UTMB
Oral and Maxillofacial Surgery
2018 – 2019
Resident Manual

utmb Health
Working together to work wonders™
The University of Texas Medical Branch, Galveston is dedicated to providing high-quality educational programs as well as service to the community. UTMB prepares residents for lifelong learning and leadership roles in business and the professions. It offers academic programs employing innovative delivery systems and rich learning resources on campus and at distant sites. The university fosters inquiry, research, and creative professional activity, by uniting faculty and students in acquiring and applying knowledge in clinical, community, and professional settings. The mission of the Division of Oral & Maxillofacial Surgery is to educate and train residents to ensure their competency to practice the art and science of their profession. This requires graduates to be biologically knowledgeable, technically skilled, compassionate, and sensitive to the needs of all patients and the community. To this end, the faculty and staff are dedicated to achieving these goals.

Roger R. Throndson, DDS, FACD
Associate Professor and Chief
Oral and Maxillofacial Surgery
Department of Surgery
UTMB - Galveston
GOALS/OBJECTIVES AND ASSESSMENT OF THE ORAL AND MAXILLOFACIAL 
SURGERY TRAINING PROGRAM

STATEMENT FROM THE PROGRAM DIRECTOR

MISSION STATEMENT

The mission of the Institution is to provide scholarly teaching, innovative scientific investigation, 
and state-of-the-art patient care in a learning environment to better the health of society. UTMB’s 
education programs enable the state’s talented individuals to become outstanding practitioners, 
teachers, and investigators in the health care sciences, thereby meeting the needs of the people of 
Texas and its national and international neighbors. The mission of the Oral and Maxillofacial 
Surgery Residency Program is to prove the OMS resident with an excellent advanced education 
grounded in the basic and clinical sciences. Surgical training provides for early and longitudinal 
didactic exposure to the basic and clinical sciences and a graduated surgical experience culminating 
in a competent chief resident level surgical experience. The training program will provide clinical 
competency in many areas, exposure in other areas, and a fundamental medical and surgical 
background providing the foundation for ongoing professional development and a long-term 
commitment to continuing education. It is also the intent of the program to instill honesty and 
integrity and a sense of accountability that is needed for surgeons to functions as trusted members of society.

Goals and Objectives

Education:

1. Provide a longitudinal didactic experience in basic and clinical sciences and oral and maxillofacial surgery 
2. Provide didactic exposure to fundamental practice management 
3. Assure satisfactory resident performance and progress 
4. Provide adequate personal educational time and resources for trainees 
5. Provide the basis for successful completion of ABOMS certification process 
6. Provide a structured review of current literature to educate residents on the processes involved in evaluating new techniques and/or materials

Patient Care:

1. Provide graduated patient care responsibilities with progressively greater independence culminating in a concentrated chief resident level patient care experience 
2. Provide adequate faculty for hands-on resident experiences 
3. Assure satisfactory resident clinical performance and progress 
4. Provide opportunities for expanded opportunities in patient care 
5. Provide the surgical basis for successful completion of ABOMS certification
Service:

1. Service responsibilities to be directed towards resident didactic and/or clinical advancement
2. Trainee duty hours will be in compliance with ACGME standards
3. Assure satisfactory resident performance of service responsibilities

Research/Scholarly Activity:

1. Residents will take an active and formal role in the presentation of didactic lectures/seminars
2. Residents are encouraged to select research or other scholarly topic(s) with the expectation of producing a publication and/or abstract presentation at a national meeting
3. Senior level and chief residents will take active roles in education of subordinate residents and dental externs when on service
4. Participation in local (ADA District Meetings), and national annual meetings as attendees, presenters and representatives to resident organizations

Roger R. Thronson DDS, FACD
Associate Professor
Director of Residency Training
Oral & Maxillofacial Surgery
UTMB-Galveston
ORAL AND MAXILLOFACIAL SURGERY EDUCATION PRINCIPLES

1. Foster individual responsibility for intellectual growth.
2. Value those who teach and facilitate learning.
3. Identify outcomes that denote progress in learning.
4. Provide an environment that optimizes learning.
6. Provide appropriate feedback on progress to faculty and residents.
7. Define goals.
8. Measure competence appropriate to the level of the learner.
9. Articulate goals and objectives to level of learner.
10. Utilize proven and effective teaching techniques to facilitate learning.
TABLE OF CONTENTS

TEACHING ROUNDS AND CONFERENCES ................................................. 8
ETHICAL/LEGAL RESPONSIBILITY ......................................................... 9
DRESS AND CONDUCT ........................................................................... 9
EDUCATION ............................................................................................ 10
  Resident Teaching Responsibilities .................................................. 10
  Research .............................................................................................. 11
GOALS AND OBJECTIVES ...................................................................... 11-24
  Graduate Program Oral and Maxillofacial Surgery ......................... 11
  Resident Competency Evaluation ..................................................... 14
  Off-Service Rotations Oral and Maxillofacial Surgery .................... 16
POLICIES ............................................................................................... 19-24
  Transition of Care .............................................................................. 19
  Alertness Management/Fatigue Mitigation ........................................ 19
  Supervision of Residents ................................................................... 19
  Resident Responsibilities/Competencies ........................................... 20
  Program Evaluation Committee and Annual Evaluation ............... 22
INPATIENT SERVICES ............................................................................ 25
  Admissions ......................................................................................... 25
  Medical Records ................................................................................ 26
WARD MANAGEMENT ............................................................................ 27
PATIENT LISTS ..................................................................................... 27
OPERATING ROOM ............................................................................... 27
  Scheduling ......................................................................................... 27
  Policies ............................................................................................... 28
CONSULTATIONS .................................................................................. 29
PATIENT DISCHARGE/FOLLOW-UP ...................................................... 30
CALL SCHEDULE .................................................................................. 30
RESIDENT DUTY HOURS ..................................................................... 30
TRAUMA TEAMS .................................................................................. 35
FACULTY/SUPPORT STAFF/HOUSE OFFICERS PHONE LIST ............ 36
SUMMARY OF RESIDENTS’ SCHEDULE ............................................. 39
OUTPATIENT SERVICES ORAL AND MAXILLOFACIAL SURGERY ...... 40
SAME-DAY SURGERY ........................................................................... 41
CLINICAL SUPPORT SERVICES ............................................................ 42
  Clinical Pathology ............................................................................. 42
  Radiology ......................................................................................... 42
  Blood Bank ....................................................................................... 43
  Pharmacy .......................................................................................... 44
BEEPERS ............................................................................................... 44
LONG-DISTANCE TELEPHONE .............................................................. 44
RESIDENT TRAVEL GUIDELINES .......................................................... 45
VACATIONS ............................................................................................ 45
JOB INTERVIEWS .................................................................................. 46
SICK LEAVE ........................................................................................... 46
GENERAL INFORMATION ................................................................. 47
GENERAL INFORMATION FOR HOUSE STAFF ......................... Appendix 1
  Appointment Information ............................................................... Appendix 1
  Salary and Fringe Benefits; Vacation and Leave ............................. Appendix 1B
  Due Process; Grievance ................................................................. Appendix 1C
  GMEC Competencies ...................................................................... Appendix 1C
  OMFS Patient Care Milestones ....................................................... Appendix 1C
# Teaching Rounds and Conferences

**Mandatory:**

<table>
<thead>
<tr>
<th>Event</th>
<th>Days</th>
<th>Time</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning Report Conference</td>
<td>Monday</td>
<td>7:00 A.M.</td>
<td>Rm. 6.106, John Sealy Annex</td>
</tr>
<tr>
<td>Oral and Maxillofacial Surgery Planning Conference</td>
<td>Tuesday/Thursday</td>
<td>4:30 P.M.</td>
<td>Rm. 6.106, John Sealy Annex</td>
</tr>
<tr>
<td>Tumor Board</td>
<td>Monday</td>
<td>4:00 P.M.</td>
<td>Rm. 6.106, John Sealy Annex</td>
</tr>
<tr>
<td>Oral and Maxillofacial Surgery Lecture</td>
<td>Every Tuesday and Thursday</td>
<td>7:00 A.M.</td>
<td>Rm. 6.106, John Sealy Annex</td>
</tr>
<tr>
<td>Department of Surgery Grand Rounds</td>
<td>1st Wednesday of each month</td>
<td>8:00 A.M.</td>
<td>SBI Auditorium</td>
</tr>
<tr>
<td>General Surgery Grand Rounds</td>
<td>Wednesday except the 1st of each month</td>
<td>7:30 A.M.</td>
<td>Rm. 6.106, McCullough</td>
</tr>
<tr>
<td>Anesthesia Lecture</td>
<td>3rd Thursday of each month</td>
<td>7:00 A.M.</td>
<td>Rm. 6.106, John Sealy Annex</td>
</tr>
<tr>
<td>Oral and Maxillofacial Physical Diagnosis Lecture</td>
<td>Monday-Friday (July)</td>
<td>5:00 P.M.</td>
<td>Rm. 6.106, John Sealy Annex</td>
</tr>
<tr>
<td>Risk Management M&amp;M Conference</td>
<td>2nd Wednesday of each month</td>
<td>7:00 A.M.</td>
<td>Rm. 6.106, John Sealy Annex</td>
</tr>
<tr>
<td>Oral Pathology Lecture and Slide Review</td>
<td>3rd Thursday of each month</td>
<td>7:00 A.M.</td>
<td>Rm. 6.106, John Sealy Annex</td>
</tr>
<tr>
<td>Journal Club</td>
<td>1st Wednesday of each month</td>
<td>7:00 A.M.</td>
<td>Rm. 6.106, John Sealy Annex</td>
</tr>
</tbody>
</table>
**ETHICAL AND LEGAL RESPONSIBILITY OF THE PATIENT'S CARE**

The ethical and legal responsibility of the patient's care rests with the Oral and Maxillofacial Surgery Faculty in both private and staff patients. The attending faculty must be cognizant of any changes in the status of patients for whom he/she is responsible. The faculty must be informed when there is any change in a patient's condition or when a change in therapy is considered.

The Resident must always be aware of potential litigation. Therefore, all patients receive the same quality of care. Treat all patients with respect and attempt to gain good rapport with all patients. Inform the Director immediately of any attorney or irate patient contact. Give no interviews to reporters. All such contacts should be made through the Legal and Public Relations offices at UTMB. All records must be complete, accurate and legible. Always sign, date and time all record entries. Each visit/patient contact must be documented. Informed written consent must be obtained as required. Protect patient confidentiality to the utmost.

**DRESS AND CONDUCT**

It is required that all members of the House Staff present a neatly groomed appearance with a white coat. Ties and shirts are encouraged. If patient care is to be administered where the House Staff may be exposed to bodily fluids, scrub attire is permitted.

Remember to have regard for the patient's feelings and to treat each patient as you would want to be treated if you were a patient. Condescending attitudes are to be strictly avoided.

Nurses are our professional colleagues. It is important to establish and maintain good relationships with the nursing staff; they are vital members of our team, upon whose help our patients depend. Always express appreciation for a job well done.
EDUCATION

RESIDENT TEACHING RESPONSIBILITIES
Teaching is a responsibility of the Residents and Faculty. The Chief Resident is designated to oversee that the Oral and Maxillofacial Surgery teaching conferences are organized and audiovisual equipment is set up and available.

RESEARCH
All Oral and Maxillofacial Surgery Residents are encouraged to spend six months of their training in research. The research rotation should be done during the PGY-4 year. A formal written request should be submitted to the Oral and Maxillofacial Surgery Program Director that includes the project topic and special needs to carry out the research.
GOALS AND OBJECTIVES

GRADUATE PROGRAM IN ORAL AND MAXILLOFACIAL SURGERY

Goals of the Rotation

1. Experience in preoperative, operative and postoperative management of patients who present to Oral and Maxillofacial Surgery.
2. It is the goal of the Oral and Maxillofacial Surgery training program that each Resident have experience in: a) dentoalveolar surgery, b) oral and maxillofacial trauma, c) pathology, d) orthognathic surgery, e) reconstructive and esthetic surgery of the jaws and associated structure of the oral and maxillofacial area.
3. An advanced Oral and Maxillofacial Surgery program must encompass a minimum duration of 48 months of full-time study.
4. Each Resident must devote a minimum of 30 months to clinical and maxillofacial surgery.
5. The Oral and Maxillofacial Surgery residency program must include education and training in the basic and clinical services which is integrated into the training program. A distinct and specific curriculum must be provided in anesthesia, clinical medicine and surgery.
6. Anesthesia assignment must be for five months, clinical medicine two months and general surgical service four months.
7. Two additional months of clinical surgery or medical education must be assigned.
8. Six months must be provided within the 48-month program for expanded research.
9. Each program must provide a complete, progressive, graduated sequence of outpatient, inpatient and emergency room experience.

Outpatient Oral and Maxillofacial Surgery Experience

1. There must be adequate training in a broad range of ambulatory oral and maxillofacial surgery procedures involving adult and pediatric patients.
2. The outpatient surgical experience must include the management of traumatic injuries, pathological conditions, dentoalveolar surgery, placement of implant devices, augmentation and other hard and soft tissue surgery, including surgery of the mucogingival tissues.

Ambulatory General Anesthesia and Deep Sedation

1. Residents must administer general anesthesia/deep sedation to a minimum of 300 patients during their 4-year training; 150 of those patients must be for OMFS and 50 must be pediatric (< 18 years old).
2. The program must be supported by a comprehensive didactic program in general anesthesia, deep sedation and other methods of pain and anxiety control.
3. Residents must be certified in advanced cardiac life support and have completed a four-month rotation in Anesthesiology.

Major Surgery

1. For each authorized Senior Resident position, Residents must perform major oral and maxillofacial surgery in 175 patients on adults and children, and documented by an operative note.
2. Of the 175 major surgical patients for each Senior Resident position, there must be at least 20 procedures in each category of surgery. The categories of major surgery are defined as: a) trauma, b) pathology, c) orthognathic surgery, d) reconstructive and 5) esthetic surgery.
3. Trauma management includes tracheostomies, open and closed fractures of mandibles, maxilla, zygomaticomaxillary, nose, naso-frontal-orbital-ethmoid and midface region, oral and soft tissue injuries.
4. Pathology category experience must include management of temporomandibular pathology and at least three types of procedures. Pathology management includes, but is not limited to, major maxillary sinus procedures, cystectomies, treatment of temporomandibular joints, sialolithotomy, sialoadenectomy, head and neck infections, and management of benign and malignant neoplasms.
5. Orthognathic category must include correction of deformities in the mandible and the middle third of the facial skeleton.
6. Reconstructive surgery includes, but is not limited to, vestibuloplasties, augmentation procedures, temporomandibular joint reconstruction, management of discentimolar defects, insertion of implants, facial cleft repair and other reconstructive surgery.
7. Esthetic surgery includes, but is not limited to, rhinoplasty, blepharoplasty, rhytidectomy, genioplasty, lipectomy, otoplasty and scar revision.

Evaluation of Residents
A system of ongoing evaluations and advancement must assure that, through the Director and faculty, each program:
1. Periodically, but at least semiannually, evaluates the knowledge, skills and professional growth of its Residents using appropriate written criteria and procedures,
2. Provides to Residents an assessment of their performance, at least semiannually,
3. Advances students to positions of higher responsibility only on the basis of an evaluation of their readiness for advancement,
4. Maintains a personnel record of the evaluation of each Resident which is accessible to the Resident and available to review during site visits.

The Program Director must provide written evaluation of the Residents based upon written comments obtained from the teaching staff to include: a) cognitive skills, b) clinical skills, c) interpersonal skills, d) patient management skills and e) ethical standards.

The Program Director must provide a final written evaluation of each Resident on completion of the program that includes the Resident’s performance and competence to practice independently. This evaluation must be included as part of the Resident’s permanent record and must be maintained by the institution.

Oral and Maxillofacial Surgery Resident Supervision
A Faculty Member is assigned each day to supervise residents in the clinic. The Faculty Member is the final responsible agent for patient care within the clinic. The progression of resident responsibilities takes place in the clinic and on service in a gradational fashion. A Faculty Member is assigned to manage trauma patients on a monthly basis. This Faculty Member is the responsible agent for the care to the facial trauma patients on service. The Chief Resident or Senior Resident is expected to report any significant events to the Faculty involved. The Chief Resident or Senior Resident is expected to have a broad general responsibility for all aspects of the service. This will include daily evaluation of patients, evaluation of laboratory and imaging information, interaction with the patient and the patient’s family, and supervision and assignment of duties and education of the Junior Residents. In the operating room the Chief Resident or Senior Resident has typically reached a point at which he/she may participate in complex procedures always under the supervision of the Faculty Member involved. Over the years of a surgical residency, the Resident is offered increasing responsibility and participation in surgical procedures based upon their performance.

A Faculty Member will be in the operating room for every operation. The decisions for delegating aspects of an operative procedure will be made at all times by the Faculty. The Chief Resident or Senior Resident may also participate in relatively less complex operative procedures with Junior Residents and serve as an instructor of Junior Residents with the Faculty present to assure quality of care.

Mid-level residents are expected to have achieved a level of competence in evaluation of patients. They are expected at all times to refer problems or questions to the Senior Resident or to the Chief Resident and simultaneously refer all issues to the Faculty involved. The Mid-level Resident may serve as a mentor or instructor for management skills on the clinical service to the Junior Residents and may also serve in this capacity in the operating room for lesser cases. In either case, the Faculty on service provides supervision.
The Junior Resident, and especially the PGY1 Resident, is expected to report all information that they obtain in their work on service to the Senior Resident and to the Faculty, where appropriate. The Junior Resident is advised that they should always err on the side of caution and that referral of all questions and uncertainties to senior level and Faculty level is mandatory. The Junior Resident is observed in his/her ability to assess patients and to collect clinical, laboratory and imaging information about their patients. It is expected that over time these individuals will gain skills at interpreting all of these and, as their interpretation skills improve, it is anticipated that the Junior Residents will be provided further independence. At the start of the residency it is understood that the independence of a Junior Resident should be minimal and that the referral of important issues to superiors be the norm.

