



**McGill**

**DEPARTMENT OF OTOLARYNGOLOGY –  
HEAD & NECK SURGERY**

**RESIDENCY TRAINING  
MANUAL**

**2012-2013**

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## **DEPARTMENT OF OTOLARYNGOLOGY – HEAD & NECK SURGERY**

### **GOAL OF THE PROGRAM**

**18/03/2013**

The goal of the program to produce a specialist in otolaryngology who has achieved competencies in all of the 7 CanMEDS roles including that of: medical expert, communicator, collaborator, manager, health advocate, scholar and professional. Graduating residents will be competent to function as a consultant otolaryngologist - head and neck surgeon.

### **GRADUATE OF RESIDENCY TRAINING PROGRAM**

A graduate of this training program will meet the requirements necessary to obtain registration forms from:

1. the Professional Corporation of Physicians of Quebec
2. the Royal College of Physicians and Surgeons of Canada
3. As of 2004, the American Board of Otolaryngology no longer recognizes Canadian training programs and has revoked eligibility of Canadian residents to write the American Board of Otolaryngology exams. There are active efforts to resolve the difficulty at this time, which applies to all residents from Canadian training programs in otolaryngology. To this end, all Canadian training programs have been modified to parallel the American training programs. At this time, the program consists of one year of surgical foundation (CORE) surgery program followed by four years of otolaryngology training. A precedent for reversing such decisions has already been set in other specialties.

The graduate in otolaryngology is expected to have acquired all 7 CanMEDS key competencies. More specifically, graduates are expected to:

1. Possess a sound knowledge of the general principles of medicine and surgery. As of July 1993, it is mandatory for residents to pass the Principles of General Surgery exam as required by the Royal College of Physicians and Surgeons of Canada.
2. Acquire sufficient knowledge of basic and clinically applied science in addition to the necessary clinical skills for the practice of otolaryngology, which includes the areas of otology, neurotology, pediatrics, general otolaryngology, rhinology, head and neck surgery, facial plastic and reconstructive surgery, Residents will also embrace components of neurology, neurosurgery, plastic surgery, dermatology, respirology, pathology and oral and maxillo-facial surgery.
3. Demonstrate the knowledge, skills and attitudes relating to gender, culture, and ethnicity pertinent to otolaryngology head and neck surgery. They will demonstrate an ability to incorporate gender, sexual orientation, age, culture and ethnic perspectives in data presentation analysis and in research methodology.
4. Develop an orderly and logical approach to patient management, elicit an accurate history, a focused physical examination selecting appropriate investigations including diagnostic imaging, laboratory testing, biopsies and vestibular and audiology testing
5. Demonstrate satisfactory interpersonal relationships with colleagues, nurses, ancillary medical personnel, patients and their families.
6. To seek appropriate consultation from other professionals recognizing the limits of their expertise.
7. Possess high standards of professional ethics, responsibility to both patients and the community, and to his/her own continuing self-education
8. Gain an appreciation of the role of basic and clinical research in the further development of the speciality to enhance areas of professional competence.
9. To use preventive and therapeutic interventions effectively by implementing a management plan in collaboration with a patient and the family by advocating specific preventative otolaryngology - head and neck surgery criteria. (ex: smoking cessation, responsible alcohol use, sun exposure protection, prevention of noise-induced hearing loss, etc.)

# **OBJECTIVES OF TRAINING AND SPECIALTY TRAINING REQUIREMENTS IN OTOLARYNGOLOGY – HEAD & NECK SURGERY**

**18/03/2013**

As of July 1, 1993, as a Quebec university program, candidates can enter directly upon graduating from fourth year medicine into speciality training "streams" of residency such as otolaryngology. As of July 1, 1990, candidates will enter general surgery (PGY1-otolaryngology) and then commence their formal otolaryngology training for four years (PGY2-5).

## **1. General objectives:**

The otolaryngologist must possess a sound knowledge of the general principles of medicine and surgery as they apply to the practice of otolaryngology. This will require adequate training and experience in eight domains:

- Head and neck surgery
- Facial plastic and reconstructive surgery
- Pediatric otolaryngology
- Rhinology
- Laryngology
- Otology
- Neurotology
- General otolaryngology

A sound knowledge of the basic sciences is necessary for the understanding and practice of otolaryngology. Training is geared toward promoting an understanding of the above domains with respect to embryology, genetics, applied anatomy, physiology, pathophysiology, histology, pathology, immunology, microbiology and biochemistry.

For both pediatric and adult population the specific areas for these domains are:

**Head and neck:** parathyroid and thyroid glands, salivary glands, nose and paranasal sinuses, oral cavities, pharynx (nasopharynx, oropharynx, hypopharynx), larynx, trachea, esophagus, neck, skin and skull base

**Ear:** ear (external, middle, inner), temporal bone and related structures including the peripheral auditory system, central auditory system, vestibular system and the component of anatomical and neurological structures, special senses of hearing and balance

**Nose:** nose and paranasal sinuses, special senses of olfaction and skull base

**Larynx:** trachea and upper airway, swallowing, airway protection and respiration as it pertain to the larynx and upper airway. This includes the principles and techniques of objective vocal testing, aerodynamic testing, electrophysiologic techniques and principles of laser therapy pertinent to the larynx.

**Face:** face and its structural components including facial nerve

In addition, the otolaryngologist must have a special knowledge of the basic principles and clinical techniques of:

- **Audiology:** Knowledge of physics of sound and neurophysiology of hearing, principles of conventional audiometry, immittance testing including tympanometry, otoacoustic emissions (OAEs), electrocochleography, auditory brain stem response (ABR) and cortical auditory evoke responses for evaluation of adult and pediatric patients with hearing disorders.
- **Speech:** Knowledge of physics of voice and speech production, and the physiology of voice. This includes principles of technique used in evaluation in treatment of speech and hearing disorders. These techniques should be based on the age of the patient.
- **Vestibular function:** Knowledge of the principles of vestibular assessment including performance and interpretation of electronystagmography (ENG), computerized dynamic posturography, rotational chair assessment, and vestibular-evoked myogenic potentials.
- **Facial nerve:** Principles of electrophysiological assessment of the facial nerve, including intraoperative monitoring.
- **Diagnostic imaging (both pediatric and adult):** The principles of diagnostic imaging including the interpretation of CT and MR imaging for all otolaryngology domains

In addition to the above objectives, the 7 CanMEDS key competencies have been solidly integrated into the program. These include the role of the otolaryngologists as medical expert, communicator, collaborator, manager, health advocate, scholar and professional. The specifics and learning and evaluating these competencies are described in some detail under the objectives for the R2, R3, R4 and R5 levels respectively.

2. **Specialty training requirements at McGill University:**

The residency-training program in otolaryngology includes one year of surgical foundation (CORE) surgery program and four years of otolaryngology as described below: Please refer to Surgical Foundation (CORE) Surgery R1 (pages 47-51), and Otolaryngology – Head and neck surgery R2, R3, R4 and R5 objectives.(pages 61-77)

# **EDUCATIONAL PROGRAM**

**18/03/2013**

1. **Lecture Series:** According to residents' requests, the academic half days were replaced by a shorter lecture series that started in September 2007. The lecture series are 1-2 hours of protected teaching time every Thursday afternoon—from 4 to 5.15 pm. The series is grouped to cover a specific topic at the end of which the residents are given a subject specific written exam. This allows the residents to structure their study. The subject lecture series is designed to cover a two-year cycle of academic material. Residents from the R2 to the R5 levels are excused from their clinic duties to attend. This time is structured to include didactic and interactive teaching sessions covering all of the major areas of general otolaryngology and the representative subspecialties of the field. In addition, special emphasis is placed in areas of perceived weakness such as otology and neurotology. It is also a forum for teaching the 7 CanMEDS competencies, ethics, medico-legal issues, and subjects in fields related to otolaryngology. Attendance on these days is compulsory for R2's to R5's and it is strongly encouraged that R1's make every effort to attend. The information presented during this protected teaching time forms the basis for 60-70% of the material covered on in-training exams.
2. **Mini-seminars:** Over the past few academic years, full day mini seminars were introduced in subspecialty areas of otolaryngology based on resident feedback. During the last academic years, full day mini-seminars were held in the areas of facial plastics (Cadaver dissection course), facial plastics and reconstructive, maxillofacial plating course, laryngology course, pediatric course, endoscopic sinus surgery course, basic and advanced airway management course, crisis resource management airway course, temporal bone dissection course, CanMEDS teaching in communication, collaboration, managerial and professional skills course and an ethics and conflict resolution course.
3. **Introductory Lectures:** A series of 10-15 introductory lectures are given by the R5 residents to the incoming R2 residents in July and August. The goal of these lectures is first to orient incoming residents with respect to otolaryngologic emergencies and study materials, and second, to allow senior residents to develop their teaching skills. These lectures are extremely useful in establishing resident relationships and empowering junior residents with the necessary knowledge to deal with on call emergencies.
4. **University grand rounds:** Grand rounds are held once a week on Thursday afternoons from 5:15 to 6:15 p.m. from September to June during the academic year. Presentations are made primarily by the residents in the training program with input and supervision by the attending staff. The rounds allow the residents to critically review the literature pertaining to a case or small series of cases. Presentations are formal in nature with appropriate audiovisual support with time left for discussion. Presentations are also made by invited guest professors from around the world with international reputations or

invited clinicians from the McGill milieu. A half day of interactive teaching with the residents takes place the day following the invited visiting professor lecture. These rounds are accredited by the Royal College of Physicians and Surgeons of Canada.

5. **Hospital rounds:** Each hospital site has in-hospital rounds once weekly. At the Montreal Children's Hospital this occurs every Monday morning and includes surgical grand rounds, morbidity rounds, clinical and radiology rounds. At the Jewish General Hospital, rounds are held on Thursday mornings and include head and neck oncology, pathology, radiology, clinical and mortality and morbidity rounds. The McGill University Health Centre rounds for the Royal Victoria Hospital and Montreal General Hospital are integrated and held Thursday mornings. These rounds are structured to cover the following topics; pathology, radiology, rhinology, otology, laryngology, and morbidity and mortality rounds. These rounds have been structured and designed to meet residency training requirements in terms of format and content. Hospital rounds have been accredited by the Royal College of Physicians and Surgeons of Canada.
6. **Tumor Board Rounds:** Formal tumor board rounds are held weekly at the JGH and MUHC (RVH/MGH). These are formal rounds with the presence of a pathologist, radiation oncologist, medical oncologist, oncology nurse and two or more surgeons. Radiologists, dieticians, social workers and speech pathologists are also invited and frequently attend for discussion of particular issues. Cases are formally and comprehensively presented by the residents and discussed in an interdisciplinary fashion by those present. Residents actively participate in these discussions and their opinions are considered in creating formal treatment plans. Tumor board rounds have been accredited by the Royal College of Physicians and Surgeons of Canada.
7. **Journals clubs:** Journal clubs are held 4 times per year on a Thursday in place of rounds at 5:15 p.m. Journals are selected based on scientific merit. Two scientific papers and two ethics papers are presented with input from selected attending staff. Presentations are in a PowerPoint format and include a critical review of the strengths and weaknesses of the paper, followed by a general discussion. Papers are chosen with particular care in order to stimulate active discussion around key ethical issues. Journal clubs have been accredited by the Royal College of Physicians and Surgeons of Canada.
8. **Temporal Bone Course:** A 3-day comprehensive temporal bone course is held annually in a modern state-of-the-art facility situated at the Montreal Children's Hospital (McGill Auditory Sciences Laboratory) or at the McGill Simulation Centre. This course is compulsory for all residents, and consists of didactic and interactive teaching sessions by experienced staff as well as hands on drilling experience in basic and advanced temporal bone drilling techniques.
9. **Guest speakers and Visiting Professors Program:** Guest speakers of international renown are scheduled on a regular basis throughout the academic year. Speakers are

usually asked to give a pre-selected lecture on a Thursday evening from 5:15 to 6:15 p.m. and to give another lecture to the residents on the following morning from 9 to 10 a.m. to be followed by case presentations from 10 to 12:00 p.m. The guests are invited well in advance, and the entire department is notified electronically through e-mail and through ENT bulletin boards at each respective hospital. Verbal announcements are also made at university rounds concerning guest speakers. Annual events include:

1. McNally Memorial Lectureship (RVH) (fall)
  2. Herbert S. Birkett Memorial Lecturer (held by Med-Chi Society – otolaryngology section) (fall)
  3. Melvin D. Schloss Pediatric Lectureship (winter/spring)
  4. Raymer Lectureship (JGH) (spring)
  5. Resident Research Day/James D. Baxter Lectureship (spring)
10. **Publications:** Residents are expected to author or co-author at least one paper annually. They are encouraged to present these papers locally or internationally. Residents are also expected to present their research papers at the annual resident research day usually held in May prior to the Canadian Society of Otolaryngology Annual Meeting. There is a progression in the quality and depth of both the clinical and basic science papers from the R2 through to the R5 level. Two prizes are awarded for the best research, one for junior (R2-3) and senior (R4-5)
11. **Resident attendance at meetings:** Residents have the right to attend, without loss of salary, one or more meetings or courses, up to a total of ten days per year subject to approved by the program director and site director of the actual rotation. Senior residents (R5) are entitled to attend one meeting during the final year, and will be financially compensated to a maximum of \$1,000.00 for said meeting. Residents presenting papers or posters are reimbursed on their expenses from \$750.00 to \$1,000. Students can be reimbursed up to \$250 for expenses incurred when attending these meetings and presenting a paper.
12. **Exams:** There are several McGill otolaryngology in-training exams held annually based on one subspecialty. These exams are written in a Royal College format and are composed of 60-70% of material covered in the lecture series, with 30-40% of the material covering general otolaryngology. Feedback is provided to the residents at their six month evaluation with the program director on an individual highlighting their strengths and weaknesses. In addition, there is a yearly Canadian otolaryngology in-training written examination in March written by all R3-5 residents across the country. The results of this exam allow residents to position themselves with respect to their peers across the country in terms of their clinical and basic science knowledge base. The results are discussed with the residents at their 6 month evaluation with the program director. There are two oral exams in Royal College format held yearly in December and June for

R2 to R5 residents. Feedback is provided to individual residents when evaluated on One-45. There are 6-12 mock orals in the various subspecialties of otolaryngology and the 7 CanMEDS competencies held specifically for graduating residents in preparation for the Royal College exams. In the past 14 years, all CARMs matched residents graduating from the McGill otolaryngology residency training program have successfully completed their Royal College exams.

13. **Vacations:** Residents are entitled to four weeks of vacation per year, not more than two (2) weeks of which shall be taken in any one rotation. Exceptions will be made for trips planned abroad and only with the approval of the program director. Graduating residents are permitted to take one month of vacation with 10 days of “study leave” for a total of six weeks study time prior to the Royal College examinations. R2's must be available in July and August to attend the introductory lectures and are not permitted to take their vacation during the Annual Canadian Society of Otolaryngology-HNS meeting.

Vacation requests should be made six months in advance and may be modified with the agreement of the chief resident, hospital rotation chief and the program director up to 3 months in advance. Residents must report their vacation to the administrative office which then enters this information into their One-45 profile. Following that date, modifications will only be made in extenuating circumstances. Residents must fill a vacation request form, which is available at each hospital, and return it to the McGill administrative office. A resident must obtain prior approval from the site director where the resident will be doing his/her rotation as well as from the program director and the chief resident who is responsible for the on call schedule and the appropriate hospital coverage. VACATION REQUEST FORMS ARE AVAILABLE FROM THE DEPARTMENTAL SECRETARY AT EACH HOSPITAL.

The department allows for one week vacation carry over to the next academic year.

#### 14. **Prizes and presentations:**

Prizes and presentations are held throughout the year and include the following:

1. **Resident Research Day/James D. Baxter Lecture;** Two prizes are awarded for junior and senior residents for best research work and presentation.
2. **University Grand Round Presentation Awards;** Two prizes are also awarded to a junior and senior resident for best university grand rounds presentation during the academic year.
3. **Facial Plastics and Reconstructive Awards;** prizes are awarded for the highest written exam score, the best facial plastics research paper, and for best facial plastics technical skills
4. **Triological Society** – sectional awards for residents

5. **American Academy of Otolaryngology – Head and Neck Surgery** – awards for resident presentations and research
  6. **Melvin D. Mendelsohn Temporal Bone Drilling Prize** – awarded for the best drilling technique
  7. **Melvin D. Schloss Pediatric Lectureship** - two prizes for best papers presentation
  8. **William H. Novick CANMEDS Resident Award** – awarded for best CanMEDS resident
15. **Study leave:** Study leave is granted for seven working days per year in accordance with the current resident agreement.
16. **Presentations at national/international meetings:** It was established at a meeting held with the residents on October 5<sup>th</sup>, 2004 and the Program Director that residents will be reimbursed for their expenses at national or international meetings. The amounts will be:
- |                         |   |
|-------------------------|---|
| Podium presentation     | <b>\$1,000.00 (limited to one per year)</b>                       |
| Poster presentation     | <b>\$ 750.00 (limited to one per year)</b>                        |
| Presentation by student | <b>up to \$250.00</b> (at the discretion of the Program Director) |
- R5 is reimbursed up to **\$1,000.00** to travel to any national or international meeting of his choice

In the event a resident does a podium or poster presentation at a sub-specialty conference (i.e.: pediatrics, otology, etc), the resident wishing to receive reimbursement must have prior approval of the hospital site director. The site director must then reimburse the resident accordingly.

17. **Inter-professional/interpersonal issues:** After consultation with the Faculty of Medicine, and after a decision made at the Residency Program Committee Meeting held on January 31, 2007, an external contact person has been assigned in the event of any interpersonal or inter-professional issues during their residency training. Dr. George Shenouda the Program Director of Radiation Oncology is the residents' external contact. He can be reached at (514) 934-8040 (MGH – Room D5.400).

At the resident orientation meeting held for the academic year 2009-2010 the residents collectively voted on the staff representatives at each site (a person they could approach for questions/issues/suggestions/etc.). The residents can also approach the Site Directors, Program Director, Chairman, Chief Resident or Junior resident rep (Dr. Keith Richardson). Each staff representative agrees with their new position:

	<u>Site director</u>
• JGH Dr. Jamie Rapport (Staff rep) -	Dr. Michael Hier
• RVH Dr. Mark Samaha (Staff rep) -	Dr. Anthony Zeitouni
• MGH Dr. Alex Mlynarek (Staff rep) -	Dr. Robert Sweet
• MCH Dr. Melvin Schloss (Staff rep) -	Dr. Sam Daniel

The program director and chairman have **an open door policy to residents** and also have access to residents 24 hours a day to deal with issues of intimidation, harassment or abuse. Residents may also choose to bring the issues to the RPC and discuss them there where appropriate action may be taken. This procedure is in addition to the Faculty of Medicine guidelines on policies and procedures available to all residents on line at [http://www.mcgill.ca/files/equity\\_diversity/harassment-sexualharassment-discrimination](http://www.mcgill.ca/files/equity_diversity/harassment-sexualharassment-discrimination).

18. **PAGERS:** Every resident is provided with a pager at the beginning of their training. The pager remains the property of the MUHC and must be returned at the end of training. There is a \$40.00 charge to replace a lost pager.

# **RESIDENCY PROGRAM COMMITTEE**

**18/03/2013**

The Residency Program Committee is comprised of each hospital site director or its representative as well as members for each curriculum i.e.: fellowship, undergraduate, CORE, oncology and part-time rep). There is one elective junior resident representative and one elected/approved by the faculty chief resident who sits on the committee. This year there are two chief residents (each has a six month rotation as per the request of the residents). In addition, the chairman is also a member of the committee by invitation The committee is headed by the program director. The Residency Program Committee meets a minimum of every two months to discuss affairs pertinent to residency training and the academic program. The minutes are sent to other teaching staff at their request (i.e.: promotion committee, site director not represented at the RPC, and any teaching staff member who requests it).

## **RPC Terms of reference:**

### **Responsibility:**

- To oversee the postgraduate training program in otolaryngology
- To enable its trainees to meet the appropriate standards of excellence and become competent practitioners in the specialty.
- to develop a clear plan including objectives based on CanMEDS competencies
- collaborate with residents on rotation to ensure that each resident advances and gains experience in accordance with the educational plan
- select residents for admission to the program (resident selection subcommittee)
- provide mechanisms for career planning and counseling for residents to deal with problems (i.e.: stress, spiritual, intellectual issues, time management, etc)
- Assessment on the performance of each resident is delegated to the resident promotion subcommittee if a resident is in trouble. Membership at the ad hoc Promotion committee is limited due to confidentiality reasons.
- Evaluate the performance of each teacher and/or supervisor
- Maintain an appeal mechanism in accordance with policies determined by the Faculty Post Graduation Education Committee
- To approve/disapprove the fellow selection submitted from the Fellowship subcommittee, and assess their rotation impact on residency training
- To improve Otolaryngology teaching curriculum for the McGill medical undergraduate training submitted by the undergraduate committee, to attract more medical school students to the Otolaryngology Head and Neck specialty
- Conduct an annual review of the program to assess the quality of the educational experience and to review the resources available to ensure maximal benefit for integration of components of the program. This should include:

- An assessment of each component of the program to ensure that the educational objectives are being met
- An assessment of resource allocation to ensure that resources are being utilized with optimal effectiveness
- An assessment of teaching in the program, including teaching in areas such as ethics, medico-legal considerations, administrative and management issues. Resident input is considered in this review.

### **Membership**

Chair (Program Director)  
 Departmental Chair (by invitation)  
 Royal Victoria Hospital representative  
 Montreal General Hospital representative  
 Montreal Children's Hospital representative  
 Jewish General Hospital representative  
 Research representative  
 Part-time staff representative  
 Chief Resident  
 Junior Resident

### **Representation**

Dr. J. Manoukian (Chair)  
 Dr. J. Rappaport (Co-Chair, Fellowships)  
 Dr. M. Hier (JGH)  
 Dr. R. Sweet (MGH)  
 Dr. A. Zeitouni (RVH)  
 Dr. S. Daniel (MCH)  
 Dr. B. Segal (Research)  
 Dr. M. Samaha (Resident Medical Curriculum Director/Community Rotation Director)  
 Dr. R. Payne (Surgical Foundation, CORE Surgery)  
 Dr. L. Nguyen (Undergraduate)  
 Dr. A. Mlynarek (H&N Oncology/part time staff rep)  
 Chief resident (elected)  
 Junior resident (elected)

## **DEPARTMENTAL SUBCOMMITTEES**

Six subcommittees are in place and meet approximately every three months. They are:

**Resident Selection Committee:** The committee is comprised of the following individuals and meets during the months of December to February; Drs. S. Frenkiel, J. Manoukian, J. Rappaport, M. Hier, S. Daniel, A. Zeitouni, M. Samaha, R. Payne, L. Nguyen, B. Segal and the junior & senior elected residents. This committee evaluates all CARMs resident applications and selects the candidates for interview. They serve to evaluate the candidates during the formal interview process and help the program director select the appropriate candidates for a residency position.

This committee is also involved in the IMG selection process in a similar fashion.

**Promotions Committee:** Drs. Saul Frenkiel, Martin J. Black, Dr. Melvin Schloss and Dr. Nabil Fanous. This committee only meets when there is a resident in difficulty and gives recommendations to the RPC. This committee met to discuss the progress of one of recent graduated resident and also met regarding one of our CORE surgery residents.

**Research Committee:** This committee is comprised of the following individuals and meets approximately every 3 months; Dr Segal (Chair), Dr. Sam Daniel, Dr. Saul Frenkiel, Dr. Robert Funnell, Dr. A. Katsarkas, Dr. John Manoukian, Dr. Richard Payne, Dr. Mark Samaha and Dr. Anthony Zeitouni. This committee is in place to approve the enrichment year projects of the residents, to give recommendations and also to decide if their research can be part of their masters in otolaryngology degree. Members also review the results at the end of their research project.

**Fellowship Committee:** The fellowship committee is comprised of the following individuals: Drs. J. Rappaport.(Chair) S. Frenkiel, M. Samaha (Rhinology), M. Hier (Head and Neck), K. Kost (Laryngology), J. Manoukian, S. Daniel (Pediatrics) and B. Segal (Research). Its function is to select fellows that meet the requirements of our objectives and to make sure a fellow does not conflict with the training of our residents currently in the program.

**Undergraduate Otolaryngology Subcommittee:** The undergraduate committee is comprised of the following individuals: Drs L. Nguyen (Chair), S Frenkiel, J Manoukian, J Young, resident representative. Its function is to improve the otolaryngology teaching curriculum for the McGill medical undergraduate training and to attract more medical school students to the Otolaryngology Head and Neck specialty

**Surgical Foundation (Core Surgery) Committee:** The undergraduate committee is comprised of the following individuals: Dr. R. Payne, Dr. John Manoukian and a senior resident representative.

### **Research**

This endeavor is largely accomplished during the enrichment year of the program (last 6 months of R3 and first 6 months of R4). Both clinical and basic research is encouraged during other years of training. Residents should present their work at local, national and international society meetings with subsequent publication of their data. A Masters Program in Otolaryngology is also offered by the Department.

## **Clinical Training**

A rotation schedule is approved by the committee and issued in the early spring of every year. The residents rotate through four institutions, The Royal Victoria Hospital, Jewish General Hospital, Montreal General Hospital, and the Montreal Children's Hospital. Residents rotate to the Lakeshore General, LaSalle General and Verdun General for community-based training. This part of their training will enable them to acquire competence of clinical skills in the fields of otology, neurotology, nasal and sinus diseases, head and neck surgery, oncology, maxillo-facial and reconstructive problems, laryngology, and the broad field of pediatric otolaryngology. Surgical skills will be acquired according to the level of training and in accordance with the guidelines set down by the Royal College of Physicians and Surgeons of Canada.

## **Admission of new residents**

An appointed Resident Selection subcommittee will review all new applicants to the program and proceed with personal interviews with a selective group. The applicants will be processed according to the Canadian Residency Match Service (CARMS), American quota and agreement with foreign government sponsorships.

## **Evaluation process of residents**

Residents are evaluated by regular oral and written examinations. After each block of academic sub-specialty teaching (4 times/ year) a Royal College exam type short answer written examination is given with personal feedback to the residents by the program director. The academic subject oriented teaching cycles every two years. Twice a year a Royal college formatted oral exam is given with appropriate feedback.

Residents are evaluated after each rotation, either a committee or the responsible chief meets with them face to face to give their evaluation on One-45. If they have a borderline global evaluation then the program director is notified and meets with the resident to discuss the problem to find a resolution to help for the next rotation. If a mentor is required, one will be assigned. If there is a borderline global evaluation, the promotion committee will be notified and will meet and give their recommendation. The Associate Dean Office is also notified. A resident in difficulty is immediately flagged on One-45 (i.e.: in CORE surgery). Meetings are held with teaching staff at this level to help improve the performance of the resident. If there is a global borderline evaluation, the program director will also meet at another session

## **Evaluation of program**

The committee attempts to review the program on an ongoing basis. It participates in other internal reviews from the university and external reviews from the Royal College and the Quebec Corporation. Critiques by the residents in the anonymous ENT website provides important feedback for teachers and the teaching program and is used by the department towards the evaluation of the program.

## **HOSPITALS OBJECTIVES**

### **SMBD-JEWISH GENERAL HOSPITAL ROTATIONAL OBJECTIVES**

*Rev: June 2011*

The Department of Otolaryngology-Head and Neck Surgery at the Jewish General Hospital is well equipped to provide comprehensive, advanced post-graduate training in our specialty. It staffs a full complement of sub-specialists, with all of the necessary tools and equipment, and services a very large and steady referral base. The administration of the Department of Otolaryngology-Head and Neck Surgery at the Jewish General Hospital includes:

Dr. Michael Hier	Chief, Dept. of Otolaryngology – Head & Neck Surgery, SMBD-Jewish General Hospital
Dr. Saul Frenkiel	Chair, Dept. of Otolaryngology – Head & Neck Surgery, McGill University
Dr. Martin Black	Director, McGill Head & Neck Surgery and Oncology Program
Dr. Jamie Rappaport	Associate Chief, Department of Otolaryngology – SMBD-JGH Assistant Program Director, Otolaryngology, McGill University Fellowship Director, Otolaryngology, McGill University
Dr. Bernard Segal, PhD	Director of Research, Department of Otolaryngology, McGill University & SMBD-Jewish General Hospital Graduate Program Director, Otolaryngology, McGill University

There are 6 geographic full time and 5 part-time attending staff, with 10 technical and clerical support staff. There is a modern, state-of-the-art clinical out-patient facility, with 8 examination-treatment rooms, an electronystagmography testing room, 3 audiological testing suites, speech language-pathology offices, a conference room, and a dedicated residents' room.

The Department runs the following clinics: General Otolaryngology Clinic, Head and Neck Oncology Clinic, Resident's Clinic for in-patient and out-patient consultations, Otology Clinic, Nasal and Sinus Clinic, Voice/dysphagia Clinic, and a Laser Clinic. In addition, extensive Speech-Language Pathology Services are integrated into the services for Head and Neck cancer patients, with a Laryngectomy Support Group and an Oncology Nurse Pivot.

Available resources for Residency Training include:

1. Complete audiological services including ABR and OAE.
2. Computerized electronystagmography testing.
3. Speech therapy department, including a speech and swallowing therapist for the oncology service.
4. Clinical services within the department include head & neck radiology, head & neck pathology, and multi-disciplinary teams for skull base surgery and oncology patients.
5. Departmental conference room and library.
6. Designated Residents' Room.

The CanMEDS roles have been implemented into our training process and now serve as the foundation upon which we structure our practice and teaching. The following will serve to demonstrate the educational objectives, strategies and evaluation process at the JGH.

## 1. Medical Expert

The process of becoming an expert in otolaryngology will be a progression from the R2 to R5 year. The R3 to R5 residents will be expected to use their knowledge of the basic sciences to gradually expand their clinical repertoire and clinical problem solving skills. The R5 residents will be able to see patients and define a treatment plan independently.

The R2 residents will learn basic office-based ENT procedures such as laryngoscopy, biopsies, minor head and neck lesion excisions as well as basic operative procedures. The OR responsibility will progress with the resident's seniority and individual abilities. Their technical training is designed to meet the requirements as outlined in the rotational objectives of the McGill Department of Otolaryngology – Head & Neck Surgery Residency Handbook. All of the general otolaryngology clinics, sub-specialty clinics and surgeries are supervised by Attending Staff. Regular informal quizzing as well as structured written and oral examinations serve as part of the evaluation process, using the One45 framework. All residents must undergo a STASER or STACER evaluation by a JGH staff person during each of their rotations at the hospital.

## 2. Communicator

The vital importance of effective communication in the practice of medicine is taught to the residents. Both verbal and written communication is emphasized. The Jewish General Hospital is situated in the heart of the most multi-ethnic neighborhood in Montreal and our trainees have the opportunity to communicate with patients from a multitude of cultural, ethnic and linguistic backgrounds. The residents are encouraged to enlist the assistance of interpreters when necessary. The importance of establishing a doctor-patient relationship based on trust and understanding is crucial. The resident evaluation process is multi-faceted and includes: observation during the implementation of their clinical duties, STACER evaluation, review of their written notes, evaluations of their OR dictations and patient discharge summaries. The

department uses the McGill Simulation Center on an annual basis, using actors acting like patients to teach residents the communicator role of CanMEDS.

### 3. Collaborator

The practice of medicine today has evolved to a point where working in isolation is not possible or desirable. Medicine, particularly in a tertiary care academic institution, is practiced in a multi-disciplinary team format. The residents must actively participate in tumor boards, and multi-specialty teaching rounds. They are encouraged to recognize the appropriate time to enlist help. Their training also teaches them how to collaborate with the patients as well as family members in the decision-making and management process. They have the opportunity to collaborate with supervisors on their various research projects. The progression from R2 to R5 mirrors the progression of responsibility in the various seminars and teaching rounds. The evaluation process for this aspect of their training seeks feedback from other specialists, peers and allied health professionals (360 degree evaluation). The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the collaborator role of CanMEDS.

### 4. Manager

Effective management skills come in to play at many levels of medical practice. The residents must demonstrate judicious use of medical tests and resources. They will be able to explain the particular purpose of each test ordered. They will learn to perform a type of cost-benefit analysis. The residents will be sensitized to the critical issue of bed utilization. A crucial component of their training is the acquisition of personal time management skills. They will be expected to respect schedules, commitments and call schedules. They will be taught to use information technology to access information and manage their responsibilities. The senior residents will be expected to delegate effectively and organize the work distribution of junior residents and medical students. Residents will be evaluated by way of observation, written and oral exams and creation of case scenarios. They will be assessed based on timely completion of assigned tasks and projects. The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the manager role of CanMEDS.

### 5. Health Advocate

The residents will become advocates of their patients' health. They will learn to counsel their patients regarding health risks such as smoking and alcohol, noise exposure and occupational hearing health, and will provide tools for change. The residents will be encouraged to involve

themselves in public health education, such as public lecture series held in the hospital or university. The evaluation of these attributes and skills will be conducted via close observation of their doctor-patient interactions.

## 6. Scholar

The residents will be expected to develop a reading plan from their R2 year onwards. They will use actual cases as well as the literature to constantly update their knowledge. Our weekly rounds and frequent journal clubs will provide them with ample opportunity to critically review the literature. The supervisors will encourage the utilization of evidence-based medicine as it applies to decision-making. The residents will be inspired towards life-long learning and will be encouraged to develop a teaching dossier early on in their careers. During their progression from R2 to R5 years, their teaching responsibility will increase. A variety of modalities will be implemented to evaluate their scholarly activity. Staff will review their research proposals and manuscripts. Their presentations will be evaluated and supervisors will assess their teaching assignments. Every resident presents a research project once a year that is presented at our Annual Resident Research Day/James D. Baxter Lectureship held in the spring.

## 7. Professional

The residents will demonstrate appreciation and sensitivity for cultural diversity. They will be expected to treat colleagues as well as all hospital employees with dignity and respect. They will be able to disagree with fellow physicians in a diplomatic and constructive fashion. The importance of punctuality will be highlighted. We will expect the care that they provide to be of the highest level, delivered ethically and with compassion. The evaluation process will be achieved by close observation, and feedback will be solicited from allied health professionals, senior residents and office support staff (360 degree evaluation). The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the ethics role of CanMEDS.

# **MONTREAL CHILDREN'S HOSPITAL ROTATIONAL** **OBJECTIVES**

Rev August 2011

The Department of Otolaryngology-Head and Neck Surgery at the Montreal Children's Hospital is well equipped to provide comprehensive, leading-edge post-graduate training in our specialty. It hosts a full complement of sub-specialists, with all of the necessary tools and equipment, and is known for being one of the busiest otolaryngology services in the country.

## **Rotational Objectives and Evaluation:**

The residency-training program at the Montreal Children's Hospital (MCH) conforms to the Royal College of Physicians and Surgeons of Canada (RCPSC) guidelines to train and educate the residents. All aspects of the training are based on the seven major roles of the CanMEDS Project:

- Medical Expert
- Communicator
- Collaborator
- Manager
- Health Advocate
- Scholar
- Professional

### **1. MEDICAL EXPERT:**

The residents attend the different specialty clinics, pediatric tumor boards and interact with other members of clinical departments. Their role as medical experts is illustrated in such activities. They express, discuss, teach and learn the various opinions regarding the investigation and treatment of challenging medical conditions and therapeutic protocols. All residents must undergo a STASER or STACER evaluation by a JGH staff person during each of their rotations at the hospital.

These are the outlined duties:

#### **A) Junior residents**

##### **Clinic:**

- Attends clinics and coordinates his/her time with the OR schedule

- Do consultations during the weekdays and discuss them with the senior resident and attending staff.

In-patients:

- Responsible for the consultations when the senior resident is not available
- Performs rounds with the senior resident and/or attending staff and plans the management and follow-up on admitted patients on the different hospital wards, emergency room including ICU

O.R.:

- Responsible for minor cases (T&As, PET tubes, etc..)
- Assist the senior resident on all other surgeries
- Assist in the O.R. on all cases when “On Call”

Other:

- Cross-cover the adult teaching hospital when on call at the MCH
- Shares responsibilities for weekend coverage of admissions and in- patients with the senior resident

**B) Senior resident**

Clinic:

- Staff the clinic
- Do consultations during the weekdays and discuss them with the attending staff
- Pre-op clinic (if junior is not available)

In-patients:

- Responsible for the consultations
- Organizes rounds with the junior resident and attending staff regarding admitted patients

O.R.:

- Responsible for surgical procedures other than minor cases (head and neck masses, otology cases, FESS, laryngoscopies, bronchoscopies, esophagoscopies)
- Assist in the O.R. when “On Call”
- Assign the junior resident operating room schedule

Other:

- Cross-cover the adult teaching hospital when on call at the MCH
- Shares responsibilities for weekend coverage of admissions and in- patients with the junior resident

### **Pediatric Audiology Montreal Children's Hospital Rotation**

Each resident will be responsible to spend sufficient amount of time in the Audiology Department at the MCH during his/her rotation. The resident will be required to gain knowledge of Pediatric Audiometric testing. An oral exam will be given to each resident prior in Audiology prior to completion of the rotation. The results of the examination will be recorded.

### **Temporal Bone Dissections**

Each resident will be responsible for completing one anatomical dissection of a temporal bone during his/her pediatric rotation. The results of the dissection will be recorded. This dissection is MANDATORY as a requirement in order to pass the rotation at the MCH.

## **2. COMMUNICATOR:**

The resident is evaluated throughout his rotation by the members of the staff as a communicator with the parents and patients. The interview, gathering of clinical information, explanation of the different therapeutic modalities as well as performing the different clinical tasks are the bases of the evaluating process. Both verbal and written communication is emphasized. An important percentage of our patient population has different ethnic background. An interpreter is always present during the interview, this constitutes an additional challenge to the resident who is an essential part of the clinic team. The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the communicator role of CanMEDS.

## **3. COLLABORATOR:**

The resident's role as collaborator is evident during daily interactions with the other physicians and allied health professionals. He is the first member of the team to evaluate the patient's needs and direct the family to the appropriate professional. Examples include: social workers, occupational therapy, audiology, speech therapy, physiotherapy, etc. The collaboration with the different divisions and departments is also of paramount importance. The daily contact with these services constitutes a major task in the resident's clinical activity and reflects an important image on the role of Otolaryngology within the MCH. The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the collaborator role of CanMEDS.

#### **4. MANAGER:**

The resident's role as manager is also elucidated in his daily activities, managing and planning his schedule and supervising the junior members of the team. The wise and proper use of the different hospital services is taken into consideration during the evaluation process. Ordering laboratory, radiological investigations and adopting different therapeutic modalities reflect important points in this process. The members of the team help to guide the senior and junior residents throughout the hospital rotation to this important aspect of medical practice. The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the manager role of CanMEDS.

#### **5. HEALTH ADVOCATE:**

He/she is a health advocate and role model for the young parents and teenagers, teaching them about the dangers and prevention of noise induced hearing loss, promote choking prevention in children, as for teenagers promote risk reduction of head and neck malignancy through smoking cessation, responsible alcohol use and UVA/UVB protection.

#### **6. SCHOLAR:**

Hospital rounds are presented once a week on Mondays at 4pm. Attendance is compulsory for the attending staff, fellows, residents and medical students who happen to be doing "elective rotations" at this time. The senior resident is responsible for the contents and scientific material. The senior resident may delegate the presentation of the rounds to a junior resident or share this responsibility with a student. During the hospital rounds, many clinical cases are discussed. A review of the pertaining literature is usually presented, and the opinions of the different members are expressed. It is through this forum and other similar daily discussions that the resident's role as a scholar is demonstrated. Every year a resident presents a research project at our annual Resident Research Day/James D. Baxter Lecture held in the spring.

#### **7. PROFESSIONAL:**

The residents must demonstrate professionalism by demonstrating the highest standards of excellence in clinical care and ethical conduct. This includes self-discipline, such as a sense of punctuality and respect for cultural diversity. They must address their peers, colleagues, staff and other allied health professionals with the utmost respect and courtesy. Residents are also expected to act as role models. Their sense towards responsibility toward the patients in terms of balancing their professional and personal lives is evaluated on an ongoing basis by their superiors, colleagues and other. The department uses the McGill Simulation Center annually,

hiring actors to portray patients in certain scenarios, to teach residents the manager role of CanMEDS.

### **MCH Resources for Residents:**

- **Pediatric Otolaryngology:**  
Training of residents in all aspects of medical and surgical pediatric otolaryngology that include otitis media and performing different types of tympanoplasties and mastoidectomies including ossicular chain reconstruction. The resident also gain experience in pediatric audiology. Different sessions are given in combination with the Audiology Department on aural rehabilitation and hearing aid assessment for children. The resident will have experience in BAHA surgery as the MCH is a leader in that field.
- **Nose and Sinuses:**  
All medical and surgical aspects of rhinology are covered. The residents perform endoscopic sinus surgery.
- **Aerodigestive diseases:**  
This includes diagnosis and treatment of foreign bodies of the aerodigestive tract, congenital and acquired laryngotracheal problems. The O.R. at the MCH is equipped with laser technology and is one of the few centers in North America that manages these kinds of pathologies. The resident is involved in the treatment of these conditions throughout his rotation at the hospital. There is a specialized airway clinic and the resident is exposed to a multidisciplinary approach to pediatric airway problems.
- **Specialty clinics:** residents exposed to specialty clinics in otology, airway, reflux, dysphagia, and saliva. These clinics focus on more complicated cases involving these domains.
- **Pediatric oncology:**  
In association with the Hematology/Oncology departments and Radiotherapy, the residents are involved in the treatment of head and neck tumors including lymphomas, rhabdomyosarcomas, etc.
- **Research:**  
The resident is involved with different basic and clinical research projects during his/her rotation at the MCH. All our physicians are keen on research. The newly established McGill Auditory Sciences Laboratory under the supervision of Dr. S. Daniel is located at the hospital and provides an excellent opportunity for basic science research.

