OMS RESIDENCY MANUAL
St. Joseph's University Medical Center
2023-4

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The following document contains the rules, regulations and requirements for oral and maxillofacial surgery residents at St. Joseph's and other affiliated institutions. Please refer to the Curriculum, Goals and Objectives for a comprehensive program description and to associated documents including: Rights and Responsibilities, Disputes and Grievances, Admissions Policy and Chief Resident Job Description.

GENERAL STATEMENT

Patients place their trust in us when they seek care in our clinics and hospitals. Providing surgical care is one of the highest honors and greatest responsibilities imaginable. Performing surgical procedures, especially within the head and neck, can have significant physical, psychological and social impact upon a patient. The patient's face, its features and function, is at the core of his/her identity. Therefore, please view it and respect it as the ultimate honor to be invited to perform surgery for our patients.

All patients treated within the hospital and clinics are patients of the attending physicians. Residents are providing treatment under the supervision of the faculty and are not allowed to determine or waive fees, contradict an attending physician's orders or provide treatment without the knowledge of an attending physician. Patients do not "belong to" a particular resident because of the call schedule or effort expended. We are a team and will always function that way.

PRIMARY GOALS OF THE PROGRAM (see attachment 1)

The primary goals of the program involve: 1) resident education, 2) patient care, 3) preparation of residents for a career in OMS, 4) scholarly activity and 5) preparation for the American Board of Oral and Maxillofacial Surgery qualifying and certifying examinations.

***Residents are responsible for their own oral and maxillofacial surgery and medical education*. The role of the faculty is to provide guidance for the residents on rounds, in clinic, in educational conferences and in the OR.**

Each resident is responsible for providing the best possible clinical care for patients seeking treatment in our department. Since resident education in the Oral and Maxillofacial Surgery program occurs primarily on a case-specific basis, each patient contact should be viewed as a teaching and a learning opportunity. Key elements in resident education include acquiring a medical history, performing a diagnostic work-up and formulating a treatment plan. To a certain extent, understanding the rationale for the procedure is educationally more important than performing the actual procedure. The patient care experience is a departure point rather than an end-point in resident education.

All residents are required to participate fully in all program activities. OMS residents will be required to spend a great deal of time reading, researching, and preparing to provide treatment and must demonstrate serious commitment. Much of this will be after normal clinic hours. It is the resident's responsibility to become knowledgeable about a subject when confronted with an unfamiliar disease, medication, procedure or operation. The resident must also know potential complications and their treatments.

The resident's education should prepare him/her for the day-to-day practice of oral and maxillofacial surgery. However, it should also enable the resident to treat many conditions or procedures that they will not have seen or treated during their residency. The resident should be able to critically analyze the patient's problem, develop a logical treatment plan, identify the potential risks and complications and determine if they have the basic surgical skills, knowledge, personnel, facility and equipment to treat the patient properly. All clinicians should also understand their limitations and that they may not be equipped or trained to treat every patient or problem. Knowing when appropriate referral is necessary is also a major part of every clinician's education.

The program meets or exceeds all CODA Standards and is designed to prepare its graduates for the American Board of Oral and Maxillofacial Surgery (ABOMS) qualifying and certifying examinations (written and oral). It is expected that all residents completing the program will sit for and successfully complete this important process.

PATIENT CARE

ADMISSION PROCEDURES

Admissions may be scheduled or unscheduled, inpatient or outpatient. For planned admissions and operations, the resident will be required to complete the appropriate information so that preauthorization for admission and surgery can be obtained from the insurance company (when applicable). Many patients may have HMO or PPO insurance and it is important that the attending is either a participating member or has the appropriate out-of-network referral authorization from the patient's primary care provider.

A letter of medical necessity is rarely adequate for complex cases, particularly orthognathic surgery. The resident should discuss with the attending or the business office what additional materials (models, radiographs/scans, photographs, additional tests, etc.) will be required by the insurer to obtain or expedite approval. This information must be submitted with a letter of necessity if indicated. Insurance companies are slow in responding and may lose or misplace diagnostic information. Letters and other materials should be sent by registered mail to document that the insurance company received the materials and who signed for them. Never send original material to the insurance companies. Do not wait until the last minute!

The resident will need to provide the appropriate ICD-10 and CPT codes. These will also be used in logging the cases after they are done so that accurate records are maintained for resident benefit and for programmatic purposes.