All clinical activity is ultimately supervised and is the ultimate responsibility of the Faculty assigned. Surgical Residents at each level are provided increasing amounts of responsibility on clinical service and in the operating room, all of which is constantly supervised and monitored by the Faculty assigned.

**Evaluation of Faculty**

A form is distributed to each Resident on an annual basis eliciting information from the resident regarding qualities of the program in Oral and Maxillofacial Surgery. In addition, each Faculty is evaluated. These Resident evaluations of the Faculty are reviewed on an annual basis.

**QA/QI/M&M**

Each month time is devoted to discussing current QA/QI measures. Patients are presented to faculty and residents by residents at the M&M conferences. Open discussion occurs with faculty and residents on how to improve patient safety. Residents are required to attend and participate in the Department of Surgery’s QA and QI initiatives on a weekly basis.
THE UNIVERSITY OF TEXAS MEDICAL BRANCH AT GALVESTON
FACULTY - RESIDENT EVALUATION FORM

In evaluating the resident's performance, use as you standard, the level of skill expected from the clearly satisfactory resident at this stage of training. For any component that is rated a 4 or less, or 9, you must provide specific comments under each one. Be as specific as possible, including reports of critical incidents and/or outstanding performance. Global adjectives or remarks, such as a "good resident," do not provide meaningful feedback to the resident.

GENERAL

Please select the range that would best fit the number of contact days spent with this House Staff:

- < 7 Days
- 7 to 14 Days
- > 14 Days

PATIENT CARE

Incomplete, inaccurate medical interviews, physical examinations, and review of other data; incompetent performance of essential procedure; fails to analyze clinical data and consider patient preferences when making medical decisions

Superb, accurate, comprehensive medical interviews, physical examinations, reviews of other data, and procedural skills; always makes diagnostic and therapeutic decisions based on available evidence, sound judgment and patient preferences

Unsatisfactory Satisfactory Superior Insufficient contact to judge

1 2 3 4 5 6 7 8 9

Comments

Remaining Characters: 5,000

MEDICAL KNOWLEDGE

Limited knowledge of basic and clinical sciences; minimal interest in Exceptional knowledge of basic and clinical sciences; highly learning; cannot explain mechanisms of disease resourceful development of knowledge; understands complex relationships and skillfully develops unifying concepts

Unsatisfactory Satisfactory Superior Insufficient contact to judge

1 2 3 4 5 6 7 8 9

Comments

Remaining Characters: 5,000

PRACTICE-BASED LEARNING AND IMPROVEMENTS

Fails to perform self-evaluation; lacks insight, initiative; resists or ignores feedback; fails to use information technology to enhance patient care or pursue self-improvement

Constantly evaluates own performance; incorporates feedback into improvement activities; effectively uses technology to manage information for patient care and self improvement

Unsatisfactory Satisfactory Superior Insufficient contact to judge

1 2 3 4 5 6 7 8 9

Comments

Remaining Characters: 5,000
New Innovations RMS Evaluations

COMMUNICATIVE AND INTERPERSONAL SKILLS

Poor listening, writing, nonverbal skills: unable to clearly explain complex problems; does not earn respect of peers; frequently unavailable to consult with patients, families, colleagues

Establishes a highly effective therapeutic relationship with patients and families; demonstrates excellent relationship building through listening, writing, and nonverbal skills; excellent education and counseling of patients, families, and colleagues; always "interpersonally" engaged

Unsatisfactory: 1 2 3
Satisfactory: 4 5 6
Superior: 7 8 9
Insufficient contact to judge: 0

Comments

Remaining Characters: 5,000

PROFESSIONALISM

Lacks respect, compassion, integrity, honesty; insensitive to diversity; shirks responsibility; disregards needs for self assessment; teaches/role models irresponsible behavior; total commitment to self places self interest above patient's and society

Always demonstrates respect, compassion, integrity, honesty;

Unsatisfactory: 1 2 3
Satisfactory: 4 5 6
Superior: 7 8 9
Insufficient contact to judge: 0

Comments

Remaining Characters: 5,000

SYSTEM BASED PRACTICE

Unable to access/mobilize outside resources independently; uses care pathways indiscriminately; actively resists efforts to improve systems of care

Effectively accesses/utilizes outside resources; effectively uses systematic approaches to reduce errors and improve patient care; enthusiastically assists in developing systems improvement

Unsatisfactory: 1 2 3
Satisfactory: 4 5 6
Superior: 7 8 9
Insufficient contact to judge: 0

Comments

Remaining Characters: 5,000

Overall Comments:

Remaining Characters: 5,000
OFF-SERVICE ROTATIONS—ORAL AND MAXILLOFACIAL SURGERY

TRAUMA SERVICE
Goals of the Rotation
The Trauma Service is the primary setting for Oral and Maxillofacial Surgery Residents to learn the principles involved in the care of injured patients, and in addition, provides significant exposure to the assessment and care of patients with non-traumatic emergent surgical conditions.

Objectives Learned
The one-month PGY-1 Oral and Maxillofacial Surgery rotation is designed to teach the principles of routine patient care including the identification of those at risk for iatrogenic complications and meticulous attention to detail in their avoidance. The PGY-1 Oral and Maxillofacial Surgery trainee will learn the indications for and technical aspects of basic procedures including a thorough physical examination, phlebotomy, intravenous access, insertion of nasogastric and urinary catheters, splinting of injured extremities, suturing of lacerations, and thoracostomy tube insertion. PGY-1 Oral and Maxillofacial Surgery trainees routinely perform appendectomy and herniorrhaphy while on the Trauma/Emergency Surgery rotation under the supervision of the Senior Resident and the attending Faculty. The PGY-1 Oral and Maxillofacial Surgery Resident will be expected to take and pass the ATLS at the end of his/her PGY-1 year.

GENERAL SURGERY SERVICE
Objectives Learned
The PGY-1 Oral and Maxillofacial Surgery Resident is expected to gain experience and instruction for preoperative evaluation and postoperative management of patients who present to the General Surgery Service. There will be an operative experience, but the focus will be primarily in evaluation and management of patients. The Resident will have exposure to the appropriate laboratory and imaging techniques involved in defining disease processes. The skills required to perform history and physical exams will be emphasized. Experiences overlap between hospitalized patients and clinic patients, and much of the diagnostic experience is obtained during clinic evaluation. Ongoing medical management of patients in the postoperative period, including laboratory and imaging information, is reviewed. Pathology reports will be discussed in order to strengthen the ability of interpreting carefully the implications of these findings.

SURGICAL INTENSIVE CARE UNIT
Rotation through the Surgical Intensive Care Unit (SICU) is intended to introduce the PGY-1 Oral and Maxillofacial Surgery Resident to the care of the critically ill surgical patients. Through supervision, the Resident is expected to establish a baseline knowledge and competency that will be utilized and further enhanced in the remainder of his/her residency.
PLASTIC SURGERY
The major goal and objective of an elective one-month rotation on Plastic Surgery during the PGY-3 Oral and Maxillofacial Surgery residency is to provide experience with the subset of patients that are treated by the specialty of Plastic and Reconstructive Surgery. The Resident will be responsible to the Junior Plastic Surgery Resident for assisting in the placement of tissue expanders, removal of tissue expanders with advancement or rotation of the subsequent flaps; harvesting and placement of composite grafts, full-thickness grafts, or split-thickness skin grafts; placement of allograft material; debridement and closure of pressure sores; scar revision by direct excision, or local flap rotation and repair of lacerations of the face, hand, and other body parts. The Resident will obtain additional exposure, but not as surgeon, to cleft lip, palate, nasal deformity repair, transfer of skin, musculocutaneous and free flaps.

ANESTHESIOLOGY
PGY-1 Oral and Maxillofacial Surgery Residents rotating in Anesthesiology will spend a total of five months on service. The Oral and Maxillofacial Surgery Resident must function as an Anesthesia Resident with a commensurate level of responsibility. The Resident will be available in the Department of Anesthesiology at 6:30 a.m. to attend the daily Anesthesiology conferences. The Oral and Maxillofacial Surgery Resident will learn and be competent in the basic principles of general anesthesia, mode of action of anesthesia drugs and pharmacokinetics and specific agents of intravenous anesthesia and inhalation anesthesia. The Resident will understand and administer, under supervision, narcotic analgesics, muscle relaxants (depolarizing muscle relaxants and non-depolarizing muscle relaxants). The Resident will learn the mechanism of action and systemic effects, uptake, distribution, and application in anesthetic practice. The Resident will learn and understand the specific muscle relaxants, the reversing of a non-depolarizing block, factors affecting their action, and the pharmacological properties of succinylcholine. After the Oral and Maxillofacial Surgery Resident's first month's rotation in Anesthesiology, he/she will understand and know the anesthetic machine and accessories, anesthetic circuits, mechanical ventilators, and respiratory function during anesthesia, including alveolar ventilation, control of breathing, airway resistance and pulmonary compliance, carbon dioxide elimination, and oxygenation.

Prior to the Oral and Maxillofacial Surgery PGY-1 Anesthesiology rotation, he/she will have completed a two-month rotation in Clinical Medicine. The Resident will understand systemic illness. During his/her Anesthesiology rotation, he/she will learn and be able to manage anesthesia in systemic illness, including ischemic heart disease, essential hypertension, chronic obstructive lung disease, liver disease, chronic renal failure, diabetes mellitus, anemia, obesity, and alcohol and drug abuse.

The PGY-1 Oral and Maxillofacial Surgery Resident, during his/her Anesthesiology rotation, will perform preoperative assessment and preparation of the patient at the end of each day. The Resident, by the end of his second month's rotation, will understand and be competent in direct laryngoscopy and tracheal intubation. He/she will be able to monitor the patient during anesthesia, including depth of anesthesia, circulatory function, measurement of blood loss, respiratory function, and renal function. The Resident will be able to recognize complications during anesthesia, be able to manage fluid and electrolyte requirements, and be familiar with the use of blood components.

MEDICINE ROTATION
The PGY-1 Oral and Maxillofacial Surgery Resident, during his/her two-month Medicine rotation, will be competent in the history and physical examination of the patient. He/she will understand the values of normal and abnormal laboratory tests, ECG interpretation, fluids and electrolytes, and management of patients with systemic disease, including infectious diseases, disorders of the cardiovascular system, disorders of the respiratory system, disorders of kidney and gastrointestinal system, hematology, endocrine and metabolic disorders, and neurological disorders.
EMERGENCY ROOM SERVICE

The PGY-2 Oral and Maxillofacial Surgery Resident will spend one month in the Emergency Room as an elective rotation. His/her work day will begin at 9:00 p.m. and end at 5:00 a.m. the following morning. His/her days will be from Tuesday evening through Sunday morning. The Oral and Maxillofacial Surgery Resident will spend equal time in the Pediatric, Medicine and Adult Surgical sections of the Emergency Room. The Oral and Maxillofacial Surgery Resident will be expected to recognize the critically ill patient. The Resident will take a complete history and perform a physical examination under Faculty supervision. He/she will understand severity indices, ie, Trauma Score and the Glasgow Coma Scale. The Resident will understand medical emergencies, including cardiovascular, endocrine, neurological, renal, respiratory and drug-induced emergencies and assist in their treatment. The Resident will learn to assess the trauma patient and suture all facial and intraoral lacerations. The Resident will learn to assess the psychiatric patient, including depression, panic attacks, hypoventilation syndrome, the suicidal and violent patient. The Oral and Maxillofacial Surgery Resident will assess all pediatric facial and trauma patients and suture all facial and intraoral lacerations. The Resident will also learn to recognize the child abuse patient. The Oral and Maxillofacial Surgery Resident will treat all facial environmental emergencies such as animal bites, insect stings and main human bites. The Oral and Maxillofacial Surgery Resident will learn to assess and treat trauma to the head, upper face, midface, nose, mouth, and lower jaw. The Resident will be able to evaluate and assist in the treatment of trauma to the eye, neck, chest, abdomen, genitalia, and extremities.
POLICIES

TRANSITIONS OF CARE
Each Monday at Morning Report, major cases, new admissions and emergency room patients are presented to residents and faculty so all are familiar with patients on our service. Daily rounds are conducted with residents and faculty and if any need for transition of care arises it is discussed and formally transferred to faculty/residents as needed. The following I-PASS format will be used for any patient handoffs from faculty or residents:

<table>
<thead>
<tr>
<th></th>
<th>Illness Severity</th>
<th>- Stable, “watcher,” unstable</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>Patient Summary</td>
<td>- Summary statement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Events leading up to admission</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Hospital course</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Ongoing assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Plan</td>
</tr>
<tr>
<td>A</td>
<td>Action List</td>
<td>- To do list</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Time line and ownership</td>
</tr>
<tr>
<td>S</td>
<td>Situation Awareness and Contingency Planning</td>
<td>- Know what’s going on</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Plan for what might happen</td>
</tr>
<tr>
<td>S</td>
<td>Synthesis by Receiver</td>
<td>- Receiver summarizes what was heard</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Asks questions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Restates key action/to do items</td>
</tr>
</tbody>
</table>

ALERTNESS MANAGEMENT/FATIGUE MITIGATION
- All faculty members and residents receive annual training to recognize the signs of fatigue and sleep deprivation. They are also educated in alertness management and fatigue mitigation processes.
- A sign-in log is maintained and reviewed by the program director to ensure our faculty and residents are educated.
- UTMB presents and Alertness Management and Fatigue Mitigation as a required lecture offered during Orientation and online training.
  o Fitness for Duty
  o Alertness Management
  o Fatigue Mitigation
  o Importance of Naps
- UTMB offers 35 private sleep rooms located on the 12th floor of John Sealy Towers, for residents who are too fatigued to safely return home.
- Residents who feel they are suffering from the effects of fatigue or are identified as such by supervising faculty will be sent home or allowed to nap in the John Sealy Towers. The residents remaining on service will assume patient responsibilities.

SUPERVISION OF RESIDENTS
To ensure oversight of resident supervision and graded authority and responsibility, the following classification of supervision will be used:

- Direct supervision – the supervising faculty is physically present with the resident and patient
Indirect supervision:
1-with direct supervision immediately available: the supervising faculty is physically within the hospital or other site of patient care, but is immediately available to provide Direct Supervision.
2-with direct supervision available: the supervising faculty is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

Oversight – The supervising faculty is available to provide review of procedures/encounters with feedback provided after care is delivered.

Supervision for trainee’s level of competence:
- PGY-1 Resident: Direct Supervision
- PGY-2 Resident: Direct Supervision
- PGY-3 Resident: Direct Supervision and Indirect Supervision as determined by the responsible faculty taking into consideration the level of resident competence.
- PGY-4 Resident: Direct Supervision with “Conditional Independence” as determined by the responsible faculty taking into consideration the level of resident competence.

Six - month evaluations will comment on resident’s progress towards competency.

Required Communication with Faculty:
Under the following circumstances, residents must communicate with faculty regarding patient care before taking action:
- Transfer to the ICU
- All operative procedures
- Significant status changes with patients
- All noted complications at the time of discovery
- All calls regarding transfer of patients from an outside facility
- All emergency rooms visits
- All cases involving conscious sedation

PROGRESSIVE RESPONSIBILITY OF RESIDENTS BASED ON COMPETENCIES

<table>
<thead>
<tr>
<th>PGY-1</th>
<th>PGY-2</th>
<th>PGY-3</th>
<th>PGY-4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncomplicated Exodontias</td>
<td>Soft tissue/Partial Bony Impactions</td>
<td>Full Bony Impactions</td>
<td>Complicated Full Bony Impactions</td>
</tr>
<tr>
<td>Local Anesthesia</td>
<td>Conscious Sedation</td>
<td>Deep Sedations</td>
<td>General Anesthesia</td>
</tr>
<tr>
<td>Simple laceration - &lt; 1 cm</td>
<td>Complicated lacerations &lt; 2cm</td>
<td>Complicated lacerations &gt; 2cm</td>
<td>Complicated lacerations requiring O.R. repair</td>
</tr>
<tr>
<td>Biopsies &lt; 5 mm</td>
<td>Biopsies &lt; 1 cm</td>
<td>Biopsies 1-2 cm</td>
<td>Biopsies – All</td>
</tr>
<tr>
<td><strong>Excision Benign lesions &lt; 5mm</strong></td>
<td><strong>Excision Benign lesions &lt; 1cm</strong></td>
<td><strong>Excision Benign lesions 1-2 cm</strong></td>
<td><strong>Excision Benign lesions – All</strong></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>----------------------------------</td>
<td>----------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Cystectomy&lt; 5mm</td>
<td>Cystectomy&lt; 1 cm</td>
<td>Cystectomy 1-2 cm</td>
<td>Cystectomy – all</td>
</tr>
<tr>
<td><em>Uncomplicated Alveoloplasty – one arch</em></td>
<td><em>Uncomplicated Alveoloplasty – tow arches</em></td>
<td><em>Complicated alveoloplasty</em></td>
<td><em>Major osseous recotouring</em></td>
</tr>
<tr>
<td>Initial evaluation of the trauma patient</td>
<td>Management of dentoalveolar trauma</td>
<td>Closed reduction of facial fractures</td>
<td>ORIF of facial fractures</td>
</tr>
<tr>
<td>Initial evaluation of TMJ patients</td>
<td>Management of TMD patients – splint therapy</td>
<td>Arthrocentesis of TMJ's in the clinic</td>
<td>Surgical Management of TMJ patients</td>
</tr>
<tr>
<td>Initial evaluation of Orthognathic patients</td>
<td>Laboratory work-up of Orthognathic patients</td>
<td>Surgical work-up / management of Orthognathic patients</td>
<td></td>
</tr>
<tr>
<td>Exposures and ligation of impactions</td>
<td>Intra-oral islolated soft tissue grafts</td>
<td>Split thickness skin grafts</td>
<td></td>
</tr>
<tr>
<td>Evaluation of cleft lip and cleft palate patients</td>
<td>Harvesting bone graft from anterior iliac crest</td>
<td>Tissue dissection and bone grafting to alveolar clefts</td>
<td>Cosmetic Procedures</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Salivary gland/duct surgery</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Implant Placement</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Grafting procedures/implant placement</td>
</tr>
</tbody>
</table>

* This is not meant to be an all-inclusive list of resident experiences while on or off service but a list of major and significant experiences that are expected to be realized during each year listed. Experiences listed could occur earlier depending on faculty evaluations and assignment of patients. Faculty discuss residents' progress and ability to perform a variety of procedures on a weekly basis. Semi-annual formal evaluations are made on each resident by each faculty member. Overall ability to perform procedures is monitored and assessed by the program director.
ORAL & MAXILLOFACIAL SURGERY-UTMB RESIDENCY PROGRAM

POLICY ON PROGRAM EVALUATION COMMITTEE AND THE ANNUAL PROGRAM EVALUATION

SECTION 1. STATEMENT, SCOPE AND PURPOSE OF POLICY
This policy is to establish that the Oral and Maxillofacial Surgery program at the University of Texas Medical Branch - Galveston establish a Program-specific policy to comprise the composition and responsibilities of the Residency’s Program Evaluation Committee. This Program-specific policy will establish a formal, systemic process to annually evaluate the educational effectiveness of the Residency program in accordance with the program evaluation and improvement requirements of the ACGME, and this Graduate Medical Education Committee (GMEC) policy. This will also meet outcomes assessment requirements of CODA, (Council on Dental Accreditation).

