# Table of Contents

1) Overall Program Goal ................................................................. Page 1
2) Overview of Program ................................................................. 2
3) Royal College Specialty Training Requirements ...................... 3
4) Program Outline ........................................................................ 4
5) Education Objectives ................................................................ 5
   5.1. Off Service Rotation Goals and Objectives
      5.1.1. Anesthesia Rotation
      5.1.2. Emergency Medicine Rotation
      5.1.3. General Surgery Rotation
      5.1.4. Internal Medicine Rotation
      5.1.5. Neurosurgery Rotation
      5.1.6. Oral Maxillo-Facial Surgery Rotation
      5.1.7. Ambulatory/ER Pediatrics Rotation
      5.1.8. Pediatric General Surgery Rotation
      5.1.9. Plastics Surgery Rotation
      5.1.10. Respiratory Medicine Rotation
      5.1.11. Gold Service Rotation
      5.1.12. Critical Care Rotation
   5.2. Otolaryngology – Head and Neck Surgery Subspecialty Training Objectives – Medical Expert
   5.3. Supporting CanMEDS Roles – Training Objectives Common to all Rotations
   5.4. Otolaryngology Rotation Specific Goals and Objectives
      5.4.1. Head and Neck Surgery
      5.4.2. Otology/Neurotology
      5.4.3. Pediatric Otolaryngology
      5.4.4. Rhinology, General Otolaryngology (St Boniface Rotation)
6) Clinical Activities ...................................................................... 48
   6.1. Rotations
   6.2. Consultations
   6.3. Call
   6.4. Moonlighting
   6.5. Education and Exam Leave
   6.6. Conflict of Interest
   6.7. Holidays and Vacation
   6.8. Otolaryngology Resident Safety Policy
7) Academic Activities ..................................................................... 55
   7.1. Grand Rounds
   7.2. Audit Rounds
   7.3. Teaching Sessions
   7.4. Laboratory Curriculum
   7.5. Journal Club
   7.6. Teaching Development
   7.7. External Courses
   7.8. Practice Exams
   7.9. Research
8) Evaluations ............................................................................... 58
9) Administrative Structure ............................................................. 59
   9.1. Residency Program Committee (RPC)
   9.2. Chief Administrative Resident
   9.3. Resident Representative on RPC
10) Counseling ............................................................................... 60
Appendices

Appendix A: Department Educational Leave Request Form.............................. Page 61
Appendix B: Vacation Request Form........................................................................ 62
Appendix C: Undergraduate ENT Curriculum Objectives.............................................. 63
Appendix D: Resident Activity Report and Portfolio ................................................... 66
Appendix E: Evaluation, Remediation, Probation, and Dismissal.................................. 68
1) Overall Program Goal

The overall goal of the University of Manitoba Otolaryngology – Head and Neck Surgery Program is to produce well trained Otolaryngology-Head and Neck Surgeons who possess a sound knowledge of the general principles of medicine and surgery. They will specifically possess the knowledge and skills in the domains of head and neck surgery, pediatric otolaryngology, facial plastic and reconstructive surgery, rhinology, laryngology, otology, neurotology and general otolaryngology.

Upon completion of the residency training program, graduating residents will be competent to function as consultants in Otolaryngology – Head and Neck Surgery, enabling them to successfully pursue careers in General Otolaryngology or to proceed with subspecialty Fellowship Training.

They will be individuals with the highest commitment to one’s patients. They will fulfill all CanMEDs domains in the role of a consultant surgeon, while demonstrating a commitment to their profession, life-long learning, their personal lives, and to society in general.

They will be able to integrate all of the CanMEDS Roles to provide optimal, ethical and patient-centered medical care. They will know how to apply their medical knowledge, clinical skills, and professional attitudes to provide effective patient-centered care.

They will function effectively as communicators who can effectively facilitate the doctor-patient relationship and the dynamic exchanges that occur before, during, and after the medical encounter.

They will function effectively as collaborators who can work within an interdisciplinary health care team to achieve optimal patient care.

They will function effectively as managers who are integral participants in health care organizations. They will be able to organize sustainable practices, make decisions about allocating resources, and contribute to the effectiveness of the health care system.

They will function effectively as health advocates who use their expertise and influence responsibly to advance the health and well-being of individual patients, communities, and populations.

They will function effectively as scholars who demonstrate a lifelong commitment to reflective learning, as well as the creation, dissemination, application and translation of medical knowledge.

They will function effectively as professionals who are committed to the health and well-being of individuals and society through ethical practice, profession-led regulation, and high personal standards of behavior.
2) Overview of Program

The University of Manitoba Department of Otolaryngology - Head and Neck Surgery Residency Program is a five-year program that is fully approved by the Royal College of Physicians and Surgeons of Canada. There are approximately ten CARMS positions in the residency program. One or two positions become available each year.

The primary objective of the residency is to provide trainees with the knowledge and skills required to practice general otolaryngology and to gain access to fellowship training in any of the otolaryngology subspecialties. Residents undergo two years of Surgical Foundations training and three years of Otolaryngology-Head and Neck Surgery specialty training. This covers the clinical aspects of practice (knowledge, clinical and technical skills), academic roles (teaching and research), and training in all CanMEDS competencies.

Instruction occurs in the clinical setting and during the weekly academic teaching sessions. During the two years of Surgical Foundations Training, residents attend the Surgical Foundations lecture series run by the Surgical Foundations Program. The Core Curriculum is a mandatory lecture series run by the Post Graduate Medical Education Program. It covers CanMEDS roles and topics common to all residents and runs throughout the 5-year training program. Residents use the temporal bone and gross anatomy labs throughout their training. The Department maintains a well-equipped Resident Office with 24-hour computer and printer access, and a spacious Departmental library with up-to-date references.

Clinical sites available to the Department include:
• Tertiary care facilities - Health Sciences Centre, St. Boniface General Hospital, and Children's Hospital
• Community locations- Victoria General Hospital, Maples Surgery Center
• Multidisciplinary oncologic care - Cancer Care Manitoba
• Rural - Northern Medical Unit of The University of Manitoba services communities of Northern Manitoba and Nunavut

Teaching staff includes 9 full time and 5 part time faculty members. The faculty staff has subspecialty training in head and neck surgery, microvascular reconstruction, otology, neurotology, rhinology, skull base surgery, pediatric otolaryngology, and laryngology.

Departmental research is done in all subspecialty areas. Studies are currently supported by local and industrial grants and departmental funds. Residents are expected to present annually at the Resident Research Day (see Resident Research Policy). Resident are encouraged to submit their research projects to national and international meetings for presentation and the department supports travel for this purpose.

The Department strives to keep itself and its residents abreast a rapidly changing field. Residents are granted one week of educational leave per year and attendance at major meetings is encouraged. Staff members actively participate on national and international academic committees. Visiting professors are invited to lecture in the department 2-3 times a year. Residents are provided office space along with computer and internet access.

Our graduates have successfully acquired fellowships throughout Canada, the United States, and in Europe. They have ultimately chosen careers in private practice or academic otolaryngology in roughly equal numbers.
3) Royal College Specialty Training Requirements

The Residency Program currently meets all Royal College requirements. However, due to differences in training that may occur for individual residents over the course of residency training; trainees must become familiar with Royal College documents to ensure eligibility and proper preparation for the pertinent exams. Any concerns regarding training content and requirements should be discussed with the Program Director so that, if necessary, the Specialty Committee of the Royal College can be contacted for a formal opinion. The documents "Objectives of Training" and "Specialty Training Requirements in Otolaryngology" and "The Objectives of Training and Specialty Training Requirements for Surgical Foundations" are available on The RCPSC website.

The Program includes two years of the Surgical Foundations Program and three years of specialty training. Surgical Foundations Program comprises general training in medical or surgical disciplines pertinent to the practice of Otolaryngology. No more than 12 months can be spent in otolaryngology during the 2 years of Surgical Foundations training. Residents are encouraged to complete MCCQE parts I and II prior to specialty training. The Surgical Foundations Examination should be written at the end of PGY2, and passing this exam is required for advancement to the PGY4 level. (See 3.1.1) Residents must be familiar with the University of Manitoba Surgical Foundations Curriculum along with attendance and mandatory course requirements for successful completion of Surgical Foundations.

The three years of specialty training must include exposure to all major aspects of adult and pediatric otolaryngology. The RC Specialty Exam in Otolaryngology – Head and Neck Surgery is taken in the spring of the PGY5 year. Residents must be aware of RC Exam requirements and registration deadlines.

Due to decisions made by the American Board of Otolaryngology, Canadian trainees are unable to sit the American Board Exam at this time.

3.1) Policy on Successful Completion of the Surgical Foundations Examination

3.1.1 Surgical Foundations trainees must provide proof of successful completion of the Surgical Foundations Examination by June 15th of their 3rd year of residency training in order to be promoted to their fourth year.

3.1.2 Residents failing to successfully complete the Surgical Foundations Examination by the end of their 3rd year of residency training WILL NOT be promoted to their fourth year but will instead complete a remedial year of training.

3.1.2.1 The composition of this remedial year will be determined on an individual basis by their Home Program Director and the Surgical Foundations Program Director, with approval of the Surgical Foundations Training Committee.

3.1.2.2 This remedial year of training may consist of a combination of (1) remedial rotations, (2) a structured and supervised reading schedule, (3) attendance at the Surgical Foundations Lecture Series and/or (4) examination training.
### Program Outline

The 5-year Residency Program consists of:
- **PGY 1 & 2:** Surgical Foundations Training
- **PGY 3, 4 & 5:** Otolaryngology Specialty training

#### PGY 1 Rotations

<table>
<thead>
<tr>
<th>Rotation</th>
<th>No. of periods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Medicine (1) and related subspecialty(1)</td>
<td>2</td>
</tr>
<tr>
<td>General Surgery (Trauma &amp; SBGH)</td>
<td>2</td>
</tr>
<tr>
<td>Pediatric Emergency/ Ambulatory Care Pediatrics</td>
<td>1</td>
</tr>
<tr>
<td>ENT *</td>
<td>4</td>
</tr>
<tr>
<td>Adult Emergency</td>
<td>1</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>1</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>1</td>
</tr>
<tr>
<td>Vacation</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>13</strong></td>
</tr>
</tbody>
</table>

* Option to replace 1 of the 4 ENT periods with an elective. An elective can be one of the following: Neurology, Cardiology, Thoracic Surgery, Respiratory Medicine, or additional time in any mandatory PGY1 or PGY2 rotations.

* All vacation time must be taken during ENT rotations.

#### PGY 2 Rotations

<table>
<thead>
<tr>
<th>Rotation</th>
<th>No. of periods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric Surgery</td>
<td>1</td>
</tr>
<tr>
<td>Plastics</td>
<td>1</td>
</tr>
<tr>
<td>ICU</td>
<td>2</td>
</tr>
<tr>
<td>Elective</td>
<td>1</td>
</tr>
<tr>
<td>ENT *</td>
<td>7</td>
</tr>
<tr>
<td>Vacation</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>13</strong></td>
</tr>
</tbody>
</table>

* Elective can be one of the following: Thoracic Surgery, Oral Surgery, Pathology, or additional time in any mandatory PGY1 or PGY2 rotations.

* All vacation time must be taken during ENT rotations.

#### PGY 3 Rotations

<table>
<thead>
<tr>
<th>Rotation</th>
<th>No. of periods</th>
</tr>
</thead>
<tbody>
<tr>
<td>U of Iowa Anatomy Course</td>
<td>1</td>
</tr>
<tr>
<td>ENT *</td>
<td>11</td>
</tr>
<tr>
<td>Vacation</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>13</strong></td>
</tr>
</tbody>
</table>

#### PGY 4 Rotations

<table>
<thead>
<tr>
<th>Rotation</th>
<th>No. of periods</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENT *</td>
<td>12</td>
</tr>
<tr>
<td>Vacation</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>13</strong></td>
</tr>
</tbody>
</table>

* 2 ENT periods may be allowed for research or electives.

#### PGY 5 Rotations

<table>
<thead>
<tr>
<th>Rotation</th>
<th>No. of periods</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENT *</td>
<td>12</td>
</tr>
<tr>
<td>Vacation</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>13</strong></td>
</tr>
</tbody>
</table>

* 2 ENT periods may be allowed for research or electives.

- ENT Training consists of roughly equal periods of time in Pediatric Otolaryngology, Rhinology/General Otolaryngology, Head and Neck Surgery, and Otology/Neurotology.
- Four weeks of study leave for the Royal College Fellowship exam is allowed. Residents are encouraged to remain clinically active during this period to further their clinical and surgical experience and skills and to ensure accurate application of their knowledge to clinical care. Attendance at teaching sessions and rounds is mandatory during study leave. Residents must return to their clinical rotations following the RC Exam. Resident status within the program will be considered incomplete if a resident fails to return to scheduled residency activity following the exam.
5) Educational Objectives

5.1 Off Service Rotation Goals and Objectives

5.1.1 ANESTHESIA ROTATION

By the end of the rotation in Anesthesia, the ENT resident will be able to:

(1) Medical Expert

Knowledge
- Summarize basic major organ system physiology/pathophysiology pertinent to perioperative care (with emphasis on respiratory system)
- Describe techniques and common agents used in conscious sedation, local anesthesia, general anesthesia and analgesia
- Manage fluid balance and hypovolemia/blood loss
- Explain the principles of ventilation

Clinical
- Perform and discuss assessment of the airway, including the “difficult airway” and the “shared airway”
- Describe options for difficult airway management
- Discuss and participate in induction and maintenance of local/general anesthesia
- Recognize the high-risk surgical patient and arrange consultation appropriately
- Perform perioperative risk assessment of patients with regards to risk vs. benefit of both anesthesia and surgery

Technical
- Demonstrate basic use of the ventilator
- Manage the airway – especially intubation and bag-mask ventilation
- Illustrate techniques of vascular access and invasive monitoring

(2) Communicator

- Establish therapeutic relationships and provides clear communication/explanation to patients and/or family members regarding anesthetic plan and anesthetic risks
- Communicate clearly and effectively with anesthesia staff, the surgical team and OR nursing staff; participating effectively in the operative patient check-list procedures

(3) Collaborator

- Demonstrate understanding of the role of all medical and other health professionals and personnel in the peri-operative care of the surgical patient
- Collaborate with Surgery and Anesthesia for the “shared airway” and “difficulty airway”
4) **Health Advocate**
   - Describe the importance of initiatives to improve patient care in the peri-operative setting such as OSA risk and difficult intubation
   - Understand the required maintenance and safety checks of Anesthetic Equipment
   - Apply the guidelines for peri-operative antibiotic use

5) **Manager**
   - Demonstrate appropriate prioritization of emergency and after hours cases
   - Effectively manage the use of OR time and discuss ways this can be maximized

6) **Scholar**
   - Refer to overarching objectives of residency

7) **Professional**
   - Model professional collaboration between anesthesia, surgery, nursing, and allied health personnel

5.1.2 **EMERGENCY MEDICINE ROTATION**

By the end of the rotation in Emergency Medicine, the ENT resident will be able to:

1) **Medical Expert**
   - **Knowledge**
     - Understand and discuss the presentation of chest pain and the diagnostic criteria for Acute Coronary Syndrome.
     - Recognize and discuss the differential diagnosis of an acute abdomen.
     - Recognize and discuss the common presentations for skin infections and their treatment.
     - Understand and discuss the principles of patient triage.
   
   - **Clinical**
     - Diagnose and manage soft tissue injuries.
     - Diagnose and initiate treatment in Acute Coronary Syndrome.
     - Diagnose and initiate treatment in congestive heart failure.
     - Participate in the acute resuscitation of a patient in cardiac arrest.
     - And/or participate in the acute resuscitation of the trauma patient.

