

Otolaryngology Residency Program Manual

The logo features the text 'UPMC' in a large, white, serif font. To its right, the words 'LIFE', 'CHANGING', and 'MEDICINE' are stacked vertically in a smaller, white, sans-serif font. The background consists of a dark purple field with a pattern of overlapping, light purple, wavy lines on the left side and a series of horizontal, light purple bars on the right side.

UPMC LIFE
CHANGING
MEDICINE

Preface

Residency training in otolaryngology requires a minimum of five years in a formal otolaryngology program with six months of general surgery experience in the initial year. We view this training program as far more than a surgical apprenticeship. Residency training at UPMC is a commitment to education. During your residency, you will have the opportunity to provide patient care under the direction of outstanding full-time faculty. You will be afforded the opportunity to attend a multitude of didactic conferences, seminars, and medical meetings. You may avail yourself of an outstanding medical library.

This manual has been developed to afford structure to this complicated educational process. As a resident of otolaryngology, you will have responsibilities to our patients, faculty, and to yourself. It is expected that you will be familiar with the information provided in the manual. When changes occur, efforts will be made to formally alert you to these changes.

I call your attention to the educational objectives associated with each of our educational rotations. Educational objectives have been organized to reflect growth in skills in six categories: 1) Medical Knowledge, 2) Patient Care, 3) Professionalism, 4) Interpersonal and Communication Skills, 5) Practice-Based Learning and Improvement, and 6) Systems-Based Practice. You are encouraged to familiarize yourself with the entire manual. As each rotation approaches, the educational objectives and resident responsibilities should be reviewed to better prepare you for that rotation.

Residency training in otolaryngology is an exciting and challenging experience. Please commit yourself to becoming the best otolaryngologist that you can be. In so doing, you can partner with the faculty in the development of your future. If there is anything I can do to improve your residency experience, I have an open door.

Sincerely,

A handwritten signature in black ink, appearing to read "Barry Schaitkin". The signature is fluid and cursive, with a long horizontal stroke at the end.

Barry Schaitkin, MD
Residency Program Director
Department of Otolaryngology

Program Guiding Principles

Our Mission Statement

The primary goal of the residency program is to train future otolaryngologists who will be leaders locally, nationally and internationally. We aim to attract diverse resident applicants with a passion for excellence in clinical care, research, and education. We seek to provide an unparalleled depth and breadth of exposure to all aspects of otolaryngology.

Our Aims

Train excellent physicians from diverse backgrounds in a model of patient-centered care, which builds a foundation for them to practice high value care, provide desirable clinical outcomes, and create scientific knowledge that improves the practice of Otolaryngology.

Build a supportive working and learning environment that helps physicians grow as role models for professionalism, caring and compassion.

Create a model of professional development for Otolaryngology residents that emphasizes expertise, leadership skills, scholarly achievement, and career advancement.

Foster a culture that centers on the well-being of the individuals in our clinical and academic community.

Harness our capabilities to deliver outstanding patient safety, quality, and value through graduate medical education at UPMC.

Universal Goals and Objectives

The following four competencies are considered the “global” resident competencies defined for all residents. The competencies of Medical Knowledge and Patient Care Skills are defined specifically by each rotation and per year and are available in MedHub.

1. Professionalism

- a. Demonstrate honesty, compassion, level-headedness, decorum, selflessness, integrity and respect for others.
- b. Demonstrate acceptance of accountability and commitment to self-improvement.
- c. Maintain patient confidentiality; demonstrate knowledge of HIPAA statutes.
- d. Show sensitivity to issues involving, but not limited to, gender, religion, race, sexual orientation, disability, socioeconomic status, and age.
- e. Demonstrate understanding of ethical issues in clinical and research settings, and critical analysis of novel ethical issues.
- f. Possess the skills necessary for a specialist consultant providing inpatient and Emergency Department consultations in a professional manner.
- g. Participate in patient care as a member of a team.
- h. Develop one’s leadership skills.
- i. Recognize the need for and develop habits of continual learning.
- j. Recognize and develop a plan for one’s own personal and professional well-being.
- k. Appropriately disclose and address conflict or duality of interest.

2. Practice Based Learning and Improvement
 - a. Use information technology to prepare for surgical cases, bringing to the OR the knowledge of current modalities of care for patients and the scientific evidence for that care.
 - b. Routinely analyzes the effectiveness of one's own practices in caring for patients and setting goals for improvement.
 - c. Improve one's own practices in patient care by integrating appropriately gathered data and feedback.
 - d. Educate medical students and other healthcare professional in the practices of otolaryngology.
 - e. Function independently with graduated advancement and appropriate faculty supervision in the evaluation and treatment of patients.
 - f. Participate in and appreciate the value of outcome studies as they apply to diagnoses and review current practices.
 - g. Use information technology to optimize learning.

