

POLICIES AND PROCEDURES

Academic Action

When a program determines that a resident's performance or conduct is unsatisfactory, the program may impose one or more academic actions on the resident. Unsatisfactory performance or conduct occurs when a resident violates any of the following standards: legal requirements whether state or federal or international; Resident Agreement; University of Utah Policies and Procedures; School of Medicine policies, standards, practices, and expectations; ACGME core competencies; GME policies, standards, practices, and expectations; program-specific policies, standards, practices, and expectations; University of Utah Hospitals and Clinics policies, standards, practices, and expectations; policies, standards, practices, and expectations of a particular training site; ethical standards for physicians; and any other expectations communicated to resident verbally or in writing (for example, by a supervising physician, chief resident, by the program, or otherwise). In addition, unsatisfactory performance or conduct occurs when a resident engages in any behavior which a reasonable person would believe to be in violation of expectations whether or not such expectation is a defined policy, practice, standard, or expectation. The program, in assessing the severity of the academic action to be imposed, may take into account any of the following factors, which list is not intended to be exclusive:

- Physical/safety issues
 - Service impact
 - Financial implications
 - Resultant disruption level
 - Violation of University, ACGME, School of Medicine, GME, Hospital, training site, ethical, or Program standards
 - Violation of law
 - Magnitude of deviation from standards
 - Past history of previous performance or conduct issues
1. Possible academic actions include but are not limited to:
 - a. Corrective action (sometimes referred to as letter of warning or letter of expectations)
 - b. Repeating a rotation or portion of a rotation
 - c. Repeating a year or portion of a year
 - d. Special program such as special supervision or defined academic reading period
 - e. Conditions placed in resident contract
 - f. Suspension
 - g. Non-renewal of contract
 - h. Probation
 - i. Dismissal
 2. Severity of Academic Action; No Requirement for Progressive Actions; Possibility of Multiple Academic Actions.
 - a. The program director or designee will determine the severity of the academic action depending on the factors above and on program director's or designee's determination of the egregiousness of the resident's performance or conduct.
 - b. There is no requirement that academic actions be progressive in nature.
 - c. As applicable, a combination of academic actions may be imposed at the same time.

3. Notification to Resident and Opportunity for Written Response
 - a. The program will notify the resident in writing of any academic action to be imposed and the reasons for that action.
 - b. In addition to the dispute resolution methods discussed in the policy below, the resident may provide a written response to any such letter imposing academic action. Resident's response must be submitted in writing within five (5) business days of the receipt of written notification of the academic action. The resident's response will be placed in the resident's file along with the written notice of academic action.
4. Non-Renewal of Contract
 - a. A resident contract does not establish any right of expectancy that the contract will be renewed for a subsequent year.
 - b. There is no requirement that an academic action must have been imposed prior to non-renewal of contract.
 - c. In cases of non-renewal, the program must provide the resident with a written notice of intent not to renew a resident's contract no later than four months prior to the end of the resident's current contract. However, if the primary reason(s) for the non-renewal occurs within the four months prior to the end of the contract, the program must 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 contract.

Dispute Resolution

1. Informal Resolution: The interests of the University of Utah, the School of Medicine, the various Graduate Medical Education programs, and the residents are best served when problems are resolved as part of the regular communication between the resident and the appropriate program director, Division Chief, Department Chair, and/or GME Director, as appropriate. Residents should first attempt to resolve any disputes concerning academic actions through informal discussions with appropriate individuals within the residency program. If informal discussions are not successful in resolving disputes, the resident may appeal the academic action according to the following procedures.
2. Applicability of Formal Dispute Resolution Processes: The formal dispute resolution processes described below apply only when a specific academic action has occurred that the resident views as being unfair or improper, and when this specific academic action has a direct and adverse effect upon the resident. These processes do not apply to:
 - a. Claims that University, GME, or program policies or procedures are unfair generally.
 - b. Complaints involving discrimination or harassment on the basis of race, color, sex, age, religion, sexual orientation, national origin, ethnic origin, disability, or veteran status; these complaints are to be referred to the University of Utah Office of Equal Opportunity and Affirmative Action.
 - c. Complaints pertaining to general levels of salary, fringe benefits, or other broad areas of financial management and staffing.
 - d. Disputes that are personal in nature and do not involve the grievant's duties as a resident.
3. Resident Review Committee
 - a. Applicability: When a resident is notified of suspension, termination, probation, or non-advancement (including non-renewal of contract), the resident may request a hearing by the Resident Review Committee. To initiate a hearing before the Resident Review Committee, the resident must make written request to the Director of the GME within

seven (7) business days after the resident's receipt of notification of suspension, termination, probation, or non-advancement (including non-renewal of contract). If the resident does not submit a written request within this timeframe, the resident will have waived the right to the dispute resolution process.

- i. The resident's written request for review must contain the following elements:
 1. A brief description of the action being disputed.
 2. A brief statement as to why the resident feels the action is unfair or inappropriate.
 3. A statement of the requested remedy.
 - ii. Hearing procedures: the hearing before the Resident Review Committee shall be conducted as set forth below in IV. Hearing Procedures
 - iii. The Resident Review Committee will issue a written report of findings and recommendations to the Senior Vice President for Health Sciences and Dean of the School of Medicine, or designee, within ten (10) business days after the conclusion of the hearing.
- b. Review and Decision by the Senior Vice President for Health Sciences and Dean of School of Medicine or Designee
- i. The Senior Vice President for Health Sciences/ Dean of the School of Medicine, or designee, shall consider the documentation submitted to the Resident Review Committee and the findings and recommendations of the Resident Review Committee, in making a decision. Based upon such review, and without conducting further hearings, the Senior Vice President for Health Sciences/ Dean or designee shall, within ten (10) business days, take one of the following actions:
 1. Accept the findings and recommendations of the Resident Review Committee;
 2. Return the report to the Committee chair, requesting that the Committee reconvene to reconsider or clarify specific matters, materials, and issues, and forward to the Senior Vice President for Health Sciences/Dean or designee a revised report relating to the specific matters referred by the Senior Vice President for Health Sciences/Dean or designee, for further consideration; or
 3. Reject all or parts of the Committee's findings and recommendations, stating reasons and actions to be taken therefore.
 - ii. Written notice of the (Senior) Vice President for Health Sciences/Dean's or designee's decision shall be communicated to the relevant parties within fifteen (15) business days of the Senior Vice President for Health Sciences/Dean's or designee's receipt of the findings and recommendations.
 - iii. The decision of the (Senior) Vice President for Health Sciences/Dean of the School of Medicine or designee is final unless appealed by either party to the Senior Vice President for Health Sciences within seven (7) business days of receipt of the written decision of the Dean or designee.
- c. Appeal to (Senior) Vice President for Health Sciences or Designee
- i. Within seven (7) business days of receipt of the written decision of the Dean or designee, either party may appeal the decision by filing a written notice of appeal with the (Senior) Vice President for Health Sciences or Designee with a copy to the Director of the GME and to the other party. The other party may file a response to the appeal within five (5) business days of receipt of the appeal.
 - ii. In making a decision, the (Senior) Vice President for Health Sciences or designee shall consider the appeal and the response and may solicit whatever counsel and advice s/he deems appropriate to arrive at a final decision. Based upon such review,

and without conducting further hearings, the (Senior) Vice President for Health Sciences or designee shall, within fifteen (15) business days, take one of the following actions and provide written notification to the parties of the action:

1. Affirm the Dean's or designee's decision.
 2. Return the report to the Committee chair, requesting that the Committee reconvene to reconsider or clarify specific matters, materials, and issues, and forward to the (Senior) Vice President for Health Sciences or designee a revised report relating to the specific matters referred by the (Senior) Vice President for Health Sciences or designee, for further consideration.
 3. Reject all or parts of the Dean's or designee's decision, stating reasons and actions to be taken therefore.
- iii. The standard of review on appeal is whether there were substantial defects that denied basic fairness and due process. If the (Senior) Vice President for Health Sciences or designee determines that there were no substantial defects that denied basic fairness and due process, the decision of the Dean or designee shall be affirmed.
4. Appeals to Program Director, and Division Chief or Department Chair
- a. Applicability: Appeals of academic actions not involving suspension, termination, probation, or non-advancement (including non-renewal of contract) are resolved by the program director, and as applicable by the relevant Division Chief or Department Chair. Thus, disputes involving actions such as corrective action letters, letters of warning, letters of expectation, verbal or written reprimands, letters of admonishment, evaluations (whether written or verbal), final evaluation letters, letters of reference, academic verification letters, placement on special programs, or imposition of new contractual conditions are resolved with the program director, and as applicable with the Division Chief or Department Chair, and not through the Resident Review Committee process described above.
 - b. Discussion with Program Director or Designee
 - i. Residents who feel that an academic action is unfair and who have been unable to resolve the problem through informal discussion shall, within seven (7) business days after the resident's receipt of notification of academic action, submit to the program director a formal written appeal of the academic action. The resident may submit written materials to the program director in support of the resident's appeal. If the resident does not file a written appeal within this time frame, the resident will have waived the right to dispute the academic action.
 - ii. The program director or designee consulted will respond in writing to the resident's claim within fifteen (15) business days.
 - iii. The program director's or designee's decision is final unless the resident submits a written appeal to the Division Chief or designee within five (5) business days of the resident's receipt of the written response from the program director or designee.
 - a. Appeal to Division Chief or Designee (or Department Chair or Designee)
 - i. As used herein, Division Chief or designee means the Division Chief or designee of the School of Medicine Division in which the program is located. If there is no applicable Division Chief or designee, then the relevant Department Chair or designee will be substituted.

- ii. If the dispute is not resolved by appeal to the program director or designee, the resident may file a written appeal with the Division Chief or designee. The resident's written appeal must contain the following elements:
 1. A description of the matter in dispute.
 2. A summary of previous attempts at resolution.
 3. A statement of the requested remedy.
- iii. The resident's written appeal must be submitted to the Division Chief or designee within five (5) business days of the resident's receipt of the written decision from the program director. If the resident does not file a written appeal within this time frame, the resident will have waived the right to refer this matter to the Division Chief or designee (or to the Department Chair or designee).
- iv. The Division Chief or designee shall discuss the dispute with the resident and the appropriate individual(s) within the program or division or elsewhere in an effort to resolve the matter and will issue a written determination within fifteen (15) business days. If the Division Chief or designee needs additional time to issue a written decision, the resident shall be notified accordingly. In no event will there be an extension of time beyond thirty (30) business days after the Division Chief's or designee's receipt of the written statement of dispute.
- v. To overturn the original academic action, the Division Chief or designee must find that the academic action was arbitrary or capricious.
- vi. The determination of the Division Chief or designee will be final.

Hearing Procedures

1. Applicability: these procedures apply to hearings before the Resident Review Committee.
2. Program's response to appeal. The program whose decision is being reviewed by the Committee may deliver a response to the resident's request for review to the chair of the Resident Review Committee, with a copy to the other party, no later than five (5) business days after receipt of the resident's written notice of request for hearing. The Program is not required to submit such a response.
3. Makeup of Committee. The Director of the GME will facilitate the appointment of the Resident Review Committee including a Committee Chair. The Resident Review Committee will consist of two faculty members and three residents, none of whom should have had substantial prior involvement in the dispute. Knowledge of the matter involved does not preclude any individual from serving as a member of the Committee.
4. Conflict of Interest. Upon written request of one of the parties or Committee members, the Committee Chair may but is not required to excuse any member of the Committee if the Committee Chair determines that the member has a conflict of interest and cannot consider the appeal in an unbiased fashion. The Committee Chair shall coordinate with the Director of the GME to select an appropriate replacement for the excused member.
5. Scheduling of Hearing. When an appeal is filed in a timely manner, the Committee Chair shall schedule a hearing date and notify the parties in writing of the date of the hearing, the names of the Committee members, and these hearing procedures at least seven (7) business days prior to the hearing.
6. Timing of Hearing. Hearings shall be conducted within a reasonable time after the resident's initiation of the request for review by the Resident Review Committee.

7. Exchange of Documents and Witness Lists. At least three (3) business days prior to the date of the hearing, the parties shall make available to each other and to the Committee: (i) a list of their witnesses; (ii) a copy of the documents to be offered at the hearing; and (iii) a brief summary of the party's position on the issues being grieved. In exceptional circumstances, the Committee may allow a party to call witnesses not listed or to submit additional documents at the hearing.
8. Right to Advisor. The parties have a right to be accompanied by any person as advisor, including legal counsel, who will be permitted to attend, but not directly participate in, the proceedings. Each party is entitled to only one advisor. If the resident chooses to hire legal counsel, the resident shall be responsible for the legal fees of that lawyer.
9. Hearings not Public. Hearings shall be closed to the public.
10. Copies. Hearings, except Committee deliberations and voting, shall be recorded and a copy made available to any party upon request. Committee deliberations and voting shall take place in closed sessions.
11. Quorum. The Committee must have a quorum present to hold a hearing. A quorum consists of three (3) members of the Committee, including at least one resident. All decisions of the Committee shall require a majority vote of the Committee members present at the hearing.
12. Presentation of Evidence. At the hearing, the parties shall have the right to present questions to witnesses through the Committee chair, to present evidence and to call witnesses, in accordance with the Committee's established internal procedures. Cross examination of witnesses is only allowed through the Committee Chair.
13. Rules of Evidence. The Committee shall not be bound by strict rules of legal evidence or procedure and may consider any evidence it deems relevant.
14. Role of the Office of General Counsel. A member of the Office of General Counsel shall serve as a resource to the Committee and may be present at the hearing and at post-hearing deliberations to provide guidance on substantive law and procedural matters.
15. Standard of Review. To recommend overturning the original academic action, the Committee must find that the academic action was arbitrary or capricious.
16. Absence of Party. If either party to the appeal fails to attend the hearing without good cause, the Committee may proceed with the hearing and take testimony and evidence and reach a decision on the basis of such testimony and evidence.

CHECK OUT

Graduating residents will report to their scheduled service until June 22nd. Graduating residents may use June 23rd to complete the requirements from Graduate Medical Education Checkout Procedure. If June 23rd occurs on a weekend (Saturday or Sunday), the checkout day will occur on the preceding Friday.

Checkout includes:

- Following the Graduate Medical Education Checkout Procedure. <http://medicine.utah.edu/gme/policies/13.2.pdf>
- Return all Keys to the Program Coordinator.
- Return all Temporal Bone Laboratory Equipment and Keys to the Course Coordinator.

CONTRACT RENEWAL CYCLE

Resident contracts for the upcoming year will be prepared and distributed on or before January 15th. Deadline for the residents to return the signed contract is January 22nd.