   - **Technical**
     - Demonstrate techniques of soft tissue wound closure.
     - Assist/observe on:
       - Cardiopulmonary resuscitation.
       - Management of the acute trauma patient.
       - Intubation
       - Central line insertion
2) **Communicator:**
- Communicate effectively with patients and families in discussing their diagnosis and treatment goals and plans
- Communicate effectively with the Winnipeg Paramedic Service personnel for appropriate transfer of care.
- Communicate effectively with consulting services, allied health, community programs in order to facilitate discharge planning and outpatient follow up.

3) **Health Advocate:**
Advocate for patients with complex social and/or cultural factors in successfully negotiating the medical system.

4) **Collaborator:**
Practice a team approach with other medical services and allied health professionals to optimize patient care and facilitate patients’ successful recovery, discharge and follow-up.

5) **Manager:**
Participate in the triage, assessment and management of emergency department patients.

6) **Scholar**
See CanMEDS Goals and Objectives common to all rotations.

7) **Professional:**
Outline the PHIA act of Manitoba and how it applies to physical environment of the emergency department, including but not limited to interaction with family, Winnipeg Police Service, RCMP or other outside agencies.

5.1.3 **GENERAL SURGERY ROTATION**
By the end of the rotation in General Surgery, the ENT resident will be able to:

1) **Medical Expert**

   **Knowledge**
   - Demonstrate understanding of the principles of fluid management, including peri-operative fluid shifts, urine output status, and fluid management during states of shock
   - Manage electrolyte imbalance in the peri-operative patient
   - Define SIRS, sepsis, and septic shock
   - Discuss the pros and cons of both enteral and parenteral nutrition, and describe scenarios in which each is appropriate
   - Describe factors contributing to wound infection, and outline treatment of abdominal wound infections
   - Discuss indications for transfusion and the administration of blood products in the peri-operative patient, including those with common pre-existing blood disorders
Clinical

• Interpret abdominal and chest x-rays in the acute surgical patient
• Interpret EKGs in the acute surgical patient
• Manage acute fluid imbalance and electrolyte abnormalities in the peri-operative setting
• Recognize acute surgical emergencies that require intensive care consultation and management
• Recognize an acute abdomen, and initiate investigation and management
• Recognize SIRS, sepsis, and septic shock, and institute appropriate management
• Diagnose delirium, initiate prompt and thorough workup, and treat the underlying cause
• Discuss the contributing factors to thromboembolic disease, its prevention, and treatment

Technical

• Demonstrate the ability to perform different methods of suturing, and describe the appropriate scenario in which each should be used
• Describe the characteristics of different suture materials, and recognize the appropriate situation in which each is used
• Optimize retraction and lighting in order to facilitate the performance of surgical procedures
• Demonstrate proper technique for instrument handling (ex. Needle drivers, cautery, forceps)
• Recognize appropriate surgical scenarios for blunt and sharp dissection, and demonstrate proper technique for both
• Demonstrate different techniques for intra-operative hemostasis

2) Communicator

• Communicate clearly with team members in the multidisciplinary team environment
• Describe the clinical condition of the acute surgical patient accurately and concisely to other members of the surgical team in order to facilitate investigation and management
• Initiate appropriate code status and end-of-life discussion with patients in the emergency and on the surgical ward
• Establish therapeutic relationships and provides clear communication/explanation to patients and/or family members
• Communicate clearly and effectively with anesthesia staff, the surgical team and OR nursing staff
• Participate effectively in operating room check-list procedures
3) **Collaborator**
   - Demonstrate the ability to collaborate with ancillary care team members with respect to daily inpatient management and discharge planning
   - Demonstrate the ability to collaborate with other medical specialties involved in general surgical patients (i.e. radiology, anaesthesia, intensive care)
   - Demonstrate the ability to collaborate with the other members of the surgical team in the division and completion of daily duties

4) **Health Advocate**
   - Encourage patients to adopt appropriate lifestyle modifications when appropriate (ex. weight loss, dietary modification, smoking/EtOH cessation)
   - Encourages evidence-based cancer screening practices
   - Summarize hospital policies regarding management of patients with ARO (Antibiotic Resistant Organisms)
   - Outline indications/protocols for antibiotic prophylaxis/DVT prophylaxis in the surgical patient

5) **Manager**
   - Coordinate care of the acute patient in the acute setting, as well as in the on-call setting
   - Recognize the appropriate setting for patients based on urgency of medical condition (ex ward, OR, ICU)
   - Coordinate surgical booking of emergency surgical procedures

6) **Scholar**
   - Critically appraise relevant literature and incorporate this knowledge appropriately in the care of the surgical patient.

7) **Professional**
   - Demonstrate a professional working relationship with other members of the medical team in multiple settings (in rounds, in emergency, in acute settings)
   - Demonstrates respect for the patient’s autonomy, and central role in the decision making process
   - Respect the privacy and confidentiality of patients’ health information

5.1.4 **INTERNAL MEDICINE ROTATION**
By the end of the rotation in Internal Medicine, the ENT resident will be able to:

1) **Medical Expert**
   **Knowledge**
   - Describe basic cardiac, pulmonary, GI, renal, endocrine, hematologic and neurologic physiology and pathophysiology
   - Diagnose and manage respiratory failure, ischemic heart disease, cardiac failure, hypertension, sepsis, renal failure, diabetes mellitus, gastroesophageal reflux disease, GI bleeding, anemia, stroke, and common bleeding disorders, autoimmune diseases, and electrolyte disorders.
Clinical
• Acquire and present historical and physical findings and outline investigation and management plans on patients with multi-system disease
• Diagnose and manage patients with medical illness in the acute, chronic and acute-on-chronic settings

2) Communicator
• Communicate with patients and their families using a patient centered approach
• Communicate with consultants, physician team, nursing staff and allied health professionals in a clear and respectful manner

3) Collaborator
• Collaborate with consultants, physician team, nursing staff and allied health professionals to achieve common goal of excellence in patient care

4) Health Advocate
• Advocate for the needs and care for individual patients
• Identify social, economic, cultural or other factors that could present as or be barriers to patients accessing or receiving care and demonstrate ways they can be overcome

5) Manager
• Manage/coordinate care for patients requiring multidisciplinary care and consultation
• Manage multiple patients with multiple issues, triaging tasks effectively
• Recognize your limitations and ask for help/guidance appropriately

6) Scholar
• Understand the concept of evidence-based medicine and levels of evidence

7) Professional
• Deliver care to all patients with integrity, honesty and compassion
• Exhibit professional behavior and promote a culture of professionalism

5.1.5 NEUROSURGERY ROTATION
The goal of the Neurosurgery Rotation is to acquaint the ENT resident with general principles and approach to Neurosurgical pathology. This exposure provides an opportunity to appreciate the clinical approach to patients with neurosurgical disease with an emphasis on lateral and anterior skullbase as well as medical management of associated conditions.

By the end of the rotation in Neurosurgery, the ENT resident will be able to:

1) Medical Expert

Knowledge
• Discuss the anatomy, the pathologies and management of conditions affecting the cranial nerves and skullbase
• Manage peri-operative neurosurgical complications including cerebral spinal fluid leak, SIADH, diabetes insipidus and meningitis
• Discuss management of Facial Nerve Injury including etiology, grading systems and static and dynamic surgical reanimation procedures
• Summarize the technique of Stereotactic RadioSurgery and outline which lesions may be addressed by Gamma Knife
• Discuss the diagnosis, etiology and treatment of CSF leaks (CSF rhinorrhea and otorrhea)

**Clinical**
• Diagnose and manage patients with head trauma, spine injury, intracranial bleed, increased intracranial pressure and intracranial infection.
• Participate in the peri-operative care of patients with neurosurgical pathology.
• Demonstrate a comprehensive Neurosurgical Exam, including detailed examination of the cranial nerves

**Technical**
• Demonstrate techniques of head frame application and scalp incision/closure
• Assist/observe on:
  • Craniotomy/bone flap
  • Dural closure/grafting techniques
  • Cranial Nerve Monitoring
  • Skull Base Surgery, including Trans-Sphenoidal Surgery
• Discuss management of lumbar and ventricular drains, including potential complications

2) **Communicator**
• Establish therapeutic relationships and provide clear communication/explanation to patients and/or family members regarding neurosurgical plan and risks
• Communicate clearly and effectively with the surgical team and OR nursing staff
• Participate effectively in the care of ward patients, recognizing the value of multidisciplinary care and the role of allied health professionals in the care and rehabilitation of this patient population

3) **Collaborator**
• Demonstrate understanding of the role of all medical and other health professionals and personnel in the clinic and on the wards
• Outline the roles and expertise of individual members of the Stereotactic RadioSurgery Team
4) **Health Advocate**
   - Describe the importance of initiatives to improve patient care
   - Demonstrate advocacy for individual patients and their families, including those unable to fully communicate and participate in their own care
   - Outline local legislation/policies/initiatives which aim to reduce the risk of head trauma

5) **Manager**
   - Demonstrate efficient use of time, personnel, and skill in the management of multiple ward patients
   - Demonstrate appropriate prioritization of emergency and after hours surgical cases
   - Utilize nursing, intensive care and allied health resources effectively

6) **Professional**
   - Model professional collaboration between anesthesia, surgery, nursing, and allied health personnel

5.1.6 **ORAL MAXILLO-FACIAL SURGERY ROTATION**
By the end of the rotation in Oral Maxillo-Facial Surgery the ENT resident will be able to:

1) **Medical Expert**
   **Knowledge**
   - Understand and discuss the dental and facial skeletal anatomy relevant to the ENT system
   - Understand and discuss the physiology of bone healing.
   - Understand and discuss pathology of the dento-alveolar system as it relates to the ENT system, which may include (but is not limited to) odontogenic infections and temporomandibular joint dysfunction
   - Understand and discuss local anesthesia techniques in the oral cavity
   - Recognize and classify the various types of maxillofacial trauma, including both facial skeletal fractures and soft tissue trauma.
   - Understand and discuss the principles of management and repair of maxillofacial trauma defects with particular focus on reconstructive facial skeletal plating techniques.
   - Understand and discuss the process and legal framework of medical decision making in patients who are unable to give informed consent

   **Clinical**
   - Diagnose and manage oral cavity soft tissue infections, odontogenic infections and temporomandibular joint dysfunction and list underlying conditions that may affect their course and management.
   - Participate in the peri-operative care of patients undergoing repair of maxilla-facial trauma. List the complications of facial skeletal repair and the management of each.
Technical
• Demonstrate techniques of boney tissue handling, reconstructive plating and intra-oral wound closure.
• Demonstrate techniques of local anesthesia in the oral cavity
• Assist/observe on:
  ▪ Reduction and plating of facial fractures
  ▪ Placement of arch bars and inter-dental wiring
  ▪ Dental extractions

2) Communicator
• Communicate effectively with patients and families in discussing their diagnosis and treatment goals and plans
• Communicate effectively with Dental and Oral MaxilloFacial specialists in discussing patient diagnoses and management plans
• Communicate effectively with allied health in order to facilitate discharge planning and outpatient follow up.

3) Health Advocate
• Advocate for patients with complex social and/or cultural factors in successfully negotiating the medical system.
• Advocate for patients who are unable to give informed consent within the “power of attorney”, “medical decision maker” and “next of kin” framework

4) Collaborator
Practise a team approach with other medical services and allied health professionals to optimize patient care and facilitate patients’ successful recovery, discharge and follow-up.

5) Manager
Participate in the triage and multidiscipline care of trauma patients, including their assessment /management/ triage for surgical intervention.

6) Scholar
See CanMEDS G&O common to all rotations

7) Professional
Outline the PHIA act of Manitoba and how it applies to inpatient and outpatient care, including private practice offices.

5.1.7 AMBULATORY/ER PEDIATRICS ROTATION

1) Medical Expert
Knowledge
• Basic major organ system physiology/pathophysiology pertinent to perioperative care (with emphasis on respiratory system)
• Basic understanding of techniques and common agents used in conscious sedation, local anesthesia, general anesthesia and analgesia
• Acquire a basic approach to the outpatient care of children including growth and development as well as immunization protocols.

• Recognize which chronic medical conditions have manifestations relevant to Otolaryngology-Head and Neck Surgery, including: cystic fibrosis, immunodeficiency, genetic syndromes.

Clinical ER
• Assessment and management of acute respiratory distress in a pediatric patient including: croup, bronchiolitis, epiglottitis, airway foreign body
• Diagnosis and management of acute otitis media and acute sinusitis and their complications
• Participate in pediatric resuscitation

Clinical Ambulatory
• Identify when allergy referral and testing are appropriate

Technical
• Removal of ear and nose foreign body in the ER setting
• Wound closure under local anesthesia

2) Communicator
• Establish therapeutic relationships and accurately illicit and record a complete and thorough history and physical exam of the pediatric patient.
• Communicate clearly and effectively with patients and their parents regarding the diagnosis, interventions and management
• Communicate clearly and effectively with attending physician, nursing and other allied health professionals to ensure timely and optimal care for the pediatric patient.

3) Collaborator
• Demonstrate understanding of the role of all medical and other health professionals and personnel in the acute outpatient management of pediatric patients
• Facilitate the involvement of other pediatric services when appropriate.

4) Health Advocate
• Identify opportunities for patient advocacy in ER and outpatient clinic settings including parental smoking cessation, obesity and weight loss counseling, foreign body ingestion.

5) Manager
• Understand the scheduling of emergency and after-hour cases
• Understand effective use of OR time and ways this can be maximized
5.1.8 PEDIATRIC GENERAL SURGERY ROTATION

By the end of the rotation in Pediatric General Surgery the ENT resident will be able to:

1) **Medical Expert**

   **Knowledge**
   a) Calculate and administer appropriate fluid and medication orders for children

   **Clinical**
   a) Recognize a critically ill patient and coordinate acute care according to the patient’s needs.

   **Technical**
   a) Demonstrate techniques of soft tissue handling and wound closure.
      • Assist/observe on:
         ▪ Aerodigestive foreign body removal
         ▪ Wound closure

2) **Professional**

   a) Outline the PHIA act of Manitoba and how it applies to inpatient and outpatient care.
   b) Outline issues of informed consent as it applies to individuals under the age of 18 years.

3) **Communicator**

   a) Communicate effectively with patients and families in discussing their diagnosis and treatment goals and plans.
   b) Communicate effectively with allied health professionals to facilitate discharge planning and outpatient follow up.

4) **Health Advocate**

   a) Advocate for patients with complex social and/or cultural factors in successfully negotiating the medical system.

5) **Collaborator**

   a) Practice a team approach with other medical services and allied health professionals to optimize patient care and facilitate patients’ successful recovery, discharge and follow-up.

6) **Manager**

   a) Understand the scheduling of emergency and after hours case
   b) Understand effective use of OR time and ways this can be maximized
5.1.9 PLASTIC SURGERY ROTATION
By the end of the rotation in Plastic Surgery the ENT resident will be able to:

1) Medical Expert

Knowledge
• Discuss the concepts and processes of wound healing.
• Understand the concept of the reconstructive ladder and apply it appropriately.
• Illustrate flap/graft physiology and anatomy as it pertains to head and neck reconstruction, maxillofacial trauma, burns, congenital abnormalities of the head and neck, and esthetic facial surgery.
• Classify maxillofacial trauma, including facial fractures and soft tissue trauma, and discuss the principles of management.

Clinical
• Diagnose and manage soft tissue infections, chronic wound infections, chronic ulceration and list underlying conditions that may affect their course and management.
• Participate in the peri-operative care of patients undergoing free flap reconstruction. List the complications of free tissue transfer and the management of each.

Technical
• Demonstrate techniques of soft tissue handling and wound closure, including split thickness and full thickness skin grafting.
• Assist/observe on:
  ■ Reduction and plating of facial fractures
  ■ Local and regional flaps
  ■ Free flaps
  ■ Cleft lip and palate repair
  ■ Rhinoplasty and other facial cosmetic procedures

2) Professional
Outline the PHIA act of Manitoba and how it applies to inpatient and outpatient care, including private practice offices.