3. Interpersonal and Communication Skills
 - a. Educate patients and families in pre- and post-operative care of patients across a broad range of socioeconomic and cultural backgrounds.
 - b. Demonstrate compassion for patients and families.
 - c. Provide adequate counseling and informed consent to patients.
 - d. Listen to patients and their families.
 - e. Assimilate data and information provided by the otolaryngology team and other members of the health care team, in the care of patients.
 - f. Act as a consultant to other members of the health care team.
 - g. Communicate effectively with patients and families regarding their care goals, and, when appropriate, their end of life goals.
 - h. Maintain comprehensive, timely, and legible medical records.

4. System Based Practice
 - a. Recognize the value of and function within a team approach to treat patients.
 - b. Participate in quality improvement to enhance patient safety and improve patient care quality.
 - c. Participate in multidisciplinary planning and treatment for patients.
 - d. Coordinate care across the health care continuum.
 - e. Work with the health care team to maximize the rehabilitation of patients partnering with multidisciplinary teams including, but not limited to:
 - i. Audiology services
 - ii. Speech Language Pathology
 - iii. Physical therapy
 - iv. Occupational therapy
 - v. Respiratory therapy
 - f. Understand health care finances and its impact on individual patients' health decisions.
 - g. Facilitate the timely discharge of patients.
 - h. Advocate for quality patient care and optimal patient care systems.

Mentoring Programs

Faculty-Resident

Each resident should develop a relationship with a faculty mentor. The faculty mentor may provide guidance in such areas as education, career planning, research development and implementation, and navigation of the daily challenges in resident life. The faculty mentor should be considered a resource as well as part of a support system for the resident.

Mentors and mentees are encouraged to meet annually, or more often as desired or indicated. However, faculty mentors should be readily available to the resident mentee via phone or email. The faculty mentor will be assigned for the PGY-1 year. Faculty mentors for all other PGY levels may be selected by the resident. At the end of the academic year, all residents will have the option of continuing with their current faculty mentor or selecting a new faculty mentor, based on their career goals and objectives as well as their educational needs.

Resident-Resident

Each PGY-1 resident will be assigned a PGY-3 mentor which will be assigned by the program director. The resident mentor may provide guidance in such areas as education and study skills, work-life balance, career planning, and interpersonal skill development. The resident mentor should be considered a resource as well as part of a support system for the resident.

The resident mentor should facilitate the resident mentee's transition to internship, navigation of the daily challenges in resident life, and integration into the otolaryngology department at an early time point. Resident mentors and mentees should meet at least once in the first 3 months of the internship year, and more often as desired or indicated. The resident mentor should be readily available to the resident mentee via phone or email. The resident mentor may also be helpful in facilitating the transition from internship to otolaryngology residency in the PGY-2 year.

For any issues or concerns regarding these mentorship programs, please contact the program director or associate program director.

Call Schedule

The purpose of the faculty call schedule is to ensure that there is always a faculty member available for phone consultation, emergency admissions or surgery. The faculty member on call does not have to be used for all patients. If the patient has an attending surgeon that individual should be called first. If the patient is unassigned or the attending surgeon is not available, the call schedule should be used. All call schedules are available in MedTrak. Because of the virtual pagers in use for the different facilities, resident call schedules are available in a shared calendar maintained by the residents.

Inpatient Responsibilities

- The chief resident on the head and neck service is the administrative chief resident.
- Each resident will report to the hospital to which he is assigned early enough to make rounds and to discharge patients prior to beginning assignments in the OR or outpatient offices. Each resident has the responsibility for follow-up care and progress notes on the patients on the service to which he has been assigned. If the resident is uncertain about orders or disposition of the patient, contact the patient's attending physician for clarification. Progress notes are required for every patient every day and more frequently if conditions warrant it. At discharge, an appropriate note will be made.
- Residents and faculty should round together daily on inpatients, as schedules permit and patient census requires. Communication between resident and faculty is essential to assuring optimal patient management and resident education.
- The residents are responsible for completion of history and physicals, work rounds and daily documentation, surgical assignments, and discharge summaries. There are times when some services will be less busy, and it is expected that the residents will distribute the workload evenly amongst themselves. In order that all residents complete their daily responsibilities within a reasonable amount of time, cooperation is of prime importance. Residents are expected to communicate with one another in order to cross-cover and share the workload.
- Decisions as to which cases the residents will assist in should be made between the resident and attending staff on a day prior to surgery. Assignments to major surgical cases will be made by the Administrative Chief Resident.
- The resident on call is responsible for in-patient emergency care from 5:00 p.m. until 7:00 a.m. and whenever the primary care team is not available. In essentially every case the patient should be seen personally by the on-call resident. Any verbal orders must be signed, and any changes documented in the medical record. The resident must notify the staff physician immediately of any untoward developments or complications with their patient.
- The resident on-call will cover Children's Hospital for in- and out-patient emergencies. The on-call resident will advise the appropriate service resident of any changes in their patients before the on-call resident assumes their regular daytime duties.
- In the unusual circumstance of concurrent emergencies in 2 hospitals, help must be sought from either another available resident, fellow or the attending physician.
- The resident on-call should make every reasonable effort to assist in emergency surgical cases performed between 7:00 p.m. and 7:00 a.m.
- Emergency inpatient consultations at night, weekends, and on holidays from the UPMC or Children's Hospital will be seen by the resident on-call. The chief resident assigned to the service, fellow and the attending physician should be notified at the time of admission of any patient admitted to their service at any time.
- Magee Womens' Hospital inpatient consults on evenings and on weekends are first to be screened by the otolaryngology in-house resident on call and if care is urgently required, the ENT staff member on call will be contacted by the resident. Non-emergent weekend consults will be negotiated between the ENT staff member on call and the consult resident.