- **Formal teaching sessions:**  
In addition to hospital rounds, formal teaching sessions are provided on a weekly basis by the residents which are supervised by an attending staff.
  
- **Feedback and Evaluation:**  
The residents should expect to get at a minimum 2 one-on-one feedback session with the director Dr Sam Daniel who will summarize the feedback provided by the staff physicians and discuss any issues pertaining to the service. Also the attending staff gives verbal feedback at mid-rotation and at the end of rotation.

# **MUHC MONTREAL GENERAL HOSPITAL SITE**

## **ROTATIONAL OBJECTIVES**

*Rev: June 2011*

### **Introduction:**

The Otolaryngology Department at the MGH is staffed by 6 attending otolaryngologists under the direction of the Otolaryngologist-in-Chief Dr. Saul Frenkiel, clinical site Director Dr. Karen Kost and resident's academic staff director Dr. Robert Sweet

Clinics are held 5 days a week in the main clinic area and/or the Voice Laboratory. In the main clinic area every examining room is equipped with a flexible video-laryngoscope, a wall mounted microscope, a computer terminal, as well as an updated motorized chair and instrument cabinet. There is also a separate outpatient operating room for minor procedures.

One day per week is devoted to a multidisciplinary clinic in head and neck oncology.

The MGH site is a pioneer in the study of voice disorders. Patients with voice disorders and dysphagia are seen in the state-of-the-art Voice Laboratory, nearby the main clinic area, with the support of Speech Pathologists.

The MGH site is a Level 1 trauma centre. Therefore, there is a steady flow of clinic patients and in-patients with all types of injuries to the head and neck, allowing for the resident to develop expertise in this area.

The general clinics are staffed by general otolaryngologists as well as otolaryngologists with fellowship training in neurotology, rhinology, laryngology and head and neck surgery.

At present, surgery is split between the MGH and RVH sites, with the MGH site receiving one day of surgery per week in the main operating room. The operations consist primarily of thyroid, microlaryngeal, and laryngeal framework surgery.

The MGH Laser Centre provides access to CO<sub>2</sub>, Yag and pulsed dye lasers.

In the main clinic area, there is a computer-equipped conference and library room available to the residents for patient results, study, and general use.

The division of Speech and Hearing is adjacent to the otolaryngology clinic and offers audiological testing and rehabilitation, and speech and voice diagnostics and rehabilitation.

## **CanMEDS Objectives:**

### **1. Medical Expert:**

The role of a medical expert is crucial and central to becoming a competent physician. The MGH provides the residents with a unique opportunity to sharpen their clinical skills and diagnostic skills in the following domains:

- Laryngology
- Otology
- Head and neck oncology
- Rhinology

During this rotation, residents should learn:

- How to elicit a pertinent, concise and accurate history and learn how to perform a history, which is tailored to the patient's problems. In laryngology, this means eliciting specific factors which may lead to vocal problems such as vocal abuse, smoking, alcohol, and the use of poor vocal technique in singing. In the case of head and neck oncology, the residents must learn to identify specific risk factors in the patient's history such as smoking and alcohol and occupational factors. In a rhinology history, occupational and environmental factors as well as a previous disposition to allergies and ciliary dysfunction are of primary importance.
- Performing a relevant and appropriate physical examination is extremely important in all these subspecialties. In laryngology, the resident should understand and master examination techniques using the rigid and flexible scopes to perform video stroboscopy. Residents should also learn how to use the basic instrumentation available for examination purposes and the artifacts, which may be produced, by the use of such instruments. The use of a database in all patients is also included in this rotation. A comprehensive laryngology examination includes observation of the patient while he or she speaks and observation of the extrinsic laryngeal muscles and other muscles of the neck. In head and neck oncology, a relevant physical examination includes a thorough examination of all mucosal surfaces of the head and neck including palpation and fiberoptic endoscopy, as well as a thorough examination of the neck. The emphasis in oncology is looking for neoplasms, abnormal masses, ulceration, etc. In Otology, residents will learn a different a skill set in performing the physical examination such as the use and interpretation of tuning forks and observation of eye movements. In rhinology, the importance of a comprehensive examination of the nasal cavities and sinus ostia with rigid endoscopy must be learned. In those presenting with facial defects following removal of cutaneous malignancies, a thorough physical examination looking

for any neuro, sensorimotor or functional deficits is crucial for assessing proper reconstruction.

- To elicit a comprehensive and relevant history and to perform a pertinent physical examination is of course predicated on an adequate knowledge of the basic and clinical sciences. Residents must learn the relevant anatomy, physiology and pathophysiology of the various areas of the head and neck. While R2 residents are expected to gain competence through practice and guidance from staff and repeated practice, senior and chief residents are expected to have gained a mastery of the various physical examination techniques and be able to teach and demonstrate these to both their junior colleagues and medical students.
- Residents must also understand how to select appropriate investigative tools such as CT scans, magnetic resonance imaging and nuclear imaging and when to apply these tools appropriately.
- The MGH provides an ideal setting for residents to gain competence and exposure to a number of outpatient procedures. This includes obtaining biopsies, including endoscopic biopsies of various head and neck sites, and fine needle aspiration cytology of variably located neck masses. A variety of microscopic techniques, such as insertion of pressure equalizing tubes should also be learned during this rotation. Minor reconstructive procedures for facial defects as well as following various head and neck procedures are frequently performed and provide residents with the opportunity to learn proper tissue handling techniques, suturing techniques, and how to evaluate patients for the best possible reconstruction.
- Based on knowledge in basic and clinical sciences and gathering pertinent information and performing an appropriate physical exam, residents are expected to learn how to synthesize the information into an appropriate diagnostic and therapeutic approach.
- Our residents are encouraged to develop a reading plan that may be focused on the particular subspecialties during the rotation such as laryngology, rhinology and otology. This reading plan should include ongoing reading in the basic and clinic sciences. Residents are also encouraged to use existing computer technology as well as libraries to access and retrieve important information for the purpose of learning, presentation at hospital and grand rounds. Residents present cases weekly at hospital rounds based on the different subspecialties. They are also encouraged to learn from their staff and from their seniors and this while recognizing their own limitations.
- Senior and chief residents should be able to function more independently in performing procedures and running clinics. They should also assume a greater role in teaching both medical students and junior colleagues.
- Residents are evaluated in a number of ways. These include case presentations, during clinics, ward rounds, and more formal presentations at hospital rounds. Residents can also expect to be observed and evaluated while performing outpatient procedures. Formal and oral and written exams are held twice a year. All residents must undergo a STASER or STACER evaluation by a JGH staff person during each of their rotations at the hospital.

## **2. Communicator:**

The resident is expected to specifically learn the importance of being a good communicator in establishing relationships with patients and physician colleagues. The resident must elicit and gather information effectively, taking into account patients' concerns and expectations about the illness and must deliver information back to the patient and family in a humane manner. The MGH sees patients from all types of ethnic and cultural backgrounds and exposes residents to the rich cosmopolitan nature of Montreal society while also sensitizing them to differences that must be taken into account in terms of treatment and communication. The importance of gathering information is illustrated in the specialty as a whole and in all the subspecialties individually. Specific, pertinent information must be elicited from the patient presenting with laryngology problems while the information elicited may be quite different for patients presenting with head and neck problems or sinus difficulties. In laryngology, it is extremely important to elicit a very detailed voice history as well as the life style history including home and work environment. During the head and neck clinic, the information will be quite different and certainly the role of the communicating information particularly as it pertains to prognosis, becomes very important. It is crucial for the resident to be empathetic and sensitive in the manner in which the information is delivered and communicated. Residents must also learn how to work with their peers, their colleagues, allied health personnel and with staff. Effective and accurate communication allows for more efficient and high quality health care delivery.

At the R2 level, residents are explicitly taught the importance of communication, and learn through role modeling from staff and senior residents. At the more senior levels, residents themselves become role models and will further refine their own skills. This may include communicating difficult information to the patient (e.g.: poor prognosis, end-of-life issues), and dealing with complex family/patient dynamics. The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the collaborator role of CanMEDS. Residents are assessed by direct observation during clinical activities and, to some extent, in examinations.

## **3. Collaborator:**

Otolaryngologists work in partnership with others involved in patient care. Residents must learn to collaborate effectively with patients and a multidisciplinary health care team in order to provide optimal patient care, education and research.

General otolaryngology, as well as each subspecialty, involves multidisciplinary interaction. In the Voice Laboratory, junior residents under direct staff supervision show and teach patients about their diagnoses with the help of digital imaging. They also interact regularly with speech-language pathologists in formulating and implementing treatment plans. In the Head and Neck clinic, collaboration with radiation oncologists, medical oncologists, nurses, social workers, dieticians and many other involved allied health care personnel is continuous and essential to

optimizing care in these highly complex patients. All residents actively participate at MUHC multidisciplinary rounds at a level that commensurate with level of training. R2's are expected to present cases, suggest treatment plans, and contribute to discussions involving other disciplines. They must also recognize their own limits and enlist help/consultation when appropriate. Contribution to these activities increases in complexity from the R2-R5 level with chief residents expected to lead and direct discussions. Research conducted through the Voice lab or other subspecialties necessarily involves ongoing collaboration with co-authors and contributors. This interaction is paramount during the enrichment year (R3 & R4). Residents also participate in committees from the R3-R5 level, which involves collaboration with peers and staff.

By the end of the rotation, residents should be able to effectively consult with physicians and health care professionals as well as contribute effectively to inter/multidisciplinary activities. The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the collaborator role of CanMEDS.

#### **4. Manager:**

Residents function as managers on a daily basis when they make decisions involving resources, co-workers, tasks and to some extent policies. They do so in the settings of individual patient care, practice organizations and in the broader context of the health care system. This means they must be able to prioritize and effectively execute tasks through collaboration with colleagues. As managers, residents are in positions of leadership, and must respect the responsibility that comes with such a position.

During the rotation at the Montreal General Hospital, residents must learn about the structure, financing and operation of the Canadian health care system and its facilities as they pertain to the practice of otolaryngology; this is important in learning to function effectively within that system. The resident must also be able to optimally use information technology in making clinical decisions. As active members of the health care team, resident managers must have a clear gradation in responsibility from the junior to senior to chief level. This begins with time management, which includes working effectively and in a timely manner within time constraints. Junior residents must acquire efficiency skills in learning to perform multiple duties within a certain time limit. They must learn to prioritize tasks and distribute their time accordingly. Senior and chief residents are expected to assist junior residents in time management skills and in helping prioritize patient care issues. Senior and chief residents must learn to balance their time between clinical duties and the stress of studying for final exams. Chief residents also assume a greater responsibility in terms of the call schedule they manage and put together within the accepted collective agreement guidelines.

Junior residents are expected to learn the availability, costs, risks and benefits of all of imaging resources. They must learn about the availability of beds and when these should be used to

admit patients. Junior residents must also be familiar with available manpower in terms of allied health care personnel which may be in the form of secretarial support, nursing availability and support, physiotherapy, social services and so on. Junior residents must be able to access information and find and retrieve data both for direct patient care and when necessary for research purposes. Senior residents must understand these resources and assist junior residents in deciding how to best prioritize and allocate their use. R5 residents will also be expected to acquire some skills in terms of future practice management that may be learned through seminars offered at the faculty level. All of these managerial skills apply to general otolaryngology as a whole and to all of its sub-specialties. The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the manager role of CanMEDS.

By the end of the MGH rotation, residents should have the following competencies; be able to utilize time and resources effectively to balance patient care outside activities and personal commitments; demonstrate an ability to allocate finite health care resources effectively and efficiently within the health care system; be able to acquire and apply information technology in a proficient fashion for self-learning and optimal patient care.

The evaluation of this role is multi-faceted and as for the others roles includes direct observation during clinical activities. Residents at all levels may be required to locate and retrieve pertinent data which may impact patient care and may later be asked to what degree they were successful in achieving this. Residents will also be evaluated in terms of their ability to complete, in a timely manner, tasks assigned and important hospital documents such as operative reports and discharge summaries. Finally, the ability to act effectively as a manger may also be evaluated both in oral and written exams that may take the form of impromptu quizzes at any time during the rotation.

### **5. Health advocate:**

The importance of the physician resident as a health advocate to the patient and community at large is self-evident. The specific objectives including acquiring an ability to demonstrate an understanding of the determinants of health by identifying socio-economic and personal risk factors in the development of certain pathologies and how to apply preventive/ corrective measures. Residents must also understand and be familiar with current policies that affect health either in a positive or negative fashion in order to effect change. These principles must be applied in the management of individual patients, the patient population as a group and finally the general population. In laryngology, residents must have a solid understanding of risk factors such as tobacco, alcohol, vocal abuse, improper singing technique and inadequate vocal hygiene. Similarly, in Head and Neck Oncology, residents must be knowledgeable in the potential risk factors for the development of carcinoma including such as tobacco and alcohol. The resident must be involved in educating both the patient and the public as a whole to the dangers involved with these lifestyle choices. In doing so, the residents may play an active role in prevention, and treatment by making tobacco cessation resources available to the patient. Residents must also be

aware of their impact on patient care. It has been clearly demonstrated that smoking cessation advice coming directly from a physician with some time spent on explaining available resources has the greatest potential positive impact on a successful outcome. In the public forum, residents may actively involve themselves and they must understand that they may be involved in implementing changes to public behaviors and public policies. For example, residents should be aware of organizations such as Physicians for Smoke Free Canada. They may also get involved, particularly at the senior and chief resident level, in public education by giving many lectures or seminars and speaking within the school system.

As a health advocate, the junior resident is also involved in obtaining investigations and implementing treatment in a timely manner. Junior residents are expected to learn this role and acquire information about the risk factors and how they can use the information as health advocates. Senior residents are expected to acquire more of the leadership roles in helping teach junior residents, in role modeling situations, and within the public forum. They may be evaluated by direct observation in the clinical setting as well as in written documents and rounds, where they may be asked questions. Patients, patients' families, and allied health care personnel may also be involved in evaluating the resident's ability to function as a health care advocate. By the end of the rotation, it is expected that the residents will be able to identify the health determinants in individual patients and therefore intervene accordingly and effectively. The resident must also be able to recognize issues, settings and circumstances in which he may be a potent advocate on behalf of the patient and act appropriately.

## **6. Scholar:**

The role of scholar is extremely important in otolaryngology. It requires the resident physician to continually ask and seek answers to questions in a lifelong pursuit of learning. Junior residents must develop a basic reading plan, which allows them to acquire the essential nuts and bolts needed to practice otolaryngology. This type of activity is essential in promoting competency and mastery of the discipline of otolaryngology. Specific objectives for residents include; asking clinical questions and acquiring the skills to answer those clinical questions. In the voice laboratory, for example, a resident physician may ask a question with respect to the treatment of a vocal condition. The question may then be partially answered by the staff in attendance, and the resident may be further directed and appropriately guided towards a literature search on the matter to further answer the question. This may in turn lead to a treatment plan and its implementation. Reviewing the literature and answering one question often leads to asking many other questions, which may be occasionally addressed in clinical or basic science research projects. Senior residents have increasing responsibilities in terms of helping junior residents answer questions and assisting them in accessing information technology to answer the questions. Junior residents may pose a simple research question that they wish to further investigate and publish. More advanced basic research with some knowledge of epidemiology is expected at the R4 level in which a major research project is developed. This research project may be part of any of the subspecialties of otolaryngology, including, of course, voice. Senior

and chief residents are expected to pose more complex questions and be able to understand and critically appraise the available literature in answering these questions. This means reading major otolaryngology textbooks. For the purposes of rounds and interesting cases, residents are directed outside of the textbook to the literature. Senior and chief residents, while using major otolaryngology textbooks must acquire the skills to do an in depth literature review when necessary and must also understand the need for ongoing education by consulting recent publications and journals, whether they be at the library or online. Junior residents must be taught how to connect the information they have acquired to the skill of evidence-based medicine, which means applying that information to decision-making and treatment plans. Chief and senior residents must refine this skill and assist in teaching it to junior residents. Not only is the responsibility in teaching applied to junior residents, but also to other allied health professionals. Furthermore, residents, particularly in their senior years, are encouraged to develop a teaching dossier.

Upon completion of the rotation, the resident should be able to develop and implement a personal continuing education strategy, which, for the junior resident, means a reading plan through residency. For the senior and chief resident, this includes evolving from basic textbooks to current journals and being able to assess the pertinent literature. Residents should also critically look at sources of medical information and this type of appraisal is discussed informally during clinics and also at rounds and other educational activities. Self-learning by residents facilitates the learning of patients, students, residents and other allied health professionals. Ongoing reading and research be it clinical or basic in nature, ultimately contributes to the development of new knowledge. Success in attaining these objectives may be evaluated by verifying the ability of junior residents to complete simple assignments and in the case of chief residents, the completion of more complex assignments including complex research papers. Chief and senior residents may be directly observed teaching junior residents and allied health care personnel, both in the clinical setting, on the ward, and in the operating room. During hospital round presentation, the degree in depth to which a particular case or problem has been researched and evaluated can easily be assessed

## **7. Professional:**

Professionalism in otolaryngology is essential in assuring the highest standards of excellence in clinical care and ethical conduct. Specific objectives for the resident physician include self-discipline, which includes a sense of punctuality, which applies to beginning the clinics on time, arriving at prearranged meetings on time, and arriving to the operating room on time. At the junior resident level, this involves being very familiar with timetables within the hospital setting and being able to meet them. Residents must learn a sense of responsibility that comes first for the patient and their family. These responsibilities must be met over and above other commitments particularly in cases of emergency. Residents must learn to balance their responsibility to patients/families with a balanced home life. The otolaryngology clinic at the Montreal General Hospital and all of its subspecialties treat patients from a wide variety of

cultural backgrounds. Residents must be familiar with the cultural diversities to which they are exposed and demonstrate sensitivity and respect for these cultural diversities. On a personal level, residents must learn to address their peers, colleagues, staff and other allied health professional with the utmost respect and courtesy. Differences in opinion must be discussed and debated and resolved on a professional level, without resorting to outbursts or foul language, both of which are highly inappropriate and unprofessional. Residents must also learn the importance of adhering to the ethical codes to which physicians are bound. This is illustrated on a day-to-day basis in the clinic and on the wards where ethical issues involving patient information or treatment planning arrives regularly. Residents must learn to resolve these issues by understanding the involved legalities, speaking to other allied health professionals and ethicists, and by a great deal of personal thought as well. Junior residents are primarily preoccupied with familiarizing themselves the cultural and ethnic diversity around them, the rules of the hospital setting, and their learning responsibilities. As they become comfortable during rotations, they are expected to expand their knowledge in these areas. Senior and chief residents have more of a leadership role in assisting and teaching junior residents about cultural diversity and familiarizing them with the resources available in solving ethical or personal differences. Residents are also expected to act as role models in terms of what it means to be punctual and responsible professionals. The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the professional role of CanMEDS.

Residents are evaluated on an ongoing basis regarding punctuality and attendance at different clinical events. Their sense towards responsibility toward the patients and in terms of balancing their professional and personal lives is evaluated on an ongoing basis through observation during clinical activities, and at the end of the day. Residents' sense of respect and courtesy towards colleagues and other health professional may be evaluated as well by obtained feedback from nurses, secretaries, OR staff and clinical staff (360 degree evaluation).

# **MUHC - ROYAL VICTORIA HOSPITAL ROTATIONAL OBJECTIVES**

Rev August 2011

The Royal Victoria Department of Otolaryngology has a history over one hundred years long of teaching post-graduate students, medical students, residents and fellows. The rich mix of clinical resources; research labs and multidisciplinary venues have been key. The Royal College of Physicians and Surgeons of Canada has been instrumental in aiding and spurring the progress of specialist teaching worldwide. The CanMEDS model has been adopted in a number of countries around the world including Australia, Denmark, the Netherlands and the UK. We have adopted with enthusiasm these objectives and have sought to integrate them into resident teaching and evaluation. These physician roles include the following: medical expert/clinical decision-maker, communicator, collaborator, manager, health advocate, scholar and professional. The CanMEDS roles and objectives are set out in the CanMEDS 2000 Project Societal Needs Working Group Report which is publicly available online. Our residents and attending staff are encouraged to be familiar with the RCPSC guidelines and specifically CanMEDS.

All residents are given a package of objectives, information and orientation materials when they start the rotation.

## **Educational objectives and strategies for their attainment:**

### **1. Medical Expert**

Clinical teaching is performed in resident-led clinics and well as at the bedside. The Department at the Royal Victoria Hospital has long recognized the importance of teaching residents key skills in the clinic; whereas Otolaryngologists they will spend most of their professional time. Residents on the service are required to attend clinics, and participate in the care of patients in clinic. With these encounters, residents have the opportunity to develop their skills in terms of history taking, performing the physical examination and proposing an appropriate, cost-efficient and ethical plan of investigation. Development of their technical skills appropriate to a clinic setting is also stressed. Patients are reviewed with attending staff and seen by the attending. Thus an apprenticeship model of teaching is used. Residents can also participate in subspecialty clinics run by the Department's attending staff. Residents are also expected to participate in the two multidisciplinary clinics run by the Department: Head and Neck Clinic and Skull Base Clinic

The Department operates three to four days a week at the Royal Victoria and Montreal Neurological Hospitals. Surgery spans the gamut of Otolaryngology Head and Neck Surgery's domain. Technical skills are developed under supervision of the attending staff, and in the case of junior residents, by more senior residents. Additionally, residents can accompany staff in a Northern Quebec visit and in accredited satellite offices.

## 2. **Communicator**

Communication skills are essential for the specialist. Residents in clinic and with patients and family at the bedside are given an opportunity to improve their skills. Their performance is assessed with respect to how they handle the dimensions of respect, trust, empathy with patients and their families as well as confidentiality. Effective communication objectives include being able to establish:

- A therapeutic relationship with patients
- Eliciting and synthesizing relevant information
- Discussing appropriate information with the patient and family.

They are also evaluated and given feedback in formal rounds within the Department. These include Monday morning rounds in which they are asked to present cases as well as at Tumor Board.

The Royal Victoria Hospital is situated in a special geographic location in Montreal. Although it has historically been part of McGill and the English Montreal community, it is the most easterly-situated McGill hospital and attracts a large proportion of francophone and allophone patients. Our connections with Northern Quebec add to the sometimes-challenging communications issues that can arise in such an environment. The attending staff is particularly sensitive to how this is handled by the residents. The skills learned in this milieu will serve our residents well in our increasingly interconnected world. The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the communicator role of CanMEDS.

## 3. **Collaborator**

The Department of Otolaryngology is proud of the creation of two interdisciplinary clinics. Residents are required to attend these clinics. They provide a forum to witness and participate with other physicians and health care professionals in the care of our patients.

Residents must participate in the weekly interdisciplinary rounds held in conjunction with nursing, social services, OT, and speech pathology. These experiences should permit them to:

- Understand and value the skills of other specialists and health care professionals
- Understand the limits of their knowledge and skills
- Be able to understand, accept and respect the opinions of others on our team.

The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the collaborator role of CanMEDS.

#### 4. **Manager**

Specialists function as managers at many different levels. The rotation at the RVH is designed to develop and challenge their management skills.

With a number of learning venues underway in parallel, effective time management on the part of the residents is key. How they manage their time, and in the case of senior or chiefs how they distribute their own resources, are carefully assessed. They must show good judgment in allocating the health care system's resources and work within the system using existing resources. They are encouraged to utilize information technology. Computers have been installed in the resident's room as well as in the clinic, the inpatient floor and the OR. Training on software use from the Department's attending staff as well from specialists from other departments (for example Radiology) has been encouraged. Residents are required to have taken the appropriate seminars and have their own codes to access the hospital's information system. Monday morning rounds and Tumor board are specific examples of rounds in which the residents are given important responsibilities in organizing. Their management effectiveness is easy to assess by the staff.

The chief residents manage resident-call schedules. They must provide coverage while assuring the schedule corresponds to legal requirements, and accommodates in a fair and professional manner the other residents. The same applies to vacations. The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the manager role of CanMEDS.

#### 5. **Health Advocate**

Specialists must recognize the importance of advocacy activities and be able to undertake them at a number of levels: directly with patients, at the level of the hospital, and as players in the public arena. The Department promotes prevention by teaching who is at risk, and by encouraging residents to discuss these issues directly with the patients. Examples include smoking cessation or avoiding noise-induced hearing loss. In addition, they are asked to discuss with the attending staff situations within the hospital where care could be better delivered to our patients. They are involved in our department's efforts to help our patients, such as laryngectomy patients who have communication challenges, or the hard of hearing.

#### 6. **Scholar**

Just like the attending staff, the residents have the responsibility to develop a personal education strategy. In the discussion of treatment option for patients, residents are required to synthesize

medical information and be able to critically appraise it. They are required to help in the teaching of students and other, especially more junior, residents. They must contribute to the development of new knowledge. Residents are encouraged to participate in Departmental research. Many presentations at meetings and publications in peer-reviewed journals started as questions and observations made at the Royal Victoria Hospital.

## 7. **Professional**

Residents are expected to strive to deliver the highest quality of care with integrity, honesty and compassion. They should show appropriate personal and interpersonal professional behaviors. They should understand the need to practice medicine in an ethically-responsible manner that respects the medical, legal and professional obligations of belonging to a self-regulated body. Specifically, they need to meet discipline-based objectives, personal/professional boundary objectives, and objectives related to ethics and professional bodies. The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the professional role of CanMEDS.

## **ROTATION TO THE QUEBEC NORTH** **KUJJUAQ, PIVURNITUQ, INUKJUAK, IVUJIVIK,** **SALLUIT**

During the residency program, residents from Canadian origin at all levels have the opportunity to spend one to three weeks in Northern Quebec with a staff member. Although not compulsory, this rotation is strongly encouraged and seems to be enjoyed by the vast majority of residents. This rotation allows residents to experience rural medicine in a culturally and geographically unique Canadian Inuit aboriginal society.

Dr. Kost is the Director of Otolaryngology at the Centre Hospitalier Inuitsilivik in Pivurnituq coordinates otolaryngology health services provided to the Nunavik Region. The region is divided into two geographic areas: the Ungava Bay region and Hudson's Bay Region. Drs. Zeitouni and Rappaport service the Ungava Bay region, and Drs. Kost, Daniel and Sweet provide services to the Hudson's Bay Region.

During their week in the North, residents have the opportunity to work one on one with their staff during outpatient clinics and in the operating room. This allows for intense teaching and has significant educational benefits for both the ambulatory setting and in the operating room, where the pressures of a large hospital do not apply. During a five-day workweek, surgery is scheduled for a minimum of 4 out of the 5 days, and consists primarily of otological procedures. Residents are taught step by step, and one on one, how to perform a tympanoplasty with a graded increment of technical experience being acquired over the week. By the end of the week, most residents are able to perform a Type I tympanoplasty entirely on their own. In the ambulatory setting, residents are exposed to a wide variety of otolaryngology complaints with a predominance of otology related disorders. These include hearing loss, tympanic membrane perforations and other abnormalities, as well as malignancies particular to the Inuit population such as nasopharyngeal carcinoma. In addition to the academic value of the rotation, weather conditions and time permitting, residents are taken out into the tundra and may participate in activities such as igloo building and ice fishing. The CanMEDS roles are actively integrated into this rotation as they are into other rotations.

### 1. **Medical Expert:**

During this rotation, the resident is expected to concentrate on and improve their diagnostic and therapeutic skills, particularly as they pertain to particular Inuit pathologies affecting the ear and nasopharynx. The resident is taught and encouraged to read the pertinent literature and develop a sound understanding of these disease processes. At the end of the rotation, the resident is expected to have mastered a complete history and physical examination as well as formulate and execute an appropriate treatment plan. Performance is evaluated throughout the week with continuous feedback

in both the ambulatory and operating room setting by the staff and nursing personnel in the hospital.

2. **Communicator:**

Effective communication with the Inuit is particularly important because of cultural differences and also because many Inuit speak only Inuqtituq. Residents must communicate with the Inuit either directly or with the help of interpreters in a manner which allows patients and their families to understand what is being said. Residents must be able to obtain a pertinent history and explain the principles of necessary treatment in a manner which is sufficiently simple to facilitate understanding.

3. **Collaborator:**

At the end of the rotation, residents should be able to consult effectively with the onsite family physicians, as well as the nursing staff who are familiar with many of the patients on an individual basis. Exchanging information and collaborating with these individuals promotes the development of optimal and realistic treatment plans.

4. **Manager:**

During this brief but intense week in the north, residents quickly become familiar with available resources pertaining to the operating room, on site personnel and diagnostic tools. These villages are remote and isolated, and patients frequently must be flown in to the hospital to undergo surgery. More complex investigations and treatments must occur in Montreal, which requires displacing patients from their native villages to a large urban center. Such a move is resource intensive and also culturally disruptive. It is therefore essential during this rotation that residents learn to allocate resources effectively, in a way which is sensitive to the personal and cultural needs of the patient.

5. **Health advocate:**

Residents must learn to identify the particular determinants of health in the Inuit population. For example, acute and chronic otitis media are frequently seen and resident must be familiar with the numerous risk factors for this disease and effectively teach both the patient and their families how to modify these risks. These would include changing infant feed practices, smoking cessation and water precautions. With this knowledge, residents are also encouraged to work with the audiologists on site who promote effective ear hygiene and preventive measures within the school system. Residents are also encouraged to engage in teaching activities of both the nursing staff and of the family practitioners. Frequent impromptu teaching sessions are held to answer concerns on behalf of the family physicians and educate them with respect to otolaryngological issues.

6. **Scholar:**

As physicians and specialists, residents must learn the importance of developing and implementing lifelong continuing medical education. This continues with ongoing reading, review of the literature in special cases, special patient problems, especially as they pertain to particular Inuit pathologies affecting the ear and nasopharynx. Residents are taught and encouraged to read pertinent information and literature to familiarize themselves with the pathologic processes they encounter.

7. **Professional:**

Residents are expected to develop sensitivity to the ethnic and cultural uniqueness of this region, and to behave in a professional manner with integrity and honesty with the patients and their families. Courtesy and respect is also expected for the opinions of the allied health care personnel with whom the residents work. For all of these roles, residents are evaluated on a day-by-day basis through their written documents, through observations with interpreters and patients, on the ward, and in the operating room.

## **COMMUNITY ROTATION ELECTIVE at the LAKESHORE GENERAL HOSPITAL**

During part of the PGY 3 & 4 year (research enrichment year) all residents will have a month of community rotation in the Lakeshore General Hospital. This rotation allows residents to experience community type of otolaryngology practice in a small hospital with its' affiliated outpatient clinics.

Dr. Richard Lafleur is the Director of the Otolaryngology Division at the Lakeshore General Hospital. The OTL Department also has 4 other teaching staff (Dr. Roger Lebel, Dr. Jack Rothstein, Dr Vi Vu and Dr. Gilles Belisle).

This rotation allows the resident an opportunity to work with our adjunct faculty members within the community. As resident, there are an ample amount of general otolaryngology cases within the ambulatory surgery center. Tonsillectomy, adenoidectomy, myringotomy, tympanoplasty, other otology cases, uvulopalatopharyngoplasty, septoplasty, rhinoplasty, turbinectomy, endoscopic sinus surgery and minor head and neck cases are performed commonly at this center.

During their month rotation, residents have the opportunity to work with their staff during outpatient clinics and in the operating room. This has significant educational benefits for both the ambulatory setting and in the operating room, where the pressures of a large hospital do not apply. In the ambulatory setting, residents are exposed to a wide variety of common otolaryngological pathology encounters in a community setting.

Residents will also learn for the clinical setup of the hospital and the staff doctor's offices which are located outside the hospital but not far from it. This will provide a new learning environment with appropriate supervision and evaluation.

The CanMEDS roles are actively integrated into this rotation as they are into other rotations.

### **1. Medical Expert:**

During this rotation, the resident is expected to concentrate on and improve their diagnostic and therapeutic skills, particularly to common otolaryngologic pathology. The resident is taught and encouraged to read the pertinent literature and develop a sound understanding of these disease processes. At the end of the rotation, the resident is expected to have a good appreciation on how to set up a community practice, what type of OTL pathology he will encounter during community based practice, how to arrange the pre & post-operative care with appropriate clinical judgment in selection of therapy, how to allocate his/her time efficiently and what type of equipment he will need to start the practice. He will master a complete history and physical examination as well as formulates and execute an appropriate treatment plan. Performance is evaluated throughout the week with continuous feedback in both the ambulatory and operating room setting by the staff.

2. **Communicator:**

To establish effective communication with the new hospital and office staff, also to establish a therapeutic relationships with patients and families with simple common pathology. Residents must be able to obtain a pertinent history and explain the principles of necessary treatment in a manner which is sufficiently simple to facilitate understanding.

3. **Collaborator:**

At the end of the rotation, residents should be able to consult effectively with the onsite physicians, as well as the nursing staff and other health care professionals. Exchanging information and collaborating with these individuals promotes the development of optimal and realistic treatment plans. Residents will contribute to the health team with their own expertise and develop good approach to collaborate with them.

4. **Manager:**

During this month the residents will quickly become familiar with available resources pertaining to the community hospital setting. He will realize the limited resources that needs for patient care; will learn which cases will need to be referred to the outside University hospital. Allocate health resources wisely and work effectively in this health care organization. The resident will also learn and appreciate the utilization of information technology to optimize patient care and life-long learning.

5. **Health advocate:**

Residents must learn to identify and improve the particular determinants of health in the general population. For example, encourage behaviors that promote hearing protection at home and work, and reduce patient's risks for head and neck malignancy through avoidance of smoking and alcohol consumption. Residents are also encouraged to engage in teaching activities of both the nursing staff and of other health care providers and the public regarding common head and neck problems that benefit from early intervention.

6. **Scholar:**

As physicians and specialists, residents must learn the importance of developing and implementing lifelong continuing medical education. This continues with ongoing reading, review of the literature in special cases, even for common Otolaryngologic pathology. Residents are taught and encouraged to read pertinent information and literature to familiarize themselves with the pathologic processes they encounter.

7. **Professional:**

Residents are expected to develop sensitivity to the ethnic and cultural uniqueness of this community, and to behave in a professional manner with integrity and honesty with the patients and their families. Courtesy and respect is also expected for the opinions of the allied health care personnel with whom the residents work. For all of these roles, residents are evaluated on a day-by-day basis through their written documents, through observations with interpreters and patients, in the clinics and in the operating room

**Department of Otolaryngology-Head and Neck Surgery**  
**McGill University**  
**Community rotation objectives**

**Medical Expert**

- Establish clinical knowledge in common ENT pathologies encountered in a community practice
- Become proficient in common surgical procedures in a community practice
- **Resident surgical procedures:**
  - Myringotomy and tubes
  - Tympanoplasty
  - Mastoidectomy
  - Otoplasty
  - Adenotonsillectomy
  - Uvulopalatopharyngoplasty
  - Septoplasty
  - Rhinoplasty
  - Turbinoplasty / turbinectomy
  - Cervical lymph node biopsy
  - Endoscopic sinus surgery – maxillary, ethmoids and sphenoid
  - Salivary gland excision

- Sistrunk procedure

### **Communicator**

- Develop communication skills as relates to allied health professionals and support staff, particularly in the setting of a community hospital
- Understand the differences in communication styles with patients consulting in a first-line community setting versus patients in a tertiary academic centre

### **Collaborator**

- Collaborate effectively and efficiently with other specialists as well as allied health care personnel and support staff
- Collaborate with professionals in available community services, including CLSC, allied health services, physicians' offices, and medical clinics and centers.

### **Manager**

- Learn to manage the allocation of resources in a community hospital setting
- Understand available resources in the community such as CLSC, smoking cessation programs, audiology, physiotherapy.
- Develop understanding and skills for managing career and practice effectively
- Appreciate the need for balancing professional and personal life.

### **Health Advocate**

- Identify the determinants of health in the population serviced
- Take advantage of opportunities for patient health advocacy and disease prevention

### **Scholar**

- Understand the public health issues addressed by first line practitioners in the community
- Develop an understanding and a cultural sensitivity for the particular population serviced by the community hospital centre

## **Professional**

- Respond to the health care needs of the community
- Understand the organization and structure of a community hospital practice in contrast to an academic setting
- know limits of consultants / resources, and when to refer to an academic center
- Understand differences in wait-times, types on consultations received, and methods of delivery of care within a community setting versus an academic centre.

# **PGY1 – SURGICAL FOUNDATION (CORE)**

## **SURGERY ROTATION PROGRAM**

General Surgery (Not HBP)	3 months (JGH/MGH/RVH)		
Pediatric Surgery	2 months (MCH)		
SICU (MCH/MGH/RVH)	2 months (JGH/MGH/RVH)	Anesthesia	1 month
Emergency	1 month (MGH)		
Neurosurgery	1 month (MNH)		
OMF Trauma (May-Sept)	1 month (MGH)		
Oncology (Surgical/Radiation)	1 month (JGH)		
Plastic Surgery	1 month (MGH)		

The Core surgery year is the first year of training in otolaryngology. It is a year in which R1's acquire knowledge and experience in the basic principles of general surgery and develop an ability to apply these. At the present time, the CORE surgery year is composed of 13 periods; 3 months of General Surgery, 2 months of pediatric surgery, 2 months in SICU, 1 month of Anesthesia, 1 month of Emergency, 1 month of neurosurgery, 1 month of OMF Trauma, 1 month oncology (surgical/radiation), and one month of plastic surgery. Each period corresponds to 4 weeks of training. The CORE surgery rotations were chosen specifically to provide residents with a sound general surgery background and compliment further training in otolaryngology. The rotations in neurosurgery, oral surgery, plastics as well as the one non surgical elective in radiation oncology are extremely helpful and pertinent to the practice of head and neck surgery. The rotations in maxillofacial, plastics and general surgery expose the R1 to the general principles of trauma and specifically to head and neck trauma.

It should be noted that the Surgical Foundation (CORE) rotations have been modified with extensive resident input such that the surgical rotations are in areas where residents are most likely to get the direct surgical exposure. Surgical Foundation (CORE) program must also comply with the specialty specific rotations required by the Royal College of Surgeons and Physicians of Canada and the American Board of Otolaryngology.

Throughout the R1 year, residents attend weekly Surgical Foundation (CORE) surgery lectures that are compulsory. In addition, they are freed from their clinical duties to attend otolaryngology academic activities such as hospital rounds, academic half days on Thursday afternoons and the Thursday afternoon grand rounds. This is not compulsory however it is highly encouraged. Permission to attend must be approved in advance by the Surgical Foundation program. This ensures an ongoing strong liaison between R1 residents and the department. At the end of their R2 year, residents can write the “**Principles of Surgery Examination**” as required by the Royal College of Physicians and Surgeons of Canada. It is necessary to obtain a pass rate before a resident is eligible to write the Royal College Otolaryngology Exam at the end of their R5 year.

During the Surgical foundation (CORE) year, residents are expected to become familiar with the CanMEDS competency roles. This familiarity is acquired through dedicated seminars at the faculty level, as well as in the Surgical Foundation (CORE) curriculum and formative OSCE surgical fundamentals at the McGill simulation center. R2’s also attend the surgical foundation curriculum teaching session on Wednesday afternoon for the first six months of their training.

## **1. MEDICAL EXPERT**

The role of the medical expert is clearly at the center of any residency-training program. In the Surgical Foundation (CORE) surgery year, there is a basic grounding in surgical anatomy, physiology and pathophysiology, as well as the management of situations such as shock, cardiac arrest, dehydration, and so on. During this year, it is expected that residents will learn the diagnostic and therapeutic skills necessary to provide effective patient care and be able to access and apply relevant information to the practice of surgery. They must also learn to work with other services and obtain appropriate consultation as well as obtain appropriate consultation from other allied health care personnel when necessary. These objectives may be achieved through self-directed learning, the occasional involvement of a mentor, and from observing staff role models. In addition, these skills may be acquired through problem-based learning in the form of case studies, interactive CDs, and various other computer programs available. Wards, clinics and the operating room all provide forums for the development of the medical expert. Residents may be evaluated during their clinical duties, while interacting with patients, at rounds, presentations and at written examinations. The McGill SIM Centre is used for teaching surgical foundation techniques e.g. suture laceration, airway basic management, etc.

## **2. COMMUNICATOR**

While the role of medical expert is paramount and essential, the role of the physician as a good communicator is also crucial. Residents must appreciate early on in their training the importance of establishing good relationships with patients, families, colleagues and allied health care personnel in order to facilitate the elicitation of relevant information and institute appropriate therapy. This involves developing a certain empathy and flexibility towards patients coming from a multitude of cultural and ethnic backgrounds. For patients who are in the ICU, communication may be primarily through next of kin and other close family members. Occasionally, the use of interpreters is required. Information, which is then collected and used in therapy, must also be discussed with the patient and their family who are involved in the decision making process. This role is taught, to a great extent, by physician role

models who demonstrate effective patient/family interaction. Residents are expected to learn the importance of empathy and respect towards patients and their families. They may be observed directly and given feedback while communicating with patients and other allied health care personnel. Residents also learn how to respect patient confidentiality, privacy and autonomy. Residents must maintain clear and accurate records (ex: written or electronic encounters and plans). The residents attend workshops at the Faculty of Medicine for learning the communicator role of CanMEDS.