3) Communicator
• Communicate effectively with patients and families in discussing their diagnosis and treatment goals and plans
• Communicate effectively with allied health in order to facilitate discharge planning and outpatient follow up.

4) Health Advocate
Advocate for patients with complex social and/or cultural factors in successfully negotiating the medical system.

5) Collaborator
Practice a team approach with other medical services and allied health professionals to optimize patient care and facilitate patients' successful recovery, discharge and follow-up.
5.1.10 RESPIRATORY MEDICINE ROTATION
By the end of the rotation in Respiratory Medicine the ENT resident will be able to:

1) **Medical Expert**
   
   **Knowledge**
   - Understand and discuss the lower respiratory tract anatomy relevant to the ENT system
   - Understand and discuss the physiology of respiration including the role of the lungs in gas exchange and acid-base balance.
   - Understand and discuss common radiologic, laboratory and polysomnographic tests employed in respiratory medicine.
   - Understand and discuss pathology of the lower respiratory tract and its effect on/relation to the upper respiratory system.
   - Understand and discuss the medical approach to managing obstructive sleep apnea patients.
   - Understand and discuss the principles of management of common lung/chest disorders.
   - Understand and discuss the various devices employed in supportive ventilation which includes (but is not limited to) devices such as CPAP and BiPap.
   
   **Clinical**
   - Participate in the medical care of patients with various respiratory disorders such as reactive airway disease, COPD/emphysema, collapse, effusion and malignancy.
   - Demonstrate competency in interpreting common radiologic, laboratory and polysomnographic tests employed in respiratory medicine.
   
   **Technical**
   - Perform a comprehensive physical examination of the respiratory/chest system including inspection, palpation, percussion and auscultation.

2) **Professional**
   - Outline the PHIA act of Manitoba and how it applies to inpatient and outpatient care, including private practice offices.

3) **Communicator**
   - Communicate effectively with patients and families in discussing their diagnosis and treatment goals and plans
   - Communicate effectively with Respiratory Medicine specialists in discussing patient diagnoses and management plans
   - Communicate effectively with allied health professionals in order to facilitate discharge planning and outpatient follow up.
4) **Health Advocate**
- Advocate for patients with complex social and/or cultural factors in successfully navigating the medical system.
- Council patients and families regarding occupational and lifestyle issues as they relate to respiratory health and disease risk (examples: smoking, environmental exposures, allergies/trigger). Be familiar with resources/treatment options available to patients and their families (example workplace health and safety, workers' compensation, smoking cessation – aids and resources).

5) **Collaborator**
Practice a team approach with other medical services and allied health professionals to optimize patient care and facilitate patients' successful recovery, discharge and follow-up.

5.1.11 **GOLD SERVICE ROTATION**
**GOALS & OBJECTIVES for ENT Residents – supplemental to the Gold Service Surgical Foundations Learning Objectives which follow.**

By the end of the rotation in GOLD Surgery (Trauma, Acute Care), the ENT resident will be able to:

1. **Medical Expert**

   **Knowledge**
   - Discuss the management of fluid balance, fluid shifts, electrolyte disorders and acid-base disorders in trauma and acute surgical care patients
   - Indicate the role for transfusion and the use of blood products in resuscitation, trauma, and surgery
   - Outline the principles of wound healing, suturing, and tissue handling
   - Discuss pain control in surgical and trauma patients
   - Outline trauma management protocols including principles of resuscitation, airway management, control of bleeding and the role of surgical intervention in trauma
   - List imaging techniques available and choose the most appropriate investigation for acute surgical or trauma patients—X-ray, CT, MRI, Angiography
   - Illustrate the investigation and management of common surgical complications such as bleeding, wound infection/dehiscence, fistula, respiratory/cardiac failure, sepsis, DVT/PE, and delirium

   **Clinical**
   - Demonstrate the ability to take a thorough and efficient history, and perform a thorough and systematic physical exam on trauma and acute surgical patients
   - Participate on the Trauma Team in the care of trauma patients presenting to a Tertiary Care Facility
Technical
• Demonstrate proper technique for instrument and tissue handling, including wound opening and closure, blunt and sharp dissection, and hemostasis and suturing
• Perform chest-tube and central line insertion
• Demonstrate proficiency with intubation and emergency surgical airway technique
• Demonstrate surgical assisting techniques that facilitate the operating surgeon

2. Communicator
• Effectively communicate care plans to the surgical team, patients and their families
• Write meaningful chart notes illustrating understanding of pertinent issues and the care plan
• Develop commonality of purpose with patient, family and staff; relate well to staff and families
• Develop skill set for delivery of bad news, explaining poor surgical results, and outlining reasonable expectations
• Participate as a team member in situations requiring input from multiple caregivers in high-stress situations (trauma team, unstable patient in operating room)

3. Collaborator
• Work effectively with consultants, other services and ward staff to organize and coordinate patient care
• Coordinate outpatient and community resources, along with Primary Care Providers to facilitate patient discharge, rehabilitation and follow-up

4. Health Advocate
• Understand socio-economic factors in determinants of health as they relate to acute surgical trauma including substance abuse, psychological/psychiatric illness and resulting resource implications
• Identify legislation/initiatives designed to provide injury/trauma prevention/reduction—such as seatbelts, helmet legislation, recognition of similar/clustered injuries, and workplace health and safety, including farm safety

5. Manager
• Apply time management skills in the setting of providing care to multiple patients and responding to numerous clinical demands
• Demonstrate appropriate use of diagnostic tests and hospital resources in surgical patients

6. Scholar
• Critically appraise relevant articles and incorporate knowledge into the management of the general surgery patient

7) Professional
• Deliver high quality care with integrity, honesty and compassion
• Exhibit appropriate personal and interpersonal professional behaviors
• Practice medicine ethically, consistent with the obligations of a physician
GOLD SERVICE Surgical Foundations Learning Objectives

Preamble
The Trauma Acute Care Surgery (Gold) Service is designated to provide the organization necessary to deliver immediate care to the acutely ill and injured patients. This rotation is intended to provide General Surgery residents with the opportunity for concentrated exposure to major trauma and acute general surgery cases beginning with presentation in the emergency department. The rotation emphasizes clinical assessment, physiologic stabilization, diagnostic evaluation and prioritized management along a continuum of care beginning in the emergency department and culminating in hospital discharge and early follow-up.

General Objectives
Upon completion of the Trauma Acute Care Surgery (Gold) rotation, the Surgical Foundations resident is expected to acquire the knowledge (cognitive), clinical and technical skills (psychomotor) and attitudes (affective) essential to the CanMEDS roles/competencies pertinent to the Trauma Acute Care Surgery Service rotation, including gender-related and ethnic perspectives. This Service challenges the resident to prioritize continually and to coordinate effectively as part of multidisciplinary team acting under the guidance and supervision of the senior resident and attending surgeon.

Specific Objectives
At the completion of the Trauma Acute Care Surgery (Gold) Service rotation, the Surgical Foundations resident will have acquired the following competencies and will function as:

1. Medical Expert
   Establish and maintain clinical knowledge, skills and attitudes appropriate to the Trauma Acute Care Surgery rotation
   • Apply knowledge of the clinical, socio-behavioural and fundamental biomedical sciences relevant to the Trauma Acute Care Surgery rotation
   The resident in Surgical Foundations is required to attain sufficient knowledge as follows:

   Trauma
   • Biomechanics of injury
   • Principles of triage
   • Appropriate measures for the disposition and safe transport of the trauma patient
   • Initial evaluation of the trauma patient, including:
   - Airway management with cervical spine protection, including:
     • Orotracheal and nasotracheal intubation
     • Cricothyroidotomy for airway obstruction
     • Tracheostomy for airway obstruction
   - Breathing and ventilation, including principles of management of life threatening chest injuries
   - Principles of circulatory assessment and management, including:
• Recognition, evaluation and management of the common causes of hypoperfusion and shock (hypovolemic/hemorrhagic, septic, neurogenic and cardiogenic) in the trauma patient
• Hemorrhage control
• Principles of vascular/intravenous access
• Principles of fluid resuscitation and use of blood components
• Types, etiology and prevention of coagulopathies typically found in patients with massive hemorrhage

■ Principles of neurologic assessment, including:
  • Glasgow Coma Scale
  • Causes of altered mental status in the trauma patient

■ Principles and conduct of the secondary survey in the trauma patient

■ Principles and methods of monitoring the trauma patient

■ Indications for and basic interpretation of diagnostic imaging and other diagnostic studies in the trauma patient, including:
  • Plain x-rays
  • Contrast x-ray studies
  • Ultrasound (FAST/echo)
  • CT
  • Angiography
  • Diagnostic peritoneal lavage (DPL)

• Indications for consultation of other surgical disciplines in the management of the trauma patient

• Indications for and principles of preparation for immediate/early surgical intervention in the trauma patient

• Principles of assessment and management of specific injuries, including:
  ■ Head trauma, including:
    • Glasgow Coma Scale
    • Subdural hematoma
    • Extradural hematoma
    • Diffuse axonal injury
    • Basilar skull fractures/CSF leaks

  ■ Spine and spinal cord trauma, including:
    • Mechanism of injury
    • Level of injury
    • Use of steroids
    • Principles of immobilization
    • Management of spinal shock

  ■ Neck trauma, including:
    • Assessment of penetrating injuries to the neck with reference to division into Zones I, II and III and indications for surgical exploration
    • Clinical manifestations and principles of management of injuries to neck structures, including:
      ✓ Great vessels
      ✓ Trachea and larynx
      ✓ Pharynx and esophagus
      ✓ Skin and soft tissues

■ Maxillofacial trauma
- Ocular trauma
- Thoracic trauma, including:
  - Tension pneumothorax
  - Open pneumothorax
  - Flail chest
  - Massive hemothorax/hemothorax, including:
    - Technique of chest tube insertion
    - Indications for thoracotomy
  - Cardiac tamponade secondary to penetrating injury, including:
    - Pericardiocentesis
    - Indications for emergency room thoracotomy
  - Simple pneumothorax
  - Pulmonary contusion
  - Tracheobronchial disruption
  - Blunt cardiac injury
  - Traumatic aortic disruption
  - Traumatic diaphragmatic injury
  - Esophageal trauma
  - Mediastinal traversing injuries
- Abdominal trauma (blunt/penetrating), including:
  - Gastric trauma
  - Duodenal trauma
  - Pancreatic trauma
  - Small intestinal trauma
  - Colonic/rectal trauma
  - Liver/biliary tract/gallbladder trauma
  - Splenic trauma, including:
    - Operative versus nonoperative management
    - Complications, including overwhelming post splenectomy infection
  - Urinary tract/penetrating flank trauma, including:
    - Renal injury
    - Ureteral injury
    - Intraperitoneal/extraperitoneal bladder injury and associated pelvic fractures
    - Urethral trauma and associated pelvic fractures
  - Abdominal vascular trauma
  - Principles and technique of damage control surgery in the trauma patient with devastating injuries
  - Abdominal compartment syndrome, including:
    - Clinical presentation/physiologic consequences
    - Principles of assessment/monitoring
    - Principles of management
Emergent care of musculoskeletal and soft tissue trauma, including:
- Major extremity trauma, including:
  - Open versus closed fractures
  - Prevention/assessment/management of compartment syndromes
  - Concepts of immobilization (splinting/internal fixation)
  - Hemorrhage control
  - Commonly associated vascular injury
  - Associated nerve injury
- Pelvic fractures, including:
  - Associated urinary tract injury
  - Associated vascular injury/hemorrhage control

Indications for and principles of antibiotic usage in the trauma patient

Tetanus prophylaxis in the trauma patient

DVT prophylaxis in the trauma patient

Management of myoglobinuria in the trauma patient

Acute Surgical Problems
- Principles of early assessment and investigation in the acute abdomen, including:
  - Conditions associated with abdominal pain, including:
    - Acute appendicitis
    - Cholecystitis/biliary colic/choledocholithiasis/cholangitis
    - Pancreatitis
    - Peptic ulcer disease (with or without perforation)
    - Gastroesophageal reflux
    - Gastritis/duodenitis
    - Diverticulitis
    - Inflammatory bowel disease
    - Enterocolitis
    - Small intestinal obstruction
    - Colonic obstruction
    - Splenomegaly
    - Mesenteric ischemia
    - Leaking/ruptured abdominal aortic aneurysm
  - Gynecologic conditions, including:
    - Ectopic pregnancy
    - Ovarian cyst (torsion; hemorrhage; rupture)
    - Tubo-ovarian abscess
    - Salpingitis
    - Endometritis
  - Genito-urinary conditions, including:
    - Urosepsis
    - Pyelonephritis
    - Ureterolithiasis
    - Testicular torsion
• Common non-surgical conditions that can present with abdominal pain, including:
  ✓ Myocardial infarction
  ✓ Pneumonia
  ✓ Pleuritis
  ✓ Hepatitis
  ✓ Gastroenteritis
  ✓ Mesenteric adenitis
  ✓ Sickle cell crisis
  ✓ Diabetic ketoacidosis
  ✓ Herpes zoster
  ✓ Nerve root compression
  ✓ Myofascial syndrome

• Conditions causing abdominal pain in the immune-suppressed patient, including:
  ✓ Neutropenic enterocolitis
  ✓ CMV enterocolitis
  ✓ Acute graft rejection

■ Investigations, including:
  • Blood tests
  • Diagnostic imaging
  • Endoscopy/laparoscopy

■ Early management of patients with acute abdominal pain, including:
  • Operative versus nonoperative approach

• Presentation, pathophysiology, principles of assessment, diagnostic strategy, specific management, complications of disease and intervention and expected outcomes of common surgical emergencies, including:

■ Perforations of the upper gastrointestinal tract, including:
  • Esophageal perforation
  • Perforated peptic ulcer
  • Perforated gastric lesions

■ Gastrointestinal hemorrhage, including:
  • Acute non-variceal upper gastrointestinal bleeding
  • Acute variceal upper gastrointestinal bleeding
  • Hematobilia
  • Aorto-enteric fistula
  • Acute lower gastrointestinal bleeding

■ Pancreaticobiliary emergencies, including:
  • Biliary colic/acute cholecystitis/acalculous cholecystitis
  • The acutely jaundiced patient
  • Choledocholithiasis/acute cholangitis
  • Acute pancreatitis

■ Hepatic emergencies, including:
  • Abscess
  • Infected cyst

■ Small intestinal emergencies, including:
  • Obstruction
  • Mesenteric ischemia
- Inflammatory conditions, including:
  - Crohn's disease
  - Radiation enteritis
  - Meckel's diverticulum
  - Bleeding
- Acute appendicitis/perforation/phlegmon
- Colorectal emergencies, including:
  - Colonic obstruction
  - Intestinal pseudo-obstruction
  - Acute colorectal bleeding
  - Colonic perforation
  - Volvulus, including:
    - Cecal volvulus
    - Sigmoid volvulus
    - Acute diverticulitis
  - Emergencies related to colorectal malignancy
  - Emergencies related to inflammatory bowel disease, including:
    - Ulcerative colitis
    - Crohn's disease
    - Emergencies related to pseudomembranous colitis
    - Ischemic colitis
- Anorectal emergencies, including:
  - Ischiorectal/perianal abscess
  - Acute anal fissure
  - Acute hemorrhoid emergencies, including:
    - Thrombosis
    - Prolapse/gangrene
    - Bleeding
    - Pilonidal abscess
    - Foreign body
    - Fulminating sepsis/fasciitis/myonecrosis
- Acute conditions related to hernias of the abdominal wall, groin (inguinal/femoral) and obturator foramen, including:
  - Incarceration
  - Strangulation
  - Obstruction
- Soft tissue infection, including:
  - Cellulitis
  - Abscess
  - Fulminating sepsis, including:
    - Fasciitis
    - Myonecrosis
    - Fournier's gangrene

