UNIVERSITY OF MARYLAND
SCHOOL OF MEDICINE

Department of Otorhinolaryngology – Head and Neck Surgery

Residency Policy Manual

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I. Objectives of the Training Program

Goal 1: Provide a comprehensive curriculum to address the requisite knowledge, skills, and attitudes needed to practice Otolaryngology and meet ACGME requirements for training.

Objective 1: Draw on the strengths in faculty, patient populations, and other resources to enhance the UMMS training program.
Objective 2: Provide a series of didactic lectures at both UMMS to cover the breath and depth of required knowledge.
Objective 3: Integrate the 6 ACGME competencies into both didactic and experiential learning.
Objective 4: Provide a series of clinical experiences that cover the diversity and volume of patients and procedures to enable one to provide optimal medical surgical care to patients with otolaryngic problems.
Objective 5: Utilize technology to enhance teaching, patient care and learner assessment.

Goal 2: Provide a comprehensive system of assessment and feedback by using multiple methods and multiple sources of feedback.

Objective 1: Assess learner competence using global as well as additional methods of evaluation such as checklist and multi-source feedback.
Objective 2: Review and provide feedback to residents regarding surgical logs on at least a semi-annual basis to ensure the technical expertise of our graduating residents.
Objective 3: Engage patients and allied health professional in the evaluation of professionalism and interpersonal and communication skills.
Objective 4: Guide residents in using feedback and evaluations to self-assess and identify learning needs.

Goal 3: Implement methods for assessment of the UMMS program in order to identify areas of needed improvement.

Objective 1: Use of the result of the in-service examinations to modify the didactic curriculum at UMMS and its affiliate training sites.
Objective 2: Use feedback from graduating residents to address content and experimental gaps in the training program
Objective 3: Use of the information gathered from the review of surgical logs to ensure the appropriate volume and diversity of cases and modify clinical experiences accordingly so that all residents meet ACGME requirements.
Objective 4: Maintain a regular schedule of formal and informal meetings with the residents and faculty, to receive actionable feedback about the educational curriculum and program morale.
Objective 5: Create a standing education committee for regular monitoring of compliance with the fulfillment of the educational goals and objectives of the residency, and to respond to any concerns raised by meetings delineated by Objective #4.

Goal 4: Establish an environment in which scholarship is encouraged, mentored, and practice.

Objective 1: Define expectations of scholarship for faculty
Objective 2: Engage faculty in teaching, mentoring and role modeling scholarly activities for residents
Objective 3: Define expectations for residents to engage in scholarly activities including but not limited to informal and formal teaching, journal club presentations, clinical, translational and/or basic science research.

II. General responsibilities of residents.

A. Clinical requirements for consultation with attending staff

Residents are required to consult with the attending staff regarding all cases in which surgery is needed, urgent treatment is required, the disease is serious in nature and in all cases where the resident has any question about the patient's care. Residents are to call the attending-on-call for all serious problems seen in the emergency room at night. Whenever there is any question, it is always better to consult an attending. You will never get in trouble for asking, but you can get in serious trouble if you don't.

B. Education and Teaching

Residents are expected to be constantly reading and studying to master the material that must be learned for daily care of their patients and to acquire the necessary breadth of knowledge for completion of training. Residents are expected to be familiar with all aspects of the diseases of their in-hospital patients and will be tested on this material in the process of presenting patients and in making daily rounds. The schedule of conferences will be distributed to allow residents to prepare for the conference. It is expected that each resident will have done reading on the conference subject so that they can make optimal use of the time and can ask intelligent questions. Residents will take the Home Study Course given by the American Academy of Otorhinolaryngology-Head and Neck Surgery. Each March, residents will take the *Annual In-service Examination*. Residents should aim for scoring 75% or higher national for their training group. Any resident scoring lower than 30% nationally for their training group will be placed on probation for one-year period. Mondays – 13 week in-service prep and each Thursday 4:30 -5:45 PM didactic.

Regularly scheduled conferences will include the following:

Multi-Modality teaching conference: Thursday at 4:30 p.m. – 6:30 p.m. Will include core curricular talks organized in blocks according to subspecialty and will include Lectures, COCLIA sessions, journal clubs and other educational formats lead by the faculty or invited speakers. Radiology Conference led by a neuroradiologist will be given on selected weeks, during which CT and MRI films from the prior month are reviewed with the Neuroradiology staff. Cadaver Dissection Labs will be held on a monthly basis according to attending availability.