### **3. COLLABORATOR**

Resident physicians work in partnership with others who are involved in patient care, and it is therefore essential to have the ability to effectively collaborate both with patients and in the setting of a multidisciplinary team of expert health professionals. During the CORE surgery year, the R1 resident must learn his/her role in interacting effectively in consulting with other physicians and health care professionals to optimize patient care. Residents must also learn when and how to contribute effectively in other interdisciplinary team activities related to patient care. This role is learned through exposure and participation in multidisciplinary and interdisciplinary activities such as rounds, clinics and other presentations. It is also learned from role models who demonstrate the ability, to effectively collaborate with others. Interdisciplinary teaching sessions also help to build upon the ability to collaborate effectively. The resident may be evaluated by direct observation, during clinical activities and also by obtaining direct feedback (360 degree) from staff, allied health care personnel, secretarial staff as well as their peers. As part of the collaborator role, residents must learn to work as part of a team. This means being able to share ward-work and operative cases with the common goal of improving services to the patient. Residents attend workshops at the Faculty of Medicine for learning the collaborator role of CanMEDS

### **4. MANAGER**

Residents entering the R1 level must learn to be managers in multiple areas. On a personal level, the ability to organize prioritize and manage time must be balanced between the work setting and outside activities. On a day-to-day basis, this ability is extremely important in allowing the timely completion of tasks, particularly as they relate to patient care. This may mean abruptly interrupting one activity to care for an acutely ill patient or performing an urgently needed intervention. Residents must also learn how to allocate finite health care resources wisely, with knowledge of the cost benefit ratio associated with each resource. Again, this means the ability to prioritize patients who require admission, surgery, diagnostic interventions, or require the use of expensive technology such as magnetic resonance scanning, PET scan etc.

At the R1 level, residents are also introduced to the concept of team management by working with staff and chief residents who function as teachers and role models. They must familiarize themselves with available technologies, their uses, interpretations, diagnostic and therapeutic implications, and balance these with availability and cost. Residents may be evaluated in the following areas: time management, timely completion of medical records and discharge summaries, punctuality, and other important tasks related to patient care. They are given the tools for the establishment of a successful medical practice through management seminars/workshops provided by the faculty on a yearly basis.

### **5. HEALTH ADVOCATE**

Junior residents must learn to identify the important determinants of health affecting patients and in so doing develop the ability to contribute effectively to improved health either through prevention or treatment. This may take the form of advising patients and their families with respect to risk factors or life style choices which impact health such as tobacco and alcohol. It may also mean personal involvement in terms of accelerating or facilitating patient access to important services such as radiological imaging or magnetic resonance imaging. Residents develop proficiency in this role by understanding the advocacy issues in terms of life style issues and other risk factors, and by familiarizing themselves with the health care organization. This is achieved through self-directed learning, interdisciplinary teaching sessions, participating in effective interventions and assistance, in collaboration with chief residents or staff. By doing this, the resident promotes the health of individual patients, communities and the general population.

## **6. SCHOLAR**

As physicians and specialists, residents must learn the importance of developing and implementing a personal lifelong continuing medical education strategy in order to maintain competence in their chosen field. At the R1 level, this begins with a rigorous reading program of basic textbooks to acquire the necessary grounding in Surgical Foundation (CORE) surgery. This continues with ongoing reading in their chosen field or specialty. Review of the literature in special cases, special patient problems or for purposes of presentations or data collection allows an evaluation of medical information and the development of skills to critically appraise the literature. With knowledge acquisition, residents develop the ability to facilitate learning for patients, house staff, students and other health care professionals. Residents are expected to formulate research questions and acquire the skills to answer these questions by developing and instituting a research plan with the help of supervisor and other resources such as CD's, textbooks, computer, etc. Self-directed learning constitutes a large part of becoming a scholar and allows for the practice of evidence-based medicine. Additional expertise is acquired through participation at rounds, presentations, and research. Residents may be evaluated in their ability to develop and complete a research project and appropriate literature review on a particular subject.

## **7. PROFESSIONAL**

It is imperative that the resident, at a very early level, learns to appreciate the importance of professionalism in all aspects of his or her career. This means behaving with integrity, honesty and compassion towards patients, their families, colleagues, and other health care personnel. Health care must be practiced ethically in a manner that is consistent with the obligations of a physician. Residents are also expected to exhibit appropriate personal and inter-personal professional behavior. Differences in opinion must be resolved using appropriate language and courtesy. This type of behavior is learned through direct observation of peers and staff as well as other health care personnel, and yearly workshops/seminars that are held at the faculty and in specialty areas. Consistent feedback must be provided to reinforce appropriate professional and ethical behavior. Illustrative cases, medical legal rounds and ethics rounds also provide adjunctive tools to teach professionalism.

Throughout the R1 year, residents attend weekly Surgical Foundation (CORE) surgery lectures that are compulsory. In addition, they are freed from their clinical duties to attend otolaryngology academic activities such as hospital rounds, academic half days on Thursday afternoons and the Thursday afternoon grand rounds. This is not compulsory however it is highly encouraged. Permission to attend must be approved in advance by the Surgical Foundation

program. This ensures an ongoing strong liaison between R1 residents and the department. At the end of their R2 year, residents are can write the **“Principles of Surgery Examination”** as required by the Royal College of Physicians and Surgeons of Canada. It is necessary to obtain a pass rate before a resident is eligible to write the Royal College Otolaryngology Exam at the end of their R5 year.

The residents attend workshops at the Faculty of Medicine for teaching CanMEDS roles including communicator, collaborator, manager and ethics (professional). The Surgical Foundation (CORE) curriculum i.e.: lectures are available on One-45.

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The residents attend workshops at the Faculty of Medicine for teaching CanMEDS roles including communicator, collaborator, manager and ethics (professional). The Surgical Foundation (CORE) curriculum i.e.: lecturers are available on One-45.

# Independent Rotation Specific Objectives for Surgical Foundation

## General Surgery:

### OBJECTIVES FOR CORE SURGERY RESIDENTS ROTATING THROUGH THE GENERAL AND COLORECTAL SURGERY SERVICE AT THE JGH

#### Introduction

Previously written objectives for the core residents rotating through our service have been modified to conform to the CanMEDS 2000 competencies.

#### AIMS OF THE PROGRAM FOR CORE RESIDENTS

1. From the rotation's first day, core residents will clearly understand what knowledge, skills and abilities will be expected throughout the rotation.
2. Core residents will be able to assess, investigate, diagnose, manage, and operate on patients at a junior resident level.

#### MEDICAL EXPERT

The JGH General Surgery CTU has subdivided this area into the following areas: basic science, clinical knowledge, and technical knowledge and skills.

##### Basic Science

- Core resident will appreciate pertinence of normal physiology and pathophysiology of the adult surgical patient and will demonstrate knowledge during rounds.
- Core resident will correctly identify anatomic structures and landmarks of junior operative cases.
- Core resident will describe the physiology of minimally invasive surgery.

##### Clinical Knowledge

- Core resident will recognize the natural history of general surgical diseases:
  - ESOPHAGUS
    - GERD
    - Paraesophageal and hiatal hernias
    - Lower esophageal tumors
  - STOMACH
    - Neoplasms
    - Ulcer disease

- Hemorrhage
- o SMALL BOWEL
  - Neoplasms
  - Crohn's disease
  - Obstruction
  - Diverticular disease
  - Enterocutaneous fistulae
  - Mesenteric vascular disease
  - Short bowel syndrome
- o APPENDIX
  - Appendicitis
  - Neoplasms
- o COLON AND RECTUM
  - Neoplasms
  - Diverticular disease
  - Inflammatory bowel disease
  - Large bowel obstruction/pseudoobstruction
  - Volvulus
  - Rectal prolapse
  - Ischemic colitis
  - Hemorrhage
- o ANUS
  - Hemorrhoids
  - Fistula and abscess
  - Fissure
  - Neoplasms
  - Condylomata
  - Pilonidal disease
- o LIVER, GALBLADDER
  - Neoplasms
  - Abscess
  - Cholelithiasis and its complications
- o PANCREAS
  - Acute pancreatitis and its complications
  - Neoplasms

- Chronic pancreatitis
- o SPLEEN
  - Splenectomy for hematologic disorders
  - Neoplasms
  - Abscess
- o HERNIAS
  - Groin
  - Umbilical
  - Incisional
- o BREAST
  - Neoplasms
- o ENDOCRINE GLANDS
  - Adrenal tumors
- o SKIN AND SOFT TISSUE
  - Neoplasms

- Core resident will demonstrate competency in the assessment of common presentations:
  - o Abdominal pain/acute abdomen
  - o GI hemorrhage
  - o Incarcerated hernia
  - o Perianal pain
  - o Jaundice
- Core resident will describe appropriate investigation and management of general surgical diseases.
- Core resident will recognize the impact of comorbidities on patients with surgical problems, and will manage them appropriately.
- Core resident will demonstrate knowledge of pre-operative and post-operative management (including prevention and recognition of complications) of the general surgical patient.
- Core resident will recognize suture differences and select them appropriately.

### **Technical Knowledge and Skills**

- Core resident will successfully utilize aseptic technique in the OR and for bedside procedures.
- Core resident will demonstrate improvement during the rotation in knot-tying, tissue handling, incision planning/performance/closure, etc.
- Core resident will recognize the appearance of normal and abnormal tissues in the OR.
- Core resident will perform safely the following procedures: repair of umbilical/incisional/inguinal hernia, appendectomy, cholecystectomy, excision of skin/subcutaneous lesions, small bowel resection, right hemicolectomy, hemorrhoidectomy, drainage of perianal abscess, sphincterotomy, segmental mastectomy, breast biopsy. The core resident is expected to be able to describe the pertinent steps of each procedure prior to the procedure, and to be

able to complete the procedure with appropriate guidance from the attending surgeon. The level of guidance will be tailored according to the resident's level of skill. This is expected to increase during the rotation.

- Core resident will perform with increasing competency the following clinical skills: unblocking central lines, replacement of gastrostomy tubes, insertion of NG tubes, and writing pre-/post-operative orders with appropriate management of post-operative pain.

Core residents will undergo knowledge assessment by CTU personnel during rounds and in clinics, the operating room, and the emergency room.

**Borderline/Unsatisfactory Behaviours:** inability to demonstrate important knowledge pertinent to general surgical care, lack of progress of technical skills or insufficient technical skills.

**Satisfactory Behaviors:** answers knowledge-based questions in OR/wards/clinics/ER at level expected.

**Superior Behaviors:** answers knowledge-based questions usually above core level.

## COMMUNICATOR

- Core resident will obtain appropriate histories from patients, family members, or other primary caregivers.
- Core resident will recount all service patients' pertinent data when asked or during rounds.
- Core resident will convey pertinent patient data from consultations to staff and senior residents effectively.
- Core resident will document in the chart in a clear and complete manner: daily ward notes, discharge summaries, consultations, and operative reports.
- Core resident will communicate timely information to patients and families.

**Borderline/Unsatisfactory Behaviors:** Unclear or incomplete histories (oral or written) requiring repetition, unable to recite a service patient's H and P, "Not my patient," or "I don't know that case", inaccurate or incomplete documentation, absences of operative reports for which the core resident was responsible and inadequate discharge summaries.

**Satisfactory Behaviors:** Clear recitation of case histories and physicals, good notes in charts, clear operative notes, clear discharge summaries and prescriptions. Few episodes of borderline behaviors.

**Superior Behaviors:** Sharp insightful recitation or written accounts of histories and physicals, command of patient results and surgeries, able to answer questions in-depth of patients at rounds. Discharge summaries will contain all pertinent information to ensure future care.

## COLLABORATOR

- Core resident will conduct themselves as a helpful member of a team whether performing a consultation, assessing a ward patient, or assisting in the OR.
- Core resident will demonstrate effective use of consultants in the management of the surgical patient.
- Core resident will complete patient discharge summaries and supporting documents to enhance communication with other health care professionals.

**Borderline/Unsatisfactory Behaviors:** not responding to repeated pages, not checking battery status of pagers provided, cases not documented, discharge summaries inadequate or requiring frequent repetitions, abusive or consistently negative interactions with ward nursing staff, other residents and other specialists.

**Satisfactory Behaviors:** Quick response to pages and seeing patients, good documentation, discharge summaries complete, nursing evaluation reports no weaknesses, maintain good relations with all healthcare personnel.

**Superior Behaviors:** Quick response to pages, sharp and clear discharge summaries, excellent nursing evaluation.

## **MANAGER**

- Core resident will demonstrate the ability to manage his/her time appropriately between ward, ER and the OR.
- Core resident will use consultations and tests to enhance the care delivered to service patients or consultations.
- Core resident will complete discharge planning in concert with consultants, ward and specialty nursing, socials services and other health care providers both in-hospital and in the community.
- Core resident will understand principles of cost-effective care, limited resources and evidence-based medicine.

**Borderline/Unsatisfactory Behaviors:** Ordering too few or unreasonable tests/consultations that cause suffering to a patient, not reviewing a case/consultation with staff or senior resident placing a patient at potential risk, inability to cooperate with other health professionals in performing a discharge.

**Satisfactory Behaviors:** Good and timely use of consultations/tests, can perform a discharge plan with other providers, prompt review of cases/consults with senior residents/staff.

**Superior Behaviors:** Speedy use of thoughtful tests/consultations, prompt communication with senior residents/staff.

## **HEALTH ADVOCATE**

- Core resident will provide prognostic information to patients and family members.
- Core resident will provide patients with pertinent criteria to return to hospital post-discharge.
- Core resident will provide realistic information as to what a family/patient can expect when at home, following surgery.

**Borderline/Unsatisfactory Behaviors:** omitting to provide prognostic information important to future health, poor explanation leading to an inappropriate ER visit or stay at home, poor description of potential worrisome signs post discharge following a surgical intervention.

**Satisfactory Behaviors:** Clear explanations of normal post-operative course, with description of signs of complications.

**Superior Behaviors:** Post-op explanations include prevention advice, as well as the usual.

## **SCHOLAR**

Core resident will demonstrate scholarly approach to medical practice in the following ways:

- Core residents will independently research issues surrounding service patients.
- Core residents will ask questions of each other and senior staff.
- Core residents will present an academic round.
- Core resident may be asked to present at Journal Club.

- Core resident will understand and utilize principles of self-education and lifelong learning.

**Borderline/Unsatisfactory Behaviors:** Inability to respond to simple basic science questions in a consistent way, no evidence of researching issues, ineffective at academic rounds.

**Satisfactory Behaviors:** Regularly answers basic science questions, regularly researches issues, and regularly asks questions.

**Superior Behaviors:** Masterful at academic rounds, asks questions leading to clinical research, performs a clinical research project.

## **PROFESSIONAL**

Core resident will be able to demonstrate professionalism in the following ways:

- Core resident will identify the emotional needs of the surgical patient and his/her family and be able to address them directly.
- Core resident will demonstrate sensitivity to gender, culture and ethnic differences.
- Core resident will demonstrate ability to address end-of-life care issues.
- Core resident will participate in organized multidisciplinary meetings on patients and appreciate their role in the surgical setting.
- Core resident will be on time.
- Core resident will perform his/her duties with a positive attitude.
- Core resident will attend rounds, clinics, O.R.'s, etc. as expected/outlined.
- Core resident will perform all educational activities and evaluations as requested including operative log.

**Borderline/Unsatisfactory Behaviors:** avoidance of family/patient emotional needs, lack of attendance at multidisciplinary meetings, rounds/conferences, O.R's etc when expected to do so, late/tardy pattern of attending CTU activities, consistently negative attitude toward the CTU.

**Satisfactory Behavior:** participates in satisfying patient/family emotional needs, notably positive attitude, performs all CTU activities in a timely manner, and submits operative logs with rotation evaluations.

**Superior Behavior:** Cited by families, patients, or nurses as exceptional provider of comfort or care, infectious positive attitude.

# Pediatric General Surgery:

March 2006

## OBJECTIVES FOR CORE SURGERY RESIDENTS ROTATING THROUGH PEDIATRIC GENERAL SURGERY MONTREAL CHILDREN'S HOSPITAL

### Introduction

Previous written objectives combined with the interim and final rotation evaluations have served the Pediatric General Surgery Clinical Teaching Unit and the Core Residents rotating through well in the past. The Royal College CanMEDS Project will retool these objectives and enhance them. Two additional innovations for the rotation will be examples of behaviors that are borderline/unsatisfactory, satisfactory and superior, and a chronological yardstick of skill development. Both tools will be used for evaluating residents. Furthermore, the rotating Core residents will review all this material at the start of their rotations and evaluate themselves at the end of their rotation. A short pretest and longer post-rotation test will more elaborately assess cognitive development of the Core resident's knowledge of Pediatric General Surgery. The protected core teaching sessions are an essential part of core training and are considered mandatory for all core surgery residents.

### Aims of the New Program for Core Residents

1. From the rotation's first day, Core residents will clearly understand what knowledge, skills and abilities will be expected throughout the two-month rotation.
2. Core residents will be able to assess, investigate, diagnose, manage clinically, and operate on infants and children at a junior resident level.
3. Core residents will comprehend children's diseases and pathophysiologies sufficiently from clinical and syllabus materials to attain 75% or better on the post-rotation test and show improvement from their pretest.

### **(A) MEDICAL EXPERT**

The Pediatric General Surgery CTU has subdivided this area into four areas: (1) Basic Science (2) General Clinical Knowledge (3) Pediatric Surgical Knowledge and (4) Technical Skills.

#### **1. Basic Science**

- Core resident will appreciate pertinence of embryology to Pediatric General Surgery and demonstrate embryologic knowledge during rounds or on tests.

- Core residents will correctly identify anatomic structures and landmarks of “junior” cases.
- Core residents will recite normal newborn physiology distinguishing differences of the premature baby

## **2. General Clinical Knowledge**

- Core residents will recognize the unique natural histories of pediatric surgical diseases.
- Core residents will recognize heat regulation issues in neonates and infants and preserve thermohomeostasis.
- Core residents will recognize limited immuno-resistance, immature organ function, compromised respiratory pacing in small/young infants and adjust clinical management to compensate.
- Core residents will individualize drug dosages and fluid orders reflecting pediatric physiology.
- Core residents will recognize suture differences and select them appropriately.
- Core residents will select crystalloid or blood resuscitation for trauma appropriately

## **3. Pediatric Surgery Knowledge**

- Core residents will diagnose, and recount treatment principles of the following conditions:
  - i. **Head and Neck:** acute and chronic lymphadenitis, thyroglossal duct cyst, dermoid cyst, congenital torticollis, branchial cleft anomalies, lymphangioma/hemangioma.
  - ii. **Abdomen:** umbilical hernia, umbilical granuloma, inguinal hernia, pyloric stenosis, intussusception, Meckels diverticulum, appendicitis.
  - iii. **Scrotum:** hydrocele, undescended testicle, torsion of the testis/appendix testis, epididymitis.
- Core residents will formulate a plan for the evaluation and treatment of a child presenting with: bilious vomiting, non-bilious vomiting, acute abdominal pain, chronic abdominal pain, constipation and rectal bleeding.
- Core residents will predict common post-operative complications of common surgical procedures and initiate their treatment.
- Core residents will diagnose and provide initial management of several conditions ideally managed in a pediatric institution but that may demand initial/definitive management locally before transfer: incarcerated inguinal hernia in the neonate or infant, aspirated/ingested foreign body, acute abdomen in the neonate or infant, acute gastrointestinal bleeding, blunt abdominal and thoracic trauma.
- Core residents will diagnose and refer: congenital lesions of the thorax, surgical gastroesophageal reflux, chest wall deformities, solid childhood tumours.
- Core residents will diagnose and apply initial care/transport care for: congenital diaphragmatic hernia, esophageal atresia with/without tracheo-esophageal fistula, gastroschisis/omphalocele, intestinal atresia, Hirschsprung’s disease, imperforate anus, malrotation, major pulmonary malformations (CCAM, CLE).

## **4. Technical Knowledge**

- Core residents will successfully utilize aseptic technique in the OR or for bedside procedures.
- Core residents will demonstrate improvement during the rotation in knot-tying, tissue handling; incision planning/performance/closure, etc. (see Chart)
- Core residents will recognize the appearance of normal and abnormal tissues in the OR.
- Core residents will perform with increasing competency the following procedures: repair of hernia/hydrocele, circumcision, appendectomy, portacath/central line insertion, umbilical hernia, and excision of skin or subcutaneous lesions.

- Core residents will perform with increasing competency the following clinical skills: unblocking central lines, replacement of gastrostomy tubes, perform the duties of Trauma Physician in the Trauma Team, order PPN/TPN, order pediatric pain medications, write pre-/post-operative orders.

Core residents will undergo knowledge assessment by CTU personnel during rounds, in clinic/ER/offices/operating room and by post-rotation testing.

**Borderline/Unsatisfactory Behaviors:** inability to recount important knowledge pertinent to pediatric surgical care, post-rotation exam result less than 75%, lack of progress of technical skills (see chart) or insufficient technical skills.

**Satisfactory Behaviors:** answers knowledge-based questions in OR/wards/clinics/office at level expected and passes end of rotation exam.

**Superior Behaviors:** answers knowledge-based questions usually above Core level, post-rotation exam result of more than 88-90%.

## **(B) COMMUNICATOR**

- Core residents will obtain pediatric histories from parents, children and other primary caregivers.
- Core residents will perform thorough physical exams despite potential situations of poor patient compliance.
- Core residents will recount all service patients pertinent data when asked or during rounds.
- Core residents will convey pertinent patient data from consultations to Staff and Fellows effectively.
- Core residents will document in the chart in a clear and complete manner: daily ward notes, discharge summaries, consultations, and operative reports.
- Core residents will lead case histories at combined rounds.
- Core residents will communicate timely information to patients and families.

**Borderline/Unsatisfactory Behaviors:** Unclear or incomplete histories (oral or written) requiring repetition, unable to recite a service patient's H and P, "Not my patient," or "I don't know that case", inaccurate or incomplete documentation, absences of operative reports for which the Core resident was responsible and inadequate discharge summaries.

**Satisfactory Behaviors:** Clear recitation of case histories and physicals, good notes in charts, clear operative notes, clear discharge summaries and prescriptions. Few episodes of borderline behaviors.

**Superior Behaviors:** Sharp insightful recitation or written accounts of histories and physicals, command of patient results and surgeries, able to answer questions in-depth of patients at rounds. Discharge summaries will contain all pertinent information to ensure future care.

## **(C) COLLABORATOR**

- Core residents will conduct themselves as a helpful member of a team whether performing a consultation, assessing a ward patient, or assisting in the OR.
- Core residents will fill a role in the MCH Trauma Team as the Trauma Physician by: responding promptly to Code 10-10, performing primary and secondary surveys on injured children, assisting when requested on any Crash Room intervention, providing continuous care throughout patient transport, documenting all trauma data on the Trauma Record Sheet, and collaborating with trauma consultants to ensure continuity of care.

- Core residents will complete patient discharge summaries and supporting documents to enhance communication with community partners.

**Borderline/Unsatisfactory Behaviors:** not responding to repeated pages, not checking battery status of pagers provided, inability to perform primary/secondary surveys in trauma context, cases not documented, discharge summaries inadequate or requiring frequent repetitions, abusive or consistently negative interactions with ward nursing staff, other residents and other specialists.

**Satisfactory Behaviors:** Quick response to pages and seeing patients, adequate trauma survey skills by 4 weeks, good documentation, discharge summaries complete, nursing evaluation reports no weaknesses, maintain good relations with all healthcare personnel.

**Superior Behaviors:** Quick response to pages, excellent trauma survey skills by 4 weeks, successful participation in Crash Room interventions, sharp and clear discharge summaries, excellent nursing evaluation.

#### **(D) MANAGER**

- Core residents will use consultations and tests to enhance the care delivered to service patients or consultations.
- Core residents will complete discharge planning in concert with consultants, ward and specialty nursing, socials services and other health care providers both in-hospital and in the community.
- Core residents will comprehend criteria for the transfer of children to pediatric institutions even if the condition is within the scope of their specialty but may exceed the expertise of their institution.
- Core residents will understand principles of cost-effective care, limited resources and evidence-based medicine.

**Borderline/Unsatisfactory Behaviors:** Ordering too few or unreasonable tests/consultations that cause suffering to a child or children, not reviewing a case/consultation with Staff or Fellows placing a child at potential risk, inability to cooperate with other health professionals in performing a discharge.

**Satisfactory Behaviors:** Good and timely use of consultations/tests, can perform a discharge plan with other providers, prompt review of cases/consults with senior staff.

**Superior Behaviors:** Speedy use of thoughtful tests/consultations, ability to recite transfer criteria to a pediatric institution.

#### **(E) HEALTH ADVOCATE**

- Core residents will provide prognostic information to children, parents, and other caregivers related to the child's surgical condition.
- Core residents will be aware of pediatric surgical alterations in anatomy or physiology that may impact a child's future health.
- Core residents will be capable of advising patients and parents on important elements of trauma prevention.
- Core residents will provide parents and patients with pertinent criteria to return to hospital post-discharge.
- Core residents will provide realistic information as to what a family/patient can expect when at home.

**Borderline/Unsatisfactory Behaviors:** omitting to provide prognostic information important to future health, inability to explain wound care or normal wound healing, poor explanation leading to an inappropriate ER visit or stay at home.

**Satisfactory Behaviors:** Clear explanations of wound healing and its problems, dietary and digestion limitations post-operatively communicated to parents/patients.

**Superior Behaviors:** Post-op explanations include prevention advice, trauma prevention advice when clinically appropriate.

#### **(F) SCHOLAR**

- Core residents will demonstrate knowledge of embryology, anatomy, physiology, and pathology related to pediatric surgical topics in a methodical and where possible, an evidence-based manner.
- Core residents will independently research issues surrounding service patients.
- Core residents will ask questions of each other and senior staff.
- Core residents will present an academic round at least once per rotation.
- Core residents will understand and utilize principles of self-education and lifelong learning

**Borderline/Unsatisfactory Behaviors:** Inability to respond to simple basic science questions in a consistent way, no evidence of researching issues, ineffective academic rounds.

**Satisfactory Behaviors:** Regularly answers basic science questions, regularly researches issues, regularly asks questions, completes service evaluation, operative log and end of rotation test when requested (at or before last Monday of rotation).

**Superior Behaviors:** Masterful academic rounds, asks questions leading to clinical research, performs a clinical research project.

#### **(G) PROFESSIONAL**

- Core residents will identify the emotional needs of the pediatric patient and his/her family and be able to address them directly.
- Core residents will demonstrate sensitivity to gender, culture and ethnic differences.
- Core residents will participate in organized multidisciplinary meetings on patients and appreciate their role in the pediatric setting.
- Core residents will attend rounds/conferences regarding pediatric ethics, outcome evaluation, peer review, and maintenance of certification occurring during the rotation.
- Core residents will be on time.
- Core residents will perform their duties with a positive attitude.
- Core residents will attend rounds, clinics, O.R.'s, etc. as expected/outlined.
- Core residents will perform all educational activities and evaluations as requested including operative log.

**Borderline/Unsatisfactory Behaviors:** avoidance of family/patient emotional needs, lack of attendance at multidisciplinary meetings, rounds/conferences, O.R's etc when expected to do so, late/tardy pattern of attending CTU activities, consistently negative attitude toward the CTU, incomplete participation in CTU tests.

**Satisfactory Behavior:** participates in satisfying patient/family emotional needs, notably positive attitude, performs all CTU activities in a timely manner, submits operative logs with rotation evaluations.

**Superior Behavior:** Cited by families, patients, or nurses as exceptional provider of comfort or care, infectious positive attitude.

<b>ATTRIBUTE/SKILL</b>	<b>WEEK 2</b>	<b>WEEK 4</b>	<b>WEEK 6</b>	<b>WEEK 8</b>
Post-op fluids	Knows maintenance amounts & types	No mistakes		
Pain management Medication orders	-Orders for morphine/codeine acetaminophen -Clear and reasonable	-Understands increased risks of opiates in infants -Selects appropriate timing dose and type of antibiotics		
Tube management	-Orders I & O's NG/Foley/CT			
Chart notes	Orders using computer	-Outpatient and inpatient notes -Complete and informative		
List of OR's	Complete for interim evaluation			
Trauma Team	Good 1° and 2° surveys	Exemplary role as Trauma Physician in cases on Mock		
Central line blockage	Orders Alteplase	res Alteplase successfully		
Hernia/Hydrocele	-Incision + closure -Scrotal + inguinal exam	-Sac dissection -Vas protocol -Cord gently handled	-Time? -Asking for tools -Showing anticipation for steps	ready for (orchidopexy)
Circumcision	Cautery skills	(could teach a med student how to....)		
Appendix	Incision	Ligatures	Difficult appy Handled intra-op	
Umbilical Hernia	Incision dissection	Placement of sutures		
Pyloromyotomy	Incision + closure	Safe delivery of pylorus	Pyloromyotomy safely performed	
Portacath + Central lines	Positioning needling vein	Pocket dissection	All steps to prevent short and long term complications	

			known
OR dictations	Dictates cases as requested	emplary	
Abdominal Pain Consult	Complete Hx + Px labs (little prompting)	iscriminatory DDX -Use of Imaging	
Knot tying Prepping Draping	Improvement	need to ask to practice	
Minimally Invasive Surgery	-Understands instruments -Trocars (disposable and reusable)	flation pressures of chest and abdomen according to age -Insert Trocar -Assist Hassan Technique -Principles of camera use -Safe cautery principles and techniques	-Able to perform introduction of all Trocars -Setting up insufflation -Able to perform appendectomy and to remove gallbladder from liver bed

# Critical care Objectives:

## Objectives for Resident Core Critical Care Training Intensive Care Unit Rotation McGill Critical Care Medicine

### General Objectives:

Over the course of their training in Critical Care Medicine at McGill, each resident should gain a working knowledge of applied clinical physiology and homeostasis, be able to recognize derangement of pathophysiology, and to treat single or multiple organ failure. The resident should become familiar with strategies to prevent such failures in the high-risk patient. The resident should also gain an appreciation for the indications for intensive care unit admissions and therapy. The resident should develop a sound understanding of the basic and applied physiology, pathophysiology, and pharmacology relevant to management of the critically ill. The resident is also expected to have mastered the fundamental aspects of technical procedures commonly used in the treatment of critically ill patients.

A graded level of responsibility will be given to the resident as he or she gains more Critical Care experience and a progressively greater depth of knowledge will be expected. On completion of residency training, the resident should have achieved proficiency in the recognition and initial management of problems commonly encountered in the intensive care unit. This proficiency includes, but is not limited to, acute respiratory failure, hemodynamic instability, sepsis, acute renal failure, overdoses and poisonings, acute neurologic insults, acute electrolyte and endocrine emergencies, and coagulation disorders. For less common problems, the trainee should gain a knowledge base that allows them to formulate a differential diagnosis, initiate a management plan, and request appropriate consultations.

Emphasis will be placed on the ability to recognize, investigate, and stabilize acute critical illness. The resident should demonstrate the ability to collect and synthesize relevant data, to formulate an appropriate differential diagnosis, and offer an initial investigational and management plan. Cost effective use of laboratory and radiological investigations are expected. As Critical Care is a multi-specialty discipline, the resident should have gained exposure to a wide variety of patients from a mixed population of medical, surgical, and obstetrical patients. All residents should develop an appreciation for the future interaction between the Critical Care Unit, themselves, and their medical discipline.

As such these general goals are pertinent to all residents during their critical care rotation. Within this framework, surgical residents will be exposed to pre-operative and post-operative assessment of general surgery, thoracic surgery and cardiovascular surgery patients during their rotation. In addition, at the MGH site they will also be involved in the ICU care of trauma patients.

These rotation specific objectives have been modified to conform to the Can MEDS 2000 competencies effective July 1, 2003.

## **MEDICAL EXPERT AND CLINICAL DECISION-MAKER**

At the end of the rotation, the resident should be able to:

Relate and apply a sound fund of basic science knowledge to patient care in the majority of cases.

Relate and apply a fund of clinical knowledge in a manner that enables resolution of common clinical situations on a consistent basis. This includes but is not limited to the ability to recognize common rhythm disturbances, determine acid-base status from arterial blood gases, provide ventilator orders for most patients, classify shock and outline hemodynamic patterns, use inotropes and vasopressors correctly, and recognize and manage acute renal failure.

Obtain an appropriate history from the patient, family, or other medical personnel, that is complete, accurate and systematic.

Perform a problem-oriented physical examination with the recognition of most findings to allow for proper diagnosis and management.

Accurately interpret the results of common lab and diagnostic tests.

Develop diagnostic plans that are appropriate and reflect current standards. Demonstrate the ability to order most tests logically and interpret the results correctly.

Institute appropriate investigations in a cost-effective manner.

Be able to synthesize historical, physical exam, and diagnostic testing information into a problem list and appropriately prioritize problems.

Outline a therapeutic plan in conjunction with the ICU fellow or attending physician. Institute appropriate therapy.

Make judgments that are usually complete and sound. Arrive at decisions appropriately with appropriate use of available information.

Demonstrate the ability to handle most common problems independently, while appropriately asking consultants for help with specific questions in more complex questions.

Develop an ability to immediately recognize acute life-threatening illness and institute immediate life sustaining supportive therapy. Display appropriate leadership of the team, utilizing resources in an effective manner.

Demonstrate adequate knowledge of monitoring techniques for the critically ill patient to allow for appropriate management.

Consistently use appropriate preventative measures and apply knowledge in a prospective manner so as to anticipate potential problems and attempt to prevent them.

Demonstrate an ability to perform an appropriate consultation assessment to and answer a question or request from another health care provider. Be able to present well-reasoned, well-documented assessments and recommendations in written and oral form in response to a request from another health care provider.

Demonstrate competency in performing essential procedures with appropriate skill and manual dexterity for level of training. Carries out techniques correctly and efficiently with appropriate knowledge of indications and risks.

Demonstrate comprehension of issues related to the post-operative care of surgical patients.

Demonstrate ability to assess patients' fitness for surgery and anticipated complications.

## **COMMUNICATOR**

Residents are expected to demonstrate communication skills in the following areas:

Interprofessional Relationships; demonstrate an ability to work well with other services, using appropriate communication skills, resulting in a constructive environment.

Communication with other allied health professionals; demonstrate an ability to communicate well with other members of the health care team. Specifically, able to provide a clear outline of the plan for patient care.

Communication with Patients; demonstrate an ability to consistently achieve good rapport with patients and gain patient respect and confidence, and to clearly explain diagnosis and treatment options in an understandable fashion. Develop communication skills with patients on a ventilator.

Communication with Families; demonstrate an ability to gain the respect and confidence of family members, to create a supportive and helpful environment, and to deliver information to families in a humane manner that is understandable and encourages discussion.

Written communication & Documentation; demonstrate an ability to write records/reports that are usually complete, orderly, systematic, generally support management, and allow a physician unfamiliar with the patient to identify the relevant daily issues.

## **COLLABORATOR**

At the end of the rotation the resident should;

Demonstrate abilities to become an active member of the Intensive Care Unit team who is able to work well with other team members.

Demonstrate an ability to give and follow appropriate instructions with nurses and allied staff, and to develop rapport, resulting in a constructive working environment.

Deal effectively with issues and achieve good results even in difficult situations without antagonizing others.

## **MANAGER**

Upon completion of the resident should be able to:

Participate in bed management issues and enable efficient care of the critically ill patient by using investigations appropriately.

Effectively organize work in such a way that priorities are established and that coordination occurs with the other members of the team ensuring total, acute, and continuing care of patients.

## **HEALTH ADVOCATE**

The resident should be able to:

Educate the families of critically ill patients on the life-style and health issues that have led to the illnesses of their family members.

## **SCHOLAR**

Residents should be able to demonstrate their scholarly approach to medical practice in the following areas during participation on patient rounds, teaching sessions, and journal clubs:

Self-education skills; demonstrate up-to-date knowledge in major clinically applicable developments. Display effective skills in continuing education. Demonstrate an ability to identify gaps in knowledge and develop a strategy to fill the gaps.

Critical Appraisal of the Medical Literature; Demonstrate ability to seek out, locate and judge the strength of the evidence in the literature. Able to pose an appropriate patient-related question, execute a systematic search for evidence, and critically evaluate medical literature in order to optimize clinical decision making

Scientific Interest; Participates in the scientific activities offered in the program. Contributes actively to discussion and teaching. Able to add to and elevate the level of discussion.

Incorporates a spirit of scientific enquiry and use of evidence into clinical decision-making.

Teaching Skills; Available, approachable. Effectively shares knowledge. Helps others to develop their potential.

Oral Presentation Skills; Able to give a clear, concise, effective oral presentation concerning a clinical or scientific topic with appropriate use of audiovisual aids.

## **PROFESSIONAL**

Residents will be able to demonstrate their professionalism in the following ways;

Integrity and honesty; demonstrate an honest, straightforward approach that is respectful of others, and deserves the respect of others.

Responsibility and self-discipline; Dependable, reliable, honest and forthright in all information and facts; prompt, appropriate follow-up of patients. Non-clinical responsibilities, (e.g. rounds, teaching, etc.) are similarly dealt with.

Bioethics; Sensitive to bioethical issues and demonstrates a reasonable approach to them.

Performs in an ethical manner with other health care professionals, patients and families.

Self-Assessment; demonstrates appropriate awareness of own limitations; seeks assistance and/or feedback to overcome/ compensate for limitations, and accepts advice graciously.

Receptiveness to Feedback Responds constructively to new suggestions and ideas.

# Anesthesia:

## **R1: CLINICAL BASE YEAR**

### **Overview:**

The R1 year is a clinical base year that provides experience in various areas of medicine, which serves as a background for anesthesia training.

### **General Goals:**

Developing increasing expertise in basic clinical competencies that are essential to the specialty practice: medical expert/clinical decision-maker, communicator, collaborator, manager, health advocate, scholar and professional.

Obtain exposure to a broad-based introductory experience in clinical medicine.

### **Specific Objectives:**

#### **Medical expert/Clinical Decision-maker**

- o Demonstrate knowledge of general internal medicine with particular reference to the cardiovascular, respiratory, renal, hepatic, endocrine, hematologic and neurologic systems.
- o Demonstrate knowledge of age related variables in medicine as they apply to neonatal, pediatric, adult and geriatric patient care.
- o Demonstrate clinical skills necessary for basic resuscitation and life support as practiced in critical care facilities.
- o Demonstrate clinical skills necessary to general internal medicine and intensive care including the ability to investigate, diagnose, and manage appropriately factors that influence a patient's medical and surgical care.
- o Recognize that prior to provision of anesthetic care specific medical intervention and modification of risk factors may be required.

#### **Communicator**

- o Establish a professional relationship with patients and families.
- o Obtain and collate relevant history from patients, and families.
- o Listen effectively.
- o Discuss appropriate information with patients and families and other members of the health care team.
- o Demonstrate appropriate oral and written communication skills.

- o Ensure adequate information has been provided to the patient prior to undertaking invasive procedures.

### **Collaborator**

- o Consult effectively with other physicians and health care professionals.
- o Contribute effectively to other interdisciplinary team activities.
- o Communicate effectively with medical colleagues, nurses, and paramedical personnel in inpatient, outpatient, and operating room environments

### **Manager**

- o Utilize personal resources effectively in order to balance patient care, continuing education, and personal activities.
- o Allocate finite health care resources wisely.
- o Work effectively and efficiently in a health care organization.
- o Utilize information technology to optimize patient care, and lifelong learning.

### **Health Advocate**

- o Identify the important determinants of health affecting patients.
- o Contribute effectively to improved health of patients and communities.
- o Recognize and respond to those issues where advocacy is appropriate.

### **Scholar**

- o Develop, implement, and monitor a personal continuing education strategy.
- o Facilitate learning of patients, students, and other health professionals.
- o Critically appraise sources of medical information.
- o Describe the principles of good research.
- o Using these principles, judge whether a research project is properly designed

### **Professional**

- o Deliver highest quality care with integrity, honesty and compassion.
- o Exhibit appropriate personal and interpersonal professional behaviors.
- o Practice medicine ethically consistent with the obligations of a physician
- o Periodically review his/her own personal and professional performance against national standards.
- o Include the patient in discussions concerning appropriate diagnostic and management procedures.

- o Respect the opinions of fellow consultants and referring physicians in the management of patient problems and be willing to provide means whereby differences of opinion can be discussed and resolved.
- o Show recognition of limits of personal skill and knowledge by appropriately consulting other physicians and paramedical personnel when caring for the patient.
- o Establish a pattern of continuing development of personal clinical skills and knowledge through medical education

**Content:**

The R1 year is composed of:

- Four periods of internal medicine: ICU, CCU, ward, emergency
- Three periods of pediatric medicine: ICU, ward, emergency
- Three periods of adult anesthesia
- Two periods of medical/surgical elective (NOT anesthesia)
- One period of McGill Epidemiology and Biostatistics Course

**R1 ADULT ANESTHESIA**

**Medical Expert/Clinical Decision-maker**

- Demonstrate knowledge of the basic sciences as applicable to anesthesia, including anatomy, physiology, pharmacology, biochemistry and physics.
  - o Knowledge of the pharmacology and indications for use of drugs commonly used in anesthetic practice
    - Inhalational agents
    - Induction agents
    - Muscle relaxants
    - Narcotic analgesics
    - Local anesthetics: xylocaine, bupivacaine
- Demonstrate knowledge of general internal medicine with particular reference to the cardiovascular, respiratory, renal, hepatic, endocrine, hematologic and neurologic systems
  - o Provide appropriate perioperative fluid and electrolyte therapy
  - o Knowledge of appropriate use of blood products

- Complications/risks of transfusion
- Demonstrate knowledge of age related variables in medicine as they apply to neonatal, pediatric, adult and geriatric patient care.
- Demonstrate knowledge of the principles and practice of anesthesia as they apply to patient support during surgery or obstetrics.
- Demonstrate knowledge of the principles of management of patients with acute pain
- Demonstrate clinical skills necessary for the independent practice of anesthesia, including preoperative assessment, intraoperative support and postoperative management of patients of any physical status, all ages and for all commonly performed surgical and obstetrical procedures
  - o Perform appropriate preoperative assessment of adult patients
    - ASA classification
    - Assessment of severity and stability of pre-existing organ system disease
    - Airway assessment
      - Prediction of ease of ventilation/intubation
      - Recognition of the difficult airway
  - o Knowledge of the use of standard intraoperative monitors
    - Monitoring standards
  - o Acquire clinical experience with various anesthetic techniques
    - GA
    - Regional: spinal, epidural
  - o Provide appropriate post-op care
    - Transfer/transport of post-op patients
    - Transfer of care to PACU nurse (report)
    - Provision of post op analgesia and antiemesis therapy
  - o Knowledge of the differential diagnosis/appropriate initial therapy of
    - Anaphylaxis
    - Upper airway obstruction
    - Intraoperative bronchospasm
- Develop increasing technical expertise in
  - o Placement of peripheral IV's
  - o Insertion of arterial lines
  - o Ventilation with bag and mask

- o Laryngoscopy and intubation of the normal airway
- o Use of airway equipment
  - Stylets
  - Bougies
  - Laryngeal mask
- Recognize that prior to provision of anesthetic care specific medical intervention and modification of risk factors may be required.
- Demonstrate knowledge of basic legal and bioethical issues encountered in anesthetic practice including informed consent

### **Communicator**

- Establish a professional and empathetic relationship with patients and families
- Obtain and collate relevant history from patients, and families.
- Listen effectively.
- Discuss appropriate information with patients and families and other members of the health care team
- Keep clear, concise, legible documentation.
- Ensure adequate information has been provided to the patient prior to undertaking invasive procedures

### **Collaborator**

- Consult effectively with other physicians and health care professionals to provide optimal patient care

### **Manager**

- Demonstrate knowledge of the management of operating rooms.
- Demonstrate knowledge of the contributors to anesthetic expenditures.
- Demonstrate knowledge of the guidelines concerning anesthetic practice and equipment in Canada.
  - o Knowledge of the use of standard intraoperative monitors
    - Monitoring standards
  - o Knowledge of practice guidelines
    - BCLS/ACLS
    - Airway algorithm
- Record appropriate information for anesthetics and consultations provided.
- Allocate finite health care resources wisely.