With respect to the above outline of cognitive objectives:

Surgical Foundations resident will be able to outline the initial management of the listed conditions.
• Perform a complete and appropriate assessment of the trauma/acute care patient
  ■ Elicit a history that is relevant, concise and accurate and in the case of
    the trauma patient includes assessment of mechanism of injury
  ■ Perform a focused physical examination that is relevant and accurate
    and in the case of the trauma patient includes initial assessment
    (primary/secondary survey)
  ■ Select medically appropriate investigations in a resource-effective and
    ethical manner
  ■ Demonstrate effective clinical problem solving and judgment to
    address the trauma and acute care problems, including interpreting
    available data and integrating information to generate differential
    diagnoses and management plans
• Use preventive and therapeutic interventions effectively
  ■ Implement an effective and prioritized management plan for the trauma/
    acute care patient, including appropriate and expeditious patient disposition
  ■ Triage and organize care of multiple casualty victims simultaneously
  ■ Demonstrate effective, appropriate and timely application of
    therapeutic interventions relevant to the Trauma Acute Care Surgery
    (Gold) Service rotation, including a thorough and expeditious trauma
    resuscitation as per ATLS guidelines
  ■ Ensure appropriate informed consent is obtained for therapies

The Surgical Foundations resident will be able to:
• Perform many of the above clinical skills
• Initiate well thought-out and appropriate management strategies; will
  require corroboration or modification by a more senior individual

Having completed the Trauma Acute Care Surgery (Gold) Service rotation,
the Surgical Foundations resident will be able to demonstrate technical
competence for the following procedures:
  ■ Initial Assessment and Resuscitation Procedures
    • Arterial puncture
    • Venipuncture
    • Urinary catheter insertion
    • Nasogastric/orogastric tube insertion
    • Suture of laceration
  ■ Advanced Airway Management
    • Cricthyroidotomy (assist)
    • Tracheostomy (assist)
  ■ Thoracic Trauma
    • Needle decompression for tension pneumothorax
    • Chest tube insertion for chest trauma
• Seek appropriate consultation from other health professionals
  ■ Demonstrate insight into his/her own limitations of expertise by self-
    assessment
  ■ Demonstrate effective, appropriate and timely consultation of another
    health professional as needed for optimal care of the trauma/acute care
    surgical patient
  ■ Arrange appropriate follow-up care services for the trauma/acute care
    surgical patient
At the completion of the Trauma Acute Care Surgery (Gold) Service rotation, the Surgical Foundations resident will be able to:

2. **Communicator**
   - Develop rapport, trust and ethical therapeutic relationships with patients and families
   - Establish positive therapeutic relationships with patients and their families that are characterized by understanding, trust, respect, honesty and empathy
   - Respect patient confidentiality, privacy and autonomy
   - Listen effectively
   - Accurately elicit and synthesize relevant information and perspectives of patients and families, colleagues and other professionals
   - Seek out and synthesize relevant information from other sources such as the trauma/acute care surgical patient’s family, caregivers and other professionals
   - Accurately convey relevant information and explanations to patients and families, colleagues and other professionals
   - Deliver information to the trauma/acute care surgical patient and family, colleagues and other professionals in a humane and understandable manner
   - Convey effective oral and written information
   - Maintain clear, accurate, appropriate and timely records of clinical encounters and operative procedures involving the trauma/acute care surgical patients
   - Maintain an accurate, complete and up-to-date electronic database (log) of operative procedures performed during the Trauma Acute Care Surgery (Gold) Service rotation
   - Effectively present verbal reports of clinical encounters and medical information during the Trauma Acute Care Surgery (Gold) Service rotation

3. **Collaborator**
   - Participate effectively and appropriately in an interprofessional healthcare team
   - Recognize and respect the diversity of roles, responsibilities and competences of other professionals in the management of the trauma/acute care surgical patient
   - Work with others to assess, plan, provide and integrate care of the trauma/acute care surgical patient

4. **Manager**
   - Manage his/her professional and personal activities effectively
   - Set priorities and manage time to balance professional responsibilities, outside activities and personal life
   - Employ information technology effectively (e.g. electronic surgical procedure database)
   - Demonstrate an understanding of cost-effectiveness in patient management
   - Utilize hospital resources wisely when managing trauma/acute care surgical patients
   - Serve in leadership roles, as appropriate
   - Participate effectively at teaching rounds and other meetings
5. **Health Advocate**
   • Respond to the needs of the trauma/acute care surgical patient
   • Identify the health needs of an individual patient
   • Identify opportunities for advocacy, health promotion and disease prevention
     (e.g. promotion of seat belt and helmet usage/trauma prevention)

6. **Scholar**
   • Maintain and enhance professional activities through ongoing learning
   • Pose an appropriate learning question
   • Access and interpret the relevant evidence
   • Integrate new learning into development as a general surgeon
   • Critically evaluate medical information and its sources and apply this appropriately to clinical decisions
   • Critically appraise the trauma/acute care evidence in order to address a clinical question
   • Integrate critical appraisal conclusions into clinical care
   • Facilitate the learning of students and residents
   • Demonstrate an effective presentation while assigned to the Trauma Acute Care Surgery (Gold) Service
   • Provide effective feedback to faculty, residents and students

7. **Professional**
   • Demonstrate a commitment to patients through ethical practice
   • Exhibit appropriate professional behaviours, including honesty, integrity, commitment, compassion, respect and altruism
   • Appropriately manage conflicts of interest
   • Recognize the principles and limits of patient confidentiality
   • Maintain appropriate relations with patients
   • Demonstrate a commitment to physician health
   • Balance personal and professional priorities
   • Strive to heighten personal and professional awareness and insight
5.1.12 CRITICAL CARE ROTATION

*All Residents are expected to have completed the ACLS course prior to the start of your critical care rotation*

Upon completion of the Critical Care rotation, the Surgical Foundations resident is expected to:

- Demonstrate knowledge, clinical and technical skills and decision-making capabilities pertinent to the management of critically ill patients
- Demonstrate awareness of the ethical principles pertinent to critically ill patients, including end-of-life care and issues around withdrawing and withholding life support

Specific Objectives

I. Medical Expert

Knowledge

- Establish and maintain knowledge, skills and attitudes appropriate to the Critical Care rotation
- Apply knowledge of the clinical, socio-behavioural and fundamental biomedical sciences relevant to the Critical Care rotation

The resident in Surgical Foundations is required to attain sufficient knowledge as follows:

Airway Management

- Principles of airway management
- Indications for intubation

Respiratory Critical Care

- Interpretation of blood gases
- Assessment of acid-base status
- Basis ventilator modes and settings
- ARDS

Cardiac Critical Care

- ACLS principles
- Recognition of common rhythm disturbances
- Interpretation of electrocardiogram/recognition of important life-threatening findings

Shock

- Classification of shock, including:
  - Hypovolemic shock
  - Distributive shock
  - Cardiogenic shock
  - Obstructive shock
- Outline of hemodynamic patterns specific to different causes of shock
- Appropriate use of inotropes and vasopressors
**Sepsis and Critical Care**
- Organ failure associated with sepsis

**Renal Problems and Critical Care**
- Renal failure and basic principles of dialysis/ultrafiltration
- Fluid and electrolyte disorders
- Myoglobinuria

**Nutritional Support in Critical Care**
- Nutritional assessment in the ICU
- Enteral nutrition
- Parenteral nutrition

**Gastrointestinal and Hepatic Critical Care**
- Stress gastritis
- Gastrointestinal bleeding
- Hepatic failure

**Clinical**
- Perform a complete and appropriate assessment of the critically ill patient
  - Elicit a history that is relevant, concise and accurate
  - Perform a focused physical examination that is relevant and accurate
  - Select medically appropriate investigations in a resource-effective and ethical manner
  - Examine and review each of the assigned patients before morning rounds
  - Demonstrate effective clinical problem solving and judgment to address the problems, including interpreting available data and integrating information to generate problem lists and to outline management plans

**Technical**
- Use therapeutic interventions effectively
  - Implement an effective and prioritized management plan for the critically ill patient
  - Demonstrate effective, appropriate and timely application of therapeutic interventions relevant to the Critical Care rotation
  - Ensure appropriate informed consent is obtained for therapies
- Demonstrate proficient and appropriate use of procedural skills
  - Demonstrate effective, appropriate and timely performance of diagnostic procedures relevant to the Critical Care rotation
  - Demonstrate effective, appropriate and timely performance of therapeutic procedures relevant to the Critical Care rotation
  - Ensure appropriate informed consent is obtained for procedures
Having completed the Critical Care rotation, the Surgical Foundations resident will be able to demonstrate knowledge and technical competence in performing the following procedures:

- Arterial line placement
- Basic airway management, including:
  - Bag/mask ventilation
  - Uncomplicated intubation
- Central venous catheter insertion under ultrasound guidance
- Application of ACLS principles in patient resuscitation
- Seek appropriate consultation from other health professionals
  - Demonstrate insight into his/her own limitations by self-assessment
  - Demonstrate effective, appropriate and timely consultation of another health professional as needed for optimal care of the critically ill patient

2. Communicator

- Develop rapport, trust and ethical therapeutic relationships with patients and families
  - Establish positive therapeutic relationships with patients and their families that are characterized by understanding, trust, respect, honesty and empathy
  - Respect patient confidentiality, privacy and autonomy
  - Listen effectively
  - Accurately elicit and synthesize relevant information and perspectives of patients and families, colleagues and other professionals
  - Seek out and synthesize relevant information from other sources such as the family, caregivers and other professionals
  - Accurately convey relevant information and explanations to patients and families, colleagues and other professionals
  - Deliver information to the patient and family, colleagues and other professionals in a humane and understandable manner, including:
    - Informed consent
    - Medical condition of the patient
    - Treatment plan
    - Prognosis
    - Primary and secondary prevention
    - Adverse events
    - Medical uncertainty
    - Medical errors
    - End-of-life wishes
    - Autopsy
    - Organ donation
    - Keep attending physicians apprised of relevant events
    - Convey effective oral and written information
    - Maintain clear, accurate, appropriate and timely records of clinical encounters with each assigned patient on a daily basis
    - Effectively present verbal reports of clinical encounters and medical information in an organized and concise manner during the Critical Care rotation
3. **Collaborator**
   - Participate effectively and appropriately in an interprofessional healthcare team
   - Recognize and respect the diversity of roles, responsibilities and competences of other professionals in the management of the critically ill patient
   - Work with nursing colleagues and others to assess, plan, provide and integrate care of the critically ill patient

4. **Manager**
   - Manage his/her professional and personal activities effectively
   - Set priorities and manage time to balance professional responsibilities, outside activities and personal life
   - Employ information technology effectively (e.g. electronic procedure database)
   - Demonstrate an understanding of cost-effectiveness in patient management
   - Utilize hospital resources wisely when managing patients
   - Serve in leadership roles, as appropriate
   - Participate effectively at teaching rounds and other meetings

5. **Health Advocate**
   - Respond to the needs of the critically ill patient
   - Identify the health needs of an individual patient

6. **Scholar**
   - Maintain and enhance professional activities through ongoing learning
   - Pose an appropriate learning question
   - Access and interpret the relevant evidence
   - Integrate new learning into development as a general surgeon
   - Critically evaluate medical information and its sources and apply this appropriately to clinical decisions
   - Critically appraise the critical care evidence in order to address a clinical question

7. **Professional**
   - Demonstrate a commitment to patients through ethical practice
   - Exhibit appropriate professional behaviours, including honesty, integrity, commitment, compassion, respect and altruism
   - Recognize and appropriately respond to ethical issues such as consent, advanced directives, confidentiality, end-of-life care and withdrawing and withholding life support
   - Appropriately manage conflicts of interest
   - Recognize the principles and limits of patient confidentiality
   - Maintain appropriate relations with patients
5.2 Otolaryngology – Head and Neck Surgery Subspecialty

Training Objectives – Medical Expert

The goal of specialty training is to have the trainee complete the program having obtained the knowledge and skills required to successfully integrate all of the CanMEDS Roles in their provision of patient-centered care. Medical Expert is the central physician role in the CanMEDS framework and as Medical Experts, Otolaryngology-Head and Neck Surgeons must successfully apply medical knowledge, clinical skills, and professional attitudes in their practice. At the completion of Residency Training in Otolaryngology-Head and Neck Surgery the resident will have demonstrated the following competencies and be ready to enter General Otolaryngology Practice or subspecialty training.

1. Function effectively as consultants, integrating all of the CanMEDS Roles to provide optimal, ethical and patient-centered medical care
2. Establish and maintain clinical knowledge, skills and attitudes appropriate to Otolaryngology – Head and Neck Surgery
3. Perform a complete and appropriate assessment of a patient
4. Use preventive and therapeutic interventions effectively
5. Demonstrate proficient and appropriate use of procedural skills, indications, contraindications, potential complications and their management, and methods, both diagnostic and therapeutic
6. Seek appropriate consultation from other health professionals, recognizing the limits of their expertise

Residents should be familiar with the Royal College document entitled “Objectives of Training in the Specialty of Otolaryngology – Head and Neck Surgery”. This detailed list of objectives can be superimposed on the following rotation specific objectives to generate a rotation specific study guide and to ensure that all areas are covered.

5.3 Supporting CanMEDS Roles – Training Objectives Common to all Rotations

1. Scholar

1. Maintain and enhance professional activities through ongoing learning
2. Critically evaluate medical information and its sources, and apply this appropriately to practice decisions.
3. Facilitate the learning of patients, families, students, residents, other health professionals, the public and others, as appropriate
4. Contribute to the development, dissemination, and translation of new knowledge and practices
5. Utilize information technology to optimize patient care, life-long learning and other CanMeds objectives

PGY1-2

- Basic study design and ability to identify sources of bias
- Perform simple prospective or retrospective study suitable for presentation at Resident's Research Day
- Compose abstract/paper with guidance
PGY3-5

• In depth knowledge of study design, ability to identify sources of bias based on increasing clinical knowledge base
• Ability to integrate findings of new studies into clinical practice
• Perform prospective or retrospective study suitable for presentation at major meetings
• Compose abstract/paper with minimal guidance

2. Communicator
   1. Develop rapport, trust, and ethical therapeutic relationships with patients and families
   2. Accurately elicit and synthesize relevant information and perspectives of patients and families, colleagues, and other professionals
   3. Convey relevant information and explanations accurately to patients and families, colleagues and other professionals
   4. Develop a common understanding on issues, problems and plans with patients, families, and other professionals to develop a shared plan of care
   5. Convey effective oral and written information about a medical encounter
   6. Deliver clear and engaging academic presentations

3. Collaborator
   1. Participate effectively and appropriately in an interprofessional health care team. Demonstrate confidence while aware of limitations and willingly accept/seek guidance.
   2. Work with other health professionals effectively to prevent, negotiate, and resolve interprofessional conflict. Recognize the value of multidisciplinary teams.

4. Manager
   1. Participate in activities that contribute to the effectiveness of their health care organizations and systems
   2. Manage their practice and career effectively. Demonstrate good time management skills through the completion/attendance of academic curriculum
   3. Allocate finite health care resources appropriately
   4. Serve in administration and leadership roles, as appropriate

5. Health Advocate
   1. Respond to individual patient health needs and issues as part of patient care
   2. Respond to the health needs of the communities that they serve
   3. Identify the determinants of health for the populations that they serve
   4. Promote the health of individual patients, communities, and populations

6. Professional
   1. Demonstrate a commitment to their patients, profession, and society through ethical practice
   2. Demonstrate a commitment to their patients, profession and society through participation in profession-led regulation
   3. Demonstrate a commitment to physician health and sustainable practice
   4. Deliver highest quality care with integrity, honesty and compassion
   5. Exhibit appropriate personal and interpersonal professional behaviors
5.4 Otolaryngology Rotation Specific Goals and Objectives

5.4.1 HEAD AND NECK SURGERY ROTATION GOALS AND OBJECTIVES

The goal of the rotations in Head and Neck Surgery is to produce skilled and professional residents who are knowledgeable and competent in the diagnosis and management of common Head and Neck conditions. At the completion of the Head and Neck Surgery rotations the ENT resident will have acquired the skills and knowledge to function as General Otolaryngologists competent in managing patients presenting to a general otolaryngology practice with Head and Neck pathologies.