SECTION 2. PROGRAM EVALUATION COMMITTEE

2.1. In accordance with this policy and the AGCME requirements, the Program Director shall appoint a Program Evaluation Committee (PEC) to participate in the development of the Program’s curriculum and related learning activities. In addition, PEC will
   2.1.a. Annually evaluate the program to assess the effectiveness of the Program’s curriculum.
   2.1.b. Identify actions needed to foster continued program improvement and correction of areas of non-compliance with ACGME/CODA standards.

2.2 The Program Evaluation Committee shall be composed of at least 2 members of the Residency program’s faculty, and include at least one Resident.

   2.2.a. The Program Director is required to be a member of the PEC because of the small size of the program. (2 full time faculty)
   2.2.b. Should there not be any Residents enrolled in the program, the Resident membership requirement will be waived.

2.3. The PEC will function in accordance with the written description of its responsibilities, as specified below and participate actively in
   2.3.a. Planning, developing, implementing, and evaluating all significant activities of the Residency program;
   2.3.b. Reviewing and making recommendations for revision of competency-based curriculum goals and objectives
2.3.c. Addressing areas of non-compliance with ACGME/CODA standards; and,
2.3.d. Reviewing the program annually, using evaluations of faculty, Residents/and others, as specified in Section 3.

SECTION 3. ANNUAL PROGRAM EVALUATION

3.1. The Program, through the PEC, will document formal, systematic evaluation of the curriculum at least annually, and will render a full, written, annual program evaluation (APE).

3.2. The annual program evaluation will be conducted on or before June 30 of each year, unless rescheduled for other programmatic reasons.

3.3. Approximately two months prior to the review date, the Program Director will:

3.3.a. Facilitate the Program Evaluation Committee’s process to establish and announce the date of the review meeting;

3.3.b. Identify an administrative coordinator to assist with organizing the data collection, review process, and report development; and,

3.3.c. Solicit written confidential evaluations from the entire specific Program faculty and Resident body for consideration in the review (if not done previously for the academic year under review).

3.4. At the time of the initial meeting, the Committee will consider:

3.4.a. Achievement of action plan improvement initiatives identified during the last annual program evaluation;
3.4.b. Achievement of correction of citations and concerns from last CODA program survey;
3.4.c. Residency program goals and objectives;
3.4.d. Faculty members’ confidential written evaluations of the program;
3.4.e. The Residents’ annual confidential written evaluations of the program and faculty;
3.4.f. Resident performance and outcome assessment, as evidenced by:
   3.4.f.1. Aggregate data from general competency assessments
   3.4.f.2. In-training examination performance
   3.4.f.3. Case/procedure logs
   3.4.f.4. Other items that are pertinent to the program/specialty;
3.4.g. Graduate performance, including performance on the certification examination; and,
3.4.h. Faculty development/education needs and effectiveness of faculty development activities during the past year.
3.5. Additional meetings may be scheduled, as needed, to continue to review data, discuss concerns and potential improvement opportunities, and to make recommendations.

3.6. As a result of the information considered and subsequent discussion, the Committee will prepare a written plan of action to document initiatives to improve performance in at least one or more of these areas:
   3.6.a. Resident performance
   3.6.b. Faculty development
   3.6.c. Graduate performance
   3.6.d. Program quality
   3.6.e. Continued progress on the previous year’s action plan

3.7. The plan will delineate how those performance improvement initiatives will be measured and monitored.

3.8. The final report and action plan will be reviewed and approved by the program’s teaching faculty.

3.9. A report will be provided to the GMEC.

**EFFECTIVE DATE: January 14, 2014**
INPATIENT SERVICES

ADMISSIONS
All admissions are arranged by the Chief Resident (or Faculty).
Patients may be:
1. Called from a waiting list
2. Admitted directly from clinic
3. Admitted from the emergency room
4. Transferred from another hospital

When the Chief Resident arranges the admission of a patient, it is his/her (or his/her designee’s) responsibility to determine if the patient has Medicare, Medicaid or other third party coverage. If the patient has any of these coverages, the Faculty Surgeon must be notified.

ADMISSION FROM CLINICS, ER AND FAMILY HEALTH CARE CENTERS
To arrange for an immediate or future admission, use the following telephone lines specific to the admitting service:

- OB/GYN/TDC ............ 747-3600
- Pediatrics/Psychiatric ... 747-3602
- Medicine/Geriatrics...... 747-3604
- Surgery.................... 747-3606
- BIC* Fax ...................... 747-3618/4808

*Bed Information Center

INTERFACILITY TRANSFERS AND ER EVALUATIONS
Transfers and ER evaluations from other facilities originate through the BIC unless the UTMB Faculty has accepted the patient independently. The BIC (1-800-962-3648, 1-800-96-ADMIT) must be notified of the patient's final acceptance via a conference call. All transfers related to trauma are seen and evaluated in the Trauma Center Resuscitation Area.

MANAGED CARE
If the patient is a member of an HMO, you must notify the PCP before the admission. The BIC representative will ask you for the authorization number.

Please provide the following information to the BIC representative to expedite the patient arrival placement process:

- Name and contact number of caller
- Patient's full name/ DOB/gender
- Patient's UH#
- Admitting MD, attending, resident names
- Admitting MD, attending, resident Dr. number
- Preferred unit placement
- Arrival mode
- Where the patient is currently located

**Special needs:** social services, curb assistance, hearing or visual impairment, >200 lbs., >6' ht., allergies, language assistance, immunosuppressed, recent exposure to infectious disease, etc.
MEDICAL RECORDS
On admission, all patients need the following:

- **Complete History and Physical** (usually done by a PGY-2; may be performed by an Oral and Maxillofacial Surgery Fellow but must have a documented short history and physical by Faculty).
- **Admission Note** by the Resident (that also documents that the Faculty has seen and examined the patient) with the indications for admission, an assessment and the plan of care. The Admission Note must indicate the name of the referring physician or dentist.
- **Admission Orders** including the name of the admitting Faculty and the Faculty of the service that will follow the patient as an inpatient (if different than the admitting Faculty).
- **A Preoperative Note must be written by the Operating Surgeon the night before elective surgery or immediately before emergency surgery.** Each Day Surgery Patient must have a Preoperative Note by the Operating Surgeon prior to the patient's arrival in the holding area.
- **A Transfer Note** must be written any time the patient's condition requires transfer to the SICU (J2A and J2B). This note should indicate the reason for transfer and the plan for treatment in the SICU. The same is required when a patient is transferred out of the unit to another unit.
- **A Discharge Progress Note** must be written when a patient is discharged from an inpatient or outpatient admission (including DSU). This is a brief summary of the hospitalization, significant results of tests or procedures, and plan of follow up.
- **A Discharge Summary** is dictated within 24 hours of discharge. This is done by the Oral and Maxillofacial Surgery Resident.

MEDICAL RECORD COMPLETION
Chart work is a necessary, time-consuming, never-ending chore which cannot be avoided, but it can be managed to make the process better and easier. The development of good habits will keep you in good standing for the rest of your professional career. Do not procrastinate - write the history and physical immediately; make the pertinent Progress Note at the time it occurs; dictate the Operative Report when the procedure is completed, etc. This practice will save you lots of grief.

A task force of physicians and representatives from Hospital Administration and Medical Records Administration addressed the problems of medical record completion and made recommendations for improvements. As a result, completion time frames and the reported processes were sanctioned by the Medical Staff Executive Committee as follows:

NEW GUIDELINES

<table>
<thead>
<tr>
<th>Record Type</th>
<th>Action</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>History and Physical</td>
<td>Written</td>
<td>on admission</td>
</tr>
<tr>
<td>Operative Reports</td>
<td>Dictated</td>
<td>dictated immediately after operation</td>
</tr>
<tr>
<td>Telephone and voice orders</td>
<td>Signed</td>
<td>within 24 hours of giving the order</td>
</tr>
<tr>
<td>Final Discharge</td>
<td>Written</td>
<td>upon discharge</td>
</tr>
<tr>
<td>Discharge Summary</td>
<td>Dictated</td>
<td>within 1 day of discharge</td>
</tr>
</tbody>
</table>

In addition to the above record completion requirements, Residents must complete all other remaining record work within 14 days of discharge.
WARD MANAGEMENT
Each service will have rounds twice a day, at the times designated by the Chief Resident and the Attending Faculty. The Residents will be responsible for the performance of diagnostic laboratory work and x-rays and collecting the results so that rounds can be efficient and organized. Nurses are an integral part of the team and should be encouraged to participate in daily rounds.

Changes in orders and new orders agreed upon will be charted or entered in the Order Entry system on the computer at the time the decision is made before proceeding to the next patient so that at the completion of rounds, the orders are already in place, diminishing the lag time. A Progress Note must be written daily by Faculty. If the progress note is written by a Resident, there must be documentation that Faculty has seen and examined the patient.

PATIENT LISTS
Maintaining a list of patients on each service is the responsibility of the Oral and Maxillofacial Surgery Resident. After rounds each morning, an updated list should be brought to the Program Director by 7:30 a.m. The list should include patient location, name, age, sex, UH#, diagnosis and any operative procedures done. Copies will be kept in the Oral and Maxillofacial Surgery Residents Office.

OPERATING ROOM SCHEDULING
All surgery, including Day Surgery and Same-Day Surgery will be scheduled with the OR Posting Clerk (ext. 23266), who is available to post Monday through Friday from 8:00 a.m. to 4:30 p.m.

The operations will be posted if there is time available. If a case is canceled, the following case will move up to the earlier time, with the Surgeon's approval. At the time of posting, the Surgeon will be asked if he/she can operate earlier if the case before him/her should cancel.

When the surgery is posted, the Posting Clerk will request a realistic estimate of the time the room will be needed for that case. One-half to one hour will be added to that time for anesthesia time, depending on the case. The room will be considered at capacity when the number of surgeries posted add up to 8 1/2 hours. The time reserved for each case will be recorded on the schedule when it is distributed.

If a Surgeon consistently underestimates the length of time required for a particular surgical procedure, the Posting Clerk may alter the time quoted after consulting with the Nursing Supervisor or the Executive Director of the Operating Room.

The deadline for adding, deleting or changing the schedule is 1:00 p.m. the day prior to the scheduled cases. Any changes thereafter must go through the Senior Anesthesia Resident on call or the OR Charge Nurse.
**OPERATING ROOM POLICIES (SEE ADDENDA – OR SCHEDULING)**

All cases must be discussed with the responsible Faculty prior to posting. Faculty will be present in the OR to supervise all cases.

Preoperative workup is required for all inpatient surgery regardless of type of anesthesia. There must be a history and physical signed by an Oral and Maxillofacial Surgery Resident within the preceding 30 days.

There must be properly signed informed consent. A patient cannot "properly" sign consent once he/she has been premedicated. A husband cannot consent for his wife and vice versa. Telephone consents, except for very unusual circumstances, are not acceptable. All aspects of the consent must be done carefully with attention given to all details. Remember, consents only become important when there is a problem.

Disputes over consent forms will be handled by the Executive Director of the Operating Room (or his designee). Consents for blood transfusion are not required by the Operating Room. On 6/1/82 UTMB adopted the new consent form entitled "Disclosure and Consent - Medical and Surgical Procedures". Please read the Questions and Answers - the Texas Medical Disclosure Panel and the Disclosure and Consent Form effective June 1, 1982. It is quite self-explanatory.

An Admissions Workup should be completed by 1500 hours in the afternoon prior to surgery so appropriate anesthesia preoperative rounds may be completed. Routine EKG’s for patients over 40 are not required but are encouraged.

Routine chest x-rays are not required preoperatively. Obviously, an Oral and Maxillofacial Surgery Chief Resident may order a pre-op chest x-ray at any time he/she feels there is definite indications.

If a room has been reserved for surgery by 1:00 p.m. on the day before surgery, that room may not be used by another service. In order for this to be effective, it is necessary for all services to abide by realistic rules:

1. Scheduling of bona fide cases only
2. Notifying the operating room immediately of any cancellation
3. No substitutions of cases, except that a service may "bump" one of its bona fide cases for a more emergent one
4. Either the Staff Surgeon or Senior Resident should review the schedule before 1:00 p.m. the day prior to surgery in an effort to complete the schedule by 3:00 p.m.

Emergency cases should be done, when possible, in the operating room ordinarily reserved for the scheduling service. If a case is more pressing, the first free room will be utilized. The seriousness of the emergency, and the waiting time permissible, will be the decision of the Surgeon scheduling the emergency case. (This is not meant in any way to deny the Consulting Anesthesiologist the time necessary to prepare the patient for anesthesia.) Common courtesy demands that a surgeon who "bumps" a fellow physician personally explain to the physician the compelling reasons.

Occasionally, selecting a room for an emergency case is an arbitrary decision, and the Operating Room Director will decide upon the room to be "bumped". The service delayed by the emergency case will have the first right to available OR space, either time previously assigned to the service doing the emergency or their own. Service Chiefs or Departmental Chairmen will be asked to settle disputes arising from the declaration of/or handling of emergencies.
Adding OR cases after 1:00 p.m. for the next day which are either "semi-emergency" cases or "forgotten" cases must be cleared with both the Head Nurse of the OR shift and the Staff Anesthesiologist on call before the case is actually scheduled. Such cases go on the Space Available list.

Canceling of cases: The Anesthesiologist may find patients not suitable or ready for anesthesia and may withhold anesthesia. Surgeons may declare patients not ready or suitable for surgery. Courtesy should be extended to fellow physicians by informing them of these decisions.

**OPERATING ROOM ASSIGNMENTS AND DUTIES FOR SURGERY RESIDENTS**

Operative assignments will be made by Chief Residents of the service. Efforts will be made for everyone to have a fair share of operative experiences. However, this will depend on a multitude of factors, not the least of which is the particular person’s level of performance in routine work. If an individual is not performing adequately, he/she should be so informed by his/her Superior House Officer and/or the Attending Surgeon.

It is the Assistant Resident's responsibility to have the patient ready, x-rays in the Operating Room, and the patient prepared for the operation (catheters, NG tubes, IV's, typed and cross matched, etc.). One of the surgery house staff members must be in the Operating Room at the time the patient is brought into the room. *This is very important.*

**INTENSIVE CARE UNIT (JENNIE 8C)**

Jennie 8C is designed as the Intermediate Care Unit to facilitate the care of critically ill patients whose care does not require respirators or invasive monitoring, but requires closer monitoring than can be provided on the regular units.

Admission of a patient to this unit is arranged between Faculty and the Charge Nurse of the unit. A call schedule for the Medical Director is posted in the nursing station. The Faculty who admitted the patient to the unit will be responsible for the care of the patient and for responding to calls from the nursing staff.

**CONSULTATIONS**

**To Other Clinical Services**

Request for consultation from another service should be written on the appropriate form, and it is the responsibility of the physician requesting the consultation to see that this is done expeditiously. In addition to the written Consult Request, a Surgical House Officer should call the appropriate physician to discuss the request.

**From Other Clinical Services**

When we receive a request for consultation, the consult must be answered on the same day it is received. PGY-1s are not permitted to answer Consult Requests, including those from the Emergency Room. The PGY-2 Resident must personally see all Consult Requests and personally supervise the disposition on the day received. Each patient seen in consultation must be seen by the Attending Faculty on the day received.

We will cover all consultations from physicians at the Extended Hours Clinic at Rebecca Sealy just as we would from any other UTMB site.
**PATIENT DISCHARGE PLANNING**

If Social Service assistance is needed in arranging transportation home, nursing home placement or visiting nurse care, please give Social Service as much advance notice as possible. Social Service must be consulted 24-48 hours prior to discharge.

Prescriptions should be written the night before discharge when possible.

Follow-up appointments will have a higher rate of compliance if there is realistic planning, taking into consideration the patient’s medical status, age, distance from home and other socioeconomic factors.

**Staff Patients:** Follow-up appointments should be made to the appropriate Oral and Maxillofacial Surgery clinic and clarified with the patient.

**Private Patients:** Follow-up appointments should be made with the Oral and Maxillofacial Surgery clinic. If discharge occurs on the weekend, it is the responsibility of the house officers to make sure follow-up appointments are made.

**CALL SCHEDULE**

As a rule, “call” starts at 7:00 a.m. and ends at 7:00 a.m. the following day. The service responsible for admissions each day will respond to requests for emergency consultation and the Emergency Room.

The Oral and Maxillofacial Surgery Residents will be on call every third night and will be responsible for all admissions and emergency operations under the supervision of the Chief Resident on call.

At the end of each call period it is the responsibility of the Oral and Maxillofacial Surgery Chief Resident to personally contact the attending Faculty on call and review any patient whose care will be managed by Oral and Maxillofacial Surgery.

**DUTY HOURS**

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, 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.

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

Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.

An 8 hour period for rest and personal activities must be provided between all daily duty periods, and after in-house call.