FELLOWSHIP SELECTION

1. Eligibility
 - a. To be eligible for appointment to the Residents at the University of Utah, School of Medicine, an applicant must:
 - b. Be a graduate of a US or Canadian medical school accredited by the Liaison Committee on Medical Education (LCME) –OR—
 - c. Be a graduate of a medical school outside the United States who meets one or more of the following qualifications: (1) Has a currently valid ECFMG certificate; (2) Has a minimum of six months' clinical experience in the United States; (3) Has a full and unrestricted license to practice medicine in a US licensing jurisdiction.
 - d. All Fellowship appointments will be offered through the SF Match.
 - e. In addition, applicants must be graduates of an ACGME-accredited Otolaryngology – Head and Neck Surgery residency training program in the US or Canada prior to the time they will begin training.
2. Program Information
 - a. Information about the program can be found on our website: <http://medicine.utah.edu/surgery/otolaryngology/residency.php>.
3. Application Process
 - a. The Division of Otolaryngology selects one fellow per year. Physicians interested in the Pediatric Otolaryngology fellowship should apply using the SF Match's Central Application Service (CAS).
 - b. We require the following to be included with each application:
 - i. Application using SF Match's Central Application Service (CAS)
 - ii. Personal Statement
 - iii. Three letters of recommendation
 - iv. Dean's letter
 - v. Medical school transcripts
 - vi. USMLE scores Step 1 and, if available, Step 2 (PGY2 or above: Step 3 must be taken before starting)
 - vii. Additional information such as research activity and community involvement may be included as the applicant wishes.
 - c. Candidates for this program are selected based on their preparedness, ability, academic credentials, communication skills, and personal qualities such as motivation and integrity.
4. Application Review and Interviewing
 - a. Applications are reviewed via criteria set forth by the ACGME Program Requirements, the Fellowship Selection Committee, and this institution. The Fellowship Selection Committee reviews applicants who meet the criteria. Based on the quality of the application packet and academic credentials, the applicant is subsequently invited, if appropriate, for an interview. Each applicant is interviewed by all available faculty members.

- b. At the conclusion of the interviews, the faculty interviewers rank the applicants. A match list is developed and submitted by the Fellowship Director to the SF Match. Strict conformance with the rules of the match is maintained throughout the selection process.
5. The University of Utah, School of Medicine does not discriminate on the basis of gender, gender identity/expression, sexual orientation, race, age, religion, color, national origin, disability, genetic information, or veteran's status.

LEAVE

Residents of the School of Medicine are entitled to necessary leave during training. Otolaryngology residents are simultaneously employees of the University of Utah and students training to become qualified for certification by the American Board of Otolaryngology (ABOto). This policy is intended to provide guidelines that will address trainees' personal needs and still allow them to be ABOto qualified at the completion of training.

Vacation Leave, Sick Leave, Maternity/Paternity Leave, and Educational and Examination time are all handled in the same fashion and are at the discretion of the Program Director, Chief Resident, and Rotation Directors. Family and Medical Leave is federally mandated and not at the discretion of the Program Director or Chief Resident. This departmental policy is on file in the Office of Graduate Medical Education and is distributed to all applicants at the time they request application information for the Otolaryngology residency program. Except for Family and Medical Leave, leave is handled on an individual basis to be determined by the Program Director, Chief Resident, Rotation Directors, and, if necessary, the Medical Education Director to comply with guidelines of the School of Medicine.

Leave taken in excess of six weeks per year affects credit toward ABOto certification requirements. If, for any reason, residents are absent more than six weeks in any one academic year, they must make up the time after their residency in order to qualify for certification by the ABOto. Residents must request leave from the Program Director and the Chief Resident. A "Notification of Resident Anticipated Absence" form must be completed and signed to authorize leave. The Academic Coordinator will send it to the Graduate Medical Education Office two weeks prior to the absence.

University of Utah residents are granted 15 calendar days of paid vacation per year. Vacation is taken in blocks of five weekdays except as noted below.

1. Vacation Leave
 - a. All vacation requests must be submitted by July 1 for that academic year. In certain cases, junior residents who are scheduled to rotate with senior residents on a two-person service may not have their winter/spring vacation dates finalized because the senior residents may need flexibility to schedule time off for fellowship or job interviews.
 - b. Residents taking more than 10 work days for fellowship interviews must use their accrued vacation days for additional time off.
 - c. Vacation blocks for each resident should be distributed evenly among the various rotations. No vacation will be granted during the last two weeks in June and the first

- two weeks in July or during regular conference weeks (AAO-HNS annual meeting, COSM, Head and Neck Dissection Course, Residency interviews, Triological, Western Rhinology conference, Utah Otolaryngology Update Conference, Western Section, etc...).
- d. Vacation date preference will be granted first to the resident who scores highest (based on training level) on the Otolaryngology Training Examination, then to other residents in descending order of scores.
 - e. Residents will be granted three days of leave. Additional days will be taken from the 15 days of vacation granted each year.
2. Sick Leave
Although Residents do not accrue sick leave, in the case of illness, and with the Program Director's permission, a Resident may take paid sick leave. Coverage will be arranged during their absence. If sick leave extends for more than two weeks per year of training, the Program Director may choose to not pay the resident or the resident may choose to use paid vacation leave. If, for any reason, the resident is absent for more than six weeks in an academic year, he or she will have to complete additional training time at the normal end of the training period in order to satisfy ABOto requirements.
 3. Leave of Absence
A resident may request a leave of absence without pay from the Residency Program Director and the Chair of the Division of Otolaryngology. Each request will be considered on an individual basis.
 4. Maternity/Paternity Leave
Residents may take seven weeks of paid leave (two weeks maternity/paternity leave, two weeks sick leave, and three weeks of vacation) to care for a new child by birth or adoption. The Chief Resident should make every effort to schedule expectant residents on lighter rotations with as little night call as possible near the expected due date. Additional training time required to satisfy ABOto requirements will be paid.
 5. Family and Medical Leave
The "Family Leave Policy" for residents at the University of Utah meets the requirements of the Family and Medical Leave Act of 1993, allowing up to 12 weeks of unpaid leave per year. However, the ABOto requires at least 46 working weeks per year of training. Thus, the ABOto permits six weeks of leave per year, which is less than that granted by the Act. Any residents taking more leave than is allowed by ABOto requirements will make up this training time after his or her scheduled residency time.
 6. Educational and Examination Time
With the permission of the Program Director, Residents may be given paid educational time each year. This would include time away from the residency to present a paper at approved national meetings, attend a national meeting in Otolaryngology, or take board or other examinations. All Residents are required to obtain a medical license to participate in the Otolaryngology training program; therefore, the department allows residents time off with pay to sit for the National Boards Part III, Flex examination, and any other licensing exam necessary. The resident is responsible for arranging coverage during his or her absence. Time taken for educational and examination purposes is included in the 46 weeks per academic year required by the ABOto for certification.
 7. Holidays

Residents are granted only holiday days received by the employees of the affiliated hospital during their current rotation. For example, residents assigned to VAMC receive only VAMC holidays, and residents assigned to University Hospital services receive only University Hospital holidays.