- Residents on call may be contacted for consultation regarding the potential referral of patients to the otolaryngology service. It is essential that these referrals be handled in a professional and collegial manner. When possible, referrals should be rotated through referral communications (412-647-7000). Transfers to the UPMC should be facilitated and the attending physician notified upon arrival of the patient. If consultation services are needed from the specialties this is, of course, arranged.
- The UPMC physicians frequently provide consultative services and coverage for community otolaryngologists. Care for these patients should be provided in a collegial way.
- Outpatient emergency room consults must be seen promptly (e.g., within 20 minutes). If urgent patient issues take precedence, the responsible ER physician must be contacted. If the delay is likely to be excessive, it may be necessary to contact the second call resident, the appropriate fellow, or on-call faculty member. All ER consults must include some plan for follow-up.
- On-call coverage remains the responsibility of the in-house resident until 7:00 a.m. It is the responsibility of all residents to be available by 7:00 a.m.
- The resident on-call on Saturday and Sunday will begin their shift at 9:00 a.m. so that ward rounds may be made before beginning duty. The resident on-call will not leave the hospital until they have discussed the in-house problems with the next resident on-call.

Patient Hand-offs

Residents must communicate effectively with on-call residents when arriving in the hospital in the morning and when leaving at the completion of the day. This is especially important on weekends and on holidays. Residents are responsible for maintaining a daily current patient list on each rotation, as appropriate. MTRAC is used for secure cloud storage of patient information used in transitions of care.

Teaching Responsibilities

An important duty of residents in this program is to teach second, third and fourth year medical students, family practice and pediatric residents, visiting scholars, nurse practitioners, fellow otolaryngology residents and other members of the medical community.

The major teaching responsibility of the residents vis-à-vis medical students occurs during the medical student's required clerkship outpatient experience (one week) and the one-month otolaryngology elective (4 weeks). During the elective, medical students are assigned to a variety of services. Medical students (no more than two at any one time) are assigned to the appropriate chief resident, who serves as their preceptor. The objectives of the elective are: 1) to increase competence in the examination of the head and neck, 2) to improve skills in history taking, and 3) to begin to accumulate sufficient knowledge about otolaryngologic conditions such that the student begins to understand the differential diagnosis process. Medical students are to be integrated into the respective resident team and provided with both a clinic experience and operative exposure. One-month elective students are expected to write and present a case report during their rotation. The chief resident should assist in case selection and direct them

to appropriate references for additional readings. The chief resident will be requested to complete a written evaluation of the student. This evaluation contributes to the overall evaluation of the student and the final grade assignment.

Medical students in the required clerkship rotate through the outpatient clinics and offices on one week schedules. These students should be instructed in basic skills and common disease processes encountered in the ambulatory setting. Outpatient clinics take precedence over operating room exposure for this rotation.

Medical Records Responsibilities

Each resident is responsible for their own medical records. Residents should make every attempt to complete their charts daily. Discharge summaries must be dictated prior to patient discharge, and all verbal orders must be signed. Delinquent or incomplete medical records charts will result in fines for the ATTENDING physician.

Resident Conference Responsibilities

Resident conferences are held on Wednesday mornings at 8am – 10am. **Attendance is mandatory** and a required part of your didactic education. A variety of courses are held through the year and published on the Academic Calendar. It is the residents' responsibility to be aware of mandatory attendance as listed on the calendar and to complete any necessary registrations.

MDC Tumor Board

The Department of Otolaryngology Head and Neck Case Discussion Conference is held each Monday at 5:00 p.m. to discuss and review patients with malignant or benign tumors of the head and neck. Attendance is mandatory for residents on the Head and Neck service. All major head and neck cancer sites found in patients seen at UPMC are discussed at this forum with recommendations made for treatment of problem cases. Head and Neck Case Discussion Conferences serve as a teaching mechanism for staff, residents, medical students and patient care providers of all disciplines. Conferences are regularly attended by representatives of the multidisciplinary group of head and neck professionals from the following departments: Otolaryngology, Plastic and Reconstructive Surgery, Pathology, Medical Oncology, Oral-Maxillofacial Surgery, and Maxillofacial Prosthodontics, Radiation Oncology, Radiology, Nursing, Social Work, and Tumor Registry.

