect an ongoing commitment to continuous professional development, ethical practice, sensitivity to diversity
- Demonstrate a responsible attitude toward patient care
- Present clinical and analytical information in a logical, concise manner during grand rounds, tumor board and journal club presentations
- Discuss and explain to patients and their families the diagnosis, operative treatment and expected postoperative course

Professionalism and Ethics

The PGY-3 Resident should:

- Be receptive to feedback on performance.
- Be attentive to ethical issues.
- Be involved in end-of-life discussions and decisions.
- Be sensitive to gender, age, race, and cultural issues.
- Demonstrate leadership.
- Demonstrate insight into own performance and identify areas and means for improvement
- Fulfill all professional responsibilities (timely medical records, adherence to compliance modules, etc.)

Systems Based Practice

The PGY-3 Resident should:

- Be aware of cost-effective care issues.
- Be sensitive to medical-legal issues.
- Utilize technology/computer resources to provide effective patient care
- Know how to properly code clinic visits, ED visits, ED treatments, inpatient care
- Learn and incorporate health system resources to provide effective patient care
- Utilize resources to complete research project for presentation at end of the year
- Utilize resources to develop research project for the dedicated research rotation

PGY-4 Training Objectives

The PGY-4 Resident educational experience consists of rotations at DUH, and a dedicated research block. In both clinical rotations, the Resident has continued educational opportunity in all areas of OHNS, including head and neck surgery, CMF Trauma, otology/neurotology, laryngology, rhinology, general otolaryngology, pediatrics, and plastic and reconstructive surgery. PGY-4 and PGY-5 Residents also provide some coverage for general otolaryngology (non-CMF) consults at Duke Regional Hospital (DRH) and Duke Otolaryngology of Durham patients admitted to DRH.

The PGY-4 Resident will continue to build upon his/her knowledge base and demonstrate the following skills:

Patient Care

The PGY-4 Resident should:

- Demonstrate expertise in the complete office-based physical exam of the head and neck, including assisting more junior Residents and medical students in the teaching clinic.
- Demonstrate advanced skills in the performance of indirect mirror and flexible laryngoscopy.
- Demonstrate application of fine needle aspiration (FNA) and diagnostic assessment of inflammatory and neoplastic diseases of the cervical lymph node, neck masses and thyroid nodules.
- Demonstrate development of medical and surgical management plans for diseases of the major and minor salivary glands.
- Demonstrate abilities with diagnostic evaluation and management of congenital and vascular abnormalities, including treatment of therapeutic complications.
- Demonstrate expertise in complex facial laceration, trauma and repair.
- Demonstrate endoscopic procedures of the upper aerodigestive tract including laryngoscopy, esophagoscopy, and bronchoscopy for junior Residents and medical students.
- Demonstrate diagnostic assessment (e.g., staging endoscopy, CT, PET and MRI imaging, and FNA) and capitulate staging parameters of squamous cell and non-squamous cell neoplasms of the head and neck in presentation of patients to Head and Neck Tumor Board, understanding of the relationship between clinical stage and prognosis.
- Explain mechanisms of carcinogenesis of upper aerodigestive cancers in the context of abnormalities of the critical elements of cell cycle regulation.
- Discuss the measures of immune suppression in head and neck cancer and their biologic basis.
- Explain the use of diagnostic procedures for diseases of the esophagus including the identification of abnormalities involving manometry, ph monitoring, and esophagoscopy.
- Apply knowledge of multi-organ system risk factors towards the management of postoperative complications.
- Create an appropriate evaluation, surgical and long-term treatment plan for a patient with thyroid malignancy.
- Establish guidelines for the surgical and medical management of patients with hyperthyroidism.
- Describe criteria for the surgical management of hyperthyroidism.
- The PGY-4 Resident should be able to assist the PGY-5 Resident in management of inpatients and the consult service.
- Identify and Manage OHNS emergencies especially airway and progressive infections.
- Based the upon the American Board of Otolaryngology Scope of Knowledge Report (2003), the PGY-4 will become proficient in the following surgical procedures:

Head & Neck:

- Partial/Complete Maxillectomy with and without orbital exenteration
- Intraoral resection
- Oral cavity resection
- Composite resection
- Glossectomy
- Total and partial laryngectomy
- Radial neck dissection
- Selective neck dissection
- Arytenoidectomy/Arytenoidopexy
- Mandibulectomy/Mandibulotomy
- Cricopharyngeal myotomy

Reconstruction of vascular malformation (lymphatic, venous, hemangioma)
Zenker's Diverticulectomy
Treatment of laryngeal cleft and tracheoesophageal fistula
Thyroidectomy
Frontal Sinus trephination, Obliteration, and obliteration
Superficial parotidectomy with preservation of facial nerve
Lateral rhinotomy
Facial degloving

Plastic and Reconstructive/CMF Trauma:

Reduction and repair of facial fractures
Rhinoplasty including revision rhinoplasty by open and close techniques
Otoplasty
Rhytidectomy
Forehead and brow lift
Blepharoplasty plus periorbital procedures
Extra-temporal facial re-animation
Soft tissue expansion
Skin resurfacing techniques
Knowledge of free tissue transfer: indications, use of various flaps, postoperative management

Laryngology/Rhinology:

Laser resection of laryngeal and pharyngeal tumors
Functional endoscopic sinus surgery (frontal and sphenoid)

Otology/Neurotology:

Canalplasty
Meatoplasty
Middle ear exploration
Mastoidectomy
Tympanomastoidectomy
Repair of perilymphatic fistula
Cochlear implant
BAHA (bone anchored hearing aid)
Ossicular Chain Reconstruction

Medical Knowledge

The PGY-4 Resident should be able to:

- Describe the anatomy, embryology, and physiology of the aerodigestive tract.
- Describe the surgical anatomy of the head and neck
- Identify critical anatomical spaces of the head and neck as defined by the fascial compartments of the head and neck.
- Describe the vascular anatomy of the head and neck.
- Discuss the classification of various congenital disorders such as branchial cleft abnormalities.
- Discuss general considerations in head and neck surgery.
- Discuss blood volume and physiologic adaptations to blood loss.
- Describe tests of intrinsic and extrinsic coagulation cascade and the assessment of platelet function.

- Explain dosage schemes of various antibiotic regimens based on particular diseases
- Define side effects of the different antibiotics used in otolaryngology.
- Describe intra-operative complications involving respiratory, cardiac, renal, and hematologic systems including the definition and pathophysiology of shock.
- Describe characteristics and management of postoperative complications involving specific organ sites.
- Discuss advantages and limitations of current equipment used in endoscopy of the upper aerodigestive tract.
- Define critical anatomic landmarks in laryngoscopy, esophagoscopy, and bronchoscopy including relative distances from central incisors.
- Discuss principles of esophageal endoscopy, manometry, and pH monitoring.
- Discuss the role of lasers, including laser biology, appropriate application, and treatment results in head and neck surgery.
- Define genetic basis of cell cycle dysregulation in cancers of the head and neck.
- Define critical cellular components in the metastatic process.
- Describe laboratory-based immunologic parameters associated with head and neck cancer.
- Describe factors associated with immune depression and escape by head and neck cancer.
- Explain the classification schemes for cervical lymph node metastases including AJCC classification schemes.
- Define the AJCC staging parameters of cancers of the upper aerodigestive tract including cancers of the nasopharynx, paranasal sinuses, oral cavity, pharynx, and larynx.
- Describe the assessment and diagnostic evaluation of patients with diseases of the oral cavity.
- Explain the histopathologic classification systems of oral cavity cancer.
- Discuss the diagnostic evaluation and staging of oral cancers
- Describe the diagnostic characteristics, histopathologic characteristics, and natural history of benign lesions of the oral cavity including odontogenic tumors.
- Describe the histopathologic classification systems of oropharyngeal cancer.
- Discuss the current methodology for assessing speech and swallowing disorders.
- Describe the techniques for post-operative rehabilitation of swallowing function in the patient treated for head and neck cancer.
- Discuss the diagnostic considerations, histopathology, clinical course of acquired and congenital lesions of the larynx and hypopharynx.
- Explain the principles of medical and surgical treatment of gastroesophageal reflux disease.
- Explain sensitivity, specificity, and limitations relevant to the diagnostic tests for the thyroid nodule.
- Describe histopathologic conditions related to the thyroid nodule.
- Describe classification of complex facial fractures.
- Describe classification schemes for benign diseases of the major and minor salivary glands.
- Describe the differential diagnosis of enlargement of the parotid gland.
- Discuss the assessment and diagnostic evaluation of patients with diseases of the major and minor salivary glands.
- Explain the epidemiology of malignant diseases of the major and minor salivary glands.
- Describe the histopathologic characteristics of salivary gland neoplasia.
- Describe the histopathologic characterization, diagnostic, and radiographic characteristics of connective tissue and granulomatous diseases of the head and neck.
- Explain the diagnosis and management of deep space infections of the head and neck.
- Define the causes of lymphadenitis, both viral and non-viral.