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

In-house call must occur no more frequently than every third night, averaged over a four-week period.

Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, maintain continuity of medical and surgical care, transfer care of patients, or conduct outpatient continuity clinics.

No new patients may be accepted after 24 hours on continuous duty, except in outpatient continuity clinics. A new patient is defined as any patient for whom the resident has not previously provided care. At-home call (pager call) is defined as call taken from outside the assigned institution.

The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.

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

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

Faculty and residents must be educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects.

**RESIDENT DUTY HOURS**

**Resident Duty Hours**

**Maximum Hours of Work per Week**

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

**Duty Hour Exceptions**

A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.

In preparing a request for an exception, the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.

Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution’s GMEC and DIO.
Moonlighting

Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.

PGY-1 residents are not permitted to moonlight.

Mandatory Time Free of Duty

Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

Maximum Duty Period Length

Duty periods of PGY-1 residents must not exceed 24 hours in duration.

Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.

It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period must be no longer than an additional four hours.

Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

Under those circumstances, the resident must:

appropriately hand over the care of all other patients to the team responsible for their continuing care; and,

document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.
The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

**Minimum Time Off between Scheduled Duty Periods**

PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.

Intermediate-level residents [as defined by the Review Committee] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

Residents in the final years of education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [as defined by the Review Committee] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.

**Maximum Frequency of In-House Night Float**

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

[The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

**Maximum In-House On-Call Frequency**

PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).
At-Home Call

Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.

At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”.
TRAUMA TEAM ACTIVATION
The Trauma Service responds to all Trauma Team activations from 0645 to 1700 hours, Monday through Friday. The on-call Trauma Team responds from 1700 to 0645 hours Monday through Friday and from 0645 hours to 0700 hours on weekends and holidays.

The response to Trauma Team activations must be immediate and involves all members of the Trauma Team (Chief Resident, Resident, Intern, and students).

Trauma Team activations are communicated through the orange trauma pagers. These pagers are passed from Resident to Resident directly at the changeover times of 0645 and 1700 hours. It is the responsibility of the oncoming Residents to ensure their prompt availability at the changeover.

MORNING REPORT
Morning report is held at 0645 hours seven days a week, in the Trauma Center conference area on the 2nd floor. At this time, the Residents from the previous night's call will present all patients seen and evaluated through the Trauma Team activation system and all non-trauma emergency surgical consults. Continued care will then be assumed by the Trauma Service for all trauma patients and all non-trauma emergency consultations will be assumed by the appropriate service.

NON-TRAUMA EMERGENCY ROOM CONSULTS
The Resident on the Trauma Surgery Service will be available for ER consultations from 0645 until 1700 hours, Monday through Friday. From 1700 to 0645 hours, Monday through Friday and from 0645 hours to 0700 hours on weekends and holidays, the Resident on-call will cover ER consultations. All patient evaluations will be reviewed by the Chief Resident and responsible surgical Faculty.

DISPOSITIONS FOR NON-TRAUMA EMERGENCY PATIENTS
1. Patients seen and requiring emergent operations will remain on the Operative Service.
2. Patients seen between 0645 and 1700 hours or evenings while the Trauma Service is on-call, and who do not require emergent/immediate surgery, will be admitted to Oral and Maxillofacial Surgery.
# DEPARTMENT OF SURGERY FACULTY

## RT. ASSISTANT

<table>
<thead>
<tr>
<th>EXT.</th>
<th>FAX</th>
<th>PAGER</th>
<th>STAFF</th>
</tr>
</thead>
<tbody>
<tr>
<td>0527</td>
<td>21285</td>
<td>25611</td>
<td>Lauren Burkharter</td>
</tr>
</tbody>
</table>

## BURN SURGERY (Shriners Burns Hospital)

| 1220 | Steven Wolf, M.D., Professor and Chief | 770-6607 | 770-6919 | Vacant |
| 1220 | David N. Herndon, M.D., Professor (SBH) | 770-6744 | 770-6919 | 643-9439 | Shari Taylor |
| 1220 | Carlos J. Jimenez, M.D., Associate Professor (SBH) | 770-6589 | 770-6919 | 643-0337 | Wendy Kinnaird |
| 1220 | Jong Lee, M.D., Professor (SBH) | 770-6589 | 770-6919 | 643-4520 | Wendy Kinnaird |

## CARDIOVASCULAR AND THORACIC SURGERY (6.120 JSA)

| 21421 | 0528 | Abe De Anda, M.D., Professor and Chief | 21203 | 646-842-1052(c) | Janie Copado |
| 0528 | Ghannam Al-Dossari, M.D., Associate Professor | 21203 | 771-6575(c) | Janie Copado |
| 0528 | Vincent R. Conti, M.D., Professor | 21203 | 643-1853 | Janie Copado |
| 0528 | Ikenna Okereke, M.D., Associate Professor | 21203 | 643-0716 | Janie Copado |
| 0528 | Patrick Roughneen, M.D., Professor | 21203 | 643-0750 | Janie Copado |

## COLORECTAL SURGERY (6.136 McCullough)

| 20088 | 0737 | Aakash Gajjar, M.D., Assistant Professor | 20218 | 713-320-7484(c) | Deanna Greer |
| 0737 | Laila Rashidi, M.D., Assistant Professor | 20529 | 858-766-8471(c) | Deanna Greer |

## MIS/FOREGUT SURGERY

| 21846 | 0541 | Alexander Perez, M.D., FACS, Professor and Chief | 72253 | Valarie Zimmerman |
| 77369 | 0544 | Guillermo A. Gomez, M.D., Professor | 70061 | 643-9399 | Esther Martinez |
| 27198 | 1172 | Dennis C. Gore, M.D., Professor | 77319 | 643-4605 | Emily Novicky |
| 21201 | 0531 | Thomas D. Kibmough, M.D., Professor | 20088 | 771-4642(c) | Erica Unice |
| 77359 | 0531 | Marilyn Marx, M.D., MBA, Professor | 77378 | 643-1523 | Emily Novicky |
| 21203 | 0527 | J. Patrick Walker, M.D., Professor | 25611 | |

## NEUROSURGERY (9.112 John Sealy Annex)

| 21742 | 0517 | Joel Patterson, M.D., Associate Professor and Chief | 21500 | 502-9421(c) | Annie Salinas |
| 0517 | Aaron Mohanty, M.D., Associate Professor | 21500 | 643-3253 | Diana Crowell |
| 0517 | Juan Ortega-Barnett, MD, Assistant Professor | 21500 | 643-0423 | Diana Crowell |

## ORAL AND MAXILLAFACIAL SURGERY (6.106 JSA)

| 77378 | 0531 | Roger R. Throndson, D.D.S., Associate Professor & Chief | 21546 | 643-9428 | Dustin Defee |
| 21546 | 0531 | Eugene Mainous, D.D.S., Professor | 21546 | Dustin Defee |

## PEDIATRIC SURGERY (3.220 Research Building 6)

| 24253 | 0353 | Ravi S. Radhakrishnan, M.D., MBA, Associate Professor and Chief | 24253 | 643-1720 | Sarah Chapman |
| 0353 | Canika Bowen-Jallow, M.D., Assistant Professor | 24253 | 643-0134 | Sarah Chapman |
| 0353 | Sifrance Tran, M.D., Assistant Professor | 24253 | 643-0125 | Sarah Chapman |

## PLASTIC SURGERY (6.130 McCullough Building)

| 21872 | 0724 | Linda G. Phillips, M.D., Professor & Chief | 21257 | 643-1482 | Yvonne Rendon |
| 1220 | Ludwik Branski, M.D, Assistant Professor | 770-6741 | 770-6919 | 643-0797 | Judy Howard |
| 0724 | Eric L. Cole, M.D., Assistant Professor | 21255 | 643-1767 | Yvonne Rendon |
| 0724 | Trung Ho, M.D., Assistant Professor | 21255 | Yvonne Rendon |
| 1220 | William Norbury, M.D., Assistant Professor | 770-6741 | 770-6919 | 643-1140 | Judy Howard |
| 0724 | Julie E. Park, MD, FACS, Assistant Professor | 21255 | Yvonne Rendon |
| 1220 | Ramon Zapata Sirvent, M.D., Assistant Professor | 770-6589 | 770-6919 | (713) 249-9341 | Wendy Kinnaird |

---

### DEPARTMENT OF SURGERY FACULTY CONT'D

Revised 5/11/18

<table>
<thead>
<tr>
<th>RT. ASSISTANT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SURGICAL ONCOLOGY (6.316 McCullough)</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EXT.</th>
<th>FAX</th>
<th>PAGER</th>
<th>STAFF</th>
</tr>
</thead>
<tbody>
<tr>
<td>0737</td>
<td>21846</td>
<td>72253</td>
<td>643-0560</td>
</tr>
<tr>
<td>0541</td>
<td>21846</td>
<td>72253</td>
<td>643-0560</td>
</tr>
<tr>
<td>0737</td>
<td>20698</td>
<td>20088</td>
<td>771-3175 (c)</td>
</tr>
<tr>
<td>0541</td>
<td>21846</td>
<td>72253</td>
<td>643-1447</td>
</tr>
<tr>
<td>0737</td>
<td>21283</td>
<td>20088</td>
<td>692-9953(c)</td>
</tr>
</tbody>
</table>
FACULTY NUMBERS

<table>
<thead>
<tr>
<th>Faculty</th>
<th>ID#</th>
<th>Medical Record #</th>
<th>Long Range Pager #</th>
<th>Web Pages</th>
<th>E-mail Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mainous</td>
<td>047774</td>
<td></td>
<td></td>
<td><a href="http://www.utmb.edu/surgery/oral/mainous.us.asp">http://www.utmb.edu/surgery/oral/mainous.us.asp</a></td>
<td><a href="mailto:emainous@utmb.edu">emainous@utmb.edu</a></td>
</tr>
<tr>
<td>Throndson</td>
<td>155640</td>
<td>6825</td>
<td>643-9428</td>
<td><a href="http://www.utmb.edu/surgery/oral/throndson.asp">http://www.utmb.edu/surgery/oral/throndson.asp</a></td>
<td><a href="mailto:rthurond@utmb.edu">rthurond@utmb.edu</a></td>
</tr>
</tbody>
</table>

FACULTY NUMBERS
# HOUSE STAFF NUMBERS

<table>
<thead>
<tr>
<th>Name</th>
<th>Employee #</th>
<th>Long Range Pager #</th>
<th>email address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Josh Manuel, DDS</td>
<td>PGY-4</td>
<td>246426</td>
<td>643-2540</td>
</tr>
<tr>
<td>Chris Thompson, DDS</td>
<td>PGY-3</td>
<td>249098</td>
<td>643-1606</td>
</tr>
<tr>
<td>Alex Geiger, DMD</td>
<td>PGY-2</td>
<td>249192</td>
<td>643-1815</td>
</tr>
<tr>
<td>Dave Szandzik, DDS</td>
<td>PGY-1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# SUMMARY OF ORAL AND MAXILLOFACIAL SURGERY RESIDENTS’ SCHEDULE

**PGY-1**
- Oral and Maxillofacial Surgery Service (Orientation)  
  July
- Anesthesiology  
  August-November;
- SICU  
  January
- Medicine  
  December
- General Surgery and Trauma  
  February-March
- April-June

**PGY-2**
- Oral and Maxillofacial Surgery Outpatient Clinic  
  Monday 8:00 A.M. – 1:00 P.M.
- Prison Oral and Maxillofacial Surgery Outpatient Clinic  
  Monday 1:00 P.M. – 7:00 P.M.
- UTMB Oral and Maxillofacial Surgery Outpatient Clinic  
  Tuesday 8:00 A.M. – 7:00 P.M.
- UTMB Oral and Maxillofacial Surgery Outpatient Clinic  
  Wednesday 8:00 A.M. – 7:00 P.M.
- UTMB Oral and Maxillofacial Surgery Outpatient Clinic  
  Thursday 8:00 A.M. – 7:00 P.M.
- UTMB Oral and Maxillofacial Surgery Outpatient Clinic  
  Friday 8:00 A.M. – 7:00 P.M.

**PGY-3**
- Prison Oral and Maxillofacial Surgery Outpatient Clinic  
  Monday 8:00 A.M. – 1:00 P.M.
- UTMB Oral and Maxillofacial Surgery Outpatient Clinic  
  Monday 1:00 P.M. – 7:00 P.M.
- UTMB Oral and Maxillofacial Surgery Outpatient Clinic  
  Tuesday 8:00 A.M. – 7:00 P.M.
- UTMB Operating Room  
  Wednesday 9:00 A.M. – 7:00 P.M.
- UTMB Outpatient Clinic  
  Thursday 8:00 A.M. – 7:00 P.M.
- UTMB Operating Room  
  Friday 7:15 A.M. – 7:00 P.M.

**PGY-4**
- Prison Oral and Maxillofacial Surgery Outpatient Clinic  
  Monday 8:00 A.M. – 1:00 P.M.
- UTMB Oral and Maxillofacial Surgery Outpatient Clinic  
  Monday 1:00 P.M. – 7:00 P.M.
- UTMB Oral and Maxillofacial Surgery Outpatient Clinic  
  Tuesday 8:00 A.M. – 7:00 P.M.
- UTMB Operating Room  
  Wednesday 9:00 A.M. – 7:00 P.M.
- UTMB Outpatient Clinic  
  Thursday 8:00 A.M. – 7:00 P.M.
- UTMB Operating Room  
  Friday 7:15 A.M. – 7:00 P.M.
ORAL AND MAXILLOFACIAL SURGERY
OUTPATIENT SERVICES

CLINIC SCHEDULE (5th Floor Hospital University Clinics/Brittany Bay Plaza)
Monday through Friday, 8:00 a.m. – 4:30 p.m.

CLINIC SUPPORT STAFF:
Nurses: Ginger Eckenrode
Operating Room Technicians: Jennifer Ditson

CLINIC PHONE – UHC (409)772-7241
--Brittany Plaza – (832)632-5222
FRONT DESK APPOINTMENT PHONE – UHC – (832)505-1450
--Brittany Plaza – (832)632-5222

OMFS OFFICE – PROGRAM COORDINATOR
Dustin Defee – Extension 21546

DIVISION PHONE – (409)772-1546

CHIEF OF ORAL AND MAXILLOFACIAL SURGERY
DIRECTOR OF RESIDENCY PROGRAM
Roger R. Throndson, D.D.S.
Office Phone – (409)772-1546
Long-range Pager – 643-9428
E-mail address – rrthrond@utmb.edu

FACULTY
Hisham A. Marwan, D.D.S.
Office Phone – (409)772-1546
Long-range Pager – n/a
E-mail address – himarwan@utmb.edu

Elgene G. Mainous, D.D.S.
Office Phone – (409)772-1546
Long-range Pager – n/a
E-mail address – emainous@utmb.edu
PROCEDURE FOR ADMISSION TO THE DAY SURGERY UNIT

1. Call the OR Posting Clerk (Ext. 23266) to schedule the case in the operating room.

2. Stipulate that the patient will be on the Day Surgery Unit.

3. Give the usual data: name, UH#, age, procedure, anesthesia, estimated length of operating time.

4. Have the following forms signed, witnessed and distributed (original copy of each must be in the patient's chart prior to surgery):
   a. Surgical Consent Form
   b. Preoperative General Instruction (preprinted)
   c. Health Questionnaire

5. Send to the Day Surgery Unit either a Short-stay Record, a history and physical, or a current Outpatient Clinic Note relating to the scheduled surgery and the scheduled date of surgery. In every case a history and physical which has been done within 30 days prior to date of surgery must be provided by the surgeon.

6. Send the patient to the Day Surgery Unit, J8B, or for anesthesia work-up before 3:00 p.m.

If the preoperative patient work-up is not completed prior to the day of surgery, the Surgeon and Medical Director will be notified and the surgery will be canceled.

Postoperatively, the surgeon must see the patient prior to discharge, and write a note describing the status of the patient and the description of any pathologic results. The patient must be accompanied by an adult in order to leave the building. If transportation is a problem, Social Services should be notified prior to the procedure.

SAME-DAY SURGERY

Many insurance plans will not cover preoperative days of hospitalization, in which case the same procedure outlined above for Day Surgery will be followed. After the operation, the patient will be admitted to an inpatient room from the Recovery Room.

DAY SURGERY

The Day Surgery Unit is currently located on Jennie Sealy 2nd floor and is open Monday through Friday from 6:30 a.m. to 11:00 p.m. This unit provides preoperative preparation of patients and allows a short postoperative observation.
CLINICAL SUPPORT SERVICES

CLINICAL PATHOLOGY

1. Stat Laboratory Requests
   The Clinical Laboratories receive several hundred emergency requests each day. It is not possible for the laboratory to expedite that many procedures, so there must be priorities. The physician ordering these tests must keep this in mind and only request "stat" laboratory studies when absolutely necessary.

2. Routine Laboratory Requests
   Careful planning on the part of the physician will result in most, if not all, of blood for laboratory tests being drawn at one time in the morning, by the most skilled personnel, with the least discomfort to the patient. Careful planning will also diminish the incidence of duplication of laboratory tests, which contributes significantly to the cost of hospitalization, whether the cost is borne by the patient, a third party or the hospital.

RADIOLOGY

A request for an x-ray is really a request for consultation from the radiologist. Therefore, providing essential medical information and clinical diagnosis on the request is as important as supplying similar information on a consultation request. Direct communication with the radiologist consultant can often facilitate this process to the benefit of the patient. The completion of an x-ray must not be delegated to the Ward Clerk.

Similarly, this responsibility should not be delegated to the student unless the student has been made privy to the reason for the request and the clinical diagnosis as perceived by the physician.