The senior resident may decide which patients will be presented at Tumor Board; however, the junior resident is responsible for Tumor Board presentations. The Tissue Committee also refers interesting cases, which it has reviewed with the senior head and neck resident for presentation at Tumor Board. Any staff member may have a patient discussed for consultative purposes by contacting the senior head and neck resident. In preparation for the Tumor Board Conference, the senior head and neck resident contacts the attending physician of the patient being presented so that this physician will attend Tumor Board Conference. Recommendations for treatment may be made to the attending physician at Tumor Board Conferences.

Grand Rounds

The Department of Otolaryngology meets for Grand Rounds every Wednesday at 7am. **Attendance is mandatory** and a required part of your didactic education. Residents will present during the year in which they have a research block and again during their chief year. Once a month, the Grand Rounds format is used for the departmental QIC Morbidity and Mortality Conference. During months with a 5th Wednesday, we have a joint Trauma Conference with Plastic Surgery and Oral/Maxillofacial Surgery.

Operative Report

Documentation of each individual resident's operative experience must be entered into the ACGME Case Log system so that it is available to the American Board of Otolaryngology, the program director, and the ACGME. Procedure entry must be up-to-date and will be monitored by the program director and the residency program evaluation committee for equity. Failure to do so can result in loss of operative privileges.

Patient Safety/QI

All events are to be reported in Riskmaster. Reporting an event is easy. There are three convenient ways to do so:

- Log on to Riskmaster, UPMC's online reporting mechanism. Riskmaster is the preferred method of reporting. Access the Riskmaster Reporting Guide on Infonet.
- Call UPMC Risk Management 412-647-3050 or the UPMC Patient Safety Officer for your facility.
- Complete a paper Initial Investigation Event Report (IIER) form.

Residents are highly encouraged to review the Risk Management page on Infonet for educational materials.

Policies

Residents are responsible to function within the policies and procedures of UPMC, UPMC GME, the Department of Otolaryngology, and this residency program. Any questions concerning policy should be addressed to the residency program leadership.

Of particular note, residents should review the following UPMC and UPMC GME policies, which can be found on Infonet or MedHub.

UPMC ME Policy - Evaluation - Residents or Fellows, Faculty, and Program Policy

UPMC ME Policy - Grievance and Appeal Policy

UPMC ME Policy - Resident or Fellow Recruitment, Eligibility, Selection and Transfer Policy

Professional Conduct Policy - Policy #: PS-PHY-006

Fitness for Duty Physician Policy - Policy #: PS-PHY-004

Harassment-free Workplace - Policy #: HSHR0705

Social Networking - Policy #: HSHR0748

Use of Institutional DEA Registration Numbers - Policy #: HSPH2011

The residency program specific policies are contained below. Many reference GME or UPMC existing policies. Every resident is expected to familiarize themselves with these policies. Policies are reviewed on a yearly basis as a part of the annual program evaluation meeting. All efforts will be made to notify residents of any changes.

Conflict of Interest Policy

The UPMC Department of Otolaryngology residency program trainees are to follow UPMC and UPMC GME policies concerning conflicts of interest. Residents are never to accept anything from any industry representative without explicit approval from the program administration.

Of note: Excerpt from Policy HS-EC1702

1. Gifts and Provision of Meals SOHS and UPMC personnel shall not accept or use personal gifts (including food) from representatives of Industry, regardless of the nature or dollar value of the gift. Although personal gifts of nominal value may not violate professional standards or anti-kickback laws, such gifts do not improve the quality of patient care, may subtly influence clinical decisions, and add unnecessary costs to the healthcare system. Gifts from Industry that incorporate a product or company logo on the gift (e.g., pens, notepads, or office items such as clocks) introduce a commercial, marketing presence that is not appropriate to a non-profit educational and healthcare system.⁵ Meals or other hospitality funded directly by Industry may not be offered in any facility owned and operated by the SOHS or UPMC.

SOHS and UPMC personnel may not accept meals or other hospitality funded by Industry, whether on campus or off campus, or accept complimentary tickets to sporting or other events or other hospitality from Industry. Modest meals provided incidental to attendance at an off-campus event that complies with the provisions of subsection 6 (Industry Sponsored Meetings or Industry Support for Off-Campus Meetings), below, may be accepted.

Industry wishing to make charitable contributions to the SOHS or UPMC may contact the Medical and Health Sciences Foundation or other charitable foundations legally organized to support UPMC hospitals or other UPMC entities. Such contributions shall be subject to any applicable policies maintained by UPMC, SOHS and the receiving organizations.

⁵ This provision does not prohibit acceptance of items bearing Industry logos provided as part of an off-site educational program (such as a meeting of a professional society), including name tag lanyards, totes, etc., where the items are provided incidental to attendance, the items are of nominal value, and the items are not used on UPMC or University premises.