- Describe the noninfectious causes of lymphadenopathy, including lymphadenopathy associated with systemic illness.
- Describe the diagnostic evaluation of obstructive sleep apnea including physiologic sleep studies, sleep disorder scales, and radiographic assessments.
- Discuss the role and characteristics of non-surgical management of sleep apnea.
- Discuss the etiology, diagnostic considerations, histopathology, and clinical characteristics of vascular anomalies of the head and neck.
- Discuss the pathogenesis and treatment of neuroendocrine lesions of the head and neck including glomus and carotid body tumors.
- Acquire fundamental principles of otolaryngic allergy.
- Be familiar with signs and symptoms of allergies.
- Take an appropriate allergy H&P.
- Recognize the physical findings caused by allergies.
- Know the different pharmacological interventions that are available to control allergy symptoms.
- Understand the indications and technique of allergy testing.
- Understand how to prescript allergy immunotherapy.
- Be able to manage adverse reactions that occur during allergy testing or immunotherapy.
- Insight into the efficient organization and management of an allergy outpatient clinic.

Practice Based Learning and Improvement

The PGY-4 Resident should demonstrate the ability to:

- Evaluate and critique published literature in OHNS and critically acclaimed journals and texts.
- Apply clinical trials data to patient management.
- Regularly attend teaching conferences and lead the new year OHNS boot camp
- Teach medical students, junior Residents and physician assistant students.
- Demonstrate insight into own performance and identify areas and means for improvement
- Attend and actively participate in conferences including tumor board, journal club and grand rounds.
- Use the inservice exam and home study course as well as performance evaluations and other feedback to identify areas of improvement and develop a plan to remediate any deficiencies in these areas
- Utilize resources to complete research project for presentation at end of the year
- Utilize resources to complete research project during the dedicated research rotation

Interpersonal and Communication Skills

The PGY-4 Resident should:

- Establish and maintain professional and therapeutic relationships with patients and healthcare team members.
- Manage and maintain efficiency of the team.
- Demonstrate behaviors that reflect an ongoing commitment to continuous professional development, ethical practice, sensitivity to diversity
- Demonstrate a responsible attitude toward patient care
- Present clinical and analytical information in a logical, concise manner during grand rounds, tumor board and journal club presentations
- Discuss and explain to patients and their families the diagnosis, operative treatment and expected postoperative course

Professionalism and Ethics

The PGY-4 Resident should:

- Be receptive to feedback on performance.
- Be attentive to ethical issues.
- Be involved in end-of-life discussions and decisions.
- Be sensitive to gender, age, race, and cultural issues.
- Demonstrate progressive leadership in having primary responsibility in leading a service at DVAMC.
- Demonstrate insight into own performance and identify areas and means for improvement
- Fulfill all professional responsibilities (timely medical records, adherence to compliance modules, etc.)

Systems Based Practice

The PGY-4 Resident should:

- Understand cost-effective care issues.
- Be sensitive to medical-legal issues.
- Utilize technology/computer resources to provide effective patient care
- Know how to properly code clinic visits, ED visits, ED treatments, inpatient care
- Learn and incorporate health system resources to provide effective patient care
- Utilize resources to complete research project for presentation at end of the year

PGY-5 Training Objectives

The PGY-5 year will be spent at DUH and the VA. The PGY-5 obtains a continued and progressive operative experience in all aspects of OHNS, and gains inpatient consultative service experience by overseeing all hospital consults. The PGY-5 resident is responsible for leading the resident teams at DUH and the VA.

