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## YNHH POLICIES & PROCEDURES

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NARRATIVE DESCRIPTION OF THE EDUCATIONAL PROGRAM

Resident responsibilities are progressively increased as they advance through the program. Attention to patient-based medicine and graduated independence colors the overall approach. Feedback on the core competencies is provided through quarterly E-value assessments by faculty in addition to multi-source evaluations. Blue sheets (surgical case evaluation) and Yellow sheets (outpatient clinical skills evaluation) solicited by the individual resident also allow for determination of advancement. PGY 2 residents are responsible for attending most of the clinics and developing clinical skills and medical knowledge in addition to observing behaviors necessary for the other core competencies. To strengthen skills of Interpersonal Communication and Professionalism, all residents with the exception of interns are required to present lectures to the group and participate in conferences. Senior residents begin to take on a more supervisory role during consultations and in the operating room. Chief residents assume significant administrative and patient care responsibilities. They also assume increased teaching responsibilities and coordinate the faculty teaching rounds date and time, presentations to the entire faculty at M&M conferences, continued presentations and lectures at Wednesday didactic conferences. Chiefs at SRC and YNHH direct the services and assignments of operating room activities coordinate resident vacation schedules and coverage and monitor informally the resident work hours at each site. VAMC residents act as the administrative chief resident for this service and coordinate all patient care activities for this service with close supervision from Dr. Nwanmegha Young.

YALE-NEW HAVEN HOSPITAL

PGY1

INTERN SURGERY ROTATIONS
The Goals and Objectives for these rotations are adapted from the “Prerequisites for Graduate Surgical Education. A Guide for Medical Students and PGY1 Surgical Residents” published by the American College of Surgeons.

PATIENT EVALUATION, ASSESSMENT, AND MANAGEMENT AND MEDICAL KNOWLEDGE
By the completion of PGY 1, the resident should be knowledgeable in the following areas and be able to do:

1) History and Physical Examination, Documentation
   a) Obtain a detailed surgical history and obtain and review relevant medical records and reports
   b) Perform a detailed physical examination.
   c) Develop a complete differential diagnosis.
   d) Maintain a personal patient log.
   e) Write a succinct H&P, including a risk assessment evaluation.
   f) Obtain a written informed consent.
   g) Document the treatment plan in the medical record, including the indications for treatment.
   h) Dictate an operative note and discharge summary.
2) **Patient Assessment and Perioperative Management**
   - a) Order and interpret basic laboratory tests and screening X-Rays, and evaluate the patient’s cardiac, pulmonary, renal, and neurological status.
   - b) Develop a preoperative assessment of risk factors.
   - c) Review, prioritize, and order medications the patient is currently taking, as appropriate.
   - d) Use and understand the nursing notes and patient data.
   - e) Prescribe activity level, management of medications, pain management, follow up appointments, and obtain urgent contact information.

3) **Assessment of Basic Diagnostic Tests and X-Rays**
   - a) Recognize abnormalities in basic radiologic and laboratory tests and learn normal values and ranges.
   - b) Choose the optimal imaging technique.
   - c) Recognize:
     - i) pleural effusion on CXR
     - ii) chest mass on CXR
     - iii) pneumonitis on CXR
     - iv) bowel gas patterns on flat plate abdomen
     - v) diaphragm abnormalities on CXR
     - vi) spinal column fractures
     - vii) cervical spine radiographs
   - d) Interpret basic EKG findings
   - e) Recognize ischemia & arrhythmia patterns on EKG.

4) **Management of Fluid/Electrolyte and Acid Base Balance**
   - a) Understand acid-base balance and the applications of body composition to fluid, electrolyte, and acid-base balance in health and disease.
   - b) Give fluid resuscitation, manage postoperative fluid requirements, and recognize and correctly manage acid-base disorders.
   - c) Make adjustments in fluid administration for comorbid conditions, e.g. renal or cardiac insufficiency, diabetes, hypovolemia.
     - i) Use CVP and urine flow rates for adjustments of fluid administration.
     - ii) Perform a saphenous cutdown.
     - iii) Recognize and treat calcium and magnesium imbalance.

5) **Fever, Microbiology, and Surgical Infection**
   - a) Know the mediators of fever, differential diagnosis, evaluation and management of the febrile patient in order to initiate appropriate workup of fever and provide supportive treatment.
   - b) Initiate definitive treatment with appropriate antibiotics.
   - c) Be able to monitor antibiotic levels and recognize drug-related complications. Know the antibiotic of choice.
   - d) Know and apply the principles of prevention of nosocomial infections, sterile technique and universal precautions.
   - e) Order and interpret the appropriate imaging studies for localization of an infected focus.
     - i) Know and apply the principles of incision and drainage.
     - ii) Know the proper use of prophylactic antibiotics.
     - iii) Know the classification of wounds (clean, clean-contaminated, contaminated, infected).
     - iv) Recognize the septic syndrome and initiate appropriate supportive treatment. Be familiar with the current literature concerning the causes and mediators of the sepsis syndrome and its pathophysiology.

6) **Epidemiology and Public Health**
   - a) Be knowledgeable in AIDS diagnosis and prevention of HIV infection.
b) Understand the epidemiology and treatment of sexually transmitted diseases and other communicable diseases.

7) Nutrition
   a) Perform a metabolic assessment of the surgical patient.
   b) Understand the metabolic implications of trauma and operation.
   c) Know the indications for nutritional support of the surgical patient.
   d) Know the methods of calculation of nutritional requirements in health and disease using the Harris-Benedict or similar formulae.
   e) Know the composition of various enteral and parenteral formulas and adjust appropriately.
   f) Calculate and order basic enteral or parenteral formulas.
   g) Recognize complications of enteral and parenteral feedings.
   h) Manage central IV lines.
   i) Manage gastrostomy or jejunostomy feeding tubes.
   j) Assess when a postoperative patient can be fed and assess adequacy of intake.
   k) Know and utilize comparative costs of nutritional support methods.

8) Perioperative Preparation
   a) Complete, document, and assess appropriate workup, write preoperative orders, and obtain required consultation from other specialists.

9) Surgical Skills
   a) Learn surgical site positioning, preparation and draping.
   b) Perform as first assistant. Know how to obtain hemostasis of small vessels and exposure of the operative field.
   c) Be familiar with common surgical instruments (scalpel, forceps, scissors, needle holders, hemostats, retractors, electrocautery) and suture materials and their proper uses.
   d) Perform basic maneuvers, e.g. suture of skin, soft tissues, fascia; tie knots; obtain simple hemostasis.
   e) Learn basic techniques of dissection and handling of tissues.
   f) Under supervision:
      i) Excise benign lesions of skin and subcutaneous tissues.
      ii) Perform lymph node biopsy.
      iii) Remove superficial foreign bodies.
      iv) Incise and drain an abscess.
      v) Repair simple lacerations.
      vi) Repair umbilical and type I and II inguinal hernias.
      vii) Perform appendectomy.

10) Sterile Technique
    a) Understand indications for and utilize appropriate methods of routine and reverse isolation procedures.
    b) Maintain appropriate sterile technique in the ER, at the bedside, in the ICU, and in the office.

11) Wound Management
    a) Differentiate between wound infection, hematoma, and seroma, and initiate therapy.
    b) Perform extensive debridement with supervision.
    c) Debride and pack wounds and apply dressings.
    d) Recognize and differentiate between wound infection and necrotizing fasciitis, and detect crepitus.
    e) Identify wound dehiscence and evisceration.
f) Know and apply the specific recommendations for tetanus immunization (active and passive).
g) Know the clinical manifestations of rabies in carrier and patient, and agents available to prevent development of the disease.
h) Obtain proper wound specimen and perform and interpret Gram stain.

12) Prioritize and Manage Complications
   a) Assess and manage complications or change in health status, such as:
      i) altered mental status.
      ii) fever.
      iii) hypotension.
      iv) hypovolemia, oliguria.
      v) hypoxia.
      vi) pain.
      vii) vomiting, distention, nausea.
      viii) bleeding at the bedside & coagulopathy.
      ix) atelectasis, pneumonia, aspiration.
      x) fecal impaction, constipation
      xi) chest pain,
      xii) dyspnea
      xiii) pneumothorax
      xiv) congestive heart failure, pulmonary edema
      xv) superficial phlebitis,
      xvi) pulmonary embolus
      xvii) urinary retention
      xviii) diabetic ketoacidosis or hyperosmolar coma
      xix) peripheral ischemia or cyanosis
      xx) seizures, alcohol or drug withdrawal

13) INTERPERSONAL COMMUNICATION
    PGY1 residents are expected to present patient updates to the surgical teams on morning rounds. Their written notes are opportunities for development of effective communications. Signouts to team members also allow for learning opportunities in communication. Discharge summary dictations provide important experience in clearly communicating the course of patient care and discharge planning. Residents are evaluated using MedHub assessments and competency-based evaluation forms provided by our Section. Feedback from senior and chief residents provides opportunities for improvements. Yellow sheets (outpatient clinical skills evaluation) for clinical performance are utilized while the PGY1 is on the ENT service.

14) PROFESSIONALISM
    Is learned through role modeling of attendings and senior residents on the PGY1 rotations. A code of recommended dress/attire is provided by the GME office. Residents are evaluated using Medhub assessments and competency-based evaluation forms provided by our Section. Yellow sheets for clinical performance are utilized while the PGY1 is on the ENT service.

15) PRACTICE-BASED LEARNING
    This is the core experience for PGY1 residents. Frequent case-based review of treatment plans, outcomes and complications are utilized in team discussions and clinic encounters with senior residents and attending staff. Dictation of discharge summaries develops direct ability of the PGY1 to summarize the care and its rationale. Discharge planning and coordination of care provide valuable learning experiences in addressing needs of patients within social and cultural systems. Morbidity and mortality conferences provide detailed evaluation of cases in which complications and/or death occur and provide valuable learning experience. PGY1 residents also participate in ENT Journal Club when on the ENT rotation; this allows for incorporation of pertinent recent literature studies into the development of clinical judgment and medical knowledge. Residents are
evaluated using MedHub assessments and competency-based evaluation forms provided by our Section. Feedback from senior and chief residents provides opportunities for improvements. Yellow sheets (outpatient clinical skills evaluation) for clinical competency performance are utilized while the PGY1 is on the ENT service. “Blue sheets” (surgical case evaluation) are utilized for evaluation of surgical competency.

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

SYSTEMS-BASED MEDICINE
The ability to develop a working team-based relationship is emphasized on this rotation. Residents work one on one with anesthesiology attending staff to experience the surgery-anesthesia team approach from the "other side" of the drape. Communication, knowing when to call an anesthesiology preoperative evaluation and contacting additional specialty services are emphasized and attained during this rotation. Constructing a plan of action with the surgeon prior to the onset of anesthesia induction is exercised.

At the completion of this rotation the PGY 1 resident should be knowledgeable in the following areas and be able to do:

1) Basic laryngeal anatomy and physiology.
2) Appropriate indications for general vs local anesthesia.
3) Appropriate preoperative evaluation including when to order a pre-operative chest x-ray, EKG, and laboratory tests based on the patient's age, past medical history and social habits.
4) Write pre-anesthetic orders
5) Obtain oropharyngeal control of airway and provide Ambu ventilation
6) Be able to perform:
   i. Orotracheal intubation
   ii. Nasotracheal intubation
   iii. Laryngeal mask ventilation
   iv. Jet ventilation
7) Interpret the anesthesia record
8) Position the patient properly for operative exposure, temperature control, and protection from pressure/traction.
9) Be familiar with intraoperative monitoring.
10) Insert arterial and venous lines.
11) Know the dose range and complications (including pulmonary edema and malignant hyperthermia) of the following agents:
   a. barbiturates
   b. local anesthetics
   c. paralyzing agents
   d. reversing agents
   e. inhalant anesthetics
12) Know when and how to use epinephrine, hyaluronidase, in local anesthesia
13) Under supervision:
   a. administer a local block
   b. administer general anesthesia
14) Understand and use conscious sedation
15) ACLS certification

THORACIC SURGERY ROTATION
The main goal of this rotation is to provide the PGY1 resident an organized experience to enable him/her to acquire the basic knowledge and skills in the evaluation and management of patients with common cardiac and pulmonary surgical problems.
SYSTEMS BASED PRACTICE
Interdependence of cardiopulmonary and otolaryngologic systems is emphasized. The ability to recognize acute and chronic illnesses of these systems and to appropriately communicate and consult with other specialists is achieved. Additionally, the interdependence of Thoracic and Otolaryngologic surgical procedures and surgical planning is appreciated. Skills are developed in the ability to plan and coordinate. Recognition of significant complications and the ability to cooperatively treat such outcomes is a goal for this rotation.

At the completion of this rotation the PGY 1 resident should be knowledgeable in the following areas and be able to do:
   a) Review applied cardiac physiology and applied pulmonary physiology
   b) Critical care and management of shock
   c) Basic surgical skills.
   d) Evaluation and management of chest masses
   e) Care for at least 15 ICU patients/month

CRITICAL CARE ROTATION (ICU)
The main goal of this rotation is to provide the PGY1 resident an organized experience to enable him/her to acquire the basic knowledge and skills in the evaluation and management of patients in the intensive care setting. At the completion of this rotation the PGY 1 resident should be knowledgeable in the following areas and be able to do:

SYSTEMS BASED PRACTICE
Interdependence of otolaryngologic systems in the critical care and trauma setting is emphasized. The ability to recognize acute and chronic illnesses of and to appropriately communicate and consult with other specialists is achieved. Additionally, the interdependence of Trauma and Otolaryngologic surgical procedures and surgical planning is appreciated. Skills are developed in the ability to plan and coordinate care and interventions with other hospital services. Understanding the role of the surgeon in the critical care setting is of utmost importance in developing positive working relationships with professional colleagues.

1) Critical Care and Management of Shock
   a) Differentiate types of shock (hemorrhagic, cardiogenic, septic, neurologic) and initiate appropriate therapy.
   b) Insert central venous and arterial catheters and obtain hemodynamic data; interpret data and initiate therapy.
   c) Recognize clinic presentation of a pneumothorax and insert chest tube
   d) Understand and utilize basic principles of mechanical ventilation.
   e) Recognize the indications for blood component therapy and initiate therapy.
   f) Recognize a transfusion reaction and initiate management.
   g) Institute measures to prevent upper GI bleeding in critically ill patients.

2) Coagulation and Anticoagulation
   a) Choose the appropriate tests for diagnosis of a coagulopathy, and have a working knowledge of factor analysis.
   b) Apply effective preventive measures for DVT and PE.
   c) Initiate and monitor therapeutic anticoagulation and its complications.
   d) Diagnose and manage acute deep venous thrombosis.
   e) Acutely manage a patient with a suspected acute pulmonary embolus, and provide a differential diagnosis.

3) Applied Cardiac Physiology
   a) Recognize rhythm disturbances, myocardial ischemia on EKG.
   b) Assess, formulate a differential diagnosis and initiate therapy for hypotension.
   c) Know and apply appropriate treatment for supraventricular tachycardia.
d) Treat congestive failure and acute pulmonary edema.
e) Manage hypertension in a surgical patient. Understand multidrug therapy and the
toxic and side effects of antihypertensive drugs.

4) **Applied Renal Physiology**
   a) Know the pathophysiology of the development of acute renal failure; the differentiation
      of prerenal, renal, obstructive types of renal failure; and the general concepts of
      prevention and treatment of ARF.
   b) Recognize and treat simple electrolyte disturbances.
   c) Understand appropriate fluid replacement and balance.

5) **Applied Pulmonary Physiology**
   a) Know the manifestations—clinical and by laboratory testing—of obstructive pulmonary
disease and pulmonary insufficiency, and their surgical perioperative management.
   b) Recognize bronchoconstrictive disorders and their perioperative management.

6) **Applied Nutrition**
   a) Learn to manage the nutritional needs of a critically ill patient.
   b) Placement of nasogastric tube and dophoff tube.

7) **Surgical Skills**
   a) Develop surgical skills in CPR, CVC placement, arterial catheter placement, and
      chest tube placement.
   b) Perform first assistant in bedside bronchoscopy, pulmonary lavage, and tracheotomy.
   c) Obtain oropharyngeal control of airway, provide Ambu ventilation and perform
      orotracheal intubation.

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

**SYSTEMS BASED PRACTICE**
Interdependence of otolaryngologic systems in the emergency and acute trauma setting is
emphasized. The ability to recognize acute and chronic illnesses of and to appropriately
communicate and consult with other specialists is achieved. Additionally, the
interdependence of Trauma and Otolaryngologic surgical procedures and surgical planning
is appreciated. Skills are developed in the ability to plan and coordinate care and urgent
surgical intervention with other hospital services. Understanding the role of the surgeon in
the Emergency Department setting is of utmost importance in developing positive working
relationships with professional colleagues.

**PROFESSIONALISM**
Professionalism and cultural competence (social issues of substance abuse, child abuse,
indigent populations) are areas with particular importance for the ED rotation. This rotation
allows for observation and role modeling of ED attending and ED support staff in how to
compassionately provide care for vulnerable and uninsured populations.

**At the completion of this rotation the PGY 1 resident should be knowledgeable in the**
following areas and be able to do:

a) Conduct primary assessment and take appropriate steps to stabilize and treat patients with trauma (penetrating and blunt), respiratory distress, congestive heart failure, metabolic imbalances, myocardial infarction, and chronic pain.

b) Establish the acuity level of patients in the ER, establish priorities and define the tasks necessary to manage the patients successfully.

c) Monitor, observe, manage, and maintain the stability of one or more patients who are at different stages in their work-ups including fundamental lab tests and radiological studies.

   d) Recognize and initiate treatment for an acute anaphylactic reaction.

   e) Collaborate with physicians and other professionals to evaluate and treat patients, arrange appropriate placement and transfer if necessary, formulate a follow-up plan, and communicate effectively with patients, family, and involved health care members.

   f) Closure of simple and complex lacerations.

g) Develop some familiarity with disaster management.

NEUROSURGERY ROTATION
The main goal of this rotation is to provide the PGY1 resident an organized experience to enable him/her to acquire the basic knowledge and skills in the evaluation and management of patients presenting with neurosurgical complaints. The resident should gain an appreciation for the collaborative efforts between the Otolaryngology and Neurosurgery specialties.

SYSTEMS BASED PRACTICE
Interdependence of neurosurgical and otolaryngologic systems is emphasized. The ability to recognize acute and chronic illnesses of these systems and to appropriately communicate and consult with other specialists is achieved. Additionally, the interdependence of Neurosurgical and Otolaryngologic surgical procedures and their planning is appreciated. Skills are developed in the ability to plan and coordinate. Recognition of significant complications and the ability to cooperatively treat such outcomes is a goal for this rotation.

At the completion of this rotation the PGY 1 resident should be knowledgeable in the following areas and be able to do:

   a) Review basic cranial anatomy including cranial nerve origin and function.

   b) Perform neurosurgical patient evaluation, assessment and management.

   c) Learn evaluation and treatment of neurological trauma, critical care and emergencies.

   d) The indications for and basic interpretation of diagnostic tests and X-rays including basic head CT and MRI imaging studies.

   e) Basic neurosurgical skills, technique, and wound management including simple craniotomy, dural suturing and craniotomy closure.

   f) Recognition, diagnosis, and basic management of CSF leaks.

   g) Insertion and management of a lumbar drain.

   h) Management of common neurosurgical complications.

   i) Differentiate between stroke, TIA, and non-cerebrovascular events causing neurological symptoms and know the diagnostic techniques.

   j) Participate in at least 5 major procedures (cranial decompression, craniotomy, removal of pituitary adenoma).

PLASTIC SURGERY ROTATION
This rotation increases the medical knowledge and patient care skills directly related to the management of plastic and reconstructive surgery. Basic medical knowledge and skills are developed in the evaluation and management of patients with needs for: craniomaxillofacial
trauma, burns, locoregional and distant free tissue reconstruction, decubitus ulcer and sentinel node biopsy for melanoma. Specific techniques to be mastered include:

   a) Soft Tissue handling
   b) Repair of complex facial and soft tissue lacerations
   c) the appropriate use and techniques of skin grafts
   d) debridement of wounds
   e) use of occlusive and debriding dressings
   f) assessment of reconstructive needs for aesthetic facial units
   g) introduction to concepts and techniques utilized in facial cosmetics and aesthetic enhancement
   h) plating of facial osseous injuries

SYSTEMS BASED PRACTICE AND PROFESSIONALISM
Interdependence of reconstructive approaches in plastic surgery and otolaryngologic systems is emphasized. The ability to recognize wound care and reconstructive challenges of soft tissue and musculoskeletal systems and to appropriately communicate and consult with other specialists is achieved. Additionally, the interdependence of Plastic and Otolaryngologic surgical procedures and their planning is appreciated. Skills are developed in the ability to plan and coordinate such procedures. Recognition of significant complications and the ability to cooperatively treat such outcomes is a goal for this rotation.

OTOLARYNGOLOGY ROTATION
The main goal of this rotation is to provide the PGY1 resident exposure to the inpatient care of otolaryngology patients and basic surgical techniques in otolaryngology. The ability to develop a working team-based relationship is also emphasized on this rotation. Residents work with residents, nurses, and attending staff to experience the team approach. Communication, knowing when to call an anesthesiology preoperative evaluation and contacting additional specialty services are emphasized and attained during this rotation.

Goals
1. Develop surgical skills in tracheotomy, wound care, treatment of facial trauma, and diagnostic endoscopy.
2. Learn comprehensive management of post-operative otolaryngology patients, including complex head and neck, neuro-otologic, and rhinologic patients
3. Perform pre-operative evaluations and assessments to prepare patients for general anesthesia.
4. Interact with otolaryngology team members, nursing staff, and consulting services during patient management.