2. Industry Sponsored Meetings or Industry Support for Off-Campus Meetings SOHS faculty, personnel or students or UPMC providers or staff may participate in or attend Industry-sponsored meetings, or other off-campus meetings where Industry support is provided, so long as: (a) the activity is designed to promote evidence-based clinical care and/or advance scientific research; (b) the financial support of Industry is prominently disclosed; (c) if the SOHS/UPMC representative is an attendee, Industry does not pay attendees' travel and attendance expenses; (d) attendees do not receive gifts or other compensation for attendance; (e) meals provided are modest (i.e., the

value of which is comparable to the Standard Meal Allowance as specified by the United States Internal Revenue Service) and consistent with the educational or scientific purpose of the event. In addition, if a SOHS/UPMC representative is participating as a speaker: (a) all lecture content is determined by the SOHS/UPMC speaker and reflects a balanced assessment of the current science and treatment options, and the speaker makes clear that the views expressed are the views of the speaker and not the SOHS or UPMC; (b) compensation is reasonable and limited to reimbursement of reasonable travel expenses and a modest honorarium not to exceed \$2,500 per event.

Criteria for Promotion/Adverse Action Policy

UPMC Department of Otolaryngology follows UPMC Medical Education's policy on Resident Appointment, Renewal, Non-Promotion, Remediation, Probation, Suspension and Dismissal.

Through the course of training in a residency program, a resident is expected to acquire progressively increasing competence in the discipline in which they are training. Promotion to the next resident level is based on the achievement of program-specific milestones, including specific cognitive, clinical, technical skills, and professional and ethical conduct at the discretion of the Program Director and the Clinical Competency Committee. The purpose of this policy is to describe procedures by which deficiencies in performance and misconduct of trainees may be addressed. All Otolaryngology decisions will be in keeping with UPMC GME policies.

Adverse Actions Defined

1. Academic deficiency: The resident is not meeting an objective assessment of competence in one or more of the ACGME Core Competencies.

Examples of academic deficiencies include but are not limited to:

- a. Issues involving knowledge, skills, job performance or scholarship
- b. Failures to timely achieve acceptable scores (USMLE, in-training, etc.)
- c. Tardiness or absenteeism
- d. Unprofessional conduct

2. Misconduct: The resident's conduct or behavior violates workplace rules or policies, applicable law, or widely accepted societal norms.

Examples of misconduct include but are not limited to:

- a. Unethical conduct, such as dishonesty or falsification of records
- b. Illegal conduct (regardless of criminal charges or criminal conviction)
- c. Sexual misconduct or sexual harassment
- d. Workplace violence
- e. Job abandonment
- f. Violation of hospital, departmental or UPMC GME policies, practices and directives

Corrective Actions: Formal disciplinary action to a resident as the result of unsatisfactory academic performance and/or misconduct. Serious academic deficiencies and/or misconduct may warrant corrective action up to and including dismissal.

A corrective action may include one of the following:

- a. Repetition of Rotation - due to identified areas of unsatisfactory performance, the resident must repeat a rotation and perform at an acceptable level in order to advance to the next level of training.
- b. Probation: Adverse academic status wherein the resident has failed to achieve academic requirements and in which possibilities of remediation or dismissal may exist. It involves temporary modification of a resident's responsibilities within the training program. These modifications are designed to facilitate the trainee's accomplishment of program requirements. There will be increased supervision and

monitoring of the resident until a satisfactory evaluation is achieved. The time period will be determined by the Program Director in accordance to the specific terms of the probation.

c. Non-promotion to the Next PGY Level: due to identified areas of unsatisfactory performance, the resident will not be promoted to the next level of training unless or until the resident's performance improves to the level required.

d. Extension of the Defined Training Period – due to identified areas of unsatisfactory performance, the resident will not complete the program on time and the defined training period will be extended to allow the resident an opportunity to perform at the level required.

e. Suspension: The Program Director or his/her designee may temporarily suspend the trainee from part or all the trainee's usual and regular assignments in the GME training program, including, but not limited to, clinical and/or didactic duties, when the removal of the trainee from the clinical service is required for the best interests of patients, staff and/or trainee due to seriously deficient performance or seriously inappropriate conduct.

f. Non-renewal of appointment/non-promotion: When a resident's training agreement will not be renewed, or when a resident will not be promoted to the next level of training. The program should provide the resident with as much written notice of the intent not to renew or not promote as circumstances will reasonably allow, prior to the end of the current resident's GME agreement.

g. Dismissal: Occurs when the trainees is permanently withdrawn of all program and institutional responsibilities and privileges. Dismissal can occur when there is failure to achieve or maintain programmatic requirements or standards in the GME program; due to unprofessional, unethical or other behavior that is considered unacceptable by the GME training program; or by a serious or repeated action against patient safety. Residents may appeal a determination by submitting a written request for an appeal as per the UPMC ME Grievance and Appeal Policy.

Dress Code Policy

UPMC Department of Otolaryngology residency program follows the UPMC Dress Code Policy HS-HR0714, UPMC Identification Badges (IDs) Policy HS-FM0250, and UPMC Dress Code in the Operating Room Policy HS-OR0010.

The department requires residents to wear a lab coat while in clinic. Lab coats are provided by the department, 3 per year for PGY1 and PGY2, maximum 2 per year by request for the remainder of a trainee's residency. Three replacement coats may be special ordered in the case of a legal name change.