The PGY-5 Resident will demonstrate superior knowledge of Head and Neck Surgery and Oncology, Rhinology, Otolaryngology/Neurotology, CMF Trauma, Pediatrics, Facial Plastics, General Otolaryngology and Laryngology.

Patient Care

The PGY-5 Resident must:

Demonstrate ability to manage the General/Head and Neck Surgery Service, including:

- Direct supervision of junior Residents and coordination of nursing, social services and administration to optimize patient care.
- Assist Faculty with supervision of the general, head and neck, pediatric, rhinology and craniomaxillofacial clinics.
- Develop the treatment plan for all patients undergoing medical or surgical care on the General/Head and Neck Surgery Service
- Direct the presentation of appropriate patients to the Head and Neck Tumor Board.
- The Resident should utilize this year to both build upon and acquire new patient management skills as outlined under Medical Knowledge and those skills required for completion of prior years of training.

- Based the upon the American Board of Otolaryngology Scope of Knowledge Report (2003), the PGY-5 will become proficient in the following surgical procedures:

Otology/Neurotology:

Stapedectomy/Stapedotomy
 Endolymphatic sac surgery
 Vestibular nerve section
 Labyrinthectomy
 Cochlear implantation
 Familiarization with removal of acoustic neuroma and other cerebellopontine angle tumors
 Glomus tympanicum tumor removal-familiarization with removal of glomus jugulare tumors
 Familiarization with congenital middle ear reconstruction
 Facial nerve decompression

Plastic & Reconstructive/CMF Trauma:

Management of alopecia and reconstructive scalp surgery
 Facial implants
 Mandibular reconstruction
 Familiarization with reconstruction of cleft lip and palate deformity
 Familiarization with reconstruction of other craniofacial deformities
 Understanding of free tissue transfer: indications, use of various flaps, postoperative management
 Facial Analysis
 Facial Rejuvenation
 Indications and applications of lasers in cosmetic settings

Head & Neck:

Total parotidectomy with facial nerve preservation and/or grafting
 Repair of caustic ingestion injuries of the pharynx and esophagus, thermal injury of the upper airway
 Partial/total laryngectomy/pharyngectomy
 Techniques of restoration of the cervical esophagus
 Excision of masses of the parapharyngeal space – i.e. chemodectoma and neurilemmoma
 Tracheal resection and reconstruction
 Parathyroidectomy
 Skull base surgery (endoscopic and open)

Rhinology/Laryngology:

Advanced endoscopic procedures including repair CSF rhinorrhea
 Revision endoscopic sinus procedures
 Endoscopic microlaryngeal procedures including cancer resection
 Transnasal and transsphenoidal resection of hypophyseal tumors

Medical Knowledge

The PGY-5 Resident must:

- Demonstrate mastery of all knowledge acquired in prior years.