8. International Humanitarian Outreach Programs

Senior residents have the opportunity to participate in an international humanitarian outreach program.

a. To be eligible, residents must meet the following requirements:

- i. Be in good standing within the residency program.
- ii. While in residency, have presented a minimum of two podium or poster presentations at a national meeting.
- iii. Arrange for and have adequate coverage on the service currently rotating (must have approval from the faculty on that service).
- iv. Program must be with a member of the faculty, or the program approved by the faculty.

b. Funding

- i. No divisional or departmental funds will be allocated to this program. Funding sources will come from a combination of those listed below:
- ii. AAO-HNSF Humanitarian Resident Travel Grant (\$1000). Residents are required to apply.
- iii. NAP funds.
- iv. Self-funding from the residents or resident donations.
- v. Individual faculty accounts.
- vi. Donations to the division.

LICENSING FOR R2's

1. Deadlines

- a. The deadline for license applications is July 31st. Any application turned in later than July 31st will be returned to the applicant and will not be paid for by the GME office. Late applications may also subject residents to disciplinary action.
- b. The deadline to receive the Utah State license is October 31st. The deadline to receive the DEA license is December 31st. Residents must provide the GME office with a copy of their licenses by October 31st or face possible suspension.

2. Controlled Substance License

The Controlled Substance License is part of the Utah State license. Residents must take and pass the Controlled Substance exam in order to receive this license. Residents must take the original copy of their CS exam scores to the GME office, which will submit it to the DOPL and reimburse for the exam cost.

3. DEA License

The Utah Controlled Substance license and the federal DEA license are two different licenses. Once residents have received their Utah licenses, they may apply for the separate federal DEA number. This requires submission of a separate application for the federal DEA. Applications are available in the GME office.

MOONLIGHTING

Graduate medical education training is a rigorous full-time educational experience. It is important that residents have time for adequate rest and personal pursuits. Residents should not be diverted from their primary responsibilities of patient care and learning by engaging in extramural professional activities.

Moonlighting is prohibited for the University of Utah Otolaryngology residency.

DUTY HOURS IN THE WORK AND LEARNING ENVIRONMENT

To comply with policies of the Accreditation Council on Graduate Medical Education (ACGME) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the University of Utah office of Graduate Medical Education concerning resident work hours.

1. Resident Duty Hours

- a. Work hours are defined as all clinical and academic activities related to the residency or fellowship program. This includes patient care, administrative duties related to patient care, provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Work hours do not include reading and preparation time spent away from the work site.
- b. Work hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all call activities, unless vacation/leave time has been taken during that period, in which case the 80 hours must be averaged over the weeks the resident was not on vacation/leave.
- c. Interns may not work more than 16 consecutive hours.
- d. Residents/fellows must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities. Vacation/leave time may not be counted as time off.
- e. A 10-hour time period for rest and personal activities should (and an 8-hour time period must) be provided between all daily work periods. In order to meet this requirement, residents who are not on call are required to leave the hospital by 8 p.m. each night, and morning rounds should not begin before 6 a.m.
- f. Intermediate residents must have at least 14 hours free of duty after 24 hours of in-house duty.

2. Resident Learning and Working Environment

Residents have a professional responsibility as physicians to appear for duty appropriately rested and fit to provide the services required by their patients. This includes:

- a. Assurance of the safety and welfare of patients entrusted to their care;
- b. Assurance of their fitness for duty;
- c. Management of their time before, during and after clinical assignments;
- d. Recognition of impairment, including illness and fatigue, in themselves and their peers;
- e. Attention to lifelong learning
- f. The monitoring of patient care performance improvement indicators; and,
- g. Honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.

- h. Residents will participate in interdisciplinary clinical quality improvement and patient safety programs.
 - i. All residents must demonstrate responsiveness to patient needs that supersedes self-interest. Residents must recognize that under certain circumstances the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.
3. On-Call Activities:
- a. There is no Otolaryngology in-house call.
 - b. At-home call (pager call) is defined as call taken from outside the assigned institution.
 - i. 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.
 - ii. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a four-week period.
 - c. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.
 - d. Continuous on-site work hours must not exceed 24 consecutive hours. Residents may remain on duty for up to 4 additional hours to transfer care of patients. At their discretion, residents may also participate in didactic activities during these additional four hours.
 - e. Strategic napping after 16 hours of continuous duty is strongly suggested.
 - f. No new patients in any patient setting (ED, Operating Room, or Outpatient Clinic) may be seen after 24 hours of continuous duty. A new patient is defined as any patient for whom the resident has not previously provided care.
 - g. Back-Up System:
 - i. For each day of the month, the call schedule designates a single resident who is responsible for call duties (1st call). On days when trauma call is the responsibility of the Otolaryngology service, another 1st call resident is assigned. For each call day, there is also designated a backup (2nd call) resident. The backup call resident will assume patient care responsibilities if unusual circumstances create resident fatigue for the 1st call resident(s) that is sufficient to jeopardize patient care or if the volume of consult cases requires that additional help be called in to facilitate timely patient care.
4. Work Hours Reporting
- a. Residents are required to log on to the online system at least weekly to record their work hours.
 - b. The online system requires that residents identify duty types.
 - c. Shift is for all regular duty hours. This may include contiguous hours spent in conferences, clinical duties, OR duties, and other educational activities.
 - d. Pager Call-Called In is for the time residents spend in the hospital after being called in from home.
 - e. Conferences are for required educational meetings *that do not immediately precede or follow shift work*.
 - f. Other is for required examinations or other non-didactic required activities (i.e., attendance during applicant interviews).

- g. Violations of work hours reporting may result in a suspension of OR privileges until the requirement is met. Should there be violation of these policies; the involved resident is requested to report these matters to the Program Director.

PROFESSIONAL ATTIRE GUIDELINES

Resident appearance and conduct should at all times reflect the dignity and standards of the medical profession. Dress guidelines for residents assist in achieving this goal while also acknowledging individual desires for diversity and self-expression. Following are guidelines for professional attire. These guidelines apply to each work day, including days with no patient care responsibilities. Maternity clothes are not exempt from these guidelines.

1. Name Tags: Proper identification as required by each training site must be worn and clearly displayed at all times while on duty.
2. White Coats: White coats are recommended, and must be clean and neat. If wearing scrubs outside the operating area, it is recommended that a clean white coat be worn over the scrubs.
3. Scrubs: Scrubs should not be worn outside of the hospital premises. Scrubs are expected to be clean and pressed. Scrubs may be worn in the operating room, delivery areas, or in the Emergency room, AO, and all ICUs. In patient care areas, it is recommended that a coat with name tag be worn over the scrubs.
4. Shoes: Footwear must be clean, in good condition, and appropriate. Open-toed shoes and sandals are not recommended in patient care areas for safety reasons.
5. Style: No tank or halter tops, midriffs, or tube tops. No sweatshirts or shirts with messages, lettering or logos (except UUMC, LDS, or VAMC). No shorts. Jeans are discouraged. A tie is recommended for men on weekdays.
6. Fragrance: No strong colognes or perfumes as patients may be sensitive to strong fragrances.
7. Hands: Fingernails must be clean and short to allow for proper hand hygiene and use of instruments, and to prevent glove puncture and injury to the patient. Artificial nails do not allow for proper hand hygiene.
8. Hair: Mustaches, hair longer than chin length, and beards must be clean and well-trimmed. Residents with long hair who render patient care should wear hair tied back to avoid interfering with performance of procedures or coming into contact with the patient.
9. Jewelry: Should not be functionally restrictive or excessive.
10. Piercings: There should be no visible body piercings, with the exception of ears. Nose piercings which have religious significance are acceptable.
11. Tattoos: There should be no visible tattoos.