PGY 2:

1. Goals & Objectives:
   A. To develop novice to intermediate skills working within the systems of outpatient care focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. This is measured by MedHub faculty assessments and surgical competency committee reviews.
      a. Head and Neck examination: Using practice-based learning, skills of interpersonal communication with patients, professionalism and expertise in the examination is developed first by observing the AAO/HNS’ introductory tape on the H&N exam and then by observation and participation in the variety of clinics the PGY2 resident attends.
      b. Diagnostic Acumen:
         i. A 2-day introductory course is given to increase medical knowledge of incoming residents to review some of the more important and common disease entities they will be called upon to treat.
ii. Second year residents who spend 6 months at Y-NHH are primarily responsible for practicing systems-based practice and modeling professional behaviors via outpatient delivery of care under the direction of Dr. Clarence Sasaki and Dr. Benjamin Judson (Head and Neck Clinic), Dr. Elias Michaelides (Otology Clinic) and Dr. Jennifer Setlur (Pediatric Clinic), Dr. Nwanmegha Young (Laryngeal Clinic). Dr. Mark Bianchi proctors a PGY 2 weekly in his clinic. This is a valuable teaching experience that incorporates modeling of professionalism, medical knowledge, interpersonal communication and practice-based learning. Dr. Bianchi works very closely with the resident evaluating and examining preoperative patients as new patients in his clinic, frequently referred from the Hill Health Clinic for surgery. Surgical decision making, surgical consent, evaluation of medical knowledge and patient care are all incorporated into this teaching experience.

iii. Attendance at the conferences below increases medical knowledge and allows residents to strengthen interpersonal communication skills; it also exposes the resident to growth opportunities in developing his diagnostic skills.

B. To develop novice to intermediate skills in emergency services
   o Critical care decision-making.
     i. Residents gradually take on increased levels of care through the management of the critically ill in-patients and emergency room consultations systems-based practice and interpersonal communication skills are a key focus of this experience. Modeling by attending staff and teamwork with consultants from other specialties is emphasized.

   b. Emergency surgical techniques focusing on Patient Care competencies, taking care to assume a patient-based approach to this care.
     i. Tracheotomy: Residents are taught in non-emergent settings the techniques required to secure a surgical airway. Supervised by attending surgeons or chief residents, the PGY2 resident is quickly taught the skills required to handle such emergencies.
     ii. Basic plastic Techniques and wound healing: In the operating room and in the classroom residents are instructed on the proper techniques to handle such emergencies
     iii. Maxillo-mandibular fixation: Residents are exposed to the indications and actual performance of the procedure.

   c. Attendance at the conferences below increases medical knowledge and allows residents to strengthen interpersonal communication skills; it also exposes the resident to growth opportunities in developing his skills in dealing with ORL emergencies.

C. To develop a graduated experience in outpatient surgical procedures focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. This is measured by MedHub faculty assessments and surgical competency committee reviews.
   a. Tonsillectomy and Adenoidectomy
   b. Myringotomy and insertion of Pressure Equalization tubes.
   c. Septoplasty
   d. Endoscopy with nasal
      i. Laryngoscopy
      ii. Bronchoscopy
      iii. Esophagoscopy
   e. Maxillo-mandibular fixation

D. To develop beginner competencies in temporal bone anatomy as assessed by direct observation and guidance by neurotology faculty (Dr. Michaelides) and other faculty. A Temporal Bone drilling competition at the end of the academic year is a performance
judged by the entire full-time faculty.

a. Introductory temporal bone course is given annually where didactic teaching provides the foundation for the resident’s independent work. This strengthens medical knowledge and identifies clinical correlations of this knowledge.

b. Residents are required to independently dissect temporal bones for 6 hours per year.

2. Outline of Resident Duties

A. Inpatient Rounds: PGY 2 residents are required to round on the inpatient service 5 days a week and when on call.

B. Clinics: PGY 2 staff General Adult & Allergy Clinics (Dr. Stanley Friedman), Head and Neck Clinic (Drs. Clarence Sasaki and Benjamin Judson), Sinus/Allergy/Sleep Apnea Clinic (Dr. Mark Bianchi), Otology Clinic (Dr. Elias Michaelides), Pediatric Clinic (Dr. Jennifer Setlur), Laryngeal Clinic (Dr. Nwanmegha Young) and Pre and Post-op Evaluation Clinics.

C. Surgeries: PGY 2 residents are assigned to act as surgeon in the level appropriate cases and as assistants in more advanced cases. This provides the opportunity for modeling by the senior resident and improvement of senior resident teaching and communication skills.

D. Consultations either inpatient or emergency: When on call, the resident is the initial evaluator of inpatient and emergency room consultations. This provides ample opportunity to strengthen practice-based learning by consultation with senior residents and attending staff. Systems-based practice and professionalism are emphasized through consultations with other specialty services. Interpersonal communication skills are improved through patient-centered provision of care.

3. Progression of Resident Responsibilities

Depending on the progression of the individual resident’s performance as determined by MedHub assessments, multi-source evaluations and surgical competency committee reviews, the PGY 2 is afforded more responsibility in independent delivery of care.

4. Organization of Teaching Clinics and Services

Clinics: Pediatric Clinic
Dr. Jennifer Setlur
Wednesdays 1:00 PM – 3:00 PM

General Adult Clinics:
Hill Health Clinic, Dr. Stanley Friedman attending
Wednesday 8:30 – 12:00 PM, Thursday 8:30 AM – 4:00 PM

Head and Neck Clinic
Dr. Clarence T. Sasaki attending
Wednesdays 8:30AM – 2:45 PM
Dr. Benjamin Judson attending
Tuesday 8:30 AM – 4:00 PM
Dr. Wendall Yarbrough
Thursday 8:30 AM – 4:00 PM

Sinus/Allergy Clinic
Dr. Mark Bianchi attending
2nd & 4th Monday of Month – 8:30 – 12:00 PM
Thursday 8:30 AM – 4:00 PM
Dr. Peter Manes attending
Wednesdays 8:30 AM – 4:45 PM
1st & 3rd Monday of Month – 8:30 – 12:00 PM

Allergy Clinic: Incorporated into Hill Health Clinic Schedule
Please see Allergy & Immunology Clinic description under Program Course of Study)
Dr. Stanley Friedman attending
Wednesday 8:30 – 12:00 PM, Thursday 8:30 AM – 4:00 PM
Otology Clinic  
Dr. Elias Michaelides attending  
Friday 8:30 AM – 4:00 PM  

Pediatric Otology Clinic  
Dr. Elias Michaelides attending  
Monday 8:30 AM - 12:00 PM  

Multidisciplinary Dizziness Clinic  
Dr. Elias Michaelides attending  
Monday 1 PM - 4:00 PM  

Laryngology Clinic  
Dr. Nwanmegha Young attending  
Tuesday 8:30 AM – 4:00 PM  

Pre-operative Evaluation Clinic  
Tues. 8:00- 11:00 AM  
Friday 8:30 – 11:30 AM  

Post-operative Evaluation Clinic  
Mon, Tues, Thurs. – 3:00 PM – 3:45 PM  
Fridays 1:00 PM – 3:35 PM  

Services:  
Adult inpatient service  
All faculty members  
Pediatric inpatient service  
Dr. Jennifer Setlur  

5. Required Conferences  
• Educational Conference at YNHH  
  ○ Wednesdays 7-9:00 AM  
• Pathology Teaching Conference at YNHH  
  ○ 4th Wednesday of each month 5-6 PM  
• Journal Club  
  ○ 2nd Wednesday of each month 5:30-6:30 PM  
• Radiology Education Conference at YNHH  
  ○ 2nd Wednesdays of each month 8-9 AM  
• Radiology Conference at YNHH  
  ○ Wednesdays 4:30-5:30 PM  
• Morbidity and Mortality Conference at YNHH  
  ○ 4th Friday of each month 7-8 AM  
• Grand Rounds Conference  
  ○ 1st Friday of each month 7-8 AM  
• Resident Speaker Grand Rounds  
  ○ 2nd Friday of each month 7-8 AM  

PGY 3  

1. Goals & Objectives:  
   A. To develop intermediate skills in outpatient care with emphasis on pediatrics focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. This is measured by MedHub faculty assessments and surgical competency committee reviews.
a. Head and Neck examination: Expertise in the examination is further developed by observation and increased participation in the variety of clinics.

b. Diagnostic Acumen:
   i. PGY 3 residents who are assigned at Y-NHH experience increased medical knowledge and allows residents to strengthen interpersonal communication skills; it exposes the resident to growth opportunities in developing their diagnostic skills.

B. To develop intermediate skills in emergency & inpatient consultation services focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. This is measured by MedHub faculty assessments and surgical competency committee reviews. Systems-based practice and interpersonal communication skills are a key focus of this experience. Modeling by attending staff and teamwork with consultants from other specialties is emphasized.

a. Critical care decision-making.
   i. PGY 3 residents gradually take on increasing levels of care for critically ill in-patients, emergency room patients, and inpatient consultations. Systems-based practice and interpersonal communication skills are a key focus of this experience. These are evaluated using MedHub assessments and multi-source evaluations.

b. Emergency surgical techniques focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. These skills are evaluated through multi-source evaluations and surgical competency committee reviews.
   i. Intermediate skills in plastic techniques and wound healing: In the operating room and in the classroom residents are instructed on the proper techniques and are expected to acquire a sufficient knowledge base to handle such emergencies.
   ii. Facial Fracture treatment: Residents are exposed to the indications and actual performance of the procedures associated with facial trauma.

c. Attendance at the conferences below also exposes the resident to growth opportunities in developing their skills in dealing with ORL emergencies. This increases medical knowledge and allows residents to strengthen interpersonal communication skills through giving lectures and running discussions. Residents are evaluated by their peers and faculty for quality of presentations using evaluation questionnaires.

B. To develop a graduated experience in operative complexity focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. Medical knowledge and the ability to use interpersonal communication skills in teaching PGY1 and PGY2 residents is emphasized. These skills are measured by MedHub faculty assessments, multi-source, residents to submit surgery rating sheets & peer reviews and surgical competency committee reviews. Residents also submit surgery rotating sheets.

a. Pediatric Procedures
b. Middle ear surgery.
c. Neck Dissections
d. Endoscopic Surgery
   i. Sinus
   ii. Zenkers Diverticulum’s
e. Maxillofacial Repair
f. Cosmetic and reconstructive surgery.
g. Salivary surgery
h. Thyroid surgery
D. To develop Intermediate competencies in temporal bone anatomy as assessed by direct observation and guidance by neurotology faculty (Dr. Michaelides) and other faculty. A Temporal Bone drilling competition at the end of the academic year is a performance judged by all the full-time faculty.
   a. An Intermediate temporal bone course is given annually where didactic teaching provides the foundation for the resident’s independent work. This strengthens medical knowledge and identifies clinical correlations of this knowledge.
   b. Residents are required to independently dissect temporal bones for 6 hours per year.

2. Outline of Resident Duties
   1. Inpatient Rounds: PGY 3 residents are required to round on the inpatient service 5 days a week and when on call. Presentations to the team and direct interactions with faculty attendings emphasizes interpersonal communication skills, practice-based learning and role modeling of professionalism and teaching skills.
   2. Clinics: PGY 3 staff General Adult & Allergy Clinics (Dr. Stanley Friedman), Head and Neck Clinic (Drs. Clarence Sasaki and Benjamin Judson), Sinus/Allergy/Sleep Apnea Clinic (Dr. Mark Bianchi), Otology Clinic (Dr. Elias Michaelides), Pediatric Clinic (Dr. Jennifer Setlur), Laryngeal Clinic (Dr. Nwanmegha Young) and Pre and Post-op Evaluation Clinics.
   3. Surgeries: PGY 3 residents are assigned to act as surgeon in the above listed cases and as assistants in more advanced cases. Gradual increases in responsibility for the surgical procedures steps are emphasized and allowed as appropriate. This also provides the opportunity for modeling by the senior resident and improvement of senior resident teaching and communication skills. Their skills are evaluated by MedHub assessments and surgical competency committee reviews.
   4. Consultations either inpatient or emergency: When on call, the resident is the initial evaluator of inpatient and emergency room consultations. This provides ample opportunity to strengthen practice-based learning by consultation with senior residents and attending staff. Systems-based practice and professionalism are emphasized through consultations with other specialty services. Interpersonal communication skills are improved through patient-centered provision of care.

3. Progression of Resident Responsibilities
   Depending on the progression of the individual resident’s performance, the PGY3 is afforded more responsibility in independent delivery of care. Determination of readiness for increased levels of responsibility are determined via multi-source & peer evaluations, MedHub assessments and surgical competency committee reviews.

4. Organization of Teaching Clinics and Services
   Clinics: Pediatric Clinic
       Dr. Jennifer Setlur
       Wednesdays 1:00 PM – 3:00 PM
   General Adult Clinics:
       Hill Health Clinic, Dr. Stanley Friedman attending
       Wednesday 8:30 – 12:00 PM, Thursday 8:30 AM – 4:00 PM
       Head and Neck Clinic
       Dr. Clarence T. Sasaki attending
       Wednesdays 8:30 AM – 2:45 PM
       Dr. Benjamin Judson attending
       Tuesday 8:30 AM – 4:00 PM
       Dr. Wendall Yarbrough
       Thursday 8:30 AM – 4:00 PM
   Sinus/Allergy Clinic
Dr. Mark Bianchi attending  
2nd & 4th Monday of Month – 8:30 – 12:00 PM  
Thursday 8:30 AM – 4:00 PM
Dr. Peter Manes attending  
Wednesdays 8:30-4:45 PM  
1st & 3rd Monday of Month – 8:30 -12:00 PM
Allergy Clinic: Incorporated into Hill Health Clinic Schedule  
Please see Allergy & Immunology Clinic description under Program Course of Study
Dr. Stanley Friedman attending  
Wednesday 8:30 – 12:00 PM, Thursday 8:30 AM – 4:00 PM
Facial Plastic Clinic  
Dr. John Schmidt attending  
2nd Monday  8:30 AM – 12:00 PM
Otology Clinic  
Dr. Elias Michaelides attending  
Friday  8:30 AM – 4:00 PM
Pediatric Otology Clinic  
Dr. Elias Michaelides attending  
Monday, 8:30 AM - 12:00 PM
Multidisciplinary Dizziness Clinic  
Dr. Elias Michaelides attending  
Monday, 1 PM - 4:00 PM
Laryngology Clinic  
Dr. Nwanmegha Young attending  
Tuesday 8:30 AM – 4:00 PM
Pre-operative Evaluation Clinic  
Tuesday 8:00 – 11:00 AM  
Friday 8:30 – 11:30 AM
Post-operative Evaluation Clinic  
Mon, Tues, Thurs – 3:00-3:45 PM  
Fridays 1:00 – 3:45 PM

Services:  
Adult inpatient service  
All faculty members  
Pediatric inpatient service  
Dr. Jennifer Setlur

Call  
From YNHH every 4th night; PGY 2 residents take first call with either PGY 4 or PGY 5 as back up.

5. Required Conferences

• Educational Conference at YNHH  
  o Wednesdays 7-9:00 AM
• Pathology Teaching Conference at YNHH  
  o 4th Wednesday of each month 5-6 PM
• Journal Club  
  o 2nd Wednesday of each month 5:30-6:30 PM
• Radiology Education Conference at YNHH  
  o 2nd Wednesdays of each month 8-9 AM
• Radiology Conference at YNHH  
  o Wednesdays 4:30-5:30 PM
• Morbidity and Mortality Conference at YNHH  
  o 4th Friday of each month 7-8 AM
• Grand Rounds Conference  
  o 1st Friday of each month 7-8 AM
• Resident Speaker Grand Rounds  
  o 2nd Friday of each month 7-8 AM
PGY 4

1. Goals & Objectives:

A. To develop competent skills in outpatient care with emphasis on facial plastic and reconstructive surgery focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. This is measured by MedHub faculty assessments and surgical competency committee reviews.

   a. Head and Neck examination: Expertise in the examination is further developed by observation and increased participation in the variety of clinics the PGY 4 resident attends. Increased emphasis is placed on development of interpersonal communication skills with patient and family (through role modeling and real-time feedback using "yellow sheets" evaluation forms). Medical knowledge is assessed through practice-based case reviews with attending faculty. Feedback is provided with yellow sheets and MedHub assessments.

   b. Diagnostic Acumen:
      i. PGY 4 residents who are assigned at Y-NHH experience increased responsibilities for outpatient delivery of care in faculty clinics and in a supervisory role for the junior (PGY1,2,3) residents.
      ii. Attendance at the conferences below increases medical knowledge and allows residents to strengthen interpersonal communication skills; it also exposes the resident to growth opportunities in developing his diagnostic skills.

B. To develop competent and independent skills in emergency & inpatient consultation services focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. This is measured by MedHub faculty assessments and clinical competency committee reviews. Systems-based practice and interpersonal communication skills are a key focus of this experience. Modeling by attending staff and teamwork with consultants from other specialties is emphasized.

   a. Critical care decision-making.
      i. PGY 4 residents take on higher levels of care of critically ill inpatients, emergency room patients, and inpatient consultations than PGY1, 2, and 3 residents. Gradual increased supervisory activities are integrated as appropriate for the level of resident skill. This increases interpersonal communication skills, patient care skills and systems-based practice skills.

   b. Emergency surgical techniques focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. Assessment of competency is made through MedHub assessments tools and surgical competency committee reviews.
      i. Competent skills in all emergency surgical techniques are expected to be achieved. In the operating room and in the classroom residents are instructed on the proper techniques and knowledge base to handle such emergencies.
      ii. Facial Fracture treatment: Residents become competent diagnosticians to perform the procedures associated with the care of facial trauma.

   c. Attendance at the conferences below increases medical knowledge and allows residents to strengthen interpersonal communication skills through giving lectures and running discussions. Residents are evaluated by their peers and faculty for quality of presentations using evaluation questionnaires also exposes the resident to growth opportunities in developing their skills in dealing with ORL emergencies.
C. To develop a graduated experience in operative complexity focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. Medical knowledge and the ability to use interpersonal communication skills in teaching PGY1 and PGY2 residents is emphasized. These skills are measured by MedHub faculty assessments and surgical competency committee reviews.

   a. Cosmetic and reconstructive surgery.
   b. Middle ear surgery
   c. Neck Dissections
   d. Endoscopic Surgery
      i. Sinus
      ii. Zenker's Diverticulum
   e. Maxillofacial Repair
   f. Salivary surgery
   g. Thyroid surgery

D. To develop Intermediate to advanced competencies in temporal bone anatomy as assessed by direct observation and guidance by neurotology faculty (Dr. Michaelides) and other faculty. A Temporal Bone drilling competition at the end of the academic year is a performance judged by all the full-time faculty.

   a. An Intermediate to advanced temporal bone course is given annually where didactic teaching provides the foundation for the resident’s independent work. This strengthens medical knowledge and identifies clinical correlations of this knowledge.
   b. Residents are required to independently dissect temporal bones for 6 hours per year.

2. Outline of Resident Duties
   A. Inpatient Rounds: PGY 4 residents are required to round on the inpatient service 5 days a week and when on call. Presentations to the team and direct interactions with faculty attendings emphasizes interpersonal communication skills, practice-based learning and role modeling of professionalism and teaching skills.
   B. Clinics: PGY 4 staff
   C. Surgeries: PGY 4 residents are assigned to act as surgeon in the above listed cases and as assistants in more advanced cases. Gradual increases in responsibility for the surgical procedures steps are emphasized and allowed as appropriate. This also provides the opportunity for modeling by the senior resident and improvement of senior resident teaching and communication skills. Their skills are evaluated by MedHub assessments and "yellow sheets"—a hard copy evaluation form supplied by our section. These supply direct feedback to be implemented in "real time" and in a case-based learning format.
   D. Consultations either inpatient or emergency: The PGY 4 resident is the initial evaluator of inpatient and emergency room consultations. This provides ample opportunity to strengthen practice-based learning by consultation with chief residents and attending staff. Systems-based practice and professionalism are emphasized through communications and consultations with other specialty services. Interpersonal communication skills are improved through patient-centered provision of care.

3. Progression of Resident Responsibilities
   Depending on the progression of the individual resident's performance, the PGY 4 is afforded more responsibility in independent delivery of care. Determination of readiness for increased levels of responsibility are determined via multi-source and peer evaluations, MedHub assessments and surgical competency committee reviews.