By the end of the rotations in Head and Neck Surgery, the ENT Resident will be able to:

**Medical Expert**

**Knowledge**

PGY1/2/3 Residents:
- Discuss the embryology, anatomy, histology, physiology, pharmacology, pathology, pathophysiology, microbiology, biochemistry, genetics and immunology of thyroid and parathyroid glands, salivary glands, nose and paranasal sinuses, oral cavity, pharynx (nasopharynx, oropharynx, and hypopharynx), larynx, trachea, esophagus, neck, skin, and skull base
- List different types of neoplasms (benign and malignant) involving the head and neck
- Describe the clinical presentation, staging, investigations, medical treatment, surgical treatment, and prognosis for each type of neoplasm involving the head and neck

PGY4/5 Residents in addition to the above:
- List the indications, contraindications, and limitations and interpretations of investigations, including imaging techniques in the diagnosis of neoplasms of the head and neck
- List the indications, contraindications, surgical techniques and complications of surgical procedures used to treat head and neck neoplasms
- Describe the different reconstructive surgical options and techniques for management of benign and malignant neoplasms of the head and neck, including the advantages, disadvantages and complications
- Illustrate treatments used in the management of head and neck neoplasms, including indications, contraindications, adverse effects and complications of chemotherapy and radiotherapy
- Demonstrate appropriate indications for consultation of other health professionals to assist in the management of neoplasms of the head and neck, including neoplasms of the larynx and upper airway
- Outline the principles of oncologic management of cutaneous malignancies of the face, head and neck and illustrate local and regional flaps and grafts
- Explain the principles and techniques of facial reconstruction
- Outline the principles of oncology as they apply to the larynx and upper airway
• Apply principles of trauma management as it relates to the larynx and upper airway
• Outline the principles of laser therapy as it pertains to the upper aerodigestive tract and larynx
• Discuss principles of diagnostic imaging and their application within Head and Neck Surgery including the interpretation of imaging techniques relevant to the head and neck, larynx and upper airway
• Demonstrate the principles of management of blunt and penetrating neck trauma
• Demonstrate the principles of management of acute airway emergencies

Clinical Skills
PGY1/2 Residents:
• Elicit and document a history that is relevant, clear, concise and accurate.
• Perform and document a complete physical examination that is relevant and accurate.
• Select medically appropriate investigations in a resource-effective and ethical manner. This includes imaging of the head and neck, biopsy and fine-needle aspiration as well as specialized laboratory testing (including immunologic and genetic testing)
• Ensure appropriate informed consent is obtained for procedures
• Ensure adequate follow-up is arranged for procedures performed
• Seek appropriate consultation from other health professionals, recognizing the limits of their expertise
PGY3/4/5 Residents in addition to the above:
• Demonstrate effective clinical problem solving and judgment to address patient problems, including interpreting available data and integrating information to generate differential diagnoses and management plans inclusive of the risks, indications, contraindications and benefits
• Document and disseminate information related to procedures performed and their outcomes

Technical Skills
PGY1/2 Residents:
• Demonstrate proficient and appropriate use of procedural skills, indications, contraindications, potential complications and their management, and methods, both diagnostic and therapeutic
• Perform the following:
  ■ Office Flexible Nasolaryngoscopy
  ■ Fine Needle Aspiration Biopsy
  ■ Punch biopsy of mucosal and skin lesions
  ■ Rigid endoscopy of the upper aerodigestive system, including microlaryngoscopy
  ■ Intra-operative surgical checklist, skin incisions, flap elevation, surgical ligation, soft tissue dissection, surgical assisting, wound closure
  ■ Lymph node biopsies
  ■ Assess and manage airway obstruction
  ■ Tracheostomy and tracheostomy care management
PGY3 Residents in addition to the above:
• Demonstrate effective, appropriate, safe and timely performance of diagnostic and therapeutic procedures relevant to Otolaryngology - Head and Neck Surgery
• Demonstrate a consultant’s expertise in Head and Neck Surgery
  ▪ Branchial cleft cysts
  ▪ Endoscopic biopsy
  ▪ Panendoscopy
  ▪ Submandibular gland excision
  ▪ Thyroglossal duct cyst excision
  ▪ Skin cancer resection
  ▪ Management of superficial and deep space neck infections
  ▪ Benign neck surgery not otherwise included
  ▪ Pre- and post-operative care by demonstrating appropriate clinical judgment in selection of therapy

PGY4/5 Residents in addition to the above:
• Demonstrate a consultant’s expertise in Head and Neck Surgery:
  ▪ Thyroid surgery
  ▪ Parotidectomy
  ▪ Neck dissection
  ▪ Laser procedures on the airway
  ▪ Reconstruction with local flaps
  ▪ Major flap reconstruction (excluding free flaps)
  ▪ Penetrating/blunt neck trauma
  ▪ Zenker's diverticulum surgery
• Demonstrate expertise but not routinely perform independently the following:
  ▪ Parathyroid surgery
  ▪ Laryngectomy
  ▪ Oral mandibular resections
  ▪ Maxillectomy (open)
  ▪ Major free flap reconstructions
  ▪ Airway reconstruction

Communicator
Develop rapport, trust, and ethical therapeutic relationships with patients and families
PGY1/2 Residents:
• Establish positive therapeutic relationships with patients and their families that are characterized by understanding, trust, respect, honesty and empathy
  ▪ Respect patient confidentiality, privacy and autonomy
  ▪ Listen effectively
  ▪ Be aware of and responsive to nonverbal cues
  ▪ Facilitate a structured clinical encounter effectively
  ▪ Convey effective oral and written information about a medical encounter
  ▪ Maintain clear, accurate, and appropriate records (written, dictated or electronic) of clinical encounters and plans
  ▪ Present verbal reports of clinical encounters and plans
PGY3/4/5 Residents in addition to the above:
- Accurately elicit, synthesize, and convey information, explanations, care plans to patients, families, colleagues and other professionals
- Demonstrate clear and effective communication by conveying relevant information and explanations accurately to patients and families, colleagues and other professionals.
- Develop a common understanding on issues, problems and plans with patients, families, and other professionals to develop a shared plan of care
- In the multidisciplinary setting, present patient histories, report on physical findings, summarize patient status and generate patient treatment plan/options
- Present medical information to the public or media about a medical issue

Collaborator
PGY1-5
1. Participate effectively and appropriately in an interprofessional health care team
   - Describe the Otolaryngology-Head and Neck Surgeon’s roles and responsibilities to other professionals
   - Describe the roles and responsibilities of other professionals within the healthcare team
   - Recognize and respect the diversity of roles, responsibilities and competences of other professionals in relation to their own
   - Work with others to assess, plan, provide and integrate care for individual patients (or groups of patients) in the ICU, ward and outpatient settings
   - Participate in (and when appropriate, lead) interprofessional team meetings including multidisciplinary Head and Neck Oncology team, Tracheostomy Team and discharge planning and/or patient family meetings
2. Work with other health professionals effectively to prevent, negotiate, and resolve interprofessional conflict
   - Demonstrate a respectful attitude towards other colleagues and members of an interprofessional team
   - Work with other professionals to prevent conflicts
   - Employ collaborative negotiation to resolve conflicts
   - Respect differences and address misunderstandings and limitations in other professionals
   - Recognize one’s own differences, misunderstanding and limitations that may contribute to interprofessional tension
   - Reflect on interprofessional team function
   - Contribute to healthy team development and conflict resolution, and contribute their own expertise to the team’s task
Manager
PGY1-5
Demonstrate the ability to prioritize professional duties when faced with multiple patients and problems

Health Advocate
PGY1-5
1. Demonstrate appropriate and timely application of preventive and therapeutic interventions relevant to Otolaryngology - Head and Neck Surgery, including smoking cessation, responsible alcohol use, ultraviolet A/ultraviolet B (UVA/UVB) exposure and protection
2. Ensure appropriate informed consent is obtained for therapies, including use of knowledge related to disease processes, patient context and interpretation of investigations to enable informed consent
3. Demonstrate appropriate and timely involvement of support services for patients and/or families who may be at risk of experiencing, or having difficulties, in accessing or managing diagnostic or treatment recommendations
4. Ensure patients receive appropriate end-of-life care

Scholar
PGY1-5
Throughout their rotations in Head and Neck Surgery, residents should be able to
a. Identify clinical problems that require research to ensure the best, evidence-based care can be provided
b. Facilitate the learning of patients, families, students, residents, other health professionals, and the public
c. Demonstrate effective use of Information Technology in clinical and academic activities, as well as in the presentation/participation in CPD activities

Professional
PGY1-5
Throughout their rotations in Head and Neck Surgery, residents should
a. Exhibit appropriate professional behaviors in practice including honesty, integrity, commitment, compassion, respect and altruism
b. Demonstrate appropriate knowledge and behaviors regarding relationships with industry
c. Illustrate the balance of personal and professional priorities necessary to ensure maintenance of personal health and sustainable practice
5.4.2  OTOLOGY / NEUROTOLOGY

Otology/ Neurotology PGY 1&2

**Knowledge:**
Basic understanding of:
1. Anatomy and embryology ear and temporal bone
2. Basic physiology of hearing and vestibular system
   - Pathophysiology of common otologic problems – conductive vs. sensorineural hearing loss, otitis media, otitis externa, chronic suppurative otitis media, tinnitus, BPPV, Meniere's, unilateral vestibular loss/vestibular neuronitis, cholesteatoma
   - Facial nerve pathology
   - Temporal bone radiology/pathology

**Clinical:**
- Otologic/Neurotologic history and physical
- Basic workup and management of above clinical conditions as well as relationship to other medical conditions

**Technical:**
- Microscopic ear exam
- T-tube insertion

PGY 3&4

**Knowledge:**
- In depth neurophysiology – both cochlear and vestibular
- eg. tonotopicity, vestibulo-ocular reflex, differential diagnosis of nystagmus, velocity storage, phase and gain.

**Clinical:**
- Ability to perform/interpret audiologic testing ENG / posturography and vemp testing
- Understanding of specialized neurotologic testing – otoacoustic emissions, electrococchleography, rotary chair, posturography and vemp testing.
- Demonstrate proficient neurotologic history and physical
- Concise case presentations of otologic problems
- Formulate differential diagnoses and management plans

**Technical:**
- tympanoplasty, simple mastoidectomy, assist in various forms of temporal bone surgery.
**PGY 5**

**Knowledge/Clinical:**
- Integrate above and demonstrate ability for independent assessment and development of management plans at consultant level

**Technical:**
- Tympanoplasty (including middle ear reconstruction, stapedectomy), mastoidectomy, labyrinthine surgery
- Assist on posterior fossa/middle fossa surgery and attend Gamma Knife Rounds

### 5.4.3 PEDIATRIC OTOLARYNGOLOGY GOALS AND OBJECTIVES

The goal of the rotations in Pediatric Otolaryngology is to produce knowledgeable, skilled, professional and competent residents in the diagnosis and management of common pediatric conditions. The skills and knowledge acquired on these rotations should produce residents competent in managing pediatric patients in a general otolaryngology practice.

#### 1. Medical Expert

The rotations in Pediatric Otolaryngology should provide knowledge and competency in the following domains:

- Embryology, anatomy, histology, physiology, pharmacology, pathophysiology, microbiology, biochemistry, genetics and immunology of the ear, upper aerodigestive tract, and related structures of the head, face and neck, including the special senses of hearing, balance, taste and olfaction, as related to disease processes and symptoms encountered in pediatric otolaryngology
- Techniques for eliciting diagnostic information from both children and care-givers and for performing diagnostic and therapeutic procedures on children in age-appropriate ways
- Principles of management of the pediatric airway, including diagnostic endoscopy and therapeutic procedures related to both endoscopic and open approaches
- Clinical characteristics, diagnostic and therapeutic interventions related to congenital and inherited conditions that affect the ear, the upper aerodigestive tract, and related structures of the head, face and neck including the special senses of hearing, balance, taste and olfaction
- Principles of therapeutic and diagnostic imaging and their application within pediatric otolaryngology including interpretation of imaging used in pediatric otolaryngology, as well as techniques for testing children with special needs
- Principles of techniques used in evaluation and treatment of speech, hearing, voice and swallowing disorders, including appropriate techniques based on developmental age
- Principles of techniques used for diagnostic and surgical procedures commonly performed in pediatric otolaryngology
- Appropriate indications for consultation of other health professionals to assist in the management of disease processes and complaints encountered in pediatric otolaryngology
- Demonstrate appropriate clinical judgment in the selection of therapies with knowledge of pre- and post-operative care
By the end of PGY 1 & 2 rotations on Pediatric Otolaryngology, residents should have clinical knowledge in the following domains:

1) General
   a. Fluid management including calculating pediatric requirements
   b. Medication calculations for pediatric patients
   c. Common ENT pathogens, antibiotic resistance and sensitivity
   d. Embryology of head and neck
   e. Anatomy, physiology, pathophysiology and histology of ear, nose and throat

2) Ear
   a. Acute Otitis media
   b. Recurrent otitis media
   c. Management of otorrhea
   d. Chronic otitis media with effusion

3) Nose
   a. Nasal obstruction
   b. Allergic/non-allergic rhinitis
   c. Anterior epistaxis

4) Throat
   a. Acute/recurrent tonsillitis
   b. Sleep disordered breathing/OSA
   c. Peritonsillar abscess

5) Airway
   a. Stridor
   b. Laryngomalacia
   c. Croup

By the end of PGY 1&2 rotations on Pediatric Otolaryngology, residents should have surgical skills in the following domains:

1) General:
   a. Familiarity with microscopes
   b. Familiarity with headlights
   c. Suturing technique
   d. Tissue handling
   e. Set up of airway equipment

2) Ear:
   a. Cerumen removal
   b. Myringotomy and tube placement

3) Nose:
   a. Foreign body removal
   b. Nasal cautery and other procedures for control of epistaxis in pediatric patients

4) Throat:
   a. Tonsillectomy
   b. Adenoidectomy
   c. I&D peritonsillar abscess
By the end of PGY 3&4 rotations on Pediatric Otolaryngology, in addition to prior expectations, residents should have clinical knowledge in the following domains:

1) General:
   a. ENT manifestations in Down Syndrome, Cleft Palate
   b. Appropriate use of imaging

2) Ear:
   a. TM perforation
   b. TM atelectasis
   c. Cholesteatoma
   d. Hearing loss (conductive and sensorineural)
   e. Acute Mastoiditis and complications
   f. Pediatric Vertigo
   g. Pediatric Audiometry

3) Nose:
   a. Nasal Polyps and Cystic Fibrosis
   b. Complications of Sinusitis

4) Throat:
   a. Esophageal foreign body
   b. Esophageal caustic ingestion
   c. Dysphagia

5) Neck:
   a. Branchial cleft cysts, sinuses, fistulae
   b. Thyroglossal duct cyst
   c. Approach to cervical adenopathy
   d. Lymphatic malformations
   e. Plunging ranula
   f. Deep neck space infections

6) Airway:
   a. Hoarseness
   b. Subglottic stenosis
   c. Recurrent Respiratory Papillomatosis (RRP)
   d. Tracheomalacia
   e. Congenital laryngeal webs
   f. Foreign body aspiration
   g. Aspiration
   h. Airway burn
   i. Subglottic hemangioma
By the end of PGY 3&4 Pediatric Otolaryngology rotations, in addition to prior expectations, residents should have surgical knowledge/skills in the following domains:

1) Ear:
   a. Tympanoplasty include fascia graft harvest (3)
   b. Foreign body removal (3)
   c. Mastoidectomy – simple cortical

2) Nose:
   a. Inferior turbinate surgery
   b. Nasal polypectomy
   c. Septoplasty

3) Neck:
   a. Incision and drainage of deep neck space infections in children
   b. Pediatric tracheostomy (4)

4) Airway
   a. Intubation
   b. Flexible endoscopy in infants and children (3)
   c. Diagnostic laryngoscopy and bronchoscopy (4)

By the end of PGY 5 Pediatric Otolaryngology rotations, in addition to prior expectations, residents should have knowledge in the following domains:

1) Ear:
   a. Ossiculoplasty
   b. Tragal cartilage harvest
   c. Cochlear implant surgery
   d. Otoplasty
   e. BAHA surgery

2) Nose:
   a. Septoplasty
   b. Rhinoplasty
   c. FESS and external sinus surgery
   d. Choanal Atresia repair
   e. Pyriform aperture stenosis repair
   f. Dacryocystorhinostomy

3) Throat:
   a. Palatoplasty
   b. Pharyngeal flap
   c. Sphincter pharyngoplasty
   d. Sublingual gland excision
   e. Sialendoscopy

4) Neck:
   a. Excision of thyroglossal duct cyst
   b. Excision of branchial cleft cyst/sinus
   c. Submandibular gland excision
   d. Superficial parotidectomy
   e. Thyroidectomy
   f. Parathyroidectomy
   g. Lymphatic Malformation excision/injection
5) Airway:
   a. Laser laryngeal surgery
   b. Resection of RRP with microdebrider
   c. Bronchoscopy with foreign body removal
   d. Vocal cord medicalization
   e. Pediatric tracheostomy
   f. Laryngotracheoplasty
   g. Airway dilatation
   h. Supraglottoplasty

By the end of PGY 5 rotations in Pediatric Otolaryngology, in addition to prior expectations, residents should have surgical skills in the following domains:

1) Ear:
   a. Mastoidectomy for cholesteatoma (CWD, CWU, facial recess)

2) Neck:
   a. Excision of cervical nodes or other neck masses
   b. Branchial cleft cyst excision
   c. Thyroglossal duct cyst excision

3) Airway:
   a. Suspension microlaryngoscopy and bronchoscopy with intervention

2. Communicator
After completing all rotations in Pediatric Otolaryngology, residents should be able to
   a. Develop rapport, trust and ethical therapeutic relationships with pediatric patients and their care-givers
   b. Accurately elicit and synthesize relevant information and perspectives of pediatric patients and families, colleagues, and other professionals
   c. Convey relevant information and explanations accurately to pediatric patients and their families/care-givers, colleagues and other professionals
   d. Develop a common understanding on issues, problems and plans with pediatric patients, families/care-givers and other professionals to develop a shared plan of care
   e. Convey effective oral and written information about medical encounters, surgical procedures

3. Collaborator
After completing all rotations in Pediatric Otolaryngology, residents should be able to
   a. Participate effectively and appropriately in an interprofessional health care team, including multidisciplinary clinics, conferences and rounds
   b. Work with other health professionals effectively to prevent, negotiate and resolve interprofessional conflict
   c. Recognize the valuable additions that other disciplines, including allied health fields can bring to the overall care of the pediatric patient in order to optimize care for the patient and their families

4. Manager
After completing all rotations in Pediatric Otolaryngology, residents should be able to
   a. Manage their resident training, practice and career effectively
   b. Demonstrate ability to appropriately triage outpatient consultation requests.
c. Demonstrate ability to appropriately triage and manage an inpatient pediatric ENT consultative service.
d. Demonstrate ability to manage a CPD pediatric ENT learning experience. (Children’s Rounds, PedsENT-Radiology Rounds)
e. Participate in Administrative meetings as appropriate and relevant to Pediatric ENT while on service.
f. Recognize scarce or limited resources relevant to pediatric otolaryngology (eg. Cochlear implants) and understand the allocation process for such resources
g. Apply evidence and management processes for cost-appropriate care

5. Health Advocate
After completing all rotations in Pediatric Otolaryngology, residents should be able to
a. Respond to individual pediatric patient health needs and issues as part of their care, including identification of opportunities for advocacy, health promotion and disease prevention, including but not limited to: Smoking cessation and its role in pediatric disease, hearing protection, choking prevention in children, promotion of hearing and language development
b. Identify opportunities for advocacy, health promotion and disease prevention in the communities they serve
c. Identify determinants of health for the populations they serve, including identification of vulnerable or marginalized populations and respond appropriately to their needs

6. Scholar
Throughout their rotations in Pediatric Otolaryngology, residents should be able to
a. Identify clinical problems that require research to ensure the best, evidence-based care can be provided
b. Facilitate the learning of patients, families, students, residents, other health professionals, and the public
c. Demonstrate effective use of Information Technology in researching clinical and academic activities; and in the presentation and participation in CPD activities

7. Professional
Throughout their rotations in Pediatric Otolaryngology, residents should be able to
a. Exhibit appropriate professional behaviors in practice including honesty, integrity, commitment, compassion, respect and altruism
b. Recognize and respond appropriately and professionally to issues that arise in pediatric practice in dealing with parents as proxy decision-makers for their children
5.4.4 ST. BONIFACE ROTATION (RHINOLOGY, GENERAL OTOLARYNGOLOGY)

PGY 1&2

Knowledge:
Basic
• Anatomy/embryology nose, oral/pharyngeal cavities, and larynx
• Physiology of above sites including olfaction, respiratory mucosa, swallowing, phonation
• Pathogenesis of common general ENT problems: rhinitis, sinusitis, epistaxis, otitis, hearing loss, tonsillitis/pharyngitis, dysphasia, hoarseness, salivary gland disorders, sleep apnea, GERD.

Clinical:
• Basic head and neck history and examination
• Otoscopy, tuning forks, indirect laryngoscopy, flexible nasopharyngoscopy and laryngoscopy, rigid nasendoscopy

Technical:
• Basic instrument handling, suturing, tying, hemostasis
• Nasal packing, I&D tonsil/neck abscess, antral puncture
• T&A, T-tubes, endoscopy, elevation of ear/nasal flaps

PGY 3&4

Knowledge:
• In depth knowledge of above
• Laser physics and safety

Clinical:
• Proficient head and neck history and physical & endoscopy
• Concise presentation clinical cases
• Formulation of accurate differential diagnoses and management plans

Technical:
• septoplasty, basic rhinoplasty, basic endoscopic sinus surgery, open sinus surgery, sleep apnea surgery, endoscopic laryngeal surgery, minor neck surgery (eg. Salivary glands, congenital neck masses/cysts), myringoplasty, simple mastoidectomy

PGY 5

Knowledge/Clinical:
• Current literature
• Ability to integrate basic/current knowledge into differential diagnoses and management at consultant level

Technical:
• Middle ear reconstruction, advanced endoscopic sinus surgery, rhinoplasty, thyroplasty, mastoidectomy
• Ability to direct own OR
6) Clinical Activities

Residents’ duty hours are typically from 0700 to 1700 while on clinical rotations. Residents are required to report to the Hospital and/or Service early enough to assess/discharge patients prior to OR. ENT call is home call from 1700 until 0700 the next day. All ENT inpatients/active consults/patients en route to OR must be signed-over between the resident on service and the resident on-call. The staff person must be consulted in a timely fashion regarding the resident’s management plan for patients. The Department office will provide staff contact information.

Residents are responsible for the initial consultation, all admissions and discharges, and daily assessments / notes on otolaryngology in-patients, including discharge summaries. Discharge summaries must be done on the day of discharge with copies sent to the patients’ primary care provider / other relevant care providers to ensure clear and timely communication. A suggested format for discharge summaries is as follows:

- Reason for Admission
- History
- Course in Hospital
- Operative Procedures
- Discharge Diagnosis
- Discharge Plan (including medications and appointments)

Residents are expected to complete operative reports whenever they have done a significant portion of the procedure. Operative reports should be dictated on the day of the procedure and a copy must be sent to the patient’s primary care provider / other relevant care providers. A suggested format for these reports is as follows:

- Clinical Preamble
- Preoperative Diagnosis
- Postoperative Diagnosis (if different)
- Operation Performed
- Operative findings
- Description of Procedure
- Complications
- Estimated Blood Loss / Surgical Counts

6.1 Rotations

(a) Head and Neck Surgery (HSC, SBGH, CCM)

Residents are exposed to Head and Neck Oncology by attending clinics, multidisciplinary Head and Neck Cancer Case Conferences and the operating room with Drs. Kerr, Sutherland and Viallet. Clinics include three multidisciplinary clinics (major head and neck) at CancerCare Manitoba, and three thyroid/parathyroid/general otolaryngology-H&N Surgery clinics per week at the HSC ENT Outpatient Clinic. Clinical areas covered include: major head and neck surgery, reconstruction with local, pedicle, and free flaps, skull base surgery, minor head and neck surgery, laryngology, and endocrine surgery.

All HSC Adult ENT consults are the shared responsibility of the Otology and H&N Surgery Residents.
(b) Otology/Neurotology (HSC)
Residents are exposed to otology and neurotology by attending clinics and the operating room with Drs. Garber, Hochman, and Blakley at the Health Sciences Center and Victoria General Hospital/Maples Surgery Center. Clinical areas covered include: Tympanic membrane and ossicular chain reconstruction, stapedectomy, mastoidectomy, and management of vertigo. Other routine ENT procedures such as septoplasty, FESS, tonsillectomy, and laryngoscopy are also performed.
All HSC Adult ENT consults are the shared responsibility of the Otology and H&N Surgery Residents.

(c) Pediatric Otolaryngology
Residents are exposed to general pediatric otolaryngology by attending pediatric outpatient clinics at the Children's Hospital under the direction of two dedicated Pediatric Otolaryngologists, Drs. Leitao and Jones. The otolaryngology service operates almost daily at the Children's Hospital and the residents are to attend surgery when not in clinic. Clinical areas covered include: tonsillectomy & adenoidectomy, pediatric otology, and management of the otolaryngology aspects of congenital syndromes. Experience in pediatric airway and neck surgeries is provided on this service.
When two residents are on the pediatric service concurrently, OR's should be divided based on the nature of the cases and the level of training of the two residents. Both residents should complete time in the clinics as well as in the operating room. The junior resident should review all pediatric consults with the senior resident prior to discussion with the attending on call.
All Pediatric and Children's Hospital consultations are the responsibility of the Pediatric Otolaryngology resident.

(d) General Otolaryngology/Rhinology (SBGH)
Residents are exposed to general otolaryngology, rhinology and laryngology, under the direction of Drs. Barker, Gall, Osler, and Meen by attending out-patient (ACF Surgery) clinics and surgical cases at SBGH. Clinical areas covered include: rhinology and functional endoscopic sinus surgery, laryngology, general otolaryngology, and minor neck surgery. All SBGH consults are the responsibility of the SBGH resident, and must be reviewed directly with the appropriate Attending Staff following patient assessment.

6.2 Consultations
Emergency consults should be seen expediently and reviewed with the attending staff person. Non-emergency consults should be seen and reviewed with the staff person within 24 hours. It is the staff person's responsibility to review inpatient consults and admissions with the residents. The staff person should make every effort to see the consult with the resident. ER consultations that are discharged with minor problems are an exception. It is the resident's responsibility, with staff person's input, to communicate a clear and concise management plan to the primary service. Junior residents are requested to involve senior residents in the review and care of consult patients and inpatients.
Active consults and inpatients should be reviewed with the responsible staff person daily, or more frequently, as patient status or management requires. Consultations/referrals/transfers from outside institutions or facilities are to be arranged directly by the on-call/attending staff person.

6.3 Call

While on ENT rotations, residents are on home-call between 1:3 - 1:5. Residents cover St. Boniface Hospital, HSC, and Children’s Hospital when on-call. Different attending staff are on-call at different hospitals. Residents are advised to contact paging (HSC and Children’s 787-2071; St. Boniface 237-2053) to determine the attending staff on-call.

Residents should contact the staff person on call for matters relating to any new patients. If a private patient is experiencing difficulties, the resident should contact the patient’s own otolaryngologist. Depending on the circumstances, staff may wish to defer to the staff person on call, and direct staff to staff communication is required. If the patient’s otolaryngologist is unavailable, and a designate for their coverage is not provided/available, the staff person on-call should be contacted. The resident should always feel comfortable asking the staff on-call for advice regarding patient coverage.

It would be unusual for the resident to be unable to contact the on-call attending. If this occurs the residents are to contact the Program Director, Site or Department Head, and failing those, any of the full-time faculty members.

Special Considerations:

- PGY 5 residents are exempt from weekend call for three months prior to the fellowship exam. They will participate in call following the exam.
- Senior residents will provide back up call for PGY 1 residents on-call during their first 2 blocks on ENT.
- Residents on research electives will participate in ENT call

6.4 Moonlighting

The practice of moonlighting is not encouraged. The Department will abide by the Postgraduate Medical Education Office Moonlighting Policy.

If Moonlighting does occur, the Department will ensure/request:

1. There is no conflict with the clinical format or educational goals of the Program.
2. Residents are meeting all CanMEDSs objectives appropriate for their level of training.
3. Moonlighting does not cause increased physical or psychological stress.
4. A schedule of Moonlighting activity is reviewed in advance with the Program Director.

Please go to site below for the entire policy:
http://umanitoba.ca/faculties/medicine/education/pgme/policies.html
6.5 Education and Exam Leave

Up to one week of education leave is permitted each year. This time is allowed for attendance at conferences or courses. Residents are eligible to receive financial support for attending conferences or courses, or presenting at conferences. The financial support is for a maximum of $900 per year for attendance and $1,400 per year for presentation. If not used, educational leave and the associated financial support cannot be transferred to another academic year.

Education leave must be requested in writing 2 months in advance of travel date using the Department Educational Leave Request Form (Appendix A) that is then signed by the Chief Resident and by the Program Director.

If a resident is considering presenting a research project at a meeting, the Faculty Postgrad Medical Education Office, will also, on an approval basis, provide some funding, on a 50/50 cost share with the Department once per year. If approved, the resident will receive a maximum of $2,000 (from the Faculty and the Department) towards the actual related costs of the travel. The resident must apply for financial support from the Faculty of Medicine Postgraduate Office before funding support from the Department will be considered. The Program Director and Program Administrator will request Faculty PGME support once the completed Education Leave Request Form is submitted by the resident. Residents cannot book any travel arrangement until the Request Form is approved in writing. Reimbursement will occur in accordance with the Department Resident Travel Reimbursement Guidelines.

Subject to Departmental approval, residents may present at more than one meeting per year and may request additional financial support from the Department. Such requests will be reviewed on a case by case basis.

Leaves are subject to approval by the Program Director and the granting of education leave may be decided on the basis of manpower.

**Examination Leave:** Each Resident shall be entitled to “leave” for the purpose of any Canadian or American Professional Medical certifying and/or licensing examination. This leave, which shall be subject to approval by the Program Director, shall be without loss of pay and in addition to vacation or other leave.

6.6 Conflict of Interest and Industry Relations Policies

The acceptance of gifts (monetary or otherwise) by residents from industry representatives is prohibited. Such activity could create, or be perceived to create, a relationship between the resident and the company which could influence the use of company products.