If a resident is in violation of these guidelines, he/she may be asked to return home to change into more appropriate attire. Repeat violations will result in a letter being placed in the resident's permanent file, addressing deficiencies in the professionalism competency portion of training.

RESIDENT EVALUATION

The overall academic quality of the training program can, in part, be measured by the performance of the residents. The training program expects a progression of knowledge in the specialty area from beginning to end of training, and such progress needs to be monitored. It is further expected that residents will be eligible for the board examination upon completion of the training program, with an overall goal that all residents will pass the examination and become

board certified. In addition to achieving board certification, the training of effective and competent physicians is the goal of each training program, and all evaluations will be directed at that ultimate objective. Residents are required to:

1. Review, learn, and put into practice the materials, standards, requirements, and expectations of the program.
2. Review and understand the criteria by which they will be evaluated for the knowledge, skills, and professional behaviors necessary to successfully complete the training program.
3. Raise any questions they may have to assure that they understand the expectations of the program and the criteria for advancement and completion.
4. Each resident will undergo a 360° evaluation at the conclusion of every rotation. The evaluators shall include faculty, peers, self, and other professional staff. Competency in Clinical/Surgical Skills, Medical Knowledge, Interpersonal and Communication Skills, Practice-Based Learning and Improvement, Professionalism, and Systems-Based Practice will be measured. These evaluations will be reviewed by the Program Director. If the resident's progress is not satisfactory, interim evaluations will be instituted.
5. Residents new to the program require special monitoring, and will have an evaluation after they have been on service for two months. Supervisors are responsible for early detection of problems, and remedial programs will be established for such residents.
6. Semiannually, the Program Director will meet with each resident and provide that resident with a written evaluation. The resident will be allowed to refute in writing any evaluation, which refutation will be placed in the resident's file along with the evaluation.
7. The Program Director will provide a final evaluation for each resident who completes the program. This evaluation will include a review of the resident's performance and will verify that the resident has demonstrated sufficient professional ability to practice competently and independently. It will also verify that the resident has successfully completed the requirements for board eligibility or list areas of deficiency for board eligibility. This evaluation will be maintained as part of the permanent record by the Office of Graduate Medical Education and in the resident's Program file.
8. All evaluations will be placed in the resident's permanent file and will be available for review by the resident upon request.

RESIDENT SELECTION PROCESS

1. To be eligible for appointment to the Residents at the University of Utah, School of Medicine, an applicant must:
 - a. Be a graduate of a US or Canadian medical school accredited by the Liaison Committee on Medical Education (LCME) –OR—
 - b. Be a graduate of a medical school outside the United States who meets one or more of the following qualifications: (1) Has a currently valid ECFMG certificate; (2) Has a minimum of six months' clinical experience in the United States; (3) Has a full and unrestricted license to practice medicine in a US licensing jurisdiction.
2. All PGY-1 positions for graduates right out of medical school will be offered through the National Resident Matching Program.
3. In addition, applicants must have passed Parts I and II of USMLE prior to the time they will begin training.

4. Information about the program can be found on our website: <http://medicine.utah.edu/surgery/otolaryngology/residency.php>.
5. Application Process

The Division of Otolaryngology selects three residents per year. Physicians or students interested in the Otolaryngology residency program should apply using the Electronic Residency Application Services (ERAS) through the dean's office of their medical school or the ECFMG office.

 - a. We require the following to be included with each application:
 - i. Application using Common Application Form (CAF)
 - ii. Personal Statement
 - iii. Three letters of recommendation
 - iv. Dean's letter
 - v. Medical school transcripts
 - vi. USMLE scores Step 1 and, if available, Step 2 (PGY2 or above: Step 3 must be taken before starting)
 - vii. Additional information such as research activity and community involvement may be included as the applicant wishes.
6. Application Review and Interviewing
 - a. Candidates for this program are selected based on their preparedness, ability, academic credentials, communication skills, and personal qualities such as motivation and integrity.
 - b. Applications are reviewed via criteria set forth by the ACGME Program Requirements, the Residency Selection Committee, and this institution. The Residency Selection Committee reviews applicants who meet the criteria. Based on the quality of the application packet and academic credentials, the applicant is subsequently invited, if appropriate, for an interview. Each applicant is interviewed by all available faculty members. All applicants meet with the current residents and have lunch and a tour with a resident.
 - c. At the conclusion of the interview, the faculty interviewers rank the applicants. Comments by the current residents are considered. The ranking is finalized at the next faculty meeting. A match list is developed and submitted by the Program Director to the NRMP. Strict conformance with the rules of the match is maintained throughout the selection process.

The University of Utah School of Medicine does not discriminate on the basis of gender, gender identity/expression, sexual orientation, race, age, religion, color, national origin, disability, genetic information, or veteran status.

SUPERVISION OF POSTGRADUATE TRAINEES

In a health care system where patient care and the training of health care professionals occur together, there must be clear delineation of responsibilities to ensure that qualified practitioners provide patient care, whether they are trainees or full-time staff. It is recognized that as resident trainees acquire the knowledge and judgment that accrue with experience, they will be allowed the privilege of increased authority for patient care.

The intent of this policy is to ensure that patients will be cared for by clinicians who are qualified to deliver that care and that this care will be documented appropriately and accurately in the

patient record. This is fundamental, both for the provision of excellent patient care and for the provision of excellent education and training for future health care professionals.

The quality of patient care, patient safety, and the success of the educational experience are inexorably linked and mutually enhancing. Incumbent on the clinician educator is the appropriate supervision of the residents as they acquire the skills to practice independently.

1. Definitions

- a. Graduate Medical Education. Postgraduate medical education is the process by which clinical and didactic experiences are provided to residents to enable them to acquire the skills, knowledge, and attitudes which are important in the care of patients. The purpose of graduate medical education is to provide an organized and integrated educational program providing guidance and supervision of the resident, to facilitate the resident's professional and personal development, and to ensure safe and appropriate care for patients. Graduate medical education programs focus on the development of clinical skills, attitudes, professional competencies, and acquisition of detailed factual knowledge in a clinical specialty.
- b. Program Director. The Program Director is responsible for the quality of the overall affiliated education and training program in a given discipline (i.e., medicine, surgery, psychiatry, pediatrics, etc.) and for ensuring the program is in compliance with the policies of the respective accrediting and/or certifying body(ies).
- c. Residents. The term "residents" refers to individuals who are engaged in a postgraduate training program in medicine (which includes all specialties such as internal medicine, surgery, psychiatry, pediatrics, etc.) The term "resident" for the purposes of this policy includes individuals in their first year of training, typically referred to as "interns," and individuals in advanced postgraduate education programs, who are typically referred to as "fellows."
- d. Attending Physician. Attending physician refers to licensed, independent physicians, who have been formally credentialed and privileged at the training site, in accordance with applicable requirements. The Attending physician may provide care and supervision only for those clinical activities for which they are privileged. This term is synonymous with the "Attending Physician" in medicine.
- e. Supervision. Supervision refers to the dual responsibility that an attending physician has to enhance the knowledge of the resident and to ensure the quality of care delivered to each patient by any resident. Such control is exercised by observation, consultation, and direction. It includes the imparting of the practitioner's knowledge, skills, and attitudes by the practitioner to the resident and ensuring that the care is delivered in an appropriate, timely, and effective manner.