Prior to each inpatient or Same Day admission at St. Joseph's, the following must be completed:

1. **Patient evaluation and treatment plan reviewed with attending**
2. **H&P**
3. **Insurance or financial arrangements completed**
4. **Scheduled OR time properly noted on OMS service and attending schedules, including SoftDent for Ephros cases.**
5. **Anesthesia pre-op appointment, if indicated**
6. **Laboratory testing and pre-op diagnostic or therapeutic procedures (if necessary)**
7. **CXR and other radiographs (if necessary)**
8. **EKG and other cardiac tests (if necessary)**
9. **Consults with other appropriate services if indicated**
10. **Collaborative medical optimization when indicated.**

All procedures generated from the clinic must be reviewed by a senior/chief resident and the attending who will be covering the case before being booked to go to the OR or Same Day. It is expected that a complete and coherent discussion of the case can take place at morning rounds on the day of the procedure and that images and other relevant materials will be available and that the chiefs will be familiar with the case. If, for any reason, the H&P, consent and any other needed documents are not in place in advance of the surgical date, the resident assigned to the case must arrive at 6:30 AM in order to complete paperwork prior to rounds. If, and only if, patient care obligations such as the ED make that impossible, the resident may leave rounds early to ensure that we do not cause the delay of a 7:30 start time.

ACCEPTANCE OF PATIENTS FROM OUTSIDE FACILITIES OR PRACTITIONERS

In the event that a transfer request is made by another hospital, the Transfer Center (973) 754-5715 will be contacted by sending facility. If a sending hospital contacts pager 0132 directly, they must be instructed to call the Transfer Center. The Transfer center will connect the 2nd call resident to the requesting MD to determine the need for transfer or outpatient follow-up and the conversation will be recorded. If a transfer is indicated: The Transfer Center Nurse will request that patient imaging/additional studies be sent, instruct the nurse or MD from the sending institution nurse to call the SJRMC ED charge nurse at (973) 754-2222 or another designated unit. The Transfer Center will arrange transportation to SJRMC ED or designated area via ambulance. When the patient arrives, pager 0132 will be called and the on-call resident will evaluate. OMS 2nd call will then be called for evaluation if indicated. If the patient does not necessarily require admission, he/she can be evaluated and discharged if appropriate. If admission indicated, the 2nd call resident will contact the OMS attending (or notify him/her in AM if that is attending's preference). Additional medical evaluation or studies (labs, X-rays, tox screens, etc) can be ordered or performed by the ED attending. However, the results of any such testing are ultimately the responsibility of OMS and there must be appropriate follow-up. Mountainside Hospital and SJRMC have a contract relating to maxillofacial trauma and related emergency care. Mountainside GPRs will contact 2nd call OMS resident at SJRMC for phone triage. If transfer indicated, the Mountainside ED attending must follow regular Transfer Center protocol.

ROUNDS

Patient care rounds will be held at 7 AM daily. All residents on service are expected to be on time and attend unless they are involved in on-going patient care. Residents are required to have examined the patient, entered daily progress notes and orders on each patient prior to formal rounds and *prior to morning conferences*. A formal presentation will be made at the request of any faculty on rounds. *All residents on service must be prepared to discuss or present all patients*. All residents must know the status of any patient's treatment, laboratory, radiology, pathology or consultation results. All available radiographic studies will be reviewed as part of rounds. Daily progress will be reviewed with the faculty. Rounds are a teaching opportunity. Residents should be prepared to answer questions regarding any aspect of the patient's care or disease.

LABORATORY, RADIOGRAPHS, PATHOLOGY REPORTS

Residents should review all laboratory, radiology and pathology reports as soon as they are available. Urgent results must be viewed as soon as available and residents should review radiographs personally and, when indicated, should ask the radiologist to review the images with them. Do not hold laboratory or radiology results until rounds. If urgent values or findings are present, quick action may be necessary to avert a problem. Report the results to the attending or chief resident for review and action. All test ordering and result documentation is done through the EMR.

CONSULTS

Requests from other services for consults will be answered within the same day or within 24 hours of notification. The attending on-call or consulted must be informed and may see and evaluate the patient personally, if indicated. The attending will verify and sign the consultation in the EMR. Consults requested by our service may be expedited by a courteous telephone call to the individual on-call for the other service. A brief explanation of what is needed should be made to that person. Be very specific about the purpose of the consultation.