Of note: Excerpt from Policy HS-HR0714

1. A professional appearance must be maintained at all times.
 - a. Clothing must be clean, neat, and odor free and appropriate undergarments are to be worn.
 - b. The UPMC photo identification badge must be worn above the waist, with name and other preprinted information visible at all times during working hours. No unauthorized attachments are to be placed on the identification badge. Further, in patient care or treatment areas (defined in Policy HS-HR0717 Solicitation and Distribution, Section IV.B.), no devices may be worn on your uniform which are identified with, bear the insignia of or bear a slogan associated with any outside entity.
2. In consideration for infection control and patient safety:
 - a. Hair should be neat, clean and pulled back with small simple hair accessories so hair does not come in contact with the patient. Hair color is at the discretion of management.

- b. Beards and mustaches should be short, clean and well groomed.
- c. Wearing rings and other jewelry during direct patient contact is strongly discouraged. Wearing excessive jewelry, cologne, fresheners, pins, buttons, and other adornments is not appropriate. Dangling earrings or hoops larger than one inch are not permitted.
- d. Presenting at work smelling of smoke is not permitted.
- e. For patient safety, nails are to be kept neat, clean, manicured and short and should not extend more than ¼ inch past the tip of the finger. Nail polish without embedded enhancements in good repair is permitted.
- f. Artificial nails are prohibited for staff who have direct patient contact, who prepare instruments for sterile procedures or who prepare sterile pharmaceuticals, or who have contact with a patient's environment. The definition of artificial fingernails includes, but is not limited to, acrylic nails, all overlays, tips, bondings, extensions, tapes, inlays, and wraps.
- g. Footwear must be a clean, closed-toed duty or leather or vinyl athletic shoe.

Expenses Policy

UPMC Department of Otolaryngology residency program follows the UPMC Travel and Business Expenses policy #HSAC0500. All residents are required to complete expense submission training during their PGY1 year as currently available in HR Direct Learning.

Residents' Education Fund

The Resident Education Fund was established in 1953 to provide support for the continuing educational endeavors of the residents from the Departments of Otolaryngology and Ophthalmology. From the principal, earned interest is divided according to the number of residents in each department on a quarterly basis. Otolaryngology's portion is deposited into the Residents' Education Fund which is managed in conjunction with the Eye and Ear Foundation.

The residency program supports resident participation in educational memberships and activities as follows:

1. Dues/Subscriptions/Required Educational Activities
 - a. Resident Membership, American Academy of Otolaryngology-Head and Neck Surgery
 - b. Annual Otolaryngology Examination
 - c. Educational course used program wide as determined yearly by the program director
 - d. PGY1 attendance at an Otolaryngology Skills Bootcamp as determined by the program director

Any invoice the resident receives regarding the above mentioned, should be forwarded upon receipt to the Residency Coordinator for payment. If an invoice is received by the Residency Coordinator from the resident past the deadline, any late charges will be assumed by the resident. The residency program does not provide financial support for any other memberships, subscriptions, or examinations.

All expenditures for travel require the submission of a departmental expense pre-authorization form which can be obtained from the program coordinator. Failure to submit this form prior to expenditures may result in denial of reimbursement.

2. Scientific Course Expenses
 - a. Reimbursement of reasonable expenses incurred as a result of attendance at a scientific course approved by the Program Director are as follows:
 - i. PGY-1 N/A
 - ii. PGY-2 N/A
 - iii. PGY-3 N/A

iv.PGY-4 \$1,000.00

v.PGY-5 \$1,000.00

The availability of these funds expires at the conclusion of each academic year and can't be combined or carried over.

3. Scientific Presentation Expenses

Monies are available in the Residents' Education Fund for residents to attend scientific meetings on a competitive basis if the resident's abstract is accepted by the sponsor for presentation at meetings. Abstracts submitted for oral presentation but accepted for poster presentation will be funded on a case-by-case basis. Once an abstract has been presented and funded in the fiscal year, this paper cannot be presented at another meeting and funded by the Residents' Education Fund again.

Leave of Absence, Absenteeism, Paid Time Off Policy

The UPMC Department of Otolaryngology residency program trainees are to follow UPMC and UPMC GME policies concerning paid time off and leaves of absence, including family/personal leave including parent leave, military leave, funeral leave, jury duty and any other approved leaves as processed by UPMC WorkPartners.

If a resident is absent in excess of 6 work weeks for any reason in a single academic year, defined as July 1 – June 30, the time taken in excess may need to be “made up” in order to meet the American Board of Otolaryngology Head and Neck Surgery requirements for board eligibility and ACGME requirements. Any such instances will be discussed with the trainee, Program Director, appropriate board representatives, and ACGME RRC representatives to ensure appropriate program completion.

Paid Time Off

Residents are allocated 15 paid time off (PTO) weekdays per academic year. In addition, residents will be allocated additional time off (APTO); 5 weekdays per academic year for travel to conferences for educational purposes, 10 weekdays for job or fellowship interviews, and 2 days per year for required exams or certifications. PTO and APTO banks expire at the conclusion of the academic year. Unused PTO days will not be paid at the end of any academic year or at the completion of training.