Grand Rounds: All Thursdays at 7 a.m. It will include lectures from Departmental Faculty, Residents and invited speakers. Morbidity and mortality conferences will be held on a monthly basis during this block of time. Senior Residents are responsible for maintaining an M&M list and discussing with the attendings the presentation of these cases.

Head and Tumor Board: Fridays 3:00 – 4:00 p.m. Multidisciplinary conference to discuss care of head and neck cancer patients.

Attendance at conferences is mandatory unless the resident is actively involved in critical clinical duties.

C. Research

Each resident will complete a research project during their residency and prepare a paper that is publishable. There is a dedicated 5- month research block in the PGY3 year. The research resident should identify his/her research mentor(s) well in advance of the research block in order to optimize use of the block. Progress toward completion of these projects will be discussed at quarterly resident evaluation conferences.

D. Vacation / Leave Policy

Each resident will have three weeks of vacation per year. One week will be taken during the Christmas/ New Year holidays. Residents can 'opt out' of the week during the holidays at the discretion of the Program Director and Chief Administrative Resident. The other two weeks can be taken during the remainder of the year. A "week" of vacation is defined as the five business days and typically includes the preceding and proceeding weekends. Vacations begin on Fridays at 5:00 p.m. and end at 6:00 AM on Mondays. One of the two remaining vacation weeks can be split into two half-week vacations (3+6 or 4+5 days), with a weekend failing either at the beginning or the end of the vacations. No more than five business days of vacation are allowed per week of vacation. Vacation time must be requested in writing to the administrative chief resident by July 31st for the fall vacation and January 30th for the spring vacation. Priority will be based on seniority on a first come basis. The Chief Residents are responsible for finalizing the vacation schedule for all residents before submission to the Residency Program Director. No more than one resident can take vacation at any one time, except during Christmas/New Year holidays. No vacations will be taken during the months of June and July unless approved by the Program director in writing. It is mandatory that the graduating chiefs take the final week of June as vacation, unless they are staying at UMMS following their training.

The following dates are mandatory attendance and therefore vacations during these times require expressed permission from the Residency Program Director: the month of January Residency Interviews; In-service Examination; Blanchard–Kleiman Graduation weekend.

Residents must also make formal written request to the Program Director for any time away from clinical duty for attending scientific meetings, courses, anticipated maternity/paternity leave, and interviewing for fellowships or future employment. It will be the prerogative of the Program Director to make changes in these plans if required to maintain adequate clinical coverage.

E. Leave of absence for job interviewing

Time off for interviews will be determined on an individual basis. Request for time off for interviews must be made in writing as far in advance as possible, and efforts should be made to avoid conflict with other scheduled vacations and to maintain continuity of care for the

rotation. If an inordinate amount of time is needed for job interviewing, the resident must use vacation time.

F. Meetings Policy

Each resident will received a least one paid trip to a national meeting during his/her residency. Residents who are presenting at a meeting will have their trip paid as well. Residents are encouraged to submit as many presentations as possible. However, to avoid having too many residents out-of-town at a particular meeting, residents must seek approval before submitting abstracts to a meeting. Attendance at meetings will be determined on an individual basis and will in part be related to whether or not a resident has attended the particular meeting in the past. Graduating chief residents will be expected to attend the American Academy of Otolaryngology Head and Neck Surgery's Annual meeting.

G. Academic Benefits

The residency program will be responsible for yearly membership dues to the American Academy of Otolaryngology Head and Neck Surgery for each resident. Additionally the program will provide residents with the Academy's Home Study Course. Residents are expected to complete each quarterly volume in a timely fashion. Responses to the self-assessment questionnaire will be handed to the Academic Coordinator for submission. Scores will be reported to the Program Director by the Academy. Additionally, the program will cover costs for a Temporal Bone Course up to a max of $2600. Residents must get approval from the program director prior to registering for the course.

H. Administrative Chief Resident

Each PGY-5 resident will serve an Administrative Chief Resident, with the length of commitment during the academic year being divided equally amongst the PGY-5 residents (4 months during years of 3 residents and 6 months during years of 2 residents). During this time, the Administrative Chief Resident will be responsible for clinical and rotation assignments, maintaining resident coverage for all clinical areas, the vacation / leave schedule, assigning conference responsibilities, and the general administration of resident affairs in accordance with the Residency Policy Manual an the liaison with the Program Director.