A stat request for an emergency radiologic service should be made only when absolutely necessary. Such requests interrupt the schedule in the Radiology Department and may lead to needless delays of a scheduled study. The Radiology Department assures us that if a radiological study is needed within the same day as the request, they will assure its performance if the Chief Technologist or his Assistant is notified of the request. One of the individuals is available in the department throughout the day and should be readily reached. As our consultant, the Radiologist evaluates the required studies with great expertise, and all of the previous films on the patient must be available for reference. It is, therefore, the Physician's responsibility to return films to the film room as rapidly as possible, certainly within 24 hours. X-ray films should not be left in the operating suite, as they are frequently misplaced.
**BLOOD BANK**

*Type and Screen for Surgery*

Type and Screen may be ordered by checking the box labeled *Type and Screen* on the Blood Component Request Form. The Blood Bank technologist will determine the patient's blood group and Rh type, screen the serum for unexpected antibodies, and assure that an adequate quantity of Group and Type specific blood will be on hand in the Blood Bank during the surgery.

The screening test used is capable of detecting 99% of significant antibodies. Therefore, should the patient experience an unexpected blood loss during surgery, he/she can be given Group and Type specific blood which has not been crossmatched with negligible risk. Should unanticipated blood loss occur during the surgery, call the Blood Bank to alert them that someone is on the way to pick up blood, giving the patient's name. Present a Blood Dispensing Request, stating the desired number of units required. It will not be necessary for the physician to sign a waiver. The Blood Bank will provide Group and Type specific blood immediately. The crossmatch will be done as soon as possible after the blood is released. Should an antibody be detected during the screening process, compatible blood will be found and a crossmatch will be done.

A recent survey conducted at UTMB enables us to identify the operative procedures, listed on the next page, as seldom requiring intraoperative transfusion and thus suitable for Type and Screen. Should circumstances exist in any particular patient undergoing one of these procedures, which make blood usage probable, then it would be inappropriate to order Type and Screen. In that case, crossmatched blood should be ordered.

Since blood that is crossmatched for an elective surgery patient is permanently removed from the Blood Bank's stores, prudence should be used in such a request. Four units should not be requested if the statistical likelihood of need is two units. Blood should only rarely be requested just to be "available", if needed. When it is anticipated that a larger amount of blood will be needed for an elective procedure, the Blood Bank should be advised several days in advance, if possible, to allow them to increase their stores.

In extreme emergencies, the Blood Bank will release "stat" two units of O negative blood. The request for this blood must be accompanied by a sample of the patient’s blood to allow subsequent typing and crossmatching. Subsequent O negative blood will be issued two units at a time until matched blood is available.
Procedures for Which Type and Screen Would Appear Adequate

Cardiovascular Surgery:
Iliofemoral, femoropopliteal bypass
Mediastinoscopy, bronchoscopy
Carotid endarterectomy

Orthopedic Surgery:
ORIF – hip prosthesis

General Surgery:
Simple mastectomy
Antrectomy, vagotomy
Gastrectomy
Gastrojejunostomy
Kidney transplant donor
Cholecystectomy
Thyroidectomy
Microporous PTFE graft

Otolaryngology:
Palatoplasty
Laryngectomy
Tracheostomy

Plastic Surgery:
Reduction mammoplasty

Neurosurgery:
Cervical laminectomy& fusion
Craniotomy
Brain biopsy
Transphenoidalhypophysectomy
Cranioplasty
Repair of meningomyelocele

Urology:
TURP
Open prostatectomy
Bladder tumor
Pyeloplasty
Nephrostomy
Ureterostomy
Cystostomy

OMFS:
Orthognathic Surgery
Facial Reconstruction
Tracheostomy
Free Flap Placement

PHARMACY
Prescriptions for total parenteral nutrition must be written no later than 1:00 p.m. to assure the solutions can be available. These prescriptions should be written in detail on TPN Order Sheet. TPN Order Sheets sent to the pharmacy after 1:00 p.m. will not be honored until the following day.

BEEPERS
Each House Officer will be assigned a personal beeper for the duration of their employment at UTMB. If the beeper is lost or damaged in any way (except normal wear and tear), notify the Resident Office and the Telecommunications Office in Room 1.115, Administration Building.

LONG DISTANCE TELEPHONE USAGE
The use of the Department of Surgery and Hospital telephones for long distance calls will be restricted to patient care communications only. You are strongly urged to use outside telephones for personal calls. Each House Officer will be assigned an access code number, which can be used to make long distance calls in Texas only.
RESIDENT TRAVEL GUIDELINES
These guidelines are changed annually due to availability of funds.

VACATIONS
House Officers
House officers will accrue vacation and holiday leave in accordance with the Holiday and Vacation Schedule for UTMB distributed by Richard Moore, Vice President for Business and Administration. At a minimum, house officers will be scheduled off for three separate, nonconsecutive Monday-through-Friday periods. Vacation accruals, holiday leave and eight hours compensatory time earned for each holiday worked will cover the leave time used. House officers may be scheduled off for additional leave time in recognition of UTMB holidays. House officers will be paid for cumulative leave balances upon separation in accordance with institutional policy.

Services
Scheduled leave for house officers will be allocated to each service in accordance with the UTMB Holiday and Vacation Schedule each year. The allocation will be based on the number of house officers assigned to rotate on the service; that is, if a service has one resident and one intern, the service is obligated to allocate leave during the year for the resident's time away, and for the intern's time away. No one will be pulled from their assigned service to cover another service for vacation or holiday leave.
INTERVIEWS
Residents seeking fellowships or subspecialty residencies will occasionally need to be absent for interviews. **Vacation time will be used for these absences.** Interview absences that exceed the amount of vacation time will be counted against vacation time for the next year. If all vacation time has been used, then permission must be obtained from Dr. Throndson and appropriate coverage must be arranged.

SICK LEAVE
Sick leave is accrued at the rate of one day for each month of employment. When illness prevents a House Officer from attending the hospital, Dr. Tyler must be notified. In addition, a Sick Leave Request form must be completed and submitted to the Resident Office. Call schedules will be coordinated by the Chief Resident and altered as necessary. There is no separate Department of Surgery policy or benefit for maternity leave. Please see Section II, paragraph K, Family and Medical Leave of the UTMB Hospitals, General Information for House Staff.
GENERAL INFORMATION

**Surgery Log Format:** patient hospital sticker, date, diagnosis, treatment, staff, ICD-10/CPT codes.

**Log Book to Include:**
1. All cases performed in the Operating Room.
2. All outpatient clinic cases that involve:
   - Application of arch bars
   - Implants
   - Complex lacerations
   - Unusual cases
   - Extraoral I&D
   - Closed nasal reductions

**Anesthetic Record:** A copy of the anesthetic record for all outpatient general anesthesia and IV conscious sedation will be kept in a separate file by the Resident performing the anesthesia.

**General Items:**
1. Do not accept patients for treatment from outlying hospitals without calling and getting permission from attending Faculty.
2. Admit all patients to Faculty “on call.”
3. When on call, inform your attending Faculty of all admissions, pertinent consults and problems.
4. Let the Chief Resident know in writing well in advance when you want vacation.
5. The Program Director must approve all absences and vacation time.
6. All I&Ds must be sent for culture and sensitivity testing and gram stain.
7. All biopsies must be sent to Pathology for histopathology diagnosis.
8. Keep all discussions with Faculty, other staff, and other Residents on a professional level.
10. Protect patient confidentiality to the utmost.
11. Report all complications and/or developing complications to the Program Director immediately.
12. Report any attorney or irate patient contact to the Program Director immediately.
13. **NO** IV sedation until after being certified in ACLS and after completion of four-month Anesthesia rotation.
14. **NO** family member allowed in treatment rooms during surgery except if mentally compromised patient or if interpreter is needed.
15. Try to have only one family member in the treatment room during outpatient evaluation or Day Surgery H&Ps.
16. Encourage adults not to bring infants into the treatment areas unless the infant is the patient.
17. Only attempt the simplest procedure at bedside.
18. A request by the Chief Resident or Faculty is a **command**.
19. Change scrubs daily and make sure you are neat and clean.
20. Don’t sell surgery to patients.
21. Always identify yourself when answering or talking on the telephone.
22. Answer pages **promptly.** Have circulator call when scrubbed.
23. Keep personal calls to a minimum.
APPENDIX 1

GENERAL INFORMATION FOR HOUSE STAFF
I. Office of the Associate Dean for Graduate Medical Education:

The ADGME Office is located at Room 5.138, Rebecca Sealy Hospital, Campus Route 0175.

<table>
<thead>
<tr>
<th>Full Name</th>
<th>Title</th>
<th>Email</th>
<th>Campus Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thomas A. Blackwell, MD</td>
<td>Designated Institutional Official and Associate Dean for GME</td>
<td><a href="mailto:tblackwe@utmb.edu">tblackwe@utmb.edu</a></td>
<td>22652</td>
</tr>
<tr>
<td>Christopher Thomas, MD</td>
<td>Assistant Dean for GME</td>
<td><a href="mailto:crthomas@utmb.edu">crthomas@utmb.edu</a></td>
<td>25284</td>
</tr>
<tr>
<td>Virginia Simmons</td>
<td>Administrative Director for GME</td>
<td><a href="mailto:vsimmons@utmb.edu">vsimmons@utmb.edu</a></td>
<td>25284</td>
</tr>
<tr>
<td>Kimberly Pandanell</td>
<td>Program Manager 25284</td>
<td><a href="mailto:kpandane@utmb.edu">kpandane@utmb.edu</a></td>
<td>24196</td>
</tr>
<tr>
<td>Lynn Schultz</td>
<td>Institutional Coordinator</td>
<td><a href="mailto:lschultz@utmb.edu">lschultz@utmb.edu</a></td>
<td>25285</td>
</tr>
<tr>
<td>Colleen Capoy</td>
<td>Institutional Coordinator</td>
<td><a href="mailto:lccapoy@utmb.edu">lccapoy@utmb.edu</a></td>
<td>20798</td>
</tr>
<tr>
<td>Roshanda Courville</td>
<td>Administrative Secretary</td>
<td><a href="mailto:rcourvi@utmb.edu">rcourvi@utmb.edu</a></td>
<td>25284</td>
</tr>
<tr>
<td>Esther Koleng</td>
<td>Project Consultant</td>
<td><a href="mailto:ekoleng@utmb.edu">ekoleng@utmb.edu</a></td>
<td>20764</td>
</tr>
<tr>
<td>LaVerne Douglas</td>
<td>Senior Administrative Secretary</td>
<td><a href="mailto:lgdougla@utmb.edu">lgdougla@utmb.edu</a></td>
<td>22652</td>
</tr>
</tbody>
</table>

II. APPOINTMENT TO UTMB RESIDENCY/FELLOWSHIP PROGRAMS

Eligibility of Appointment

All programs sponsored by UTMB:

- Will select Residents/Fellows from among eligible applicants on the basis of preparedness, ability, aptitude, academic credentials, communication skills and person qualities such as motivation and integrity; the Essential Functions for GME programs are outlined on the GME web site at http://www.utmb.edu/gme/PDF/EssentialFunctions100907.pdf and include Observation/Sensory Modalities, Communication, Psychomotor Skills, Intellectual and Cognitive Abilities, and Professional Behavioral and Social Attributes; Will not discriminate with regards to sex, race, age, religion, ancestry, color, national origin, disability or any other applicable legally protected status;

- Will participate in and abide by the rules and regulations established by the National Resident/Fellow Matching Programs.

A. APPOINTMENT/REAPPOINTMENT

House staff and advanced subspecialty house staff (fellowship) appointments are assigned at a postgraduate year (PGY) level commensurate with the Accreditation Council for Graduate Medical Education (ACGME) and American Board of Medical Specialties (ABMS) guidelines. House staff appointments are recommended by the Program Director and are subject to review and acceptance by the Associate Dean for Graduate Medical Education. All appointments are one year in length and are renewable annually on the recommendation of the Program Director and with the concurrence of the Associate Dean for Graduate Medical Education. Failure to reappoint may be grieved by the house staff as per Section III of this document.
PRE-EMPLOYMENT DRUG TESTING
Any person who applies for employment with UTMB including without salary employees (WOS). Drug tests are not required for volunteers. Residents and Fellows must have drug testing completed before employment.

Americans with Disabilities Act Policy

The University of Texas Medical Branch provides equal employment opportunities, with reasonable accommodations when appropriate, to qualified applicants and employees with disabilities. UTMB also provides to employees, students, and members of the general public who have disabilities equal access, with reasonable accommodations when appropriate, to the services, programs, and activities of UTMB.

The University of Texas Medical Branch, in compliance with applicable federal laws and regulations, strives to maintain an environment free from discrimination against individuals on the basis of race, color, national origin, sex, age, religion, disability, sexual orientation, genetic information, or veteran status. The UTMB Policy for Americans with Disabilities Act Policy can be found at http://www.utmb.edu/Policies_And_Procedures/Employee_Related/PNP_004856

B. ORIENTATION

The UTMB Graduate Medical Education Office holds an orientation program for all house staff newly appointed to UTMB’s residency programs regardless of the training level to which they are appointed. Attendance is mandatory. The new house staff begins a week early and are paid for those days as regular workdays. The intent of the orientation is to provide general and specific information about the institution which will facilitate the new house staff’s entry into UTMB’s residency programs, allow completion of required Human Resources processing as a new employee, provide training for the electronic medical record system, comply with health service requirements including immunization and TB testing, allow an opportunity for the new house staff to meet each other socially, and to get to know the house staff already at UTMB. The UTMB Graduate Medical Education Office provides specific details about the orientation to new house staff before their arrival. Residents/Fellows who have disabilities requiring reasonable accommodations should notify the GME Office. This allows the GME Office to make appropriate arrangements for orientation and employment.

C. HOUSE STAFF WORKSHOPS

All new house staff are required to attend mandatory annual house staff Risk Management and Medical Economics workshops. The workshops are held to respond to requirements of the Accreditation Council for Graduate Medical Education.

Risk Management - The mandatory Risk Management Workshops focus on medico/legal aspects of practicing medicine including laws and institutional policies that physicians need to know related to risk prevention. Requirements of faculty supervision, drug prescribing, and sexual misconduct guidelines within UTMB are also discussed. A consultant teaches communication skills, particularly communicating with patients. Attorneys from UTMB and the UT System Office of General Counsel review the UT System’s Medical Liability Plan and National Practitioner Data Bank. Local private attorneys present an advanced legal didactic for the senior house staff including case playing. All physicians and dentists (faculty, fellows, and residents) covered by the UT System Professional Medical Liability Benefit Plan (Plan) are required to complete five (5) hours of Risk Management Education (RME) each year as a condition of coverage. To meet this requirement, physicians may take online courses provided by UT or faculty physicians may participate in other risk management events and activities. Department coordinators provide
information about these additional activities as well as other institution-specific requirements.

About the on-line course:

• Education in Legal Medicine (ELM) Exchange, Inc., is the vendor selected by UT System to offer this course.
• ELM’s editorial board members are primarily physicians who are also attorneys.
• Courses use actual cases to teach physicians to identify and manage medical-legal risk.
• Each course is worth 1.75 hours credit.
• New users must complete a specialty-specific Standard of Care unit worth 1 hour. Any excess credit earned will not roll over into the new year.
• Once the specialty-specific Standard of Care course has been taken, physicians may select courses from the menu offered in subsequent years.
• Credits earned through the on-line courses qualify for continuing medical education (CME) credit.

Medical Economics - The Medical Economics Workshops provide training to house staff physicians regarding managed care systems to enhance quality, accessible, and efficient health care. Upon completion of the program, the house staff physician should be able to identify and understand managed care concepts, understand how managed care impacts clinical practice at UTMB, understand the financial impact of clinical decisions as related to managed care companies, understand the managed care system in order to secure house staff’s own health care and assist patients with their health coverage. The presentations include an ethics didactic and socioeconomic discussion.

D. EMPLOYMENT CERTIFICATION

House staff applying for mortgage loans, student loan deferments, etc., may instruct the lender to direct requests for information or certification to the UTMB Graduate Medical Education Office, Room 5.138, Rebecca Sealy Hospital, campus route 0175.

E. VETERANS ADMINISTRATION EDUCATION BENEFITS

UTMB is fully approved by the Texas Education Agency to provide education and training to eligible persons. If house staff are veterans currently enrolled or anticipating enrollment in any of the graduate medical education programs offered by UTMB and are eligible to receive veteran’s benefits, he/she contact the UTMB Graduate Medical Education Office for assistance needed in the application process.

F. TEXAS MEDICAL BOARD (TMB) PERMITS

The Texas Medical Board (TMB) requires an individually held Physician in Training Permit. Information about this permit is sent to all applicants of GME programs. All house staff at UTMB will be required to have an appropriate TMB issued Physician in Training Permit or a permanent Texas medical license as a condition of appointment by the first day of employment. If the training permit is not received within 30 days of the initial work agreement date, the program director may void the work agreement.

To expedite the Physician-in-Training Permit and to ensure that all house staff hold a valid permit, UTMB requests that all information pertaining to the permits be sent to the UTMB Associate Dean for Graduate Medical Education Office. The house staff’s signature on the UTMB House Staff Work Agreement gives his/her approval to use the UTMB Associate Dean for Graduate Medical Education Office’s address.
Physician in Training Reports

UTMB Program Directors may be asked to submit information regarding any adverse action taken on a resident such as academic probation or arrests in order to keep the TMB informed on a permit holder’s progress while in the approved training program. The Office of the Associate Dean for Graduate Medical Education will support the House Staff and Program Directors in providing the required information on forms provided by the TMB. The required information shall include:

a) Information regarding the permit holder’s criminal and disciplinary history, professional character, mailing address, and place where engaged in training since the Program Director’s last report;

b) Certification of the permit holder’s training;

c) Such other information or documentation the TMB and/or the Executive Director deem necessary to ensure compliance with Chapter 171 of the TMB Rules, all other TMB Rules, and the Texas Medical Practice Act (TEX. OCC. CODE §161, et seq. (Vernon 2006).

The permits are valid in Texas training programs only. If house staff do an elective rotation outside of Texas, they must obtain a permit to practice medicine from the appropriate State Medical Board. Additional information can be obtained from house staff’s Program Coordinator.

It is imperative for house staff to be aware of the proper procedures and entities to contact when they are named in a claim or lawsuit and are completing an application for a license or permit. The TMB verifies every Physician-in-Training permit and license renewal for the correctness of these verifications of coverage with UT System insurance carriers. Erroneously answering this question is viewed as fraud by the TMB and results in severe difficulties in obtaining a permit to practice medicine.