4. Organization of Teaching Clinics and Services
   Clinics: Pediatric Clinic
Dr. Jennifer Setlur  
Wednesdays 1:00 PM – 3:00 PM

General Adult Clinics:
Hill Health Clinic, Dr. Stanley Friedman attending  
Wednesday 8:30 – 12:00 PM, Thursday 8:30 AM – 4:00 PM

Head and Neck Clinic
Dr. Clarence T. Sasaki attending  
Wednesdays 8:30 AM – 2:45 PM  
Dr. Benjamin Judson attending  
Tuesday 8:30 AM – 4:00 PM  
Dr. Wendall Yarbrough  
Thursday 8:30 AM – 4:00 PM

Sinus/Allergy Clinic
Dr. Mark Bianchi attending  
2nd & 4th Monday of Month – 8:30 – 12:00 PM  
Thursday 8:30 AM – 4:00 PM  
Dr. Peter Manes attending  
Wednesdays 8:30 – 4:45 PM  
1st & 3rd Monday of Month – 8:30 – 12:00 PM

Allergy Clinic: Incorporated into Hill Health Clinic Schedule  
Please see Allergy & Immunology Clinic description under Program Course of Study  
Dr. Stanley Friedman attending  
Wednesday 8:30 – 12:00 PM, Thursday 8:30 AM – 4:00 PM

Facial Plastic Clinic
Dr. John Schmidt attending  
2nd Monday 8:30 AM – 12:00 PM

Otolaryngology Clinic
Dr. Elias Michaelides attending  
Friday 8:30 AM – 4:00 PM

Pediatric Otolaryngology Clinic
Dr. Elias Michaelides attending  
Monday, 8:30 AM - 12:00 PM

Multidisciplinary Dizziness Clinic
Dr. Elias Michaelides attending  
Monday, 1 PM - 4:00 PM

Laryngology Clinic
Dr. Nwanmegha Young attending  
Tuesday 8:30 AM – 4:00 PM

Pre-operative Evaluation Clinic
Tuesday 8:00-11:00 AM  
Friday 8:30 – 11:30 AM

Post-operative Evaluation Clinic
Mon, Tues, Thurs. 3:00 – 3:45 PM  
Friday 1:00- 3:45 PM

Services:  
Adult inpatient service  
All faculty members  
Pediatric inpatient service  
Dr. Jennifer Setlur

Call  
From home every fourth night, PGY 4 Residents take second call for the PGY 2s and PGY3s.

5. Required Conferences
• Educational Conference at YNHH  
  ○ Wednesdays 7-9:00 AM
• Pathology Teaching Conference at YNHH
  o 4th Wednesday of each month 5-6 PM
• Journal Club
  o 2nd Wednesday of each month 5:30-6:30 PM
• Radiology Education Conference at YNHH
  o 2nd Wednesdays of each month 8-9 AM
• Radiology Conference at YNHH
  o Wednesdays 4:30-5:30 PM
• Morbidity and Mortality Conference at YNHH
  o 4th Friday of each month 7-8 AM
• Grand Rounds Conference
  o 1st Friday of each month 7-8 AM
• Resident Speaker Grand Rounds
  o 2nd Friday of each month 7-8 AM

PGY 5

1. Goals & Objectives:
   A. To develop competent skills in comprehensive patient care focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. This is measured by MedHub faculty assessments and surgical competency committee reviews.
      a. Head and Neck examination: teaching and supervising junior residents and students are intended to further develop Expertise in the examination, allowing for increased emphasis on interpersonal communication and teaching skills.
      b. Diagnostic Acumen:
         i. A chief resident who is assigned 6 months at Y-NHH will experience increased responsibilities for outpatient delivery of care under the direction of resident to further sharpen his diagnostic acumen and expand his fund of knowledge.
   B. To develop competent, supervisory, and independent skills on emergency & inpatient consultation services focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. This is measured by MedHub faculty assessments and surgical competency committee reviews. Systems-based practice and interpersonal communication skills are a key focus of this experience. Modeling by attending staff and teamwork with consultants from other specialties is emphasized.
      a. Critical care decision-making.
         i. The chief resident takes on highest permissible level of care and responsibility for critically ill inpatients, emergency room patients, and inpatient consultations. Gradual increased supervisory activities are integrated as appropriate for the level of resident skill. This increases expectations of fund of knowledge, interpersonal communication skills, patient care skills and systems-based practice skills.
      b. Emergency surgical techniques focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. Assessment of competency is made through MedHub assessments tools and surgical competency committee reviews.
         i. Competent skills in all emergency surgical techniques are expected to be achieved. In the operating room and in the class room the chief resident aids in instructing others on the proper techniques to handle such emergencies
         ii. Facial Fracture treatment: In supervisory roles chief residents are expected to become competent diagnosticians, competent surgeons, and competent teachers.
c. Attendance at the conferences below increases medical knowledge and allows residents to strengthen interpersonal communication skills through giving lectures and running discussions. Residents are evaluated by their peers and faculty for quality of presentations using evaluation questionnaires. It also exposes the resident to growth opportunities to develop their skills in dealing with Oto-rhino-laryngologic (ORL) emergencies.

C. Competent skills in all emergency surgical techniques are expected to be achieved. In the operating room and in the class room the chief resident aids in instructing others on the proper techniques to handle such

Develop competent surgical skills focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. Medical knowledge and the ability to use interpersonal communication skills in teaching PGY1-PGY4 residents is emphasized. These skills are measured by MedHub faculty assessments and surgical competency committee reviews.

a. Cosmetic and reconstructive surgery.
b. Middle ear surgery.
c. Head and neck oncology
d. Neck Dissections
e. Endoscopic Surgery
f. Maxillofacial Repair
g. Salivary surgery
h. Thyroid surgery

D. Advanced competencies in temporal bone anatomy as assessed by direct observation and guidance by neurotology faculty (Dr. Michaelides) and other faculty. A Temporal Bone drilling competition at the end of the academic year is a performance judged by all the full-time faculty.

a. Residents are required to independently dissect temporal bones for 6 hours per year. This strengthens medical knowledge and identifies clinical correlations of this knowledge. Chief residents typically obtain the highest number of neurotology cases available for resident surgeon designation. Therefore, the drilling course is especially relevant and meaningful at this level of resident skill.

2. Outline of Resident Duties
A. Inpatient Rounds: PGY 5 residents are required to lead rounds on the inpatient service 5 days a week and when on call. Running the team rounds and direct interactions with faculty attending emphasizes skills in interpersonal communication skills, practice-based learning and role modeling of professionalism and teaching skills.

B. Clinics: Helps supervise the General Adult and Pediatric Clinics neurotology clinics with Dr. Michaelides on Fridays. This allows for maximization of continuity of patient care and provides opportunity for seeing follow-up and results of surgery. This increases clinical acumen, case-based learning, interpersonal communication skills with patients and fund of knowledge.

C. Surgeries: PGY 5 residents act as surgeon in most cases and are required to help the staff surgeon in instructing junior residents and students. Gradual increases in responsibility for the surgical procedures steps are emphasized and allowed as appropriate. This also provides the opportunity for modeling by the senior resident and improvement of senior resident teaching and communication skills. Their skills are evaluated by MedHub assessments and surgical competency committee reviews.

D. Supervise consultations either inpatient or emergency: The chief resident provides supervisory support for all consultations.

E. PGY5 serves as administrative resident and supervisor of residents and students. This increases opportunity for improved interpersonal communications skills and systems-based practice skills.
F. PGY5 advises Program Director on any programmatic changes.

3. Progression of Resident Responsibilities
The chief resident is supervised by the faculty. He is the administrative supervisor of the junior residents and students. He is expected to set an appropriate example as a mature physician and surgeon.

4. Organization of Teaching Clinics and Services
Clinics: Pediatric Clinic
   Dr. Jennifer Setlur
   Wednesdays 1:00 PM – 3:00 PM

General Adult Clinics:
   Hill Health Clinic, Dr. Stanley Friedman attending
   Wednesday 8:30 – 12:00 PM, Thursday 8:30 AM – 4:00 PM

Head and Neck Clinic
   Dr. Clarence T. Sasaki attending
   Wednesdays 8:30 AM – 2:45 PM
   Dr. Benjamin Judson attending
   Tuesday 8:30 AM – 4:00 PM
   Dr. Wendall Yarbrough
   Thursday 8:30 AM – 4:00 PM

Sinus/Allergy Clinic
   Dr. Mark Bianchi attending
   2nd & 4th Monday of Month – 8:30 – 12:00 PM
   Thursday 8:30 AM – 3:00 PM
   Dr. Peter Manes attending
   Wednesdays 8:30-4:45 PM
   1st & 3rd Monday of Month – 8:30 – 12:00 PM

Allergy Clinic: Incorporated into Hill Health Clinic Schedule
   Please see Allergy & Immunology Clinic description under Program Course of Study)
   Dr. Stanley Friedman attending
   Wednesday 8:30 – 12:00 PM, Thursday 8:30 AM – 4:00 PM

Otology Clinic
   Dr. Elias Michaelides attending
   Friday 8:30 AM – 4:00 PM

Pediatric Otology Clinic
   Dr. Elias Michaelides attending
   Monday, 8:30 AM - 12:00 PM

Multidisciplinary Dizziness Clinic
   Dr. Elias Michaelides attending
   Monday, 1 PM - 4:00 PM

Laryngology Clinic
   Dr. Nwanmegha Young attending
   Tuesday 8:30 AM – 4:00 PM

Pre-operative Evaluation Clinic
   Tuesday 8:00 – 11:00 AM
   Friday 8:30 – 11:30 AM

Post-operative Evaluation Clinic
   Mon, Tues, Thurs 3:00- 3:45 PM
   Fridays 1:00- 3:45 PM
Services: Adult inpatient service
All faculty members
Pediatric inpatient service
Dr. Jennifer Setlur

Call From home and on average every fourth night, PGY 5 Residents take second call for the PGY 2s and PGY3s.

5. Required Conferences
• Educational Conference at YNHH
  o Wednesdays 7-9:00 AM
• Pathology Teaching Conference at YNHH
  o 4th Wednesday of each month 5-6 PM
• Journal Club
  o 2nd Wednesday of each month 5:30-6:30 PM
• Radiology Education Conference at YNHH
  o 2nd Wednesdays of each month 8-9 AM
• Radiology Conference at YNHH
  o Wednesdays 4:30-5:30 PM
• Morbidity and Mortality Conference at YNHH
  o 4th Friday of each month 7-8 AM
• Grand Rounds Conference
  o 1st Friday of each month 7-8 AM
• Resident Speaker Grand Rounds
  o 2nd Friday of each month 7-8 AM

SAINT RAPHAEL’S CAMPUS (SRC)

The Saint Raphael's Campus provides a high volume of operative experience in General Otolaryngology. Twenty-one ENT clinicians are members of the SRC staff. Three of eight residents are assigned to SRC at any given time.

PGY 2

1. Goals & Objectives:
   A. To develop novice to intermediate skills in outpatient care focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. This is measured by MedHub faculty assessments and surgical competency committee reviews.
      a. Head and Neck examination: Two general otolaryngology clinics afford the PGY 2 resident sufficient experience to improve his/her ability to perform a head and neck examination.
      b. Diagnostic Acumen:
         i. PGY 2 residents at SRC and are supervised in the clinic by a rotating attending staff member. Emphasis is placed on systems-based practice and modeling professional behaviors via collaborating with these attending physicians.
         ii. Attendance at the conferences below increases medical knowledge and allows residents to strengthen interpersonal communication skills; it also exposes the resident to growth opportunities in developing their diagnostic skills.
   B. To develop novice to intermediate skills in emergency, consultation services, systems-based practice and interpersonal communication skills are a key focus of this experience. Modeling by attending staff and teamwork with consultants from other specialties is emphasized:
      a. Critical care decision-making.
i. Residents gradually take on increasing levels of responsibility for inpatients and emergency room consultations focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. Systems-based practice and interpersonal communication skills are a key focus of this experience. Modeling by attending staff and teamwork with consultants from other specialties is emphasized.

b. Emergency surgical techniques focusing on Patient Care competencies, taking care to assume a patient-based approach to this care.

i. Tracheotomy: Residents are taught in non-emergent settings the techniques required to secure a surgical airway. Supervised by attending surgeons or chief residents, the PGY 3 resident is quickly taught the skills required to handle such emergencies.

ii. Maxillo-mandibular fixation: Residents are exposed to the indications and actual performance of the procedure.

c. Attendance at the conferences listed below increases medical knowledge and allows residents to strengthen interpersonal communication skills; it also exposes the resident to growth opportunities in expanding their knowledge base about ORL emergencies.

C. To develop a graduated experience in outpatient surgical procedures focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. This is measured by MedHub faculty assessments, "blue sheets" and surgical competency committee reviews.

a. Tonsillectomy and Adenoidectomy

b. Myringotomy and insertion of Pressure Equalization tubes.

c. Septoplasty

d. Endoscopy
   i. Laryngoscopy
   ii. Bronchoscopy
   iii. Esophagoscopy
   iv. Maxillo-mandibular fixation

2. Outline of Resident Duties

A. Inpatient Rounds: PGY 2 residents are required to round on the inpatient service 5 days a week and when on call. Presentations to the team and direct interactions with faculty attendings emphasizes interpersonal communication skills, practice-based learning and role modeling of professionalism and teaching skills.

B. Clinics: PGY 2 residents staff the two general otolaryngology clinics per week.

C. Surgeries: PGY 2 residents are assigned to act as surgeon in the above listed cases and as assistants in more advanced cases. This provides the opportunity for modeling by the senior resident and improvement of senior resident teaching and communication skills.

D. Consultations either inpatient or emergency: When on call the resident is the initial evaluator of inpatient and emergency room consultations. This provides ample opportunity to strengthen practice-based learning by consultation with senior residents and attending staff. Systems-based practice and professionalism are emphasized through consultations with other specialty services. Interpersonal communication skills are improved through patient-centered provision of care.

3. Progression of Resident Responsibilities

Depending upon the progress of the individual resident's performance as determined by MedHub assessments, multi-source evaluations and surgical competency committee reviews, the PGY 2 is afforded more responsibility in independent delivery of care.

4. Organization of Teaching Clinics and Services

Clinics: 2 General Otolaryngology Clinics
Rotating faculty members

Services: Inpatient service
Call From YNHH every fourth night, PGY 2 residents take first call with either PGY 4 or PGY 5 as back up.

5. Required Conferences
   - Educational Conference at YNHH
     - Wednesdays 7-9:00 AM
   - Pathology Teaching Conference at YNHH
     - 4th Wednesday of each month 5-6 PM
   - Journal Club
     - 2nd Wednesday of each month 5:30-6:30 PM
   - Radiology Education Conference at YNHH
     - 2nd Wednesdays of each month 8-9 AM
   - Radiology Conference at YNHH
     - Wednesdays 4:30-5:30 PM
   - Morbidity and Mortality Conference at YNHH
     - 4th Friday of each month 7-8 AM
   - Grand Rounds Conference
     - 1st Friday of each month 7-8 AM
   - Resident Speaker Grand Rounds
     - 2nd Friday of each month 7-8 AM

PGY 3

1. Goals & Objectives:
   A. To develop intermediate skills in outpatient care with emphasis on pediatrics focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. This is measured by MedHub faculty assessments and surgical competency committee reviews.
      a. Head and Neck examination: Expertise in the examination is further developed by observation and increased participation in the two weekly clinics.
      b. Diagnostic Acumen: PGY3 residents who are assigned at SRC have increased responsibilities for outpatient delivery of care.
      c. Attendance at the conferences below increases medical knowledge and allows residents to strengthen interpersonal communication skills; it also exposes the resident to growth opportunities in developing their diagnostic skills.

   B. To develop intermediate skills in emergency & inpatient consultation services focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. This is measured by MedHub faculty assessments and surgical competency committee reviews. Systems-based practice and interpersonal communication skills are a key focus of this experience. Modeling by attending staff and teamwork with consultants from other specialties is emphasized.
      a. Critical care decision-making.
         i. PGY3 residents gradually take on increased levels of care for critically ill in-patients, emergency room patients, and inpatient consultations. Systems-based practice and interpersonal communication skills are a key focus of this experience. These are evaluated using MedHub assessments and multi-source evaluations.
      b. Emergency surgical techniques focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. These skills are evaluated through multi-source evaluations and surgical competency committee reviews.
i. Intermediate skills in plastic techniques and wound healing: In the operating room and in the classroom residents are instructed on the proper techniques to handle such emergencies.

ii. Facial Fracture treatment: Residents are exposed to the indications and actual performance of the procedures associated with facial trauma.

c. Attendance at the conferences below also exposes the resident to growth opportunities in developing their skills in dealing with ORL emergencies. This increases medical knowledge and allows residents to strengthen interpersonal communication skills through giving lectures and running discussions. Residents are evaluated by their peers and faculty for quality of presentations using evaluation questionnaires.

C. To develop a graduated experience in operative complexity focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. Medical knowledge and the ability to use interpersonal communication skills in teaching PGY1 and PGY2 residents is emphasized. These skills are measured by MedHub faculty assessments, multi-source & peer reviews and surgical competency committee reviews.

a. Pediatric Procedures
b. Middle ear surgery.
a. Neck Dissections
b. Endoscopic Surgery
   i. Sinus
   ii. Zenkers Diverticulum
c. Maxillofacial Repair
d. Cosmetic and reconstructive surgery.
e. Salivary surgery
f. Thyroid surgery

2. Outline of Resident Duties

A. Inpatient Rounds: PGY 3 residents are required to round on the inpatient service 5 days a week and when on call.

B. Clinics: PGY 3 residents Presentations to the team and direct interactions with faculty attendings emphasizes interpersonal communication skills, practice-based learning and role modeling of professionalism and teaching skills staff the two general otolaryngology clinics per week

C. Surgeries: PGY 3 residents are assigned to act as surgeon in the above listed cases and as assistants in more advanced cases. Gradual increases in responsibility for the surgical procedures steps are emphasized and allowed as appropriate. This also provides the opportunity for modeling by the senior resident and improvement of senior resident teaching and communication skills. Their skills are evaluated by MedHub assessments and surgical competency committee reviews.

D. Consultations either inpatient or emergency: When on call, the PGY 3 resident is the initial evaluator of inpatient and emergency room consultations. This provides ample opportunity to strengthen practice-based learning by consultation with senior residents and attending staff. Systems-based practice and professionalism are emphasized through consultations with other specialty services. Interpersonal communication skills are improved through patient-centered provision of care.

3. Progression of Resident Responsibilities

Depending on the progression of the individual resident’s performance, the PGY 3 is afforded more responsibility in independent care delivery and operative procedures. Determination of readiness for increased levels of responsibility are determined via multi-source & peer evaluations, MedHub assessments and surgical competency committee reviews.

4. Organization of Teaching Clinics and Services
Clinics:  2 General Otolaryngology Clinics
Rotating faculty members

Services:  Inpatient service
All faculty members

Call  From YNHH every fourth night, PGY 3 Residents take first call with either a PGY 4 or 5 as their back up.

5. Required Conferences

• Educational Conference at YNHH
  o Wednesdays 7-9:00 AM
• Pathology Teaching Conference at YNHH
  o 4th Wednesday of each month 5-6 PM
• Journal Club
  o 2nd Wednesday of each month 5:30-6:30 PM
• Radiology Education Conference at YNHH
  o 2nd Wednesdays of each month 8-9 AM
• Radiology Conference at YNHH
  o Wednesdays 4:30-5:30 PM
• Morbidity and Mortality Conference at YNHH
  o 4th Friday of each month 7-8 AM
• Grand Rounds Conference
  o 1st Friday of each month 7-8 AM
• Resident Speaker Grand Rounds
  o 2nd Friday of each month 7-8 AM

PGY 4

1. Goals & Objectives:
   A. To develop competent skills in outpatient care with emphasis on facial plastic and reconstructive surgery focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. This is measured by MedHub faculty assessments and surgical competency committee reviews.
      a. Head and Neck examination: Expertise in the examination is further developed by observation and increased participation in the two clinics per week.
      b. Diagnostic Acumen:
         i. PGY 4 residents who are assigned at SRC experience increased responsibilities for outpatient delivery of care. Increased emphasis is placed on development of interpersonal communication skills with patient and family (through role modeling and real-time feedback using "yellow sheets" evaluation forms). Medical knowledge is assessed through practice-based case reviews with attending faculty. Feedback is provided with yellow sheets and MedHub assessments.
         ii. Attendance at the conferences below increases medical knowledge and allows residents to strengthen interpersonal communication skills; it also exposes the resident to growth opportunities in developing their diagnostic skills.
   B. To develop competent and independent skills in emergency & inpatient consultation services focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. This is measured by Medhub faculty assessments and surgical competency committee reviews. Systems-based practice and interpersonal communication skills are a key focus of this experience. Modeling by attending staff and teamwork with consultants from other specialties is emphasized.
a. Critical care decision-making.
   i. PGY 4 residents take on higher levels of care of critically ill inpatients, emergency room patients, and inpatient consultations than PGY 1, 2, and 3 residents. Gradual increased supervisory activities are integrated as appropriate for the level of resident skill. This increases interpersonal communication skills, patient care skills and systems-based practice skills.

b. Emergency surgical techniques focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. Assessment of competency is made through MedHub assessments tools and surgical competency committee reviews.
   ii. Competent skills in all emergency surgical techniques are expected to be achieved. In the operating room and in the classroom PGY 4 residents are instructed on the proper techniques and knowledge base to handle such emergencies.
   iii. Facial Fracture treatment: Residents become competent diagnosticians to perform the procedures associated with the care of facial trauma.

c. Attendance at the conferences below increases medical knowledge and allows residents to strengthen interpersonal communication skills through giving lectures and running discussions. Residents are evaluated by their peers and faculty for quality of presentations using evaluation questionnaires also exposes the resident to growth opportunities in developing their skills in dealing with ORL emergencies.