Subsidies for resident presentations, and/or academic activity, can be accepted by the Department and then allocated to resident activities in keeping with University policies. For details on both UM and WRHA policies in this regard, please go to:

UM Conflict of Interest Policy: http://umanitoba.ca/admin/governance/governing_documents/community/248.html


6.7 Holidays and Vacation

Vacation will be granted as outlined in the PARIM contract. Each Resident will receive four (4) weeks of vacation with pay to be taken per year. The scheduling of vacation shall be decided normally prior to July 15, but not later than September 15, by consultation between the Resident, Chief Resident and the Program Director. A Resident's vacation shall, at the option of the Resident, be consecutive (one 4-week block), two 2-week periods or, if scheduling will permit, one 2-week period and two 1-week periods. Vacation is not permitted during off-service rotations or The Department of Otolaryngology Resident Research Day. It may not be possible to grant vacation requests that overlap with events such as the Canadian Society of Otolaryngology Annual Meeting and Royal College or other Licensing or Qualifying Examinations. In PGY3, residents will be assigned two full weeks of vacation in the month of July to complete the scheduling of Block 1 along with the time granted to attend the IOWA Anatomy Course. Please refer to Appendix B “Vacation Request Form” for details.

If a Resident does not indicate a preference for a particular vacation period that can be granted, this may result in vacation time being scheduled by the Program Director. Vacation time not taken by June 30 is lost, as vacation time cannot be accumulated and carried over into the next academic year, or paid out.

Five consecutive days off at Christmas or New Year’s (or other time as mutually agreed to by PD) is granted as per the PARIM contract.

Statutory Holidays, or days off with pay in lieu of, will be managed as outlined in the PARIM contract.

6.8 Otolaryngology - Head and Neck Surgery Resident Safety Policy

Purposes of this Policy:
To augment the FPGME Resident Safety Policy (http://umanitoba.ca/faculties/medicine/education/pgme/media/FPGME_Resident_Safety_Policy.pdf), the Department has identified specific provisions to address safety concerns related to educational activities undertaken as part of the Otolaryngology-Head and Neck Surgery residency program.
1) To describe the mechanisms in place at the program level for addressing, reporting, and/or reducing unsafe events and conditions.
2) To establish that residents have the right to use their judgment when deciding if, when, where, and how to engage in clinical and/or educational experiences that they perceive to involve safety risks.

Scope and Responsibility
• The University and all affiliated teaching sites as well as ambulatory, outpatient and private practice locales are accountable for the environmental, occupational, and personal health and safety of their employees.
• Residents must adhere to the relevant health and safety policies and procedures of their current teaching site.
• All teaching sites must meet the requirements of the PARIM collective agreement.
• The Otolaryngology-Head and Neck Surgery residency program is responsible for identifying and communicating foreseeable safety risks related to education carried out within the program, educating residents about risk minimization strategies, and for making decisions about educational experiences that take into account, among other things, the educational benefit relative to any safety risk.

Policy Statement
• The Otolaryngology, Head and Neck Surgery residency program formally acknowledges, endorses and agrees to adhere to the FPGME Resident Safety Policy.
• Reporting of, and response to, all manner of incidents related to Environmental, Occupational Health, and Personal Health and Safety will be addressed as outlined in FPGME Resident Safety Policy.
• The residency program requires residents to engage in the following specific situations that may pose a safety risk:
  ■ work in isolated or poorly protected environments
  ■ exposure to potentially dangerous environments
  ■ exposure to potentially harmful bodily fluids
  ■ exposure to environmental hazards
  ■ encounters with potentially violent or aggressive patients
  ■ exposure to potentially dangerous equipment and/or high risk transportation
  ■ travel to and from hospital while on home call
  ■ travel to and from parking facilities at night while on call
• The program commits to providing residents with a full disclosure of foreseeable risks associated with these activities.
• The program will ensure that residents receive education and preparation for these activities using best available evidence and practices AND assess residents for appropriate understanding PRIOR TO involvement in these activities.
• Residents will not be required to see patients alone in any of the above situations if not appropriately supervised.
• Residents must immediately notify their supervisor, clinical administrator, program or more senior resident of perceived safety concerns
• Residents involved in safety-related events, or who have safety concerns, are encouraged to contact their Residency Program Director, the Associate Dean, PGME or the Associate Dean, Professionalism.
• A resident should not encounter negative repercussions for decisions they made in good faith related to personal safety concerns.
• The Residency Program Committee will review all concerns brought forth and take steps to minimize future risk.
• At times, a resident may be called upon to respond to an acute situation involving a patient who poses a risk to the resident’s personal safety and wellbeing. Residents are expected to consider the effect on themselves and the patient when deciding on a course of action. Every effort should be made to consult more experienced health care providers or staff and seek assistance, support or alternative courses of action. Ultimately, residents should use their best judgment when deciding if, when, where, and how
to engage in clinical and/or educational experiences. Should a resident fail to engage in such an experience (or engage in a manner other than what has been requested or expected of them) due to perceived safety concerns, the resident will report this to their site supervisor immediately AND to the residency program director at the earliest reasonable time.

- Should a resident repeatedly fail to engage in an activity that can be reasonably considered part of their specialty practice, that is a mandated component of the residency training, and for which all means of risk reduction and education have been instituted by the program, the residency program committee will review the circumstances in the context of the CanMeds physician competency framework.

- Disputes of decisions made by the residency program committee will be referred to the Associate Dean, PGME for discussion at the PGME Executive Committee.

- Appeals of decisions will follow the standard Faculty of Medicine appeal process.
7) Academic Activities

Attendance at the following academic activities is mandatory for ENT Residents on the Otolaryngology service.

7.1 Grand Rounds
Grand Rounds are held twice a month, September to June, Wednesdays from 07:30-08:30. Grand Rounds are presented by ENT residents, department staff members or visiting lecturers/professors. All on-service residents are required to attend.

7.2 Audit Rounds
Audit rounds are held twice a month. Interesting cases, along with cases having adverse patient outcomes, prolonged admission, or surgical complications, are presented by the residents for review and discussion. Following discussion at Audit Rounds, cases or issues of concern may be referred to the Standards Committee.

7.3 Teaching Sessions
Academic half-day sessions occur Mondays from 1300 to 1600, September to June. This is “protected time” and residents are dismissed from clinical duty to attend. Attending staff cover calls during these sessions. Residents are responsible for signing out to paging. These sessions consist of didactic presentations by residents and ENT staff; case-based presentations by ENT staff; sessions with staff from related departments and allied health professions. Residents are to return to clinical duties at the completion of the sessions.

PGY1 & 2 residents must attend the Surgical Foundations Seminar Series. The Postgraduate Medical Education Core Curriculum sessions occur throughout the five years of resident training and are mandatory for successful completion of residency training program. This includes the Teaching Development Program and other topics beneficial to all physicians. The Department of Surgery and PGME determine these schedules and track attendance. Protected time from clinical duties is granted for attendance of these sessions.

7.4 Laboratory Curriculum
Dr. Hochman directs three temporal bone sessions per year in conjunction with the Department of Anatomy at HSC. Dr. Viallet directs a plating course and a suturing/soft tissue handling course, which alternate on a two-year schedule. Animal Labs, also under the direction of Dr. Viallet, are scheduled every second year.

7.5 Journal Club
Attending staff host Journal Club on a monthly basis from October through April. All Department Staff are invited and encouraged to attend. Attendance is mandatory for all on-service residents. Off service residents are encouraged to participate. An assigned resident and the hosting staff select 2 articles for review
and discussion. The articles are circulated to all residents and staff one week prior to Journal Club. Senior residents should prepare a 15-minute summary and critique of each article. Junior residents should review pertinent topics to put the articles in context and determine strengths and weaknesses of the article, including study design. Articles do not have to be from the latest journal issues. It is often useful to seek out and review landmark studies to better understand the basis for current standards of care.

7.6 Teaching Development

Physicians are expected to be life-long learners and teachers. Residents come in contact with medical students, nurses and other allied health care professionals and, as part of their responsibilities and development, they are expected to engage in teaching opportunities as they arise. While Otolaryngology Staff have the overall teaching responsibility for Otolaryngology Residents, senior level residents are expected to mentor and teach junior residents. Faculty teaching development courses for both residents and staff are available throughout the year through the Faculty of Medicine Post Graduate Office. All residents must complete the TDP course, which is part of the PGME Core Curriculum.

Residents are required to become familiar with the documents describing The University of Manitoba Undergraduate ENT Objectives (Appendix C).

7.7 External Courses

All residents are required to attend the following mandatory courses. Time-off and financial support is provided. This time is in addition to the Educational Leave described in Article 5.5. Whenever applicable, financial support for expenses from the Faculty of Medicine Postgraduate Office must be requested before support from the ENT Department will be granted.

I. The University of Iowa Anatomy Course (at the start of PGY3)

The Winnipeg Regional Health Authority covers the registration fee. The Department and the Faculty PGME Office share the standard travel expenses, up to a maximum of $1,500.

II. The National Resident Sinus Course (held in Winnipeg once every 3 years and elsewhere the other 2 years)

When this course is held outside of Winnipeg, the resident will be eligible for up to a maximum of $1,200 for travel expenses. There is no registration fee.

III. A Temporal Bone Course in the PGY4 year.

WRHA will cover the registration fee and the resident is eligible for up to a maximum of $1,200 for the usual travel expenses.

IV. Halifax Review Course. Mandatory course status - pending.

WRHA or Department will cover registration cost. Expenses must be submitted to Faculty PGME; up to $1200 for travel expenses.

Residents who are ready to attend these courses must discuss their intent with the Program Director at least 3 months in advance of attending the course. Please complete the Department Education Leave Request form and follow the procedure as outlined in Article 6.5.
7.8 Practice Exams

Scheduled practice oral examinations are held 3 times per year. These exams are for on-service residents, and attendance is mandatory. These exams are provided to give the residents practice in a situation that simulates the Royal College oral exam and are used in resident evaluation. Dr. Jones, along with the Program Director, co-ordinates the practice oral exams.

Written in-house exams covering the various disciplines of Otolaryngology are written three times per year. Dr. Viallet is the written practice exam coordinator, and all Department members contribute to the development of these exams.

The National-in-Training written examination is administered to PGY2-5 residents each year. The University of Manitoba participates in the development of this exam. This exam gives residents exposure to and practice writing a test that simulates the Royal College written exam. Results are used in resident evaluation, and give the residents information of their performance relative to other residents in the country. Yearly participation is mandatory. PGY1 residents are exempt from this exam.

Additional oral exam preparation for PGY5 residents is arranged throughout the last 8 months of their final year. Residents must stay informed about Royal College Examination requirements, registration, dates, and exam formats.

7.9 Research

Residents must present four times at the annual Department Resident Research Day (generally held in May) over the course of their residency, ideally, from PGY 1 – PGY IV. Residents not completing the required research component of the residency program (four presentations) prior to the PGY 5 year will not be excused from presenting in their PGY 5 year. Dr. Blakely is the Department Research Director and is responsible for coordinating all resident research activity. Residents should determine where their research interests lay, then approach and align themselves with an appropriate staff person who will be their mentor. Residents must submit the name of their mentor and an outline of their project to Dr. Blakely by September 30th each year. Dr. Blakely will meet with the residents regarding resident research prior to Sept 30. He will have a list of research proposals that residents can choose from if necessary. Residents are to formally present their research project outline to the Department Research Committee by October 15th in the form of a brief power point presentation outlining research goals and design. Mentors should be actively involved in every aspect of the project including preliminary paper work such as the ethics submission. Cost incurred (e.g. slides, statistician fees), must be approved by the Department Research Committee if they are to be covered by the Department. Funding, to a maximum of $2000/ project, may be approved. Refer to the Department of Otolaryngology-Head and Neck Surgery Research Committee Terms of Reference for details of allowable uses of these funds.

Case reports and non-systematic literature reviews are unacceptable. Prospective projects are generally much more rewarding and useful. They require a lot of preliminary work to get up and running, but are often less work than retrospective chart reviews in the end. Prospective projects require significant lead-time. It is essential to start planning these projects at least one to two years prior to the anticipated presentation date. Therefore, residents who strive
to complete significant prospective studies can apply to the Residency Program Committee to present “a work in progress” as one of their yearly residency day research presentations over the course of their residency program.

Residents are encouraged to present their completed projects to their mentors by mid-April. A Resident Research Evaluation will be conducted and used to assess resident research annually. Successful completion of the research component of the Residency Program Training Program is indicated on the Royal College FITER.

A visiting professor will attend and adjudicate, along with the Department Research Committee, the Resident Research Day. Presentations are to be 10 minutes long and are followed by a five-minute question period. A formal, rehearsed slide presentation is expected. Projects will be graded on scientific merit, originality, and the quality of the presentation. The best project is awarded a $500.00 bookstore certificate. All projects are judged for a pass/fail grade in regards to meeting the research requirements of the Residency Program. Projects of appropriate quality should be submitted for presentation at the Canadian Society of Otolaryngology or similar meeting. Attendance at Resident Research Day is mandatory.

Residents are also encouraged to present at the Faculty of Medicine Research Day held in May. All residents who have projects ready for our Research Day should submit their projects for presentation at the Faculty Research Day. As well, CancerCare Manitoba has a research symposium that residents with appropriate projects should present at.

8) Evaluations

Residents are evaluated at the end of each 4-week rotation (ITER), and at the midpoint of longer rotations (MITER). Face to face meetings with the Service Chief or designate, must occur with each MITER/ITER. Residents are to request their evaluations in the last week of their rotation so that they are completed in a timely fashion and can be reviewed directly with the Service Chief. Evaluations are reviewed with the Program Director 3 times per year, at formally scheduled meetings. Prior to these meetings, residents must complete and submit a Resident Activity Report and Portfolio (Appendix D) and update their surgical electronic log.

Formal evaluation of residents’ clinical and surgical performance must be observed and documented using a STACER, Min-CEX or CanMEDS encounter card. Staff must arrange for and complete these evaluations at the resident’s request. Residents must have one clinical and one surgical encounter formally documented in this way, per 4-week ENT block, or risk the rotation to be deemed incomplete.

If a resident experiences difficulty with staff completing any part of the evaluation process, she/he is asked to bring it to the attention of the Program Director, Resident Representative, Site or Rotation Coordinator, or Department Head.

Staff evaluations must be completed by residents at the end of each academic year. These are done anonymously.

Residents are formally evaluated during their Grand Rounds, Audit Rounds, and Resident Research Day presentations, and receive feedback on their presentations. Residents’ teaching ability is evaluated by medical students following participation in Undergraduate ENT Skills Training Sessions.
The Faculty has established a formal policy entitled “Evaluation, Remediation, Probation, and Dismissal”. Appendix E is the flow diagram summarizing this policy. The full version of the policy is located in the Resident Binder or can be found at http://umanitoba.ca/faculties/medicine/education/pgme/policies.html

9) Administrative Structure

9.1 Residency Program Committee (RPC)

Committee membership consists of the Program Director, ENT Site Heads from the St. Boniface General Hospital and Children’s Hospital, Rotation Representatives from Head and Neck Surgery and Otology/Neurotology, the Research Director, a resident representative who is elected by their peers and the chief resident.

This Committee meets a minimum of 4 times a year and discusses the following:
• Structure, implementation and evaluation of the ENT Residency Program
• Educational activities/formats such as Academic Half-days, Rounds, Journal Club, practice exams and Resident Research Day
• Selection of new residents
• Issues/concerns arising from resident evaluation
• Matters affecting the well-being of residents
• Ongoing review of the Overall Program, Goals and Objectives, Resident Evaluation and matters pertaining to the Residency Program Curriculum
• Other relevant matters

9.2 Chief Administrative Resident

Selection: The Chief Administrative Resident is appointed by the Program Director

Term: 1 year

Remuneration: A stipend as per PARIM contract.