2. Responsibilities:

- a. Associate Dean for Graduate Medical Education. The Associate Dean for Graduate Medical Education is responsible for establishing local policy to fulfill the requirements of this policy and the applicable accrediting and certifying body(ies) requirements.
- b. Residency Program Director. The Residency Program Director is responsible for the quality of the overall education and training program in a given discipline (i.e., medicine, surgery, psychiatry, pediatrics, etc.) and for ensuring that the program is in compliance with the policies of the respective accrediting or certifying body(ies). The

Residency Program Director works with the faculty to gather information and then defines the levels of responsibilities for each year of training by preparing a description of the types of clinical activities residents may perform and those for which residents may act in a teaching capacity.

- i. Assess the attending physician's discharge of supervisory responsibilities. At a minimum, this includes written evaluations by the residents and interviews with residents, other practitioners, and other members of the health care team.
 - ii. Structure training programs consistent with the requirements of the accrediting and certifying body(ies) (as identified above) and the affiliated sponsoring entity.
 - iii. Arrange for all residents entering their first rotation to participate in an orientation to policies, procedures, and the role of residents within the affiliated training program.
 - iv. Ensure that residents are provided the opportunity to contribute to discussions in committees where decisions being made may affect their activities.
- c. Attending physician. The attending physician is responsible for and must be personally involved in the care provided to individual patients in inpatient and outpatient settings as well as long-term care and community settings. When a resident is involved in the care of the patient, the responsible attending physician must continue to maintain a personal involvement in the care of the patient. The procedures through which the attending physicians provide and document appropriate supervision is outlined below in section 5.
- d. Resident. The residents, as individuals, must be aware of their limitations and not attempt to provide clinical services or do procedures for which they are not trained. They must know the graduated level of responsibility described for their level of training and not practice outside of that scope of service. Each resident is responsible for communicating significant patient care issues to the attending physician. Such communication must be documented in the record. Failure to function within graduated levels of responsibility or to communicate significant patient care issues to the responsible attending physician may result in the removal of the resident from patient care activities.
3. Procedures:
- a. Resident Supervision by the attending physician. Attending physicians are responsible for the care provided to each patient, and they must be familiar with each patient for whom they are responsible. Fulfillment of such responsibility requires personal involvement with each patient and each resident who is providing care as part of the training experience. Each patient will be assigned an attending physician whose name will be clearly identified in the patient's record. It is recognized that other attending physicians may, at times, be delegated responsibility for the care of a patient and provide supervision instead of, or in addition to, the assigned practitioner. Such a delegation will be documented in the patient's record. The attending physician is expected to fulfill this responsibility, at a minimum, in the following manner:
 - i. The attending physician will direct the care of the patient and provide the appropriate level of supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the resident being supervised. Medical or surgical services must be rendered under the supervision of the attending physician or be

personally furnished by the attending physician. Documentation of this supervision will be by progress notes entered into the record by the attending physician or reflected within the resident's progress note at a frequency appropriate to the patient's condition. The medical record should reflect the degree of involvement of the attending physician, either by staff physician progress note, or the resident's description of attending involvement. . The resident note shall include the name of the attending physician with whom the case was discussed as well as a summary of that discussion. The attending may choose to countersign and add an addendum to the resident note detailing his/her involvement and supervision. Attending physicians will be responsible for following the admitting procedures required by the institutions at which they are admitting patients in association with resident physicians.

- ii. For patients admitted to an inpatient team, the attending physician must meet the patient early in the course of care. In most cases, this means within 24 hours of admission, including weekends and holidays. This supervision must be personally documented in a progress note no later than the day after admission. The attending physician's progress note will include findings and concurrence with the resident's initial diagnosis and treatment plan as well as any modifications or additions. The progress note must be properly signed, dated, and timed. Attending physicians are expected to be personally involved in the ongoing care of the patients assigned to them in a manner consistent with the clinical needs of the patient and the graduated level of responsibility of the trainee.
- iii. The attending physician, in consultation with the resident, will ensure that discharge or transfer of the patient from an inpatient team or clinic is appropriate, based on the specific circumstances of the patient's diagnoses and therapeutic regimen. This may include physical activity, medications, diet, functional status, and follow-up plans. At a minimum, evidence of this assurance will be documented by the attending physician's countersignature of the discharge summary or clinic discharge note.
- iv. For outpatients, all new patients to the clinic for which the attending physician is responsible should be supervised by the attending physician. This supervision must be documented in the chart via a progress note by the attending physician or the resident's note and include the name of the attending physician and the nature of the discussion. New patients should be supervised as dictated by graduated level of responsibility outlined for each discipline. In general, new patients should be seen and evaluated by the attending physician at the time of the patient visit. Return patients should be seen by or discussed with the attending physician at such a frequency as to ensure that the course of treatment is effective and appropriate. This supervision must be documented in the record via a note by the attending physician or the resident's note that indicates the nature of the discussion with the attending physician. The medical record should reflect the degree of involvement of the attending physician, either by staff physician progress note or the resident's description of attending involvement. The attending may choose to countersign and add an addendum to the resident note detailing his/her involvement. All notes must be signed and dated.

- v. The attending physician is responsible for official consultations on each specialty team. When trainees are involved in consultation services, the attending physician will be responsible for supervision of these residents. The supervision of residents performing consultation will be determined by the graduated levels of responsibility for the resident. The attending physician must meet with each patient who received consultation by a resident and perform this personal evaluation in a timely manner based on the patient's condition. The patients seen in consultation by residents must be discussed and/or reviewed with the attending physician supervising the consultation within 24 hours of initial consultation by the resident. The attending physician must document this official consultation supervision by writing a personal progress note or by writing his/her concurrence with the resident consultation note by the close next working day. The attending may choose to countersign and add an addendum to the resident note detailing his/her involvement.
- vi. Emergency room consultations. Emergency room consultations by residents may be supervised by a specialty attending physician or the emergency room attending physician. All emergency room consultations by residents should involve the attending physician supervising the resident's discipline specific specialty consultation activities for which the consultation was requested. After discussion of the case with the discipline specific attending physician, the resident may receive direct supervision in the emergency room from the emergency room attending physician. For cases of a routine nature (such as control of epistaxis and treatment of peritonsillar abscess), a standard treatment protocol has been established and will be followed; these cases will be discussed with the attending within eight hours of treatment. In such cases where the emergency room attending physician is the principal provider of care for the patient's emergency room visit, the specialty specific attending physician does not need to meet directly with the patient. However, the specialty specific attending physician's supervision of the consultation should be documented in the medical record by co-signature of the consultation note or be reflected in the resident physician consultation note.
- vii. Ensure all Do Not Resuscitate (DNR) orders are appropriate and ensure the supportive documentation for DNR orders are in the patient's medical record. All DNR orders must be signed or countersigned by the attending physician.
- b. Assignment and Availability of Attending physicians
 - i. Within the scope of the training program, all residents, without exception, will function under the supervision of attending physicians. A responsible attending physician must be immediately available to the resident in person or by telephone and able to be present within a reasonable period of time (generally considered to be within 30 minutes of contact), if needed. Each discipline will publish, and make available "call schedules" indicating the responsible attending physician(s) to be contacted.
 - ii. In order to ensure patient safety and quality patient care while providing the opportunity for maximizing the educational experience of the resident in the ambulatory setting, it is expected that an appropriately privileged attending physician will be available for supervision during clinic hours. Patients followed

in more than one clinic will have an identifiable attending physician for each clinic. Attending physicians are responsible for ensuring the coordination of care that is provided to patients.