C. To develop a graduated experience in operative complexity focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. Medical knowledge and the ability to use interpersonal communication skills in teaching PGY1 and PGY2 residents is emphasized. These skills are measured by MedHub faculty assessments and surgical competency committee reviews.
   a. Cosmetic and reconstructive surgery
   b. Pediatric Procedures
   c. Middle ear surgery.
   d. Neck Dissections
   e. Endoscopic Surgery
   f. Sinus
   g. Zenker’s Diverticulum
   h. Maxillofacial Repair
   i. Salivary surgery
   j. Thyroid surgery

2. Outline of Resident Duties
   A. Inpatient Rounds: PGY 4 residents are required to round on the inpatient service 5 days a week and when on call. Presentations to the team and direct interactions with faculty attendings emphasizes interpersonal communication skills, practice-based learning and role modeling of professionalism and teaching skills.
   B. Clinics: PGY 4s staff the 2 general otolaryngology clinics per week. Their skills are evaluated by MedHub assessments and "yellow sheets"--a hard copy evaluation form supplied by our section. These supply direct feedback to be implemented in "real time" and in a case-based learning format.
   C. Surgeries: PGY 4 residents are assigned to act as surgeon in the above listed cases and as assistants in more advanced cases. Gradual increases in responsibility for the surgical procedures steps are emphasized and allowed as appropriate. This also provides the opportunity for modeling by the senior resident and improvement of senior resident teaching and communication skills. Their skills are evaluated by MedHub assessments and "blue sheets"--a hard copy evaluation form supplied by our section. These supply direct feedback to be implemented in "real time" and in a case-based learning format. Additional feedback is provided by a surgical competency committee review.
   D. Consultations either inpatient or emergency: When on call the PGY 4 resident is the initial evaluator of inpatient and emergency room consultations. This provides ample
opportunity to strengthen practice-based learning by consultation with chief residents and attending staff. Systems-based practice and professionalism are emphasized through communications and consultations with other specialty services. Interpersonal communication skills are improved through patient-centered provision of care.

3. Progression of Resident Responsibilities
Depending on the progression of the individual resident's performance, the PGY 4 is afforded more responsibility in independent care delivery. Determination of readiness for increased levels of responsibility are determined via multi-source & peer evaluations, MedHub assessments and surgical competency committee reviews.

4. Organization of Teaching Clinics and Services
Clinics: General Otolaryngology Clinics
Rotating faculty member

Services: Inpatient service
All faculty members

Call From home every fourth night, PGY 4 residents take second call for the PGY 2s and PGY 3s.

5. Required Conferences
- Educational Conference at YNHH
  - Wednesdays 7-9:00 AM
- Pathology Teaching Conference at YNHH
  - 4th Wednesday of each month 5-6 PM
- Journal Club
  - 2nd Wednesday of each month 5:30-6:30 PM
- Radiology Education Conference at YNHH
  - 2nd Wednesdays of each month 8-9 AM
- Radiology Conference at YNHH
  - Wednesdays 4:30-5:30 PM
- Morbidity and Mortality Conference at YNHH
  - 4th Friday of each month 7-8 AM
- Grand Rounds Conference
  - 1st Friday of each month 7-8 AM
- Resident Speaker Grand Rounds
  - 2nd Friday of each month 7-8 AM

PGY 5

1. Goals & Objectives:
   A. To develop competent skills in comprehensive patient care focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. This is measured by Medhub faculty assessments and surgical competency committee reviews.
     a. Head and Neck examination: teaching and supervising junior residents and students are intended to further develop expertise in the examination, allowing for increased emphasis on interpersonal communication and teaching skills.
     b. Diagnostic Acumen:
        i. A chief resident who is assigned 6 months at SRC would experience increased responsibilities for outpatient delivery of care.
   B. To develop competent, supervisory, and independent skills on emergency & inpatient consultation services focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. This is measured by Medhub faculty
assessments and surgical competency committee reviews. Systems-based practice and interpersonal communication skills are a key focus of this experience. Modeling by attending staff and teamwork with consultants from other specialties is emphasized.

a. Critical care decision-making.
   i. The chief resident takes on highest permissible level of care and responsibility for critically ill inpatients, emergency room patients, and inpatient consultations. Gradual increased supervisory activities are integrated as appropriate for the level of resident skill. This increases expectations of fund of knowledge, interpersonal communication skills, patient care skills and systems-based practice skills.

b. Emergency surgical techniques focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. Assessment of competency is made through MedHub assessments tools, "blue sheets" and surgical competency committee reviews.
   i. Competent skills in all emergency surgical techniques are expected to be achieved. In the operating room and in the class room the chief resident aids in instructing others on the proper techniques to handle such emergencies.
   ii. Facial Fracture treatment: Chief residents are expected to become competent diagnosticians, competent surgeons, and competent teachers.

c. Attendance at the conferences below increases medical knowledge and allows residents to strengthen interpersonal communication skills through giving lectures and running discussions. Residents are evaluated by their peers and faculty for quality of presentations using evaluation questionnaires. It also exposes the resident to growth opportunities to develop their skills in dealing with ORL emergencies.

C. Develop competent surgical skills focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. Medical knowledge and the ability to use interpersonal communication skills in teaching PGY1-PGY4 residents is emphasized. These skills are measured by MedHub faculty assessments, "blue sheets" and surgical competency committee reviews.

a. Cosmetic and reconstructive surgery
b. Pediatric Procedures
c. Middle ear surgery.
d. Head and neck oncology
e. Neck Dissections
f. Endoscopic Surgery
g. Maxillofacial Repair
h. Salivary surgery
i. Thyroid surgery

2. Outline of Resident Duties

   A. Inpatient Rounds: PGY 5 residents are required to lead rounds on the inpatient service 5 days a week and when on call. Running the team rounds and direct interactions with faculty attendings emphasizes skills in interpersonal communication skills, practice-based learning and role modeling of professionalism and teaching skills.

   B. Clinics: PGY 5 residents staff the general otolaryngology clinics. This allows for maximization of continuity of patient care and provides opportunity for seeing follow-up and results of surgery. This increases clinical acumen, case-based learning, interpersonal communication skills with patients and fund of knowledge.

   C. Surgeries: PGY 5 residents act as surgeon in most cases and are required to help the staff surgeon in instructing junior residents and students. Gradual increases in responsibility for the surgical procedures steps are emphasized and allowed as appropriate. This also provides the opportunity for modeling by the senior resident.
and improvement of senior resident teaching and communication skills. Their skills are evaluated by MedHub assessments and surgical competency committee reviews.

D. Supervise consultations either inpatient or emergency: The chief resident provides supervisory support for all consultations.

E. PGY 5 serve as an administrative resident, supervisor of residents and students. This increases opportunity for improved interpersonal communications skills and systems-based practice skills.

F. PGY 5 advises Program Director on any need for programmatic changes.

3. Progression of Resident Responsibilities

The chief resident is supervised by the faculty. He is the administrative supervisor of the junior residents and students. He is expected to set an appropriate example as a mature physician and surgeon.

4. Organization of Teaching Clinics and Services

Clinics: General Otolaryngology Clinics
Rotating faculty member

Services: Inpatient service
All faculty members

Call: From home every fourth night, PGY 5 residents take second call for the PGY2s and PGY3s.

5. Required Conferences

• Educational Conference at YNHH
  ○ Wednesdays 7-9:00 AM

• Pathology Teaching Conference at YNHH
  ○ 4th Wednesday of each month 5-6 PM

• Journal Club
  ○ 2nd Wednesday of each month 5:30-6:30 PM

• Radiology Education Conference at YNHH
  ○ 2nd Wednesdays of each month 8-9 AM

• Radiology Conference at YNHH
  ○ Wednesdays 4:30-5:30 PM

• Morbidity and Mortality Conference at YNHH
  ○ 4th Friday of each month 7-8 AM

• Grand Rounds Conference
  ○ 1st Friday of each month 7-8 AM

• Resident Speaker Grand Rounds
  ○ 2nd Friday of each month 7-8 AM

WEST HAVEN VETERAN AFFAIRS HOSPITAL

PGY 3 or PGY 4

1. Goals & Objectives:

A. To develop competent skills in comprehensive patient care

a. Head and Neck examination: Skills are honed through ample patient volume focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. Particular emphasis is placed on Systems-based practice through the use of a well-established Electronic medical record. Performance is measured by MedHub faculty assessments and surgical competency committee reviews.

a. Diagnostic Acumen:

i. Assigned 3 month rotations at the VA residents experience increased responsibilities for outpatient delivery of care under the direction of
Dr. Michaelides, Dr. Nwanmegha Young and Dr. Ben Judson. Increased emphasis is placed on development of interpersonal communication skills with patient and family (through role modeling with faculty attendings along with professionalism). Medical knowledge is assessed through practice-based case reviews with attending faculty. Feedback is provided with MedHub assessments.

b. Residents are expected to further develop skills in pre and postoperative patient management.

B. To develop competent and independent skills in emergency & inpatient consultation services focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. This is measured by MedHub faculty assessments and surgical competency committee reviews. Systems-based practice and interpersonal communication skills are a key focus of this experience. Modeling by attending staff and teamwork with consultants from other specialties is emphasized.

a. Critical care decision-making.
   i. The VA resident is afforded the highest permissible level of care and responsibility for critically ill inpatients, emergency room patients, and inpatient consultations. Gradual increased supervisory activities are integrated as appropriate for the level of resident skill. This increases interpersonal communication skills, patient care skills and systems-based practice skills.

b. Emergency surgical techniques focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. Assessment of competency is made through MedHub assessments tools and surgical competency committee reviews.
   i. Competent skills in all emergency surgical techniques are expected to be achieved. In the operating room and in the class room the chief resident aids in instructing others on the proper techniques to handle such emergencies.
   ii. Facial Fracture treatment: Chief residents are expected to become competent diagnosticians, competent surgeons, and competent teachers.

c. Attendance at the conferences below also exposes the resident to growth opportunities to develop their skills in dealing with ORL emergencies.
   i. Attendance Tuesday at SPLIT ROCK SURGICAL for Plastic Surgery experience.

C. To develop competent surgical skills focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. These skills are measured by MedHub faculty assessments and surgical competency committee reviews.

   a. Cosmetic and reconstructive surgery
   b. Middle ear surgery
   c. Head and neck oncology
   d. Neck Dissections
   g. Endoscopic Surgery
   h. Maxillofacial Repair
   i. Salivary surgery
   j. Thyroid surgery

2. Outline of Resident Duties
   A. Inpatient Rounds: The VA resident is required to round on the inpatient service 5 days a week and when on call focusing on Patient Care competencies, taking care to assume a patient-based approach to this care. Medical knowledge and the ability to use interpersonal communication skills in teaching PGY1 and PGY2 residents is emphasized. These skills are measured by MedHub faculty assessments and surgical competency committee reviews.

   B. Staff Clinics: There are currently three clinics per week. Their skills are evaluated by MedHub assessments.
a. Mondays 8:30 AM – 2:30 PM (variable)
b. Wednesdays 1:00 PM – 4:00 PM
c. Thursday 8:30 AM – 4:00 PM

C. Surgeries: VA residents act as surgeon in most cases. Their skills are evaluated by MedHub assessments and "blue sheets"—a hard copy evaluation form supplied by our section. These supply direct feedback to be implemented in "real time" and in a case-based learning format. Additional feedback is provided by a surgical competency committee review.

D. VA residents perform consultations on either the inpatient or emergency services.

E. VA residents plan and schedule surgeries, monitor patient progress and provide adequate levels of follow up, advise Program Director on any improved programmatic changes. Systems-based practice and professionalism are emphasized through communications and consultations with other specialty services. Interpersonal communication skills are improved through patient-centered provision of care.

3. Progression of Resident Responsibilities
   The VA resident is directly supervised by the VA faculty. Determination of readiness for increased levels of responsibility are determined via multi-source & peer evaluations, MedHub assessments and surgical competency committee reviews.

4. Organization of Teaching Clinics and Services
   Clinics: Mondays 8:30 AM – 2:30 PM (variable)
   Wednesdays 1:30 PM – 4:00 PM
   Thursday 8:30 AM – 4:00 PM

   Services: Adult inpatient service (All VA faculty members)

   Call From home every fourth night, PGY 4 or 5 residents take second call for the PGY 2s and PGY 3s.

5. Required Conferences
   • Educational Conference at YNHH
     o Wednesdays 7-9:00 AM
   • Pathology Teaching Conference at YNHH
     o 4th Wednesday of each month 5-6 PM
   • Journal Club
     o 2nd Wednesday of each month 5:30-6:30 PM
   • Radiology Education Conference at YNHH
     o 2nd Wednesdays of each month 8-9 AM
   • Radiology Conference at YNHH
     o Wednesdays 4:30-5:30 PM
   • Morbidity and Mortality Conference at YNHH
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   • Grand Rounds Conference
     o 1st Friday of each month 7-8 AM
   • Resident Speaker Grand Rounds
     o 2nd Friday of each month 7-8 AM
swallowing, and hearing restoration whose mission is not only to provide the best medical care to patients with head and neck disease and disorders, but to train highly confident, responsible, and compassionate otolaryngologists. The Program offers an exceptionally strong training program, while encouraging independent thinking and scholarly investigation. Graduates from our Program can expect to pass the American Board of Otolaryngology qualifying examination so that they may pursue their goals in fellowships, scientific research, private and/or academic practice.

PROGRAM
Yale-New Haven Hospital, Yale-New Haven Children's Hospital and the new state-of-the-art Smilow Cancer Center are the primary teaching hospitals of the Yale University School of Medicine. Graduate training in Otolaryngology is a five-year program, approved by the American medical Association for certification by the American Board of Otolaryngology. Three candidates per year are accepted for training.

The Otolaryngology Sections see approximately fifteen-thousand outpatient per year. Of these, approximately two-thousand are emergencies. A full spectrum of surgical procedures are performed.

The work of the resident staff in the clinic and operating room is under the supervision of full-time chief of service and the attending staff. The house officers are given progressively more responsibility as his/her judgment and technical skills develop.

The Hearing and Balance Center and Speech & Swallow Centers of the Otolaryngology Section provide complete services for patients with hearing or speech problems. Audiologists work closely with the house officers during clinic sessions and are active in the training program. Specialized audiologic tests, including current neuro-otologic techniques, help localize the site of pathology in the auditory or vestibular pathways. An active Speech Pathology Program is conducted providing services for a wide range of speech and swallowing disorders.

In addition to opportunities for clinical research in the above areas, the house officers participate in laboratory research, either in the Laryngology or Otology laboratories. Dedicated research time is available during the fourth year of training.

CONFERENCES
Weekly conferences are held for the attending and house staff. Other conference alternate between case presentations, specific problems in Otolaryngology, and review of basic sciences.

Each Wednesday throughout the academic year, sessions in a portion of the Basic Science is held in the Otolaryngology Library. Part of the year is devoted to the dissection of the head and neck, other parts of the temporal bone surgery, to pathology, to Rhinology and audiology.

Medical students are in constant attendance during the academic year in the clinics, patient divisions and operating rooms. The house officers thus have the opportunity of benefiting from the didactic teaching by the faculty. This includes weekly neoplasm conference, research in progress seminar, morbidity and mortality conference, and conferences of special interest in the Department of Medicine and Pediatrics.

PRIMARY TEACHING SITES
**Yale-New Haven Medical Center & Smilow Cancer Center**
Yale-New Haven Medical Center is the primary teaching institution for the Otolaryngology Residency Program. Over 7,000 otolaryngology OR cases are generated annually. Smilow Cancer Hospital is only one of forty NCI designated cancer centers in the nation.
Otolaryngology Service provides a lead function in the Head and Neck Cancer disease management team.

**Saint Raphael Campus**
Residents will receive private practice experience and a variety of general otolaryngology cases. Approximately 3,000 cases are seen in the OR.

**Veterans Affairs Medical Center**
The VA rotation provides a clinical experience in faculty supervised clinics and operating rooms. The residents are exposed to varied otolaryngologic problems with an emphasis on head and neck surgery. Approximately 2,000 cases are seen in the OR.

**Retreat at Split Rock**
Residents on the VA rotation will also rotate through the Retreat at Split Rock where full complements of cosmetic and reconstructive surgical procedures are offered in a very private setting.

**Hill Health Clinic**
Hill Health Clinic is a federally qualified community health center established in 1968 in collaboration between the community and Yale Medical School. Residents participate in general ENT outpatient and allergy/immunology clinics.

**Bridgeport Hospital**
The Bridgeport Hospital is a large community hospital offering a wide range of common and complex surgical disorders. It also has the only burn center in the state. The PGY-1 residents receive experience of caring for critically ill burn patients in an intensive care setting.

**MORNING ROUNDS**
The goals of AM rounds are:

1. Patient Care
2. Education of trainees
3. Experience for visiting and Yale students

The rounds with residents will be at 6:30am on Mondays, Tuesdays and Thursdays. On Wednesdays and Fridays rounds will start at 6:15am unless modified due to no grand rounds, etc. If the service is large at the agreement of the chief resident and the chief of the section,
rounding could be moved to an earlier time. In addition, on weekends, the earliest that rounds can be performed with the residents is 6:30am.

Rounding as a group should serve the stated goals.

Regardless of these guidelines, faculty are welcome to round at any time and if residents are in the hospital and free, of course they are welcome to round with the attending, but this is not to be expected. If earlier or disparate times of rounding occur amongst different faculty, it should be anticipated that residents will not be accompanying the faculty members and that communications regarding patient care or other issues should be made directly with the chief resident.

OVERALL RESIDENT GOALS AND OBJECTIVES

YEAR 01:  Goals:  Proficiency in inpatient care and developing a foundational knowledge base.

            Objectives:  1) Home Study Course
                        2) In-training Examination (5th stanine or higher)

YEAR 02:  Goals:  Proficiency in outpatient evaluation and emergency room assessment.

            Objectives:  1) Operative  a) T&A, PET
b) Septoplasty  
c) Tracheotomy  
d) Laryngoscopy  
e) Bronchoscopy  
f) Esophagoscopy  
g) Maxillo-Mandibular Fixation

2) Research - mini NIH proposal (Due April 1)

3) Dissected Temporal Bone (Due June 1)

4) Home Study Course

5) In-training Examination (5th stanine or higher)

YEAR 03, 04 Goals: Increasing proficiency in more complex operative procedures and in developing more independent judgment of medical and surgical management.

Objectives: 1) Operative 
   a) Middle ear surgery  
   b) Pediatric otolaryngologic procedures  
   c) Functional neck dissection and radical neck dissection  
   d) FESS  
   e) Maxillofacial Repair (bone plating)  
   f) Cosmetic facial surgery (20/yr)  
   g) Salivary/thyroid surgery

2) Research - Completion of research project by end of year 02, presentation on Research Day (3rd week of June)

3) Dissected Temporal Bone (Due June 1)

4) Home Study Course

5) In-training Examination (5th stanine or higher)

YEAR 05 Goals: Demonstration of:
   a) Independent judgment and operative proficiency.  
   b) Active teaching of medical students and junior residents.  
   c) Administration of resident assignments and conference schedules.

Objectives: 1) Operative 
   a) Neuro-otologic procedures  
   b) Composite resections with reconstructions
c) Laryngeal resections with reconstructions

d) Cosmetic facial procedures (20/yr)

2) Dissected Temporal Bone (Due June 1)

3) Home Study Course

4) In-training Examination (5th stanine or higher)

SAINT RAPHAEL CAMPUS ROTATION SERVICE GUIDELINES

There will be three (3) residents rotating during any given rotation. The only time that the team should be down to two (2) residents (after September 1, 2011 when the night float rotation begins and no SRC residents will be "post-call") will be:

1. When one resident is on vacation, or
2. During the six (6) week time period that a resident will be away on research rotation (this year, January 1 to February 14, 2014)

The chief resident will serve as the leader for the team, and will have full knowledge of all in-house patients, all consults and all emergencies.

OPERATING ROOM

1. Review patient record before the case, be prepared to perform the operation, and arrive promptly for the case.
2. Blue cards will be completed by attending physicians at the request of the resident.
3. For clinic cases, if resident availability permits and if resident skill levels are appropriate, the chief resident will supervise and lead the junior residents through the care.

CLINIC

1. There should always be two (2) residents to staff every clinic and three (3) residents if possible. If extenuating circumstances exist, then (1) resident is acceptable.
2. Any surgical case seen on a given day will be supervised by the Clinic Attending assigned to that day.
3. If the attending wishes to ask for alternative attending coverage, the chief resident or the attending will make these arrangements.
4. The following clinic sessions will take place on a regular basis:

<table>
<thead>
<tr>
<th>DATE</th>
<th>ATTENDING</th>
<th>PRACTICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Tuesday</td>
<td>Dr. Vining</td>
<td>Rhinology</td>
</tr>
<tr>
<td>1st Thursday</td>
<td>Dr. Hirokawa</td>
<td>Head and Neck Cancer</td>
</tr>
<tr>
<td>3rd Thursday</td>
<td>Dr. Astrachan</td>
<td>General ENT</td>
</tr>
<tr>
<td>4th Thursday</td>
<td>Dr. Yanagisawa</td>
<td>General ENT</td>
</tr>
</tbody>
</table>

All other participating attending will rotate for clinic coverage according to the published schedule.

5. For any surgical cases which are performed, the Clinic Attending (or his/her covering group) will be responsible for the patient’s care for 30 days postoperatively.
IN-HOUSE PATIENTS
1. Rounding on all inpatients (on service and consults) will be done by the team every morning and late afternoon/evening, and all members of the team will be knowledgeable about all of the inpatients.
2. On Wednesday mornings, residents must round prior to the Yale Resident Lectures.
3. Sign out unstable patients to the SICU resident on Wednesdays or when/if residents are not available immediately in house.

IN-PATIENT CONSULTS
1. Consults must be seen on the same day as the consult is called in.
2. Junior resident will report finding to chief resident who will then contact covering attending.
3. URGENT or EMERGENT consults must be discussed with the ER attending on call on the same day as the consult.
4. NON-URGENT consults seen on Monday or Tuesday can be discussed with the Tuesday Clinic Attending, and those on Wednesday and Thursday may be discussed with the Thursday Clinic Attending. Every clinic attending agrees to see these consults and to sign off on each consult on the same day as they are seen and presented by the chief resident.