I. Illness Policy

In the event of illness or other personal emergency, the Administrative Chief Resident will arrange for coverage by other members of the housestaff. Such arrangements are to be approved by the Residency Program Director or the Departmental Chair, who may choose to redesignate duties to any person at any level in the program, regardless of their general plan of duties.

J. Immunizations and Health

Each resident must document immunizations and undergo routine PPD evaluation as required by the University of Maryland Medical Systems.

K. ACLS Certification

ACLS certification is required. Certification and recertification courses are offered free of charge several times per year. In view of the certainty that all surgeons will be faced with managing a cardiac arrest situation, this is an essential part of training.

L. Drug Policy

Abuse of controlled drugs is absolutely prohibited and is grounds for immediate dismissal from the program. Consumption of any amount of alcohol while on duty is similarly prohibited.

M. Moonlighting Policy

Residents are not permitted to moonlight, that is to engage in after-hours medical practice for pay outside assigned duties.

N. Professional Attire

At all times, residents shall maintain professional appearance and hygiene. Appropriate professional attire shall be worn in clinic. Clean scrubs may be used according to the situation.

O. Evaluations

Residents will be evaluated on their performance midway through and after each clinical block by the faculty. Faculty are expected to provide personal feedback as well as written evaluation. The residents will have access to their written evaluations. In turn, the resident's will evaluate the faculty and their residency after each clinical block. Samples of the evaluations forms are in Appendix A. Additionally the Program Director and/or Chairman will meet with the residents every three to four months to evaluate and identify potential issues in the program.

P. ACGME Case Logs

Residents are encouraged to maintain their case log entries on a regular basis. We consider this responsibility to be a sign of professionalism, and believe it is a critical skill to be taught and learned during residency. Electronic reminders will be sent out for residents who fall more than 2-3 weeks behind. After 3 weeks of failure to maintain the log, a warning will be sent out to the resident and the attending of that particular rotation.

Failure to maintain a case log over more than a 4-week period will result in a 3 day pre-suspension period for the resident, beginning on the Friday of that week. If after the pre-suspension the resident has still not updated their operative log, suspension from all surgical cases will commence, and continue until the log has been updated.

At the completion of residency, no resident will be certified as having completed the requirements for graduation until their case logs are up to date.

III. Responsibilities at each level of training

Residents will rotate on a 2.5 month block schedule through the various mentors' services. The residency rotation schedule and daily resident locations are depicted in Appendix B and C. In general, a senor resident (PGY4 or 5) will be paired with a junior resident (PGY2 or 3). The Senior and Junior Residents on the service will act as a team to hold primary responsibility and provide continuity of care for their mentor's patients. In addition every effort should be made to share learning experiences between residents in other blocks and to develop familiarity with the other residents' inpatients.

PGY-1 Residents spend six months under the direction of the General Surgery Program and six months under the direction of the Department of Otorhinolaryngology –Head and Neck Surgery. A schedule will be given to each PGY-1 resident at the start of the year. The six months under our control will include one month each of Emergency Medicine, Neurological Surgery. Anesthesiology and Plastic Surgery.

Junior Residents (PGY2 and PGY3): Junior residents will serve as the junior member of the block team under the auspices of the senior resident and the mentors. In this capacity they will perform basic and intermediate operative procedures as deemed appropriate by the mentors. They will also carry much of the burden for completing ward chores and writing progress notes, which should be completed prior to the completion of morning rounds to the satisfaction, and, possibly with the assistance, of the senior resident. All junior residents will make morning rounds with the senior residents each day. Residents assigned to the OR or clinic will leave in time to pre-op their 7:15 a.m. patient to be in clinic by 8:20 a.m. When OR or clinic is over, any remaining ward work will be completed prior to evening rounds. Only urgent emergencies on the inpatient service will take priority to the responsibility to work in OR or clinic. Junior residents will stay until the completion of evening rounds and all assigned inpatient work before leaving for the day.