DO NOT request "clearance" or ask for permission from physicians regarding the treatment to be rendered by our service. Consults are indicated to:

1. **gain additional information that may affect treatment;**
2. **provide a primary care or other physician the courtesy of knowing what it is that the OMS service plan to do and offer the opportunity to provide us with input regarding that patient;**
3. **collaborate in the medical optimization of a patient who requires treatment by the OMS service.**

ON CALL RESPONSIBILITIES AND SCHEDULING

All consultation requests from the Emergency Department and the Pediatric ED generate an immediate, polite, appropriate and professional response.

The chief resident or his/her designee is responsible for determining and providing the Program Director with the resident's call schedule. This will include first and second call for OMS. The Program Director will arrange faculty coverage. (see attachment 2)

All residents involved in providing care for patients in the ED will be under the charge of the on call OMS attending, the OMS Program Director and/or, the ED attending. OMS residents assigned to other services for which they take call are not to be given any call responsibilities for the OMS service. The Commission on Dental Accreditation states the following in OMS program standards: "When assigned to another service, the oral and maxillofacial surgery student/resident must devote full-time to the service and participate fully in all the teaching activities of the service, including regular on-call responsibilities." Additional language in the Standards makes it quite clear that the intent of the Commission is to have off-service residents devoted fully to their rotations and they are NOT to be required to perform on-service responsibilities.

When third year OMS residents are on second call, one of the fourth year residents will provide back-up. Third year residents can call their seniors with any significant questions and report on admissions. By morning rounds, the chiefs and senior residents assigned to the OMS service must be aware of, engaged with and responsible for all new and continuing inpatients and events/activities that may require follow-up. Patients seen in the ED (or clinic) who may require surgery and have been reappointed for evaluation must be mentioned on rounds *and* discussed with the on-call attending who is responsible for their care.

Dental extractions are not done off hours for the following reasons: 1. Complexities or surgical complications are best avoided by doing definitive procedures during working hours with a clinic staff; 2. Resident and patient safety is compromised by bringing a patient to the clinic where interactions take place remote from witnesses and out of the view of the security staff; 3. If we were to offer that service, we would be even more overwhelmed than we are now; 4. Attempting to do extractions off hours without staff or direct supervision violates departmental policy and long-established protocol.

Major OR cases done after-hours and on weekends should be attended by a fourth year resident (only one fourth year resident would be preferable). When a third year is on second call, the chief providing back-up as described above is expected to attend. This is done not to "take away a case" from the third year but to promote mentorship by the chief residents, to foster a sense of teamwork and to enhance the teaching and communication skills of the fourth year residents with guidance from their attendings.

At the same time, key elements of training in the third year include exercising clinical judgment and gaining confidence in independent decision-making. As such, constant oversight or micromanagement by chief residents, especially in straightforward and frequently encountered situations, is not desirable.

CHAIN OF COMMAND

First call residents are expected to function within the scope of their competency, an evolving process over the course of the intern year, first year of residency and beyond. While mutual respect is more highly valued than pure hierarchy in this program, the chain of command must nonetheless be understood and followed. If told by a senior to do something that a more junior resident feels may not be in the best interests of the patient, an attempt must be made to resolve that prior to treatment. If unsuccessful, the on call attending must be notified and program leadership involvement might be necessary. If the disagreement is not one that will affect patient outcome, the junior resident must follow the instructions from a more senior resident and then the issue can be discussed collegially during work hours as necessary.

BLS/ACLS/ATLS

All residents must obtain BLS and ACLS certification when enrolled into the program and maintain that certification without interruption. Residents are responsible for providing documentation of continuous certification (along with other permits, licenses and documents) to the program coordinator. ATLS will be provided prior to the general surgery rotation and successful completion is a program requirement. PALS is offered year round every year and successful completion is a program requirement.

TELEPHONE CALLS FROM PATIENTS

At the end of each day (at the latest), residents will return phone messages from patients of record. If a specific patient of record calls and the treating resident is on service and available, he/she should return that telephone call promptly.

EMR/CHARTS

Patient notes should be entered contemporaneously, however, if that is not possible, write-ups may be deferred until the end of a session, or if necessary, the end of the day, however, it is critical that note entry into the EMR is timely. No one may leave the building for the day until notes from that day are entered into the EMR. Notes for surgical visits and post-ops done by Dr. Ephros, Dr. Szumita or Dr. Bolding in the clinic will be entered by the resident who was in the room with the attending for that encounter. If the resident is uncertain about how to document the visit, they must communicate with the attending prior to entering the note.