G. LICENSURE

All eligible house staff are encouraged to obtain valid medical licensure from the Texas Medical Board. It is the personal financial responsibility of the house staff to obtain or renew his/her medical license. The UTMB Graduate Medical Education Office should be notified immediately upon medical licensure/relicensure in Texas and a copy of the physician permit portion of the license should be submitted to that office. The Texas Medical Board’s address is: P. O. Box 2018, Austin, TX 78768-2018.

H. LICENSURE EXAM REQUIREMENTS

To ensure that house staff complete the three steps of exams required for licensure, the UTMB Graduate Medical Education Committee adopted a policy regarding time lines to pass the three USMLE steps (ANNEX D). It is beneficial to the house staff if the exams are completed within the first two years of residency because the exams cover multiple disciplines. It ensures that house staff meet the exam requirements of USMLE before completion of training regardless if they remain in Texas or practice medicine in other states.

I. INSTITUTIONAL DEA NUMBER

Those house staff covered under a Physician-in-Training Permit will be assigned an Institutional DEA Number. This is a one to three-digit suffix number to be used in conjunction with the DEA institutional number at UTMB. This number will be assigned through the Outpatient Pharmacy and will provide the house staff’s prescription writing privileges in the UTMB Hospitals.

IMPORTANT NOTE: Prescription order forms should show in addition to a legal signature:
1) prescribing physician’s name printed in full and legally;
2) DEA number for controlled drugs; and
3) patient’s name and address.
Do this for your patients. Many pharmacists will not fill prescriptions if this information is missing.

Department of Public Safety /Physicians-in-Training Identification Number
All Physician-in-Training (PIT) Permit Holders are required to have a personal DPS PIT ID. This is a state requirement and all prescriptions written must include a DPS PIT ID number in addition to your Institutional DEA number.

J. DEA NUMBER
Since the UTMB Institutional DEA number cannot be used once medical licensure is obtained, all eligible house staff are responsible for obtaining their individual Texas Department of Public Safety (DPS) number and Federal Drug Enforcement Agency (DEA) number once licensed in Texas. The Federal DEA and the Texas DPS charge a fee for each of these numbers. The UTMB Graduate Medical Education Office should be provided copies of these documents when obtained.

K. LEAVES OF ABSENCE
In the event of a house staff’s absence from a training assignment, other than on vacation or sick leave, a formal leave of absence (with or without pay, depending on the circumstances and at the discretion of the Program Director, under institutional guidelines) will be recognized by the UTMB Graduate Medical Education Office. The Program Director must notify the UTMB Graduate Medical Education Office of leaves of absence and conditions relative thereto. House staff should be aware that completion of residency training and eligibility for Board specialty certification depend on the completion of certain “time in training” requirements specific to the medical specialty. Extended absences from the program may require additional time and training. This can be best clarified by discussion with the Program Director.

L. MOONLIGHTING
Professional and patient care activities that are external to the educational program are called moonlighting. Moonlighting activities, whether internal or external, may be inconsistent with sufficient time for rest and restoration to promote the house staff’s educational experience and safe patient care. Therefore, institutions and program directors must closely monitor all moonlighting activities. This includes moonlighting within UTMB. When house staff "moonlight," it should be with the knowledge that:

1. Residents/Fellows are not required to moonlight;
2. PGY-1 residents are not permitted to moonlight.
3. Moonlighting must not interfere with the ability of the resident to achieve the goals/objectives of the educational program.
4. Time spent by residents/fellows in internal and external moonlighting must be counted towards the 80-hour maximum weekly hour limit.
5. Independent licensure by the State of Texas for the practice of medicine is mandatory;
6. Within UTMB, the department to which the house staff is assigned will assure that
appropriate levels of malpractice coverage retained through The University of Texas Professional Liability Plan is in place. Outside UTMB, no malpractice insurance is provided nor will any other fringe benefits ordinarily afforded to the house staff be in effect.

7. No house staff may "moonlight" during assigned duty time;

8. Permission of the residency Program Director must be obtained in writing before arranging to "moonlight." Individual Program Directors may forbid moonlighting. The Program Director must monitor the number of moonlighting hours as required by an ACGME Institutional Requirements to ensure compliance with duty hours. The Program Director must acknowledge in writing that she/he is aware that the house staff is moonlighting, and this information should be part of the house staff’s file. The house staff’s performance will be monitored for the effect of these activities upon performance and that adverse effects may lead to withdrawal of permission.

9. House Staff are required to notify the Program Director of their participation/involvement in other committees outside the institution or any involvement in the community that would impact duty hours.

10. The U.S. Code of Federal Regulations clearly prohibits exchange visitors (J1 visa holders) participating in programs of graduate medical education from pursuing work outside of their training programs. Therefore, any Graduate Medical Education Officer holding a J1 visa may not moonlight or earn extra income under any circumstances.

M. HEALTH INFORMATION MANAGEMENT

Dictation and timely completion of medical charts, signing patient orders, and general compliance with the rules and regulations of the UTMB Health Information Management Department is considered an integral component of graduate medical education. House staff will complete all medical record assignments in a timely manner and accept responsibility for familiarizing themselves with hospital medical records policy. Failure to complete medical records, as prescribed by applicable Medical Staff Bylaws, hospital rules and regulations, clinic rules and regulations, and/or departmental policy, may result in corrective action, which may include suspension without pay. A Certificate of Completion of residency training will not be issued until all medical record assignments are completed at the end of the training period.

N. DISASTER PLAN

House staff should be familiar with the Institutional http://intranet.utmb.edu/emergency_plan/plan/default.htm and Departmental Disaster Plans and understand their role and responsibilities if such an event occurs. House Staff are designated by their department as essential employees during a disaster and required to remain in the hospital until formally released by the residency program director.

If UTMB cannot provide at least an adequate educational experience for each of its residents/fellows because of a disaster, it will:

a) arrange temporary transfers to other programs/institutions until such time as the residency/fellowship program can provide an adequate educational experience for each of its residents/fellows, or

b) assist the residents/fellows in permanent transfers to other programs/institutions, i.e., enrolling in other ACGME accredited programs in which they can continue their education.
Programs will make transfer decision expeditiously so as to ensure that each resident/fellow will complete the year in a timely fashion.

At the outset of a temporary resident/fellow transfer, the residency program director will inform each transferred resident of the minimum duration and the estimated actual duration of his/her temporary transfer, and continue to keep each resident informed of such durations. If and when a program decides that a temporary transfer must continue to and/or through the end of a residency/fellowship year, it will so inform each such transferred resident/fellow.

O. **HOUSE STAFF DIRECTORY**

It is essential that the UTMB Graduate Medical Education Office maintain accurate and up-to-date information on House Staff including home address, telephone number, etc. Any change in this data should be reported promptly to the UTMB Graduate Medical Education Office and the Human Resources Department.

P. **INTERNATIONAL MEDICAL GRADUATES**

Individuals who received their medical education outside the United States must be sponsored through the Educational Commission for Foreign Medical Graduates. Any unique circumstances requiring visa definition should be brought to the attention of the UTMB Graduate Medical Education Office well in advance of arrival on campus.

UTMB accepts the J-1 visa, and although uncommon, the H1-B visa is acceptable on an individual basis with approval of the Clinical Department through the Office of International Affairs. The UTMB ID badge is the only area in which the International Medical Graduate who receives an MBBS may choose to use “MD.” All other references will reflect the “MBBS.”

Q. **UTMB RELATIONSHIP WITH SHRINERS HOSPITALS FOR CHILDREN AT GALVESTON**

House Staff from some of the UTMB residency programs have required rotations to the Shriners Burns Hospital in Galveston for portions of their educational and clinical experience. UTMB faculty who are also members of the Shriners Burns Hospital’s Medical Staff provides supervision. Although formally affiliated with UTMB, the Shriners Burns Hospital is administratively independent and establishes its own rules and regulations for its medical staff and employees.

R. **OFF-CAMPUS ELECTIVES**

The GMEC External Training Site Review Subcommittee must approve off-campus electives in advance. An affiliation letter must be fully processed before the elective begins to ensure that appropriate criteria are met. Electives must be in an ACGME accredited program and/or count toward residency and/or specialty board requirements. Electives outside the U.S. will generally not be allowed because of licensure and liability coverage issues. Further, the Associate Dean for Graduate Medical Education must approve them before scheduling with an off-campus facility. Procedures for off-campus electives are available in the UTMB Graduate Medical Education Office.
S. HARASSMENT (INCLUDING SEXUAL HARASSMENT)

House Staff are subject to the provisions and protection of the Institutional Handbook of Policies and Procedures related to this issue (www.utmb.edu/policy/ihop, Policy 3.2.4).

T. PHYSICIAN IMPAIRMENT

House staff physicians are subject to the provisions of the UTMB Institutional Handbook of Policies and Procedures related to this issue under the policy entitled “Evaluation and Treatment of Impaired Physicians” (www.utmb.edu/policy/ihop, Policy 8.1.7). Residents/Fellows must complete a mandatory educational module on anxiety and depression. They must also complete the institutional annual compliance training.

U. RESIDENCY CLOSURE/HOUSE STAFF COMPLEMENT REDUCTION

In the event that UTMB reaches a decision to reduce the size of a residency or to close a residency or fellowship program, all house staff in training, or applying for such programs, will be informed as soon as possible. In the event of such a reduction or closure, all house staff already in the program will be allowed to complete their GME educational program at UTMB or, where this is impossible, will be assisted in enrolling in an ACGME accredited program in which they can continue their GME educational program.

V. VENDOR INTERACTIONS

There are two UTMB policies for use by all employees who interact with vendor representatives. Both policies can be found in the UTMB Handbook of Operating Procedures. The policy “Vendor Visitation: UTMB Clinical Enterprise,” Section 9, Policy 9.7.2. can be found at http://intranet.utmb.edu/PoliciesAnd_Procedures/Clinical/PNP_005069. The policy “Acceptance and/or Solicitation of Gifts or Benefits from Vendors,” Section 2, Policy 2.6.5 can be found at http://intranet.utmb.edu/Policies_And_Procedures/General-Administrative/PNP_004842.

W. AMERICAN BOARD OF MEDICAL SPECIALTIES

The ACGME requires that institutions provide information relating to access to eligibility for certification by the relevant certifying board. This information can be found at http://www.abms.org/Who_We_Help/Physicians/.

X. GUIDELINES FOR APPROPRIATE USE OF THE INTERNET, ELECTRONIC NETWORKING AND OTHER MEDIA

Guidelines for the appropriate use of the Internet, Electronic Networking, and other media apply to all pre and postgraduate trainees registered at the School of Medicine at the University of Texas Medical Branch, including medical students, residents in training, postdoctoral fellows, graduate students, clinical and research fellows, or equivalent. Use of the Internet includes posting on blogs, instant messaging [IM], social networking sites, e-mail, posting to public media sites, mailing lists and video-sites. Residents/Fellows are required to complete an online compliance module. The details of the guidelines are found in ANNEX E.

Y. AMERICAN MEDICAL ASSOCIATION PRINCIPLES OF MEDICAL ETHICS

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize...
responsibility to patients first, as well as to society, to other health professionals, and to self. The Principles adopted by the American Medical Association are not laws, but standards of conduct, which define the essentials of honorable behavior for the physician. The Principles can be found at www.amaassn.org/ama/pub/physician resources/medical-ethics.

Z. NATIONAL PRACTITIONER DATA BANK (NPDB)
The NPDB is primarily an alert or flagging system intended to facilitate a review of health care practitioner’s professional credentials. The information contained in the NPDB is intended to direct discrete inquiry into, and scrutiny of, specific areas of a practitioner’s licensure, professional society memberships, medical malpractice payment history, and record of clinical privileges. NPDB information is not available to the general public. However, information in a form that does not identify any particular entity or practitioner is available. Information reported to the NPDB is considered confidential and shall not be disclosed except as specified in the NPDB regulations. This information about NPDB can be found at http://www.npdb-hipdb.hrsa.gov/npdb.html.

III. SALARY AND FRINGE BENEFITS; VACATION AND LEAVE

UTMB administers the Resident/Fellow’s employment contracts and other relevant Human Resources matters including leave, medical benefits, salary, insurance coverage, etc. Residents/Fellows shall abide and receive salary, annual leave, medical benefits, insurance coverage and other benefits set out in UTMB employment contract. The Leave Categories specific to House Staff are found in ANNEX F. A detailed description of benefits can be found at http://hr.utmb.edu/benefits/.

A. SALARIES AND PAYROLL POLICIES
House Staff salaries are paid by UTMB on a monthly basis. The current salary schedule for various house staff appointment levels is listed in ANNEX G. Checks are issued once a month for a total of twelve checks per year. Payment is inclusive from the first to the last day of the current month. Checks are issued on the first working day of the following month. House staff should check with their department regarding distribution of paychecks. House staff are strongly urged to have their paychecks automatically deposited directly to their bank using a Direct Deposit Form.

B. FRINGE BENEFITS - GENERAL
As employees of UTMB, house staff participate in the premium sharing benefit. Several excellent insurance programs are available to the house staff as a UTMB employee including health, dental, accidental death and dismemberment, and life insurance. All house staff are covered under the UTMB House staff & Fellow Long Term Disability Insurance Program. It is designed to provide comprehensive coverage that is uniquely tailored to house staff physicians’ needs. A permanent salary increase is provided to allow House Staff to pay for this program themselves to achieve a significant IRS advantage. Specifics of each of the insurance programs can be found at http://hr.utmb.edu/benefits/.

C. HEALTH AND DENTAL INSURANCE
The State of Texas, through its premium-sharing program, will pay for house staff and their families’ medical insurance coverage. The University of Texas Medical Branch will pay for house staff’s dependent coverage through a salary adjustment.

Premiums for dental coverage will also be paid through this salary adjustment. However, house staff will pay the premiums for their dependents’ dental coverage through payroll deduction.
There is an annual open enrollment period in the summer for employees to make changes in insurance benefits that become effective on September 1, which is the beginning of the fiscal year. If house staff has a qualified family status change, such as a marriage, divorce, or a newborn, they can make changes within 31 days of the change. However, if house staff add previously eligible dependents sometime after their initial enrollment as a new hire, their dependents who are required to complete an evidence of insurability form may be subject to a temporary reduction of benefits due to a pre-existing condition.

D. **WORKER’S COMPENSATION**

Worker’s Compensation Insurance covers all house staff. Any on-the-job injury must be reported immediately to the house staff’s supervisor. The supervisor must complete the necessary forms and forward them to the Capability Management Office. If the on-the-job injury is such that house staff needs to report to the Hospital Emergency Room, advise the Hospital that the injury was received on the job. Reimbursement for on-the-job injury cannot be considered unless an appropriate report has been filed. This should be done immediately following the incident.

E. **COUNSELING, PSYCHOLOGICAL, AND OTHER SUPPORT SERVICES**

House staff, as both employees and students in a particularly stressful assignment, are eligible for the counseling and support services provided by the Employee Assistance Program at http://www.utmb.edu/poem/EAP/EAP.htm. Residents/Fellows must complete mandatory online compliance training on anxiety and depression as stated in Section IX.T Physician Impairment.

F. **RETIREMENT BENEFITS**

Each house staff, as an employee of UTMB and the State of Texas is provided retirement benefits under either the Teacher’s Retirement System or an Optional Retirement Program. Specifics of these programs are provided to each employee during employee orientation.

G. **PROFESSIONAL LIABILITY INSURANCE**

Professional liability coverage for UTMB house staff is provided under the University of Texas System Professional Medical Liability Benefit Plan. Liability is limited to $100,000 per claim. In addition, UTMB house staff continue to have indemnity protection up to $100,000 per claim provided by Chapter 104 of the Texas Civil Practice and Remedies Code. Any house staff who even suspects the possibility of an incident which might provoke a malpractice suit is required to simultaneously: 1) notify the program director/department in which appointed), (2) call the Risk Management Department at (409)772-6897 so that the occurrence can be reported to the U.T. System and a decision may be made regarding an investigation.

Coverage as stated above shall commence on the effective date of residency training and shall be renewed annually or cease on the date that employment with or assignment to The University of Texas System is terminated, whichever occurs first. Incidents that occur during official University of Texas System employment are covered, even though a claim or lawsuit is filed subsequent to cessation of employment (thus, there is no necessity for tail coverage).

H. **VACATION LEAVE**

Vacations are to be arranged with the house staff’s department of appointment. Advance notification guidelines will be determined by the Program Director. The amount of vacation allowed at any one time will be the decision of the Program Director. Any changes to the vacation schedule require written approval from the Program Director. General policies and procedures related to house staff vacations are the same as for other UTMB employees and can be found in the “UTMB Institutional Handbook of Operating Procedures” www.utmb.edu/policy/ihop). House Staff shall be granted vacation as per institutional policies related to faculty and employees and are encouraged to use vacation during the fiscal year in which it was earned.
I. **SICK LEAVE**
The house staff shall be entitled to sick leave subject to the following conditions:
The house staff shall earn sick leave entitlement beginning on the first day of employment and terminating on the last day of duty (last day of duty defined as termination of contract or completion of residency program.) Sick leave entitlement shall be earned by a full-time house staff at the rate of eight hours for each month or fraction of a month of employment, and shall accumulate with the unused amount of such leave carried forward each month. Sick leave accrual shall terminate on the last day of continuous duty.
Sick leave may be taken when sickness, injury, or pregnancy and confinement prevent the house staff’s performance of duty or when a member of his/her immediate family is ill and requires the house staff’s attention. A house staff who must be absent from duty because of illness shall notify his/her Program Director of that fact at the earliest practical time.

J. **MATERNITY/PATERNITY LEAVE**
There is no separate policy or benefit for maternity and/or paternity leave. Please see Section K below, Family and Medical Leave Act. Maternity and paternity leave are discussed in this section.