Examples of some of the procedures that junior residents will perform under supervision by the senior resident and faculty include, tonsillectomies, adenoidectomies, insertion of PE tubes, tracheostomies, direct laryngoscopies, skin lesion removals, small neck mass excisions, closed reduction of nasal fractures, closure of traumatic soft tissue injuries, portions of neck dissections, septoplasties, endoscopic maxillary antrostomy, and any other procedures thought by the faculty to be within their abilities. The PGY3 will have five months of dedicated research time without daily clinical responsibilities. Junior residents will take primary call at University Hospital on average every fourth night. Primary Call is in-house call on every day. Any resident found in violations of the in-house policy is subject to termination.

Senior residents (PGY4 and PGY 5): The senior residents are responsible for assuming primary responsibility over patients on their mentor's service as deemed appropriate by the mentor. They are responsible for reviewing the work done by the junior residents and providing assistance to them when needed. They will be available in the institution during the daytime and available by phone when on Secondary Call so that they can immediately be contacted for emergencies.).

The Senior Residents are responsible for the management of all OTO-HNS inpatients on their rotation service and for delegating, educating, and directing a team of junior residents and/or medical students such that comprehensive care for their mentors' patients is delivered. S/He should strive as well, for learning purposes, to gain familiarity with inpatients on the other rotations. The senior resident is responsible for consultation before any surgical procedure is carried out. No patient will be scheduled for the Operating Room without approval from an attending staff member.

Senior residents shall perform intermediate and advanced level procedures under the supervision of their mentors. Senior residents shall take precedence over junior residents when selecting operative cases or clinical learning experiences but should also strive to provide the junior residents with operative experience. When not in the OR, the senior resident should be in Clinic to supervise the junior residents, help with seeing patients, and to help in teaching the medical students. Examples of senior level procedures include neck dissections, head and neck tumor resections, thyroidectomy, tympanomastoidectomy, endoscopic sinus surgery, facial fracture repair, selected septorhinoplasties, and facial/head/neck/tracheal reconstructions. The senior residents will rotate on weekly basis taking Secondary Call. Secondary Call is home call during which time the senior resident assumes responsibility for patients seen by the junior resident on Primary Call and to act as a liaison to the Attending On-Call. For complicated or unstable patients, the senior resident is expected to help junior resident and personally evaluate the patients.

Residents should understand that the right to operate on a patient is earned and not guaranteed. Residents will not participate in surgery on patients 1) if they do not display ownership of their patients 2) if they do not make themselves available for valuable learning points regarding their patients; 3) if they are not thoroughly familiar with the patient; 4) if they have not read about the disease in question, they pertinent surgical anatomy, and the technical details of the planned surgery; 5) if they are tardy to the OR without good reason; or 6) if their logging of duty hours is not current.

Since each resident is an essential member of their mentor's team and of the Department, it is important that residents keep their pagers or contact numbers functional at all times, even after hours, in order to provide for an emergency line of communication in rare cases of urgent correspondence needed for their patients' care and in the event of locoregional catastrophe or Homeland Security emergency. Pager availability does not and shall not violate *Residency Work Hour Regulations* (see Section IV). Residents who demonstrate a pattern of avoiding pager calls are subject to disciplinary action.

IV. RESIDENCY WORK HOUR REGULATIONS

In accordance with *ACGME* and *RRC* requirements, residents must strictly adhere to work hour regulations which include the following:

1) Residents shall perform no more than 80 on-site duty hours per week, averaged over 4 weeks, inclusive of all in-house call activities. Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.
2) Residents shall have 1 of 7 days free from all educational and clinical responsibilities, averaged over 4 weeks, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
3) In-house call must occur no more frequently then every third night averaged over a four-week period.
4) 24 (+6) hour continuous on-site duty restriction: Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. No new patients, as defined in clause 5, shall be accepted after 24 hours of continuous on-site duty. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics and maintain continuity of medical and surgical care. During this time, residents may assist in surgery.
5) No new patients may be accepted after 24 hours of continuous duty. A new patient is defined as one for whom the OTO-HNS Department has not previously provided care. The resident should evaluate the patient before participating in surgery.
6) Adequate time for rest and personal activities must exist and should consist of a ten-hour time period between all daily duty periods and after in-house call.