BIOPSIES

Biopsy reports should be reviewed by each resident. The resident performing the biopsy should inform the patient in the clinic at the scheduled follow-up appointment. A cancer diagnosis or other significant issue must be discussed with the appropriate attending prior to seeing the patient and discussing further treatment recommendations and the appropriate routing of the patient must be ensured. Routine, benign results should be handled appropriately by the treating resident with appropriate oversight. Any discordance between a clinical suspicion and the biopsy result must be discussed with the attending.

SURGICAL LOG

All OR cases must be entered in the OMSNIC Surgical Log. Appropriate codes must be entered as well. Each resident and intern will receive an ID and password to access the website and record data in their log. The log is used when applying for clinical privileges at hospitals and when applying to ABOMS. The Program Director has access to the residents' logs and relies on the accuracy of this data for annual reports to the ADA and for site visits that take place every five years.

<u>PERSONAL LOGS</u>

These are distributed to each resident and it is critical that each resident records all significant activities on every service. These include outpatient oral surgery procedures of all kinds, delivery of anesthesia in the OR on rotation or on service in the clinic, all inpatient and Same Day or experiences, all off-service procedures in any venue and all significant treatments performed in the ED/Pediatric ED. If any of this is kept electronically, hard copies must be provided to the program coordinator at the end of each quarter.

<u>ANESTHESIA LOG</u>

In view of the current method used by CODA to assess anesthesia volume, it is incumbent upon all residents to log *all* of their anesthesia encounters and to use the clinic anesthesia log (purple book) for all cases done in the OMS facility.

<u>RECORDS</u>

1. Daily Progress Notes and Physician Orders

All progress notes and orders are entered into the EMR contemporaneously or no later than end of day. Any remaining handwritten documents must be completed legibly. Verbal orders may only be given for *emergency* situations where a resident is not available to respond in person. Verbal orders must be signed within 24 hours. Failure to sign verbal orders can lead to suspension of hospital privileges for the resident and/or faculty by the hospital.

2. Medical Records

All institutional requirements relative to timely record keeping apply to OMS residents as they do to faculty members. Post-op notes and orders must be completed immediately. All required elements of training for use of the EMR at each training site must be successfully completed.

3. Operative Reports

Hospital Bylaws require completion of the operative note within 24 hours. In order to enable good transitions and to ensure that the procedure is as fresh in our minds as possible, the recommended time for entering an operative report is right after surgery at the time the immediate post-op note is done. The attending on the case must have the report in their workflow as quickly as possible so that it make sure this happens consistently, the resident should text the attending and inform them that the note is done and forwarded for review and signature. For night cases entered into the EMR late, a text the next morning is preferable.

4. Operative Record

At the conclusion of the operation, the patient's pre-operative diagnosis, post-operative diagnosis and a precise and detailed description of the procedure performed must be recorded. This information must be complete and accurate and the ICD-10 and CPT codes generated must match the pre-operative codes. If the diagnosis or procedures changed, this must be reported to the OR nurse and to the OMS billing department. Please have these codes readily available for use by in-house faculty members who submit routing slips.

5. Discharge Summaries

Patients who stay in the hospital longer than 23 hours must have a discharge summary completed.

6. Consultations

In-house consultations are to be seen on the day the consult is received. An available resident, or the resident on-call is expected to review the record, determine what services are required and review the recommended treatment with the faculty on-call if indicated. The resident may schedule the patient to come to the clinic after discussion with the faculty and establishing a time that is least likely to disrupt scheduled patient flow. A formal reply must be completed and entered into the record within 24 hours of the consultation request.

7. Confidentiality of Medical/Dental Information

All information regarding a patient's care is confidential. Any discussion or distribution of a patient's information except to those involved in the patient's care (physicians, dentists, nurses, administrators, social workers, etc.) is strictly forbidden. Unauthorized release of confidential patient information may subject the hospital and you to legal action. Information may be released only if the patient or legal guardian signs a Release of Information form. A copy is not acceptable. All inpatient record requests must be forwarded to the Medical Records in the hospital or to the clinic receptionist. Do not take it upon yourself to copy and transfer records. HIPAA regulations and penalties apply.