c. Graduated Levels of Responsibility

- i. Each training program will be structured to encourage and permit residents to assume increasing levels of responsibility commensurate with their individual progress in experience, skill, knowledge, and judgment.
- ii. As part of their training program, residents should be given progressive responsibility for the care of the patient. The determination of a resident's ability to provide care to patients without a supervisor present or to act in a teaching capacity will be based on documented evaluation of the resident's clinical experience, judgment, knowledge, and technical skill. Ultimately, it is the decision of the attending physician as to which activities the resident will be allowed to perform within the context of the assigned levels of responsibility. The overriding consideration must be the safe and effective care of the patient that is the personal responsibility of the attending physician.
- iii. The Residency Program Director will define the levels of responsibilities for each year. These levels of responsibility will come, in part, by faculty submitting to the program director the technical details of clinical skills appropriate for each year of training. The documentation of the assignment of graduated levels of responsibility will be made available to other staff as appropriate. These guidelines will include the knowledge, attitudes, and skills which will be evaluated and must be present for a resident to advance in the training program, assume increased responsibilities (such as the supervision of lower level trainees), and be promoted at the time of the annual review.

d. Supervision of Procedures

- i. Diagnostic or therapeutic procedures require a high level of expertise in their performance and interpretation. Although gaining experience in performing such procedures is an integral part of the education of the resident, such procedures may be performed only by residents with the required knowledge, skill, and judgment and under an appropriate level of supervision by attending physicians. Attending physicians will be responsible for authorizing the performance of such procedures, and such procedures should only be performed with the explicit approval of the attending physician. NOTE: Excluded from the requirements of this section are procedures that, although invasive by nature, are considered elements of routine and standard patient care (Examples: Nasopharyngoscopy, myringotomy and tube placement, tracheostomy tube change, drainage of superficial abscess, control of epistaxis).
- ii. Attending physicians will provide appropriate supervision for the patient's evaluation, management decisions and procedures. For elective or scheduled procedures, the attending physician will evaluate the patient and write a pre-procedural note describing the findings, diagnosis, plan for treatment, and/or choice of specific procedure to be performed.
- iii. During the performance of such procedures, an attending physician will provide an appropriate level of supervision. Determination of this level of supervision is generally left to the discretion of the attending physician within the context of the

previously described levels of responsibility assigned to the individual resident involved. This determination is a function of the experience and competence of the resident and of the complexity of the specific case.

- iv. Emergency Situation. An "emergency" is defined as a situation where immediate care is necessary to preserve the life of, or to prevent serious impairment of the health of a patient. In such situations, any resident, assisted by other clinical personnel as available, shall be permitted to do everything possible to save the life of a patient or to save a patient from serious harm. The appropriate attending physician will be contacted and apprised of the situation as soon as possible. The resident will document the nature of that discussion in the patient's record.
- e. Evaluation of Residents and Supervisors
 - i. Each resident will be evaluated according to accrediting and certifying body(ies) requirements on the basis of clinical judgment, knowledge, technical skills, humanistic qualities, professional attitudes, behavior, and overall ability to manage the care of a patient. Evaluations by faculty will occur every at the end of each rotation. The Program Director will take these evaluations into consideration when preparing the semi-annual evaluation. The semi-annual evaluation will be discussed with the resident.
 - ii. If a resident's performance or conduct is judged to be detrimental to the care of a patient(s) at any time, action will be taken immediately to ensure the safety of the patient(s).
 - iii. Semi-annually, each resident will be given the opportunity to complete a confidential written evaluation of attending physicians. Such evaluations will include the adequacy of clinical supervision by the attending physician. The evaluations will be reviewed by the program director.
 - iv. Residents will evaluate the quality of the training at the end of each rotation. Residents will also anonymously evaluate the program as a whole at the end of each academic year. These evaluations will be used by the Rotation Directors and Program Director to make substantive changes to the program.
 - v. All written evaluations of residents, attending physicians, rotations and the program will be kept on file by the Residency Program Director in the Division of Otolaryngology office in the residents' permanent records.
- 4. Monitoring Procedures:

Monitoring of the compliance with these procedures will be performed by the program director and as part of the scheduled internal program reviews.

Handoff Policy

The purpose of this policy is to facilitate safe management of inpatient otolaryngology service patients and hospital consultations across University of Utah Hospitals including the Huntsman Cancer Hospital. There is an inherent risk to patients during cross coverage between the treating platinum, gold, and silver teams and the on-call team and weekend coverage teams. This resident handoff policy will ensure that patient care issues are communicated between teams in an organized and reproducible fashion and mitigate communication issues that may place a patient at risk during these times of highest risk.

- 1. Each team will maintain an updated list of patients in the Epic electronic medical record. All attending physicians who admit patients to these services will have access to the list

of patients on their service. In addition, the note function in Epic will be used to communicate relevant patient care issues and will be available to all residents and attending otolaryngology physicians. The list and notes will be kept current and updated by the designated junior resident on each service and will be finalized each day by 8 PM. It is the responsibility of the chief resident on each service to communicate current patient care issues to the junior resident ensuring that ongoing management issues have been updated in Epic.

2. By 8 PM daily, the junior level resident will conduct a verbal sign out to the on-call junior level resident of each patient on the service highlighting patient management considerations that may become issues overnight. Critical patient management issues with impending complications will be communicated by the treating chief resident to the on-call chief resident to ensure a second level of protection for patients with impending overnight management issues.
3. By 8 PM Friday, each chief resident will conduct a verbal sign out with the weekend covering chief resident concerning each patient on individual otolaryngology services including the platinum, gold, and silver teams. In addition, each junior level resident on individual teams will conduct a verbal sign out to the oncoming on-call junior level resident. As the junior level on-call weekend coverage rotates that junior level resident will in turn conduct a verbal sign out to each new oncoming on-call junior level resident.
4. For weekend coverage, an email will be generated and distributed to the on-call team regarding all patients on all services. This will be in addition to a verbal sign out and maintenance of the services lists and ENT on-call notes. This email provides additional details regarding patients; including history, allergies, relevant medical issues, medication issues, and pertinent surgical history. The email will be distributed with PHI in the subject line to ensure HIPPA compliance.
5. The weekend on-call junior level resident will maintain the patient list for each of the otolaryngology services and the notes for each patient on all services and update these by 8 PM daily.
6. Attending otolaryngology physicians will either maintain control of their individual patients during the week and weekends or verbally sign out their patients to another attending physician on their team or to the on-call attending physician. Changes in coverage will be communicated to the chief resident of their service and noted in Epic.