Residents shall immediately notify their block mentor(s) or the Residency Program Director of any situations that cause a violation of these regulations. The residents shall also notify the Program Director if there are any instances of a home-call resident performing on-side duties throughout the night (thereby approximating an in-house call scenario). In this situation, the post-call resident must observe the 24 (+6) continuous on-site duty restrictions. All attendings shall enforce the above regulations. If for any reason a resident is struggling to complete clinical tasks within the time limits stipulated in the *Residency Work Hour Regulations*, the resident has the responsibility to reveal the problem to the Program

Director or Departmental Chair. Residents who do not log in their duty hours or who are not in compliance with the *Residency Work Hour Regulations* are subject to disciplinary action including dismissal from the residency program.

In addition to the above policy, residents in their contractual agreement with *University of Maryland Medical Systems (UMMS*) are required to report, at least anonymously, any noncompliance of duty hours to the *UMMS Graduate Medical Education office.*

V. GUIDELINES FOR MANAGEMENT OF THE OTO-HNS SERVICE

1. The Senior Residents are responsible for the management of all OTO-HNS inpatients on their rotation service and for delegating, educating, and directing a team of junior residents and/or medical students such that comprehensive care for their mentors' patients is delivered. This responsibility means being familiar with the history and physical findings of all of the patients, their labs results, details of their progress, and ensuring that all points of treatment and care are completed.
2. Daily morning and evening rounds should be conducted in a manner to ensure continuity of care, to foster a patient-doctor relationship, to exercise resident ownership over his/her patient, and to facilitate learning. The senior and junior residents on the rotation share responsibility for rounding on their mentors' patients. In addition, an effort should be made for all residents to round as group in order to share patients across rotations for the purposes of learning and to promote familiarity of all the residents with the inpatients. The morning will be lead by the senior residents, who facilitate rounds so as to allow ample time for seeing all inpatients on their particular rotation before OR or clinic. Review of radiology films for new admissions or critical inpatients will be a part of morning rounds and is an opportunity for senior residents to teach junior residents hands-on film reading. Residents assigned to the OR will leave in time to pre-op their 7:15 a.m. patient. The other residents will continue rounding or complete essential ward work until the start of clinic at 8:30 a.m. Any remaining ward work should be completed by evening rounds. On both weeknights and weekends, the resident from each rotation service are responsible for checking out their patients to the Senior and Junior Resident on-call. Likewise, at the end of the call period, the senior and junior residents on-call are responsible for checking out any new admissions to the resident(s) on that respective mentor's service. In all cases where continuity of care is severed, the continuity of care shall be re-established through detailed transfer of patient information between residents, including history and physical, diagnoses and treatment plans.
3. Residents should write a preoperative note on all patients on whom they are going to operate, that describes the problem, pertinent physical findings and labs, the plan of treatment, the indications for the surgery and the risks and alternatives to surgery that were discussed with the patient. Residents should understand that the right to operate is earned not guaranteed. Residents will not participate in surgery on patients if they do not display ownership of their patient, if they do not make themselves available for valuable learning points regarding their patients, if they are not thoroughly familiar with the patient, and if they have not read about the disease in question, the pertinent surgical anatomy and the technical details of the planned surgery. Residents should be present in the OR before the start of a procedure to

ensure proper communication regarding patient care between members of the operating team (anesthesiologist, scrub nurse, circulator, etc.)

4. Progress notes are required to be written on each inpatient every day, including Saturday and Sunday. Morning rounds are not finished until this has been completed. If a patient is off the floor at the time that morning rounds are made this should be noted and later in the day the patient must be seen and a note written. The Senior Residents are responsible for adequate completion of the medical records. Residents at all levels will be expected to help with this task.
5. History and physical performed by all are residents for both elective and emergent patients should be accurate and complete. If the H&P is not satisfactory it is the responsibility of the Senior Resident to see that it is properly completed. An effort should be made to diagram all abnormalities on the ENT exam. In the case of cancer patients, include in the H&P the TNM classification and staging of the tumor.
6. The purpose of progress notes is to ensure optimal patient care, to ensure communication between personnel caring for the patient, to aid in the educational process of the house staff, to provide legal documentation that hospitalization is needed and that proper medical care is being carried out. The results of all laboratory tests, x-rays, EKG's, biopsies, consults, and other special tests must be noted in the progress notes. Doing this prevents overlooking important information, and provides medical-legal documentation that the test results were seen and acted upon. Progress notes are required on the morning of discharge.
7. At the time of discharge, the residents are responsible for dictating a discharge summary with accurate documentation of all diagnoses made during the hospitalization. Patients being discharged to other hospitals, nursing homes or other chronic care facilities need a dictated discharge summary to go with them to that facility.
8. Prior to evening rounds with the attending staff the Senior Residents should discuss the patients with the Junior Residents so that they are aware of all current information on the patients. The discussion of the patients with the Attendings should be done primarily by Senior Residents although at times the Junior Residents are free to add information or ask questions for the purposes of continuity of care.
9. We will review all lab data on the next day's OR patients on evening rounds.