- Demonstrate application of acquired knowledge to the preoperative selection, operative and perioperative care, and avoidance and management of complications of patients on the OHNS Service.
- Discuss, in detail, the management of patients undergoing:
 - Airway surgery: palatoplasty, tracheotomy.
 - Endoscopy of the esophagus, larynx, sinuses, and trachea.
 - Open reduction and internal fixation with or without stenting of laryngeal fractures
 - Laryngeal framework surgery, vocal fold medialization by injection and airway management by arytenoidectomy/arytenoidopexy.
 - Laryngectomy: total, horizontal, supraglottic and supracricoid.
 - Maxillectomy: medial and total with and without orbital extenuation.
 - Neck dissection, modified and radical.
 - Marginal and segmental mandibular resection.
 - Resection of neoplasms of the upper aerodigestive tract.
 - Parotidectomy, resection of parapharyngeal space and submandibular gland neoplasms.
 - Thyroidectomy, parathyroidectomy.
 - Vascular surgery; resection of carotid body tumors, repair of venous and arterial lacerations and ligation of major vessels of the head and neck.
 - Panfacial/Complex facial trauma including pre-operative/post-operative management.
 - Intraoperative application of reconstruction hardware and bone grafts.
 - Treatment of acquired and congenital ear disease as described in the PGY-4 section of Otolaryngology/Neurotology.
 - Airway surgery: bronchoscopy, esophagoscopy, management of acute epiglottitis, obstructive sleep apneas and removal of foreign bodies
 - Excision of congenital cysts and sinuses (branchial cleft, thyroglossal duct).
 - Resection of vascular tumors.
 - Dacryocystorhinostomy.
 - Drainage of orbital abscess; endoscopic and external approaches.
 - Endoscopic antrostomy, ethmoidectomy, frontal sinusotomy and sphenoidotomy.
 - External approaches to the paranasal sinuses; Caldwell Luc, ethmoidectomy, ligation of the internal maxillary artery, osteoplastic frontal sinusotomy and trephination.
 - Orbital/optic nerve decompression.
 - Repair of CSF rhinorrhea; endoscopic and external approaches.
 - Septoplasty.
- Discuss the obligations and skills necessary to direct the care of patients and the supervision of more junior Residents in an acute care specialty hospital.

Practice Based Learning and Improvement

The PGY-5 Resident must demonstrate the ability to:

- Evaluate and effectively critique published literature in critically acclaimed journals and texts.
- Apply clinical trials data to patient management.
- Lead academic and clinical discussions.
- Attend and actively participate, and direct/organize teaching conferences as needed.
- Demonstrate insight into own performance and identify areas and means for improvement.
- Regularly attend teaching conferences and lead the new year OHNS boot camp
- Teach medical students, junior Residents and physician assistant students.
- Demonstrate insight into own performance and identify areas and means for improvement

- Use the inservice exam and home study course as well as performance evaluations and other feedback to identify areas of improvement and develop a plan to remediate any deficiencies in these areas
- Utilize resources to complete research project for presentation at end of the year
- Utilize resources to write up the research project completed during the dedicated research rotation

Interpersonal and Communication Skills

The PGY-5 Resident must:

- Establish and maintain professional and therapeutic relationships with patients and healthcare team members.
- Manage and maintain efficiency of the team.
- Demonstrate behaviors that reflect an ongoing commitment to continuous professional development, ethical practice, sensitivity to diversity
- Demonstrate a responsible attitude toward patient care
- Present clinical and analytical information in a logical, concise manner during grand rounds, tumor board and journal club presentations
- Discuss and explain to patients and their families the diagnosis, operative treatment and expected postoperative course

Professionalism and Ethics

The PGY-5 Resident must:

- Actively seek and be receptive to feedback on performance.
- Be attentive to ethical issues.
- Be involved in end-of-life discussions and decisions.
- Be sensitive to gender, age, race, and cultural issues.
- Demonstrate leadership.
- Demonstrate insight into own performance and identify areas and means for improvement
- Demonstrate progressive leadership in having primary responsibility in leading a service at DUH.
- Fulfill all professional responsibilities (timely medical records, adherence to compliance modules, etc.)

Systems Based Practice

The PGY-5 Resident must:

- Understand cost-effective care issues.
- Be sensitive to medical-legal issues.
- Utilize technology/computer resources to provide effective patient care
- Know how to properly code clinic visits, ED visits, ED treatments, inpatient care
- Learn and incorporate health system resources to provide effective patient care
- Utilize resources to complete research project for presentation at end of the year

Research

Goals for the research component of resident training are designed to establish competency in the design, conduct, interpretation and presentation of research. To this end, residents will have the minimal requirement to have 2 completed projects during residency. These projects must be of

publishable quality and is expected to be presented when appropriate at the end of the year research session. In addition, submission for publication is expected. The research experience is based on a mentorship model. Therefore, the resident and faculty research mentor work together to develop and execute a research project. Residents also need to identify someone on the Resident Research Committee. Members of the committee include: Drs. Dennis Frank-Ito, Harrison Jones, Deb Tucci, Walter Lee, and David Witsell. This committee mentor is available to develop and refine research projects and will meet with the resident(s) in addition to the faculty research mentor as needed to assist in research related issues. Kris Schulz, MPH is an invaluable resource for advice and direction as well.