All PTO and APTO must be entered by the resident in MedHub in advance of the time off except for unplanned sick time which is to be entered upon the resident's return to work.

1. Unplanned sick time use of PTO may result in an unpaid absence and/or result in corrective action. In those instances where additional absences would result in a critical staffing shortage, unscheduled PTO may be denied. Proof of an emergency situation may be required.
2. Requests for planned PTO and educational travel are to be submitted at least 2 months in advance.
3. No vacations or educational PTO will be granted in June.

The requesting resident must arrange their own service coverage during their time away. This is not the responsibility of the Chief Administrative Resident or the Program Coordinator.

When choosing a course to attend, it is recommended that the choice be limited to those experiences that fill in gaps in the residency program. Once a course has been selected by the resident, permission to attend the course must be granted by the Program Director prior to initiating the remainder of the time off request procedure.

To request planned time off:

1. The resident will contact the appropriate faculty in the division they are assigned to for the duration of their time off. Approval must be received from that division.
2. The resident will contact the chief resident on that service during the requested time off and notify them of the division's approval.

3. The resident will enter the time off request in the Absence Request portal in MedHub in advance of their planned time off. A chief resident will approve, and the Program Coordinator will give final approval.

Failure to follow administrative data entry procedures in MedHub can result in the loss of the privilege to attend conferences.

To ensure delivery of quality patient care, advance scheduling of PTO is required whenever possible. The program will endeavor to accommodate residents' requests for PTO, but such requests cannot be guaranteed.

Supervision and Progressive Responsibility Policy

UPMC Department of Otolaryngology residency program follows the UPMC GME policy for Supervision and Progressive Responsibility. In addition to that policy:

1. Annual update of supervision competencies within MedHub will be conducted by the program leadership in conjunction with milestone progress as noted by the Clinical Competency Committee. This information is available in the Privilege Lookup App per UPMC policy.
2. Residents are educated on "must call" situations including:
 - a. Patient admission to hospital
 - b. Transfer of patient to the intensive care unit
 - c. Need for intubation or ventilator support
 - d. Cardiac arrest or significant changes in hemodynamic status
 - e. Development of significant neurological changes
 - f. Development of major wound complications
 - g. Medication errors requiring clinical intervention
 - h. Any significant clinical problem that will require an invasive procedure or operation
 - i. Any condition which requires the response of a special team
 - j. Any patient request to do so
 - k. Transfusion greater than 2 units of RBC
 - l. Development of DVT/PE
 - m. Unexpected pathology finding
3. Residents on call during the PGY1 level will have direct supervision or immediately accessible in-house supervision at all times, classified as "buddy call". During this training period, residents are educated as to the multiple layers of supervision always available to them: senior resident, fellow, and attending. Back up call coverage schedules are immediately available electronically to all residents.
4. Faculty development is conducted to discuss effective resident supervision.
 - a. Educational topics include:
 - i. Setting expectations
 - ii. Planning mandatory communication in addition to spontaneous communication for urgent issues
 - iii. Ensuring faculty availability and approachability
 - iv. Respecting safe autonomy
 - v. Acceptable models for resident supervision
5. Residents will only be assigned to hospitals and offices where the department has determined that there is sufficient support for the training program by both the otolaryngology staff and by the institution itself.
6. All attending physicians who participate in resident supervision must:
 - a. be board-certified or board-eligible in their specialty.
 - b. have a current and valid license in the State of Pennsylvania.
 - c. have privileges at the hospital at which supervision will take place.

7. All patients are assigned to an attending physician. Residents participate in clinical and surgical care of patients as appropriate to their level of needed supervision (direct, indirect with supervision immediately available, indirect with direct supervision available, or oversight). The attending physician has ultimate responsibility for all medical decisions regarding their patients.
 - a. The attending physician responsible for supervision in the clinic must:
 - i. be available throughout the clinic session
 - ii. supervise actively during major portions of physical examination
 - b. Consultations on service patients may be performed by residents without the attending physician being present.
 - i. The proposed plan of action must be discussed with the attending physician before it is undertaken.
 - ii. The attending physician is responsible for signing the consultation report within 24 hours.
 - c. The attending physician assigned to cover any resident surgical procedure must:
 - i. have privileges for performing that procedure.
 - ii. be present during major portions of the surgical Procedure.
8. Inadequate supervision should be reported by a resident to the Program Director. All reports will be handled in a manner to protect the resident from any reprisal. If a resident does not feel comfortable speaking with the Program Director, they are encouraged to speak to program leadership and/or the Department Chair. If a resident is still not comfortable speaking with anyone related to the department, they can speak with a member of leadership within the UPMC Medical Education Office or can contact the Residents and Fellows Assistance Program (RFAP).
9. The departmental policies for resident supervision are to be reviewed annually with all residents and attending physicians. The policies are also included in the orientation process for new residents.