10. Brief operative notes should include a description of the operative findings and a diagram of the lesion if appropriate. Operative notes should ideally be dictated immediately after completion of the case or within 24hs at the latest. It should consist of an initial paragraph outlining the history and the indications of the operation, and then a complete description of the surgery and the findings.
11. When residents change assignments at the end of each rotation, off-service notes and discussions should be undertaken to summarize the current status of each patient. The off-service team must provide **detailed** transfer of patient management information to the on-service team.
12. The nursing staff should participate in morning rounds and a frequent check should be made of the cardex to see what medications and other treatments a patient is currently receiving. For optimal running of the ward service the Chief Residents should meet periodically with the nursing staff during the day to discuss long term plans for certain patients, any problems that they nursing staff has noted and to

maintain good communications with other health care professionals such as the social worker, community health nurse, psychiatric liaison, nurse, nutritionist, respiratory therapist, etc.

13. **Consultation / Emergencies**

During weekday work hours, the Senior Resident on the Facial Plastics/Consult/Clinic Service shall carry the consult pager. This Senior Resident shall arrange for the timely evaluation of all consults or emergencies based on the level of urgency. Urgent consults must be seen immediately whereas nonurgent consults can be seen at the end of the working day or under special circumstances can be scheduled for Outpatient Consult Clinics. Any patient whose case is deemed operative after evaluation by the Medical Otolaryngology Attending shall have their care referred to the Attending On-Call, who may in turn (especially for Code 1 emergencies) request that an Attending in the Operating Room staff the case, and therefore the resident(s) on that Attending's service shall assume continuity of care for that patient.

During weeknight and weekend hours, the Junior Resident shall carry the consult pager. It is very important that all efforts are made to insure that emergency room consultations are seen within an hour. Based on complexity of the consult, Junior Residents are expected to finalize the diagnosis and treatment plan for all consultations to the satisfaction of the Senior Resident On-Call, who in turn will serve a liaison to the Attending On-Call. **Telephone consultation is not acceptable.**

An Otorhinolaryngology-Head and Neck consult requires the complete examination of the patient's ears, nose, throat, neck and a response in writing reporting the diagnosis and advice. All consults that remain in-house must be staffed with an attending within 24 hours, and a copy of the consult with attending's signature/note should be delivered to the OTO-HNS administrative office for billing purposes.

VI. SHOCK TRAUMA CONSULTS

A facial trauma schedule will be posted in the emergency area. The OTO-HNS service is on facial trauma call on Tuesdays 8AM to Thursday 8AM. Every effort should made for all STC facial-trauma/TRU consults should be seen within 1-2 hours from the time the consult is placed. All floor consults should be seen within 4 hours from the time the consult is placed. Obviously, emergent consults must be seen sooner or immediately

All treatment plans for facial fracture repair should be reviewed with the Attending within 12 hours. (If trauma arrives during the daytime, a formal plan should be in the chart by the end of the day. If trauma arrives during the nighttime, a formal plan should be placed in the chart during the next morning rounds.) All notes in the chart shall state clearly, "Plan confirmed by Attending."

Ophthalmology will be consulted on all cases when the orbit or globe is involved. All efforts should be made to expedite processing of patients so that they may have their indicated facial fracture repairs. Patients must have written clearance in the chart from all involved services, particularly ophthalmology, spine, neurosurgery, and trauma surgery (cont: C-spine, Ophtho, Neuro, and Trauma).

A resident from Walter Reed will serve as co-senior of the Facial Plastics / Consult service. During the three to four months that this resident is rotating on the service, s/he will act as an integral member of the team and will therefore have all the benefits and responsibilities of a Senior Resident in the University Of Maryland OTO-HNS Department as outlined in the Residency Policy Manual. The WR resident's vacation and leave time during the rotation must be coordinated with the UM co-senior of the Facial Plastics / Consult Service, the Administrative Chief, and the Facial Plastics Attending.