ON CALL COVERAGE
1. Beeper #2322 will remain the designated ENT beeper.
2. To avoid problems with reaching the resident staff when beeper #2322 is not answered/not working, the chief resident will ensure that ALL residents’ cell phone numbers will be provided to the PAGE OPERATOR, the secretary on 5 West, and the OPERATING ROOM – this will serve as the backup system for resident contact.

MEETINGS
1. American Academy of Otolaryngology / Triological Society – resident presenting papers or posters will plan to attend these meetings.
2. New England Otolaryngologic Society (3 meetings per year – typically spring, October and December) – junior residents should plan to attend these meetings. If possible, the chief resident should also try to attend.
3. CT ENT Society Meeting (2 meetings per year) – Junior and chief resident should make every effort to attend these meetings.

IN SERVICE EXAMINATION
1. During the In Service Examination (typically on a Saturday), the attending on call must be responsible for any hospital needs. The #2322 beeper has been held by the surgical in house resident in the past, to cover any routine calls. We will try to continue this in the future.

Ken Yanagisawa, MD, Chief of HSR Otolaryngology, July 2011

YALE HEALTH PLAN EMERGENCY COVERAGE

When patients from the Yale University Health Services (YUHS or “Yale Health Plan”) are referred to our offices during normal work hours, they will be assigned to the attending in the clinic that specific day. Should a patient from the Yale Health Plan come in after hours, that call should be directed to the on-call resident on Beeper 2322. He/she will evaluate that patient in...
the Emergency Room and discuss his management with either Dr. Bianchi, Dr. Judson, Dr. Manes, Dr. Michaelides, Dr. Sasaki, Dr. Yarbrough or Dr. Young before that patient is discharged from the Emergency Service. If a University attending is unavailable the attending assigned on-call for YNHH will be the backup provider.

Revised 9/2012

ACGME GENERAL COMPETENCIES

ACGME COMPETENCIES
The program must integrate the following ACGME competencies into the curriculum:

PATIENT CARE
Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents are expected to: [as further specified by the RC]

MEDICAL KNOWLEDGE
Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. [as further specified by the RC]

PRACTICE-BASED LEARNING & IMPROVEMENT
Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:

• identify strengths, deficiencies, and limits in one’s knowledge and expertise;
• set learning and improvement goals;
• identify and perform appropriate learning activities;
• systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
• incorporate formative evaluation feedback into daily practice;
• locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;
• use information technology to optimize learning; and,
• participate in the education of patients, families, students, residents and other health professionals. [as further specified by the RC]

INTERPERSONAL & COMMUNICATION SKILLS
Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:

• communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
• communicate effectively with physicians, other health professionals, and health related agencies;
• work effectively as a member or leader of a health care team or other professional group;
• act in a consultative role to other physicians and health professionals; and,
• maintain comprehensive, timely, and legible medical records, if applicable.
PROFESSIONALISM
Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:
- compassion, integrity, and respect for others;
- responsiveness to patient needs that supersedes self-interest;
- respect for patient privacy and autonomy;
- accountability to patients, society, and the profession; and,
- sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

SYSTEMS-BASED PRACTICE
Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:
- work effectively in various health care delivery settings and systems relevant to their clinical specialty;
- coordinate patient care within the health care system relevant to their clinical specialty;
- incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
- advocate for quality patient care and optimal patient care systems;
- work in interprofessional teams to enhance patient safety and improve patient care quality; and
- participate in identifying system errors and implementing potential systems solutions.

RESIDENTS’ SCHOLARLY ACTIVITIES
The curriculum must advance residents’ knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.
- Residents should participate in scholarly activity.
- The sponsoring institution and program should allocate adequate education resources to facilitate resident involvement in scholarly activities.

Common Program Requirements: General Competencies
Effective July 1, 2011
ACCOUNTABILITY

Accountability for one’s own actions is an ethical imperative particularly incumbent upon surgeons, who assume responsibility for the care and well being of patients who have serious and potentially life threatening illnesses and injuries. An important aspect of this professional responsibility is the need to assure that the patient is receiving the most informed, current and appropriate treatment. A surgeon must have appropriate confidence in his/her knowledge, skills and ability to provide such treatment. If there is uncertainty, the surgeon must seek consultation with others to assure that the patient receives optimal care. This stricture applies to the greenest intern and to the most seasoned attending. It is impossible to define specific and detailed instructions suitable for all occasions. Rather, it is the responsibility of individual surgeons continually to be aware of the limits of their ability and to use sound judgment as to when they must seek guidance or assistance form others. The following general guidelines are offered to help in the discharge of this responsibility.

RESIDENT RESPONSIBILITY TO REPORT TO A MORE SENIOR LEVEL

Surgical training in the United States is hierarchical and based on graded responsibility. With increasing experience, residents can and should assume more independence in the care of patients. However, they must remember at all times that the attending physician is responsible for the patient and must be kept informed. Generally this is done “through the ranks”, i.e., each resident reports to the next level resident until the chief resident reports to the attending surgeon. Some of these steps may be bypassed depending on the service and circumstances. The controlling principle must always be the welfare of the patient. The resident must always know to who they should report, whether during the day, at night, or on weekends. This is particularly important when cross covering other services.

In general, PGY 1 residents are expected to report almost all new information about patients to the next level resident promptly. This includes new physical findings or observations of patients, changes in vital signs, and abnormal laboratory or imaging results. The intern should be able to manage routine problems, which are not unexpected but must always have a low threshold for seeking advice.

The PGY 2 resident has greater knowledge and experience and is expected to assume more responsibility for evaluation new patients in consultation or in the ED and provide some level of supervision for the interns. However, the PGY 2 resident is not ready for significant independence and must report promptly to the next level when new patients are seen or when current patients have a change in status or fail to progress as expected. Historically, the PGY 2 year has been the most difficult for residents accurately to judge the limits of their capability. If there is even the slightest doubt, they must call for assistance.

The PGY 3, 4, and 5 residents, and surgical fellows, increase in knowledge, experience, and judgment at different rates, which makes it particularly important for them to make careful decisions about reporting patient information to the next senior level or to the attending surgeons.

RESPONSIBILITIES OF ATTENDING SURGEONS

Attending surgeons should provide guidance to residents at all levels about appropriate expectations for notification of events. It is critically important that senior residents, fellows and attendings never imply by word or behavior that a junior resident has called them
unnecessarily. One of the common reasons cited by residents for not calling to report changes in patient status is a fear of being labeled as inadequate or unwilling to make decisions. While this may have no basis in reality, it is essential for the attending surgeon to actively encourage residents to call and report. The attending surgeon must always make it clear to the care team who is covering if he/she will be unavailable.

**WHEN SHOULD THE ATTENDING SURGEON BE NOTIFIED OF CHANGES IN PATIENT STATUS?**

1. **Mandatory immediate notification**
   - Patient admitted to the surgeon’s service, unless it is clear they already know
   - Consideration of or actual transfer of a patient to an ICU
   - New neurological findings

2. **Notification in a timely fashion, at the discretion of the senior resident or by explicit preference of the attending surgeon** (i.e., events which must be reported directly to the attending surgeon, or to the senior resident or fellow, who then has some leeway in the timing of calling the attending surgeon.) These might include such things as hypotension, falls, new physical findings or unexpected laboratory results. Obviously this is not a comprehensive list. There will be many other events which should be reported “up the chain.” The need to report changes in patient status varies with circumstances – a trivial event in one patient may be a critical event in another. If there is ever any doubt, the attending should be notified promptly.

3. Finally, any resident, or any caregiver for that matter, should be able to call the attending surgeon if they have serious concerns about a patient’s welfare that cannot be addressed adequately or resolved by the next person up in the chain. This should not be necessary very often but must be part of our culture.

**DUTY HOURS**

YNHMC recognizes that providing residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents’ time and energies. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients. The following policy will define the parameters that are to be used in constructing and monitoring duty hours.

**POLICY**

1. Duty hours are defined as all clinical and academic activities related to the residency program, ie, 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 such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

2. Each program director is responsible for establishing a written policy that addresses duty hours policies within the Program. These policies of the training program must be consistent with ACGME requirements.

3. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.

4. Maximum Duty Period Length
• Duty periods of PGY-1 residents must not exceed 16 hours in duration.
• Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty. Strategic napping, especially after 16 hours of continuous duty between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.
  ○ Residents may be allowed to remain on-site in order to accomplish effective transitions in patient care and attend resident education. This must be no longer than 4 additional hours.
• In unusual circumstances, residents, on their own initiative may remain beyond their scheduled duty period to provide care to a single severely ill or unstable patient. The resident must hand over the care of all other patients to the team responsible for their continuing care and document the reasons for remaining to care for the patient in question and submit the documentation to the program director.
  ○ The program director must track individual resident and program-wide episodes of additional duty.

5. Residents must be scheduled for a minimum 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. At-home call cannot be assigned on these free days. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.

6. Adequate time for rest and personal activities must be provided. This should consist of a 10 hour time period provided between all daily duty periods and after in-house call and must have eight hours off. Residents must have 14 hours free of duty after 24 hours of in-house duty.

7. Residents must not be scheduled for more than six consecutive nights of night float.

8. Trainees, program directors and attendings must be informed of the duty hours policies and must complete an attestation statement to that effect on a yearly basis.

9. Failure of adherence to this policy by the program will result in citation by the GMEC and the need for an immediate development of a corrective action plan with monitoring by the OGME.

10. On-Call Activities: The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal work day when residents are required to be immediately available in the assigned institution.

   a. In-house call must occur no more frequently than every third night, averaged over a four-week period.
   b. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to four additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care as defined in Specialty and Subspecialty Program Requirements.
   c. No new patients, as defined in the ACGME Specialty and Subspecialty Program Requirements, may be accepted after 24 hours of continuous duty.
   d. At-home call (pager call) is defined as call taken from outside the assigned institution.

   1. 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.

2. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

3. The program director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

e. All moonlighting (within any of the major participating institutions) must be considered within the 80-hour work week. The resident must request permission from the program director to participate in any moonlighting activities.

11. Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.

12. The OGME will be responsible for instructing residents and faculty via various seminars in the recognition and awareness of fatigue and sleepiness, and the interventions possible when it is recognized.

13. Oversight:
   a. Each program is responsible for establishing monitoring procedures for compliance with the work hours policies. All residents will be expected to document their weekly duty hours and these will be monitored by the program as well as the OGME.
   b. The Office of Graduate Medical Education will conduct regular surveillance of adherence to the work hours policy through:
      1. Review of electronic recording of duty hours
      2. Resident meetings with DIO
      3. Resident surveys conducted by DIO
      4. Voicemail "hotline" for monitoring complaints and compliance issues
      5. Annual resident questionnaires
      6. Nursing surveys

14. Duty Hours Exception: Applications to the GMEC for exceptions up to 10% of the 80-hour limit for PGY-2 and higher levels of trainees may be submitted according to established policy of the GMEC.

Revision 5/20/2011

FIBEROPTIC RHINOLARYNGOSCOPY POLICY

PURPOSE
To provide a system to track the cleaning, processing, distribution and retrieval of ENT scopes.

LOCATION/CARE
The storage location of the scopes will be in YNHH West Pavilion basement, Central Sterile Department. The care, maintenance and servicing will be completed by Central Sterile processing personnel. The scope cleaning/sterilization time should be approximately one hour. The scopes will be issued in an approved clear-view container, with one blue towel and one portable light source. Any scope which malfunctions or requires maintenance service will be identified by CS and either replaced or serviced by the manufacturer with an appropriate loaner scope to keep stock levels appropriate.
**USERS**

Use of these scopes will be limited to otolaryngology staff, residents, and affiliated mid-level providers. Providers requesting use of the rhinolaryngoscope will be required to be registered with Central Sterile, and a bar scan code will be affixed to the back of their Hospital ID. The Central Sterile Department will need the user's cell phone number, pager, and Hospital ID. Scopes will not be issued without proper ID or to unregistered users.

**USAGE**

1. **a. Adult Sized Scopes**
   i. Routine scope use will require the user to report to Central Sterile WP Basement and the processing tech will sign-out a clean/tested scope, with light source. Both the scope and light source will be scanned out to the registered user. The day user on M-F may sign-out one scope at 7am. That day scope should be returned by 5pm to Central Sterile. If the scope is used during the day, and the user requires another scope, the tech can sign-out a clean/tested scope with light source as exchange. If the scope/light source is not returned by the required return time of 5pm M-F, the processing tech will page the user. If there is no call-back in a reasonable amount of time, the chief resident will then be called and be responsible for locating and returning the equipment.
   ii. On off shift hours which include M-F 5p-7am, or weekends, the scopes/light sources will be signed out on demand, and will be required to be returned within two hours after pick-up. Again, if not returned within the allotted time frame, the processor will page the user, and if no call back the chief resident will then be called.

2. **b. Pediatric Size Scopes**
   i. Pediatric scopes can be signed out 2 at a time for clinic use only, the sign-out time is anytime after 7am, and returned by 5pm by an authorized user with an affixed bar code on their Hospital ID. Otherwise, the pediatric scope can be requested for inpatient use, but should be returned within 2 hours to central sterile.
   ii. If the pediatric scope for inpatient use is not returned within the 2 hour time frame, the user will be paged and if no call back the chief resident will be paged.

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**GME HOTLINE**

The GME Hotline is a way to report residency program violations, non-compliance with ACGME regulations, work related concerns, duty hours or other issues that need to be addressed.

The GME Hotline

688-2277

This phone is on voicemail; the GME secretary transcribes messages before giving the message to Dr. Fisher to preserve caller's anonymity.

Duty Hour rules reminder:

- 80-hour week limit, averaged over 4 weeks.
- 24 hour limit of continuous duty with up to 4 hours added for continuity of care and education
- Interns up to 16 hours per shift.
- One day in seven free from patient care and educational obligations, averaged over 4 weeks.
- In-house call no more than once every 3 nights, averaged over 4 weeks.
Adequate rest period (10 hours of rest) between duty periods.

### HOME STUDY COURSE & IN-TRAINING EXAMINATION

YNHH will pay the annual fee for the home study course for each resident, but it is the responsibility of the resident to renew their own membership annually with the American Academy of Otolaryngology. Membership dues are refundable through the resident funds provided annually. Results of the Home Study Course Examination will be sent to the Program Director from the AAO serves to verify each resident's participation. If a resident does not promptly complete each home study assignment, the next year’s annual fee may be withheld.

All residents are expected to take the in-training exam annually. NO EXCEPTIONS. Annual dates can be found at ENTNET.ORG. A minimal percentile is required. If the percentile is not achieved a resident will be placed on academic remediation until the following in-service examination. Further disciplinary action could result from continued below standard performance.

### MAX-FACIAL PANEL

#### PROCEDURE
A “Maxillo-facial Panel” on-call list will be posted in the Emergency Service. Either the ENT or Plastic Surgical Service will be “on-call” on a weekly, alternating basis. The appropriate service will be called for all cases in which fractures are suspected and become responsible for further management: examining the patient, ordering any further studies that may be indicated, and making a disposition. There will be an attending surgeon available from either Plastic Surgery or ENT on a weekly alternating basis. It will be the responsibility of the resident to:

1. Notify the attending
2. Obtain indicated consultations

#### CONSULTATIONS
Consultations will be required in the following circumstances:
1. Ophthalmology will be consulted whenever it is indicated.
2. OMF for fractures involving occlusion.

#### DISTRIBUTION OF CASES
All cases will be admitted to the service of, and under the name of, the attending surgeon who is on call and who will become the responsible surgeon. The ES resident may not circumvent the primary panel attending by calling Oral Surgery directly. The panel attending and team will clear all patients first.

If a specific surgeon has been requested by the patient, referring physician, employer, etc. it will, of course, be the responsibility of the resident-on-call to personally notify the surgeon and, if possible, to assist him in the care of the patient.

#### ORAL MAXILLO-FACIAL SURGERY
Alternating with ENT and Plastic, OMF will be primary attending when they are primary call. ENT residents should attend cases that come in on weeks where ENT is on secondary call and OMF is primary.
MOONLIGHTING

YNHMC and its clinical training programs recognize that because residency/fellowship education is a full-time endeavor, the institution and the program director must ensure that moonlighting does not interfere with the ability of the resident/fellow to achieve the goals and objectives of the educational program. Professional and patient care activities that are external to the educational program are called moonlighting. Moonlighting activities, whether internal or external, may be inconsistent with sufficient time for rest and restoration to promote the residents' educational experience and safe patient care. In addition, YNHMC abides by the ACGME institutional requirements which set policies for moonlighting. The following policy will define the parameters that are to be used in monitoring and approving moonlighting activities.

SECTION OF OTOLARYNGOLOGY POLICY

1. Residents are NOT permitted to engage in moonlighting.
2. Non-compliance with this policy may result in adverse actions, including probation and dismissal from the program.
3. A signed statement attesting to this fact will be signed by the trainee and the Program Director and maintained in the resident's/fellow's file.

Moonlighting of professional services outside the Yale-New Haven Medical Center is NOT permitted. These activities are not covered by the Medical Center’s liability insurance. That is to say, care by house staff outside the scope of this training program leaves a resident unprotected by professional liability insurance. Furthermore, treatment of a friend or professional colleague without registering same as a patient in the hospital or clinic incurs unnecessary risks. By the same token, attempting to treat any patient for a condition outside the resident's specialty is again fraught with unnecessary risk by exposing him to a standard of the second specialty in which competence has not been achieved.

MORBIDITY & MORTALITY CONFERENCE

Otolaryngology Morbidity & Mortality (M&M) Conference is a required monthly conference for active otolaryngology physician staff and otolaryngology residents of Yale-New Haven Hospital. The purposes of this peer-review conference is to:

1. Identify and analyze complications, unexpected outcomes, and deaths of otolaryngology patients treated at YNHH
2. Modify behavior and judgment based on experiences and evidence in order to prevent repetition of errors
3. Identify quality-improvement measures to improve patient safety and outcomes. In addition, M&M is a valuable educational and teaching opportunity for resident and attending physicians.

CASE SUBMISSION

Any and all patients who have had morbidity or mortality related to their care at YNHH should be brought to the attention of the chief of service, or an appointed M&M designee. Attending physicians, resident physicians, and physician assistants may submit patients for consideration of presentation at the M&M conference.

CASE SELECTION
The Chief of Service and/or designee will review the submitted patients and determine which cases are to be fully presented at the conference, based on time available, nature of the M&M, opportunity for quality improvement or education, and/or similarity to recently presented cases.

**CASE PRESENTATION**

The attending physician who treated the patient has ultimate responsibility for the accurate and complete presentation of the salient facts of the case. If a resident physician has had significant participation in the patient's care they will be requested to present the case, however, the attending physician must be present. Before presentation at the M&M conference, the resident who will be presenting the case should review the presentation materials with the treating attending physician. This is to ensure that all appropriate case details, some of which are recorded in disparate locations (such as outpatient correspondence and tests), and which may not be easily available to the resident, are included in the presentation.

**PRESENTATION FORMAT**

Cases will be presented using a projected PowerPoint slide format. Patient data should be de-identified to the extent possible. The case should be presented in a concise yet comprehensive fashion including the relevant clinical history, physical examination, and treatment course. Appropriate radiographic images and other studies should be included in the presentation to allow for their review.

**ANALYSIS**

The purpose of the M&M conference is to learn from the events leading to the morbidity or mortality. To this end, a systems error analysis, including the six ACGME General Competencies of patient care, practice-based learning and improvement, communications skills, professionalism, medical knowledge, and systems-based practice will be included at the end of the discussion with identification of where errors in the case occurred. Relevant information from the literature should be referenced and incorporated into the discussion.

### NEOS RESIDENT PRESENTATION GUIDELINES

NEOS resident presentations should be in a case presentation format. They should be approximately twelve minutes long to allow for questions in the allotted fifteen minute time slot.

Each presentation should include a patient case and a brief review of the relevant literature and treatment options. The topic should be germane to the topic of the NEOS meeting if possible.

It is not appropriate to present a case series, original research or a lecture on a topic as the main thrust of the talk.

The visiting lecturer will pick a first, second and third place presentation. Currently, there is a cash prize for first place, second place, and third place.

The criteria that the visiting lecturer should use to judge presentations include adherence to the above format, the quality of the presentation, and the learning opportunity from the case, its management, and a concise review of the literature regarding the problem.

### RESIDENT RESEARCH
Residents are expected to complete manuscripts for at least one Basic Science research project and at least one Clinical research project during their residency.

Six weeks of dedicated research is made available to each resident at the fourth year level (PGY4). However, research within the department is considered to be a privilege made possible by a highly focused and dedicated effort. Second-year residents (PGY2) are to provide to Dr. Michaelides, Dr. Sasaki and the Section Research Committee a paragraph of intent that succinctly describes the research proposal to be pursued with the identified mentor. This is due by January 15 of the PGY2 year. Once notification is received from the committee that the proposal is accepted, an abbreviated NIH-style research proposal is to be submitted to Dr. Michaelides, Dr. Clarence Sasaki and the Section Research Committee by April 1 of the PGY2 year. This should be a hypothesis-driven proposal written with the aid of the mentor.