In addition to the two projects during residency, all residents in the PGY 3 year will write a grant proposal. As there are federal and institutional requirements for all research that require a defined process, the following is a timeline that accounts for the necessary approvals and subsequent completion of the yearly grant project.

- By July 31: Review the list of Grant Opportunities provided by Dr. Lee and identify an appropriate grant mechanism. The AAO-HNSF CORE Grants Program is the most comprehensive opportunity where all Residents should be able to find a fit for their project, but there are many other opportunities.
- By August 15: have project, mentors and basic outline of project. Begin literature search to help refine project.

For CORE Grant submission:

- By September 1:
 - review the Clinical Scholars modules (Website: sakai.duke.edu)
 - “Developing a Hypothesis”;
 - “Study Design Protocol Development”; and
 - “Winning Grant Applications – A Primer”
- By October 1:
 - Develop a one-page description of your study including: significance (why your study is important – cite at least 2 literature sources); hypothesis; methods/study design; and proposed analysis plan.
 - Register and take grant submission tutorial and download grant proposal requirements and templates on the ProposalCentral website and review (go through AAO-HNSF website link provided in grants information below).
- By November 15:
 - Meet with your mentor to discuss, edit and finalize your one-page description – this description will also be vetted with the OHNS Research Committee.
 - Review the required templates with your mentor and find out internal notification dates at Duke for grant submission and make appropriate contacts/notifications.
 - Begin preparing grant.
- By December 17:
 - Submit LOI via instructions on AAO-HNSF website (ProposalCentral).
 - Request letters of support required for grant.
 - Finalize budget for internal Duke submission/approval deadlines.
- By December 31:
 - Provide a draft version of your grant application to your mentor and the Research Committee.
 - Meet with Erika to discuss IRB submission.

- Touch base with Duke internal grants contact about submission.
- By January 15:
 - Submit your grant online via ProposalCentral

If residents have identified a different grant opportunity, meetings with the mentor and Kris Schulz are mandatory to develop a timeline for development of the project and submission of the grant proposal. The resident will work with the project mentor to execute the research project and present the findings at the end of the academic year (typically no earlier than June 15). Publication plan and manuscript submission is expected for each project.

Residents on the research rotation meet regularly with Dr. Lee (usually weekly). During the research rotation, Residents will

- execute the previously submitted grant funded project if applicable or at least one other research project that has already been developed and approved by Dr. Lee and the Resident's research mentor and other self-initiated or team projects
- complete the Research Article Reading List (typically an article weekly)
- complete a mentored review of a journal article submitted for peer review (as available) no more than one every two weeks
- complete the AAO-HNS Clinical Scholars Program

Medical Knowledge

The Resident must:

- Learn sound research methodology
- Learn statistical methods and their application
- Complete and remain current with all IRB and other institutional required coursework and certifications that are prerequisites to performing research

Patient Care

As a result of the Research Rotation the Resident will:

- Better evaluate medical literature pertaining to the care of patients
- Appropriately apply medical literature results to the care of patients

Practice Based Learning and Improvement

The Research Resident must:

- Understand the research process with regards to development of a hypothesis, formulation of research methodology to investigate the hypothesis, proper execution of the research project, appropriate statistical analysis and presentation of data.
- Understand the fundamentals of grant writing.
- Learn how to write a manuscript suitable for publication in a peer reviewed medical journal.
- Evaluate and effectively critique published literature in critically acclaimed journals and texts.
- Learn how to apply clinical trials data to patient management.
- Participate in routine academic discussions and journal clubs.
- Knowledge of the research process will allow the Resident to attend and actively participate in research conferences.

Interpersonal and Communication Skills

- The research experience will help the Resident establish and maintain professional relationships with patients and healthcare team members.
- The Resident will learn how to manage and maintain efficiency of the research team efforts.