- Work effectively and efficiently in a health care organization
- Utilize information technology to optimize patient care, and lifelong learning.
- Demonstrate principles of quality assurance, and be able to conduct morbidity and mortality reviews

### **Health Advocate**

- Identify the important determinants of health affecting patients.
- Provide direction to hospital administrators regarding compliance with national practice guidelines and equipment standards for anesthesia.
- Recognize the opportunities for anesthesiologists to advocate for resources for chronic pain management, emerging medical technologies and new health care practices in general

### **Scholar**

- Develop, implement, and monitor a personal continuing education strategy.
- Critically appraise sources of medical information.
- Develop criteria for evaluating the anesthetic literature
- Facilitate learning of patients, students, and other health professionals

### **Professional**

- Deliver highest quality care with integrity, honesty and compassion.
- Exhibit appropriate personal and interpersonal professional behaviors.
- Practice medicine ethically consistent with the obligations of a physician
- Include the patient/family in discussions concerning appropriate diagnostic and management procedures.
- Respect the opinions of fellow consultants and referring physicians in the management of patient problems and be willing to provide means whereby differences of opinion can be discussed

# Emergency:

## Emergency Medicine rotation

### Montreal General Hospital

The Resident is expected to achieve competency in the areas described below during their rotations in the Emergency Department at the Montreal General Hospital. It is expected that a resident's knowledge, skills, and attitudes will evolve as they progress from a first-year resident to a fifth-year resident in the Emergency Department.

The resident is expected to:

#### **Medical Expert**

1. Obtain an appropriately focused history and physical
2. Be able to present the history and physical in a concise, organized approach, including all relevant information.
3. Must have an approach to and be able to develop a differential diagnosis to the common presenting complaints.
3. Be able to develop a work-up plan, understanding the indications and limitations of:
  - a. laboratory tests
  - b. radiologic investigations
  - c. ECGs.
4. Be able to develop a comprehensive care plan for the patient to the point of disposition (discharge, admission, consult).
5. Demonstrate an understanding of the natural history, pathophysiology, treatment of the acute and common disorders that present to the ED.
6. Demonstrate technical skills (listed below, but not limited to), and be knowledgeable of indications, contraindications and complications:
  - a. Vascular access (peripheral and central)
    - b. Wound Management (examination, anesthesia, irrigation, debridement, closure techniques).
    - c. Anesthesia (local, nerve blocks, procedural sedation)
    - d. Orthopedic procedures (reduction, immobilization, splinting and casting, arthrocentesis)
  - e. Abdominal procedures (NG insertion, abdominal paracentesis)
  - f. Arterial Blood gas
  - g. Lumbar puncture
  - h. Airway management (oxygenation and ventilation techniques, RSI, rescue techniques)

- i. ACLS skills (CPR, cardioversion, defibrillation, pacemaker placement, cardiocentesis)
- j. ATLS skills (RSI, tracheostomy, FAST, DPL, decompression of a pneumothorax including chest tube, thoracotomy)
- k. ENT procedures (anterior and posterior nasal packing; Foreign body removal from ear, nose, throat; hematoma drainage of ear, septal; wick placement in canal)
- l. Ophthalmologic procedures (use of slit lamp, contact lens removal, eye irrigation, extraocular foreign body removal)
- m. Hand and Foot procedures (drainage of subungual hematoma and paronychia, removal ingrown toenail, extensor tendon repair)
- n. GU procedures (Foley catheter placement, suprapubic bladder aspiration, reduction of paraphimosis)
- o. Rectal procedures (anoscopy, foreign body removal, pilonidal or perianal abscess drainage, evacuation of thrombosed hemorrhoid)

### **Communicator**

- 1. Demonstrate appropriately concise and legible emergency charting, with follow-up notes and interpretation/analysis of the lab and radiologic investigations.
- 2. Demonstrate effective verbal communication with:
  - a. Patients and their families
  - b. Nurses, Respiratory Therapists, Unit Clerks, Patient Attendants, Social Worker
  - c. Attending Physicians, Residents and Medical Students within the Department, EMS personnel
  - d. Consultants by telephone/in person
- 3. Demonstrate ability to deliver “bad news” to patients/families in a manner consistent with being a specialist.

### **Collaborator**

- 1. Work as a member of the multi-disciplinary emergency health care team.
- 2. Respect the other members of the Emergency Department and seek out their opinions and skills when necessary.
- 3. Demonstrate flexibility in one’s role within the Emergency Department if the need arises.
- 4. Be capable of involving the patient and family in decision-making when appropriate.

### **Manager**

- 1. Work at a pace that is appropriate for level. By the time the resident is at a senior level, should be able to manage 3-4 acutely patients concurrently.
- 2. Effective use of consultants and of follow-up consultant visits (i.e. clinics)
- 3. Be able to triage multiple patients arriving in the Emergency Department and see patients in order of priority
- 4. Show efficient and effective use of ancillary testing including but not limited to: Blood tests, cultures, diagnostic radiology.
- 5. Comprehend the importance of and manage the flow of patients within the Emergency Department.

6. Incorporate the patient's family physician or primary care physician into the management plan.
7. Be cognizant of the role of the ED and the Emergency Physician with respect to the hospital's disaster management plan.

### **Health Advocate**

1. Understand that the patient's well being is central to all medical care
2. Demonstrate understanding of various harm reduction strategies for patients
3. Be the patient's advocate at all times, particularly when they are unable to do so themselves

### **Scholar**

1. Continuously seeking out new knowledge e.g. texts, journals and incorporate this into daily practice.
2. The resident will have the ability to use information technology to direct self-learning as well as patient care.
3. Apply Evidence-based medicine to ongoing emergency care.
4. The senior resident must be able to apply landmark studies to patient care.

### **Professional**

1. Demonstrate awareness of the racial, cultural and societal facets that colour Emergency Care deliverance
2. Show respect all times for the patient's:
  - a. Race/ethnicity
  - b. Language
  - c. Religion/Belief system
  - d. Gender
  - e. Sexual orientation
  - e. Confidentiality
3. Be insightful of one's own strengths and weaknesses, and recognize when to call for back up.
4. Be able to receive and accept constructive feedback.
5. Display ethical behavior compatible with a physician at all times with respect to:
  - a. Patients and their families
  - b. Allied health staff
  - c. Attending Staff, residents and medical students
6. Be a role model for medical students, residents, staff physicians, nurses.

### ***Montreal General Hospital***

Orientation to the Emergency Department will take place on the first day of the rotation at 08h00. At this time the resident will receive the goals and objectives for the rotation as well as a package of relevant reading material on Emergency Medicine related topics, which they are encouraged to read during their rotation.

The Montreal General Hospital Emergency Department registers 36 000 patients per year, 12 500 of which arrive by ambulance. The overall admission rate is 14%. 9 000 cases annually are classified as trauma-related, of which 1 400 are admitted.

This rotation is designed to give the resident clinical exposure to allow him/her to acquire the appropriate knowledge, skills and attitudes consistent with the practice of emergency medicine at a consultant level. The resident's shifts will be prorated to approximately 60% ambulance room and 40% ambulatory care shifts, with the total number of hours being 38 hours per week, or 16 to 18 shifts per month. Senior Emergency residents will be paired preferentially with FRCP or CPSQ staff, or exceptional teachers. The rotation will emphasize the differences between the Montreal General Hospital and other McGill University teaching hospitals, namely, its Tertiary Trauma Centre designation and its partnership with the Montreal Sexual Assault Centre.

Residents will be expected to manage trauma cases. They will be expected to lead or assist in directing further trauma patient management with the emergency staff physician, including accompanying the patient to CT scan or for other interventions.

The emergency resident is expected to share on-call for sexual assault with the other emergency medicine residents on the rotation; (s)he is expected to partake in the initial intake by the social worker, and then collect the medicolegal samples required for the "kit" with the assistance of the staff physician.

Daily teaching sessions are mandatory from Monday to Friday 15h00 -16h00. Different Emergency Medicine related topics will be taught and reviewed. All residents will teach one of these sessions during the rotation and be evaluated on their teaching skills by the staff working with them that day. Senior Emergency residents will also be expected to teach the ICM students as well as clerkship elective students, either at the bedside or small group teaching format.

Schedule requests should be submitted at least 4 weeks in advance. The final schedule will be completed 2 weeks prior to the start of the rotation.

Residents are responsible to ensure that attending staff fills out daily evaluations (thru ONE45). Should there be any concerns about the performance of the resident, a mid-rotation evaluation will be scheduled. At the end of the rotation, an In-Training Evaluation Form (ITER) will be completed and discussed with the resident who should sign the ITER and complete a rotation evaluation form.

Residents have a room B2.114.4 where they can leave their belongings and where there is a computer for professional or personal use. Memos or schedule changes will be posted in this room or on the door.

The Postgraduate Coordinator is Dr. Vincent Poirier: [vincent.poirier@mcgill.ca](mailto:vincent.poirier@mcgill.ca)

The Administrative Secretary is Madeleine Becker: [madeleine.becker@muhc.mcgill.ca](mailto:madeleine.becker@muhc.mcgill.ca)  
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# Neurosurgery:

## OBJECTIVES McGill Specialty Training Requirements in Neurosurgery

### Specific objectives for junior resident CORE SERVICE

#### General Objectives

Residents must demonstrate the knowledge, skills and attitudes relating to gender, culture and ethnicity pertinent to Neurosurgery. In addition, they must demonstrate an ability to incorporate gender, culture and ethnic perspectives in research methodology, data presentation and analysis.

The resident is expected to demonstrate unequivocal high moral and ethical behavior.

#### **KNOWLEDGE**

As a basis for clinical competence, the neurosurgery resident must be familiar with and able to describe and discuss:

1. A.T.L.S. principles
2. Herniation syndromes
3. Glasgow Coma Scale (GCS)
4. Spinal cord syndromes (anterior, central, Brown Sequard)
5. Basal skull fractures
6. Classification of head injury and heir prognosis
7. Pathophysiological principles
  - A. Autoregulation
  - B. Monro-Kellie doctrine
  - C. Intracranial hypertension
  - D. Cerebral perfusion pressure
  - E. Cerebral ischemia

## **CLINICAL SKILLS**

1. A.T.L.S. principles
2. demonstration of skills in ordering and interpreting appropriate diagnosis, C spine x-ray, CT scan for cranial and spinal trauma
3. able to use GCS scale
4. demonstrate the ability to manage
  - a) herniation syndromes
  - b) spinal cord syndromes
  - c) basal skull fractures / CSF leak
  - d) ICP management
    - venous drainage
    - CO<sub>2</sub>
    - Cooling
    - Mannitol
    - DI
    - SIADH
5. can council the return to play or to school post-concussion, post general head injuries post-traumatic seizures

## **TECHNICAL SKILLS**

At the completion of training, the neurosurgical residents must have demonstrated a thorough understanding of the surgical anatomy, and the technical ability to satisfactorily and safely perform in patients of all ages:

1. placement of ventricular drain
2. placement of ICP monitor
3. debridement of open wound
4. burr hole placement
5. positioning for craniotomy for trauma
6. tong immobilization of neck for spinal trauma

## **COMMUNICATOR**

### General Requirements

1. Establish therapeutic relationships with patients/families
2. Obtain and synthesize relevant history from patients/families/communities
3. Listen effectively
4. Discuss appropriate information with patients/families and the health care team
5. Respond appropriately to patients, families, and colleagues, who express anger, hostility, or a complaint.
6. Share information with other healthcare providers that supports teamwork and effective care planning and provision in an expeditious manner.
7. Be sensitive to the needs of patients and their families as they are affected by gender, cultural and ethnic perspectives.
8. Be able to communicate in a clear, concise and collegial manner with referring physicians.
9. Be able to present data to a group of peers or allied health personnel in a clear and understandable way.
10. Learn the avenues of communication with institutional managers and administrators to be able to clearly express the needs of his/her service.
11. Prepare written documentation regarding patient consultations in a timely and accurate fashion.

## **COLLABORATOR**

### General Requirements

1. Consult effectively with other physicians and health care professionals.
2. Contribute effectively to other interdisciplinary team activities.

## **MANAGER**

### General Requirements

1. Utilize resources effectively to balance patient care, learning needs, and outside activities.
2. Allocate finite health care resources wisely.
3. Work effectively and efficiently in a health care organization.
4. Utilize information technology (e.g., searching medical databases) to optimize patient care, life-long learning and other activities.

## **HEALTH ADVOCATE**

### General Requirements

1. Identify the important determinants of health affecting patients with spinal and peripheral nerve pathologies
2. Contribute effectively to improved health of patients and communities.
3. Recognize and respond to those issues where advocacy is appropriate.

## **SCHOLAR**

### General Requirements

1. Develop, implement and monitor a personal continuing education strategy.
2. Critically appraise sources of medical information on spine and peripheral nerve pathologies and diseases.
3. Facilitate learning of patients, house staff/students and other health professionals.
4. Contribute to development of new knowledge in spine and peripheral nerve.

## **PROFESSIONAL**

### General Requirements

1. Deliver highest quality care with integrity, honesty and compassion.
2. Exhibit appropriate personal and interpersonal professional behaviors.
3. Practice medicine ethically consistent with obligations of a physician

# Plastic and Reconstructive Surgery:

## **ROTATION SPECIFIC OBJECTIVES FOR JUNIOR RESIDENTS (CORE)** **PLASTIC & RECONSTRUCTIVE SURGERY** **MC GILL UNIVERSITY**

Welcome to the Plastic and Reconstructive Surgery Service at McGill University. During your 8 or 12 week rotation on our Service, you will be exposed to a wide variety of surgical situations which you have not yet encountered in your training. In order for you to benefit the most from your short rotation, we have outlined our objectives as a teaching unit. These subjects are the ones we feel are the most important for the resident to learn in order to gain an appreciation for the field of Plastic Surgery. Equally important, many of the topics below are those required by anyone considering a career in surgery to establish a solid foundation of surgical principles. The Core Teaching Seminars are essential to your training and are considered mandatory for your development.

### **OBJECTIVES**

#### **General**

- A. Provide an introduction to the field of Plastic and Reconstructive Surgery.
- B. Establish sound surgical principles with regard to the pre- and post-operative care of Plastic Surgical patients.
- C. Furnish a healthy atmosphere for learning and understanding the principles of surgery.

### **EVALUATION USING THE CanMEDS COMPETENCY FRAMEWORK**

#### **A. Medical Expert**

##### 1. Basic Surgical Principles

- (a) Wound healing, hypertrophic scars, and keloids
  - assessment of the complex wound
  - basics of wound care and debridement
- (b) The basics of skin grafts and flaps
  - definitions, applications
  - classifications
- (c) Local anesthetics
  - different classes of local anesthetics
  - learn how to properly administer these agents

## 2. Clinical Knowledge

### (1) Surgical Technique

#### (a) Sutures and needles

- classifications, usage

#### (b) Instruments

- learn to identify those common to Plastic Surgery

#### (c) Drains and dressings

- knowledge of surgical drains and their functions
- learn the principal types of dressings and how they are applied

#### (d) Patient prepping and draping

- proper technique

#### (e) Operating Room etiquette

#### (f) Suturing techniques

- principles and mastery of basic suturing techniques

### (2) Physical Examination

#### (a) Head and neck

- the principles of facial anatomy
- proper examination of the head and neck

#### (b) Upper extremity and hand

- nerve distributions
- muscle and tendon locations/functions
- learn to systematically examine the upper extremity

### (3) Topics in Plastic Surgery

#### (a) Skin tumours

- squamous cell carcinoma, basal cell carcinoma, malignant melanoma
- classifications, presentation, treatment

#### (b) Burns

- presentation, assessment, treatment options

#### (c) Facial fractures

- presentation of upper and lower facial skeleton fractures
- treatment options

(d) Pressure sores

- learn what they are and how they are treated

(e) Breast surgery

- principles of augmentation, reduction, and reconstructive breast surgery

(f) Microsurgery

- observe and participate in these complex cases
- understand the basics of microvascular and microneural surgery

(g) Hand surgery

- general principles – tourniquet, dressings, splints, x-rays
- anesthesia in hand surgery
- infections
- common tumours in the hand
- common fractures
- fingertip injuries
- Dupuytren's, trigger finger
- DeQuervain's
- carpal tunnel syndrome
- tendon lacerations and repair

Obviously, thorough coverage of all topics may not be possible due to time restraints. If you are unsure of any of the above topics, please ask your chief resident or senior resident, both of whom are training specifically in Plastic Surgery.

**What is Expected of a Junior Resident Rotating on the Plastic Surgery Service**

Under the direction of your chief resident, you will act as the daily manager of the ward under his/her supervision. These include:

- daily orders and medication prescriptions
- observing and participating with dressing changes
- performing wound debridement as required
- observing and teaching medical students
  - playing a major role in the operating theatre by assisting the staff and senior residents
  - by the end of your rotation, you will be the primary surgeon for cases such as simple and complex wound closures, reduction of hand fractures, simple tendon lacerations, excision of facial lesions and similar types of basic Plastic Surgery.

Plastic Surgery is a very “hands on” specialty for the junior residents and much can be learned about the basics of Surgery and the principles of Plastic Surgery technique.

**B. Communicator**

- Core residents will communicate timely clinical information to patients, families, and to the resident and attending staff on the service.
- Core residents will document clearly in the chart histories and physical examinations of their patients and will provide progress notes daily.
- Core residents will provide pertinent patient data from consultations to resident and attending staff.

**C. Collaborator**

- Core residents will conduct themselves as a helpful member of the Surgical Team. They will assist the senior resident staff and/or the members of the attending staff with consultations, participate in the clinics, and assist in the operating room.
- Core residents as a member of the Surgical Team will complete patient discharge summaries and supporting documents to enhance communication with community partners (referring physicians; referral health centers) and also assist in providing information to the patients and families.

**D. Manager**

- Core residents will assist in discharge planning using collaboration with nurses, Social Service and other health care providers both in the hospital and in the community.
- Core residents will understand principals of cost-effective care, limited resources, and management of equipment.

**E. Health Advocate**

- Core residents will provide information to the patient and/or family regarding the specific surgical problem.
- Core residents will discuss the care of the patient before and after surgery along with the expected length of hospital stay and the follow-up visits at the hospital or in the office setting.
- Core residents will outline to the patient appropriate prevention techniques to decrease chances of recurrence of the disease process, where applicable. (e.g., skin cancer, melanomas, diet, and weight control, etc.)

**E. Scholar**

- Core residents will obtain and demonstrate knowledge of each individual patient under treatment.
- Core residents will research issues surrounding his/her patients and provide feedback to senior residents and the attending staff.
- Core residents will be responsible for case presentations to the Surgical Team and to formal hospital and university rounds.

- Core residents will ask learning questions and they will continue along the road of lifetime education.
- Core residents will assist the patient and family in learning about the specific surgical-medical problem.

#### **F. Professional**

- Core residents will be committed to professional standards of care and they must demonstrate this commitment.
- Core residents must be honest and committed to patient care and demonstrate compassion to the patient and family.
- Core residents must be ethical in all relationships with patients, families, and other members of the treatment team.
- Core residents must exhibit a life time commitment to professional standards and must use self-assessment to satisfy this requirement.

### **LECTURES**

A special topic of concern to all students and residents is presentations. You will find during your career you will be expected to present either patient cases or topic presentations in a wide variety of situations. These include:

- (a) presenting to a senior resident a patient you have just admitted
- (b) presenting cases to the attending surgeon or surgeons on ward rounds
- (c) presenting short topics to your service or other small groups

During your first week on the service, you will be given special training on “How to Give a Presentation”. The important principles will be discussed to give you the basics on presenting yourself in the best possible way. In order to practice what you have learned, you will be required to present case reports and one short topic to the service. By keeping your audience small and friendly, we hope to maximize your learning experience and help you overcome any shyness when presenting in front of groups. You will soon learn that much of the anxiety and apprehension involved with presenting in front of people stems solely from the fact that nobody has taught you what to do and expect.

### **END OF ROTATION**

Your ITER will be discussed with you and the Program Director. The specific areas of learning as outlined in this document will be assessed and evaluated using the CanMEDS competencies.

# Oral and Maxillofacial (OMF) Surgery and Trauma

## **Rotation Specific Objectives for Surgical Foundations Residents** **Oral and Maxillofacial Surgery and Trauma**

The Oral and Maxillofacial Surgery and Trauma rotation is designed to expose you to the many different facets of this specialty. You will be exposed to benign and malignant pathologies of the oral cavity as well as trauma. Below are specific objectives that will enhance your experience and help to guide you during the rotation. This will help you focus your reading and clinic time with us.

### **Objectives**

#### **General**

- A. Introduce the specialty of Oral Maxillofacial Surgery and Trauma.
- B. Establish sound surgical principles with regard to investigating benign and malignant neoplasms of the oral cavity.
- C. Develop an Algorithm for managing maxillofacial trauma.
- D. Identify and understand the management and treatment of infections of the oral cavity.

## **Evaluation Using the CANMEDS Framework**

### **A. Medical Expert**

1. **Basic Oral Maxillofacial Physical Exam**
  - a. Dentition and Occlusion
    - i. Understand normal dentition and occlusion
  - b. Oral pathology
    - i. Identify risk factors for malignancy
    - ii. Learn proper biopsy techniques
  - c. Trauma
    - i. Develop an approach to maxillofacial trauma
  - d. Infections
    - i. Develop an approach to treatment
    - ii. Understand the natural progression
2. **Clinical Knowledge**
  - a. Physical Examination
    - i. Examine the oral cavity with a headlight
    - ii. Assess the degree of trismus

- iii. Assess for temporomandibular disorders
    - iv. Assess a patient with maxillofacial trauma using a focused physical examination
    - v. Assess the facial nerve
    - vi. Assess for infections
  - b. Imaging
    - i. Evaluate a panorex
    - ii. Understand a CT scan
  - c. Operating Room
    - i. Proper prepping and draping
    - ii. Learn operating room etiquette
    - iii. Assist during complex surgeries
  - d. Reading
    - i. Review benign and malignant neoplasms of the oral cavity
    - ii. Causes of temporomandibular disorders
    - iii. Causes of trismus
    - iv. Infections of the oral cavity

#### **B. Communicator**

- Surgical Foundation residents will assess consultations from the emergency department, the wards, and the clinic and discuss with the attending in a timely fashion.
- The urgency of a trauma patient or a life threatening infection will be discussed with the attending staff immediately.
- Surgical Foundation residents will communicate in timely fashion clinical information to patients, families, and to the resident and attending staff on the service.
- Surgical Foundation residents will document clearly in the chart histories and physical examinations of their patients and will provide progress notes daily.

#### **C. Collaborator**

- Surgical Foundation residents will collaborate with physicians and residents from other specialties. They will conduct themselves as a helpful member of the Surgical Team. They will assist the senior resident staff and/or the members of the attending staff with consultations, participate in the clinics, and assist in the operating room.
- Surgical Foundation residents will collaborate with local dentists and maintain communication regarding patient care. Completing discharge summaries and supporting documents will be a means to that end.
- Surgical Foundation residents will collaborate with nurses, Social Service and other health care providers both in the hospital and in the community.

#### **D. Manager**

- Surgical Foundation residents will learn to manage patients in an appropriate manner. Moreover, they will learn to prioritize patients, and manage resources appropriately (CT scans, urgent consults...etc).

#### **E. Health Advocate**

- Surgical Foundation residents will explain to the patient about causes of TMD and ways to avoid it.
- Surgical Foundation residents will explain to the patient about causes of infections of the oral cavity and ways to avoid it.
- Surgical Foundation residents will explain to the patient about the dangers of smoking and alcohol consumption, and its relationship to neoplasms of the oral cavity.

#### **F. Scholar**

- Surgical Foundation residents will read about the cases that they see.
- They will review the current literature on specific topics.
- They will read about oral infections, neoplasms, and TMD.
- They will learn to properly present a patient to the attending staff.

#### **G. Professional**

- Surgical Foundation residents will be committed to professional standards of care and they must demonstrate this commitment.
- Surgical Foundation residents must be honest and committed to patient care and demonstrate compassion to the patient and family.
- Surgical Foundation residents must be ethical in all relationships with patients, families, and other members of the treatment team.

#### **End of Rotation**

Your evaluation will be discussed with you and your Program Director. The specific areas of learning as outlined in this document will be assessed and evaluated using the CANMEDS Roles.

# **Oncology (Surgical/Radiation)**

## **Rotation Specific Oncology (Surgical/Radiation) Objectives**

The Oncology rotation is designed to expose you to the many different facets of radiation oncology, including surgical adjuvant such as the implantation of brachytherapy catheters. You will be exposed to multidisciplinary tumor boards, the planning of radiation (dose and site), and the complications of radiation to the head and neck, and the surgical placement of brachytherapy catheters in the operating rooms.

### **Objectives**

#### **General**

- E. Introduce the unique needs and care that patients undergoing radiation therapy encounter.
- F. Introduce the role of the multidisciplinary team in dealing with this group of patients, including psychologists, nursing, physical therapists, surgeons, and medical oncologists.
- G. Understand the post-treatment complications these patients must deal with (nutritional deficits, sialadenitis, secondary malignancies, lifelong follow up...etc).

## **Evaluation Using the CANMEDS Framework**

### **A. Medical Expert**

- 3. Head and Neck Physical Exam
  - a. Oral Cavity
    - i. Tongue
    - ii. Lips
    - iii. Buccal mucosa
    - iv. Mucosal surfaces
  - b. Oropharynx
    - i. Base of tongue
    - ii. Lateral tongue
    - iii. Tonsils
    - iv. Soft palate
  - c. Lymphadenopathy
    - i. Levels 1-6
  - d. Skin and Scalp
    - i. Assess for worrisome lesions

- ii. Understand normal dentition and occlusion

4. Clinical Knowledge

a. Physical Examination

- i. Examine the oral cavity and oropharynx identifying abnormal masses/lesions.
- ii. Assess for complications of radiation treatment
  - B. Thrush
  - C. Trismus
  - D. Sialadenitis
  - E. Tooth decay
  - F. Dysphagia
  - G. Odynophagia

- iii. Evaluate for tumor recurrence

b. Imaging

- i. CT scan
- ii. MRI
- iii. PET scan

c. Operating Room

- i. Learn operating placement of brachytherapy catheters

d. Reading

- i. TNM staging for the following malignancies

- B. Oral cavity
- C. Oropharynx
- D. Nasopharynx
- E. Hypopharynx
- F. Larynx
- G. Malignant melanoma
- H. Parotid gland
- I. Thyroid gland

- ii. Review risk factors for malignancy

- B. Smoking
- C. Alcohol
- D. HPV

- iii. Review past and current radiation therapy protocols for malignancies of the head and neck, including the role of chemotherapy

- iv. Short-term and long-term complications of radiation therapy

**B. Communicator**

- Surgical Foundation residents will assess consultations from other specialists including the emergency department.

- Surgical Foundation residents will communicate with members of the multidisciplinary team as well as the patient and the patient's families.
- Surgical Foundation residents will document clearly in the chart histories and physical examinations of their patients and will provide progress notes daily.

### **C. Collaborator**

- Surgical Foundation residents will collaborate with all members of the multidisciplinary team with respect to the care of the patient.
- Surgical Foundation residents will collaborate with local dentists to ensure the teeth are assessed prior to radiation treatment.
- Surgical Foundation residents will collaborate with nurses, Social Service and other health care providers both in the hospital and in the community.

### **D. Manager**

- Surgical Foundation residents will learn to manage patients in an appropriate manner. Moreover, they will learn to prioritize patients, and manage resources appropriately (PET scans, urgent consults...etc).

### **E. Health Advocate**

- Surgical Foundation residents will explain to the patient about causes of malignancies (smoking, alcohol, HPV, radiation exposure).
- Surgical Foundation residents will explain to the patient about the importance of adequate nutrition and dental care.

### **F. Scholar**

- Surgical Foundation residents will read about the cases that they see.
- They will review the current literature on specific topics.
- They will read about current treatment protocols.
- They will learn to properly present a patient to the attending staff.

### **G. Professional**

- Surgical Foundation residents will be committed to professional standards of care and they must demonstrate this commitment.
- Surgical Foundation residents must be honest and committed to patient care and demonstrate compassion to the patient and family.
- Surgical Foundation residents must be ethical in all relationships with patients, families, and other members of the treatment team.

## **End of Rotation**

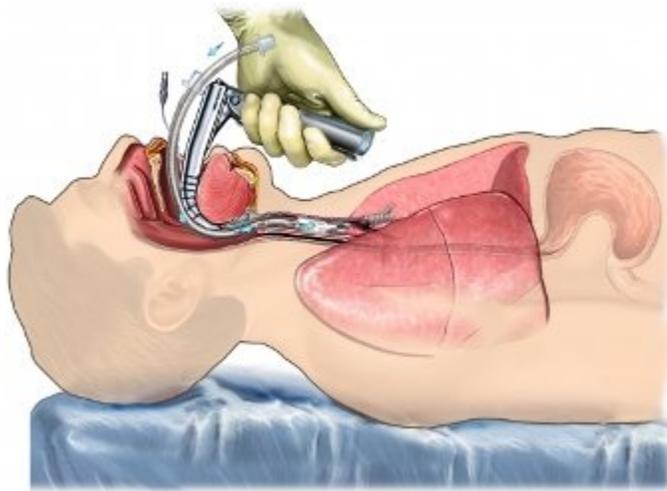
Your evaluation will be discussed with you and your Program Director. The specific areas of learning as outlined in this document will be assessed and evaluated using the CANMEDS Roles.

**McGill University**



# Airway Basics Course

**What:**



basics of airway management

**When:**

u  
bation, bag-mask, surgical airway etc...)

Half-day session

Wednesday Sept 7th AM, PM

**Where:**

McGill Medical Simulation Center

**Who:**

Free for all McGill University PGY1s  
(currently >100 residents enrolled)

For more information, contact

**Dr Lily HP Nguyen**

Dept. of Otolaryngology – Head & Neck Surgery

[lily.hp.nguyen@gmail.com](mailto:lily.hp.nguyen@gmail.com)



## **Airway Basics Course (ABC)**

**Department of Otolaryngology - Head and Neck Surgery**  
**Department of Anesthesia**

September 7<sup>th</sup>, 2011

### **Planning Committee:**

Dr. Lily HP Nguyen, Dept. of OTL-HNS, MCH  
Dr. Francesco Ramadori, Dept. of Anesthesia, MGH  
Dr. Angelina Guzzo, Dept. of Anesthesia, MGH  
McGill Medical Simulation Center – Linda Crelinstein and Guylaine Neveu

### **Invited Faculty:**

Dr. Dev Jayaraman, Dept of Critical Care, RVH  
Dr. Josee Lavoie, Dept. of Anesthesia, MCH  
Dr. William Li Pi Shan, Dept. of Anesthesia, RVH  
Dr. Pat Melanson, Critical Care Medicine, RVH  
Dr. Keith Richardson, Dept. of OTL-HNS  
Fellow, Dept. of Anesthesia

## **Overall Goal of Course**

To overcome the barriers of teaching basic airway management to residents

### **Barriers of teaching difficult airway management**

1. Infrequent training opportunities for obtaining specific skills
2. Difficulty in justifying an airway as a hands-on teaching case
3. Early staff intervention during airway cases

## **Course Objectives**

1. Provide trainees with the opportunity to master the skills of bag mask ventilation and endotracheal intubation
2. Provide residents with exposure to airway simulation scenarios not covered in ACLS or ATLS
3. Familiarize the residents to cricothyroidotomies and to tracheostomy care
4. Provide trainees with the opportunity to practice using the numerous alternative airway devices and skills

## **Target audience of ABC**

PGY-1s in the following departments:

- Internal Medicine
- Neurology
- Family Medicine
- Emergency Medicine
- Anesthesia
- Otolaryngology – Head and Neck Surgery
- General Surgery + all surgical subspecialties
- Obstetrics/Gynecology

### **Course Outline**

*Trainees will be taught using a combination of didactic lectures, hands-on practicum and case-based simulations at the McGill Simulation Center. During the half day teaching course, all trainees will rotate through 5 stations, each representing a major teaching objective in basic airway management. Each station will have key teaching points that will also be addressed.*

**Schedule**

<b>FORMAT</b>	<b>AM SESSION</b>	<b>PM SESSION</b>
Introduction	7:45 - 8:00 am	12:15 – 12:30 pm
Lecture	8:00 – 8:30 am	12:30 – 1:00 pm
Rotation through 2 stations <ul style="list-style-type: none"><li>○ Intubation</li><li>○ Bag Mask</li></ul>	8:30 – 9:30 am	1:00 – 2:00 pm
Break		
Rotation through 3 stations <ul style="list-style-type: none"><li>○ Alternative Airway Devices</li><li>○ Basics of Surgical Airway</li><li>○ Simulation Scenarios</li></ul>	9:40 -11:10 am	2:10 – 4:10 pm
Closing remarks	11:40 – 11:50 am	4:10 – 4:20 pm

### Details of Stations

<b>Station Description</b>	<b>Duration</b>	<b>Site</b>	<b>Leaders AM session</b>	<b>Leaders PM session</b>
<b>Lecture</b>	30 min	Main Conference Room	Guzzo or Ramadori	Guzzo or Ramadori
<b>Intubation</b> (3 stations running parallel)	30 min	Technical Skills Room	<ul style="list-style-type: none"> <li>• Lavoie</li> <li>• Li Pi Shan</li> <li>• Jayaraman</li> </ul>	<ul style="list-style-type: none"> <li>• Nguyen &amp; Richardson</li> <li>• Li Pi Shan</li> <li>• Jayaraman</li> </ul>
<b>Bag Mask Ventilation</b> (3 stations running parallel)	30 min	Technical Skills Room	<ul style="list-style-type: none"> <li>• Guzzo</li> <li>• Melanson</li> <li>• Ramadori</li> </ul>	<ul style="list-style-type: none"> <li>• Guzzo</li> <li>• Melanson</li> <li>• Ramadori</li> </ul>
<b>Alternative airway devices</b> (2 stations running parallel)	30 min	Technical Skills Room	<ul style="list-style-type: none"> <li>• Lavoie</li> <li>• Li Pi Shan</li> </ul>	<ul style="list-style-type: none"> <li>• Anesthesia Fellow</li> <li>• Li Pi Shan</li> </ul>
<b>Basics of Surgical Airway</b> (2 stations running parallel)	30 min	Technical Skills Room	<ul style="list-style-type: none"> <li>• Nguyen</li> <li>• Richardson</li> </ul>	<ul style="list-style-type: none"> <li>• Nguyen</li> <li>• Richardson</li> </ul>
<b>Simulation Scenarios</b> <ul style="list-style-type: none"> <li>○ 2 rooms running parallel</li> <li>○ 2 scenarios each room</li> </ul>	1 hour	Hi-fi Simulation Room	<ul style="list-style-type: none"> <li>• Jayaraman &amp; Ramadori</li> <li>• Guzzo &amp; Melanson</li> </ul>	<ul style="list-style-type: none"> <li>• Jayaraman &amp; Ramadori</li> <li>• Guzzo &amp; Melanson</li> </ul>

# **PGY2 – FIRST YEAR OF RESIDENCY TRAINING IN**

## **OTOLARYNGOLOGY – HEAD AND NECK SURGERY**

The residents rotate, for 3 months duration, throughout the four teaching hospital sites:

- Montreal Children's
- Montreal General
- Jewish General
- Royal Victoria hospitals

Junior residents (PGY2 & PGY3) at each hospital site are evaluated according to their specific exposure using the One45 system. These evaluations are different from the senior residents (PGY4 & PGY5) evaluations.

### **During the first year of residency in otolaryngology – head and neck surgery (in all hospital rotations), residents are expected to develop proficiency in:**

1. Obtaining the otolaryngological history and performing physical examination. This includes:
  - use of head mirror and headlight
  - nasopharyngoscopy using the mirror, the flexible nasopharyngoscope and the telescopes
  - indirect laryngoscopy using mirror and flexible nasopharyngolaryngoscope
  - use and interpretation of videostrobolaryngoscopy with flexible and rigid scopes
  - otoscopy
  - use of the operating microscope in the examination and management of ear disease
  - evaluation of facial nerve function
2. Performance and interpretation of audiological and vestibular tests
3. Interpretation of medical imaging techniques
4. Management of common otolaryngological emergencies:
  - epistaxis (cautery, anterior and posterior packing)
  - airway problems (foreign body, epiglottitis, croup, upper airway obstruction)
  - Perform open and percutaneous tracheostomy
  - esophageal emergencies (foreign body, caustic ingestion)
  - peritonsillar and deep neck infections
  - facial trauma
  - the dizzy patient

- acute otitis media, otitis media with effusion and otitis externa

## 5. Operative objectives

### a) Gain experience and proficiency in the following:

- Pre and post operative patient care management
- Clinical procedures, fine needle aspiration, cytology (FNAB), biopsy, excisional biopsy
- Tonsillectomy and Adenoidectomy (T&A)
- Myringotomy and ventilating tubes
- Microdebridement of ears
- Development of principles of soft tissue surgery, e.g.: suturing techniques
- Tracheotomy
- Direct laryngoscopy, bronchoscopy and esophagoscopy
- Assistance at major head and neck surgery

### b) acquire experience in the following procedures with adequate supervision near the end of the first year of training:

- Septoplasty
- Nasal polypectomy
- Sinus surgery
- Removal of lumps and bumps
- Microlaryngeal surgery

6. Residents are introduced to the techniques of temporal bone surgery by attending a bone drilling course held annually at the temporal bone lab.

7. Didactic objectives: Residents should be involved in seminars, lectures, rounds and teaching of medical students and clerks.

8. In this first year of otolaryngology, careful attention is directed to matters of ethical and responsible behavior, and ability to work with and relate well to fellow members of the medical team.

# **PGY2 MONTREAL CHILDREN'S HOSPITAL**

## **(PEDIATRIC JUNIOR ROTATION OBJECTIVES & EVALUATION):**

PGY2 Residents rotate as a junior pediatric otolaryngology resident at the MCH for a period of 3 months. Junior pediatric PGY2 residents at the MCH are evaluated according to their specific objectives using the one45 system. These evaluations are different from the senior MCH residents (PGY3) evaluation. All residents must undergo a STASER (Standardized Assessment of a Clinical Encounter) or STACER (Standardized Assessment of a Surgical Encounter) evaluation by a MCH staff person during each of their rotations at the hospital. They are also evaluated by 360 degree inter-professional evaluation (feedback from allied health care personnel, nurses, secretaries)

### **1. MEDICAL EXPERT:**

The residents attend the different specialty clinics, pediatric tumor boards and interact with other members of clinical departments. Their role as medical experts is illustrated in such activities. They express, discuss, teach and learn the various opinions regarding the investigation and treatment of challenging medical conditions and therapeutic protocols.

#### **The Expert Role specific objectives are:**

- **General skills**
  - Take a relevant, appropriately-detailed history from a patient presenting for otolaryngology assessment
  - Perform a detailed, thorough head and neck examination
  - Promptly and effectively assess patients with airway emergencies including airway obstruction
  - Perform effective flexible nasopharyngoscopy with accurate interpretation of findings
  - Perform effective anterior nasal packing for epistaxis
  - Manage a tracheostomy/change a tracheostomy tube
  - Participate in the post-operative ward and office management of patients who have undergone head and neck surgery, otologic surgery, sinus surgery, and general otolaryngological surgery
  - Interpret X-ray and cross-sectional imaging of temporal bones, paranasal sinuses, and soft tissues of the head and neck in children
  - Become familiar with specialty clinics in Laryngology, Combine Reflux/ENT, dysphagia, drooling and Otology

- **Pediatric Otolaryngology**
  - Perform adenoidectomy and tonsillectomy with limited direct consultant intervention
  - Know the indications, complications, anatomy related to adenotonsillectomy
  - Develop a classification scheme and approach to management of common congenital and acquired causes of pediatric hearing loss
  - Assess children with ENT emergencies and manage them with direct supervision in ER, PICU and NICU
  - Upper aero-digestive endoscopy in pediatric patients
  - Know the indications for pediatric tracheotomy, perform the procedure, and manage the patient post-operatively
  - Embryology of the head and neck and relevant application to the clinical setting
  
- **Pediatric Otology**
  - Demonstrate ability to remove cerumen from external ear
  - Perform effective, accurate otomicroscopy
  - Be able to perform and interpret conventional audiometry and tympanometry in children and adults
  - Understand the principles and application of auditory brainstem response (ABR) and Otoacoustic Emissions (OAEs)
  - Know the indications, complications, anatomy related to PET's
  - Perform myringotomy with ventilation tube insertion with limited direct consultant intervention
  
- **Pediatric Head and Neck Surgery**
  - Perform effective, accurate Fine Needle Aspiration of neck lesions
  - Effectively biopsy nasal or oral cavity lesions
  - Effectively assist at basic head and neck surgical procedures (neck mass excision)
  - Incise and drain a wound abscess including indications for the procedure
  - Incise and drain a peritonsillar abscess including recognition of the signs and symptoms associated with a peritonsillar abscess
  - Know the indications, complications and anatomy of peritonsillar abscess drainage

**The expert objectives duties are carried by:**

**Clinic:**

- attend clinics and coordinates his/her time with the OR schedule
- do consultations during the weekdays and discuss them with the senior resident and attending staff.