The application should consist of:

- Page 1, Front page with title and named mentor
- Page 2, Curriculum vitae of the applicant
- Page 3-5:
  - a) double-spaced one paragraph Abstract
  - b) two paragraphs of Significance and Background
  - c) one paragraph Specific Aims
  - d) one page Methods
  - e) two paragraphs Analysis of Data
- Page 6: Budget

**DETAILED GUIDE**

Abstract should contain all the elements of the application in a few concise sentences. A section for Conclusions and Expected Findings should be based on the research hypothesis. Significance and Background should include well-researched and salient background literature as well as a framing statement for the significance of the research question; in other words, what gaps in our current knowledge will be filled by the data from this project? Specific Aims are concise goals to be answered by the planned experiments; there should be no more than two or three Specific Aims. Methods should be as detailed as possible and include the reagents to be used and detailed experimental design. Analysis of Data should include specifics about the statistical analysis and other analysis procedures that are to be used. This section is critical to the success of a submission for grant funding. Budget should include reasonable estimates and provide justification for how the applicant arrived at the number per item. Be sure to include cage and upkeep costs if animal experiments are planned.

Your mini-application should be submitted *in triplicate* for review by Dr. Clarence Sasaki, Dr. Michaelides and the Section Research Committee after which you will be expected to revise your protocol accordingly and present your research proposal to the Visiting Research Professor in June on Research Day.

Residents are encouraged to submit this application to the AAO-HNS Foundation for research funding. The Letter of Intent (LOI) for this application is due in December of the PGY 3 year. The AAO-HNS website is [www.entnet.org](http://www.entnet.org) where instructions can be found for submission.
From time to time it is necessary to review the lines of supervision for patient care by the resident staff. Although these have not changed much over the past years, please review them and keep them in mind when managing or supervision the management of patients.

Management of patients by residents is a cooperative partnership between the trainees and their supervisors. Each patient will have an assigned attending physician and will be assigned to a specific resident team for care. The diagnostic and therapeutic plan must be discussed with the supervisor and the supervisor must play a direct role in the critical portion of diagnosis and care. The responsible physician, generally the supervising attending, must be aware of any significant interventions or changes in condition, such as surgery or ICU admission, and agree with any patient discharge and follow up arrangements.

During the course of normal patient care, circumstances may arise in which the hierarchy of consultation and care must be employed.

1. Development of complications not anticipated in the diagnostic or therapeutic course.
2. A degree of difficulty in the clinical problem not anticipated.
3. Specific patient requests for a more experienced physician.
4. Any feeling of discomfort on the resident’s part regarding any aspect of the diagnostic and therapeutic regimen.

Under the circumstances, it is appropriate to move up the hierarchical line of the residency, for example, from junior to senior resident. While it may not be necessary to consult the supervisor when seeking the advice of a more senior resident, it is expected that the supervisor will be notified of any major changes in the diagnostic or therapeutic plan before they are carried out.

If at any time the resident feels that his/her concerns are not being promptly and properly addressed, he/she is responsible for bringing this matter to the attention of the Hospital GME Residency Coordinator or the Program Director. These concerns will be treated confidentially.

**TEMPORAL BONES EXIT**

Dissected temporal bones are expected by Dr. Elias Michaelides by Tuesday prior to June M&Ms. Plan and prepare a temporal bone specimen for the demonstration of a particular surgical procedure or demonstrates a particular anatomic structures or relationships.

- Specimens should have soft tissue removed unless part of the anatomic demonstration.
- Specimens should include a written description of the dissection. Markings may be made on the specimen if needed

An annual prize will be awarded to the resident submitting the “best” exit bone.

*Submissions of a dissected T-bone is an absolute requirement toward completion of the academic year without which promotion may be withheld.*
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YALE OTOLARYNGOLOGY RESIDENT HANDBOOK

54 | Page
YNHH ENT MAX-FACE PANEL  
July 1, 2013 – July 6, 2014

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*On these days, OMFS will be primary for all fractures involving dental occlusion.*
PATHOLOGY TEACHING CONFERENCE 2013-2014

Starting in September, there will be a pathology teaching conference on the 4th Wednesday of each month. These will be held from 5pm – 6pm in the EP2 646 conference room where a multi-headed microscope is available. The format of the conference is that the Chief Resident at Yale will identify interesting cases to review and communicate these to the Head & Neck Pathology Fellow at least 1 week prior to the conference. An otolaryngology resident familiar with the case will present the clinical history and pull up any pertinent radiology images to provide context during the conference.

Here are the dates:

<table>
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<tr>
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<td>28</td>
</tr>
<tr>
<td>Jun</td>
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**(substitute day because of Thanksgiving and Christmas conflicts)**

Residents are required to attend. Faculty are welcome to attend.
## PHYSICIAN’S WEEKLY SCHEDULE

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<tr>
<th></th>
<th>MONDAY</th>
<th>TUESDAY</th>
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<td>AM – Stratford</td>
<td>AM – Stratford</td>
<td>AM – OR</td>
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<td>Stan Friedman, MD</td>
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<tr>
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<td>AM – Smilow Clinic</td>
<td>AM – VA OR</td>
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<td>PM – OR Overflow</td>
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<td>PM - OR</td>
<td>PM – VA Medical Ctr.</td>
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<tr>
<td>Clarence Sasaki, MD</td>
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Revised 14-SEP-2012

## FACULTY BACK UP CONSULT COVERAGE

The following faculty will act as back-up consult coverage on their respective days.
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<tr>
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<tr>
<td>Wednesday</td>
<td>Nwanmegha Young, MD</td>
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<tr>
<td>Thursday</td>
<td>Mark Bianchi, MD</td>
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<tr>
<td>Friday</td>
<td>Benjamin Judson, MD</td>
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Weekends: On-call
### OTOLARYNGOLOGY CURRICULUM 2013-2014

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<td>Dr. Lerner</td>
<td>Dr. Judson</td>
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<td>Dr. Astrachan</td>
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<td>Residency Meeting 30 / Neuro-Otology</td>
<td>7 - 9 AM</td>
<td>Dr. Schutt</td>
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<td>March 12, 2014</td>
<td>Neuro-Otology</td>
<td>7 - 9 AM</td>
<td>Dr. Schutt</td>
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<td>March 19, 2014</td>
<td>Anatomy</td>
<td>7 - 11 AM</td>
<td>Dr. Aaronsen</td>
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<td>March 26, 2014</td>
<td>Anatomy</td>
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<td>April 2, 2014</td>
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<td>April 9, 2014</td>
<td>Bio-statistics</td>
<td>7 - 9 AM</td>
<td>Dr. Schutt</td>
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<td>April 16, 2014</td>
<td>Temporal Bone Lab</td>
<td>7 - 11 AM</td>
<td>Dr. Adam / Yan</td>
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<td>April 23, 2014</td>
<td>Residency Meeting 30 min / Competencies</td>
<td>7 - 9 AM</td>
<td>Dr. Blumberg</td>
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<td>April 30, 2014</td>
<td>Trauma Conference (ENT) / Rhinology &amp; Allergy</td>
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<td>May 14, 2014</td>
<td>Rhinology &amp; Allergy Dissection Course</td>
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<td>Dr. Srinet</td>
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<td>Year End Resident Review</td>
<td>7 - 9 AM</td>
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<td>Dr. Michaelides</td>
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**RESIDENT ROTATION (PGY 2-5)**

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SA – Stewart Adam, MD – Chief Resident  
WY – Wayne Yan, MD – Chief Resident  
DF – David Folk, MD – PGY 2  
KB – Kenneth Bagwell, MD – PGY 2
## WEEKLY CONFERENCES

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<tr>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
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<tr>
<td>Head &amp; Neck Conf.</td>
<td>Skull Base Conference</td>
<td>Resident Didactic</td>
<td>Grand Rounds</td>
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<td>4:00 PM, Smilow, 4-215B</td>
<td>2nd Tues of Month</td>
<td>Lectures</td>
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<td>Tumor Board Room</td>
<td>5:15 – 6:15 PM, YPB 419</td>
<td>7:00-9:00 AM, YPB 419</td>
<td>7:00- 8:00 AM, HOPE 216</td>
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<td>(4th Wed. of Month)</td>
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<td>5:00-6:00 PM, EP2 646</td>
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<td>Radiology Education</td>
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<td>Journal Club</td>
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<td>5:30 – 6:30 PM, YPB 419</td>
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Residents will be reimbursed for actual, reasonable and authorized expenses incurred while traveling or conducting business on behalf of the Hospital. The Housestaff Office will notify residents of the total yearly amount to be allocated to expense reimbursement. Items not specifically covered by this policy should be reviewed with the Rosemarie Fisher, M.D., Director, GME, and/or the Internal Audit department. The Director of Medical Education holds final approval on all submitted requests. **Mandatory Training requirements must be completed before submitting an educational reimbursement request.**

**PROCEDURES**

A. Process:

1. Housestaff must submit all travel related expenses on Form F-617 (Travel & Business Expense Report - Attached) or other suitable format providing the same information. If the employee’s expenses are paid in advance by the hospital, such expenses must be listed and deducted as prepaid on the report. The expense report, along with all the attachments, should be sent to the Housestaff Office for review and signature by the Administrative Coordinator.

2. The Housestaff Office Administrative Coordinator is responsible for reviewing the expense reports and clarifying expenses when required.

3. Incomplete or inaccurate forms will be returned to the resident with a brief message regarding why the form was returned. A corrected form should be resubmitted to the Housestaff Office.

4. Copies of Travel Expense Reports and receipts must be maintained by the resident physician in case they are lost in the mail. No reimbursement will be approved without copies of receipts.

5. The Internal Audit department is responsible for reviewing the expense reports and for clarifying items when necessary.

6. The Accounting department is responsible for reimbursement in accordance with this policy.

7. When the traveler’s expenses are less than the amount of a travel advance, a check payable to YNHH must be attached to the report when submitted.

8. Amounts remaining in the account at the end of the fiscal year (9/30) will not be carried over.

B. Pre-approval of Travel Forms

1. When airline/rail travel and/or hotel expenses are to be prepaid by the Hospital, the resident must use Pre-approval of Travel Forms 3243 and 3244.

2. The forms must be submitted to the Housestaff Office for signature of the Administrative Coordinator.

C. Allowable Travel Expenses

1. Transportation
a. Taxis or airport limousines (employees are encouraged to use the most cost effective form of transportation).

b. Auto rentals, including fee, fuel, parking and tolls. Car rentals must be pre-approved by the Housestaff Office and should be less expensive than the available public transportation or be used in the absence of other transportation.

c. IRS mileage rate (Effective 1/1/13; 56.5 cents per mile), parking and tolls for use of personal automobile. The number of miles is calculated as follows: For trips originating from the Hospital, use the actual round trip mileage between Hospital and destination. For trips originating from home: round trip mileage between home and destination less round trip mileage between home and New Haven.

d. Airport parking.

e. Coach fare on airlines and railroads (booking fares through Medical Center Travel is encouraged and can be charged directly to the department’s YNHH cost center).

2. Lodging
   a. Basic, single occupancy room rates.
   b. Extra nights spent for lodging required to obtain reduced airfare will be reimbursed IF employee provides proof from the travel agent that the extra expense of lodging and meals is less than the savings obtained on the airfare.

3. Meals
   Reasonable, actual costs will be reimbursed for meals while traveling on Hospital business. If a meal charge includes others, receipt must state names and business affiliation of individuals involved.

4. Miscellaneous
   Reasonable expenses for gratuities, telephone calls for business (includes one call per day to home), books for seminars. Unusual expenses must be approved in advance by the Housestaff Office Administrative Coordinator.

D. Allowable Business Expenses
   “Business expense” is any reimbursable expenditure for a hospital activity involving employee participation. This includes all employee business meals when NOT out-of-town and when the expense has been incurred by the employee seeking reimbursement. Reasonable expenditures for entertaining persons outside the Hospital who have an influence on Hospital business activities are reimbursable as follows:

   1. If the business expense directly proceeds, follows, or is concurrent with a substantial and bonafide business discussion, including meetings at a convention.
   2. The business expense must not conflict with the Hospital’s standards of conduct (see Administrative Policy NC: B-3 Business Conduct Policy).

E. Allowable Educational Expenses
   1. Travel expense to and from affiliated hospital rotations (refer to C., e.). Mileage must be verified with copy of block schedule. Form F-617A (Mileage Detail form) must be completed and attached to the Travel Expense form.
   2. Costs related to scientific meeting/courses/international health rotations (costs funded by an outside agency or required by department are not reimbursable).
   3. Medical journal subscriptions (including online subscriptions).
   4. Scientific/Professional Association dues.
   5. Scientific books (paper or electronic), receipt must state they are “trade books” or have title of book.
   6. Computer software related to basic computing for research activity for laptops, desktops or PDAs.
   7. Productions of meeting presentations, including poster presentation.
   8. Surgical loupes.
   9. Licensing fees.
   10. Examination fees (USMLE, Boards).
   11. Stethoscopes, tuning forks, otoscopes, ophthalmoscopes.
F. Expenses Disallowed
1. Unsupported, unapproved, unexplained expenses.
2. Travel expenses for spouse or family member.
3. Travel expenses for fellowship/job interviews.
4. Movies, fitness room fees, travel club dues, dry cleaning, medical, dental or pharmaceutical expenses, any other personal items.
5. Cost of regular commuting between the employee’s residence and normal work location.
6. Computer hardware.
7. Costs funded by an outside agency.

G. Documentation Required for Expenses
1. Seminar registration information detailing dates MUST be attached to the report even if fees were prepaid by the Hospital. This information substantiates the business reason for travel and the dates for expenses the Hospital is to reimburse.
2. ORIGINAL receipts are required for the following expenses:
   a. Individual expenses greater than $25.00.
   b. Airline/rail ticket receipts must be attached to the report even if paid directly by the Hospital (in which case it should be deducted as a prepaid expense).
   c. Lodging-Itemized hotel bill and credit card receipt if employee paid. If Hospital paid, itemized hotel bill is still required and expense must be listed on the report and deducted as prepaid.
   d. Meals.
   e. Rental Car-Bill and credit card receipt. (The Hospital does not carry insurance for auto damage or theft. Employees should determine if their own auto insurance and personal credit card policies cover them if they plan to rent a car. If not, insurance must be purchased at the time of rental).
   f. Seminar Registration – If paid by employee, credit card receipt, both sides of canceled check, or receipt issued by conference personnel. (Registration form stating the dollar amount required is not proof that employee paid.) If Hospital paid, expense must be deducted as prepaid.

H. Use of Personal Automobile
It is required that employees who use their personal automobiles on Hospital business maintain adequate automobile insurance. The rate per mile paid by the Hospital is intended to include a portion of the expense of such insurance. The Hospital does not maintain insurance for the protection of employees while using their own automobiles nor does it assume responsibility for any costs for which an employee may be liable as a result of the operation of the personal automobile.

I. Travel Expenses
1. The Hospital will issue advances up to $500.00 to employees to assist them in meeting cash expenditure needs while on authorized Hospital business.
2. All requests for advances must be submitted to the Accounting department on Form F-238, (Check Request). A travel advance will not be issued to any employee who has an outstanding travel advance from a previous trip.

J. Foreign Travel
When travel is outside the United States, all expenses on the report must be converted to US dollars using the foreign exchange rate at the time when the currency was actually exchanged. Documents (such as a credit card bill or the receipt from the exchange) supporting the exchange rate must be attached to the report. In the absence of such support, Internal Audit will use the rate published in the Wall Street Journal. Any employees serving as board members on associations related to hospital business may have their travel expenses paid by the association. **Travel expenses may be paid by a vendor only when employees need training by the vendor for existing systems or equipment and this is stated in the purchase contract.**
NOTE: Before allowing an outside entity to pay for travel, it is very important that the Hospital’s Conflict of Interest Policy (NC:B-3) not be violated. Any question as to the appropriateness of the travel with regard to this policy should be discussed with the department head, administrator and/or the Internal Audit Department.

10/3/2011

PROGRAM REIMBURSEMENT

All requests for reimbursement by the Program must be preapproved by the Program Director and requests submitted to the Program Coordinator.

1. Residents must have written approval from the Program Director that his/her reimbursement (before traveling) will be accepted. Complete the Department of Surgery, Section of Otolaryngology Expense Approval Cover Page before you travel or purchase merchandise/equipment. Make sure to provide reason for travel/purchase, location, date and an estimate of cost.

2. Housestaff must submit all travel related expenses on Form F-617 (Travel & Business Expense Report) or other suitable format providing the same information. If the resident's expenses are paid/partially paid by another organization, such expenses must be listed and deducted as prepaid on the report.

3. The expense report, along with all the attachments (original receipts), should be given to the Program Coordinator for review and signed by the Program Director, if necessary.

4. All of the above listed Allowable Travel Expenses, Lodging, Meals, Miscellaneous, Allowable Education Expenses, Allowable Business Expenses and Expenses not Allowed applies.

ON-CALL MEAL REIMBURSEMENT

It is the policy of Yale-New Haven Hospital to provide House Staff discount swipe cards for meals while on-call within the Institution. This policy applies to all House Staff in specialty residency training programs at Yale-New Haven Hospital. House Staff must remain on hospital premises while on-call consecutively for an 18-hour period.

I. ADMINISTRATIVE GUIDELINES

A. Each resident's employee I.D. badge serves as his or her meal card.

B. Cards can be used to purchase meals in any of the cafeterias.

C. House Staff are provided $6.50 each for each night required to stay in the hospital.

D. Cards are not transferable.
E. House Staff will not be reimbursed for any charges incurred on lost cards up until the time it is reported to the House Staff Office. Once your account is on 'hold' status, a message on the cash register will notify the cashier to alert a manager. **Trying to use another person's cash card for the purpose of making cafeteria purchases is a serious violation of the Basic Code of Employee Conduct.**

F. For protection, transactions are limited to $13.00 a day.

II. ROTATING RESIDENTS
   A. Visiting residents who serve on-call 18 hours consecutively will be provided one $6.50 pre-paid meal card per night oncall.
   B. Visiting residents can obtain meal cards directly from the House Staff Office with prior approval of the Y-NHH training program office.

III. SUB-INTERNS
   A. Sub-interns who serve on-call 18 hours consecutively will be provided with one $6.50 pre-paid meal card per night oncall.
   B. Departments will be responsible for obtaining meal cards from the House Staff Office for distribution to sub-interns.

IV. ADMINISTRATIVE PROCEDURE
   A. Program will be administered by the House Staff Office and Food & Nutritional Services.
   B. The Chief Resident of each department will be responsible for supplying the House Staff Office with an on-call schedule listing the affected House Staff and number of in-house call each is taking yearly.
   C. Based on the Chief Residents’ on-call schedule, Food & Nutritional Services will enter amounts into each resident’s account using the resident’s name and social security number.
   D. Money will not be placed in residents’ accounts without an on-call schedule from the Chief Resident.
   E. Each month the Food & Nutritional Services will provide the House Staff Office with a printout.
   F. The money will be charged to each department’s Yale-New Haven Hospital cocenter.

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**RESIDENT TRAVEL SUPPORT**

Any resident who orally presents a manuscript at a scientific meeting is eligible for support of travel expenses. In order for residents to qualify for support if a poster is being presented, he/she must be first author on the poster presentation. You must notify the Program Director as soon as **your abstract is accepted** in order to qualify for funding.

Chief Resident travel to either COSM or AAO-HNS will be supported provided an abstract is submitted by the resident to either scientific program. Acceptance of the submitted abstract is not a criteria for payment of the trip.

All residents are given the opportunity and are encouraged to attend the twice yearly Connecticut State ENT meeting and the three yearly New England Otolarynogological Society meeting.
If expecting a travel reimbursement by the Program, please refer to the guidelines listed under Continuing Education Fund & Reimbursements, Program Reimbursement.
YNHH POLICIES & PROCEDURES

The Graduate Medical Education Training Programs of the Yale-New Haven Medical Center are committed to the highest standards of professionalism and professional image to all persons, agencies and associations. This foremost includes our patients, their families and other visitors. We believe that professionalism and the image we present inspires confidence in the care and services we provide as professionals and as an institution.

We expect that trainees must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles, including:

1. compassion, integrity, and respect for others;
2. responsiveness to patient needs that supersedes self-interest;
3. respect for patient privacy and autonomy;
4. accountability to patients, society and the profession; and,
5. sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation;
6. a safe, comfortable and healthy work environment;
7. presenting a professional and identifiable appearance to patients, their families and visitors, YNHH staff, and the medical and business communities;
8. supporting a culture of confidence and service excellence while at the same time, accommodating sincerely held religious and cultural beliefs when operationally feasible.

In order to promote the professional image, the following standards of appearance are put into place. This policy applies to all residents/fellows at Yale-New Haven Medical Center. Individual Program Directors have the discretion to define appropriate attire for the work environment and the nature of the work performed within the scope of this policy.

POLICY

1. General Appearance
   In all circumstances, professionalism and appropriateness are the guiding standards. Extremes of fashion in clothing, hair styles and accessories must be avoided, as well as any clothing or adornment that detracts from the trainees’ roles and responsibilities.

2. Identification
   a. All residents/fellows must wear their identification badges with the photo plainly visible above the waist when in patient care areas.
   b. A lab coat with name will not replace the use of a name badge
   c. Name badges should be clipped on and lanyards should not be used in areas and roles that necessitate patient contact
   d. Personal statements expressed by symbols, messages or insignia must be appropriate and consistent with our mission and patient satisfaction goals. This includes personal statements reflected on clothing, accessories, pins, buttons, stickers, fabric patterns and non-YNHH/YSM logo wear.