K. **FAMILY AND MEDICAL LEAVE ACT**
Eligible UTMB employees may take up to 12 weeks paid or unpaid leave under certain qualifying conditions based on the terms of the Family and Medical Leave Act of 1993 (FMLA).
Eligible employees are entitled to a total of 12 weeks of leave time during any 12-month period for any one or more of the following qualifying reasons: birth or adoption of a child; placement of a foster child; or a serious health condition of an employee or an employee's dependent, defined as a child, parent or spouse (excluding parent-in-law).

Employees must exhaust all sick and vacation accruals before going out on “leave without pay.”

During pregnancy, a female house staff may be able to continue to work as long as she is able to carry a regular schedule and fulfill the duties and responsibilities of the position in the judgment of her Program Director. The Program Director may not require that a pregnant house staff take the full six weeks of postpartum leave as long as a doctor’s release is provided. Additional time may be authorized by the program director if needed. The amount of time to be made up will be determined by the Program Director, subject to residency program and specialty board requirements.

NOTE: House Staff should be aware that graduation from residency and Board specialty certification depends on the completion of certain time in training requirements. Extended absences from the program may require additional time and training. For more information, employees should contact and discuss their FMLA options with their supervisor.

**FMLA References:**
HOP Policy Family and Medical Leave 3.9.10
IHOP Policy Sick Leave 3.9.8
IHOP Policy Parental Leave 3.9.7
SAO Leave Interpretations 97-01, 00-01

L. **EDUCATIONAL LEAVES**
Absence from training to attend educational conferences must be approved by the house staff’s department, and the department’s administrative officer must execute an official travel request.
form. Failure to do so may jeopardize certain survivor and other benefits, which may be forfeited if the house staff is not on an official leave of absence. Subject to residency program requirements, such leave is granted with pay and not charged to vacation time. Travel time must not extend beyond the dates of the meeting plus the time necessary to travel (based on direct air route), usually one day to go, and one day to return. Additional days will be considered as vacation time.

IV. INSTITUTIONAL SERVICES

A. **EMPLOYEE IDENTIFICATION BADGE**
   Employee identification badges are provided at no charge to the house staff and are to be worn while on duty. Increasingly, these ID badges are being used to control various house staff benefits such as meals when on-call, security access, etc. Replacement of a lost badge will require a fee paid by the resident.

B. **UNIFORMS AND LAUNDRY SERVICE**
   All House Staff are initially furnished three lab coats. Three additional lab coats are provided each year. The institution does not provide laundry and embroidery services for the lab coats.

C. **ACCESS TO FOOD SERVICE/MEALS ON CALL**
   Residents/Fellows on regular assignment have access to adequate and appropriate food services 24 hours a day in all institutions. Each site has its own policies regarding the provision of food for Residents/Fellows. Residents/Fellows should check with the relevant site information regarding meal benefit and charging policies.

   Meals are not provided at institutional expense except for House Staff who are officially on-call inhouse. They will be provided one free meal a day. Please check with the Program Coordinator as to the specific mechanics which operates on a voucher system currently utilizing the House Staff’s employee ID #.

D. **FIELD HOUSE MEMBERSHIP**
   Arrangements have been made for a discounted rate for UTMB Field House membership for house staff and their families. For further information about this, contact the Field House at (409) 772-1304.

E. **PARKING**
   Parking information and permits may be obtained from the Parking Facilities Office located in Room 2.756at the Rebecca Sealy Building, ext. 21581. The house staff pays a minimal amount for parking spaces during regular work hours. Fee for the garages is $20.00 per month and surface lots are $12.50 per month. After-hours parking access can be obtained at no charge to house staff in the Parking Facilities Office. These are institutionally subsidized rates.

E. **HOUSING**
   While housing is not provided as an institutional benefit, information about local housing is available at the GME home-finder web page.

V. DUE PROCESS; GRIEVANCE

A. **GENERAL PRINCIPLES**
   Although house staff are UTMB employees and render professional medical services to UTMB patients, UTMB’s residency training programs are primarily educational. The entire accreditation
process under the auspices of the ACGME acknowledges this academic focus, and the standards for accreditation require that: academic goals be set by the residency training programs; academic resources including appropriate faculty, facilities, equipment and clinical material be provided; and regular evaluation of the trainees related to academic achievement occur and be documented. Appropriate policies and procedures for due process also are required for ACGME accreditation, but such policies and procedures are in the context of a primarily academic educational process. In fact, the ACGME accreditation standards explicitly protect the house staff against excess service employment obligations that interfere with their training programs.

Since the UTMB residency training programs are primarily educational programs, the institution vests responsibility and authority for conducting the programs and determining the success of academic achievement of the individual trainee in the program faculty and the Program Directors with the departmental Chairs ultimately responsible for process management.

The Program Directors and faculty responsible for the training of house staff have an obligation to: provide appropriately organized educational opportunities to the trainees; convey clearly the educational objectives of the program and the performance required by the trainees for academic success (including those patterns of individual personal behavior that reasonably should positively impact patients, institutional employees and/or other trainees); and develop a regular evaluation process that alerts trainees to academic and performance deficiencies and provides direction in their correction. These requirements are integral elements of the ACGME accreditation standards.

The Program Directors and faculty responsible for training house staff additionally are obligated to apply these academic standards to each individual trainee in the program to protect both the individual patients who are the source of the trainees' opportunities to learn in a practical way and the public at large who rely on the process to protect them against unqualified practitioners claiming expertise of a specific type. This obligation includes removal from the program of (or a decision not to reappoint) those trainees who are academically unsuccessful or whose behavior creates a risk for patients, disrupts the multidisciplinary health care team, or interferes with the educational program of other trainees.

Finally, the Program Directors and faculty must attest to the satisfactory completion of the academic training program for each trainee seeking certification from the involved board to acknowledge the trainee's qualifications as a specialist or subspecialist.

In conclusion, residency training is primarily an academic and educational process. The development of institutional policies and procedures for due process and oversight of those policies must be based on this guiding principle.

B. APPOINTMENT OF HOUSE STAFF

Initial appointments of House Staff are, in general, through the applicable matching program. Appointments at UTMB are formalized through a UTMB House Staff Work Agreement and are for one (1) year. Annual reappointment through the conclusion of the particular house staff’s program will be based on the house staff’s acceptable academic and professional performance.

Exceptions to the one year appointment include a three (3) month trial appointment and the institutional permit program as worked out with the Texas Medical Board for selected International Medical Graduates being considered for regular one year appointments by UTMB’s residency programs. Occasional appointments for less than one year may be required to address unique circumstances created by house staff illness or the need for remediation.
C. TRAINING PROGRAM OVERSIGHT

A process of regular institutional oversight and periodic internal review of each residency training program is in place through the Graduate Medical Education Committee as required by the ACGME’s Institutional Requirements. It is through this process that the institution monitors training program compliance with the accreditation standards including those related to the development of educational objectives, appropriate academic structure and function, and regular evaluation of trainees.

D. HOUSE STAFF EVALUATION

The institutional electronic evaluation system in New Innovations is used at UTMB and is mandatory for all residency programs including faculty and house staff. Each UTMB residency training program is to have a written procedure approved by the institution for regularly scheduled electronic evaluations of the performance of each house staff by such program’s Program Director as required by the ACGME’s Institutional Requirements. The fact that these evaluations have been reviewed with the house staff will be documented in the individual’s electronic file. House Staff will be notified by email when their evaluation is completed. A log of the house staff viewing the evaluation will be maintained. These electronic evaluations are intended to document the strengths and weaknesses of the house staff’s knowledge and/or performance including the core competencies required by the ACGME. The training program is expected to notify the house staff at the earliest time possible of significant deficiencies in knowledge or performance, document plans for correction or improvement, and monitor success or lack thereof in doing so. Evaluations completed on each house staff will be retained in the electronic evaluation system permanently.

Each house staff will be required to evaluate his/her residency program and faculty annually using the electronic evaluation systems. Training is offered by online training simulations.

E. UNSATISFACTORY PERFORMANCE

1. All house staff are subject to the UTMB Institutional Policies and Procedures related to discipline and discharge (www.utmb.edu/ihop, policy 3.10). If according to the guidelines established by the individual training program, a house staff’s academic performance (including patterns of personal behavior that may or do negatively impact patients, institutional or affiliates’ employees and/or other trainees) and overall progress in the training program is deemed unsatisfactory, a consultation shall be held between the house staff and the applicable Program Director or his/her designee to discuss all aspects of the problem and to develop appropriate remedial actions on the part of the house staff. This consultation shall not of itself constitute a Corrective Action and shall not preclude the Program Director from also recommending simultaneously a formal Corrective Action. The consultation shall be documented in the house staff’s file and the expected efforts at correction and timelines for carrying them out sufficiently detailed as to allow periodic assessment of the house staff’s success or lack thereof.

2. A consultation is not a prerequisite for Corrective Action when, in the opinion of the Program Director or his/her designee, a determination is made that a house staff’s discharge of clinical responsibilities would expose patients to unnecessary medical risks and the hospital to unnecessary liability. In this case, a house staff may be temporarily relieved of his/her clinical responsibilities, with pay, reassigned to other duties with pay or suspended with pay pending the outcome of an investigation by the Program Director. A house staff who has been so relieved/reassigned with pay or suspended with pay pending the outcome of an investigation, shall receive, within a reasonable length of time, not to exceed ten (10) working days, a written statement from the Program Director or designee containing a description of the deficiencies in the performance of the house staff. Expected corrections and time lines for achieving them also
should be sufficiently detailed in this statement and the house staff’s file as to allow periodic assessment of the house staff’s success or lack thereof. Action taken pursuant to this paragraph shall be deemed a Corrective Action, subject to the ten-day notice specified above and the other requirements set forth in Section G below, and shall not preclude further action being taken.

F. PROBATION
1. The Associate Dean for Graduate Medical Education must be notified in advance and approve the placement of a house staff on probation.

2. The decision to place a house staff on probation for educational reasons such as inadequate reading or lack of adequate knowledge base generally evolves over time and is supported by evaluations of the house staff, which reflect inadequate performance. Interactions between the Program Director and the house staff concerning inadequate performance should be documented and reflect that lack of improvement led to the decision for probation.

3. The decision to place a house staff on probation may occur abruptly because of problems in the delivery of clinical care. These problems may be of such acuity as to require modification of clinical assignment along with probation. In such cases, it is possible that previous documentation of inadequate performance may not exist.

4. After appropriate discussion, advice, and recommendation by the Department’s Residency Advisory Committee, the recommendation to place a house staff on probation may be made by the Program Director and Chair of the Department. The ultimate responsibility for the decision to place a resident/fellow on probation rests with the Chair of the Department.

5. The nature of the deficiencies of the house staff should be listed and it should be stated whether these deficiencies might impact clinical performance. The terms of the probation must be delineated in writing by the Program Director based on identified problems. If a limitation of clinical duties is deemed necessary or if there is any obligation of the house staff to obtain extra supervision during clinical duties, these terms must be delineated.

6. The Program Director must notify the Office of Associate Dean for Graduate Medical Education of the probationary status of a house staff.

7. The Program Director must notify all faculty who will be working in a clinical setting with the house staff of the probation status of a house staff. The decision to inform other personnel who have a need to know will be at the discretion of the Program Director.

8. The house staff may challenge the decision for probation using the standard policies for grievance for house staff. If a house staff appeals probation, probation will be delayed until the final appeal decision is reached. Any modification in clinical assignment or privileges that was instituted in the probation will remain in effect until final disposition of the appeal. If the probation is upheld after appeal, the Texas Medical Board will be notified of the probationary status.

9. At the end of the probationary period, documentation should be made of satisfactory or unsatisfactory remediation by the house staff. The Institutional Graduate Medical Education Committee and all faculty working with the house staff should be informed of his/her return to regular working status.

G. CORRECTIVE ACTIONS IN GENERAL
1. If the time periods specified in a consultation or a Corrective Action have lapsed without correction of the house staff’s performance deficiencies, he or she will be subject to initial or
further Corrective Action, as the case may be, including without limitation reprimand, probation, suspension or termination for insufficient/unsatisfactory knowledge and/or performance by recommendation of the Program Director. Any recommendation for Corrective Action shall be in writing, delivered to the house staff by certified mail, (return receipt requested); shall describe the deficiencies in performance and/or knowledge; the reasons why the specific Corrective Action is being taken; and (unless the Corrective Action is termination), expected corrections and timelines for achieving them.

2. Corrective Actions, except termination, will be final on receipt of the Program Director’s written notice unless the house staff successfully grieves the action. The Corrective Action of termination will be final on receipt of the Program Director’s written notice unless the house staff successfully appeals the action pursuant to Section H below.

H. APPEAL RIGHTS AND PROCEDURES FOR TERMINATION

1. The house staff subject to the Corrective Action of termination shall have the option to appeal the action in writing to the Associate Dean for Graduate Medical Education (Associate Dean) within ten (10) working days of receiving notice of the action. Failure to appeal within the prescribed ten working days shall constitute waiver of the option of appeal.

2. Upon timely receipt of the house staff’s written appeal of termination, the house staff may elect to meet personally with the Associate Dean to discuss the reasons for the recommended termination and to present the house staff’s response. Regardless whether the house staff elects to meet with the Associate Dean, the Associate Dean shall, within ten (10) working days of receiving the appeal, conduct a thorough review of the process that led to the recommended termination, including the documentation in the house staff’s file.

3. After such review, the Associate Dean shall notify the house staff in writing by certified mail, return receipt requested, whether he/she shall either uphold or rescind the termination, with a copy to the applicable Program Director and Chair/Division Chief.

4. The house staff may appeal further in writing to the Dean of the School of Medicine (Dean). The timelines to initiate a written appeal and to deliver written decisions by certified mail, return receipt requested, at the next two (2) steps of an appeal are the same as listed above in Section H1.

5. No compensation, whether salary or other benefit, may be withheld from a house staff appealing his/her termination in accordance with this Section H., until a written decision at the final level appealed to is rendered upholding the termination. A final decision to uphold a house staff’s termination shall also preclude any reappointment of the house staff to any subsequent year of training at UTMB.

6. No specialty or sub-specialty certifying board or national state or local medical organization shall be notified of a Corrective Action until a final determination has been made.

I. GRIEVANCE PROCEDURE FOR CORRECTIVE ACTIONS OTHER THAN TERMINATION

1. If a house staff has a grievance related to his/her training program or has been subject to any Corrective Action other than termination, the house staff should first attempt to resolve the matter informally by consulting with the applicable Chief Resident, Program Director, and/or Chair/Division Chief.

2. If the house staff is unable to resolve the matter informally or wishes to grieve a Corrective Action other than termination, he/she should present his/her grievance in writing to the
Associate Dean within 10 (ten) working days of the date the matter arose or recommendation for Corrective Action other than termination was made. The Associate Dean shall notify the house staff in writing of his decision regarding the matter, or to uphold or rescind the Corrective Action, other than termination, within 20 (twenty) working days of receiving the written grievance, unless extended by the Associate Dean’s and house staff’s mutual agreement.

3. Subject to the UTMB Grievance Policy (Institutional Handbook of Policies 3.10.3) the Associate Dean’s level shall be the final level of grievance.

J. REAPPOINTMENT
1. A decision not to reappoint a house staff does not constitute Corrective Action. If a house staff is not to be reappointed to the next year of training, he/she should receive written notice (by certified mail, return receipt requested, or hand delivered with written acknowledgment of receipt) from the Program Director by March 1 of the current contract year, or four (4) months prior to the last date of the current contract if the house staff was appointed other than in the late June or early July time frame. If the primary reason(s) for the non-renewal or non-promotion occurs within the four months prior to the end of the agreement, the Program Director will provide the resident/fellow with as much written notice of the intent not to renew or not to promote as circumstances will reasonably allow prior to the end of the agreement.

2. House Staff who plan not to continue in the succeeding year of their training program should notify the Program Director in writing by March 1 of the current year, or four (4) months prior to the last date of the current contract.

3. The Associate Dean is to be copied on the notifications of intent not to reappoint or intent not to accept reappointment referenced above.

4. If grieved in writing by the house staff, the Associate Dean will review a decision not to reappoint a house staff. Such grievance will be subject to the grievance procedures stated in Section I., except that the Associate Dean level shall be sole and final level of grievance.

VII. Residency/Fellowship Responsibilities

1. Residents/Fellows shall:

   a. Provide patient care, under appropriate supervision, as assigned by the Program Director (PD) and his/her designee, consistent with the educational goals of the Program and the highest standards of patient care (“patient care” includes responsibility for associated documentation in the medical record, which should be completed in a timely fashion, and attendance at patient care rounds as assigned);

   b. Make appropriate use of the available supervisory and support systems, seeking advice and input from faculty as and when appropriate, and in accordance with the GME Policy on Resident/Fellow Supervision;

   c. Participate fully in the educational and scholarly activities of the program as specified by the Program Director, including attendance at didactic conferences, and other responsibilities which may include a research project, completion of examinations, maintenance of procedure logs, or other items;

   d. Develop a personal program of learning to foster continued professional growth, with guidance from the faculty;
e. Assume responsibility, as called upon, in teaching more junior trainees and medical students, within the scope of the program;

f. Participate in improving the quality of education provided by the program, in part by submitting at least annually confidential written evaluations of the faculty, the program and the overall educational experience;

g. Adhere to established practices, procedures and policies of the Sponsoring Institution, the Sponsoring Institution’s Medical/Professional Staff, the Department and affiliated training sites;

h. Participate in institutional programs, councils or committees and other medical staff activities, as appropriate;

i. Abide by the institutional and program-specific Resident/Fellow policies on duty hours and, as scheduled by the Program Director, accurately report his/her duty hours;

j. Comply with institutional requirements for health and safety training, vaccinations and tuberculosis testing, if applicable;

k. Complete medical records in a timely manner.

2. The Program Director is responsible for overseeing the Resident/Fellow’s training and rotations throughout the period of residency. The Resident/Fellow should check with the UTMB GME Office prior to beginning rotations at an affiliated site to obtain the necessary procedures for reporting to the rotation site. Upon arrival for a rotation in an affiliated hospital, Residents/Fellows must report to the appropriate office to complete necessary paperwork. Residents/Fellows are responsible for adhering to the policies and procedures established by the GMEC, the institutions in which they function, and their individual programs.

