

OMS RESIDENCY MANUAL
St. Joseph's Regional Medical Center
in affiliation with
New York Medical College
2017-8

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The following document contains the rules, regulations and requirements for the 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. Being asked to provide surgical care is one of the highest honors and greatest responsibilities of all professions. 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 their identity. Therefore, consider it 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.

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 your 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. Understanding how to acquire a medical history, perform a diagnostic work-up and formulate a treatment plan are key elements in your education. To a certain extent, understanding the rationale for the procedure is educationally more important than performing the actual procedure. The patient care experience thus becomes a departure point rather than an end point in your education.

All residents are required to participate fully in all teaching activities of the Oral and Maxillofacial Surgery program. The residents will be required to spend an extensive amount of time and commitment on reading, research, and preparation. 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 the 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 he/she will not have seen nor 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 he/she has the basic surgical skills, knowledge, personnel, facility and equipment to treat the patient properly. The resident needs to understand his/her limitations and that he/she may not be equipped or trained to treat every patient or problem. Understanding when appropriate referral is necessary is also a major part of every clinician's education.

The program is also designed to prepare the resident 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. Regardless of whether it is scheduled or unscheduled, the procedure is essentially the same. There are small differences between inpatient and outpatient admissions however.

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 faculty be either a participating members or have the appropriate out-of-network referral authorization from the patient's primary care provider.

The resident should discuss with the attending or the business office what additional materials (models, radiographs, 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 models, radiographs or photographs to the insurance companies.

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 resident and attending schedules
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.

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 on-service chief 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 at 7:10 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 ER or designated area via ambulance. When the patient arrives, pager 0132 will be called and the on-call resident will evaluate. OMFS 2nd call will then be called for evaluation if indicated. 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 OMFS 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 OMFS 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 OMFS 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 daily. All residents on service are expected to attend unless they are involved in on-going patient care. Residents are required to have examined the patient, written daily progress notes and orders on each patient prior to formal rounds and *prior to morning conferences*. A formal presentation shall 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 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

The residents should review all laboratory, radiology and pathology reports as soon as they are available. Urgent results should be obtained directly from the laboratory; radiologist or pathologist and the resident should not wait for the results to be posted on the hospital information system. The residents should review radiographs personally and those without sufficient knowledge should ask the radiologist to review the film 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 laboratory, pathology or radiology order forms must have the ICD-9 code listed or the laboratory will refuse the test.

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 must sign the consult sheet or place a note in the chart. Consults requested by our service require 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 what we want them to evaluate! A written consult should be placed in the medical chart or mailed in non-emergent outpatient situations.

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 Emergency Room 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. As per arrangement with the Anesthesiology Service, OMS residents may take call for the OMS service, if necessary, on Tuesday nights and then stay for OMS didactics on Wednesday mornings. The resident assigned to the VA may take limited OMS call if necessary, however, VA call remains that resident's first priority. 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 on-service chief and all 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.

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.

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.

CHARTS

Charts should be written up 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. Clinic charts are to be returned to the receptionist. Dr. Ephros' charts must be returned to his office. Dr. Ephros' charts on private patients scheduled on any given day, must be placed in the appropriate rack in his office so that these charts may be located on the day of surgery. Any deficiencies or other issues must be identified prior to the day of surgery and resolved or brought to Dr. Ephros' attention.

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. Routine, benign results should be handled appropriately by the treating resident. 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 ICD-9 and CPT 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.

PERSONAL LOGS

These are distributed to each resident and it is required of each resident to record 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, 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.

RECORDS

Hospital Medical Records

1. Daily Progress Notes and Physician Orders

All progress notes and orders are entered into the EMR. 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

All operative reports should be dictated at the completion of the operation. Reports must be dictated within 24 hours of the operation and must be clear, detailed and thorough. Failure to dictate the operation and dictate it correctly may lead to loss of operating room privileges and/or suspension. All dictations must now contain the attestation paragraph for attending surgeon's signature.

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.

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. The floater or 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 in the chart 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 written indicating the correction or clarification. 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.

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 visibly soiled, it will be necessary to remove and replace it with a clean coat. 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. OR attire is strictly scrubs. No one should enter the OR unless appropriately attired. 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.

CLINIC SCHEDULING

Scheduling is a cooperative effort among the on-service residents, the receptionist and clinic supervisor, clinic attendings and the program director. No unilateral decisions are made by residents regarding clinic scheduling.

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. 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.

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, the patient is 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 - written 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

All encounters 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 treated may result in underestimating your productivity and may jeopardize program accreditation as well as the financial viability of the clinic and the entire 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)

SCHOLARLY ACTIVITY

Each resident 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 at 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 the Seton Hall Research Colloquium. All abstracts must be developed by the resident with a faculty mentor. The program director must review all entries for which the mentor is a junior member of the faculty.

Topic selection must be complete by mid-December and any literature review and data gathering must be complete 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 a member of the faculty 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 OMFS 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 although only biannual evaluation is required by CODA. 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. All resident comments will be screened by the program director and anonymity will be maintained. If they choose to do so, residents may present the program director with a consensus evaluation of each member of the faculty.

DISCIPLINARY ACTION

Residents may 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 which 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 program coordinator after clearing the time with the chief resident. The request should indicate that the on-service chief has approved and ensured that the service will be covered.

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.

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 tumor board 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 Trauma Conference, Pediatric Grand Rounds or other educational activities. Resident involvement is encouraged but all 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.

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 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 SJRMC. He/she oversees the activities of all of the OMS and general practice dental residents. 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 general dentistry at the FHC – 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.