- Perform flexible endoscopy in infants and children
- Microscopic ear examination and debridement
- Nasal packing, foreign body removal, cautery epistaxis
- pre-op clinic

**In-patients:**

- responsible for the consultations when the senior resident is not available
- performs rounds with the senior resident and/or attending staff and plans the management and follow-up on admitted patients on the different hospital wards, emergency room including ICU

**O.R.:**

- responsible for minor cases (T&As, PET tubes, etc..)
- assist the senior resident on all other surgeries
- assist in the O.R. on all cases when “On Call”

**Other:**

- cross-cover the adult teaching hospital when on call at the MCH
- shares responsibilities for weekend coverage of admissions and in- patients with the senior resident

**Pediatric Audiology Montreal Children’s Hospital Rotation**

Each resident will be responsible to spend a sufficient amount of time in the Audiology department at the MCH during his/her rotation. The resident will be required to gain knowledge of pediatric audiometric testing. An oral exam will be given to each resident on audiology prior to completion of the rotation. The results of the examination will be recorded.

**Temporal Bone Dissections**

Each resident will be responsible for completing one anatomical dissection of a temporal bone during his/her pediatric rotation. The results of the dissection will be recorded. This dissection is MANDATORY as a requirement in order to pass the rotation at the MCH.

**MCH Resources for Residents:**

- Pediatric Otology:  
Training of residents in all aspects of medical and surgical pediatric otology that include otitis media and performing different types of tympanoplasties and mastoidectomies including ossicular chain reconstruction. The resident also gain experience in pediatric audiology. Different sessions are given in combination with the Audiology Department

on aural rehabilitation and hearing aid assessment for children. The resident will have experience in BAHA surgery as the MCH is a leader in that field.

- **Nose and Sinuses:**  
All medical and surgical aspects of rhinology are covered. The residents perform endoscopic sinus surgery.
  
- **Aerodigestive diseases:**  
This includes diagnosis and treatment of foreign bodies of the aerodigestive tract, congenital and acquired laryngotracheal problems. The O.R. at the MCH is equipped with laser technology and is one of the few centers in North America that manages these kinds of pathologies. The resident is involved in the treatment of these conditions throughout his rotation at the hospital. There is a specialized airway clinic and the resident is exposed to a multidisciplinary approach to pediatric airway problems.
  
- **Specialty clinics:** residents exposed to specialty clinics in otology, airway, reflux, dysphagia, and saliva. These clinics focus on more complicated cases involving these domains.
  
- **Pediatric oncology:**  
In association with the Hematology/Oncology departments and Radiotherapy, the residents are involved in the treatment of head and neck tumors including lymphomas, rhabdomyosarcomas, etc.
  
- **Research:**  
The resident is involved with different basic and clinical research projects during his/her rotation at the MCH. All our physicians are keen on research. The newly established McGill Auditory Sciences Laboratory under the supervision of Dr. S. Daniel is located at the hospital and provides an excellent opportunity for basic science research.
  
- **Formal teaching sessions:**  
In addition to hospital rounds, formal teaching sessions are provided on a weekly basis by the residents which are supervised by an attending staff.
  
- **Feedback and Evaluation:**  
The residents should expect to get at a minimum 2 one-on-one feedback session with the director Dr Sam Daniel who will summarize the feedback provided by the staff physicians and discuss any issues pertaining to the service. Also the attending staff gives verbal feedback at mid-rotation and at the end of rotation.

## **2. COMMUNICATOR:**

The resident is evaluated throughout his rotation by the members of the staff as a **communicator** with the parents and patients. The interview, gathering of clinical information, explanation of the different therapeutic modalities as well as performing the different clinical tasks are the bases of the evaluating process. Both verbal and written communication is emphasized. An important percentage of our patient population has different ethnic background. An interpreter is always present during these interviews. This constitutes an additional challenge to the resident who is an essential part of the clinic team. The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the communicator role of CanMEDS.

### **The communicator role is evaluated especially on:**

- Demonstrate effective establishment of therapeutic relationships with patients and their families
- Present histories, physical findings, and management plan to consultants in an organized, efficient, and confident manner
- Obtain and synthesize relevant history from patients, their families, and communities
- Demonstrate ability to contextualize relevant psychosocial, occupational, and social consequences of ENT disorders in pediatric patients
- Recognize unique biopsychosocial issues related to deafness and the deaf community
- Prepare clear, accurate, concise, appropriately detailed clinical notes, consultation notes, discharge summaries, and operative reports
- Discuss common (e.g. tonsillectomy) procedures with patients and their families in a clear and understandable form including risks/benefits, informed consent, and post-operative care
- Prepares, participates, and presents effectively in organized rounds and seminars

## **3. COLLABORATOR:**

The resident role as **collaborator** is evident during daily interactions with the other physicians and allied health professionals. He is the first member of the team to evaluate the patient's needs and direct the family to the appropriate professional. Examples include: social workers, occupational therapy, audiology, speech therapy, physiotherapy, etc. The collaboration with the different divisions and departments is also of paramount importance. The daily contact with these services constitutes a major task in the resident's clinical activity and reflects an important image on the role of Otolaryngology within the MCH. The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the collaborator role of CanMEDS.

**The collaborator role is evaluated especially on:**

- Demonstrate an understanding of the team structure of an in-patient service (the resident team) and fulfill his/her role in this structure
- Demonstrate recognition and respect for the opinions and roles of other team members
- Identify appropriate situations where the interdisciplinary team is most useful
- Identify the situations and instances where consultation of other physicians or health care professional is useful or appropriate
- Demonstrate collegial and professional relationships with other physicians, office and clinic support staff, operating room personnel, and emergency room staff
- Recognize the expertise and role of allied health professionals such as speech language pathologists, audiologists, technicians, nurses, and clerical staff

**4. MANAGER:**

The resident role as **manger** is also elucidated in his daily activities, managing and planning his schedule and supervising the junior members of the team. The wise and proper use of the different hospital services is taken into consideration during the evaluation process. Ordering laboratory, radiological investigations and adopting different therapeutic modalities reflect important points in this process. The members of the team help to guide the senior and junior residents throughout the hospital rotation to this important aspect of medical practice. The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the manager role of CanMEDS.

**The manager role is evaluated especially on:**

- Utilize resources effectively to balance patient care duties, learning needs, Educational/teaching responsibilities and outside activities
- Allocate finite health care resources in a wise, equitable, and ethical fashion
- Utilize information technology to optimize patient care and life-long learning including facile use of hospital IT resources (e.g. filmless radiology, electronic charting)
- Demonstrate an appreciation of the importance of quality assurance/improvement
- Actively participate in preparation, presentation, analysis, and reporting of morbidity and mortality rounds
- Accurately identify criteria for patient admission to hospital in the urgent/emergent situation as well as the implications of such decisions

**5. HEALTH ADVOCATE:**

He/she is a **health advocate** and role model for the young parents and teenagers, teaching them about the dangers and prevention of noise induced hearing loss, promote choking prevention in children, as for teenagers promote risk reduction of head and neck malignancy through smoking cessation, responsible alcohol use and UVA/UVB protection.

**The manager role is evaluated especially on:**

- Recognize and respond to opportunities for advocacy within Otolaryngology, both for your patients as well as for the community in which we practice
- Encourage behaviors that promote hearing protection and conservation at work and at home
- Recognize and promote policies that enable early identification of hearing impairment through infant and childhood screening programs
- Facilitate patients' access to local and national resources available for the hearing impaired
- Promote choking prevention in children
- For teenagers promote risk reduction of head and neck malignancy through smoking cessation, responsible alcohol use and UVA/UVB protection

**6. SCHOLAR:**

Hospital rounds are presented once a week on Mondays at 4pm. Attendance is compulsory for the attending staff, fellows, residents and medical students who happen to be doing “elective rotations” at this time. The senior resident is responsible for the contents and scientific material. The senior resident may delegate the presentation of the rounds to a junior resident or share this responsibility with a student. During the hospital rounds, many clinical cases are discussed. A review of the pertaining literature is usually presented, and the opinions of the different members are expressed. It is through this forum and other similar daily discussions that the resident’s role as a scholar is demonstrated. Every year a resident presents a research project at our annual Resident Research Day/James D. Baxter Lecture held in the spring.

**The scholar role is evaluated especially on:**

- Actively participate in the teaching of medical students (didactic, in clinics, and on wards/in OR)
- Facilitate learning in patients and other health professionals
- Actively participate in preparation and presentation of weekly Grand Rounds
- Demonstrate a critical appraisal of research methodology, biostatistics, and the medical literature as part of monthly Journal Clubs
- Practice the skill of self-assessment
- Develop, implement, and monitor a personal Educational strategy and seek guidance for this Educational strategy as appropriate
- Demonstrate the evolving commitment to, and the ability to practice, life-long learning
- Contribute to the development of new knowledge through participation in clinical or basic research studies

- Demonstrate commitment to evidence based standards for care of common problems in Otolaryngology
- Actively participate in weekly academic round series including advance preparation for the topic(s)

## **7. PROFESSIONAL:**

The residents must demonstrate **professionalism** by demonstrating the highest standards of excellence in clinical care and ethical conduct. This includes self-discipline, such as a sense of punctuality and respect for cultural diversity. They must address their peers, colleagues, staff and other allied health professionals with the utmost respect and courtesy. Residents are also expected to act as role models. Their sense towards responsibility toward the patients in terms of balancing their professional and personal lives is evaluated on an ongoing basis by their superiors, colleagues and other. The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the manager role of CanMEDS.

### **The professional role is evaluated especially on:**

- Deliver highest quality care with integrity, honesty, and compassion
- Exhibit appropriate professional and interpersonal behaviors
- Practice medicine and Otolaryngology in an ethically responsible manner
- Recognize limitations and seek assistance as necessary
- Seek out and reflect on constructive criticism of performance
- Endeavour to develop an appropriate balance between personal and professional life to promote personal physical and mental health/well-being as an essential to effective, life-long practice

# **PGY2 JEWISH GENERAL HOSPITAL**

## **(JUNIOR RESIDENT ROTATION):**

- At the JGH there is a modern, state-of-the-art clinical out-patient facility, with 8 examination-treatment rooms, an electronystagmography testing room, 3 audiological testing suites, speech language-pathology offices, a conference room, and a dedicated residents' room.
- The Department runs the following clinics: General Otolaryngology Clinic, Head and Neck Oncology Clinic, Resident's Clinic for in-patient and out-patient consultations, Otology Clinic, Nasal and Sinus Clinic, Voice/dysphagia Clinic, and a Laser Clinic. In addition, extensive Speech-Language Pathology Services are integrated into the services for Head and Neck cancer patients, with a Laryngectomy Support Group and an Oncology Nurse Pivot.
- The CanMEDS roles have been implemented into our training process and now serve as the foundation upon which we structure our practice and teaching. The following will serve to demonstrate the educational objectives, strategies and evaluation process at the JGH.
- Available resources for Residency Training include:
  - Complete audiological services including ABR and OAE.
  - Computerized electronystagmography testing.
  - Speech therapy department, including a speech and swallowing therapist for the oncology service.
  - Clinical services within the department include head & neck radiology, head & neck pathology, and multi-disciplinary teams for skull base surgery and oncology patients.
  - Departmental conference room and library.
  - Designated Residents' Room.

### **1. MEDICAL EXPERT:**

- The PGY2 year will focus on acquiring expertise in obtaining an appropriate history and performing a comprehensive head and neck examination.
- Residents at the PGY2 level should focus on acquiring a sound basic science knowledge base in head and neck anatomy and physiology as they pertain to otolaryngology.
- The PGY2 residents will learn basic office-based ENT procedures such as laryngoscopy, biopsies, minor excision of head and neck lesions as well as basic operative procedures.
- The OR responsibility will progress with the resident's seniority and individual abilities.

- Junior residents (PGY2 & PGY3) at each hospital site are evaluated according to their specific exposure using the one45 system. Evaluations forms are different from the senior residents (PGY4 & PGY5) evaluation.
- The PGY2 residents will learn basic office-based ENT procedures such as laryngoscopy, biopsies, minor head and neck lesion excisions as well as basic operative procedures. The OR responsibility will progress with the resident's seniority and individual abilities. Their technical training is designed to meet the requirements as outlined in the rotational objectives of the McGill Department of Otolaryngology – Head & Neck Surgery Residency Handbook. All of the general otolaryngology clinics, sub-specialty clinics and surgeries are supervised by Attending Staff. Regular informal quizzing as well as structured written and oral examinations serves as part of the evaluation process, using the One45 framework. All residents must undergo a STASER or STACER evaluation by a JGH staff person during each of their rotations at the hospital.
- **The main exposure / evaluation of the residents at the JGH in descending priority order are in the domains of:**
  - **head and neck surgery**
  - **otology**
  - **rhinology**
  - **laryngology**
  - **facial plastic reconstructive surgery**
  - **general otolaryngology**
- **The Expert Role specific objectives are:**
  - **General skills**
    - Take a relevant, appropriately-detailed history from a patient presenting for otolaryngology assessment
    - Perform a detailed, thorough head and neck examination
    - Perform effective flexible nasopharyngolaryngoscopy with accurate interpretation of findings
    - Perform effective anterior and posterior nasal packing for epistaxis
    - Incise and drain a peritonsillar abscess including recognition of the signs and symptoms associated with a peritonsillar abscess
    - Manage a tracheostomy/change a tracheostomy tube
    - Perform rigid esophagoscopy with or without removal foreign body
    - Promptly and effectively assess patients with airway emergencies including airway obstruction
    - Perform open and percutaneous tracheostomies
    - Accurately assess patients suffering facial trauma including ordering appropriate investigations

- Participate in the post-operative ward and office management of patients who have undergone ENT surgery
- Pre-operative assessment and preparation of patient for surgery
- Management of post-operative patient care issues (e.g., pain, labs, wounds)
- Interpret X-ray and cross-sectional imaging of the head and neck
- **Head and Neck Oncologic Surgery**
  - Diagnose and accurately stage malignancies of the upper aero-digestive tract
  - Principles of communication/ speech/swallowing and the challenges encountered in head and neck cancer patients
  - Perform fine needle aspiration of neck lesions
  - Effectively biopsy nasal or oral cavity lesions
  - Manage head and neck oncology in-patients with attention to the unique airway and nutritional needs of these patients
  - Pack a pharyngocutaneous fistula and provide ongoing wound care/debridement
  - Effectively assist at major head and neck ablative surgical procedures (pharyngolaryngectomy, neck dissection etc.)
  - Effectively plan incisions, dissect tissues, and close wounds
  - Demonstrate attention to issues surrounding end-stage malignancies such as end-of-life care and palliation
  - Demonstrate a basic grasp of adjuvant therapies for the treatment of head and neck malignancies (radiotherapy, chemotherapy) and management of their complications
- **Facial Plastic and Reconstructive Surgery**
  - Demonstrate basic understanding of the hierarchy of reconstructive options for defects in the head and neck
  - Understand indications for and design of local and regional flaps/grafts in the cervicofacial region.
  - Harvest split and full-thickness skin grafts
  - Effectively assist at major reconstructive surgical procedures (e.g. harvest of pedicled or free tissue transfer)
  - Refinement of tissue handling, tying, and suturing techniques
- **Laryngology**
  - Develop a differential diagnosis of dysphonia
  - Develop a differential diagnosis for dysphagia
  - Diagnose basic pathology of the larynx
  - Diagnostic approach for and management of vocal cord paralysis
  - Understanding of laser applications in Head and Neck surgery

- **Neurotology/Otology**

- Take a relevant, appropriately-detailed history from a patient presenting for vestibular/dizziness assessment
- Perform a detailed, thorough examination of the vestibular system
- Perform myringotomy and tube insertion with consultant supervision
- Participate in the post-operative ward and office management of patients who have undergone otologic surgery and lateral skull base surgery
- Interpret X-ray and cross-sectional imaging of temporal bones and soft tissues of the head and neck
- Be able to interpret conventional audiometry and tympanometry in adults
- Understand the principles and application of auditory brainstem response (ABR) and otoacoustic emissions (OAEs)
- Understand the principles and application of electronystagmography including interpretation of findings
- Accurately diagnose benign positional vertigo and demonstrate a rational approach to its treatment
- Perform, in an effective manner, the particle repositioning maneuver

- **Rhinology**

- Perform a relevant history on patients presenting with sinonasal complaints
- Perform diagnostic nasal endoscopy (rigid and flexible) including preparation of the nose and accurate interpretation of findings
- Perform biopsy of sinonasal lesions
- Provide post-operative care for patients post sinus surgery including appropriate medical therapy and endoscopic debridement
- Develop an appreciation of the indications for endoscopic sinus surgery
- Gain experience with basic endoscopic sinus surgery such as handling of endoscopes and instruments, local anesthetic infiltration, polypectomy
- Acquire familiarity with indications for surgery and approaches for management of nasal obstruction including nasal septoplasty
- Perform inferior turbinate reduction with direct consultant supervision

## **2. Communicator**

The vital importance of effective communication in the practice of medicine is taught to the residents. Both verbal and written communication is emphasized. The Jewish General Hospital is situated in the heart of the most multi-ethnic neighborhood in Montreal and our trainees have the opportunity to communicate with patients from a multitude of cultural, ethnic and linguistic backgrounds. The residents are encouraged to enlist the assistance of interpreters when necessary. The importance of establishing a doctor-patient relationship based on trust and

understanding is crucial. The resident evaluation process is multi-faceted and includes: observation during the implementation of their clinical duties, STACER evaluation, review of their written notes, evaluations of their OR dictations and patient discharge summaries. The department uses the McGill Simulation Center on an annual basis, using actors acting like patients to teach residents the communicator role of CanMEDS.

**The communicator role is evaluated especially on:**

- Demonstrate effective establishment of therapeutic relationships with patients and their families
- Present histories, physical findings, and management plan to consultants in an organized, efficient, and confident manner
- Obtain and synthesize relevant history from patients, their families, and communities
- Demonstrate the capacity to recognize the psychological, occupational and social consequences of speech and voice disorders, particularly relevant to vocational demands
- Prepare clear, accurate, concise, appropriately detailed clinical notes, consultation notes, discharge summaries, and operative reports
- Demonstrate the capacity to recognize the psychological, occupational and social consequences of speech and voice disorders, particularly relevant to vocational demands
- Recognize unique issues related to head and neck patients particularly relevant to patients with cancer of the head and neck including end-of-life discussions
- Prepares, participates, and presents effectively in organized rounds and seminars
- Respect diversity and difference, including gender, religion and cultural beliefs on decision-making
- Address challenging communication issues effectively, such as obtaining informed consent, delivering bad news, and addressing anger, confusion and misunderstanding

**3. Collaborator**

The practice of medicine today has evolved to a point where working in isolation is not possible or desirable. Medicine, particularly in a tertiary care academic institution, is practiced in a multi-disciplinary team format. The residents must actively participate in tumor boards, and multi-specialty teaching rounds. They are encouraged to recognize the appropriate time to enlist help. Their training also teaches them how to collaborate with the patients as well as family members in the decision-making and management process. They have the opportunity to collaborate with supervisors on their various research projects. The progression from R2 to R5 mirrors the progression of responsibility in the various seminars and teaching rounds. The evaluation process for this aspect of their training seeks feedback from other specialists, peers and allied health professionals (360 degree evaluation). The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the collaborator role of CanMEDS.

**The collaborator role is evaluated especially on:**

- Demonstrate an understanding of the team structure of an in-patient service (the resident team) and fulfill his/her role in this structure
- Demonstrate recognition and respect for the opinions & roles of other team members
- Recognize the advantages for optimal patient care provided by a Multidisciplinary head and neck oncology team.
- Demonstrate collegial and professional relationships with other physicians, office and clinic support staff, operating room personnel, and emergency room staff
- Recognize the expertise and role of allied health professionals such as speech language pathologists, audiologists, technicians, nurses, and clerical staff

**4. Manager**

Effective management skills come in to play at many levels of medical practice. The residents must demonstrate judicious use of medical tests and resources. They will be able to explain the particular purpose of each test ordered. They will learn to perform a type of cost-benefit analysis. The residents will be sensitized to the critical issue of bed utilization. A crucial component of their training is the acquisition of personal time management skills. They will be expected to respect schedules, commitments and call schedules. They will be taught to use information technology to access information and manage their responsibilities. The senior residents will be expected to delegate effectively and organize the work distribution of junior residents and medical students. Residents will be evaluated by way of observation, written and oral exams and creation of case scenarios. They will be assessed based on timely completion of assigned tasks and projects. The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the manager role of CanMEDS.

**The manager role is evaluated especially on:**

- Utilize resources effectively to balance patient care duties, learning needs, educational responsibilities & outside activities
- Allocate finite health care resources in a wise, equitable, and ethical fashion
- Utilize information technology to optimize patient care and life-long learning including facile use of hospital IT resources (e.g. filmless radiology, electronic charting)
- Actively participate in preparation, presentation, analysis, and reporting of morbidity and mortality rounds
- Accurately identify criteria for patient admission to hospital in the urgent/emergent situation as well as the implications of such decisions
- Serve in administrative and leadership roles, such as participate effectively in committees and meetings.

## **5. Health Advocate**

The residents will become advocates of their patients' health. They will learn to counsel their patients regarding health risks such as smoking and alcohol, noise exposure and occupational hearing health, and will provide tools for change. The residents will be encouraged to involve themselves in public health education, such as public lecture series held in the hospital or university. The evaluation of these attributes and skills will be conducted via close observation of their doctor-patient interactions.

### **The health advocate role is evaluated especially on:**

- Recognize and respond to opportunities for advocacy within Otolaryngology, both for your patients as well as for the community in which we practice and populations at large
- Encourage behaviors that promote hearing protection and conservation at work and at home
- Facilitate patients' access to local and national resources available for the hearing impaired
- Encourage behaviors that reduce/eliminate risk factors for the development of head & neck cancer (e.g., tobacco, alcohol, sun exposure)

## **6. Scholar**

The residents will be expected to develop a reading plan from their R2 year onwards. They will use actual cases as well as the literature to constantly update their knowledge. Our weekly rounds and frequent journal clubs will provide them with ample opportunity to critically review the literature. The supervisors will encourage the utilization of evidence-based medicine as it applies to decision-making. The residents will be inspired towards life-long learning and will be encouraged to develop a teaching dossier early on in their careers. During their progression from R2 to R5 years, their teaching responsibility will increase. A variety of modalities will be implemented to evaluate their scholarly activity. Staff will review their research proposals and manuscripts. Their presentations will be evaluated and supervisors will assess their teaching assignments. Every resident presents a research project once a year that is presented at our Annual Resident Research Day/James D. Baxter Lectureship held in the spring.

### **The scholar role is evaluated especially on:**

- Actively participate in the teaching of medical students (didactic, in clinics, and on wards/in OR)
- Facilitate learning in patients and other health professionals
- Actively participate in preparation and presentation of weekly rounds and grand rounds
- Demonstrate a critical appraisal of research methodology, biostatistics, and the medical literature as part of monthly Journal Clubs

- Develop, implement, and monitor a personal educational strategy and seek guidance for this educational strategy as appropriate
- Contribute to the development of new knowledge through participation in clinical or basic research studies
- Demonstrate commitment to evidence based standards for care of common problems in Otolaryngology
- Demonstrate the evolving commitment to, and the ability to practice life-long learning.

## **7. Professional**

The residents will demonstrate appreciation and sensitivity for cultural diversity. They will be expected to treat colleagues as well as all hospital employees with dignity and respect. They will be able to disagree with fellow physicians in a diplomatic and constructive fashion. The importance of punctuality will be highlighted. We will expect the care that they provide to be of the highest level, delivered ethically and with compassion. The evaluation process will be achieved by close observation, and feedback will be solicited from allied health professionals, senior residents and office support staff (360 degree evaluation). The department uses McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the ethics role of CanMEDS.

### **The professional role is evaluated especially on:**

- Deliver highest quality care with integrity, honesty, and compassion
- Exhibit appropriate professional and interpersonal behaviors
- Practice medicine and Otolaryngology in an ethically responsible manner
- Recognize limitations and seek assistance as necessary
- Seek out and reflect on constructive criticism of performance
- Endeavour to develop an appropriate balance between personal and professional life to promote personal physical and mental health/well-being as an essential to effective, life-long practice
- Demonstrate a commitment to their patients, profession and society through participation in profession-led regulation (e.g.: recognize and respond to other unprofessional behavior in practice, understand the legal and ethical codes of practice)

# **PGY2 Royal Victoria Hospital**

## **( JUNIOR RESIDENT ROTATION):**

### **1. MEDICAL EXPERT:**

- Clinical teaching is performed in resident-led clinics and well as at the bedside. The Department at the Royal Victoria Hospital has long recognized the importance of teaching residents key skills in the clinic; where as an Otolaryngologist they will spend most of their professional time. Residents on the service are required to attend clinics, and participate in the care of patients in clinic. With these encounters, residents have the opportunity to develop their skills in terms of history taking, performing the physical examination and proposing an appropriate, cost-efficient and ethical plan of investigation. Development of their technical skills appropriate to a clinic setting is also stressed. Patients are reviewed with attending staff and seen by the attending. Thus an apprenticeship model of teaching is used. Residents can also participate in subspecialty clinics run by the Department's attending staff. Residents are also expected to participate in the two multidisciplinary clinics run by the Department: Head and Neck Clinic and Skull Base Clinic
- The Department operates three to four days a week at the Royal Victoria and Montreal Neurological Hospitals. Surgery spans the gamut of Otolaryngology Head and Neck Surgery's domain. Technical skills are developed under supervision of the attending staff, and in the case of junior residents, by more senior residents. Additionally, residents can accompany staff in a Northern Quebec visit and in accredited satellite offices.
- Junior residents (PGY2 & PGY3) at each hospital site are evaluated according to their specific exposure using the one45 system. Evaluation forms are different from the senior residents (PGY4 & PGY5) evaluation. All residents must undergo a STASER or STACER evaluation by a RVH staff person during each of their rotations at the hospital.
- The main exposure / evaluation of the residents at the RVH in descending priority order are in the domains of:
  - **head and neck surgery**
  - **Neurotology**, skull base neurotology procedures are performed at the Montreal Neurological Institute (MNI)
  - **rhinology**
  - **facial plastic reconstructive surgery**
  - **otology**
  - **laryngology**
  - **general otolaryngology**

- **The Expert Role specific objectives are:**

- **General skills**

- Take a relevant, appropriately-detailed history from a patient presenting for otolaryngology assessment
- Perform a detailed, thorough head and neck examination
- Perform effective indirect laryngoscopy
- Perform effective head mirror, flexible and rigid nasopharyngoscopy with accurate interpretation of findings
- Perform effective anterior and posterior nasal packing for epistaxis
- Incise and drain a peritonsillar abscess including recognition of the signs and symptoms associated with a peritonsillar abscess
- Incise and drain a wound abscess including indications for the procedure
- Manage a tracheostomy/change a tracheostomy tube
- Perform rigid esophagoscopy with or without removal foreign body
- Promptly and effectively assess patients with airway emergencies including airway obstruction
- Perform open and percutaneous tracheostomies
- Accurately assess patients suffering facial trauma including ordering appropriate investigations
- Participate in the post-operative ward and office management of patients who have undergone head and neck surgery
- Interpret X-ray and cross-sectional imaging of the head and neck
- Understand regional anesthesia

- **Head and Neck Oncologic Surgery**

- Management of Head and Neck surgical complications with supervision
- Can effectively manage pain
- Recognition and management of Head and Neck emergencies such as acute airway obstruction, post-operative hemorrhage, and blunt/penetrating neck trauma
- Diagnose and accurately stage malignancies of the upper aero-digestive tract
- Principles of communication/speech/ swallowing and the challenges encountered in head and neck cancer patients
- Perform fine needle aspiration of neck lesions
- Effectively biopsy nasal or oral cavity lesions
- Manage head and neck oncology in-patients with attention to the unique airway and nutritional needs of these patients
- Manage pain in post-operative head and neck oncology patients
- Manage surgical airways (e.g. tracheotomy, laryngectomy stoma) in post-operative head and neck oncology patients

- Pack a pharyngocutaneous fistula and provide ongoing wound care/debridement
  - Effectively assist at major head and neck ablative surgical procedures (pharyngolaryngectomy, neck dissection etc.)
  - Demonstrate attention to issues surrounding end-stage malignancies such as end-of-life care and palliation
  - Demonstrate a basic grasp of adjuvant therapies for the treatment of head and neck malignancies (radiotherapy, chemotherapy) and management of their complications
  - Present effectively at tumor board and demonstrate the ability to effectively document the tumor board plans
- **Plastic and reconstructive surgery**
    - Demonstrate basic understanding of the hierarchy of Reconstructive options for defects in the head and neck
    - Excise cutaneous lesions of the head and neck with appropriate closure/reconstruction of the resulting defect.
    - Harvest split and full-thickness skin grafts
    - Effectively assist at major Reconstructive surgical procedures (e.g. harvest of pedicled or free tissue transfer)
    - Become familiar with diagnosis and treatment of facial nerve disorders and reanimation strategies
    - Harvesting of nerve, tendon, fascia grafts with supervision
    - Refinement of tissue handling, tying, and suturing techniques
    - Diagnosis and treatment of cutaneous lesions of the cervicofacial region with appropriate closure/reconstruction of the resulting defect.
    - Anatomical basis for and design of local and regional flaps in the cervicofacial region (types, indications and techniques)
    - Indications for the various types of grafts & implants used in facial plastic surgery: (FTSG, STSG, Bone grafts, Cartilage grafts, etc)
    - Surgical principles employed in facial reanimation surgery.
    - Assessment of facial aesthetics and evaluation of patients presenting for consideration of cervicofacial cosmetic surgery/procedures.
    - Approach to facial analysis of patient presenting for esthetic nasal surgery, with consideration for cosmetic and functional aspects of the nose
    - Indications and execution of external nasal reduction under local anesthesia, including the administration of appropriate local anesthesia blocks
    - Diagnosis and treatment and post operative care of patients suffering from facial trauma (e.g. orbitozygomatic, mandible fractures)

- **Laryngology**
  - Take a competent vocal history and develop a differential diagnosis of dysphonia
  - Develop a differential diagnosis for dysphagia
  - Perform indirect rigid laryngoscopy
  - Perform microlaryngeal surgery with microlaryngeal instruments, CO2 laser and microdebrideur
  - Understand intraoperative airway management during microlaryngeal surgery
  - Understanding of laser applications in Head and Neck surgery risks (laser safety) and manage complications
  
- **Neurotology/Otology**
  - Take a relevant, appropriately-detailed history from a patient presenting for vestibular/dizzy assessment
  - Perform a detailed, thorough examination of the vestibular system
  - Effectively manage pain associated with surgery (e.g. mastoidectomy, skull base surgery)
  - Perform myringotomy and tube insertion with consultant supervision in clinic
  - Be able to perform diagnostic bedside tests such as the head-thrust (Halmagy) maneuver
  - Participate in the post-operative ward and office management of patients who have undergone otologic surgery and lateral skull base surgery
  - Interpret X-ray and cross-sectional imaging of temporal bones and soft tissues of the head and neck
  - Be able to perform and interpret conventional audiometry and tympanometry in adults
  - Understand the principles and application of auditory brainstem response (ABR) and Otoacoustic Emissions (OAEs)
  - Understand the principles of VEMP and be able to interpret results
  - Understand the principles and application of electronystagmography including interpretation of findings
  - Accurately diagnose benign positional vertigo and demonstrate a rational approach to its treatment
  - Perform an effective manner, the Hallpike maneuver
  - Can perform tympanometry and interpret findings
  - Attend Skull Base Clinic and understand controversies in patient management
  - Present cases at Skull Base Tumor Board
  
- **Rhinology**
  - Perform a relevant history on patients presenting with sinonasal complaints

- Perform diagnostic nasal endoscopy (rigid and flexible) including preparation of the nose and accurate interpretation of findings
- Perform biopsy of sinonasal lesions
- Provide post-operative care for patients post sinus surgery including appropriate medical therapy and endoscopic debridement
- Develop an appreciation of the indications for endoscopic sinus surgery
- Effectively prepare patients for endonasal surgery such as septoplasty and endoscopic sinus surgery, including the informed consent process (description of risks/possible complications)
- Gain experience with basic endoscopic sinus surgery such as handling of endoscopes and instruments, local anesthetic infiltration, polypectomy
- Acquire familiarity with indications for surgery and approaches for management of nasal obstruction including nasal septoplasty
- Perform inferior turbinate reduction with direct consultant supervision
- Perform endoscopic maxillary ostiotomy, and anterior ethmoidectomy with direct consultant supervision

## **2. Communicator**

Communication skills are essential for the specialist. Residents in clinic and with patients and family at the bedside are given an opportunity to improve their skills. Their performance is assessed with respect to how they handle the dimensions of respect, trust, empathy with patients and their families as well as confidentiality. Effective communication objectives include being able to establish:

- A therapeutic relationship with patients
- Eliciting and synthesizing relevant information
- Discussing appropriate information with the patient and family.

They are also evaluated and given feedback in formal rounds within the Department. These include Monday morning rounds in which they are asked to present cases as well as at Tumor Board.

The Royal Victoria Hospital is situated in a special geographic location in Montreal. Although it has historically been part of McGill and the English Montreal community, it is the most easterly-situated McGill hospital and attracts a large proportion of francophone and allophone patients. Our connections with Northern Quebec add to the sometimes-challenging communications issues that can arise in such an environment. The attending staff is particularly sensitive to how this is handled by the residents. The skills learned in this milieu will serve our residents well in our increasingly interconnected world. The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the communicator role of

CanMEDS. The evaluation process for this aspect of their training seeks feedback from other specialists, peers and allied health professionals (360 degree evaluation).

**The communicator role is evaluated especially on:**

- Demonstrate effective establishment of therapeutic relationships with patients and their families
- Present histories, physical findings, and management plan to consultants in an organized, efficient, and confident manner
- Obtain and synthesize relevant history from patients, their families, and communities
- Demonstrate the capacity to recognize the psychological, occupational and social consequences of speech and voice disorders, particularly relevant to vocational demands
- Recognize unique biopsychosocial issues related to deafness and the deaf community
- Recognize unique issues related to head and neck patients particularly relevant to patients with cancer of the head and neck including end-of-life discussions
- Prepare clear, accurate, concise, appropriately detailed clinical notes, consultation notes, discharge summaries, and operative reports
- Discuss common (e.g. tonsillectomy) procedures with patients and their families in a clear and understandable form including risks/benefits, informed consent, and post-operative care
- Prepares, participates, and presents effectively in organized rounds and seminars
- Respect diversity and difference, including gender, religion and cultural beliefs on decision-making
- Address challenging communication issues effectively, such as obtaining informed consent, delivering bad news, and addressing anger, confusion and misunderstanding

**3. Collaborator**

The Department of Otolaryngology is proud of the creation of two interdisciplinary clinics. Residents are required to attend these clinics. They provide a forum to witness and participate with other physicians and health care professionals in the care of our patients.

Residents must participate in the weekly interdisciplinary rounds held in conjunction with nursing, social services, OT, and speech pathology. These experiences should permit them to:

- Understand and value the skills of other specialists and health care professionals

- Understand the limits of their knowledge and skills
- Be able to understand, accept and respect the opinions of others on our team.

The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the collaborator role of CanMEDS.

**The collaborator role is evaluated especially on:**

- Demonstrate an understanding of the team structure of an in-patient service (the resident team) and fulfill his/her role in this structure
- Demonstrate recognition and respect for the opinions and roles of other team members
- Recognize the advantages for optimal patient care provided by an interdisciplinary cleft palate clinic
- Identify appropriate situations where the interdisciplinary team is most useful
- Identify the situations and instances where consultation of other physicians or health care professional is useful or appropriate
- Demonstrate collegial and professional relationships with other physicians, office and clinic support staff, operating room personnel, and emergency room staff
- Recognize the expertise and role of allied health professionals such as speech language pathologists, audiologists, technicians, nurses, and clerical staff

**4. Manager**

Specialists function as managers at many different levels. The rotation at the RVH is designed to develop and challenge their management skills.

With a number of learning venues underway in parallel, effective time management on the part of the residents is key. How they manage their time, and in the case of senior or chiefs how they distribute their own resources, are carefully assessed. They must show good judgment in allocating the health care system's resources and work within the system using existing resources. They are encouraged to utilize information technology. Computers have been installed in the resident's room as well as in the clinic, the inpatient floor and the OR. Training on software use from the Department's attending staff as well from specialists from other departments (for example Radiology) has been encouraged. Residents are required to have taken the appropriate seminars and have their own codes to access the hospital's information system. Monday morning rounds and Tumor board are specific examples of rounds in which the residents are given important responsibilities in organizing. Their management effectiveness is easy to assess by the staff.

The chief residents manage resident-call schedules. They must provide coverage while assuring the schedule corresponds to legal requirements, and accommodates in a fair and professional manner the other residents. The same applies to vacations. The department uses the McGill

Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the manager role of CanMEDS.

**The manager role is evaluated especially on:**

- Utilize resources effectively to balance patient care duties, learning needs, Educational/teaching responsibilities and outside activities
- Use patient information tools effectively
- Allocate finite health care resources in a wise, equitable, and ethical fashion
- Utilize information technology to optimize patient care and life-long learning including facile use of hospital IT resources (e.g. filmless radiology, electronic charting)
- Demonstrate an appreciation of the importance of quality assurance/improvement
- Actively participate in preparation, presentation, analysis, and reporting of morbidity and mortality rounds
- Accurately identify criteria for patient admission to hospital in the urgent/emergent situation as well as the implications of such decisions
- Take care of charts and use head and neck patient database
- Serve in administrative and leadership roles, such as participate effectively in committees and meetings

**5. Health Advocate**

Specialists must recognize the importance of advocacy activities and be able to undertake them at a number of levels: directly with patients, at the level of the hospital, and as players in the public arena. The Department promotes prevention by teaching who is at risk, and by encouraging residents to discuss these issues directly with the patients. Examples include smoking cessation or avoiding noise-induced hearing loss. In addition, they are asked to discuss with the attending staff situations within the hospital where care could be better delivered to our patients. They are involved in our department's efforts to help our patients, such as laryngectomy patients who have communication challenges, or the hard of hearing.

**The health advocate role is evaluated especially on:**

- Recognize and respond to opportunities for advocacy within Otolaryngology, both for your patients as well as for the community in which we practice and population at large
- Encourage behaviors that promote hearing protection and conservation at work and at home
- Recognize and promote policies that enable early identification of hearing impairment through infant and childhood screening programs
- Facilitate patients' access to local and national resources available for the hearing impaired

## **6. Scholar**

Just like the attending staff, the residents have the responsibility to develop a personal education strategy. In the discussion of treatment option for patients, residents are required to synthesize medical information and be able to critically appraise it. They are required to help in the teaching of students and other, especially more junior, residents. They must contribute to the development of new knowledge. Residents are encouraged to participate in Departmental research. Many presentations at meetings and publications in peer-reviewed journals started as questions and observations made at the Royal Victoria Hospital.

### **The scholar role is evaluated especially on:**

- Actively participate in the teaching of medical students (didactic, in clinics, and on wards/in OR)
- Facilitate learning in patients and other health professionals
- Actively participate in preparation and presentation of weekly Grand Rounds
- Demonstrate a critical appraisal of research methodology, biostatistics, and the medical literature as part of monthly Journal Clubs
- Practice the skill of self-assessment
- Develop, implement, and monitor a personal Educational strategy and seek guidance for this Educational strategy as appropriate
- Demonstrate the evolving commitment to, and the ability to practice, life-long learning
- Contribute to the development of new knowledge through participation in clinical or basic research studies
- Demonstrate commitment to evidence based standards for care of common problems in Otolaryngology
- Actively participate in weekly academic rounds series including advance preparation for the topic(s)

## **7. Professional**

Residents are expected to strive to deliver the highest quality of care with integrity, honesty and compassion. They should show appropriate personal and interpersonal professional behaviors. They should understand the need to practice medicine in an ethically-responsible manner that respects the medical, legal and professional obligations of belonging to a self-regulated body. Specifically, they need to meet discipline-based objectives, personal/professional boundary objectives, and objectives related to ethics and professional bodies. The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the professional role of CanMEDS.