Transition of Care Policy

1. UPMC Department of Otolaryngology will educate residents, fellows, faculty and additional interprofessional team members on departmental transition of care processes as a part of educational Grand Rounds on an annual basis.
2. Transition of care processes are monitored by faculty, fellows, and chief residents at each individual site and annually by anonymous electronic survey. Feedback is provided by the program evaluation committee annually at the annual program evaluation meeting and by faculty, fellows, and chief residents at each site.
3. In the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency, the resident will sign out to a chief resident, fellow, or faculty. This is also governed by the clinical and educational work hours, moonlighting, and fatigue management policy.
4. All UPMC Department of Otolaryngology call schedules are available in MedTrak which is accessible to all members of the care team. In addition to this, a weekly email is sent with the call schedules for attending call coverage, attending consult coverage, and resident call coverage with contact information for all participants in the call schedule.
5. Call schedules are reviewed annually to minimize transitions in patient care within the context of established work hour standards.
6. Information included in the exchange of information in a resident-to-resident patient transition will include:
 - a. Patient identification

- b. Contact information for responsible resident or fellow and attending physician
 - c. Important diagnoses
 - d. Discussion of anticipated patient care issues with a plan of management
 - e. Relevant transfer or discharge planning.
7. Transition of Care Process: Patient lists and relevant care information at each site is regularly updated and stored in secure cloud servers and referred to during verbal sign out between care providers. All faculty, fellows, and resident have access to this information.

Clinical and Educational Work Hours, Fatigue Management, and Moonlighting Policy

The Department of Otolaryngology has a Clinical and Education Work Hours, Fatigue Management, and Moonlighting Policy that is consistent with the UPMC policy.

I. Clinical Experience and Education (CEE)

- a. CEE is defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities. All academic or administrative activities that residents are required to attend should be counted towards the work hour standards. This should include required onsite educational activities such as meetings, conferences and research. Work hour do not include reading and preparation time spent away from the clinical site, but do include at home clinical activities, such as completing electronic health records and taking calls related to patients.
- b. Work hours are averaged over a four-week period, inclusive of all in-house call hours and hours spent on clinical work at home. Hours must be limited to 80 hours per week on average.
- c. CEE work may be scheduled to a maximum of 24 hours of continuous work in the hospital with up to four hours of additional time for activities related to patient safety.
- d. Residents are to use alertness management strategies in the context of patient care responsibilities especially after 16 hours of continuous work and between 10pm and 8am.
- e. Residents are not assigned additional clinical responsibilities after 24 hours of continuous in-house work hours. There can be a four hour period following 24 work hours for effective transitions. They must have fourteen hours free of work after 24 hours of continuous work.
- f. In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient, humanistic attention to the needs of a patient or family, or to attend unique educational events. These additional hours of care will be counted toward the 80-hour weekly limit.
- g. Averaged over a four-week period, inclusive of call, residents must be provided with 1 day in 7 free from all education and clinical responsibilities. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities. At home call cannot be assigned on these free days.
- h. Residents should have 8 hours between scheduled work periods. There may be circumstances where residents choose to stay to care for their patients or return to the hospital with fewer than 8 hours free of clinical experience and

education. These must occur within the context of the 80-hour and one-day-off-in-seven requirements. The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional work.

i. Residents have the flexibility to attend medical, mental health, and dental care appointments, including those scheduled during their working hours.

II. On-Call Activities

a. Averaged over a four-week period, in-house call will not occur more frequently than every third night.

b. Clinical and educational work periods, including in-house call, will not exceed 24 consecutive hours. Residents may be allowed to remain on-site for activities related to patient safety, such as providing effective transitions of care and/or resident education; however, this period of time must be no longer than an additional four hours. Additional patient care responsibilities must not be assigned to a resident during this time. These additional hours will be counted toward the 80-hour weekly limit.

c. The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period. The hours spent on patient care activities in the hospital and at home are counted toward the 80-hour limit. The program director, faculty, and residents must monitor the demands of at-home call and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

III. Program Process

a. Residents will log work hours in MedHub no later than the Saturday following the Sunday-Saturday work week.

b. Work hours violations are monitored and documented in MedHub by the Program Director on an ongoing basis to ensure an appropriate balance between education and service.

IV. Protection from Retaliation

a. Retaliation for honest reporting of clinical and educational work hours is strictly prohibited.

V. Fatigue management

a. Residents will receive education in fatigue during orientation.

b. Residents who feel that they are unsafe to leave the hospital will be provided with compensation for transportation and have access to sleeping rooms post call.

c. There must be no retaliation against a resident for reporting or requesting assistance with fatigue management and/or mitigation.

d. The program will update and upload to MedHub a program-specific well-being plan annually that includes fatigue management.

e. Residents who are unable to perform their patient care responsibilities are to contact the senior resident and faculty on service to complete a transition of care as per standard procedure within the department. This is done without fear of negative consequences for the resident who is unable to provide the clinical work.

VI. "Moonlighting"

a. Moonlighting is defined as clinical professional work performed outside the scope of the accredited UPMC Medical Education training program and conducted independently under the Resident's PA unrestricted medical license and personal DEA license.

b. No resident may participate in any moonlighting activities.