TECHNICAL STANDARDS

The University of Utah, School of Medicine Graduate Medical Education Program in Otolaryngology-Head and Neck Surgery complies with Section 504 of the 1973 Vocational Rehabilitation Act, as amended, and the Americans with Disabilities Act of 1990, in providing opportunities for qualified individuals with disabilities. At the same time, prospective candidates must be capable of meeting certain technical standards. The following technical standards specify those attributes the faculty considers to be essential in successfully completing residency training and in practicing medicine safely and responsibly. These standards describe the essential functions that residents must demonstrate in the requirements of post-graduate medical education, and thus, are pre-requisites to entrance, continuation, and completion of residency training in the Otolaryngology-Head and Neck Surgery Program. Requests for reasonable accommodation are evaluated on an individual basis. The resident must possess abilities and skills in five areas:

1. Observation. The resident must be able to:
 - a. Observe a patient accurately at a reasonable distance and close at hand, noting non-verbal as well as verbal signals
 - b. Visualize and discriminate findings on X-rays and other imaging studies
 - c. Interpret digital or analog representations of physiologic phenomena, such as EKG's
 - d. Acquire information from written documents, films, slides, videos, or other media
 - e. Observe and differentiate changes in body movement
 - f. Observe anatomic structures
 - g. Efficiently read written and illustrated materials
 - h. Observe and detect the various signs and symptoms of the disease processes that will be encountered during the training program
 - i. Possess visual acuity to be able to perform surgical procedures
 - j. Have stereoscopic binocular vision to enable working through a binocular microscope and see in a three-dimensional fashion
2. Communication. The resident must be able to:
 - a. Communicate effectively and sensitively with all patients
 - b. Communicate and work effectively and efficiently with all members of the health care team in oral and written English
 - c. Communicate clearly with and observe patients and families in order to elicit information including a thorough history from patients, families, and other sources
 - d. Accurately describe changes in mood, activity, and posture
 - e. Perceive verbal as well as non-verbal communications, and promptly respond to emotional communications (sadness, worry, agitation, confusion)
 - f. Communicate complex findings in appropriate terms to patients and their families
 - g. Adjust form and content of communications to the patient's functional level or mental state
 - h. Engage in a collaborative relationship with patients and families
 - i. Record observations and plans legibly, efficiently, and accurately
 - j. Complete forms according to direction in a complete and timely fashion
 - k. Prepare and communicate precise but complete summaries of individual encounters
 - l. Possess sufficient hearing for required diagnostic functions (e.g., use of stethoscope to assess breath sounds, heart sounds, etc.)
 - m. In emergency situations, understand and convey information for the safe and effective care of patients in a clear, unambiguous, and rapid fashion, including receiving and understanding input from multiple sources simultaneously or in rapid-fire sequence
3. Motor. The resident must be able to:
 - a. Perform palpation, percussion, auscultation, and other diagnostic maneuvers
 - b. Provide general care and emergency medical care such as airway management, placement of intravenous catheters, cardiopulmonary resuscitation, and application of pressure to control bleeding; such procedures include the ability to roll/move the patient as necessary
 - c. Respond promptly to medical emergencies within the training facility, including emergencies in varied environments such as stairwells, elevators, parking lots and unpredictable environments created by disasters such as earthquakes, etc.
 - d. Not hinder the ability of co-workers to provide prompt care

- e. Perform basic diagnostic and therapeutic procedures (e.g. venipuncture, phlebotomy, intravenous line placement and administration of intravenous medicines, tying of knots, etc.) as well as more advanced procedures such as: radical neck dissection, ethmoidectomy, tympanoplasty and mastoidectomy, and pediatric laryngoscopy and bronchoscopy
- f. Have sufficient fine motor control to enable the performance of surgical procedures under high magnification
- 4. Cognitive. The resident must be able to:
 - a. Demonstrate clinical reasoning and problem solving
 - b. Identify significant findings from history, physical exam, and laboratory data
 - c. Perceive subtle cognitive and behavioral findings and perform a mental status evaluation
 - d. Provide a reasoned explanation for likely diagnoses
 - e. Construct an appropriate diagnostic plan
 - f. Prescribe appropriate medications and therapy
 - g. Recall and retain information
 - h. Deal with several tasks or problems simultaneously
 - i. Identify and communicate the limits of their knowledge to others
 - j. Incorporate new information from peers, teachers, and the medical literature in formulating diagnoses and plans
 - k. Show good judgment in patient assessment, diagnostic, and therapeutic planning
- 5. Social and Behavioral. The resident must be able to:
 - a. Maintain a professional demeanor
 - b. Maintain appropriate professional and ethical conduct
 - c. Be able to function at a high level in the face of long hours and a high stress environment including the ability to remain focused on a single task at operating table for at least several hours
 - d. Develop empathic relationships with patients and families while establishing professional boundaries
 - e. Provide comfort and reassurance where appropriate
 - f. Protect patient confidentiality and the confidentiality of written and electronic records
 - g. Possess adequate endurance to tolerate physically taxing workloads
 - h. Flexibly adapt to changing environments
 - i. Function in the face of uncertainties inherent in the clinical problems of patients
 - j. Accept appropriate suggestions and criticisms and modify behavior
 - k. Give and accept criticism appropriately and without prejudice
 - l. Prioritize multiple conditions and address the most important items
 - m. Function during overnight and weekend call times despite sleep interruptions

Travel

- 1. General travel policies
 - a. Residents are responsible for complying with all University of Utah travel policies. The official policy is available at <http://www.admin.utah.edu/ppmanual/3/3-10.html>.
 - b. Reimbursable expenses are registration, airfare, hotel, and meals. Rental cars must be approved prior to the meeting by the Residency Director. If early bird rates are available, those deadlines must be met. Residents will be paid a per diem to cover

- expenses for meals. Residents must submit receipts for all other expenses. No reimbursement will be provided for spouses who travel to the meetings.
- c. Residents will be charged for lost deposits due to cancellation of travel plans.
 - d. Residents must inform the program coordinator of their travel dates as soon as their attendance has been approved.
 - i. The program coordinator will submit a Trip Request and generate a Travel Number.
 - ii. Flights may be booked through the in-house travel agency. This will be charged to the division rather than to the resident.
 - iii. Meeting registration may be charged on the division credit card.
 - iv. Hotel reservations must be made by the resident, but arrangements can be made to pay room charges in advance.
 - e. Before reimbursement will be approved, a final manuscript of the publication-ready article must be attached to the Final Reimbursement Request for review by Division Chief.
2. Residents must attend the full meeting each day.
 3. All R2 residents will be sent to the annual AAO-HNS meeting at division expense. They must apply for available travel grants and comply with their restrictions.
 4. Any resident who has a podium or poster presentation accepted at AAO-HNS, Western Section, COSM, SENTAC, ASPO, ASPS, International Head and Neck Cancer (when held in the U.S.), AAOA, or American Cleft Palate will be sent to the meeting at division expense.
 - a. Residents Must submit abstracts for Podium-Only or Poster/Podium but may not apply for Poster-Only.
 - b. Residents must prepare a publication-ready article (meeting “Instructions for Authors” standards) and submit it to the faculty advisor before leaving for the meeting.
 - c. Residents presenting at the Triological Society must register as Resident Members and apply for the travel grant.
 5. The resident on research rotation during the AAOA meeting is encouraged to apply for the AAOA travel grant. Vacation time is not required to attend this meeting.
 6. One resident each year is encouraged to apply for an Academy travel grant to Washington Advocacy Week. Vacation time is not required to attend this meeting.
 7. At their discretion, individual faculty members may pay for residents to attend other meetings. The faculty member may set additional requirements/restrictions.
 - a. Vacation time is required to attend non-approved meetings.
 - b. Residents whose attendance at external conferences is funded by Dr. Orlandi must attend the entire conference. Residents choosing not to attend lectures will be held responsible for the material in the form of a scholarly paper covering each lecture they choose to miss. Each paper will be at least 2,500 words, excluding the bibliography, which will include at least 20 references. This paper will be due 14 days after the missed lecture and will be submitted by e-mail to facilitate delivery. Each resident will be expected to submit an independent paper for each lecture missed. This is not a group assignment.