8. Correction of Handwritten Records

Whenever information recorded in the chart or medical record is found to be incorrect or require additional clarification, an addendum to the record must be entered indicating the correction or clarification. For any remaining handwritten documents, the addendum must be dated and sequenced in the chart as a normal course of the patient's care. The resident should not remove previously written notes nor cross out previous entries. Correction at the time the original note is written should be handled as follows:
1. strikethrough the incorrect portion with a single line, 2. date, time and initial the strikethrough and 3. add the correct information as a regular part of the note.

9. Consent

No treatment is rendered without informed consent. The consent form must be *dated, timed and signed* and the documentation must reflect the patient's clear understanding of the risks and benefits of the proposed treatment and note that the patient was offered other alternatives including no treatment. The chart must reflect that questions were answered and that the patient understood and accepted the proposed treatment and anesthesia plan. A parallel process is followed for post-operative pain management.

CLINIC

CLINIC ATTIRE

Residents should wear surgical scrubs when providing patient care in the clinic. All residents are expected to comply with OSHA guidelines regarding personal safety and infection control. Cover gowns, hats and scrubs are provided and should be changed when visibly soiled. Masks and glasses must be worn when providing care. Gloves must be worn when treating all patients when contact with bodily fluids is expected. Hands are to be washed with soap or acceptable sanitizers between patients.
Lab coats must be clean and should be laundered frequently. If street clothes are worn in the clinic, a cover gown should be worn to protect you from splatter. Jewelry should be removed prior to treating patients. Fingernails must be trimmed and clean. No one should enter the OR unless appropriately attired in scrubs. Hats and masks are available and must be used. Scrubs are not acceptable attire when traveling from unit to unit in the hospital and must be covered by a white coat when you leave a treatment area. SJUMC issued scrubs are never to be worn outside the hospital.

CLINIC SCHEDULING
Scheduling is a cooperative effort among on-service residents, the receptionist and clinic supervisor, clinic attendings and the program director. No unilateral decisions are made by residents involving changes in clinic scheduling. "Squeeze-ins" are strongly discouraged, but when absolutely necessary, the patient must appear on the schedule. *Do not* tell a patient to come in without that appointment being reflected on the schedule.

FINANCIAL
Many patients have some insurance and pre-authorization is required for most elective procedures. Some clinic patients are NJ Charity Care and are eligible for the same care as would be provided to those with Medicaid. There are no restrictions on core OMS care under this program, however excluded services such as implants require patient acceptance of the clinic fee and advance payment. All unused fixtures must be returned to the clinic supervisor immediately. Patients must understand that implant restoration generates an additional fee and they must agree to this as well prior to initiating care. Implant treatment forms require sign-off by a surgical attending, a restorative attending and the patient. Dr. Ephros is the default attending on all implant cases not being done under the direct supervision of another member of the faculty.

REFERRALS / PATIENT SATISFACTION
Patients are entitled to our best efforts whether or not they have "earned' it by being nice, or "deserve" it because they do their part to care for themselves. We have to do our job whether or not our patients treat us with deference and respect, appreciate the quality of our care, or take our advice and follow our instructions. We are bound by professional ethics, but patients are not held to the same high standards. Referrals are a courtesy – the absence of a formal referral for a patient with urgent needs is never a reason to deny treatment. It is always good to have an understanding between an established GP and a specialist if the patient is to have something done by the specialist. However, when a patient is in pain or treatment is necessary for other reasons, the absence of a referral should prompt a phone call and should not be an excuse to defer or withhold needed care. Please note – emailed or paper referrals are absolutely required for the elective removal of healthy teeth for orthodontic purposes and other elective strategic extractions. If there is any uncertainty about the plan, the referring GP or orthodontist must be contacted and a progress note must be written reflecting the conversation and confirming the plan with absolute clarity.

DOCUMENTATION
Every encounter must be logged on the routing form so that you can be credited for your work and the clinic can bill for the procedures done. Failure to do this every time a patient is seen may result in underestimating your productivity and the may jeopardize program accreditation as well as the financial viability of the clinic and the department.