- The Resident will communicate effectively with the research mentor and other members of the research team (e.g. data entry personnel, statistician, editor)

Professionalism and Ethics

The Resident must:

- Learn the ethical and professional responsibilities of researchers and research endeavors.
- Demonstrate behaviors that reflect an ongoing commitment to continuous professional development, ethical practice, sensitivity to research bias and responsible attitudes.
- Complete and remain current with all required research modules and certifications.

Systems Based Practice

The Resident will:

- Learn to be aware of cost effective research issues.
- Be sensitive to research bias.
- Be sensitive to medico-legal issues.
- Understand the information technology/computer resources necessary

POLICY ON RESIDENT PROGRESSION

FIRST YEAR (PGY-1)

OBJECTIVE: The first year OHNS Resident functions as an integral part of the OHNS surgical team caring for patients in the ward setting, leading ward rounds with efficiency and precision and developing clinic and operative experience in the clinic and OR to begin formation of medical and surgical skills in OHNS. Non-OHNS rotations are designed to enhance OHNS related medical knowledge. The Resident should demonstrate substantial achievement of the following attributes and goals before advancing to the second year of training:

Operative:

Demonstrates professional behavior to all staff
Sterile technique and draping
One and two-handed knots with silk
Common instrument terminology
Closure of wounds

Performs:

Exam under anesthesia
Direct laryngoscopy with intervention
Fiberoptic laryngoscopy

Didactic/Clinical/Educational

Demonstrates professional behavior to all staff
Reliable in performing assigned tasks
Reliable in clerical responsibilities (daily notes, discharge summaries, post-op checks, clinic notes, operative notes).
Responds in a timely fashion for floor rounds
Has most recent data available
Recognizes and follows role as part of the Care Team
Integrates medical students into the Team

Reads Otolaryngology texts focusing on inpatient care issues, laryngology, otology and general otolaryngology
Acquires adequate knowledge of clinical and basic science principles as it applies to disease processes and patient care
Performs appropriately focused history and physical examinations with identification of pertinent physical findings
Presents patients in a focused, coherent manner
Tracks clinical data and patient studies and understands how these determine patient care
Prepares for each operation through readings, practice of skills (i.e., knot tying, etc.) and preparation of the integrated approach of patient care through the use of the ACGME General Competencies.
Fulfills all professional obligations

SECOND YEAR (PGY-2)

OBJECTIVE: The second year OHNS Resident incorporates the scope of patient management skills learned in the PGY-1 year to develop the skills and competence to assess and care for the OHNS patient, particularly regarding the timeliness (elective, emergent, urgent) of otolaryngologic management. The Resident should demonstrate substantial achievement of the following attributes and goals before advancing to the third year of training:

Operative:

Demonstrates professional behavior to all staff
Performs setup of instrumentation and patient preparation for OHNS surgical procedures
Demonstrates appropriate use of surgical instrumentation in performance of simple general otolaryngologic procedures, and avoidance of complications
Becomes proficient in dictation of operative notes
Independent in clerical responsibilities (including supervision of PGY-1 in daily notes, discharge summaries, post op checks)
Performs:
Tonsillectomy
Adenoidectomy
Placement of pressure equalization tubes
Maxillary antrostomy
Anterior ethmoidectomy

Didactic/Clinical/Educational:

Demonstrates professional behavior to all staff
Assists in supervision of first year Residents with the basic procedures on the floor
Actively participates in appropriate outpatient clinics
Teaches PGY-1's and medical students
Learns to investigate, prepare, and deliver grand rounds, journal club articles, tumor board presentations and morbidity and mortality conference presentations
Reads and completes assignments in didactic education course
Becomes competent in the comprehensive head and neck history taking, physical examination and ordering of appropriate diagnostic testing for the clinical problem
Presents in an organized, brief fashion, and begins to develop treatment plans
Tracks clinical data with immediate availability
Reads in preparation for each operation including summary of pertinent anatomy, indications, contraindications, and complications

Engages more senior Residents and Attending physicians in preoperative discussion.
Becomes familiar with monitoring and management of medically and surgically complex OHNS patients
Learns the principles and methods of scientific investigation, and how to apply these principles in the development of a scientific study and grant proposal
Begins to understand basic statistical methods, reads pertinent specialty journals with a critical eye
Prepares a research project for presentation at the end of the year
Fulfills all professional obligations