3. Grooming and Hygiene
   a. All residents/fellows will maintain reasonable personal hygiene and grooming standards essential to a professional image.
   b. Scents of any kind (perfumes, lotions, hair products, etc) must be used sparingly and are not permitted where there is sensitivity to fragrances.
c. Cosmetics should be used in moderation.
d. Hair must be clean and neat and worn off the face when working with patients or as required for safety and sanitation.
e. Facial hair and fingernails must be clean and trimmed according to applicable health standards and Hospital policies. For additional information, please refer to the Fingernails, Natural and Artificial C: F-1 in the Administrative Policies and Procedures Manual.

4. Jewelry and Accessories
a. Jewelry must be discreet and appropriate, and not cause a safety or infection control hazard. Earrings must be small and unobtrusive, and not detract from the professional image or represent a safety risk.
b. Visible body piercings (other than earrings) are prohibited.
c. Tongue piercings can impact communications and are therefore prohibited.
d. Tattoos and body art that are considered offensive, sexually explicit, racist or threatening must be covered.
e. Authorized head coverings, i.e. surgical caps, may be worn correctly and as appropriate to the task and work environment.

5. Professional Dress:
a. When residents are not required to wear scrubs, their dress must be professional.
   i. For men this includes: collared shirts (dress shirts, button downs), turtlenecks or sweaters (including cardigans), tailored trousers (dress slacks, khakis, corduroys) and loafers or laceup shoes with socks. Blazers and sports jackets are optional.
   ii. For women this includes: shirts (collared) or blouses with sleeves, turtlenecks, sweaters and sweater sets, skirts or tailored pants, and flats, pumps or boots.
   iii. It is understood that when residents/fellows are asked to return to the hospital at night, in an emergency, the above requirements may be relaxed as arriving for patient care is the first priority.
b. Inappropriate attire includes: denim, shorts, tee shirts (sleeveless shirts, tank tops, halter tops, crop tops), sandals (beach sandals, Birkenstocks, flip flops), athletic wear of any kind (sweatshirts, rugby shirts, sweatpants, leggings, stirrup pants, jogging suits, spandex, lycra, caps), torn clothing (clothing with holes or frayed ends), and provocative or revealing clothing.
c. Clothing when on night call may include heavier upper garments, including fleece jackets/vest/sweatshirts, if clean, neat and in good repair without hoods.
d. Clothing must be clean, neat and in a good state of repair.
e. Clothing must cover the shoulders and midriff.
f. Undergarments:
   i. Undergarments must be worn under clothes and must not be distinguishable through attire.
g. Ties:
   i. Neck ties may be worn. In roles that require direct patient contact neck ties must be clipped or worn with a buttoned white lab coat or suit coat, so as to prevent transmission of infection.

h. Lab Coats:
   i. A clean, neatly pressed, white lab coat should be worn.
i. Footwear/Shoes:
   i. Shoes worn by direct patient care residents must be clean, well kept and should have an enclosed toe.
   ii. Athletic or walking shoes (sneakers) may be worn, but must be plain and clean.

6. Scrubs
a. Direct patient care employees will wear scrubs as designated by their role and their department.
b. Scrubs must be neat, wrinkle free and clean.
c. Soiled scrubs need to be changed immediately.
d. Scrubs should not be worn outside of the workplace, with the exception of transport to and from the hospital.
e. Midriff must be covered.
f. Clean, neat T shirts without logos or turtle necks can be worn under scrub tops but not in the place of scrub tops.

ACCOUNTABILITY
Every resident/fellow has the responsibility of being fit for duty within the core competency of professionalism. As such, it is expected that each resident/fellow will hold one another accountable. Residents/fellows who report for duty in unacceptable attire, improper grooming or uniform, may be sent home by a supervising resident/fellow, a Chief Resident or an attending. If sent home, they must return to duty in a timely manner. After counseling, continued violations of this policy will result in progressive discipline including written notice of failure to achieve competency in professionalism and possible probation, suspension or dismissal from the training program.

Reasonable accommodations based on religion and/or cultural observances or practices such as, but not limited to, style of dress, head coverings, grooming requirements will be considered on a case by case basis.

BENEFIT SUMMARY
Yale-New Haven offers its residents and fellows a comprehensive benefits package. The following is a summary of the various house staff benefits offered at Yale-New Haven Hospital.

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<th>Salary from 7/1/2013 to 6/30/2014</th>
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Administrative Chief Residents receive an additional $5,000, or a portion of it if shared with other Administrative Chief Residents.

VACATION
2-4 weeks, at the discretion of the department and its needs. *(The Otolaryngology Program offers 3 weeks of vacation for PGY 2-5)*

PROFESSIONAL LEAVE
Professional leaves are determined at the discretion of the department on an individual basis due to need.

FAMILY/MEDICAL LEAVE OF ABSENCE
It is the policy of Yale-New Haven Hospital to grant a leave of absence to employees who are absent from work due to physical or mental disability, parental needs for newborn or child adoption, or the serious illness of a family member. The hospital is interested in ensuring that parental and family leaves of absence are granted in order to allow an employee personal time to meet family and parental needs. Under this policy, a family/
Medical leave of absence (FMLA) may be granted for a period up to 16 weeks during a 24-month period for all eligible house staff. Under some circumstances, additional time may be available if more than 12 months have elapsed since the beginning of the last FMLA. The leave may be paid, unpaid, or a combination, and is reserved for purposes of either child adoption, care of a newborn infant, the serious illness of a child, spouse, or parent, parent-in-law, or medical leave of absence for an employee who is absent from work due to a physical or mental illness or disability. It is the intention of the hospital to comply with the Federal Family and Medical Leave Act of 1993, as well as applicable federal or state statutes.

LONG TERM DISABILITY

The hospital has a disability insurance program that provides individual coverage to a resident/fellow while employed at Yale-New Haven Hospital. This insurance provides salary continuation up to age 65 for eligible house staff once extended sick leave benefits cease. The residents/fellows (policy owners) may continue this policy after leaving Yale-New Haven Hospital. The plan provides total disability, partial disability, future purchase option, indexing, portability, and billing discounts.

PROFESSIONAL LIABILITY

Yale-New Haven Hospital provides its residents and fellows with professional liability insurance coverage for professional activities performed within the scope of hospital-assigned duties. The insurance coverage is provided by Yale-New Haven Hospital while the resident/fellow is functioning within the medical center; however, insurance may be provided by an affiliate hospital if the resident/fellow is on rotation at that hospital. Insurance coverage generally is not provided for personal activities, like moonlighting. Insurance coverage is provided for the duration of graduate medical training, but may exclude periods during which the resident is assigned exclusively to non-clinical duties, like bench research. The insurance pays for the costs of legal defense, settlements and awards, and will protect the resident against awards from claims reported or filed after the completion of the residency as long as the case involves acts or omissions undertaken within the scope of the residency program.

EMPLOYEE ASSISTANCE PROGRAM

Yale-New Haven Hospital offers free, prompt, professional problem assessment, grief counseling and/or referral to other resources for ongoing help for employees and their immediate family. These services are provided through the YNHH Employee Assistance Program.

PARKING

Secure on-site parking in the Air Rights Garage is provided to house staff at a subsidized rate through payroll deductions.

FINANCIAL BENEFITS PROGRAM

1. Yale-New Haven Federal Credit Union Savings, IRAs, Checking and other services
2. Bank of America – Free checking with Direct Deposit, Automatic Teller Machines and Preferred Credit, in addition to all other banking needs
3. Direct deposit into participating banks
4. U.S. Savings Bonds
5. Personal Lines of Insurance (auto, homeowners)
6. Voluntary Life Insurance (self, spouse, children)
7. Long Term Care Insurance

FLEXPLAN BENEFITS

Medical insurance is provided to house staff and dependents at no cost to the resident/fellow.

MEDICAL PLAN
Yale-New Haven Hospital Advantage Plus Plan offers in and out-of-network options. In-network expenses are paid at 100% with $25 co-pay for office visits. Out-of-network expenses are paid at 70% with a $700 (single)/$2100 (family) deductible.

Prescription Drug Program Employees and dependents are covered by the Prescription Drug Program administered by CVS Caremark. The employee’s charge for a 30 day supply of a covered prescription is ($6) for a generic drug, a 20% coinsurance ($30 min/$55 max) for a brand name drug on the formulary list and a 40% coinsurance ($50 min/$95 max) for brand name drug not on the formulary list. A 90-Day supply of Maintenance drugs, taken on a regular basis for chronic conditions, may be purchased either through CVS Caremark Mail Service, any CVS Pharmacy, or at a YNHH Medical Center Pharmacy.

Vision Care Coverage (In-Network)
- Vision Care coverage is provided through Vision Service Plan (VSP) and their participating providers. It is selected separately from medical and dental coverage at an additional charge.
- Exam: covered in full every 12 months after $15 copay.
- Corrective Lens: standard lenses are covered in full every 12 months after a $15 co-pay for lenses and frames.
- Frames: large selection of frames is covered in full (up to $155) every 24 months. Plus, 20% discount off any out-of-pocket costs.
- Contact Lenses: $155 allowance every 12 months when you choose contacts instead of glasses. Plus, the VSP doctor provides a 15% discount off his/her professional services.

Delta Dental Plans
You will be able to choose dental coverage at an additional charge under one of the following plans.
- Delta Dental Plus Plan covers 100% of preventative and 80% of restorative services, 50% of major services, 50% orthodontic services after a $50 (single)/$100 (family) deductible.
- Delta Dental Basic Plan covers 100% of preventative and 80% of restorative services after a $50 (single)/$100 (family) deductible.
- Dental Coverage elections can be changed only for even plan years (e.g. 2014, 2016)

Other Insurance Benefits
These benefits are provided to house staff at no cost to the resident.
- Group Life Insurance: Regular full-time resident staff members are covered for $100,000 as of the first day of employment. This term life insurance has no cash value and if you die pays a benefit to your designated beneficiaries.
- Accidental Death & Dismemberment: The insurance coverage provides up to $100,000 coverage for any accidental death or dismemberment injury.

FLEXIBLE SPENDING ACCOUNTS
Each year employees eligible for flexible benefits may elect to have a portion of their salary deducted on a before tax basis, to pay for out of pocket medical expenses, and dependent care expenses. Use of these salary conversion dollars reduces the amount of gross income subject to income taxes and social security. Yale-New Haven Hospital matches 5% of the amount which an employee deposits in the Health Care and Dependent Care Flexible Spending Accounts. This is a calendar election.
Tax Sheltered Annuity (TSA) 403(b) Plan
You may contribute up to $17,000, (the annual IRS limits for 2012) on a before-tax basis. Yale New Haven Hospital match 1% to 3%; 100% vested after 5 years of service; partial vesting 2 years (25%), 3 years (50%), 4 years (75%). You will be automatically enrolled for a 1% contribution after 60 days of employment, your contributions and investment earnings are tax-sheltered until a distribution is made. You may choose from several investment funds and personalized quarterly statements mailed to your home; plus online statements are available.

SAME GENDER MARRIAGE OR CIVIL UNION PARTNER
Employees who have entered into a Civil Union or marriage in either CT or VT will be eligible to add their partner to our medical, dental, vision care, and dependent life insurance plans. Proof of Civil Union must be provided.

ADOPTION ASSISTANCE
Adoption – Reimbursable expenses include legal, court and agency fees plus foreign adoption charges; expenses reimbursed up to $8,000 maximum benefit per child.

PERSONAL INSURANCE OPTIONS
House staff may have the opportunity to purchase homeowner, automobile, boat, condominium and/or personal liability insurance at a discount through payroll deductions. This program is an individual policy and subject to the guidelines of the insurance carrier.

IN ADDITION:
• oncall rooms for every service
• white lab coats (laundry services not provided)
• a lounge for house staff with TV, VCR, 24-hour brewed coffee, food provided every night, refrigerator, SCM terminal

HOUSING
Yale-New Haven Hospital does not provide Housing or subsidy for housing.

MOVING EXPENSES
Yale-New Haven Hospital does not provide moving expenses or subsidy for moving.

Yale-New Haven Hospital requires mandatory drug testing for new employees. Failure to submit to such testing will disqualify a person from employment.

For additional information about employee benefits, contact the Benefits office at 203-688-2401.

Equal Employment Opportunity, Male/Female/Disabled/Veteran

DISCIPLINARY PROCEDURES

This policy is adopted consistent with the hospital mission to educate physicians for a leadership role in clinical and academic medicine as well as to protect and improve the health and maintain the safety of our patients, visitors and staff.
DEFINITIONS
Probation: A trial period in which a resident is permitted to redeem academic performance or behavioral conduct that does not meet the standard of the program
Suspension: A period of time in which a resident is not allowed to take part in all or some of the activities of the program. Time spent on suspension may not be counted toward the completion of program requirements.
Dismissal: The condition in which the resident is directed to leave the residency program, with no award of credit for the current year, termination of the resident’s appointment and termination of all association with the Medical Center.

POLICY
It shall be the policy of Yale-New Haven Medical Center that the decision for probation, suspension and/or dismissal of residents in accredited training programs is the primary responsibility of the program director. This process should be progressive and objective and the final decision must be reviewed and approved by the chair of the department and reported to the Director/Associate Dean of GME prior to the probation, suspension and/or dismissal. The program director must have records, in writing, of discussions, with the resident, involving faculty and the chair of the department concerning the problems that have led to the probation and/or dismissal. A resident involved in any of the actions of probation, suspension or dismissal has the right to appeal according to GMEC policy.

PROCEDURE
Classification of Progressive Discipline Steps
There are basic steps of progressive disciplinary action, as follows:

RESIDENT COUNSELING
Resident is counseled by the Program Director in an effort to eliminate possible misunderstandings and to explain what constitutes proper conduct or acceptable job/academic performance.

VERBAL WARNING (ORAL REPRIMAND)
Following unsuccessful attempts (number of attempts is proportionate to the level of the problem) to correct the problem through repeated counseling, the resident should be verbally warned that further discipline may follow if the resident continues to commit the offense in question, or does not otherwise correct the academic/performance problem.

WRITTEN WARNING
Resident receives written notice of discipline on following intentional or repeated offenses. The purpose of a written warning is to make certain that the resident is fully aware of the misconduct he/she has committed and what is expected, thereby enabling the resident to avoid a recurrence of the incident. A written warning requires prior approval by the department Chair or appropriate residency review committee in the Department.

PROBATION
1. A resident may be placed on probation by a Program Director for reasons including, but not limited to any of the following:
   a. Failure to meet the performance standards of an individual rotation;
   b. Failure to meet the performance standards of the program;
   c. Failure to comply with the policies and procedures of the GME Committee, the Medical Center, or the participating institutions;
   d. Misconduct that infringes on the principles and guidelines set forth by the training program;
   e. When reasonably documented professional misconduct or ethical charges are brought against a resident, which bear on his/her fitness to participate in the training program.
2. When a resident is placed on probation, the Program Director shall notify the resident in writing in a timely manner, usually within a week of the notification of probation. The written statement of probation will include a length of time in which the resident must correct the deficiency or problem, the specific remedial steps and the consequences of non-compliance with the remediation.

3. Based upon a resident’s compliance with the remedial steps and other performance during probation, a resident may be:
   a. Continued on probation;
   b. Removed from probation;
   c. Placed on suspension; or
   d. Dismissed from the residency program.

SUSPENSION
1. A resident may be suspended from a residency program for reasons including, but not limited to any of the following:
   a. Failure to meet the requirements of probation;
   b. Failure to meet the performance standards of the program;
   c. Failure to comply with the policies and procedures of the GME Committee, the Medical Center, or the participating institutions;
   d. Misconduct that infringes on the principles and guidelines set forth by the training program;
   e. When reasonably documented professional misconduct or ethical charges are brought against a resident which bear on his/her fitness to participate in the training program;
   f. When reasonably documented legal charges have been brought against a resident which bear on his/her fitness to participate in the training program;
   g. If a resident is deemed an immediate danger to patients, himself or herself or to others.

2. When a resident is suspended, the Program Director shall notify the resident with a written statement of suspension to include:
   a. Reasons for the action;
   b. Appropriate measures to assure satisfactory resolution of the problem(s);
   c. Activities of the program in which the resident may and may not participate;
   d. The date the suspension becomes effective;
   e. Consequences of non-compliance with the terms of the suspension;
   f. Whether or not the resident is required to spend additional time in training to compensate for the period of suspension and be eligible for certification for a full training year.

A copy of the statement of suspension shall be forwarded to the Director/Associate Dean for Graduate Medical Education and the Director of Housestaff Office.

3. During the suspension, the resident will be placed on “administrative leave”, with or without pay as appropriate depending on the circumstances.

4. At any time during or after the suspension, resident may be:
   a. Reinstated with no qualifications;
   b. Reinstated on probation;
   c. Continued on suspension; or
   d. Dismissed from the program.

DISMISSAL
1. Dismissal from a residency program may occur for reasons including, but not limited to, any of the following:
a. Failure to meet the performance standards of the program;
b. Failure to comply with the policies and procedures of the GME Committee, the Medical Center, or the participating institutions;
c. Illegal conduct;
d. Unethical conduct;
e. Performance and behavior which compromise the welfare and of patients, self, or others;
f. Inability of the resident to pass the requisite examinations for licensure to practice medicine in the United States.

2. The Program Director shall contact the Director/Associate Dean for GME and provide written documentation, which led to the proposed action.

3. When performance or conduct is considered sufficiently unsatisfactory that dismissal is being considered, the Program Director shall notify the resident with a written statement to include:
   a. Reasons for the proposed action,
   b. The appropriate measures and timeframe for satisfactory resolution of the problem(s).

4. If the situation is not improved within the timeframe, the resident will be dismissed.

5. Immediate dismissal can occur at any time without prior notification in instances of gross misconduct (e.g., theft of money or property; physical violence directed at an employee, visitor or patient; use of alcohol/drugs while on duty).

6. When a resident is dismissed, the Program Director shall provide the resident with a written letter of dismissal stating the reason for the action and the date the dismissal becomes effective. A copy of this letter shall be forwarded to the Director/Associate Dean for GME and the Director of Housestaff Records.

7. If a contract is not to be renewed, and the resident dismissed, the program will provide the resident with written notice of intent not to renew the agreement no later than four (4) months prior to the end of the resident's current agreement. If the primary reason for non-renewal occurs within the four months prior to the end of the agreement, the program will provide the resident with as much written notice of the intent not to renew as the circumstances will reasonably allow, prior to the end of the agreement.

8. At that time, the resident will also be given a written copy of the grievance process.

EMPLOYEE ASSISTANCE PROGRAM

Recognizing the need to provide support services for the resident in training, this policy is adopted consistent with the hospital mission to educate physicians for a leadership role in clinical and academic medicine as well as to protect and improve the health and maintain the safety of our patients, visitors and staff, recognizing the importance of regular and structured feedback in teaching.

POLICY

It shall be the policy of Yale-New Haven Medical Center that residents in ACGME accredited training programs will have available to them the Employee Assistance Programs of either Yale-New Haven Hospital or Yale University School of Medicine. In addition, the Director/Associate Dean of Graduate Medical Education and the Office of Graduate Medical Education will serve as an Ombudsman's Office to all trainees.
FAMILY MEDICAL LEAVE OF ABSENCE

It is the policy of Yale-New Haven Hospital and Yale University School of Medicine to grant a leave of absence to employees who are absent from work due to physical or mental disability, parental needs for newborn or child adoption, or the serious illness of a family member. The Hospital and the Medical School are interested in ensuring that parental and family leaves of absence are granted in order to allow an employee personal time to meet family and parental needs. Under this policy, a family/medical leave of absence (FMLA) may be granted for a period up to sixteen (16) weeks during a 24-month period for all eligible employees. Under some circumstances, additional time may be available if more than twelve (12) months have elapsed since the beginning of the last FMLA leave. The leave may be paid, unpaid, or a combination. The leave is reserved for purposes of either child adoption, care of a newborn infant, the serious illness of a child, spouse, or parent, parent-in-law, or medical leave of absence for an employee who is absent from work due to a physical or mental illness or disability. For resident staff, this leave is paid for. It is the intention of the Hospital and the Medical School to comply with the Federal Family and Medical Leave Act of 1993, as well as applicable Federal or State Statutes.

ELIGIBILITY

A. All residents are entitled to family/medical leave of absence for a period generally not to exceed sixteen (16) weeks for the purposes of parental and family needs and not to exceed 26 weeks for the purposes of their own disability.

B. Parental and family leaves of absence are limited to sixteen (16) weeks per employee within a 24-month period of eligibility. Approved FMLA time granted by this policy will be reduced by the amount of time granted prior to the request during that 24-month rolling period.

C. If at least twelve (12) months have elapsed since the commencement of a FMLA and the employee requests a second FMLA, an additional twelve (12) weeks is available.

D. For birth mothers, the date of delivery is considered the commencement of the FMLA period.

E. The FMLA may be used consecutively or intermittently, or under certain circumstances maybe used to reduce the workweek or workday. In no case will the total leave exceed 16 weeks. For birth, adoption or foster care of a child, the Hospital and/or Medical School must agree to the schedule. For a serious health condition of the employee or family member, there must be mutual agreement to intermittent leave unless the employee can prove it medically necessary.