EDUCATIONAL PROGRAM

Goals, objectives, rotation and didactic schedules are distributed as needed and revised periodically with input from residents. Such input is critical to the continuous improvement of the program.
(see Curriculum, Goals and Objectives, Rotation Schedule, Didactic Schedule)

ROTATIONS
Residents are expected to adhere to the weekly rotation grid and prepare for transitions by contacting their counterparts on other services prior to the first day of rotation. As required by CODA, core rotations are full immersion experiences and unless there are scheduled exceptions, rotating residents belong to the service to which they are assigned.

Basic principles include:

1. **Be a good ambassador of your program and your department**
2. **Prioritize activities associated with the rotation for full immersion**
3. **Maintain your connection with your home program/department during working hours when your rotation is not active**
4. **As a resident, you are expected to work a full day, every day (sometimes more) regardless of the hours required by your assigned rotation**
5. **Resident work rules and limits on weekly averaged hours are respected**

Specific rotation issues include:

1. **You are not expected at OMS morning rounds if:**
    a. **You are on a rotation that is off campus and requires travel to that site from home to be on time (except Wednesdays when at the VA)**
    b. **You are on a rotation on campus that begins at 7 AM or earlier (except Wednesdays when on Anesthesia)**
2. **You may return to your home service and lend a hand if your rotation day ends early and your colleagues on OMS service are still working**
3. **General Surgery days begin at 5:30 in the first floor resident room**
4. **Anesthesia days typically begin at 6:30 in the anesthesia conference room**
5. **Internal Medicine days begin at 7:00 by the billiards table**
6. **Family Medicine days begin at 6:30 when Dr. DeLisi is rounding at the hospital**
7. **ENT and Cosmetics times and locations are variable, please keep in close contact with Drs. Manolakakis, Caloway and Folk**

SCHOLARLY ACTIVITY

Each sident is required to perform a minimum of one project each year during his/her tenure in the program. It is anticipated that at least one of these projects will lead to the publication of a paper in a peer-reviewed journal, or to a presentation a national meeting or to IRB acceptance as a longer term project to be completed by subsequent residents.

The minimal requirement is a poster presentation annually for St. Joseph's Research Day. All abstracts must be developed by the resident with a faculty mentor. No submissions may be made without approval from the program director or associate program director.

Topic selection should be complete by mid-December and any literature review and data gathering should be done by the end of February. The abstract must be available for review at least two weeks prior to the submission deadline. All posters should be checked for inaccuracies, spelling and format errors by the program director or associate program director prior to final printing.

OMSITE and MOCK BOARDS

Each year, all residents will be required to sit for the mock boards and the OMSITE examination. The program will assume the cost of this annual examination.

ABOMS

All residents completing the OMS program are expected to take the ABOMS written qualifying and oral certifying examinations.

ADMINISTRATIVE ISSUES

COMPLAINTS

Residents who feel that the program does not adhere to Standards published by the Commission on Dental Accreditation (CODA) may submit written comments to:

Commission on Dental Accreditation, 211 East Chicago Avenue, Chicago, IL 60611.
Alternatively, residents wishing to contact CODA may do so by calling 1-800-621-8099 ext 4653

EVALUATIONS

Residents will be evaluated quarterly with the more formal biannual evaluation done at the end of the academic and calendar years. Results and recommendations for improved performance will be discussed with the program director. Unsatisfactory evaluations will be discussed and an appropriate plan of action will be outlined. Failure by the resident to improve performance to an acceptable level as determined by the faculty may lead to a probationary period, remediation and/or ultimate dismissal from the program.

All scoring and comments by individual faculty members will be merged into a consensus evaluation to ensure anonymity and fairness. Grossly outlying scores will be discussed with the faculty member in question.

January and July reviews will include a resident self-assessment based on personal log entries and other data sources. Residents are encouraged to take this process seriously and respond honestly and accurately. Each fourth year resident will have a final evaluation drafted and presented to him/her for review. That final evaluation includes the elements required by CODA and remains part of the resident's permanent record.

Faculty will be evaluated on a yearly basis as required by CODA. Anonymous faculty evaluations are part of the Survey Monkey end of year annual program assessment. If they choose to do so, residents may also present the program director with a consensus evaluation of each member of the faculty.

ASSIGNMENT OF TASKS WITH NO EDUCATIONAL VALUE

Residents will not be sent out of the building when assigned to the SJUMC OMS service to go on errands or for any other purpose without approval from the director or associate director of the program. On the very rare occasions when a departure from the building is approved by program administration, chief residents must also be informed as they are responsible for ensuring that the service is covered properly. There are numerous reasons for this including liability, appropriateness and basic principles: a resident is a learner and an employee and is engaged in patient care, service to the institution or advancement of his/her education. Assignment of tasks that are not in any of those realms must be strictly limited to situations in which no other reasonable options exist and such assignment requires approval as indicated above.