THIRD YEAR (PGY-3)

OBJECTIVE: The PGY-3 is an effective leader with an emphasis placed on the diagnosis and refinement of a treatment plan in more complex cases. He/she concentrates on technical learning in the operative theater. The Resident should demonstrate substantial achievement of the following attributes and goals before advancing to the fourth year of training:

Operative:

Demonstrates professional behavior to all staff
Knowledge of prep and drape of major OHNS cases
Full terminology of all aspects of the operative theatre
Develops surgical skills and decision-making in the planning and performance of more complex OHNS procedures
Participates in the pre-intra-post-operative care of all patients

Clinical/Didactic/Educational:

Demonstrates professional behavior to all staff
Clinical knowledge appropriate for all operative experiences
Teaches and supervises PGY-1's and medical students in the Emergency Department and floor
Supervises basic techniques for medical students in the OR
Critically evaluates literature for clinical merit
Engages senior Residents and Attendings in preoperative and postoperative discussions
Attends and participates in appropriate service clinics
Prepares a research project for presentation at the end of the year
Completes the planned research proposal under the guidance of the Faculty mentor
Fulfills all professional obligations

FOURTH YEAR (PGY-4)

OBJECTIVE: The fourth year Resident is becoming a recognized leader in the OHNS Division and Medical Center. He/she is immersed in the technical aspects of OHNS and is devoted to participating in the total management of the OHNS patient. The PGY-4 demonstrates the skills to perform at the senior Resident level. The Resident should demonstrate substantial achievement of the following attributes and goals before advancing to the fifth year of training:

Operative:

Demonstrates professional behavior to all staff
Has full understanding, knowledge and technical steps of major OHNS operative cases
Progressive autonomous function in the OR with appropriate available supervision
Integration of OR assistants

Fully able to set up operation (retractors, assistants, equipment, etc.)
Understands and can formulate indications, contraindications and develops appropriate
intraoperative decision making when treatment plans must be changed

Clinical/Didactic/Educational:

Demonstrates professional behavior to all staff
Teaches and supervises junior housestaff and medical students in the wards, Emergency
Department or OR
Consistently consults and applies current literature (evidenced based medicine) to clinical
management of patients
Actively participates in didactic sessions
Demonstrates knowledge of indications, contraindications and potential complications of
assigned operative procedures
Attends and participates in appropriate service clinics
Prepares a research project for presentation at the end of the year
Completes research project and performs data analysis, writes manuscript and submits
work for publication/presentation at national OHNS meeting
Fulfills all professional obligations

FIFTH YEAR (PGY-5)

OBJECTIVE: The Chief Resident is an acknowledged leader, able to assume control of
emergency situations and demonstrate a measured and knowledgeable approach to surgical
disease. He/she is well versed in the current literature and is primed to pass the written and oral
portions of the American Board of Otolaryngology Examinations. A dedicated teacher for medical
students and Residents alike, the Chief Resident manages a busy OHNS Service with efficiency
and attention to detail. The Resident should demonstrate substantial achievement of the following
attributes and goals before being allowed to graduate from the residency and sit for his/her Board
examinations:

Operative:

Demonstrates professional behavior to all staff
Fully autonomous
Leadership role in all cases
Sufficient operative cases

Clinical/Didactic/Educational:

Demonstrates professional behavior to all staff
Administrative supervision of rotation schedule for all Residents
Management of patients in conjunction with Faculty
Service oriented teaching of medical students and junior Residents
Evaluates progress of team members
Full integration of basic and clinical science in leading a ward service
Leads OHNS service demonstrating autonomy
Prepares a research project for presentation at the end of the year
Submits research for publication/presentation at a national OHNS meeting
Fulfills all professional obligations

Communication

To facilitate smooth functioning of the OHNS Residency Program, strong communication is required. Please do not hesitate to contribute to this process. Keep in mind that a written e-mail message is preferable follow-up on any conversational request or inquiry.

Telephone Numbers:

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