F. If both husband and wife work for the Hospital/Medical School and each wishes to take leave for the birth of a child, adoption or placement of a child in foster care, or to care for a parent, or parent-in-law with a serious health condition, the husband and wife combined may only take a total of sixteen (16) weeks of leave.
TYPE OF LEAVE COVERED

A. In order to qualify as FMLA leave under this policy, the employee must be taking the leave as defined by one of the following circumstances:
1. within one year of birth of a child and in order to care for that child
2. within one year of placement of a child for adoption or foster care
3. to care for a spouse, child, parent, or parent-in-law with a serious health condition
4. the serious health condition of the employee, whether considered work-related or not

B. DEFINITIONS
1. "Parent" means a natural parent, foster parent, adopted parent, stepparent, or legal guardian of an eligible employee; "parent-in-law" means the parent (see above) of current spouse.
2. "Child" means a natural, adopted, or foster child, stepchild, or legal ward, provided such child is under the age of 18 or, if over 18 years, unable to care for themselves because of a serious disability
3. "Rolling period" commences with the first day of FMLA leave.
4. "Spouse" means an individual legally married to an eligible employee
5. "Serious health condition" for employees means that the employee is unable to perform the functions of the employee's position. The origin of this condition may or may not be a work-related incident. As it applies to both employees and family member, a serious health condition is defined as a condition, which requires inpatient care at a hospital, hospice, or residential medical care facility or a condition that requires continuing care by a licensed, health care provider. The serious health condition also includes illnesses of a long-term nature, resulting in recurring or lengthy absences. Generally, a chronic or long-term health condition, which if left untreated, would result in a period of incapacity of more than three days, would be considered a serious health condition.

If an employee takes extended sick leave for a condition that progresses into a serious health condition, the Hospital may designate all or a portion of the related leave taken as leave under the FMLA policy, to the extent that the earlier leave meets the necessary qualifications.

ADMINISTRATIVE PROCEDURES

A. Except where a leave is not foreseeable, all employees requesting leave under this policy must submit the request in writing to their immediate supervisor. The Department must notify the House Staff Office/Departmental Office in writing of such leave and the applicable dates. Failure to notify the House Staff Office/Departmental Office may result in lost pay or benefits to the resident. The Request for Family and/or Medical Leave form must be completed by the resident and program director and submitted to the House Staff Office.

B. When an employee plans to take leave under this policy, the employee must give the Hospital/Department 30 days notice. If it is not possible to give 30 days notice, the employee must give as much notice as is practical and reasonable. An employee undergoing planned medical treatment is required to make a reasonable effort to schedule the treatment to minimize disruptions to the Hospital's/Medical School's operations.

C. If an employee fails to provide 30 days notice for foreseeable leave with no reasonable
explanation for the delay, the leave request may be denied until at least 30 days from the
date the Hospital/Department receives notice.

D. When the supervisor receives a request for FMLA, it may be appropriate to contact the
Benefits Office to confirm the employee's eligibility for such a request, since that on
previous utilization of FMLA leave during the rolling 24-month period.

E. The Hospital/Department requires certification of the serious health condition when the
reason for the leave is either the employee's health or that of an eligible family member.
The employee should respond to such a request within fifteen (15) days or provide a
reasonable explanation for the delay. Failure to provide certification may result in a denial
of the continuation of the leave. Certification of the serious health condition shall include:

- the date when the condition began
- its expected duration
- diagnosis
- brief statement of treatment

If the certification is for the employee's own medical condition, it must include a statement
that the employee is unable to perform any work or unable to perform the essential
functions of the employee's position. The medical certification should be reviewed by the
immediate supervisor with Personnel Health Services. For a seriously ill family member,
the certification must include a statement that the patient requires assistance and that the
employee's presence would be beneficial or desirable.

If the employee plans to take intermittent leave or work a reduced schedule, the medical
certification must also include dates and the duration of treatment, and a statement of
medical necessity for taking intermittent leave or working a reduced schedule.

F. The Hospital/Department has a right to ask for a second opinion. If this occurs, the
Hospital/Department will pay for a certification from a second doctor, who will be selected
by the Hospital/Department. If necessary to resolve a conflict between the original
certification and the second opinion, the Hospital/Department will require the opinion of a
third doctor. The Hospital/Department and the employee will jointly select the third doctor
and the Hospital/Department will pay for the opinion. This third opinion will be considered
final.

G. The Benefits Office will prepare the notification of the request for a family medical leave
and forward it to the employee. This notification confirms the conditions and the
privileges provided under this policy.

H. While on FMLA, employees are requested to report periodically to the Hospital/
Department regarding the status of the medical condition and their intent to return to work
documentation should be sent to the immediate supervisor every 30 days or whenever a
substantial change occurs.

STATUS OF COMPENSATION AND BENEFITS WHILE ON FMLA

A. Salary Continuation

Family and Medical Leave available under this policy is unpaid. In certain circumstances,
such as maternity, residents may be eligible for short term disability with appropriate
physician certification. Six (6) weeks of paid leave is given for maternity situations.
Paternity leave is unpaid leave.

Extended Sick leave, or short-term disability (up to 6 months) is considered paid leave for
purposes of FMLA substitution. The total time away from the Hospital/Department cannot
exceed 16 weeks (except where ESL is extended for employee's own medical reasons).

An employee who is taking FMLA because of the employee's own serious health
condition which is work-related, may be receiving worker's compensation payments or be
placed on short-term disability.
B. FLEXplan Benefits
While the employee is on FMLA, the Hospital/Department will continue during the approved leave period, generally not to exceed six months, the employee's health care benefits at the same level and under the same conditions as if the employee had continued to work. If the employee is paying a portion of the health care premium, the Hospital/Department will continue to make payroll reductions while the employee is on paid leave.

C. Arrangements should be made directly with the Parking Office to discontinue parking deductions during FMLA.

D. If the employee chooses not to return to work for reasons other than a continued serious health condition, the Hospital will require the employee to reimburse it for the amount the Hospital paid for the employee's health care premium during the leave period. The employee may continue health care coverage after notification of the intent not to return under the COBRA extension option, which entails the employee paying the full premium plus a 2% administration fee.

RETURN FROM FMLA LEAVE
A. An employee who takes leave under this policy will be able to return to the same job.

B. If the reason for the FMLA leave was for personal disability, the employee must provide certification of fitness to return to work. This documentation should be forwarded to Personnel Health Services, which will review it for appropriateness prior to the employee's returning to work.

C. When a FMLA leave exceeds 16 weeks due to a personal, serious health condition, the employee's job may be filled or held, based on the operational and staffing requirements as determined by the Department Head. If it were not feasible to hold the employee's position, the employee would receive consideration for job vacancies if the employee were fit to return to work within the additional ten (10) weeks.

D. Departmental Requirements to Extend Training Time
Residents taking Medical leave of absence and/or parental/family leave may be required to extend their time of training by an amount of time equal to that missed during such leave in order to satisfy Board certification eligibility requirements. In some cases the Chief of Service may suggest a longer absence (to cover a complete rotation) to simplify subsequent rescheduling of duties. During such a requested absence and extended training time, all salary and nonsalary benefits will be continued at the same level, again, with the exception that malpractice coverage may be suspended during absence from duties at the Hospital. A resident should not be required to make up substantially more training time than was actually missed for this leave.

EXCEPTIONS
Any exceptions to the policy above must be appealed, in writing, to the Director of Compensation and Benefits. This appeal should include the reasons or special circumstances that should be considered as the basis for exception.

GRIEVANCE

It is the policy of Yale-New Haven Medical Center to foster sound communications between Specialty and Subspecialty Residents programs (hereafter known as Residents) in ACGME accredited, ABMS accredited and GMEC approved training programs and their respective
Chiefs of Service and to ensure that problems arising within the programs are appropriately discussed and resolved. This policy is intended to address those situations in which a trainee may have a disagreement with an action taken or treatment received within the program.

APPLICATION AND DEFINITIONS

This policy shall apply to all Specialty and Subspecialty Residents in ACGME accredited, ABMS accredited and GMEC approved training programs who are employed under a contract with Yale-New Haven Hospital or Yale University School of Medicine. This policy does not apply to research post-doctoral fellows.

RESIDENTS

Specialty and Subspecialty (Clinical Fellows) Residents in ACGME accredited, ABMS accredited and GMEC approved training programs.

GRIEVANCE

A grievance is defined as an expression of dissatisfaction regarding any of the following:

a) The Resident’s written contract
b) Duties assigned to a Resident
c) Application of Hospital or University policies
d) Unfair or inequitable discipline or performance reviews or evaluations
e) An issue regarding non-renewal of a Resident’s appointment
f) Termination of a Resident's appointment prior to the end of the contract term
g) Discrimination of any type

Complaints related to sexual harassment must be made pursuant to the Hospital’s Policy or the University policy, depending on the salary source of the Resident.

Complaints of academic fraud/scientific misconduct must be brought under the "Policies and Procedures for Dealing with Allegations of Academic Fraud at Yale University" (see http://www.yale.edu/grants/acadfraud.html) and will be referred to the Special Advisor to the Dean of the School of Medicine.

Violations of Title VII (acts of discrimination against protected classes under federal law) may be directed to the Hospital or University Compliance Officer.

GRIEVANCE PANEL

A standing panel will be selected consisting of 4 Chief Residents, three Program Directors, three Chiefs/Associate Chiefs of the Medical Staff, three administrative officials (from both Hospital and Medical School). These individuals will serve for a period of two years. Upon submission of a grievance, the Director/Associate Dean of GME will select with the Resident pursuing the grievance a panel consisting of 2 Chief Residents not from their specialty. The Director/Associate Dean will select one Program Director not from the trainee’s specialty, one member of the Medical Staff not from their specialty and an administrative officer. The Chair of each panel will be selected by the panel members.

WORKING DAYS

Monday through Friday, excluding Hospital holidays.

POLICY AND PROCEDURE

A. When an incident forming the basis for a grievance arises, the grievant must follow the procedure outlined below. Each grievance shall be handled promptly and impartially,
without fear of coercion, discrimination or reprisal. Each participant in a grievance shall do his or her part to protect this right.

B. All time limits specified in this policy refer to working days. To achieve a prompt resolution of Resident’s grievances, the action at each step of the Grievance Procedure should be taken as rapidly as possible, but not later than the prescribed time limits. In the event of extenuating circumstances, a time limit may be extended by mutual agreement of the parties at that step.

C. Grievance meetings shall be scheduled at times which are mutually satisfactory to all parties concerned. No resident, faculty member, member of the Grievance panel, administrator, or witness shall suffer loss of compensation or leave time for the time spent in any step of this procedure.

D. A Resident may obtain the assistance of another Hospital or University employee of his/her choice in preparing and presenting a grievance at any step, including a member of the Human Resources Department. In the latter case of a Hospital employee, notification should be made to the Manager, Employee Relations. Other outside individuals, including attorneys, are not permitted to participate directly in the grievance process, though consultation with an attorney is permitted.

E. All issues to be raised in a grievance must be raised from the first step and may not be introduced for the first time in Step 2 without having been previously raised.

F. At each step of the grievance, the Resident must prepare a written summary of the complaint, facts, information accumulated, and the remedy or outcome being sought. This must be forwarded to the Chairperson of the Graduate Medical Education Committee (GMEC), as well as to the individual/panel hearing the next level of the grievance.

G. The Chairperson of the GMEC will serve to ensure that the procedure for the grievance is adhered to at each step.

H. At the conclusion of each step of the Grievance Procedure, the involved Resident and the Chief of Service and/or Section Chief, as appropriate, shall both receive a copy of the written decision which includes an explanation of the reasoning behind the decision.

I. All information, whether provided in writing or through interviews, obtained in connection with a grievance shall be treated in a confidential manner by all parties involved. Only the final outcome and disposition will be recorded and maintained in the Resident’s file, while the detailed information referred to in paragraph F above shall be discarded by the Chief of Service or Section Chief and others hearing the grievance. However, the complete record will be maintained in the Program Director’s file.

J. Data regarding numbers of grievances, their general subject matter and their departments, as well as their final outcomes will be an agenda item at each scheduled meeting of the GMEC, when applicable. Annually the GMEC shall summarize the number of grievances, the Department and type of grievances for the committee. Trends in this data may be used by the GMEC to provide specific feedback to the Departments.

ADMINISTRATIVE PROCEDURES
General Conflict Resolution
Every effort should be made to resolve all questions, problems and misunderstandings as soon as they arise. Accordingly, Residents are encouraged to initiate discussions with their Chief of Service, and when appropriate, Section Chief, at the time the dissatisfaction or questions arise. In addition, the Director/Associate Dean GME may be asked to facilitate this discussion.
Step 1 – Grievance Panel
If a Resident is unable to resolve his/her problem, a grievance may be initiated through the Director/Associate Dean of GME. A written statement setting forth the basis for the grievance and the outcome or remedy sought shall be submitted to the GME Coordinator, who will give it to the Chairperson of the GMEC. To be accepted for consideration, a grievance must be initiated by the Resident within ten (10) working days of the time he/she first had knowledge of the incident that gave rise to the grievance. The Chair of the GMEC shall then arrange a meeting with the House Officer to select the grievance panel. The panel will be immediately notified and shall meet with the resident within fourteen (14) working days after receiving the Step 1 appeal. The panel shall conduct a review of the grievance, shall develop the facts and information which are relevant to the grievance, shall meet with all other relevant parties and shall issue a written decision. The panel's decision shall be issued within fourteen (14) working days of the meeting. A copy of the decision shall be given to the Resident and to the GME Coordinator, who shall give it to the GMEC Chairperson.

Step 2 - Chief of Staff or Dean’s Representative
If the Resident is not satisfied with resolution of the Grievance at Step 1, the Resident may appeal to Step 2 of the Grievance Procedure. This appeal must be in writing and comply with the requirements of paragraph F under Policy above, 2 copies must be submitted to the GME Coordinator, within seven (7) working days after receiving the Step 1 decision. He/she will deliver the appeal to individuals who will hear the Step 2 grievance. In the event a grievance is not appealed to Step 2 within the seven (7) working day time frame, the Step 1 decision shall be considered final.

A second step grievance will be reviewed by one of the following, depending on the salary source of the Resident: 1) Chief of Staff/Senior Vice-President for Medical Affairs of Yale-New Haven Hospital, 2) Representative of the Dean, Yale University School of Medicine.

Either the panel or the Chief of Staff, as applicable, shall meet with the resident within fourteen (14) working days after receiving the Step 2 appeal. The Chief of Staff/Representative of the Dean shall conduct a review of the grievance and reach a written decision promptly. The Chief of Staff’s/Representative of the Dean’s decision shall be issued within ten (10) working days of his/her meeting with the Resident. Either decision shall be deemed final and binding on all concerned parties.

HIPPA

We appreciate your care of our private patients but we must remind you of your medical/legal responsibilities.

1. Never transport charts from immediate office area.
2. Never leave patient charts exposed to other patients.
3. Never extract any original pages from attendings charts.
4. Enter any phone encounters directly into patient charts or summarize in a dated note given to the attending the next day.

MEDICAL LEAVE
It is the policy of the YNHMC to provide resident physicians with appropriate leave time for personal illness.

1. Residents are to be ensured by their programs from retribution for reasonable periods of sick leave (illness).
2. Residents may be allowed up to 10 days sick leave per year. Time of training with this amount or more of leave, may need to be extended, depending on the requirements of the appropriate certifying Board.
3. Periods of absence for longer than three days may require a physician’s note for fitness to return to work.

PROGRAM CLOSURE / REDUCTION

This policy is adopted consistent with the hospital mission to educate physicians for a leadership role in clinical and academic medicine, recognizing the importance of medical training.

If the institution deems it necessary to reduce the capacity of or close a training program, residents will be notified in writing of this plan as soon as possible. Whenever possible YNHH will make every effort to allow residents currently enrolled in the training program to complete their training at YNHMC. Where the program will not continue or when the residents are unwilling to complete the training program at YNHMC, the institution will assist in identifying and transferring the resident to other similar training programs where they may be able to continue their training.

PROMOTION

This policy is adopted consistent with the hospital mission to educate physicians for a leadership in clinical and academic medicine as well as to protect and improve the health and maintain the safety of our patients, visitors and staff, recognizing the importance of commensurate, increasing levels of responsibility.

It shall be the policy of Yale-New Haven Medical Center that residents in accredited training programs will be promoted to higher levels of responsibility based on their accomplishments and achievements during the past year. Yale ORL requires that a resident achieves all goals and objectives set forth in the curriculum section of this manual in order to advance or graduate. The Program Director is responsible for communicating these specific standards for promotion to their residents. For each trainee the program must document the trainee’s performance on a regular basis and review the performance at least semi-annually with the candidate.

RESTRICTIVE COVENANTS

YNHMC recognizes that trainees should not be restricted in their ability to find positions commensurate with their abilities and competency. No restrictive covenants (non-compete) clauses will be entered into any resident or sub-specialty resident contracts.
SEXUAL HARASSMENT

Yale-New Haven Hospital is committed to maintaining a productive workplace, free of sexual harassment and other forms of discrimination. Sexual harassment and conduct, which presents a hostile work environment, is prohibited. Sexual harassment includes unwelcome advances, requests for sexual favors, offensive verbal or physical conduct of a sexual nature (e.g., unsolicited remarks, gestures, or physical contact, name-calling, sexually suggestive comments, conduct or sexually oriented profanity.) Sexual harassment occurs when one or any combination of the following three (3) criteria are met:

1. Submission to that conduct is made either explicitly or implicitly a term or condition of an individual's employment; or
2. Submission to or rejection of such conduct by an individual is used as a basis for employment, work assignment, promotion, or award decisions affecting the individual; or
3. The conduct has the purpose or effect of interfering with an individual's work performance or creating an intimidating, hostile, or offensive work environment.

The responsibility for administering this policy lies on essentially three (3) levels of the organization:

1. The entire management staff who are individually responsible for this policy as it affects employees under their supervision directly or indirectly,
2. Each individual manager or department head is responsible where a specific complaint of sexual harassment is raised and,
3. The Manager of Employee Relations is responsible for providing staff assistance in interpreting and investigating incidents or allegations of sexual harassment.

PROCEDURE

A. If an employee believes that he or she is the victim of sexual harassment, the employee should:
   1. Directly inform, if possible, the person(s) engaging in the sexual harassing conduct or communicate that such conduct is offensive and should stop.
   2. If the alleged harassment continues, the employee should contact his/her supervisor regarding the incident or the behavior. The complaint should identify the person(s) alleged to have committed the sexual harassment with all-pertinent facts and information to facilitate an investigation and should be submitted within seven (7) working days of the alleged incident or pattern of behavior. If the alleged harassment originates with the employee's supervisor or manager, then the complaint should be raised with the manager to whom the supervisor or manager reports so that a responsible investigation can be made.
   3. Should the complaining party not be satisfied with the result of the manager's efforts to resolve the matter, the employee may, after receiving the manager's response, file a grievance with the administrative officer for the employee's division. Such a complaint should be submitted in writing to the administrative officer with a copy for the Manager of Employee Relations within seven (7) working days of receipt of the department head's (or responsible manager) answer to the complaint.
   4. The administrative officer will review the complaint in consultation with the Manager of Employee Relations and will meet with the employee to discuss his or her concerns and possible remedies to settle the complaint. The administrative officer will issue a written decision to the employee within seven (7) working days of the meeting.
   5. If the employee is not satisfied with the answer he/she receives from the administrative officer for the division, the employee can, within seven (7) working days of receiving this answer, contact the Manager of Employee Relations for the
hospital to discuss an appeal to a Senior Vice President for a final review and decision.

6. The Senior Vice President responsible for the investigation will meet with the employee to discuss the grievance and consult with the Manager of Employee Relations to conduct a review of the case. The Senior Vice President will issue a final decision to the grieving party within 14 working days of the initial review meeting and that decision will be final and binding on all parties within the Hospital.

B. It is the responsibility of any management staff member receiving a complaint alleging sexual harassment to immediately notify the Manager of Employee Relations to:
   1. Seek assistance regarding hospital policy, and
   2. To coordinate and conduct a timely and thorough investigation in conjunction with department head and administrative officer as appropriate.

Supervisors or managers should also inform their division's director/administrative officer of the complaint and any follow up action taken to resolve the problem. The supervisor/manager will ultimately meet with the employee who filed the complaint to discuss the results of the investigation and to inform the employee of any action taken.

COUNSELING AND DISCIPLINE
Yale-New Haven Hospital will take immediate and appropriate corrective action regarding all reports of sexual harassment in recognizing its responsibilities under applicable laws as an employer committed to diversity of opportunity in its workforce. Employees who are found to have engaged in sexual harassment will be subject to appropriate counseling and/or discipline, including discharge if warranted, in accordance with the guidelines established in Human Resources Policy B:8, Employee Conduct and Discipline. Both the original complaint and any resulting corrective action taken will be treated as confidentially as possible in deference to all parties involved.

TIME OFF POLICY

ALL time off must be approved by the Program Director. Unscheduled or unauthorized time off is grounds for disciplinary action, up to and including dismissal from the program.

VACATION
1. Residents schedule up to three weeks of vacation per academic year.
2. Vacations begin on Friday at 5 pm and end on the next Friday at 5 pm. If the schedule allows, the following weekend will be scheduled without clinical responsibilities, but this is not guaranteed.
3. No vacations may be taken on the last two weeks of June and all of July. Additionally, residents may not take vacation between November 15 and February 15.
4. No more than one vacation week per three month block may be taken.
5. Consecutive weeks are not allowed.
6. Chief Residents must clear non-vacation time off with respective hospital service chiefs, Program Director, and must ensure adequate cross coverage by a resident at the senior rank.
7. Unused vacation time cannot be carried over to the following year.
8. ALL vacations must be approved by the hospital site director and the Program Director by June 15th of the prior academic year.
INTERVIEWS
1. During either PGY 4 or 5, residents may utilize an additional 3-days to interview for fellowship or practice positions.
2. If additional time off is needed, a resident may utilize up to one week (5 weekdays and 2 weekend days) of their regular vacation time. These additional days may used as single days off, instead of consecutive days.
3. Interview days are not guaranteed.

SICK TIME AND MEDICAL LEAVE
1. YNHH policies will be followed.