ALIGNMENT WITH PROGRAM PHILOSOPHY

While the individuality of each resident is respected, it is critical that every resident enrolled in the OMS program aligns him/herself with program philosophy and abides by the ethical principles and the mission of the sponsoring institution. The humanity of each of our patients is respected and, as our patients, they are entitled to dignity, compassionate care and our very best efforts to provide help. Residents are afforded the privilege of combining employment with education. You are not in training to "cut cases," but to care for people in need and learn in that context. Patients will be referred to by name among team members, not by their diagnosis or the procedure they may need. Persistent failure to align with program philosophy is grounds for disciplinary action up to and including dismissal from the program. The same principles also guide interactions among residents. Abuse, belittlement, malicious behavior, punitive assignment of tasks and other disrespect will not be tolerated.

DISCIPLINARY ACTION
Residents may also be subjected to disciplinary action (probation, limitation of privileges, suspension or dismissal) for any of the following:

• Failure to follow program/hospital/University policies and procedures;

• Insubordination (willful disregard of a faculty member's orders or wishes regarding patient care or assigned job responsibilities)

• Jeopardizing patient care including neglect or the ordering or performing of unnecessary, improper and dangerous tests or procedures;

• Scheduling or performing an operation without the knowledge of the attending responsible for the patient;

• Failure to successfully complete Medicine, Surgery and/or Anesthesia rotations

• Theft, misrepresentation of credentials, education or background or other unethical behavior or illegal acts;

• Use of controlled substances without a physician's prescription and being under that physician's care;

• Use of illegal drugs, alcohol or other substances that impair one's judgment while caring for patients or while on-call;

• Failure to respond to calls for consultation, treatment, assistance by fellow residents or attendings;

• Unsatisfactory evaluations by faculty with failure to follow the prescribed remediation or improvement outlined by the program director and faculty;

• Wanton and willful disrespect of faculty, staff, fellow residents and/or patients.

VACATIONS
Each resident is allowed vacation as stipulated by his or her resident contract. All requests for time off must be submitted in writing to the program director *and* clinic supervisor after clearing the time with the chief resident. The request must indicate that the OMS chief has approved and ensured that the service will be covered. In addition, requests for vacation during rotation time require approval from the appropriate service chief. This must be noted on the request *along with* (not in place of) OMS chief resident approval. Time at the VA is tracked meticulously when outside rotators serve at that site. The "VA way" must be honored by each resident during that rotation.

PROFESSIONAL MEETINGS
The program and its affiliates will make every effort to support residents when they are presenting a paper, research project or poster at a recognized meeting. Discretionary funds may be available to support resident activities that enhance their academic/clinical experience and/or reflect positively on the program. Chief residents who wish to use contractually provided funds must have the utilization pre-approved as per Academic Affairs policy. Pre-approved use will be reimbursed up to the contractual allotment while any additional expenses incurred are the responsibility of the resident.

IN-HOUSE PRESENTATIONS

Residents are required to report any morbidities or mortalities from either the clinic or the OR. These should be discussed with the program director and may be utilized as presentations for M&M sessions. Residents are also expected to present cases at multidisciplinary cancer conferences as new cases of malignancy or aggressive benign tumors are diagnosed. The presentation must be reviewed by Dr. Szumita or Dr. Ephros prior to the resident representing the service at tumor board. Residents may also be asked to present at other educational activities including presentations outside the department. All such presentations must be reviewed by OMS faculty prior to the resident representing the OMS service.