### **The professional role is evaluated especially on:**

- Deliver highest quality care with integrity, honesty, and compassion

- Exhibit appropriate professional and interpersonal behaviors
- Practice medicine and Otolaryngology in an ethically responsible manner
- Recognize limitations and seek assistance as necessary
- Seek out and reflect on constructive criticism of performance
- Endeavor to develop an appropriate balance between personal and professional life to promote personal physical and mental health/well-being as an essential to effective, life-long practice
- Demonstrate a commitment to their patients, profession and society through participation in profession-led regulation (e.g.: recognize and respond to other unprofessional behavior in practice, understand the legal and ethical codes of practice)

# **PGY2 MONTREAL GENERAL HOSPITAL**

## **(JUNIOR RESIDENT ROTATION):**

### **1. MEDICAL EXPERT:**

- The MGH site is a pioneer in the study of voice disorders. Patients with voice disorders and dysphagia are seen in the state-of-the-art Voice Laboratory, nearby the main clinic area, with the support of Speech Pathologists. Residents get their laryngology exposure mainly in this hospital including stroboscopy.
- The MGH site is a Level 1 trauma centre. Therefore, there is a steady flow of clinic patients and in-patients with all types of injuries to the head and neck, allowing for the resident to develop expertise in this area.
- The MGH Laser Centre provides access to CO<sub>2</sub>, YAG and pulsed dye lasers.
- Junior residents (PGY2 & PGY3) at each hospital site are evaluated according to their specific exposure using the One45 system. Evaluation forms are different from the senior residents (PGY4 & PGY5) evaluation. All residents must undergo a STASER or STACER evaluation by a MGH staff person during each of their rotations at the hospital.
- The main exposure / evaluation of the residents at the MGH in descending priority order are in the domains of:
  - **Laryngology**, residents are exposed to numerous laryngological procedures in the voice lab and dysphagia clinic
  - **otology**
  - **head and neck surgery**
  - **general otolaryngology**
- **The Expert Role specific objectives are:**
  - **General skills**
    - Take a relevant, appropriately-detailed history from a patient presenting for otolaryngology assessment
    - Perform a detailed, thorough head and neck examination
    - Perform effective indirect laryngoscopy
    - Perform effective head mirror, flexible and rigid nasopharyngoscopy with accurate interpretation of findings
    - Perform effective anterior and posterior nasal packing for epistaxis

- Incise and drain a peritonsillar abscess including recognition of the signs and symptoms associated with a peritonsillar abscess
  - Incise and drain a wound abscess including indications for the procedure
  - Manage a tracheostomy/change a tracheostomy tube
  - Perform rigid esophagoscopy with or without removal foreign body
  - Promptly and effectively assess patients with airway emergencies including airway obstruction
  - Perform open and percutaneous tracheostomies
  - Accurately assess patients suffering facial trauma including ordering appropriate investigations
  - Participate in the post-operative ward and office management of patients who have undergone head and neck surgery
  - Interpret X-ray and cross-sectional imaging of the head and neck
  - Understand regional anesthesia
- **Head and Neck Oncologic Surgery**
    - Management of Head and Neck surgical complications with supervision
    - Can effectively manage pain
    - Recognition and management of Head and Neck emergencies such as acute airway obstruction, post-operative hemorrhage, and blunt/penetrating neck trauma
    - Diagnose and accurately stage malignancies of the upper aero-digestive tract
    - Principles of communication/speech/ swallowing and the challenges encountered in head and neck cancer patients
    - Perform fine needle aspiration of neck lesions
    - Effectively biopsy nasal or oral cavity lesions
    - Manage head and neck oncology in-patients with attention to the unique airway and nutritional needs of these patients
    - Manage pain in post-operative head and neck oncology patients
    - Manage surgical airways (e.g. tracheotomy, laryngectomy stoma) in post-operative head and neck oncology patients
    - Pack a pharyngocutaneous fistula and provide ongoing wound care/debridement
    - Effectively assist at major head and neck ablative surgical procedures (pharyngolaryngectomy, neck dissection etc.)
    - Demonstrate attention to issues surrounding end-stage malignancies such as end-of-life care and palliation
    - Demonstrate a basic grasp of adjuvant therapies for the treatment of head and neck malignancies (radiotherapy, chemotherapy) and management of their complications

- **Plastic and reconstructive surgery**
  - Demonstrate basic understanding of the hierarchy of Reconstructive options for defects in the head and neck
  - Excise cutaneous lesions of the head and neck with appropriate closure/reconstruction of the resulting defect.
  - Harvest split and full-thickness skin grafts
  - Effectively assist at major Reconstructive surgical procedures (e.g. harvest of pedicled or free tissue transfer)
  - Become familiar with diagnosis and treatment of facial nerve disorders and reanimation strategies
  - Harvesting of nerve, tendon, fascia grafts with supervision
  - Refinement of tissue handling, tying, and suturing techniques
  - Diagnosis and treatment of cutaneous lesions of the cervicofacial region with appropriate closure/reconstruction of the resulting defect.
  - Anatomical basis for and design of local and regional flaps in the cervicofacial region (types, indications and techniques)
  - Indications for the various types of grafts & implants used in facial plastic surgery: (FTSG, STSG, Bone grafts, Cartilage grafts, etc)
  - Surgical principles employed in facial reanimation surgery.
  - Assessment of facial aesthetics and evaluation of patients presenting for consideration of cervicofacial cosmetic surgery/procedures.
  - Approach to facial analysis of patient presenting for esthetic nasal surgery, with consideration for cosmetic and functional aspects of the nose
  - Indications and execution of external nasal reduction under local anesthesia, including the administration of appropriate local anesthesia blocks
  - Diagnosis and treatment and post operative care of patients suffering from facial trauma (e.g. orbitozygomatic, mandible fractures)
  
- **Laryngology**
  - Take a competent vocal history and develop a differential diagnosis of dysphonia
  - Develop a differential diagnosis for dysphagia
  - Perform indirect rigid laryngoscopy
  - Perform video stroboscopy
  - Perform FEESST and interpret findings
  - Perform microlaryngeal surgery with microlaryngeal instruments, CO2 laser and microdebrideur
  - Understand intraoperative airway management during microlaryngeal surgery
  - Understanding of laser applications in Head and Neck surgery risks (laser safety) and manage complications

- **Neurotology/Otology**

- Take a relevant, appropriately-detailed history from a patient presenting for vestibular/dizzy assessment
- Perform a detailed, thorough examination of the vestibular system
- Effectively manage pain associated with surgery (e.g. mastoidectomy, skull base surgery)
- Perform myringotomy and tube insertion with consultant supervision in clinic
- Be able to perform diagnostic bedside tests such as the head-thrust (Halmagy) maneuver
- Participate in the post-operative ward and office management of patients who have undergone otologic surgery and lateral skull base surgery
- Interpret X-ray and cross-sectional imaging of temporal bones and soft tissues of the head and neck
- Be able to perform and interpret conventional audiometry and tympanometry in adults
- Understand the principles and application of auditory brainstem response (ABR) and Otoacoustic Emissions (OAEs)
- Understand the principles of VEMP and be able to interpret results
- Understand the principles and application of electronystagmography including interpretation of findings
- Accurately diagnose benign positional vertigo and demonstrate a rational approach to its treatment
- Perform an effective manner, the Hallpike maneuver
- Can perform tympanometry and interpret findings
- Attend Skull Base Clinic and understand controversies in patient management
- Present cases at Skull Base Tumor Board

## **2. Communicator:**

The resident is expected to specifically learn the importance of being a good communicator in establishing relationships with patients and physician colleagues. The resident must elicit and gather information effectively, taking into account patients' concerns and expectations about the illness and must deliver information back to the patient and family in a humane manner. The MGH sees patients from all types of ethnic and cultural backgrounds and exposes residents to the rich cosmopolitan nature of Montreal society while also sensitizing them to differences that must be taken into account in terms of treatment and communication. The importance of gathering information is illustrated in the specialty as a whole and in all the subspecialties individually. Specific, pertinent information must be elicited from the patient presenting with laryngology problems while the information elicited may be quite different for patients presenting with head and neck problems or sinus difficulties. In laryngology, it is extremely important to elicit a very detailed voice history as well as the life style history including home and work environment. During the head and neck clinic, the information will be quite different and certainly the role of

the communicating information particularly as it pertains to prognosis becomes very important. It is crucial for the resident to be empathetic and sensitive in the manner in which the information is delivered and communicated. Residents must also learn how to work with their peers, their colleagues, and allied health personnel and with staff. Effective and accurate communication allows for more efficient and high quality health care delivery.

At the R2 level, residents are explicitly taught the importance of communication, and learn through role modeling from staff and senior residents. At the more senior levels, residents themselves become role models and will further refine their own skills. This may include communicating difficult information to the patient (e.g.: poor prognosis, end-of-life issues), and dealing with complex family/patient dynamics. The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the collaborator role of CanMEDS. Residents are assessed by direct observation during clinical activities and, to some extent, in examinations.

**The communicator role is evaluated especially on:**

- Demonstrate effective establishment of therapeutic relationships with patients and their families
- Present histories, physical findings, and management plan to consultants in an organized, efficient, and confident manner
- Obtain and synthesize relevant history from patients, their families, and communities
- Recognize unique biopsychosocial issues related to deafness and the deaf community
- Recognize unique issues related to head and neck patients particularly relevant to patients with cancer of the head and neck including end-of-life discussions
- Prepare clear, accurate, concise, appropriately detailed clinical notes, consultation notes, discharge summaries, and operative reports
- Discuss common (e.g. tonsillectomy) procedures with patients and their families in a clear and understandable form including risks/benefits, informed consent, and post-operative care
- Prepares, participates, and presents effectively in organized rounds and seminars
- Demonstrate the capacity to recognize the psychological, occupational and social consequences of speech and voice disorders, particularly relevant to vocational demands
- Respect diversity and difference, including gender, religion and cultural beliefs on decision-making
- Address challenging communication issues effectively, such as obtaining informed consent, delivering bad news, and addressing anger, confusion and misunderstanding

### **3. Collaborator:**

Otolaryngologists work in partnership with others involved in patient care. Residents must learn to collaborate effectively with patients and a multidisciplinary health care team in order to provide optimal patient care, education and research.

General otolaryngology, as well as each subspecialty, involves multidisciplinary interaction. In the Voice Laboratory, junior residents under direct staff supervision show and teach patients about their diagnoses with the help of digital imaging. They also interact regularly with speech-language pathologists in formulating and implementing treatment plans. In the Head and Neck clinic, collaboration with radiation oncologists, medical oncologists, nurses, social workers, dieticians and many other involved allied health care personnel is continuous and essential to optimizing care in these highly complex patients. All residents actively participate at MUHC multidisciplinary rounds at a level that commensurate with level of training. R2's are expected to present cases, suggest treatment plans, and contribute to discussions involving other disciplines. They must also recognize their own limits and enlist help/consultation when appropriate. Contribution to these activities increases in complexity from the R2-R5 level with chief residents expected to lead and direct discussions. Research conducted through the Voice lab or other subspecialties necessarily involves ongoing collaboration with co-authors and contributors. This interaction is paramount during the enrichment year (PGY3 & PGY4). Residents also participate in committees from the PGY3-PGY5 level, which involves collaboration with peers and staff.

By the end of the rotation, residents should be able to effectively consult with physicians and health care professionals as well as contribute effectively to inter/multidisciplinary activities. The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the collaborator role of CanMEDS.

#### **The collaborator role is evaluated especially on:**

- Demonstrate an understanding of the team structure of an in-patient service (the resident team) and fulfill his/her role in this structure
- Demonstrate recognition and respect for the opinions and roles of other team members
- Recognize the advantages for optimal patient care provided by an interdisciplinary cleft palate clinic
- Identify appropriate situations where the interdisciplinary team is most useful
- Identify the situations and instances where consultation of other physicians or health care professional is useful or appropriate
- Demonstrate collegial and professional relationships with other physicians, office and clinic support staff, operating room personnel, and emergency room staff

- Recognize the expertise and role of allied health professionals such as speech language pathologists, audiologists, technicians, nurses, and clerical staff

#### **4. Manager:**

Residents function as managers on a daily basis when they make decisions involving resources, co-workers, tasks and to some extent policies. They do so in the settings of individual patient care, practice organizations and in the broader context of the health care system. This means they must be able to prioritize and effectively execute tasks through collaboration with colleagues. As managers, residents are in positions of leadership, and must respect the responsibility that comes with such a position.

During the rotation at the Montreal General Hospital, residents must learn about the structure, financing and operation of the Canadian health care system and its facilities as they pertain to the practice of otolaryngology; this is important in learning to function effectively within that system. The resident must also be able to optimally use information technology in making clinical decisions. As active members of the health care team, resident managers must have a clear gradation in responsibility from the junior to senior to chief level. This begins with time management, which includes working effectively and in a timely manner within time constraints. Junior residents must acquire efficiency skills in learning to perform multiple duties within a certain time limit. They must learn to prioritize tasks and distribute their time accordingly. Senior and chief residents are expected to assist junior residents in time management skills and in helping prioritize patient care issues. Senior and chief residents must learn to balance their time between clinical duties and the stress of studying for final exams. Chief residents also assume a greater responsibility in terms of the call schedule they manage and put together within the accepted collective agreement guidelines.

Junior residents are expected to learn the availability, costs, risks and benefits of all of imaging resources. They must learn about the availability of beds and when these should be used to admit patients. Junior residents must also be familiar with available manpower in terms of allied health care personnel which may be in the form of secretarial support, nursing availability and support, physiotherapy, social services and so on. Junior residents must be able to access information and find and retrieve data both for direct patient care and when necessary for research purposes. Senior residents must understand these resources and assist junior residents in deciding how to best prioritize and allocate their use. R5 residents will also be expected to acquire some skills in terms of future practice management that may be learned through seminars offered at the faculty level. All of these managerial skills apply to general otolaryngology as a whole and to all of its sub-specialties. The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the manager role of CanMEDS.

By the end of the MGH rotation, residents should have the following competencies; be able to utilize time and resources effectively to balance patient care outside activities and personal commitments; demonstrate an ability to allocate finite health care resources effectively and efficiently within the health care system; be able to acquire and apply information technology in a proficient fashion for self-learning and optimal patient care.

The evaluation of this role is multi-faceted and as for the others roles includes direct observation during clinical activities. Residents at all levels may be required to locate and retrieve pertinent data which may impact patient care and may later be asked to what degree they were successful in achieving this. Residents will also be evaluated in terms of their ability to complete, in a timely manner, tasks assigned and important hospital documents such as operative reports and discharge summaries. Finally, the ability to act effectively as a manger may also be evaluated both in oral and written exams that may take the form of impromptu quizzes at any time during the rotation.

**The manager role is evaluated especially on:**

- Utilize resources effectively to balance patient care duties, learning needs, Educational/teaching responsibilities and outside activities
- Use patient information tools effectively
- Allocate finite health care resources in a wise, equitable, and ethical fashion
- Utilize information technology to optimize patient care and life-long learning including facile use of hospital IT resources (e.g. filmless radiology, electronic charting)
- Demonstrate an appreciation of the importance of quality assurance/improvement
- Actively participate in preparation, presentation, analysis, and reporting of morbidity and mortality rounds
- Accurately identify criteria for patient admission to hospital in the urgent/emergent situation as well as the implications of such decisions
- Take care of charts and use head and neck patient database
- Serve in administrative and leadership roles, such as participate effectively in committees and meetings

**5. Health advocate:**

The importance of the physician resident as a health advocate to the patient and community at large is self-evident. The specific objectives including acquiring an ability to demonstrate an understanding of the determinants of health by identifying socio-economic and personal risk factors in the development of certain pathologies and how to apply preventive/ corrective measures. Residents must also understand and be familiar with current policies that affect health either in a positive or negative fashion in order to effect change. These principles must be applied in the management of individual patients, the patient population as a group and finally the general population. In laryngology, residents must have a solid understanding of risk factors

such as tobacco, alcohol, vocal abuse, improper singing technique and inadequate vocal hygiene. Similarly, in Head and Neck Oncology, residents must be knowledgeable in the potential risk factors for the development of carcinoma including such as tobacco and alcohol. The resident must be involved in educating both the patient and the public as a whole to the dangers involved with these lifestyle choices. In doing so, the residents may play an active role in prevention, and treatment by making tobacco cessation resources available to the patient. Residents must also be aware of their impact on patient care. It has been clearly demonstrated that smoking cessation advice coming directly from a physician with some time spent on explaining available resources has the greatest potential positive impact on a successful outcome. In the public forum, residents may actively involve themselves and they must understand that they may be involved in implementing changes to public behaviors and public policies. For example, residents should be aware of organizations such as Physicians for Smoke Free Canada. They may also get involved, particularly at the senior and chief resident level, in public education by giving many lectures or seminars and speaking within the school system.

As a health advocate, the junior resident is also involved in obtaining investigations and implementing treatment in a timely manner. Junior residents are expected to learn this role and acquire information about the risk factors and how they can use the information as health advocates. Senior residents are expected to acquire more of the leadership roles in helping teach junior residents, in role modeling situations, and within the public forum. They may be evaluated by direct observation in the clinical setting as well as in written documents and rounds, where they may be asked questions. Patients, patients' families, and allied health care personnel may also be involved in evaluating the resident's ability to function as a health care advocate. By the end of the rotation, it is expected that the residents will be able to identify the health determinants in individual patients and therefore intervene accordingly and effectively. The resident must also be able to recognize issues, settings and circumstances in which he may be a potent advocate on behalf of the patient and act appropriately.

**The health advocate role is evaluated especially on:**

- Recognize and respond to opportunities for advocacy within Otolaryngology, both for your patients as well as for the community in which we practice and populations at large
- Encourage behaviors that promote hearing protection and conservation at work and at home
- Recognize and promote policies that enable early identification of hearing impairment through infant and childhood screening programs
- Facilitate patients' access to local and national resources available for the hearing impaired
- encourage behaviors that reduce/eliminate risk factors for the development of head and neck cancer (e.g.: tobacco, alcohol, UVA/UVB sun exposure)

## **6. Scholar:**

The role of scholar is extremely important in otolaryngology. It requires the resident physician to continually ask and seek answers to questions in a lifelong pursuit of learning. Junior residents must develop a basic reading plan, which allow them to acquire the essential nuts and bolts needed to practice otolaryngology. This type of activity is essential in promoting competency and mastery of the discipline of otolaryngology. Specific objectives for residents include; asking clinical questions and acquiring the skills to answer those clinical questions. In the voice laboratory, for example, a resident physician may ask a question with respect to the treatment of a vocal condition. The question may then be partially answered by the staff in attendance, and the resident may be further directed and appropriately guided towards a literature search on the matter to further answer the question. This may in turn lead to a treatment plan and its implementation. Reviewing the literature and answering one question often leads to asking many other questions, which may be occasionally addressed in clinical or basic science research projects. Senior residents have increasing responsibilities in terms of helping junior residents answer questions and assisting them in accessing information technology to answer the questions. Junior residents may pose a simple research question that they wish to further investigate and publish. More advanced basic research with some knowledge of epidemiology is expected at the R4 level in which a major research project is developed. This research project may be part of any of the subspecialties of otolaryngology, including, of course, voice. Senior and chief residents are expected to pose more complex questions and be able to understand and critically appraise the available literature in answering these questions. This means reading major otolaryngology textbooks. For the purposes of rounds and interesting cases, residents are directed outside of the textbook to the literature. Senior and chief residents, while using major otolaryngology textbooks must acquire the skills to do an in depth literature review when necessary and must also understand the need for ongoing education by consulting recent publications and journals, whether they be at the library or online. Junior residents must be taught how to connect the information they have acquired to the skill of evidence-based medicine, which means applying that information to decision-making and treatment plans. Chief and senior residents must refine this skill and assist in teaching it to junior residents. Not only is the responsibility in teaching applied to junior residents, but also to other allied health professionals. Furthermore, residents, particularly in their senior years, are encouraged to develop a teaching dossier.

Upon completion of the rotation, the resident should be able to develop and implement a personal continuing education strategy, which, for the junior resident, means a reading plan through residency. For the senior and chief resident, this includes evolving from basic textbooks to current journals and being able to assess the pertinent literature. Residents should also critically look at sources of medical information and this type of appraisal is discussed

informally during clinics and also at rounds and other educational activities. Self-learning by residents facilitates the learning of patients, students, residents and other allied health professionals. Ongoing reading and research be it clinical or basic in nature, ultimately contributes to the development of new knowledge. Success in attaining these objectives may be evaluated by verifying the ability of junior residents to complete simple assignments and in the case of chief residents, the completion of more complex assignments including complex research papers. Chief and senior residents may be directly observed teaching junior residents and allied health care personnel, both in the clinical setting, on the ward, and in the operating room. During hospital round presentation, the degree in depth to which a particular case or problem has been researched and evaluated can easily be assessed

**The scholar role is evaluated especially on:**

- Actively participate in the teaching of medical students (didactic, in clinics, and on wards/in OR)
- Facilitate learning in patients and other health professionals
- Actively participate in preparation and presentation of weekly hospital and Grand Rounds
- Demonstrate a critical appraisal of research methodology, biostatistics, and the medical literature as part of monthly Journal Clubs
- Practice the skill of self-assessment
- Develop, implement, and monitor a personal Educational strategy and seek guidance for this Educational strategy as appropriate
- Demonstrate the evolving commitment to, and the ability to practice, life-long learning
- Contribute to the development of new knowledge through participation in clinical or basic research studies
- Demonstrate commitment to evidence based standards for care of common problems in Otolaryngology
- Actively participate in weekly academic rounds series including advance preparation for the topic(s)

**7. Professional:**

Professionalism in otolaryngology is essential in assuring the highest standards of excellence in clinical care and ethical conduct. Specific objectives for the resident physician include self-discipline, which includes a sense of punctuality, which applies to beginning the clinics on time, arriving at prearranged meetings on time, and arriving to the operating room on time. At the junior resident level, this involves being very familiar with timetables within the hospital setting and being able to meet them. Residents must learn a sense of responsibility that comes first for the patient and their family. These responsibilities must be met over and above other commitments particularly in cases of emergency. Residents must learn to balance their responsibility to patients/families with a balanced home life. The otolaryngology clinic at the

Montreal General Hospital and all of its subspecialties treat patients from a wide variety of cultural backgrounds. Residents must be familiar with the cultural diversities to which they are exposed and demonstrate sensitivity and respect for these cultural diversities. On a personal level, residents must learn to address their peers, colleagues, staff and other allied health professional with the utmost respect and courtesy. Differences in opinion must be discussed and debated and resolved on a professional level, without resorting to outbursts or foul language, both of which are highly inappropriate and unprofessional. Residents must also learn the importance of adhering to the ethical codes to which physicians are bound. This is illustrated on a day-to-day basis in the clinic and on the wards where ethical issues involving patient information or treatment planning arrives regularly. Residents must learn to resolve these issues by understanding the involved legalities, speaking to other allied health professionals and ethicists, and by a great deal of personal thought as well. Junior residents are primarily preoccupied with familiarizing themselves the cultural and ethnic diversity around them, the rules of the hospital setting, and their learning responsibilities. As they become comfortable during rotations, they are expected to expand their knowledge in these areas. Senior and chief residents have more of a leadership role in assisting and teaching junior residents about cultural diversity and familiarizing them with the resources available in solving ethical or personal differences. Residents are also expected to act as role models in terms of what it means to be punctual and responsible professionals. The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the professional role of CanMEDS.

Residents are evaluated on an ongoing basis regarding punctuality and attendance at different clinical events. Their sense towards responsibility toward the patients and in terms of balancing their professional and personal lives is evaluated on an ongoing basis through observation during clinical activities, and at the end of the day. Residents' sense of respect and courtesy towards colleagues and other health professional may be evaluated as well by obtained feedback from nurses, secretaries, OR staff and clinical staff (360 degree evaluation).

**The professional role is evaluated especially on:**

- Deliver highest quality care with integrity, honesty, and compassion
- Exhibit appropriate professional and interpersonal behaviors
- Practice medicine and Otolaryngology in an ethically responsible manner
- Recognize limitations and seek assistance as necessary
- Seek out and reflect on constructive criticism of performance
- Endeavor to develop an appropriate balance between personal and professional life to promote personal physical and mental health/well-being as an essential to effective, life-long practice
- Demonstrate a commitment to their patients, profession and society through participation in profession-led regulation (e.g.: recognize and respond to other unprofessional behavior in practice, understand the legal and ethical codes of practice)



# **PGY3** SECOND YEAR OF RESIDENCY TRAINING IN OTOLARYNGOLOGY- HEAD AND NECK SURGERY

- First 6 month rotation (July 1<sup>st</sup> – December 31<sup>st</sup>):
  - 3 months at the MCH
  - 3 months at an adult hospital, either JGH or RVH or MGH
- Second 6 months Enrichment year rotation (January 1<sup>st</sup> - June 3<sup>0th</sup>)

# **PGY3** – MONTREAL CHILDREN’S HOSPITAL (SENIOR PEDIATRIC OTOLARYNGOLOGY RESIDENT):

PGY3 residents rotate as a senior pediatric otolaryngology resident at the MCH for 3 months. Senior pediatric PGY3 residents at the MCH are evaluated according to their specific objectives using the One45 system. Evaluations forms are different from the junior residents (PGY2) evaluation. (The senior MCH ITER is available on One-45). All residents must undergo a STASER (Standardized Assessment of a Clinical Encounter) or STACER (Standardized Assessment of a Surgical Encounter) evaluation by a MCH staff person during each of their rotations at the hospital. They are also evaluated by 360 degree inter-professional evaluation (feedback from allied health care personnel, nurses, secretaries)

## **1. MEDICAL EXPERT:**

The residents attend the different specialty clinics, pediatric tumor boards and interact with other members of clinical departments. Their role as medical experts is illustrated in such activities. They express, discuss, teach and learn the various opinions regarding the investigation and treatment of challenging medical conditions and therapeutic protocols.

### **The Expert Role specific objectives are:**

- **General skills**
  - Assess children with ENT emergencies and manage them with limited consultant intervention
  - Assess the pediatric airway in ER, PICU, NICU with formulation of diagnosis and management plan

- Participate in the post-operative ward and office management of patients who have undergone general head and neck surgery, otologic surgery, and pediatric otolaryngological procedures
  - Demonstrate a sophisticated approach to imaging studies including independent interpretation of findings
  - Interpret X-ray and cross-sectional imaging of temporal bones, paranasal sinuses, and soft tissues of the head and neck in children
  - Become familiar and run the specialty clinics in Laryngology, Combine Reflux/ENT, Rhinology, Otolaryngology, drooling and dysphagia
- **Pediatric Otolaryngology**
    - Know the indications for pediatric tracheotomy, perform the procedure, and manage the patient post-operatively
    - Perform rigid esophagoscopy with or without removal foreign body with limited consultant intervention
    - Perform pediatric rigid bronchoscopy with or without removal of foreign body
    - Assist at and begin to perform airway reconstruction in the pediatric population (e.g. laryngotracheoplasty)
    - Differential diagnosis and management of a pediatric neck mass
    - Endoscopic sinus surgery in children
    - Pediatric syndromes and management of associated H&N problems
    - Know the indications, complications and anatomy of common performed surgeries
- **Pediatric Otology**
    - Be able to perform and interpret conventional audiometry and tympanometry in children
    - Understand the principles and application of auditory brainstem response (ABR) and Otoacoustic Emissions (OAEs) & ENG testing
    - Classification scheme and approach to management of common congenital and acquired causes of pediatric hearing loss
    - Demonstrate a sophisticated approach to auditory and vestibular rehabilitation including surgical and non-surgical options
    - Perform tympanoplasty with limited consultant intervention
    - Perform ossiculoplasty with consultant supervision
    - Perform mastoidectomy with consultant supervision
    - Know the indications, complications and anatomy of common performed surgeries
- **Pediatric Head and Neck Surgery**
    - Effectively manage pain associated with head and neck surgery

- Participate in the post-operative ward and office management of patients who have undergone general head and neck surgery
  - Interpret X-ray and cross-sectional imaging of soft tissues of the head and neck
  - Perform lymph node and neck mass biopsy with decreasing degree of consultant intervention
  - Perform excision of submandibular glands with decreasing degree of consultant intervention
  - Perform parotidectomy with increasing degree of autonomy
  - Perform neck dissections with increasing degree of autonomy
  - Perform excision of branchial cleft cysts and thyroglossal duct cysts with gradually decreasing degree of consultant intervention
  - Perform thyroidectomy, parathyroidectomy with decreasing degree of consultant intervention
  - Perform excision of oral cavity lesions with and without laser
  - Know the indications, complications and anatomy of common performed surgeries
- **Pediatric Laryngology**
    - Perform indirect rigid laryngoscopy and videostroboscopy
    - Participate actively in the Voice Lab including focused history and relevant physical examination
    - Diagnose and manage pathology of the glottis (e.g. nodules, cysts)
    - Management of vocal cord paralysis including investigation, medical therapy, and surgical therapy
    - Perform microlaryngoscopy with gradually decreasing consultant intervention
    - Perform microlaryngeal surgery with microlaryngeal instruments, CO2 Laser, microdebrideur
    - Understanding of intraoperative airway management during microlaryngeal surgery
    - Perform, with supervision, endoscopic laser resections of early tumors of the larynx
    - Diagnosis and management of airway and aerodigestive trauma
    - Know the indications, complications and anatomy of common performed surgeries

**The expert objectives duties are carried by:**

**Clinic:**

- staff the clinic
- do consultations during the weekdays and discuss them with the attending staff

- pre-op clinic (if junior is not available)

### **In-patients:**

- responsible for the consultations
- organizes rounds with the junior resident and attending staff regarding admitted patients

### **O.R.:**

- responsible for surgical procedures other than minor cases
  - head and neck cases
    - excision benign and malignant masses, e.g. thyroglossal duct cyst, branchial cleft cyst, neck nodes and masses
    - incision of superficial and deep neck abscess
    - pediatric tracheostomy
  - otology cases
    - tympanoplasty
    - various types of mastoidectomy
    - pre-auricular sinus excision
    - exposure for BAHA (bone anchored hearing aids)
  - rhinology cases
    - endoscopic sinus surgery – FESS
    - external sinus surgery
    - nasal polypectomy
    - septoplasty
    - turbinate surgery
    - epistaxis control procedures
  - endoscopic cases
    - laryngoscopy
    - bronchoscopy
    - esophagoscopy
  - facial plastics and reconstructive surgery cases
    - Otoplasty
    - Rhinoplasty
- assist in the O.R. when “On Call”
- assign the junior resident operating room schedule

### **Other:**

- cross-cover the other adult hospital when on call at the MCH
- shares responsibilities for weekend coverage of admissions and in- patients with the junior resident

### **Pediatric Audiology Montreal Children's Hospital Rotation**

Each resident will be responsible to spend sufficient amount of time in the audiology department at the MCH during his/her rotation. The resident will be required to gain knowledge of pediatric audiometric testing. An oral exam will be given to each resident prior in Audiology prior to completion of the rotation. The results of the examination will be recorded.

### **Temporal Bone Dissections**

Each resident will be responsible for completing one anatomical dissection of a temporal bone during his/her pediatric rotation. The results of the dissection will be recorded. This dissection is MANDATORY as a requirement in order to pass the rotation at the MCH.

### **MCH Resources for Residents:**

- **Pediatric Otology:**  
Training of residents in all aspects of medical and surgical pediatric otology that include otitis media and performing different types of tympanoplasties and mastoidectomies including ossicular chain reconstruction. The resident also gain experience in pediatric audiology. Different sessions are given in combination with the Audiology Department on aural rehabilitation and hearing aid assessment for children. The resident will have experience in BAHA surgery as the MCH is a leader in that field.
- **Nose and Sinuses:**  
All medical and surgical aspects of rhinology are covered. The residents perform endoscopic sinus surgery.
- **Aerodigestive diseases:**  
This includes diagnosis and treatment of foreign bodies of the aerodigestive tract, congenital and acquired laryngotracheal problems. The O.R. at the MCH is equipped with laser technology and is one of the few centers in North America that manages these kinds of pathologies. The resident is involved in the treatment of these conditions throughout his rotation at the hospital. There is a specialized airway clinic and the resident is exposed to a multidisciplinary approach to pediatric airway problems.
- **Specialty clinics:** residents exposed to specialty clinics in otology, airway, reflux, dysphagia, and saliva. These clinics focus on more complicated cases involving these domains.
- **Pediatric oncology:**

In association with the Hematology/Oncology departments and Radiotherapy, the residents are involved in the treatment of head and neck tumors including lymphomas, rhabdomyosarcomas, etc.

- **Research:**  
The resident is involved with different basic and clinical research projects during his/her rotation at the MCH. All our physicians are keen on research. The newly established McGill Auditory Sciences Laboratory under the supervision of Dr. S. Daniel is located at the hospital and provides an excellent opportunity for basic science research.
- **Formal teaching sessions:**  
In addition to hospital rounds, formal teaching sessions are provided on a weekly basis by the residents which are supervised by an attending staff.
- **Feedback and Evaluation:**  
The residents should expect to get at a minimum 2 one-on-one feedback session with the director Dr Sam Daniel who will summarize the feedback provided by the staff physicians and discuss any issues pertaining to the service. Also the attending staff gives verbal feedback at mid-rotation and at the end of rotation.

## **2. COMMUNICATOR:**

The resident is evaluated throughout his rotation by the members of the staff as a **communicator** with the parents and patients. The interview, gathering of clinical information, explanation of the different therapeutic modalities as well as performing the different clinical tasks are the bases of the evaluating process. Both verbal and written communication is emphasized. An important percentage of our patient population has different ethnic background. An interpreter is always present during these interviews. This constitutes an additional challenge to the resident who is an essential part of the clinic team. The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the communicator role of CanMEDS.

### **The communicator role is evaluated especially on:**

- Demonstrate effective establishment of therapeutic relationships with patients and their families
- Present histories, physical findings, and management plan to consultants in an organized, efficient, and confident manner
- Obtain and synthesize relevant history from patients, their families, and communities
- Prepare clear, accurate, concise, appropriately detailed clinical notes, consultation notes, discharge summaries, and operative reports
- Discuss more complex procedures (e.g. tympanoplasty, thyroidectomy) with patients and their families in a clear and understandable form including risks/benefits, informed consent, and post-operative care

- Prepares, participates, and presents effectively in organized rounds and seminars
- Know the indications, complications and anatomy of common performed surgeries

### **3. COLLABORATOR:**

The resident role as **collaborator** is evident during daily interactions with the other physicians and allied health professionals. He is the first member of the team to evaluate the patient's needs and direct the family to the appropriate professional. Examples include: social workers, occupational therapy, audiology, speech therapy, physiotherapy, etc. The collaboration with the different divisions and departments is also of paramount importance. The daily contact with these services constitutes a major task in the resident's clinical activity and reflects an important image on the role of Otolaryngology within the MCH. The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the collaborator role of CanMEDS.

#### **The collaborator role is evaluated especially on:**

- Identify the situations and instances where consultation of other physicians or health care professional is useful or appropriate
- Demonstrate collegial and professional relationships with other physicians, office and clinic support staff, operating room personnel, and emergency room staff
- Recognize the expertise and role of allied health professionals such as speech language pathologists, audiologists, technicians, nurses, and clerical staff

### **4. MANAGER:**

The resident role as **manger** is also elucidated in his daily activities, managing and planning his schedule and supervising the junior members of the team. The wise and proper use of the different hospital services is taken into consideration during the evaluation process. Ordering laboratory, radiological investigations and adopting different therapeutic modalities reflect important points in this process. The members of the team help to guide the senior and junior residents throughout the hospital rotation to this important aspect of medical practice. The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the manager role of CanMEDS.

#### **The manager role is evaluated especially on:**

- Demonstrate ability to lead a health care team
- Utilize resources effectively to balance patient care duties, learning needs, Educational/teaching responsibilities and outside activities
- Allocate finite health care resources in a wise, equitable, and ethical fashion
- Utilize information technology to optimize patient care and life-long learning including facile use of hospital IT resources (e.g. filmless radiology, electronic charting)
- Demonstrate an appreciation of the importance of quality assurance/improvement

- Actively participate in preparation, presentation, analysis, and reporting of morbidity and mortality rounds
- Accurately identify criteria for patient admission to hospital in the urgent/emergent situation as well as the implications of such decisions

## **5. HEALTH ADVOCATE:**

He/she is a **health advocate** and role model for the young parents and teenagers, teaching them about the dangers and prevention of noise induced hearing loss, promote choking prevention in children, as for teenagers promote risk reduction of head and neck malignancy through smoking cessation, responsible alcohol use and UVA/UVB protection.

### **The manager role is evaluated especially on:**

- Recognize and respond to opportunities for advocacy within Otolaryngology, both for your patients as well as for the community in which we practice
- Demonstrate familiarity with important determinants of health relevant to Otology such as environmental noise exposure
- Encourage behaviors that promote hearing protection and conservation at work and at home
- Recognize and promote policies that enable early identification of hearing impairment through infant and childhood screening programs
- Facilitate patients' access to local and national resources available for the hearing impaired
- Promote choking prevention in children
- For teenagers promote risk reduction of head and neck malignancy through smoking cessation, responsible alcohol use and UVA/UVB protection

## **6. SCHOLAR:**

Hospital rounds are presented once a week on Mondays at 4pm. Attendance is compulsory for the attending staff, fellows, residents and medical students who happen to be doing “elective rotations” at this time. The senior resident is responsible for the contents and scientific material. The senior resident may delegate the presentation of the rounds to a junior resident or share this responsibility with a student. During the hospital rounds, many clinical cases are discussed. A review of the pertaining literature is usually presented, and the opinions of the different members are expressed. It is through this forum and other similar daily discussions that the resident’s role as a scholar is demonstrated. Every year a resident presents a research project at our annual Resident Research Day/James D. Baxter Lecture held in the spring.

### **The scholar role is evaluated especially on:**

- Actively participate in the teaching of medical students (didactic, in clinics, and on wards/in OR)
- Facilitate learning in patients and other health professionals
- Actively participate in preparation and presentation of weekly Grand Rounds
- Demonstrate a critical appraisal of research methodology, biostatistics, and the medical literature as part of monthly Journal Clubs
- Practice the skill of self-assessment
- Develop, implement, and monitor a personal Educational strategy and seek guidance for this Educational strategy as appropriate
- Demonstrate the evolving commitment to, and the ability to practice, life-long learning
- Contribute to the development of new knowledge through participation in clinical or basic research studies
- Demonstrate commitment to evidence based standards for care of common problems in Otolaryngology
- Actively participate in weekly academic round series including advance preparation for the topic(s)

## **7. PROFESSIONAL:**

The residents must demonstrate **professionalism** by demonstrating the highest standards of excellence in clinical care and ethical conduct. This includes self-discipline, such as a sense of punctuality and respect for cultural diversity. They must address their peers, colleagues, staff and other allied health professionals with the utmost respect and courtesy. Residents are also expected to act as role models. Their sense towards responsibility toward the patients in terms of balancing their professional and personal lives is evaluated on an ongoing basis by their superiors, colleagues and other. The department uses the McGill Simulation Center annually, hiring actors to portray patients in certain scenarios, to teach residents the manager role of CanMEDS.

### **The professional role is evaluated especially on:**

- Deliver highest quality care with integrity, honesty, and compassion
- Exhibit appropriate professional and interpersonal behaviors
- Practice medicine and Otolaryngology in an ethically responsible manner
- Recognize limitations and seek assistance as necessary
- Seek out and reflect on constructive criticism of performance
- Endeavour to develop an appropriate balance between personal and professional life to promote personal physical and mental health/well-being as an essential to effective, life-long practice

## **PGY3 – FIRST HALF OF THE YEAR (July1-Dec31)**

### **ADULT HOSPITAL ROTATIONS (JGH, RVH, MGH)**

- For 3 months during the first half of PGY3 (July 1<sup>st</sup> – December 31<sup>st</sup>):  
Rotation occurs at an adult hospital, either JGH or RVH or MGH
- Objectives and evaluation of the rotation are similar to the PGY2 junior adult hospital rotation.

## **PGY3 - SECOND HALF OF THE YEAR (Jan 1- June 30)**

### **ENRICHMENT YEAR**

- The enrichment year is for a duration of one year
- Duration: Starts Jan 1<sup>st</sup> and end Dec 31<sup>st</sup>
- Second Half of PGY3 and First half PGY4

## **RESIDENT ENRICHMENT YEAR**

**First Half of enrichment year: is the second half of PGY3**

**Second Half of enrichment year: is the first half of PGY4:**

- **Last Half of PGY3 for 6 months from January to June**
- **First Part of PGY4 for 6 months from July to December**

The enrichment year (from January 1<sup>st</sup> to December 31<sup>st</sup>) is divided into periods

- 6 months for full time research time
- 3 months of electives including
  - 1 month of community rotation at Lakeshore General hospital or other site approved by the program director
  - 1 month of facial plastic and reconstructive surgery (Dr Nabil Fanous and Dr Mark Samaha clinic)
  - 1 month of selective rotation

### **Goals and objectives**

The main objective of this program should be to show residents the principles of good basic research and to provide high quality research in otolaryngology.

In addition to the research involvement, the resident will maintain certain clinical exposure and obligations. This will include mandatory duties as well as elective opportunities. The resident must be present at grand rounds, hospital rounds, academic half and full days, journal clubs and special seminars. The regular on call schedule will be part of the enrichment year.

The resident will avail himself/herself to certain mandatory pedagogical experiences. These will include anatomy (as a demonstrator) during the head and neck portion and epidemiology and biostatistics. This course will be taken for credit and the resident must achieve a passing grade.

The resident may enroll in other elective courses with the approval of the program director.