Responsibilities:
• Responsible for coordinating resident activities under the direction of the program director
• Ensuring functionality of the Academic Half-Day Schedule as set by the Program Director
• Setting resident call schedules
• Coordinating requests for resident leave along with the Program Director
• Providing orientation, along with the Program Director, to all otolaryngology residents at the beginning of each academic year with respect to organizational structure of the Program, resident responsibilities, deadlines, and the process of requesting leave.
9.3 Resident Representative on RPC

Term: 1 year
Selection: Elected by the residents

Responsibilities:
- The resident representative acts as a liaison between the residents and the Residency Program Committee (RPC). He/she is a voting member of the RPC. Information/concerns/opinions that the residents wish to convey to the RPC is communicated through the resident rep.
- As a member of the Residency Program Committee, this individual is expected to provide the Committee with the residents' opinions regarding the structure and function of the Program. He/she (and/or fellow residents) is expected to participate in resident selection through CaRMS, or otherwise, and will have a vote during the selection process.

10) Counseling

Residents are encouraged to seek early counseling for any personal or professional problems or concerns that they find difficult to resolve on their own. The Program Director is available for residents to contact outside of regular hours should any resident have significant concerns or distress and wish to involve the Program Director in this way. The Program Director may actively seek another source to provide professional counseling to the resident.

The Faculty of Medicine Counseling Services offers free, confidential counseling by clinical psychologists who offer scheduled and drop-in appointments. They can be reached at (204) 474-8592 or click on the link below www.umanitoba.ca/student/counseling

Free, confidential consultation and treatment for students experiencing emotional stress, is offered by Dr. Prober and Dr. Perlov from the Department of Psychiatry. This service is available to students, their spouses and immediate family. The Department of Psychiatry can be reached at (204) 789-3328 for appointments.

The Physician at Risk Program (PAR) is a peer assistance program funded by Doctors Manitoba. The program offers help to physicians and their families experiencing difficulties in their private and/or professional lives. Individuals having problems with social, marital, financial, behavioral, or chemical dependency issues can access help from PAR resource people on a confidential basis. To speak to a male or female colleague, a message can be left with the 24-hour telephone answering service at (204) 237-8320.
EDUCATION/CONFERENCE LEAVE REQUEST FORM

RESIDENT NAME _______________________________ PGY LEVEL ____________

EDUCATION LEAVE REQUESTED DURING ROTATION WITH: ______________(faculty name)

CONFERENCE:

NAME ____________________________________ LOCATION ____________

AWAY FROM: _________ TO _________ I WILL BE AWAY FROM SERVICE ______________

CHECK ONE OF THE FOLLOWING:

☐ Presenter($1,400 max) Presentation Title ______________________________

☐ Attendee($900 max)

RESIDENT SIGNATURE ___________________ DATE ____________

RECOMMENDATION

CHIEF RESIDENT __________________________ Date ________________

☐ Recommends Approval to Service Chief/ Program Director

☐ Does Not Recommend Approval to Service Chief/Program Director

If not recommended, please give reason: ______________________________

APPROVAL

☐ Approved  ☐ Not Approved

Comments: ________________________________

______________________________

PROGRAM DIRECTOR: __________________________ Date ________________

(Signature)

Date received by Program Coordinator: __________________

Please send a copy of completed form to Resident

Form REVISED: 13 December 2013
VACATION REQUEST FORM

RESIDENT NAME __________________________ PGY Level __________

Requested Days Off from: ____________ to: ________________

Rotation Period_____________ Service Affected _____________

Resident Signature___________ Date _______________________

RECOMMENDATION

CHIEF RESIDENT __________________________ Date ____________

☐ Recommends Approval
☐ Does Not Recommend Approval to Program Director

If not recommended, must give reason:

____________________________________________________________________

____________________________________________________________________

APPROVAL

PROGRAM DIRECTOR: __________________________ Date ____________

(Signature)

☐ Approval ☐ Not Approved

Comments: _______________________________________________________

____________________________________________________________________

Please send copy of completed form to the Resident
Appendix C: ENT Undergraduate objectives and curriculum 2013

Course Objectives

- ET.1 Perform a complete Otolaryngology-Head and Neck history, using a patient centered and culturally appropriate approach
- ET.2 Discuss the components of a complete head and neck examination.
- ET.3 Perform an otoscopic examination and identify all normal structures.
- ET.4 Describe the Pathophysiology, Diagnosis, and Management of common problems related to the ears, nose, paranasal sinuses, oral cavity, pharynx, salivary glands, larynx and neck.

Session Objectives

(Brackets refer to Overarching objectives for ENT course)

- ENT Physical exam
  By the end of the session, the medical student will be able to apply the following to patient care at the level of a clinical clerk:
  - Examination of the ear (ET2,3)
  - Examination of the nasal cavity (ET2)
  - Examination of the oral cavity and pharynx (ET2)
  - Examination of the neck (ET2)

- ET 009 General ENT I
  By the end of the session, the medical student will be able to apply the following to patient care at the level of a clinical clerk:
  - Etiology, presentation, and management of pharyngitis, acute tonsillitis and peritonsillar abscess (ET4)
  - Indications for tonsillectomy and adenoidectomy (ET4)
  - Risks of tonsillectomy and adenoidectomy (ET4)
  - Presentation and management of deep neck space infections (ET4)

- ET 010 General ENT II
  By the end of the session, the medical student will be able to apply the following to patient care at the level of a clinical clerk:
  - The anatomy of the larynx and trachea (ET5)
  - Indications for tracheostomy (ET4)
  - Risks of tracheostomy (ET4)
  - Causes of sleep apnea in children (ET4)
  - Airway problems in children (ET4)
ET 011  Ear I
By the end of the session, the medical student will be able to apply the following to patient care at the level of a clinical clerk:
- Appreciate hearing loss in society (ET4)
- Be familiar with the etiology of ear disease (ET4)
- Describe common abnormalities of the tympanic membrane and middle ear (ET4)
- Differentiate conductive & sensorineural hearing loss (ET4)
- List the most common causes and treatments for hearing loss (ET4)
- Interpret audiograms (ET4)

ET 012  Ear II
By the end of the session, the medical student will be able to apply the following to patient care at the level of a clinical clerk:
- Identifying common causes of “Dizziness” (ET4)
- General assessment of Tinnitus (ET4)

ET 013  Nose
By the end of the session, the medical student will be able to apply the following to patient care at the level of a clinical clerk:
- Treatment of epistaxis (ET4)
- Nasal fractures (ET4)
- Management of acute and chronic rhinosinusitis (ET4)

ET 014  Head and Neck I
By the end of the session, the medical student will be able to apply the following to the care of Head and Neck cancer patients at the level of a clinical clerk:
- Most common histology (ET4)
- 2 most common sites (ET4)
- 2 most common etiologic agents (ET4)
- Basic epidemiology (ET4)
- Common presenting symptoms (ET4)
- Basic diagnostic workup (ET4)

ET 015  Head and Neck II
By the end of the session, the medical student will be able to apply the following to patient care at the level of a clinical clerk:
- Give a differential diagnosis of a neck mass (ET4)
- Describe the appropriate clinical work-up of a neck mass (ET4)
- Features of a malignant neck mass (ET4)

ET 016  ENT Tutorial
By the end of the session, the medical student will be able to manage common ENT clinical presentations at the level of a clinical clerk: (ET1,2,4)

ET 017  ENT Review
By the end of the session, the medical student will be able to apply common and critical topics in ENT to patient care as a clerk and in preparation for the examination (ET1,2,3,4,5,6)
### ENT Curriculum - Undergraduate Medical EducationCuRE

**OUMEC (Otolaryngology Undergraduate Medical Education Committee)**

- Meeting committee: Course Director, ENT Reps, Anatomy, Medical Student ENT reps (8)
- Advisory committee (by email): Pediatrics, Neurology, Respiratory, Diagnostic Imaging, Genetics, Psychology, Pathology, Infectious Disease, Radiology, Indigenous Health, Psychology, Clinical Skills

#### Instructional Sessions

<table>
<thead>
<tr>
<th>Med 1</th>
<th>Intro Lecture</th>
<th>Anatomy &amp; Embryology</th>
<th>Self-Directed Learning</th>
<th>Tutorial 2 hours – T7</th>
<th>Group Presentations and Review Lecture</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 hour – L1</td>
<td>Pt videos</td>
<td>9 hours</td>
<td></td>
<td>2 hours – L1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Goals and expectations</td>
<td>8 hrs: 8 Online lectures with self-quizzes, case modules, team-learning core topics and questions</td>
<td>Case studies</td>
<td>1 hr: Groups presents core topic (5 min each)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Core Topics Group Project (Dropbox)</td>
<td></td>
<td>1 hr: active real-time review questions (iClickers or online)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 hr – 16 groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>8 groups hand-in a 5 min presentation and 1 page summary on a student-chosen core topic</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>8 groups: each hands-in 2 multiple choice questions on student-chosen core topics</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Deliverables: the class creates their own course notes and practice questions on core topics</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Med 2</th>
<th>ENT Clinical Skills I (Basic Physical Exam)</th>
<th>TTT/ Med 3</th>
<th>ENT Clinical Skills II (Procedural Skills)</th>
<th>“ENT in Clerkship” session</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4 sessions (each session: 2hs, ¼ of class, 4 instructors)</td>
<td>ENT Clinical Skills II (Procedural Skills)</td>
<td>4 sessions (each session: 2hs, ¼ of class, 4 instructors)</td>
<td>“ENT in Clerkship” session</td>
</tr>
<tr>
<td></td>
<td>[Total 8hs of session time]</td>
<td>[Total 8hs of session time]</td>
<td>[Total 8hs of session time]</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physical examination of Ear, Nose, Throat, Neck</td>
<td>ENT Clinical Skills II (Procedural Skills)</td>
<td>ENT Clinical Skills II (Procedural Skills)</td>
<td>Online discussion board for student-anchored topics in ENT</td>
</tr>
<tr>
<td></td>
<td>Simulation, bronchoscopy simulator, OtoSim, mannequins</td>
<td>ENT Clinical Skills II (Procedural Skills)</td>
<td>ENT Clinical Skills II (Procedural Skills)</td>
<td>ENT case review from clerkship with active real-time polling</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(iClickers or online)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Med 4</th>
<th>ENT Elective (option)</th>
<th>Exam-Prep Lecture</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2 weeks</td>
<td>1-2 hours – L1</td>
<td>Active real-time review questions (iClickers or online polling)</td>
</tr>
</tbody>
</table>

#### Evaluation

<table>
<thead>
<tr>
<th>Med 1</th>
<th>Online Quiz (1%)</th>
<th>Tutorial (1%)</th>
<th>Group Project (1%)</th>
<th>End-of-Block exam (2%)</th>
<th>Anatomy Bell-ringer (1%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(24 questions)</td>
<td>Mark for attendance or Hand-in</td>
<td>Mark for handing in assignment</td>
<td>(12 Questions) 6 questions based on Class Core-Topics Presentations</td>
<td>(6 Questions)</td>
</tr>
<tr>
<td></td>
<td>Based on Online lecture and case modules. Randomized.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Med 2-4</th>
<th>ENT Clinical Skills I (Basic Physical Exam), ENT Clinical Skills II (Procedural Skills), Exam-Prep Lecture</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Formative assessment – Skills Checklists, real-time polling, end-of-elective quiz</td>
<td></td>
</tr>
</tbody>
</table>
Appendix D: Resident Activity Report and Portfolio

Please type and send by e-mail to Yvonne Groshak (YGroshak@exchange.hsc.mb.ca) and Dr. Donna Sutherland (dsutherland@exchange.hsc.mb.ca) before your semi-annual meeting with Dr. Sutherland. If there is nothing to fill in for a particular category, please put “Nothing to report” or “Not applicable”.

NAME:       PGY LEVEL:

DATE SUBMITTED:

A. ROTATIONS FOR CURRENT ACADEMIC YEAR

<table>
<thead>
<tr>
<th>Dates</th>
<th>Rotation</th>
<th>Other Residents on Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. VACATION TIME TAKEN/PLANNED (Please put dates):

C. CONFERENCES ATTENDED (Please put names of conferences and dates attended):

D. TEACHING (Didactic/clinical; time commitment):
   i) Undergraduate
   ii) Postgraduate (Other Residents)

E. RESEARCH COMPLETED (e.g. title, clinical/basic, prospective/retrospective, supervisor(s), time commitment):

F. SCHOLARLY WORK IN PROGRESS (Indicate title and anticipated date of completion; include manuscripts in preparation, submitted for publication, accepted but not yet published):

G. PUBLICATIONS (author(s); title; journal; volume number; issue number; page numbers; year of publication. Please identify with an asterisk the primary supervisor(s)):

H. CONTRIBUTIONS TO CONFERENCES (abstracts submitted, papers/posters/videos presented). If a multi-authored paper is presented, list the name(s) of all authors and underline the presenter. (Title of paper; name of conference/meeting; location of meeting; month and year. Please identify with an asterisk the primary supervisor(s)):

I. GRAND ROUNDS PRESENTATIONS (List date(s), title, and faculty mentor(s)):

J. HOSPITAL ROUNDS GIVEN (List date(s) and title):

K. RESEARCH GRANTS (New and continuing, project title, agency, duration, amount, co-investigators on application):
L. **EXAMS TAKEN** (List exam name - e.g. Dept Oral/Written Exams, National In-Training, date taken and mark):

M. **TEACHING EVALUATIONS** (Please list or attach any teaching evaluations not already submitted)

N. **UNIVERSITY/PROGRAM SERVICE** (e.g. official administrative positions, memberships on committees):

P. **PROFESSIONAL ACTIVITIES** (e.g. journal reviewer, membership on grant selection committees):

Q. **PROFESSIONAL SOCIETIES** (Please list the professional societies you belong to):

R. **SCHOOL AND PUBLIC LIAISON ACTIVITIES** (Community activities that have some relation to the University such as Anatomy lab assist, public lectures, science fair judge, popular articles):

S. **HONOURS/AWARDS** (Please list):

T. **HEALTH ADVOCACY ROLES** (e.g. roles taken in smoking and/or alcohol cessation, hearing preservation, screening for cancer/hearing loss, counseling, ensuring follow-up):

U. **MANAGER ROLES** (e.g. how have you helped manage rotations, medical students, rounds, journal club, social events, how has you helped manage resident allocation to ORs/clinics, how have you managed beds on the ward, consults etc.):

V. **COLLABORATOR ROLES** (e.g. give examples of how you participated in interprofessional healthcare teams – H/N rounds, consulting with other teams, working with nurses, social workers, audiologists etc., Can you give any examples of how you dealt with conflict in team dynamics? Can you give any examples of how you addressed gender, cultural, socio-economic or power differences within one or more of these groups?)

W. **OTHER** (Please list any other activity you would like to highlight not covered above):
Occurrence of an event requiring intervention
• One unsatisfactory rotation evaluation OR
• Two borderline rotation evaluations OR
• A pattern of consistent weakness at a summary evaluation OR
• A failing grade on a program examination OR
• A single occurrence of a serious nature

Remediation
PROGRAM DIRECTOR
• appoints supervisor
• writes remediation agreement
• reviews agreement with resident

PD submits Remediation Agreement to PGME Associate Dean (copy to resident)

Remediation as per Agreement

Supervisor submits Remediation Evaluation to PD (copy to resident)

UNSATISFACTORY OR BORDERLINE
PASS

PD submits (after consultation with the RPC) written request to PGME Associate Dean

1-5 days

Probation or Dismissal
PGME Associate Dean - appoints probation committee

PD submits
• Initial request
• Probation agreement to Committee Chair

Probation or Dismissal
PROBATION COMMITTEE CHAIR meets with Resident and PD, reviews files, etc. to adjudicate request and will recommend one of three options

DISMISSAL
FPGME Executive Committee
Reviews the recommendation for dismissal

Supervisor submits Probation Evaluation to Chair of Probation Committee (copy to resident)

PROBATION COMMITTEE
Determines appropriate outcome

Extended probation
PASS
Dismissal

Probation as per Agreement

1-5 days

Supervision submits Remediation Evaluation to PD (copy to resident)

1-10 days

Return to training

Return to training

Discontinuation of training

Appendix E: PG Policy: Evaluation, Remediation, Probation, and Dismissal flow chart