COMMUNICATION DEVICES AND SOCIAL MEDIA

Cell phones now play a major role in communication and are, in many ways, more effective than pagers. Texting is an acceptable and often a superior way of transmitting information, however, there are some important concepts:

1. **Personal texting whether out in the open or under the table is completely unacceptable at educational sessions. It is distracting and reflects a lack of respect for the speaker and the others in the room.**
2. **Texting to convey important information (e.g. we are going into room 3, the patient was extubated smoothly, we need you in the clinic etc.) is an appropriate use of this mode of communication. Please note, however, that an unanswered text cannot be assumed to have been received and read.**
3. **Cell phone photography may be subject to hospital policies intended to protect patient privacy.**

The integrity of the program may not be subject to Federal law, but its protection is important for reasons similar to those that have spurred HIPPA regulations. As such, the use of social media and other public fora by residents to air grievances, snipe at one another or discuss the inner workings of the program is prohibited. The posting of any images or information that can possibly be connected to a specific patient is also prohibited and is a violation of Federal law. Image transmission and sharing of other patient-related data is subject to institutional policy as well as any relevant external regulation. Use of professional status on social media for any kind of personal gain is unethical and is prohibited.

Attachment 1

OVERALL PROGRAM GOALS

1. **To provide intensive training leading to competency, and ultimately, after additional experience in practice, to proficiency in the core components of oral and maxillofacial surgery: history taking and physical examination, dentoalveolar surgery, and anesthesia services including local, inhalation analgesia, all forms of sedation and general anesthesia;**

2. **To provide comprehensive training in the full spectrum of oral and maxillofacial surgery so that program graduates are able to become Board Certified and competently practice the full scope of the specialty and are well prepared to enter fellowships if they choose to sub-specialize;**

3. **To deliver a didactic program that is multifaceted and that integrates basic and clinical sciences at a level well above pre-doctoral education so that residents are prepared to utilize that knowledge in clinical practice and to succeed on standardized test including the written qualifying examination of the ABOMS;**

4. **To conduct a program with faculty members who provide mentorship and set appropriate examples for residents in their dedication to patient care, to the specialty and to lifelong learning, community service and teaching;**

5. **To ensure that residents are stakeholders in the program by giving them the opportunity to provide feedback anonymously as well as openly and by utilizing the input of current and past residents to help shape and refine the residency program; and,**

6. **To foster an environment conducive to learning and an open exchange of ideas, promoting scholarly activity and a thoughtful approach to clinical and philosophical questions related to the practice of the specialty.**

Detailed goals and objectives for each component of the program and for each rotation are found in the Curriculum, Goals and Objectives document which is revised periodically with resident input.

Attachment 2

Oral and Maxillofacial Surgery Chief Resident Job Description

The chief resident is responsible for running the OMS service at SJUMC. He/she oversees the activities of all of the residents in the department. In addition, the chief resident functions as a junior associate in the program director's private practice. Privileges are commensurate with the level of responsibility successfully maintained by the chief resident.

The following list of responsibilities and privileges are chief resident specific and are in addition to the rights and responsibilities listed for all OMS residents in the resident manual.

Responsibilities and Privileges

The chief resident will:

1. organize resident assignments and activities on a daily basis and ensure the development of fair and reasonable call and vacation schedules for the residents (pending program director approval);
2. oversee all patient care by the department's residents other than those taking place at 11 Getty under the supervision of GP and Pediatric Dentistry faculty, this includes ER patients when other OMS residents are on second call;
3. provide (or arrange for the timely provision of) information to attendings about their patients and act as the liaison between the attending and all those who contact the patient at St. Joseph's;
4. ensure that all OR cases are ready for surgery far enough in advance so that issues that arise can be managed prior to patient admission – this includes the program director's private cases as well as all cases generated through clinics;
5. arrange for appropriate resident coverage of activities outside the OR while cases are being done;
6. represent the service, the faculty and the program director by ensuring timely, appropriate, professional and polite interactions by all residents with guests, patients, colleagues, employees and all others with whom contact is made;
7. make certain that all residents not engaged in emergent or urgent acute patient care attend all didactic sessions;
8. conduct an organized and informative session including review of in-patients, duties of the upcoming day, and a brief educational topic on mornings when attending coverage of AM rounds is not possible;
9. identify cases for review or for M&M sessions and collaborate with the program director in the selection of articles for journal club sessions;
10. participate (or assign a designee to participate) as a member of the St. Joseph's resident advisory committee so that the OMS and dental services are represented on that body;
11. maintain an accurate log of all OR activity (in the book and the OMSNIC database) and log all significant outpatient cases, including sedations;
12. oversee the logging of all consults, ER activities and OR cases done by the dental/OMS service;
13. ensure full compliance with drug counting, administration and waste reporting as well as adherence to the sedation checklist;
14. perform additional functions as assigned by the program or other faculty members as needed to facilitate patient care and/or resident education.