3. While on rotations, Residents/Fellows shall also be:

a. Responsible to the Program Director to whom they have been assigned for all matters pertaining to the professional care of patients. They are responsible to the Site Director and Chairperson of the Medical Board at each facility to which they are assigned for matters of administrative policy and procedure;

b. Responsible for checking with the relevant Program Director regarding any response time requirements while taking call from home.

VIII. ACADEMIC RECORDS

1. The UTMB GMEC upholds the highest standards regarding the management of Resident/Fellow academic records and confidentiality. Faculty and administrative staff may have access to Resident/Fellow records on a need-to-know basis in the course of training, performance improvement, research, or education/training. Misuse of medical data and/or inappropriate releases or disclosure of information may result in penalties for violation of medical privacy.

2. Disclosure of Resident/Fellow information and requests from outside parties shall require an appropriate signed release from the Resident/Fellow specifying what information UTMB shall disclose. Exceptions to this policy may apply for requests from governmental agencies where UTMB is required to respond to requests for information, inspections, or investigations.

3. UTMB does not typically release evaluations of residents/fellows past three years after completion of training. The program director may provide a copy of a final summative evaluation if the resident/fellow completed training during the past three years. If there has been no
contact with the resident/fellow since completion of the program, only verification of the training program and completion date will be provided.

**IX. SUPERVISION, DUTY HOURS, AND ALERTNESS MANAGEMENT & FATIGUE MITIGATION**

1. **UTMB and** all residency programs it sponsors are committed to abiding by Duty Hour Standards set by ACGME and responsible for:
   a. Promoting patient safety and Resident/Fellow well-being and to providing a supportive educational environment;
   b. Ensuring that the learning objectives of the programs are not compromised by excessive reliance on Residents/Fellows to fulfill service obligations;
   c. Ensuring that Residents/Fellows’ education and clinical training have priority in the allotment of Resident/Fellow’s time and energy;
   d. Ensuring that duty hour assignments recognize that faculty and Residents/Fellows collectively have responsibility for the safety and welfare of patients
   e. Providing guidelines for Alertness Management and Fatigue Mitigation to all residents/fellows at the annual house staff orientation and located also on the GME web site.

2. The House Staff Sleep Rooms are available at all times for residents/fellows too fatigued to drive home after in-house call. If they choose to use the sleep rooms after completion of duty, it will not count towards their duty hours.

The ACGME Policy on Resident/Fellow Supervision and Duty Hours is attached as Annex H for reference. Residents/Fellows are also to refer to the program specific policies on Resident/Fellow Supervision, Duty Hours, and Alertness Management and Fatigue Mitigation, where applicable.

**X. E-MAIL ACCESS**

All Residents/Fellows will be assigned a UTMB e-mail account. Communications to Residents/Fellows will be done via this e-mail. Residents/Fellows are expected to check their UTMB email accounts on a regular basis. Residents/Fellows must abide by the institutional policies and procedures related to use of the UTMB e-mail system.

**XI. INSTITUTIONAL RESIDENT FORUMS**

a. **THE HOUSE OFFICERS ASSOCIATION**

The House Officers Association is an advisory group on matters affecting graduate medical education from the Residents/Fellows’ perspective. Membership includes all Residents/Fellows from each training program. Members of the HOA are in a unique position to share information with their peers and bring questions/concerns to the attention of the DIO and GMEC. As part of their membership, they are encouraged to disseminate information to and bring forth issues from their colleagues to the DIO and GMEC. The five officers of the HOA serve as voting members on the GMEC. The HOA Bylaws are found in Annex I.

b. **CHIEF RESIDENTS COMMITTEE**

The Chief Residents Committee is an advisory group on matters affecting graduate medical education at the Chief Resident’s level. Membership includes Chief Residents from all programs. There are six Chief Residents selected by the committee to serve as voting members on the GMEC.
XII. OUTSTANDING RESIDENT AWARDS

The GMEC Work Environment/Operations Subcommittee selects annually an Overall First Year Resident and Overall Resident Fellow. The resident/fellow is nominated by the Program Director and the selection criteria includes performance during residency based on the ACGME six core competencies and service to the university and community. The awards are presented to the recipients at a quarterly meeting of the GMEC. Certificates are also presented to the residents/fellows nominated for the awards.

XIII. OTHER IMPORTANT POLICIES AND PROCEDURES

1. Release of Information
   All Residents/Fellows are to note that should another institution, organization or individual to which the Resident/Fellow has applied for a position request for a reference from UTMB, UTMB may share all appropriate information that it possesses concerning the Resident/Fellow, including information relating to disciplinary proceedings, suspension or termination from the program or perceived inability to practice within commonly accepted standards of care. The Resident/Fellow acknowledges that UTMB will release such information in good faith and without any malice whatsoever.

2. Other Important UTMB Institutional Policies:
   Residents/Fellows are to note that the UTMB GMEC requires all UTMB Residents/Fellows to comply with the following institutional policies as well. Relevant policies will apply when Residents/Fellows rotate to other participating sites.
   a. General Conduct
   b. Personal Appearance/Dress Code
   c. Attendance and Punctuality
   d. Confidentiality
   e. External Communication
   f. Secondary Employment
   g. Breach of EMR Usage
   h. Disciplinary P&P
   i. Ethical Code & Guidelines
   j. Staff Grievance
   k. UTMB Medical Staff Bylaws
   l. Adherence to Clinic and Inpatient Unit Policies
APPENDIX 1B

GMEC COMPETENCIES

ANNEX A
ACGME COMPETENCIES

The residency/fellowship program must integrate the following ACGME competencies into the curriculum:

**Patient Care**

Residents/Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

**Medical Knowledge**

Residents/Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.

**Practice-based Learning and Improvement**

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

1. identify strengths, deficiencies, and limits in one’s knowledge and expertise;
2. set learning and improvement goals;
3. identify and perform appropriate learning activities;
4. systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
5. incorporate formative evaluation feedback into daily practice;
6. locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems;
7. use information technology to optimize learning; and,
8. participate in the education of patients, families, students, residents and other health professionals.

**Interpersonal and Communication Skills**

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

1. communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
2. communicate effectively with physicians, other health professionals, and health related agencies;
3. work effectively as a member or leader of a health care team or other professional group;
4. act in a consultative role to other physicians and health professionals; and,
5. maintain comprehensive, timely, and legible medical records, if applicable.

**Professionalism**
Residents/Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:

(1) compassion, integrity, and respect for others;
(2) responsiveness to patient needs that supersedes self-interest;
(3) respect for patient privacy and autonomy;
(4) accountability to patients, society and the profession; and,
(5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

**Systems-based Practice**

Residents/Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

(1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;
(2) coordinate patient care within the health care system relevant to their clinical specialty;
(3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
(4) advocate for quality patient care and optimal patient care systems;
(5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,
(6) participate in identifying system errors and implementing potential systems solutions.
APPENDIX 1C

OMFS PATIENT CARE MILESTONES
### Oral and Maxillofacial Surgery Patient Care Milestones

#### Surgical Care: Medical Knowledge

<table>
<thead>
<tr>
<th>PGY 1</th>
<th>PGY 2</th>
<th>PGY 3</th>
<th>PGY 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understands normal physiology, fluid and electrolyte balance,</td>
<td>Understands the effect of age, pregnancy, and obesity on the surgical</td>
<td>Understands the effect of comorbidities on the surgical patient (e.g.,</td>
<td>Understands the management of complex multisystem surgical pathophysiology,</td>
</tr>
<tr>
<td>hemostasis, sepsis, and wound healing</td>
<td>patient</td>
<td>cardiac, pulmonary, renal, hepatic failure</td>
<td>including intensive care and organ system support (e.g., dialysis,</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ventilator use)</td>
</tr>
<tr>
<td>Understands the principles of safe surgical performance (e.g.</td>
<td>Understands the effects of alcohol, tobacco, and substance abuse</td>
<td>Understands the effects of chemotherapy, radiation, immunosuppression,</td>
<td>Systematically reviews outcomes and publishes in peer-reviewed journals</td>
</tr>
<tr>
<td>checklist, surgical consent, aseptic technique, patient positioning,</td>
<td></td>
<td>and medications, including homeopathic regimens</td>
<td></td>
</tr>
<tr>
<td>skin preparation, draping, use of appropriate instruments, universal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>precautions)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Understands the use of anesthetic agents for IV conscious sedation in</td>
<td></td>
<td>Understands potential reasons to decline offering surgical services</td>
</tr>
<tr>
<td></td>
<td>the clinical environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understands the anatomy of deep cervical facial spaces in managing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>infection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PGY 1</td>
<td>PGY 2</td>
<td>PGY 3</td>
<td>PGY 4</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Performs history and examination of the surgical patient and employs algorithms such as advanced trauma life support (ATLS) and advanced cardiac life support (ACLS)</td>
<td>Explains risks and benefits of odontogenic procedures and obtains consent</td>
<td>Formulates a treatment plan with assistance</td>
<td>Independently formulates treatment plans including patients with comorbidities</td>
</tr>
<tr>
<td>Manages several uncomplicated patients, with assistance</td>
<td>Manages a surgical patient with single system disease with assistance when indicated</td>
<td>Manages a surgical patient with multiple system diseases with assistance</td>
<td>Helps lead a multidisciplinary team for dental reconstruction (e.g., implants and orthognathic surgery)</td>
</tr>
<tr>
<td>Independently performs basic techniques in the care of the surgical patient.</td>
<td>Provides surgical consultations with assistance</td>
<td>Independently manages multiple patients and surgical consultations</td>
<td>Independently manages a surgical patient with multiple system diseases; manages a surgical patient with one or more life threatening conditions with consultation</td>
</tr>
<tr>
<td>Performs extractions and biopsies under local anesthesia</td>
<td>Independently performs routine procedures (e.g. incision and drainage, biopsy, and laceration repair)</td>
<td>Recognizes exception to treatment and describes three or more solutions</td>
<td>Teaches and supervises other learners who manage patients</td>
</tr>
<tr>
<td>Gathers and categorizes information</td>
<td>Performs routine and surgical extractions in the clinic</td>
<td>Understands surgical principles of routine procedures, (e.g. extractions, impactions, biopsies, single implants)</td>
<td>Manages a surgical service</td>
</tr>
<tr>
<td>Understands pathophysiology of wounds</td>
<td>Recognizes patterns and establishes major priorities while being able to describe at least</td>
<td>Able to perform complex surgical extractions, impactions, biopsies, and single</td>
<td>Applies known solution in novel ways; anticipates and has a plan for potential</td>
</tr>
<tr>
<td>one solution</td>
<td>implants</td>
<td>problems</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>----------</td>
<td>----------</td>
<td></td>
</tr>
<tr>
<td>Performs routine post-operative care</td>
<td>Understands indication for intervention in acute infections</td>
<td>Independently performs routine procedures.</td>
<td>Understands surgical principles of complex procedures (e.g. bone grafts, harvesting and placement, soft tissue graft, implant placement and coordinating treatment with general dentist, orthognathic procedures)</td>
</tr>
<tr>
<td>Understands the diagnostic tools used (e.g. cultures, biopsies and imaging)</td>
<td>Manages complications with assistance</td>
<td>Understands hard and soft tissue augmentations needed in implant surgery</td>
<td></td>
</tr>
<tr>
<td>Understands bone physiology and bone healing</td>
<td></td>
<td>Independently performs complex procedures</td>
<td></td>
</tr>
<tr>
<td>Recognizes complications (e.g., bleeding, oral-antral fistulas) and enlists help;</td>
<td></td>
<td>Independently manages complications (e.g., infections, fractures, failed implants, non-unions/malunions)</td>
<td></td>
</tr>
<tr>
<td>PGY 1</td>
<td>PGY 2</td>
<td>PGY 3</td>
<td>PGY 4</td>
</tr>
<tr>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>Understands etiology and incidence of routine facial soft tissue injuries and fractures.</td>
<td>Understands etiology and incidence of injuries to associated structures and late effects of injury (e.g., enophthalmos, malocclusion).</td>
<td>Understands indications and timing for the operative and non-operative treatment of facial trauma.</td>
<td>Understands the late sequelae of facial trauma (e.g., ectropion, airway obstruction, mucocele formation).</td>
</tr>
<tr>
<td>Understands the anatomy of the head and neck; describes the pattern of facial fractures.</td>
<td>Understands the principles of surgical treatment (e.g., open vs. closed approaches, methods of reduction and fixation).</td>
<td>Understands the surgical principles of routine procedures (e.g., eyelid laceration repair, maxillomandibular fixation, closed vs. open reductions).</td>
<td>Systematically review outcomes and publishes in peer-reviewed journals.</td>
</tr>
<tr>
<td>Understands the risks of other injuries (e.g., airway compromise, cervical spine injury).</td>
<td>Understands the management of associated injuries (e.g., tracheostomy).</td>
<td>Understands the surgical principles of complex procedures (e.g., repair of nasoethmoid (NOE) fractures with telecanthus).</td>
<td>Understands the surgical principles of multiple facial fracture repairs. (e.g., TMJ fx’s, Lefort I, II,III Fx’s).</td>
</tr>
</tbody>
</table>
### Maxillofacial Trauma – Patient Care

<table>
<thead>
<tr>
<th>PGY 1</th>
<th>PGY 2</th>
<th>PGY 3</th>
<th>PGY 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performs history and physical examination and orders diagnostic and imaging studies</td>
<td>Elicits the focused clinical findings associated with common facial fractures and soft tissue injuries; interprets radiological findings; explains the risks and benefits of treatment and obtains consent</td>
<td>Formulates a treatment plan with assistance</td>
<td>Manages complex secondary deformities (e.g., malocclusions associated with mal-unions, non-unions and poor reduction/fixations)</td>
</tr>
<tr>
<td>Triages and performs ATLS protocols; assists with procedures (e.g., closing lacerations and early stabilization of fractures)</td>
<td>Performs routine procedures (e.g., laceration repair, MMF, closed reductions)</td>
<td>Independently performs routine procedures; performs more complex procedures (e.g., NOE, pan-facial fracture treatment) with assistance</td>
<td>Independently formulates a treatment plan, including patients with poly-trauma and co-morbidities</td>
</tr>
<tr>
<td>Provides routine post-operative care for surgical patients</td>
<td>Recognizes complications (e.g. airway compromise, cerebrospinal fluid (CSF leak) and enlists help</td>
<td>Manages complications with assistance</td>
<td>Independently performs complex procedures</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Independently manages complications (e.g., nasal-airway obstruction, inferior alveolar nerve injuries)</td>
</tr>
</tbody>
</table>
Maxillofacial – Medical Knowledge

<table>
<thead>
<tr>
<th>PGY 1</th>
<th>PGY 2</th>
<th>PGY 3</th>
<th>PGY 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understands the anatomy of the head and neck</td>
<td>Understands surgical treatments for cancers of the head and neck</td>
<td>Understands the indications for surgical and non-surgical treatment and ancillary procedures</td>
<td>Understands the sequelae of interventions (e.g., surgical deformities, long term outcomes)</td>
</tr>
<tr>
<td>Understands the epidemiology and staging of head and neck cancer</td>
<td>Understands the principles of extirpation (e.g., margins) and reconstruction for lesions of the head and neck; understands diagnostic workup and imaging studies</td>
<td>Understands the effects of prior treatment modalities on reconstructive options (e.g., osteoradionecrosis)</td>
<td>Understands adjunctive reconstructive options (e.g., dental implants, maxillofacial prosthetics)</td>
</tr>
<tr>
<td>Understands benign and malignant bony lesions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understands the role of additional modalities (e.g. tracheostomy, feeding tube)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Maxillofacial – Patient Care

<table>
<thead>
<tr>
<th>PGY 1</th>
<th>PGY 2</th>
<th>PGY 3</th>
<th>PGY 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performs history and physical of the patient</td>
<td>Explains risks and benefits of odontogenic procedures and obtains consent</td>
<td>Performs History and Physical of ASA II patients</td>
<td>Performs History and Physical of ASA III and IV patients</td>
</tr>
<tr>
<td>Performs uncomplicated exodontia</td>
<td>Performs Conscious Sedations</td>
<td>Performs Deep Sedations</td>
<td>Performs General Anesthetics</td>
</tr>
<tr>
<td>Simple lacerations: &lt; 1 cm</td>
<td>Complicated lacerations &lt; 2 cm</td>
<td>Complicated lacerations &gt; 2 cm</td>
<td>Complicated lacerations requiring O.R. repair</td>
</tr>
<tr>
<td>Excisional biopsies &lt; 5 mm</td>
<td>Excisional biopsies &lt; 1 cm</td>
<td>Excisional biopsies 1-2 cm</td>
<td>Biopsies: All</td>
</tr>
<tr>
<td>Uncomplicated full mouth extractions</td>
<td>Full mouth extractions with uncomplicated tori</td>
<td>Complicated Full mouth extractions on patients with significant co-morbidities</td>
<td>Complicated Full mouth extractions with major osseous recontouring or implant placement</td>
</tr>
<tr>
<td>Initial evaluation of TMJ patients</td>
<td>Management of TMD patients: pain management/splint management</td>
<td>Arthrocentesis of TMJ patients in the clinic</td>
<td>Surgical Management of TMJ patients in the operating room</td>
</tr>
<tr>
<td></td>
<td>Initial evaluation of Orthognathic patients</td>
<td>Laboratory work-up of Orthognathic patients</td>
<td>Surgical work-up/management of orthognathic patients</td>
</tr>
<tr>
<td></td>
<td>Surgical management of soft tissue impactions</td>
<td>Surgical management of bony impactions</td>
<td>Surgical management of all impactions</td>
</tr>
<tr>
<td></td>
<td>Exposure and ligations of impacted canines</td>
<td>Intra-oral isolated soft and hard tissue grafts</td>
<td>Bone grafts for reconstruction</td>
</tr>
<tr>
<td></td>
<td>Evaluation of cleft lip and palate patients</td>
<td>Bone graft harvesting from the anterior iliac crest</td>
<td>Tissue dissections and bone grafting to alveolar clefts</td>
</tr>
</tbody>
</table>