### **Program outline**

Year-round activities of the enrichment year resident include:

- Research related:

- Research seminars with Dr. Segal
  - Biostatistics course at McGill or at the Meakins-Christie Lab
  - Head and neck anatomy demonstration for McGill medical students in the spring
  - Anatomy preceptorship for the “back to basics” course
- University related:
    - University grand rounds
    - Thursday academic half days
    - Journal clubs
    - Weekly hospital rounds (choose between JGH, RVH or MCH sites)
    - Monthly Thursday pathology conference at JGH
    - Monthly Thursday radiology conference at JGH
    - Monthly thyroid conference – JGH
    - Weekly Tumor board rounds (choose between JGH, RVH)
    - Weekly rounds at the RVH respectively, radiology, pathology otology, laryngology, rhinology and M&M
  - Community rotation: one month at the Lakeshore General hospital
  - Facial plastic and reconstructive rotation: one month at the clinics of Dr Nabil Fanous and Dr Mark Samaha
    -
  - One month of selective rotation in the following rotations:
    - Maxillofacial surgery – MGH
    - Head and neck radiology
    - Head and neck pathology
    - Medical oncology
    - Radiation oncology
    - Voice lab – MGH
    - Vestibular laboratory – RVH
    - otology
    - Audiology service – JGH, MGH, RVH, MCH
    - Facial nerve unit
    - Extra month in facial plastics rotation
    - Extra month in community rotation

### **Procedures for research activities**

Eight months before the enrichment year, residents will seek advice from faculty, and work out details of the proposed program. A new method to assign residents to projects was implemented

in 2011 where each resident completed a questionnaire about their research plans and their interest in ongoing research projects. This permitted matching of student interests with suitable projects for their enrichment year. As a result, there was better matching of residents to strong supervisors and appropriate research projects.

Residents must submit a timetable of their proposed enrichment year activities 3 months before their enrichment year begins. The research committee must approve the proposed timetable.

Exceptional McGill OTL residents may be permitted to enter a double-program Master's, combining both normal residency and Master of Science activities. Double-program activities must start 6 months before the Enrichment year starts, and normally continue after the end of the Enrichment year. The double master proposal is reviewed by the research committee and highly scrutinized before approval.

**Timetable for Enrichment year:**

May – August (preceding enrichment year)	Find project and supervisor
October (preceding enrichment year)	Submit timetable for enrichment year activities
December (preceding enrichment year)	Complete research proposal form, specifying when epidemiology and demonstrating will be done. Submit to research committee
January	Literature review and finalize proposal
February/March/April/May	Research in lab
June	Progress report
July	Compiling statistics
August/September	Starting writing paper
October/November	Progress report
December	Final report due
May (following enrichment year)	<b>Cutoff date for final report</b>
June (following enrichment year)	Presentation at annual Canadian meeting
Following year	Keep research committee updated with new publications

# **PGY4**

## **THIRD YEAR OF RESIDENCY TRAINING IN OTOLARYNGOLOGY- HEAD AND NECK SURGERY**

- Adult hospital rotations of total of 9 months rotation (JGH, MGH, RVH)
- Duration: During the Second Half of PGY4 (Jan 1- June 30), two rotations of 3 months  
In addition to one rotation of 3 months during the enrichment year as PGY4
- The PGY4 residents will be expected to use their knowledge of the basic sciences to gradually expand their clinical repertoire and clinical problem solving skills.
- Their technical training is designed to meet the requirements as outlined in the rotational objectives of the McGill Department of Otolaryngology – Head & Neck Surgery Residency Handbook
- All of the general otolaryngology clinics, sub-specialty clinics and surgeries are supervised by attending staff.
- All pre and post operative care management are fortified
- Regular informal quizzing as well as structured written and oral examinations serves as part of the evaluation process, using the One45 framework.
- All residents must undergo a STASER or STACER evaluation by attending staff person every six months. They are also evaluated by 360 degree inter-professional evaluation (feedback from allied health care personnel, nurses, secretaries)

### **1. MEDICAL EXPERT:**

#### **1. Operative objectives:**

- a) In addition to acquiring greater proficiency in the procedures encountered during the first year, development will be acquired in the following skills:
  - Septal surgery (septoplasty, nasal polypectomy)
  - Sinus surgery
  - Cervical node biopsy
  - Assistance at major head and neck surgery
  - Microlaryngeal surgery
- b) Some experience of the following procedures with adequate supervision should be obtained near the end of the second year:
  - Rhinologic surgery
    - rhinoplasty
    - ethmoidectomy, functional endoscopic sinus surgery
  - Otologic surgery

- myringoplasty
    - tympanoplasty
    - mastoidectomy
  - Neurotologic surgery
    - intratympanic injections
  - Head and neck surgery
    - salivary gland surgery e.g. submandibular gland excision
    - Neck dissection different types
  - Facial plastics and Reconstructive surgery
    - Flaps local and locoregional
    - split and full thickness skin graft
  - Laryngologic procedures
    - vocal fold injection
    - laser laryngeal procedures
    - medialization
  - General Otolaryngology
    - rigid upper endoscopy with foreign body extraction
    - management of obstructive sleep apnea and surgical options
    - management of head and neck manifestations of systemic disease
    - cricothyroidotomy
    - tracheostomy
- c) Exposure to the following procedures:
- Otology
    - Stapedectomy
    - facial nerve surgery
    - labyrinthine surgery
    - neurotologic procedures
  - Head and Neck
    - Parotidectomy
    - composite resection maxillectomy
    - thyroid and parathyroid surgery
    - Zenker's diverticulum surgery
    - laryngectomy
  - Facial Plastic and reconstructive
    - Otoplasty
    - face lift
    - blepharoplasty

## **2. Didactic objectives:**

Active resident participation in academic half and full day seminars, lectures, hospital rounds and journal clubs will increase. Where possible, the residents will be increasing involvement in

teaching junior medical staff to include medical students, clinical clerks and junior residents. The resident will be introduced to the methods of clinical research and ethics in clinical trials.

### **3. Temporal bone dissection:**

The resident will complete his program of temporal bone dissection in preparation for the development of his clinical otological skills. A temporal bone course is given in the fall of every year.

## **• PGY4 at the JGH- The Expert Role specific objectives**

### **• General Skills**

- Participate in the post-operative ward and office management of patients who have undergone major head and neck ablative and Reconstructive surgery
- Demonstrate a sophisticated approach to imaging studies including independent interpretation of findings
- Perform fine needle aspiration of neck lesions
- Biopsy nasal or oral cavity lesions
- Insert or change a tracheoesophageal puncture prosthesis
- Pack a pharyngocutaneous fistula and provide ongoing wound care/debridement
- Effectively manage pain associated with surgery and malignancy
- Demonstrate understanding of the indications for tracheotomy in a critical care setting
- Promptly and effectively assess patients with airway emergencies including airway obstruction and supervise junior colleagues in this situation
- Perform open and percutaneous tracheostomies
- Pre-operative assessment and preparation of patient for surgery
- Management of post-operative patient care issues (e.g., pain, labs, wounds)
- Participate in the post-operative ward and office management of ENT patients
- Interpret X-ray and cross-sectional imaging of temporal bones, paranasal sinuses, and soft tissues of the head and neck

### **• Head and neck Oncologic Surgery**

- Rapidly stage malignancies of the head and neck & develop approach to management
- Perform pan-endoscopy independently with accurate interpretation of findings
- Perform lymph node and neck mass biopsy
- Perform excision of branchial cleft cysts and thyroglossal duct cysts
- Perform parotidectomy with increasing degree of autonomy
- Perform neck dissections with increasing degree of autonomy

- Perform thyroidectomy, parathyroidectomy with limited consultant intervention
- Perform excision of oral cavity lesions
- Perform composite resections as well as pharyngolaryngectomies with increasing degree of autonomy
- Perform more extensive maxillectomies with consultant supervision
- **Facial Plastic and Reconstructive Surgery**
  - Demonstrate sophisticated understanding of the hierarchy of reconstructive options for defects in the head and neck
  - Formulate plan for reconstruction of head and neck defects with attention to form and function
  - Design and harvest flaps for major Reconstructive surgical procedures with direct consultant supervision
  - Perform or assist at microvascular anastomosis for vessels and nerves in free tissue transfers
  - Diagnosis and treatment of facial nerve disorders and reanimation strategies
  - Assessment for septorhinoplasty including an appreciation of the nasal valve, open vs. closed approaches, as well as grafting techniques.
  - Perform septorhinoplasty with direct consultant supervision.
  - Management of patients suffering from facial trauma including the techniques of soft tissue repair and closed/open reduction of facial fractures.
- **Laryngology**
  - Develop a differential diagnosis and management plan for dysphonia
  - Develop a differential diagnosis and management plan for dysphagia
  - Management of vocal cord paralysis including investigation, medical therapy, and surgical therapy
  - Perform rigid suspension laryngoscopy
  - Perform microlaryngeal surgery with microlaryngeal instruments, CO2 Laser
  - Understanding of intraoperative airway management during microlaryngeal surgery
  - Perform, with supervision, endoscopic laser resections of early tumors of the larynx
  - Assist at and begin to perform airway reconstruction (e.g. laryngotracheoplasty)
- **Neurotology / Otology**
  - Accurately assess patients suffering temporal bone trauma including ordering appropriate investigations
  - Be able to interpret conventional audiometry and tympanometry in adults
  - Understand the principles and application of auditory brainstem response (ABR) and otoacoustic emissions (OAEs)

- Understand the principles and application of electronystagmography including interpretation of findings
  - Accurately diagnose benign positional vertigo and demonstrate a rational approach to its treatment
  - Perform the particle repositioning maneuver
  - Develop a rational approach to vestibular rehabilitation and participate in delivery of this care
  - Participate in and demonstrate understanding of the indications for surgical treatment of vertigo (includes labyrinthectomy, vestibular nerve section, endolymphatic sac surgery, and posterior canal occlusion)
  - Demonstrate an understanding of electro-diagnostic testing of the facial nerve
  - Elevate a tympanomeatal flap with limited consultant intervention
  - Perform tympanoplasty with limited consultant intervention
  - Perform ossiculoplasty with consultant supervision
  - Perform mastoidectomy with consultant supervision
  - Demonstrate a rational, organized approach to management of disorders of the facial nerve
  - Demonstrate a rational approach to selection of patients for cochlear implant surgery
  - Assist at surgery for treatment of otosclerosis
  - Assist at and demonstrate a logical approach to surgery for treatment of lateral skull base lesions including acoustic neuromas, other benign CPA lesions, and petrous apex lesions
- **Rhinology**
    - Perform effective rigid nasal and sinus endoscopy
    - Biopsy nasal cavity lesions
    - Participate actively in the post-operative office management of patients who have undergone sinus surgery including pharmacotherapy and debridement
    - Demonstrate a sophisticated approach to selection of the surgical candidate for treatment of nasal obstruction and chronic rhinosinusitis
    - Perform nasal septoplasty including choice of incision, method of septoplasty, and closure materials with decreasing degree of direct consultant supervision
    - Perform inferior turbinate reduction
    - Refine knowledge of paranasal sinus anatomy and perform surgical techniques of endoscopic polypectomy, uncinectomy, ethmoidectomy, and middle meatal antrostomy with decreasing degree of direct consultant supervision
    - Acquire familiarity with indications for and performance of endoscopic sphenoidotomy and frontal sinusotomy
    - Perform external approaches to the paranasal sinuses such as external ethmoidectomy, frontal sinus trephine, and frontal sinus osteoplasty

- Perform surgical treatments for epistaxis including endoscopic sphenopalatine artery ligation and anterior ethmoid artery ligation as well as internal maxillary artery ligation
- Acquire familiarity with techniques for the management of benign sinonasal neoplasms such as inverted papilloma (e.g. endoscopic medial maxillectomy)

## • **PGY4 at the RVH - The Expert Role specific objectives:**

### • **General Skills**

- Understands medical literature its limitations and can argue based on the published literature
- Participate in the post-operative ward and office management of patients who have undergone major head and neck ablative and Reconstructive surgery
- Demonstrate a sophisticated approach to imaging studies including independent interpretation of findings
- Perform fine needle aspiration of neck lesions
- Biopsy nasal or oral cavity lesions
- Insert or change a tracheoesophageal puncture prosthesis
- Incise and drain a wound abscess including a demonstrated understanding of the indications for the procedure
- Pack a pharyngocutaneous fistula and provide ongoing wound care/debridement
- Effectively manage pain associated with surgery and malignancy
- Demonstrate understanding of the indications for tracheotomy in a critical care setting
- Promptly and effectively assess patients with airway emergencies including airway obstruction and supervise junior colleagues in this situation
- Perform open and percutaneous tracheostomies
- Perform percutaneous tracheostomy/translaryngeal tracheotomy with limited consultant supervision
- Provide effective counseling for patients regarding tracheotomy/stoma care
- Effectively manage pain associated with surgery (e.g. mastoidectomy, skull base surgery)
- Participate in the post-operative ward and office management of patients who have undergone otologic surgery, lateral skull base surgery, and general otolaryngological surgery
- Interpret X-ray and cross-sectional imaging of temporal bones and soft tissues of the head and neck

- **Head and Neck Oncologic Surgery**
  - Rapidly stage malignancies of the head and neck and develop approach to surgical management
  - Appropriate use and recommendation of alternate/adjuvant therapies for management of malignancies of the head and neck
  - Effectively perform a transnasal esophagoscopy and understand the findings
  - Comprehensive management of complications from Head and Neck surgery with limited consultant intervention
  - Comprehensive understanding and management of Head and Neck emergencies such as airway obstruction and trauma
  - Perform pan-endoscopy independently with accurate interpretation of findings
  - Perform lymph node and neck mass biopsy limited consultant intervention
  - Effectively perform cervical echography and ultrasound guided fine needle biopsy
  - Perform excision of submandibular glands with limited consultant intervention
  - Perform excision of branchial cleft cysts and thyroglossal duct cysts with gradually decreasing degree of consultant intervention
  - Perform parotidectomy with increasing degree of autonomy
  - Perform neck dissections with increasing degree of autonomy
  - Perform thyroidectomy, parathyroidectomy with limited consultant intervention
  - Perform excision of oral cavity lesions with and without laser
  - Perform medial maxillectomy with consultant supervision
  - Perform composite resections as well as pharyngolaryngectomies with increasing degree of autonomy
  - Perform more extensive maxillectomies with consultant supervision
  - Assist at anterior craniofacial resections
  
- **Facial Plastic and Reconstructive Surgery**
  - Demonstrate sophisticated understanding of the hierarchy of Reconstructive options for defects in the head and neck
  - Formulate plan for reconstruction of head and neck defects with attention to form and function
  - Design and harvest flaps for major Reconstructive surgical procedures with direct consultant supervision
  - Perform or assist at microvascular anastomosis for vessels and nerves in free tissue transfers
  - Diagnosis and treatment of facial nerve disorders and reanimation strategies
  - Diagnose, evaluate and perform treatments of cutaneous malignancies including appropriate reconstruction.

- Observe, assist in and perform various types of local and regional flaps in cervicofacial reconstruction
  - Approach to facial analysis of patient presenting for esthetic surgery
  - Observe, assist in and perform septorhinoplasty including an evaluation of the nasal valve, open vs. closed approaches, as well as grafting techniques
  - Perform septorhinoplasty with direct consultant supervision.
  - Observe, assist in cervicofacial cosmetic surgery such as blepharoplasty, rhytidectomy, forehead lifts, and various facial implants.
  - Observe, assist in and perform Facial reanimation including skin resurfacing, chemical peels, microdermabrasion, and laser peels
  - Observe, assist in and perform cosmetic procedures such as botox injection and soft tissue injectable fillers (hyaluronic acid derivatives, collagen, etc.)
  - Observe, assist in and perform scar revision including techniques such as Z - plasty, W - plasty, and geometric broken line closure, etc.
  - Management of patients suffering from facial trauma including the techniques of soft tissue repair and closed/open reduction of facial fractures and post-operative care.
  - Perform surgical repair of mandible fractures including the use of M-M fixation and plates.
  - Management of mid facial fractures including choice of incisions and repair materials.
  - Perform or assist at repair of orbitozygomatic and frontal sinus fractures
- **Laryngology**
    - Perform indirect rigid laryngoscopy and video-stroboscopy
    - Develop a differential diagnosis and management plan for dysphonia
    - Develop a differential diagnosis and management plan for dysphagia
    - Management of vocal cord paralysis including investigation, medical therapy, and surgical therapy
    - Perform office-based laryngeal procedures
    - Perform rigid suspension laryngoscopy
    - Perform microlaryngeal surgery with microlaryngeal instruments, CO2 Laser, microdebrideur
    - Understanding of intraoperative airway management during microlaryngeal surgery
    - Perform thyroplasty and other laryngeal framework surgeries
    - Perform, with supervision, endoscopic laser resections of early tumors of the larynx
    - Diagnosis and management of airway and aerodigestive trauma
    - Assist at and begin to perform airway reconstruction (e.g. laryngotracheoplasty)

- **Neurotology / Otology**
  - Accurately assess patients suffering temporal bone trauma including ordering appropriate investigations
  - Be able to perform and interpret conventional audiometry and tympanometry in adults
  - Understand the principles and application of auditory brainstem response (ABR) and Otoacoustic Emissions (OAEs)
  - Understand the principles and application of electronystagmography including interpretation of findings
  - Accurately diagnose benign positional vertigo and demonstrate a rational approach to its treatment
  - Perform the particle repositioning maneuver
  - Develop a rational approach to vestibular rehabilitation and participate in delivery of this care
  - Participate in and demonstrate understanding of the indications for surgical treatment of vertigo (includes labyrinthectomy, vestibular nerve section, endolymphatic sac surgery, and posterior canal occlusion)
  - Observe performance of and interpret electrocochleography
  - Perform and interpret electro-diagnostic testing of the facial nerve
  - Elevate a tympanomeatal flap with limited consultant intervention
  - Perform tympanoplasty with limited consultant intervention
  - Perform ossiculoplasty with consultant supervision
  - Perform mastoidectomy with consultant supervision
  - Demonstrate a rational, organized approach to medical management of disorders of the facial nerve
  - Demonstrate a rational approach to selection of patients for cochlear implant surgery
  - Assist in performance of cochlear implant surgery and actively participate in post-operative rehabilitation and assessment
  - Assist at/observe surgery for treatment of otosclerosis
  - Assist at and demonstrate a logical approach to surgery for treatment of lateral skull base lesions including acoustic neuromas, other benign CPA lesions, and petrous apex lesions
  - Attend Skull Base Clinic and understand controversies in patient management
  - Present cases at Skull Base Tumor Board
  - Participate at skull base surgeries and perform some of the procedure under supervision
  - Perform the particle repositioning maneuver and be able to distinguish horizontal canal from posterior canal BPPV
  
- **Rhinology**
  - Perform effective rigid nasal and sinus endoscopy

- Biopsy nasal cavity lesions
- Participate actively in the post-operative office management of patients who have undergone sinus surgery including pharmacotherapy and debridement
- Interpret X-ray and cross-sectional imaging of the paranasal sinuses
- Demonstrate a sophisticated approach to selection of the surgical candidate for treatment of nasal obstruction and chronic rhinosinusitis, including indications for endoscopic sinus surgery and the extent of the procedure to be performed.
- Effectively prepare patients for endonasal surgery such as septoplasty and endoscopic sinus surgery, including the informed consent process (description of risks/possible complications)
- Perform nasal septoplasty including choice of incision, method of septoplasty, and closure materials with decreasing degree of direct consultant supervision
- Perform inferior turbinate reduction with limited consultant supervision
- Refine knowledge of paranasal sinus anatomy and perform surgical techniques of endoscopic polypectomy, uncinectomy, ethmoidectomy, and middle meatal antrostomy with decreasing degree of direct consultant supervision
- Perform endoscopic sphenoidotomy and frontal recess dissection with direct consultant supervision
- Acquire familiarity and assist at endoscopic approaches to the pituitary gland
- Perform surgical treatments for epistaxis including endoscopic sphenopalatine artery ligation and anterior ethmoid artery ligation as well as internal maxillary artery ligation
- Acquire familiarity with techniques for the management of benign sinonasal neoplasms such as inverted papilloma (e.g. endoscopic medial maxillectomy)

## • **PGY4 at the MGH - The Expert Role specific objectives:**

### • **General Skills**

- Understands medical literature its limitations and can argue based on the published literature
- Participate in the post-operative ward and office management of patients who have undergone major head and neck ablative and Reconstructive surgery
- Demonstrate a sophisticated approach to imaging studies including independent interpretation of findings
- Perform fine needle aspiration of neck lesions
- Biopsy nasal or oral cavity lesions
- Insert or change a tracheoesophageal puncture prosthesis
- Incise and drain a wound abscess including a demonstrated understanding of the indications for the procedure

- Pack a pharyngocutaneous fistula and provide ongoing wound care/debridement
  - Effectively manage pain associated with surgery and malignancy
  - Demonstrate understanding of the indications for tracheotomy in a critical care setting
  - Promptly and effectively assess patients with airway emergencies including airway obstruction and supervise junior colleagues in this situation
  - Perform open and percutaneous tracheostomies
  - Perform percutaneous tracheostomy/translaryngeal tracheotomy with limited consultant supervision
  - Provide effective counseling for patients regarding tracheotomy/stoma care
  - Effectively manage pain associated with surgery (e.g. mastoidectomy, skull base surgery)
  - Participate in the post-operative ward and office management of patients who have undergone otologic surgery, lateral skull base surgery, and general otolaryngological surgery
  - Interpret X-ray and cross-sectional imaging of temporal bones and soft tissues of the head and neck
- **Head and Neck Oncologic Surgery**
    - Rapidly stage malignancies of the head and neck and develop approach to surgical management
    - Appropriate use and recommendation of alternate/adjuvant therapies for management of malignancies of the head and neck
    - Effectively perform a transnasal esophagoscopy and understand the findings
    - Comprehensive management of complications from Head and Neck surgery with limited consultant intervention
    - Comprehensive understanding and management of Head and Neck emergencies such as airway obstruction and trauma
    - Perform pan-endoscopy independently with accurate interpretation of findings
    - Perform lymph node and neck mass biopsy limited consultant intervention
    - Effectively perform cervical echography and ultrasound guided fine needle biopsy
    - Perform excision of submandibular glands with limited consultant intervention
    - Perform excision of branchial cleft cysts and thyroglossal duct cysts with gradually decreasing degree of consultant intervention
    - Perform parotidectomy with increasing degree of autonomy
    - Perform neck dissections with increasing degree of autonomy
    - Perform thyroidectomy, parathyroidectomy with limited consultant intervention
    - Perform excision of oral cavity lesions with and without laser

- Perform medial maxillectomy with consultant supervision
  - Perform composite resections as well as pharyngolaryngectomies with increasing degree of autonomy
  - Perform more extensive maxillectomies with consultant supervision
  - Assist at anterior craniofacial resections
- **Facial Plastic and Reconstructive Surgery**
    - Demonstrate sophisticated understanding of the hierarchy of Reconstructive options for defects in the head and neck
    - Formulate plan for reconstruction of head and neck defects with attention to form and function
    - Design and harvest flaps for major Reconstructive surgical procedures with direct consultant supervision
    - Perform or assist at microvascular anastomosis for vessels and nerves in free tissue transfers
    - Perform or assist at microvascular anastomosis for vessels and nerves in free tissue transfers
    - Diagnosis and treatment of facial nerve disorders and reanimation strategies
    - Diagnose, evaluate and perform treatments of cutaneous malignancies including appropriate reconstruction.
    - Observe, assist in and perform various types of local and regional flaps in cervicofacial reconstruction
    - Approach to facial analysis of patient presenting for esthetic surgery
    - Observe, assist in and perform septorhinoplasty including an evaluation of the nasal valve, open vs. closed approaches, as well as grafting techniques
    - Perform septorhinoplasty with direct consultant supervision.
    - Observe, assist in cervicofacial cosmetic surgery such as blepharoplasty, rhytidectomy, forehead lifts, and various facial implants.
    - Observe, assist in and perform Facial reanimation including skin resurfacing, chemical peels, microdermabrasion, and laser peels
    - Observe, assist in and perform cosmetic procedures such as botox injection and soft tissue injectable fillers (hyaluronic acid derivatives, collagen, etc.)
    - Observe, assist in and perform scar revision including techniques such as Z - plasty, W - plasty, and geometric broken line closure, etc.
    - Management of patients suffering from facial trauma including the techniques of soft tissue repair and closed/open reduction of facial fractures and post-operative care.
    - Perform surgical repair of mandible fractures including the use of M-M fixation and plates.
    - Management of mid facial fractures including choice of incisions and repair materials.
    - Perform or assist at repair of orbitozygomatic and frontal sinus fractures

- **Laryngology**
  - Perform indirect rigid laryngoscopy and video-stroboscopy
  - Develop a differential diagnosis and management plan for dysphonia
  - Develop a differential diagnosis and management plan for dysphagia
  - Management of vocal cord paralysis including investigation, medical therapy, and surgical therapy
  - Perform office-based laryngeal procedures
  - Perform rigid suspension laryngoscopy
  - Perform microlaryngeal surgery with microlaryngeal instruments, CO2 Laser, microdebrideur
  - Understanding of intraoperative airway management during microlaryngeal surgery
  - Perform thyroplasty and other laryngeal framework surgeries
  - Perform, with supervision, endoscopic laser resections of early tumors of the larynx
  - Diagnosis and management of airway and aerodigestive trauma
  - Assist at and begin to perform airway reconstruction (e.g. laryngotracheoplasty)
  
- **Neurotology / Otology**
  - Accurately assess patients suffering temporal bone trauma including ordering appropriate investigations
  - Be able to perform and interpret conventional audiometry and tympanometry in adults
  - Understand the principles and application of auditory brainstem response (ABR) and Otoacoustic Emissions (OAEs)
  - Understand the principles and application of electronystagmography including interpretation of findings
  - Accurately diagnose benign positional vertigo and demonstrate a rational approach to its treatment
  - Perform the particle repositioning maneuver
  - Develop a rational approach to vestibular rehabilitation and participate in delivery of this care
  - Participate in and demonstrate understanding of the indications for surgical treatment of vertigo (includes labyrinthectomy, vestibular nerve section, endolymphatic sac surgery, and posterior canal occlusion)
  - Observe performance of and interpret electrocochleography
  - Perform and interpret electro-diagnostic testing of the facial nerve
  - Elevate a tympanomeatal flap with limited consultant intervention
  - Perform tympanoplasty with limited consultant intervention
  - Perform ossiculoplasty with consultant supervision

- Perform mastoidectomy with consultant supervision
- Demonstrate a rational, organized approach to medical management of disorders of the facial nerve
- Demonstrate a rational approach to selection of patients for cochlear implant surgery
- Assist in performance of cochlear implant surgery and actively participate in post-operative rehabilitation and assessment
- Assist at/observe surgery for treatment of otosclerosis
- Assist at and demonstrate a logical approach to surgery for treatment of lateral skull base lesions including acoustic neuromas, other benign CPA lesions, and petrous apex lesions
- Attend Skull Base Clinic and understand controversies in patient management
- Present cases at Skull Base Tumor Board
- Participate at skull base surgeries and perform some of the procedure under supervision

- **Rhinology**

- Perform effective rigid nasal and sinus endoscopy
- Biopsy nasal cavity lesions
- Participate actively in the post-operative office management of patients who have undergone sinus surgery including pharmacotherapy and debridement
- Interpret X-ray and cross-sectional imaging of the paranasal sinuses
- Demonstrate a sophisticated approach to selection of the surgical candidate for treatment of nasal obstruction and chronic rhinosinusitis, including indications for endoscopic sinus surgery and the extent of the procedure to be performed.
- Effectively prepare patients for endonasal surgery such as septoplasty and endoscopic sinus surgery, including the informed consent process (description of risks/possible complications)
- Perform nasal septoplasty including choice of incision, method of septoplasty, and closure materials with decreasing degree of direct consultant supervision
- Perform inferior turbinate reduction with limited consultant supervision
- Refine knowledge of paranasal sinus anatomy and perform surgical techniques of endoscopic polypectomy, uncinectomy, ethmoidectomy, and middle meatal antrostomy with decreasing degree of direct consultant supervision
- Perform endoscopic sphenoidotomy and frontal recess dissection with direct consultant supervision
- Acquire familiarity and assist at endoscopic approaches to the pituitary gland
- Perform surgical treatments for epistaxis including endoscopic sphenopalatine artery ligation and anterior ethmoid artery ligation as well as internal maxillary artery ligation

- Acquire familiarity with techniques for the management of benign sinonasal neoplasms such as inverted papilloma (e.g. endoscopic medial maxillectomy)

## **2. Communicator Role:**

As a communicator the otolaryngology resident should effectively facilitate the doctor-patient relationship and the dynamic exchanges that occur before, during, and after the medical encounter. The resident is thought and evaluated on these issues:

- Demonstrate effective establishment of therapeutic relationships with patients and their families
- Recognize unique issues related to head and neck patients, particularly relevant to patients with cancer of the head and neck including end-of-life discussions
- Recognize unique biopsychosocial issues related to deafness and the deaf community and recognize their unique communication requirements
- Demonstrate the capacity to recognize the psychological, occupational and social consequences of speech and voice disorders, particularly relevant to vocational demands
- Obtain and synthesize relevant history from patients, their families, and communities
- Prepare clear, accurate, concise, appropriately detailed clinical notes, consultation notes, discharge summaries, and operative reports
- Present histories, physical findings, and management plan to consultants in an organized, efficient, and confident manner
- Respect diversity and difference, including gender, religion and cultural beliefs on decision-making
- Discuss common procedures with patients and their families in a clear and understandable form including risks/benefits, informed consent, and post-operative care
- Address challenging communication issues effectively, such as obtaining informed consent, delivering bad news, and addressing anger, confusion and misunderstanding
- Participate, and present effectively in organized rounds and seminars

- **The communicator role is evaluated especially on:**

- Demonstrate effective establishment of therapeutic relationships with patients and their families
- Present histories, physical findings, and management plan to consultants in an organized, efficient, and confident manner
- Obtain and synthesize relevant history from patients, their families, and communities
- Prepare clear, accurate, concise, appropriately detailed clinical notes, consultation notes, discharge summaries, and operative reports

- Discuss more complex procedures (e.g. tympanoplasty, thyroidectomy) with patients and their families in a clear and understandable form including risks/benefits, informed consent, and post-operative care
- Prepare, participate, and present effectively in organized rounds and seminars
- Demonstrate the capacity to recognize the psychological, occupational and social consequences of speech and voice disorders, particularly relevant to vocational demands
- Recognize unique issues related to head and neck patients particularly relevant to patients with cancer of the head and neck including end-of-life discussions
- Respect diversity and difference, including gender, religion and cultural beliefs on decision-making
- challenging communication issues effectively, such as obtaining informed consent, delivering bad news, and addressing anger, confusion and misunderstanding

### **3. Collaborator Role:**

As collaborators the otolaryngology residents effectively work within a health care team to achieve optimal patient care. The resident is thought and evaluated on these issues:

- Demonstrate an understanding of the team structure of an in-patient service ('the resident team') and fulfill his/her role in this structure
  - Demonstrate recognition and respect for the opinions & roles of other team members
  - Identify the situations and instances where consultation of other physicians or health care professional is useful or appropriate
  - Demonstrate collegial and professional relationships with other physicians, office and clinic support staff, operating room personnel, and emergency room staff
  - Recognize the expertise and role of allied health professionals such as speech language pathologists, audiologists, technicians, nurses, and clerical staff
  - Recognize the advantages for optimal patient care provided by an multidisciplinary Head and Neck oncology team
- **The collaborator role is evaluated especially on:**
    - Identify the situations and instances where consultation of other physicians or health care professional is useful or appropriate
    - Demonstrate collegial and professional relationships with other physicians, office and clinic support staff, operating room personnel, and emergency room staff
    - Recognize the expertise and role of allied health professionals
    - Recognize the advantages for optimal patient care provided by a multidisciplinary head and neck oncology program

#### **4. Manager Role:**

As managers the otolaryngology residents are integral participants in health care organizations, making decisions about allocating resources, and contributing to the effectiveness of the health care system. The resident is thought and evaluated on these issues:

- Utilize resources effectively to balance patient care duties, learning needs, educational / teaching responsibilities & outside activities and personal life
  - Allocate finite health care resources in a wise, equitable, and ethical fashion
  - Utilize information technology to optimize patient care and life-long learning including facile use of hospital IT resources (e.g. filmless radiology, electronic charting)
  - Actively participate in preparation, presentation, analysis, and reporting of morbidity and mortality rounds
  - Accurately identify criteria for patient admission to hospital in the urgent/emergent situation as well as the implications of such decisions
  - Use patient information tools effectively
  - Demonstrate an appreciation of the importance of quality assurance/improvement, such as patient safety initiatives
  - Take care of charts and use head and neck patient database
  - Demonstrate ability to lead a health care team
  - Serve in administrative and leadership roles, such as participate effectively in committees and meetings
- **The manger role is evaluated especially on:**
    - Demonstrate ability to lead a health care team
    - Utilize resources effectively to balance patient care duties, learning needs, Educational/teaching responsibilities and outside activities
    - Allocate finite health care resources in a wise, equitable, and ethical fashion
    - Utilize information technology to optimize patient care and life-long learning including facile use of hospital IT resources (e.g. filmless radiology, electronic charting)
    - Demonstrate an appreciation of the importance of quality assurance/improvement
    - Actively participate in preparation, presentation, analysis, and reporting of morbidity and mortality rounds
    - Accurately identify criteria for patient admission to hospital in the urgent/emergent situation as well as the implications of such decisions
    - Serve in administrative and leadership roles, such as participate effectively in committees and meetings
    -

## **5. Health Advocate Role:**

As Health Advocate the otolaryngology residents responsibly use their expertise and influence to advance the health and well-being of individual patients, communities, and populations. The resident is thought and evaluated on these issues:

- Recognize and respond to opportunities for advocacy within Otolaryngology, both for your patients as well as for the community in which we practice and populations at large
  - Encourage behaviors that promote hearing protection and conservation at work and at home
  - Facilitate patients' access to local and national resources available for the hearing impaired
  - Encourage behaviors that reduce/eliminate risk factors for the development of head & neck cancer (e.g., tobacco, alcohol, UVA/UVB sun exposure)
- **The health advocate role is evaluated especially on:**
    - Recognize and respond to opportunities for advocacy within Otolaryngology, both for your patients as well as for the community in which we practice
    - Demonstrate familiarity with important determinants of health relevant to Otolaryngology such as environmental noise exposure
    - Encourage behaviors that promote hearing protection and conservation at work and at home
    - Facilitate patients' access to local and national resources available for the hearing impaired
    - Encourage behaviors that reduce/eliminate risk factors for the development of head and neck cancer (e.g.: tobacco, alcohol, UVA/UVB sun exposure)

## **6. Scholar Role:**

As Scholars the otolaryngology residents demonstrate a lifelong commitment to reflective learning, as well as the creation, dissemination, application and translation of medical knowledge. The resident is thought and evaluated on these issues:

- Actively participate in the teaching of medical students (didactic, in clinics, and on Wards / in OR
- Facilitate learning in patients and other health professionals
- Actively participate in preparation and presentation of weekly hospital and grand rounds
- Demonstrate a critical appraisal of research methodology, biostatistics, and the medical literature as part of monthly Journal Clubs

- Develop, implement, and monitor a personal educational strategy and seek guidance for this educational strategy as appropriate
- Contribute to the development of new knowledge through participation in clinical or basic research studies
- Demonstrate commitment to evidence based standards for care of common problems in Otolaryngology
- Demonstrate the evolving commitment to, and the ability to practice, life-long learning
- **The scholar role is evaluated especially on:**
  - Actively participate in the teaching of medical students (didactic, in clinics, and on wards/in OR)
  - Facilitate learning in patients and other health professionals
  - Actively participate in preparation and presentation of weekly hospital and Grand Rounds
  - Demonstrate a critical appraisal of research methodology, biostatistics, and the medical literature as part of monthly Journal Clubs
  - Practice the skill of self-assessment
  - Develop, implement, and monitor a personal Educational strategy and seek guidance for this Educational strategy as appropriate
  - Demonstrate the evolving commitment to, and the ability to practice, life-long learning
  - Contribute to the development of new knowledge through participation in clinical or basic research studies
  - Demonstrate commitment to evidence based standards for care of common problems in Otolaryngology
  - Actively participate in weekly academic rounds series including advance preparation for the topic(s)

## **7. Professional Role:**

- As professionals the otolaryngology residents are committed to the health and well-being of individuals and society through ethical practice, profession-led regulation, and high personal standards of behavior. The resident is thought and evaluated on these issues:
- Deliver highest quality care with integrity, honesty, and compassion
- Exhibit appropriate professional and interpersonal behaviors
- Practice medicine and Otolaryngology in an ethically responsible manner
- Recognize limitations and seek assistance as necessary
- Seek out and reflect on constructive criticism of performance

- Endeavour to develop an appropriate balance between personal and professional life to promote personal physical and mental health/well-being as an essential to effective, life-long practice
- Demonstrate a commitment to their patients, profession and society through participation in profession-led regulation, e.g. recognize and respond to others unprofessional behavior in practice, understand the legal and ethical codes of practice
- **The Professional role is evaluated especially on:**
  - Deliver highest quality care with integrity, honesty, and compassion
  - Exhibit appropriate professional and interpersonal behaviors
  - Practice medicine and Otolaryngology in an ethically responsible manner
  - Recognize limitations and seek assistance as necessary
  - Seek out and reflect on constructive criticism of performance
  - Endeavor to develop an appropriate balance between personal and professional life to promote personal physical and mental health/well-being as an essential to effective, life-long practice
  - Demonstrate a commitment to their patients, profession and society through participation in profession-led regulation (e.g.: recognize and respond to other unprofessional behavior in practice, understand the legal and ethical codes of practice)

# **PGY5**

## **FOURTH YEAR OF OTOLARYNGOLOGY – HEAD AND NECK SURGERY TRAINING (FINAL YEAR OF OTL PROGRAM)**

- Rotation-specific CanMEDS objectives have been elaborated. The residents rotate throughout the three teaching hospitals: the Montreal General, Jewish General and Royal Victoria hospitals.
- The PGY5 residents will be able to see patients and define a treatment plan independently; the resident should possess sufficient basic and clinical knowledge and technical skills to undertake the management of patients under the supervision of the appropriate staff.
- At this level, the resident will be responsible for the supervision and teaching of more junior residents, medical students, the management of patients on the wards, and ensuring coverage of emergency and inpatient consultations.
- The senior resident will be responsible for many activities within the post-graduate program to include: sitting on post-graduate committees, organization of education activities including rounds, journal clubs and seminars as well as organization of all the vacation schedules.
- Their technical training is designed to meet the requirements as outlined in the rotational objectives of the McGill Department of Otolaryngology – Head & Neck Surgery Residency Handbook.
- Senior residents (PGY4 & PGY5) at each hospital site are evaluated according to their specific exposure using the One45 system. Evaluations forms are different from the junior residents (PGY2 & PGY3) evaluation. All residents must undergo a STASER or STACER evaluation by attending staff person every six months. They are also evaluated by 360 degree inter-professional evaluation (feedback from allied health care personnel, nurses, secretaries)
- During their final year in otolaryngology, residents are expected to develop proficiency in the following:

### **1. MEDICAL EXPERT:**

#### **1. Operative objectives / experience:**

Obtain proficiency in the following:

- Otolaryngology
  - excision of exostosis
  - tympanoplasty
  - mastoidectomy and tympanomastoidectomy
  - ossiculoplasty
  - Canaloplasty
  - stapedectomy
- Neurotology
  - facial nerve decompression
  - intratympanic injections
  - surgical excision of middle ear tumors e.g. paraganglioma tympanicum
- Rhinology
  - surgical management of epistaxis
  - external sinus procedures
  - drainage of intra-orbital abscess
  - Maxillectomy
- Head and neck
  - radical neck dissection,
  - composite resection,
  - laryngectomy
  - thyroid surgery
  - parathyroid surgery
  - parotidectomy,
  - regional flaps,
  - Zenker's diverticulum repair surgery
  - major flap reconstruction
- Facial Plastics and Reconstructive
  - rhinoplasty
  - cartilage graft
  - bone graft e.g. calvarial
  - composite graft e.g. auricular
  - cervicofacial cosmetic surgery (face lift, blepharoplasty)
  - facial trauma and reconstructive surgery
- Laryngology
  - microlaryngeal surgery,
  - endoscopic partial laryngectomy,
  - medialization thyroplasty
  - laser procedures of the airway,
  - repair of laryngeal fracture
  - laryngotracheal reconstruction

Obtain some experience in the following:

- Otology
  - endolymphatic shunts
  - vestibular neurectomy
  - posterior fossa surgery
- Rhinology
  - advanced rhinoplasty
  - advanced endoscopic sinus surgery techniques for the management of sinonasal neoplasms

• **PGY5 - The Expert Role specific objectives at the JGH / RVH / MGH.**

• **General Skills**

- Understands medical literature its limitations and can argue based on the published literature
- Participate in the post-operative ward and office management of patients who have undergone major head and neck ablative and Reconstructive surgery
- Demonstrate a sophisticated approach to imaging studies including independent interpretation of findings
- Perform fine needle aspiration of neck lesions
- Biopsy nasal or oral cavity lesions
- Insert or change a tracheoesophageal puncture prosthesis
- Incise and drain a wound abscess including a demonstrated understanding of the indications for the procedure
- Pack a pharyngocutaneous fistula and provide ongoing wound care/debridement
- Effectively manage pain associated with surgery and malignancy
- Demonstrate understanding of the indications for tracheotomy in a critical care setting
- Promptly and effectively assess patients with airway emergencies including airway obstruction and supervise junior colleagues in this situation
- Perform open and percutaneous tracheostomies
- Perform percutaneous tracheostomy/translaryngeal tracheotomy with limited consultant supervision
- Provide effective counseling for patients regarding tracheotomy/stoma care
- Effectively manage pain associated with surgery (e.g. mastoidectomy, skull base surgery)
- Participate in the post-operative ward and office management of patients who have undergone otologic surgery, lateral skull base surgery, and general otolaryngological surgery

- Interpret X-ray and cross-sectional imaging of temporal bones and soft tissues of the head and neck
- **Head and Neck Oncologic Surgery**
  - Rapidly stage malignancies of the head and neck and develop approach to surgical management
  - Appropriate use and recommendation of alternate/adjvant therapies for management of malignancies of the head and neck
  - Effectively perform a transnasal esophagoscopy and understand the findings
  - Comprehensive management of complications from Head and Neck surgery with limited consultant intervention
  - Comprehensive understanding and management of Head and Neck emergencies such as airway obstruction and trauma
  - Perform pan-endoscopy independently with accurate interpretation of findings
  - Perform lymph node and neck mass biopsy limited consultant intervention
  - Effectively perform cervical echography and ultrasound guided fine needle biopsy
  - Perform excision of submandibular glands with limited consultant intervention
  - Perform excision of branchial cleft cysts and thyroglossal duct cysts with gradually decreasing degree of consultant intervention
  - Perform parotidectomy with increasing degree of autonomy
  - Perform neck dissections with increasing degree of autonomy
  - Perform thyroidectomy, parathyroidectomy with limited consultant intervention
  - Perform excision of oral cavity lesions with and without laser
  - Perform medial maxillectomy with consultant supervision
  - Perform composite resections as well as pharyngolaryngectomies with increasing degree of autonomy
  - Perform more extensive maxillectomies with consultant supervision
  - Assist at anterior craniofacial resections
- **Facial Plastic and Reconstructive Surgery**
  - Demonstrate sophisticated understanding of the hierarchy of Reconstructive options for defects in the head and neck
  - Formulate plan for reconstruction of head and neck defects with attention to form and function
  - Design and harvest flaps for major Reconstructive surgical procedures with direct consultant supervision
  - Perform or assist at microvascular anastomosis for vessels and nerves in free tissue transfers

- Perform or assist at microvascular anastomosis for vessels and nerves in free tissue transfers
  - Diagnosis and treatment of facial nerve disorders and reanimation strategies
  - Diagnose, evaluate and perform treatments of cutaneous malignancies including appropriate reconstruction.
  - Observe, assist in and perform various types of local and regional flaps in cervicofacial reconstruction
  - Approach to facial analysis of patient presenting for esthetic surgery
  - Observe, assist in and perform septorhinoplasty including an evaluation of the nasal valve, open vs. closed approaches, as well as grafting techniques
  - Perform septorhinoplasty with direct consultant supervision.
  - Observe, assist in cervicofacial cosmetic surgery such as blepharoplasty, rhytidectomy, forehead lifts, and various facial implants.
  - Observe, assist in and perform Facial reanimation including skin resurfacing, chemical peels, microdermabrasion, and laser peels
  - Observe, assist in and perform cosmetic procedures such as botox injection and soft tissue injectable fillers (hyaluronic acid derivatives, collagen, etc.)
  - Observe, assist in and perform scar revision including techniques such as Z - plasty, W - plasty, and geometric broken line closure, etc.
  - Management of patients suffering from facial trauma including the techniques of soft tissue repair and closed/open reduction of facial fractures and post-operative care.
  - Perform surgical repair of mandible fractures including the use of M-M fixation and plates.
  - Management of mid facial fractures including choice of incisions and repair materials.
  - Perform or assist at repair of orbitozygomatic and frontal sinus fractures
- **Laryngology**
    - Perform indirect rigid laryngoscopy and video-stroboscopy
    - Develop a differential diagnosis and management plan for dysphonia
    - Develop a differential diagnosis and management plan for dysphagia
    - Management of vocal cord paralysis including investigation, medical therapy, and surgical therapy
    - Perform office-based laryngeal procedures
    - Perform rigid suspension laryngoscopy
    - Perform microlaryngeal surgery with microlaryngeal instruments, CO2 Laser, microdebrideur
    - Understanding of intraoperative airway management during microlaryngeal surgery
    - Perform thyroplasty and other laryngeal framework surgeries

- Perform, with supervision, endoscopic laser resections of early tumors of the larynx
  - Diagnosis and management of airway and aerodigestive trauma
  - Assist at and begin to perform airway reconstruction (e.g. laryngotracheoplasty)
- **Neurotology / Otology**
    - Accurately assess patients suffering temporal bone trauma including ordering appropriate investigations
    - Be able to perform and interpret conventional audiometry and tympanometry in adults
    - Understand the principles and application of auditory brainstem response (ABR) and Otoacoustic Emissions (OAEs)
    - Understand the principles and application of electronystagmography including interpretation of findings
    - Accurately diagnose benign positional vertigo and demonstrate a rational approach to its treatment
    - Perform the particle repositioning maneuver
    - Develop a rational approach to vestibular rehabilitation and participate in delivery of this care
    - Participate in and demonstrate understanding of the indications for surgical treatment of vertigo (includes labyrinthectomy, vestibular nerve section, endolymphatic sac surgery, and posterior canal occlusion)
    - Observe performance of and interpret electrocochleography
    - Perform and interpret electro-diagnostic testing of the facial nerve
    - Elevate a tympanomeatal flap with limited consultant intervention
    - Perform tympanoplasty with limited consultant intervention
    - Perform ossiculoplasty with consultant supervision
    - Perform mastoidectomy with consultant supervision
    - Demonstrate a rational, organized approach to medical management of disorders of the facial nerve
    - Demonstrate a rational approach to selection of patients for cochlear implant surgery
    - Assist in performance of cochlear implant surgery and actively participate in post-operative rehabilitation and assessment
    - Assist at/observe surgery for treatment of otosclerosis
    - Assist at and demonstrate a logical approach to surgery for treatment of lateral skull base lesions including acoustic neuromas, other benign CPA lesions, and petrous apex lesions
    - Attend Skull Base Clinic and understand controversies in patient management
    - Present cases at Skull Base Tumor Board

- Participate at skull base surgeries and perform some of the procedure under supervision
- **Rhinology**
  - Perform effective rigid nasal and sinus endoscopy
  - Biopsy nasal cavity lesions
  - Participate actively in the post-operative office management of patients who have undergone sinus surgery including pharmacotherapy and debridement
  - Interpret X-ray and cross-sectional imaging of the paranasal sinuses
  - Demonstrate a sophisticated approach to selection of the surgical candidate for treatment of nasal obstruction and chronic rhinosinusitis, including indications for endoscopic sinus surgery and the extent of the procedure to be performed.
  - Effectively prepare patients for endonasal surgery such as septoplasty and endoscopic sinus surgery, including the informed consent process (description of risks/possible complications)
  - Perform nasal septoplasty including choice of incision, method of septoplasty, and closure materials with decreasing degree of direct consultant supervision
  - Perform inferior turbinate reduction with limited consultant supervision
  - Refine knowledge of paranasal sinus anatomy and perform surgical techniques of endoscopic polypectomy, uncinectomy, ethmoidectomy, and middle meatal antrostomy with decreasing degree of direct consultant supervision
  - Perform endoscopic sphenoidotomy and frontal recess dissection with direct consultant supervision
  - Acquire familiarity and assist at endoscopic approaches to the pituitary gland
  - Perform surgical treatments for epistaxis including endoscopic sphenopalatine artery ligation and anterior ethmoid artery ligation as well as internal maxillary artery ligation
  - Acquire familiarity with techniques for the management of benign sinonasal neoplasms such as inverted papilloma (e.g. endoscopic medial maxillectomy)

## **2. Communicator Role:**

As a communicator the otolaryngology resident should effectively facilitate the doctor-patient relationship and the dynamic exchanges that occur before, during, and after the medical encounter. The resident is thought and evaluated on these issues:

- Demonstrate effective establishment of therapeutic relationships with patients and their families
- Recognize unique issues related to head and neck patients, particularly relevant to patients with cancer of the head and neck including end-of-life discussions

- Recognize unique biopsychosocial issues related to deafness and the deaf community and recognize their unique communication requirements
- Demonstrate the capacity to recognize the psychological, occupational and social consequences of speech and voice disorders, particularly relevant to vocational demands
- Obtain and synthesize relevant history from patients, their families, and communities
- Prepare clear, accurate, concise, appropriately detailed clinical notes, consultation notes, discharge summaries, and operative reports
- Present histories, physical findings, and management plan to consultants in an organized, efficient, and confident manner
- Respect diversity and difference, including gender, religion and cultural beliefs on decision-making
- Discuss common procedures with patients and their families in a clear and understandable form including risks/benefits, informed consent, and post-operative care
- Address challenging communication issues effectively, such as obtaining informed consent, delivering bad news, and addressing anger, confusion and misunderstanding
- Participate, and present effectively in organized rounds and seminars

- **The communicator role is evaluated especially on:**

- Demonstrate effective establishment of therapeutic relationships with patients and their families
- Present histories, physical findings, and management plan to consultants in an organized, efficient, and confident manner
- Obtain and synthesize relevant history from patients, their families, and communities
- Prepare clear, accurate, concise, appropriately detailed clinical notes, consultation notes, discharge summaries, and operative reports
- Discuss more complex procedures (e.g. tympanoplasty, thyroidectomy) with patients and their families in a clear and understandable form including risks/benefits, informed consent, and post-operative care
- Prepare, participate, and present effectively in organized rounds and seminars
- Demonstrate the capacity to recognize the psychological, occupational and social consequences of speech and voice disorders, particularly relevant to vocational demands
- Recognize unique issues related to head and neck patients particularly relevant to patients with cancer of the head and neck including end-of-life discussions
- Respect diversity and difference, including gender, religion and cultural beliefs on decision-making

- Address challenging communication issues effectively, such as obtaining informed consent, delivering bad news, and addressing anger, confusion and misunderstanding

### **3. Collaborator Role:**

As collaborators the otolaryngology residents effectively work within a health care team to achieve optimal patient care. The resident is thought and evaluated on these issues:

- Demonstrate an understanding of the team structure of an in-patient service ('the resident team') and fulfill his/her role in this structure
  - Demonstrate recognition and respect for the opinions & roles of other team members
  - Identify the situations and instances where consultation of other physicians or health care professional is useful or appropriate
  - Demonstrate collegial and professional relationships with other physicians, office and clinic support staff, operating room personnel, and emergency room staff
  - Recognize the expertise and role of allied health professionals such as speech language pathologists, audiologists, technicians, nurses, and clerical staff
  - Recognize the advantages for optimal patient care provided by an multidisciplinary Head and Neck oncology team
- **The collaborator role is evaluated especially on:**
    - Identify the situations and instances where consultation of other physicians or health care professional is useful or appropriate
    - Demonstrate collegial and professional relationships with other physicians, office and clinic support staff, operating room personnel, and emergency room staff
    - Recognize the expertise and role of allied health professionals
    - Recognize the advantages for optimal patient care provided by a multidisciplinary head and neck oncology program

### **4. Manager Role:**

As managers the otolaryngology residents are integral participants in health care organizations, making decisions about allocating resources, and contributing to the effectiveness of the health care system. The resident is thought and evaluated on these issues:

- Utilize resources effectively to balance patient care duties, learning needs, educational / teaching responsibilities & outside activities and personal life
- Allocate finite health care resources in a wise, equitable, and ethical fashion
- Utilize information technology to optimize patient care and life-long learning including facile use of hospital IT resources (e.g. filmless radiology, electronic charting)

- Actively participate in preparation, presentation, analysis, and reporting of morbidity and mortality rounds
  - Accurately identify criteria for patient admission to hospital in the urgent/emergent situation as well as the implications of such decisions
  - Use patient information tools effectively
  - Demonstrate an appreciation of the importance of quality assurance/improvement, such as patient safety initiatives
  - Take care of charts and use head and neck patient database
  - Demonstrate ability to lead a health care team
  - Serve in administrative and leadership roles, such as participate effectively in committees and meetings
- **The manger role is evaluated especially on:**
    - Demonstrate ability to lead a health care team
    - Utilize resources effectively to balance patient care duties, learning needs, Educational/teaching responsibilities and outside activities
    - Allocate finite health care resources in a wise, equitable, and ethical fashion
    - Utilize information technology to optimize patient care and life-long learning including facile use of hospital IT resources (e.g. filmless radiology, electronic charting)
    - Demonstrate an appreciation of the importance of quality assurance/improvement
    - Actively participate in preparation, presentation, analysis, and reporting of morbidity and mortality rounds
    - Accurately identify criteria for patient admission to hospital in the urgent/emergent situation as well as the implications of such decisions
    - Recognize the advantages for optimal patient care provided by a multidisciplinary head and neck oncology program

## **5. Health Advocate Role:**

As Health Advocate the otolaryngology residents responsibly use their expertise and influence to advance the health and well-being of individual patients, communities, and populations. The resident is thought and evaluated on these issues:

- Recognize and respond to opportunities for advocacy within Otolaryngology, both for your patients as well as for the community in which we practice and populations at large
- Encourage behaviors that promote hearing protection and conservation at work and at home
- Facilitate patients' access to local and national resources available for the hearing impaired

- Encourage behaviors that reduce/eliminate risk factors for the development of head & neck cancer (e.g., tobacco, alcohol, UVA/UVB sun exposure)
- **The health advocate role is evaluated especially on:**
  - Recognize and respond to opportunities for advocacy within Otolaryngology, both for your patients as well as for the community in which we practice and populations at large.
  - Demonstrate familiarity with important determinants of health relevant to Otolaryngology such as environmental noise exposure
  - Encourage behaviors that promote hearing protection and conservation at work and at home
  - Facilitate patients' access to local and national resources available for the hearing impaired
  - Encourage behaviors that reduce/eliminate risk factors for the development of head and neck cancer (e.g.: tobacco, alcohol, UVA/UVB sun exposure)

## **6. Scholar Role:**

As Scholars the otolaryngology residents demonstrate a lifelong commitment to reflective learning, as well as the creation, dissemination, application and translation of medical knowledge. The resident is thought and evaluated on these issues:

- Actively participate in the teaching of medical students (didactic, in clinics, and on Wards / in OR)
- Facilitate learning in patients and other health professionals
- Actively participate in preparation and presentation of weekly hospital and grand rounds
- Demonstrate a critical appraisal of research methodology, biostatistics, and the medical literature as part of monthly Journal Clubs
- Develop, implement, and monitor a personal educational strategy and seek guidance for this educational strategy as appropriate
- Contribute to the development of new knowledge through participation in clinical or basic research studies
- Demonstrate commitment to evidence based standards for care of common problems in Otolaryngology
- Demonstrate the evolving commitment to, and the ability to practice, life-long learning
- **The scholar role is evaluated especially on:**
  - Actively participate in the teaching of medical students (didactic, in clinics, and on wards/in OR)
  - Facilitate learning in patients and other health professionals

- Actively participate in preparation and presentation of weekly hospital and Grand Rounds
- Demonstrate a critical appraisal of research methodology, biostatistics, and the medical literature as part of monthly Journal Clubs
- Practice the skill of self-assessment
- Develop, implement, and monitor a personal Educational strategy and seek guidance for this Educational strategy as appropriate
- Demonstrate the evolving commitment to, and the ability to practice, life-long learning
- Contribute to the development of new knowledge through participation in clinical or basic research studies
- Demonstrate commitment to evidence based standards for care of common problems in Otolaryngology
- Actively participate in weekly academic rounds series including advance preparation for the topic(s)
- Demonstrate the evolving commitment to, and the ability to practice, life-long learning

## **7. Professional Role:**

- As professionals the otolaryngology residents are committed to the health and well-being of individual s and society through ethical practice, profession-led regulation, and high personal standards of behavior. The resident is thought and evaluated on these issues:
  - Deliver highest quality care with integrity, honesty, and compassion
  - Exhibit appropriate professional and interpersonal behaviors
  - Practice medicine and Otolaryngology in an ethically responsible manner
  - Recognize limitations and seek assistance as necessary
  - Seek out and reflect on constructive criticism of performance
  - Endeavour to develop an appropriate balance between personal and professional life to promote personal physical and mental health/well-being as an essential to effective, life-long practice
  - Demonstrate a commitment to their patients, profession and society through participation in profession-led regulation, e.g. recognize and respond to others unprofessional behavior in practice, understand the legal and ethical codes of practice
- **The Professional role is evaluated especially on:**
  - Deliver highest quality care with integrity, honesty, and compassion
  - Exhibit appropriate professional and interpersonal behaviors
  - Practice medicine and Otolaryngology in an ethically responsible manner

- Recognize limitations and seek assistance as necessary
- Seek out and reflect on constructive criticism of performance
- Endeavor to develop an appropriate balance between personal and professional life to promote personal physical and mental health/well-being as an essential to effective, life-long practice
- Demonstrate a commitment to their patients, profession and society through participation in profession-led regulation (e.g.: recognize and respond to other unprofessional behavior in practice, understand the legal and ethical codes of practice)

# **APPROVED RESEARCH LABORATORIES**

**2013-03-18**

## **VOICE LABORATORY RESEARCH PROGRAM**

Research Lab: Voice Laboratory  
Site: The Montreal General Hospital  
Director: Dr. Karen Kost

The Voice Laboratory, situated at the Montreal General Hospital (Room C2.125) is a clinical and research unit for voice and laryngeal disorders. Technology available includes video-laryngostroboscopy and spectrography.

The Voice Lab supports multi-disciplinary endeavours between laryngologists, speech-language pathologists, voice scientists and vocal pedagogues.

The following fields of research are suggested:

1. Objective assessment of vocal disability in patients and laryngeal dystonia
2. Ultrasound guided injection of Botulinum Toxin to vocalis muscle
3. Optical biopsy of vocal fold lesions using fluorescent spectroscopy
4. A study of vocal fold asymmetry (vertical height) using focused low energy laser patterns
5. Application of informatics to the multi-modality assessment of vocal pathology
6. Acoustic and visual measurements of reinforced harmonic phonation (complex vibratory modes in overtone singing)

## **AUDITORY MECHANICS**

Research Lab: Auditory Mechanics Laboratory  
Site: Dept. of Biomedical Engineering, Duff Medical Bldg.  
Director: W. Robert J. Funnell, Ph.D., Eng., Assoc. Professor

The overall objectives of the research in this laboratory are improved diagnosis and treatment of hearing disorders, based on a quantitative understanding of the mechanical behavior of the middle ear. Our approach involves the development and analysis of three-dimensional computer-based finite-element models. The goal is to enhance:

1. The design of techniques and prostheses for middle-ear surgery; and
2. The clinical evaluation of middle-ear and inner-ear function.

The theoretical work in this lab is done in close collaboration with experimental work in other labs, especially Dr. W. Decraemer's lab in Antwerp and Dr. S. Daniel's lab here at McGill. The 3-D models are built using very high-resolution MRI, X-ray CT and histological data obtained here and elsewhere. Please see Web site at <http://audilab.bmed.mcgill.ca>

### **OTL RESEARCH LABORATORY**

Site: Royal Victoria Hospital (E4)  
Supervisors: Dr. A. Katsarkas, Dr. H. Galiana, Ph.D.  
Tel. No. 842-1231 ext. 4974

In the OTL Research Laboratory, under the directorship of Drs. A. Katsarkas and H. Galiana, the main research thrust is in the function and dysfunction of the vestibular system in humans. The Laboratory is equipped with a rotating chair, computer-driven, and a rigid platform. The computer facilities of the Department of Biomedical Engineering are also available for this type of work. In addition, we have a fully equipped routine ENG Laboratory and facilities for the study of otolith function using auditory-evoked stimuli (VEMP).

Any project involving human experimentation in the area of the function and dysfunction of the vestibular system can be supported by our facilities. Projects involving mathematical modeling of the vestibular and related functions can also be supported.

### **MCGILL AUDITORY SCIENCES LABORATORY**

Site: Montreal Children's hospital  
Supervisors: Dr S. Daniel, Dr R Funnell, PhD

This laboratory has implemented a collaborative research program in pediatric and adult auditory processes, with strong clinical and biomedical engineering components.

### **BASIC RHINOLOGY RESEARCH**

Location: Meakins-Christie Laboratories  
Supervisors: Drs. Q. Hamid and S. Frenkiel

This Laboratories deals with ongoing basic research projects dealing with the molecular biology of chronic rhinosinusitis. Patient material is coordinated through the nasal and sinus unit of the Jewish General Hospital. The resident is involved with all aspects of tissue sampling and analysis. The resident is also enrolled as a clinical fellow of the Meakins-Christie Laboratories

for the duration of the project. The laboratory is well established and has produced numerous publications of international stature.

### **WIRELESS INFORMATICS IN HEALTH CARE DELIVERY**

Location: SMBD Jewish General Hospital  
Director: Dr. Bernard Segal, PhD  
Co-investigators: Dr C Trueman, PhD, Dr T. Pavlasek, PhD, Dr. R Grad,  
Dr. R Tamblyn, PhD, Dr J. Barkun

This highly interdisciplinary group was established in response to concerns that radio waves (due to walkie-talkies, cellular phones, wireless LANs, etc.) can cause life-supporting medical equipment to malfunction. A new component of this study will examine how to best integrate wireless informatics and evidence-based medicine (including mobile access to patient information) into health care.

### **RESEARCH IN HEAD AND NECK ONCOLOGY**

Physiology Department (Dr. John White's Lab)

Location: McIntyre Medical Sciences Bldg.  
Investigators: Dr. John White, PhD, Dr. Martin J. Black  
Title of research: **Vitamin D & retinoids: Chemo-prevention studies of head & neck cancer.**

Department of Oncology - Epidemiology

Location: Bronfman Building - Pine Ave.  
Investigators: Dr. Edouardo Franco/Dr. M.J. Black  
Title of research: **HPV and oral cancer epidemiologic studies**

Lady B. Davis Research Institute - Jewish General Hospital

Location: Laboratory of Dr. Gerald Batist and Dr. Alaoui-Jamali  
Investigators: Drs. Batist, Alaoui-Jamali, M.J. Black and J. White  
Title of research: **Tissue culture and animal studies of oral cancer**

### **MICROSURGICAL RESEARCH**

Research Lab: Microsurgical Research Laboratory facilities  
Site: Royal Victoria Hospital, L4.53  
Director: Dr. Lucie Lessard

This research unit has been in place for 15 years at the Royal Victoria Hospital in the microsurgical research laboratory facilities and represents about 1,500 sq. ft. of space including two small offices for residents and medical students involved in the projects. Computers are available at each station.

Dr. Lessard spends 15-30% of her time in this laboratory. In 1997, the Masters of Science program in experimental surgery has received numerous honors. A total of 8 awards were received. Dr. M. Elahi, an otolaryngology resident, was a research fellow and he published 2 peer-reviewed articles. Dr. B. Mizerny, another otolaryngology resident, also received one American award for her work and published one article in a peer-reviewed journal.

### **Past and Present research:**

**Laryngeal transplant project:** The first clinical laryngeal transplant was done recently in the U.S. (January 1997). We have several branches to this project including the assessment of several immunosuppression protocols using a rat model. This project is progressing nicely and we are now successful at proceeding with a heterotopic laryngeal transplant in this animal model. This will be ongoing for several years. The reinnervation of the larynx is another portion of the project.

**Ultrasound assessment of the maxilla:** We have been studying the maxilla with the ultrasound system to assess the thickness of the maxilla in preparation for implant surgery. This has been completed as well with the B-mode ultrasound and will be submitted for publication soon. This is in collaboration with biomedical engineering. Dr. Shuren Wang has been our fellow working full-time on this project.

**Ultrasound:** A non-invasive in-vivo assessment of the skull - A new modality: We have been working at establishing a clinical tool to assess the skull thickness to harvest cranial bone graft safely. This research was completed and received eight prizes, American, Canadian and Provincial. It was also the winning clinical research at the Fraser Gurd Day in Surgery in 1997. This research has brought about many presentations as well as one article published in the Journal of Craniofacial Surgery. Another article has been accepted by the Annals of Plastic Surgery. This ultrasound technology has been submitted for U.S. patent using A-mode ultrasound for skull assessment. This project is now complete.

***RESEARCH IN OTHER LABORATORIES MAY BE PERFORMED,  
ONLY WITH APPROVAL OF THE RESEARCH COMMITTEE***

# **EDUCATIONAL COURSES**

## **FACIAL PLASTIC SURGERY** **CADAVER DISSECTION COURSE** 2013-03-18

**Course Instructor:** Dr. Nabil Fanous

**Course objectives:**

- To review the anatomy of the face and neck as it relates to facial plastic surgery
- To perform all the major facial plastic surgery procedures (Rhinoplasty, Blepharoplasty, face lift and SMAS manipulation, otoplasty, etc.) on cadaver heads.
- After performing each surgery, surgical dissection is done to expose the deep structures and find out how things look on the inside at the end of each procedure.

### **IMPORTANT**

**Bring with you:**

- a. the notebook from last year facial plastic surgery course
- b. a white coat
- c. a set of septorhinoplasty from the OR in you hospital (good for 2 Residents)
- d. any 4 sutures with medium/large needles (ask OR nurses for disregarded sutures)
- e. A 15 blade
- f. A marker pen
- g. 3 disposable gloves

**FACIAL PLASTIC CADAVERIC DISSECTION COURSE**  
**Course director: Mark Samaha MSc, MD, FRCSC**

**OBJECTIVES:**

1. To gain deeper appreciation of nasal anatomy
2. To understand different types of incisions and approaches used in septoplasty and septorhinoplasty
3. *To have the opportunity to practice various maneuvers in Septoplasty as well as septorhinoplasty*

The course is held at the McGill simulation centre. Two presentations, one related to facial and nasal anatomy, and a second describing surgical technique, are given to the candidates for the first 45 minutes. This is followed by cadaver dissection.

*Eight phenol-fixed cadavers are made available to the candidates. Candidates are given a list of surgical maneuvers to complete. The cadaver dissection session lasts 3 hours. Candidates are assigned to cadavers in teams of one senior and one junior resident to allow for each to gain experience commensurate with their level.*

The instructors circulate around the 8 different stations to provide hands on instruction and demonstrate maneuvers.

## **TEMPORAL BONE COURSE** 2013-03-18

Objectives: On hands training for all R2's and R3's at the new temporal bone laboratory situated at the Montreal Children's Hospital

Course Director: Dr. Sam Daniel

Instructors: Drs. Sweet, Rappaport, Tarantino, Zeitouni,

Text: Otologic surgery, edited by Brackmann, Skelton and Arriaga (1994)  
Temporal Bone Surgical Dissection Manual, by Nelson (1991)

Two bones are allotted per resident

### **Topics covered:**

Facial recess and epitympanotomy (Video 1: myringoplasty)

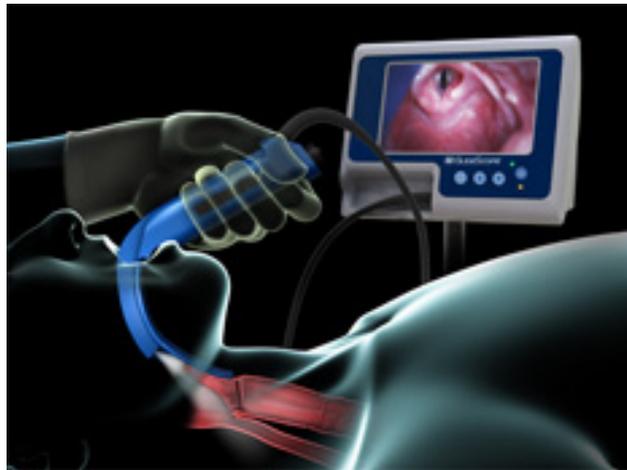
Facial nerve decompression/middle ear

Complete mastoid (videos: ossiculoplasty, tympanoplasty, skin grafting and facial nerve repair)

Labrinthectomy and middle ear fossa (video: otosclerosis, glomus tumor)

Exam at the end of course – supervised by Dr. Sam Daniel

# Advanced Airway Management Simulation (AAMS) Course



- What:** “Hands-On” approach to learning the advanced management of a difficult airway (video-assisted intubation, surgical airway etc...)
- When:** Full-day session  
Tuesday September 14<sup>th</sup>, 2010
- Where:** McGill Medical Simulation Center
- Who:** McGill University residents - by invitation only

For more information, contact  
**Dr Lily HP Nguyen**  
Dept. of Otolaryngology – Head & Neck Surgery  
[lilynguyen1@yahoo.com](mailto:lilynguyen1@yahoo.com), 514-412-4304

# **Advanced Airway Management Simulation (AAMS) Course**

**Department of Otolaryngology - Head and Neck Surgery**  
**Department of Anesthesia**

September 14<sup>th</sup>, 2010

## **Planning Committee:**

**Dr. Lily HP Nguyen, Dept. of OTL-HNS, Course Director**

Dr. Francesco Ramadori, Dept. of Anesthesia

Dr. Angelina Guzzo, Dept. of Anesthesia

McGill Medical Simulation Center – Linda Crelinstein and Guylaine Neveu

## **Invited Faculty:**

Dr. Natalie Buu, Dept. of Anesthesia, MCH

Dr. Karen Kost, Dept. of Otolaryngology – Head & Neck Surgery, MGH

Dr. John Manoukian, Dept. of Otolaryngology – Head & Neck Surgery, MCH

Dr. Catherine Paquette, Dept. of Anesthesia, MCH

Dr. Tarek Razek, Dept. of Surgery, MGH

Dr. Keith Richardson, Senior Resident, Dept. of OTL-HNS

## **Overall Goal of Course**

To overcome the barriers of teaching difficult airway management to residents

Barriers of teaching difficult airway management

- Infrequent training opportunities for obtaining specific skills (Low frequency of Difficult airways in the general population).
- Difficulty in justifying a difficult airway as a hands-on teaching case
- Early staff intervention during difficult airway cases
- Lack of accepted protocols in difficult airway management

## **Course Objectives**

- Provide trainees with the opportunity to practice using the numerous advanced airway devices and skills, including the development of airway algorithms.

- Provide trainees with a simulation of the high stress environment that accompanies difficult airway management
- Provide residents with exposure to difficult airway scenarios not covered in ACLS or ATLS

### **COURSE OUTLINE**

Trainees will be taught using combination of lectures (theoretical base) and case based simulations (practical hands-on experience) in the McGill Medical Simulation Center. The full day teaching course will be divided into morning and afternoon sessions. During each session all trainees will rotate through 7 stations, each representing a major teaching objective in advanced airway management. Each station will have key teaching points that will also be addressed. Lectures will review the scientific basis of each airway technology.

#### **Registered Participants (Total n = 38)**

- Anesthesia (n = 6)
- Otolaryngology (n = 8)
- Emergency Medicine (n = 3)
- General Surgery (n = 13)
- Sports Medicine (n = 0)
- Critical Care Fellows (n = 8)
- Critical Care Staff (n = 1)

## Schedule

8:30 – 9:00 am	Welcome Breakfast + Introduction
9:00 – 10:00 am	Lecture Dr. Angelina Guzzo: <i>The Difficult Airway</i>
10:00 – 10:30 am	Station
10:30 – 11:00 am	Station
<b>Break</b>	
11:15 – 11:45 am	Station
11:45 am – 12:15 pm	Station
<b>Lunch</b>	
1:00 – 1:30 pm	Station
1:30 – 2:00 pm	Station
2:00 – 2:30 pm	Station
2:30 – 3:00 pm	Station
3:00 – 3:15 pm	Short post-test + Closing remarks

### **Details of Each Stations**

Conference Room – Introduction, Lecture and Closing Remarks

<b>Station</b>	<b>Duration</b>	<b>Site</b>	<b>Leader</b>
Fiberoptic Familiarization	30 min	Large Conference Room	Keith Richardson
Video-Assisted Intubation	30 min	Technical Skills Room	Catherine Paquette
Anticipated Difficult Airway	30 min	Technical Skills Room	Natalie Buu
Emergency Surgical Airway	30 min	Technical Skills Room	Tarek Razek
Controlled Open Tracheostomy	30 min	Technical Skills Room	Karen Kost
Pediatric Airway	30 min	Small Conference Room	John Manoukian
Simulation Scenarios	1 hour	High-fidelity Simulation Room	Angelina Guzzo / Francesco Ramadori

### **Station 1. Anticipated Difficult Airway**

**Station Leader: Dr. Sonia Charbonneau, Dept. of Anesthesia**

**Major teaching objective:** To familiarize the trainee with the different techniques available in an anticipated difficult intubation

#### **Key teaching objectives:**

1. Preparation of patient and setting
2. Key points in positioning of the patient
3. Airway maneuvers
  - a. Cricoid pressure
  - b. BURP technique
  - c. 2 man technique
4. Indications and contraindications of:
  - a. Stylet intubation
  - b. Gum elastic bougie
  - c. Light Wand
  - d. LMA
  - e. Tube exchanger
5. Hands-on practice of above mentioned techniques

### **Station 2. Pediatric Airway**

**Station Leader: Dr. Sam Daniel, Dept. of Otolaryngology**

**Major teaching objective:** Outline the major differences of the pediatric airway.

#### **Key teaching objectives:**

1. Familiarize trainee with the differences of a pediatric airway:
  - a. Preparation and positioning
  - b. Laryngeal landmarks
  - c. Laryngoscope blades
  - d. Endotracheal tubes
    - I. Indications for cuffed vs uncuffed ETT
  - e. Tracheostomy tubes
2. Congenital malformations and syndromes
3. Pediatric subglottic stenosis and implications on intubation

### **Station 3. Controlled Surgical Airway**

**Station Leader: Dr. Karen Kost, Dept. of Otolaryngology**

**Major teaching objective:** To familiarize the trainee with the anatomy, indications and techniques of securing a surgical airway.

#### **Key teaching objectives:**

1. Indications and Contraindications of
  - a. Planned Tracheotomy
  - b. Awake Tracheotomy
2. Hands-on practice of above mentioned techniques
3. Innovative Surgical Airway
4. Tips and Tricks in dealing with acute surgical airway

### **Station 4. Airway Trauma**

**Station Leader: Dr. Paola Fata, Dept. of General Surgery**

**Major teaching objective:** To highlight the challenges of securing an airway in a patient with a traumatized upper airway and of obtaining a quick surgical airway.

#### **Key teaching objectives:**

1. Indications and contraindications of:
  - a. Cricothyrotomy
  - b. Needle jet ventilation
2. Hands-on practice of above mentioned techniques

**McGill Department of Anesthesia & OTL-HNS**  
**Simulation Scenario Template**

**Case Title:** Airway Fire  
**Date Submitted:** 2008-09-26/ March 2012  
**Authors:** F. Ramadori  
R. Fisher  
LHP Nguyen  
**Level of Learner:** PGY-3, PGY-4

**Scenario in a nutshell:**

OTL-HNS surgeon performs a suspension microlaryngoscopy for CO2 laser removal of JRRP in a child. Accidental airway fire occurs after ignition of an eschar. OTL and Anesthesiology must deal with airway fire and burnt ETT, must re-establish airway and ventilation, and must plan for post-op care.

This scenario can be run in 2 ways.

- Both anesthesiology and OTL are in the room from the get go.
- Anesthesiology has stepped out to help in another room. The RT is present so anesthesiology must be called back in.

**Goals and Objectives:**

- Close reassessments and reevaluation given the patient's risk of rapid deterioration
- Recognizes limits of his/her abilities
- Calls for help - anesthesia, ICU, OTL-HNS
- Assigns appropriate roles to team members, including knowing their limitations
- Call for difficult airway equipment
- Call for surgical airway equipment

**Assessment and Diagnosis:**

- Turn off oxygen and anesthetic gases
- Turn off source of fire (laser)
- Clamp ET tube and remove
- Administer water down airway
- Call for difficult airway equipment and surgical airway equipment
- Immediate re-intubation
- Endoscopic examination of airway

- Appropriate investigation for lower lung injury
- Investigate for CO poisoning
- Implement protective ventilation strategies (i.e. ARDS prevention)
- Arrangement for ICU

## **ETHICS & COMMUNICATIONS COURSE COURSE:**

Course co-directors: Dr. L. Nguyen and Dr. J. Rappaport

Date: October 23, 2012

A four-year curriculum, based on the RCPSC's Position Paper on Biomedical ethics, was developed to teach medical ethics to Otolaryngology - Head and Neck Surgery residents.

Through the use of simulation-based standardized encounters, residents attend yearly courses and learn the key knowledge, skills and attitudes to appropriately deal with ethical issues in a variety of medical settings.

The simulation structure is Otolaryngology-Head and Neck Surgery specific. The evaluation and feedback is done first in the debriefing period by the supervising otolaryngology staff, two observing otolaryngology residents and the actor, (full 360 feedback by peers, staff, actor, self). Also a general debriefing is done by all otolaryngology staff involved, all residents and the invited professional in the field according to the scenarios. Individual resident evaluation is also reviewed by the program director during their 6 months evaluation. These are the scenario topics:

2012 Scenarios:

- 1) Surgery, yes please! Blood, no thank-you!, Informed consent in a Jehovah's witness
- 2) Speaking into my OTHER ear!, Medical error in SNHL
- 3) It's going to be OK., Breaking bad news Ca in JRLP

2011 Scenarios:

- 1) But I need to drive! Patient-physician relationship
- 2) A Flirtatious Encounter, Patient-physician relationship
- 3) Strategic Collection of Data, Research ethics

2010 Scenarios:

- 1) We told him not to move, truth telling and communication (disclosure)
- 2) You don't want to treat my dying father? Incompetent patient
- 3) But I can't keep living with this, resource allocation / waiting times

2009 Scenarios:

- 1) New Thyroid Cancer Diagnosis, Delivering bad news new thyroid cancer diagnosis
- 2) Do not resuscitate (DNR) my mother, do not resuscitate (DNR) Head and neck Oncology patient
- 3) Ooops wrong ear? Medical error-ooops-wrong ear operated

2008 Scenarios:

- 1) Medical error, telling the truth for performance of tracheostomy during sinus surgery
- 2) Obtaining informed consent to mastoid surgery

### 3) HIV infection confidentiality

## **CRISIS RESOURCE MANAGEMENT COURSE (CRM)**

**Course co-director: Dr. L. Nguyen**

**Date: April 24, 2012**

The program is a simulation-based inter-specialty team-training course in CRM with specific focus on inter-specialty team training between residents from Anesthesia, OTL-HNS, and EM.

An initial pilot study is planned for April 25th 2012, in which senior residents from the above specialties will be invited to participate. The format will be a one-day course at the Arnold and Blema Steinberg McGill Medical Simulation Center. The session will begin with a 30-minute introductory lecture on principles of crisis resource management and introduction to the high-fidelity mannequin. Residents will then participate in and observe high-fidelity simulations. These simulations will include scenarios (10 to 12 minutes in length) designed to represent crisis situations that would necessitate them to collaborate with an inter-specialty and multidisciplinary health care team (specifically the specialties of the participants). All possible combinations of inter-specialty teams involving the three specialties will be covered in the selected scenarios, which will be set in either a simulated emergency room (ER), operating room (OR), or post-anesthesia care unit (PACU), as appropriate. The scenarios are designed to require inter-specialty collaboration in order to build teamwork and crisis resource management skills. The focus of the simulation will be to assess residents' ability to function in an inter-specialty and multidisciplinary team to manage the crisis at hand. The other roles of the multidisciplinary team members (e.g. nurses, respiratory therapists (RT)) will be played by either healthcare professionals from these domains familiar with these clinical environments, or if unavailable, by residents not participating in the course acting in these roles). Each debriefing session (20 minutes in length) will be facilitated by trained staff physicians from all three specialties and will be held after each scenario with a focus on principles and skills of CRM and inter-specialty teamwork.

The full implementation of the program will take place in Fall 2012. The new senior residents of all three specialties will be invited to participate in a one-day course, as described above, with a 6-week and a 4-month follow-up session.

## **Basic techniques in endoscopic sinus surgery (ESS)**

**Location:** The McGill Medical Simulation Centre.

**Co-directors:** Marc Tewfik and Mark Samaha

**Invited Faculty:** Saul Frenkiel, Martin Desrosiers, Shamim Khan

### **Introduction**

Chronic rhinosinusitis (CRS) is a heterogeneous disease that is generally treated with medical measures and for which surgery is reserved for medically refractory cases. The surgical procedure is generally tailored to the severity of disease; however, every sinus surgery is a progression of several basic steps. The aim of this course is to teach common techniques for performing these steps in a safe fashion and to allow residents to gain proficiency on cadavers prior to operating on patients.

The session will consist of a half-day of lectures followed by one or two days of hands-on dissections. Ten cadaveric heads as well as endoscopic surgical workstations will be provided, and the enrollment would be limited to Otolaryngology residents from the Quebec universities.

### **Learning Objectives**

After attending this workshop, otolaryngology trainees will:

1. Become familiar with basic ESS techniques, including the surgical steps of each technique
2. Be able to discuss the indications and contraindications of ESS
3. Become familiar with the instrumentation required
4. Be able to discuss the postoperative management after ESS.

### **Lecture Schedule – Wednesday May 23, 18:30 pm, Carmine’s Tuscany Grill, 5525 Chemin de la Côte Saint Luc, Montreal**

18:45 – Introduction – **Dr. Mark Samaha**

19:00 – Sinonasal anatomy & radiology – **Dr. Marc A. Tewfik**

19:20 – Question period

19:30 – Basic steps in ESS – **Dr. Mark Samaha**

19:50 – Question period

20:00 – Avoiding complications – **Dr. Saul Frenkiel**

20:20 – Question period

20:30 – Postoperative care – **Dr. Martin Desrosiers**

20:50 – Question period

### **Live Dissection Schedule – Thursday May 24 am & pm**

8:00 – Breakfast, lecture room

8:30 – Intro & Orientation, lecture room – **Marc Tewfik**

8:45 – The Maxillary sinus: demonstrator prosections, dissection lab – **Mark Samaha and Martin Desrosiers**

- The sickle knife anterograde uncinectomy
- Swing-door retrograde uncinectomy
- Antrostomy enlargement

9:00 – The Maxillary sinus: registrant cadaver dissections, dissection lab

10:00 – The Ethmoid sinuses: demonstrator prosections, dissection lab – **Saul Frenkiel and Shamim Khan**

- The anterior ethmoidectomy
- The posterior ethmoidectomy
- Clearing the skull base and lamina papyracea

10:30 – The Ethmoid sinuses: registrant cadaver dissections, dissection lab

12:00 – Lunch break, lecture room

13:00 – Sphenoid sinuses: demonstrator prosections, dissection lab – **Mark Samaha and Marc Tewfik**

- The trans-ethmoid sphenoidectomy
- The trans-nasal sphenoidectomy

13:30 – The Sphenoid sinuses: registrant cadaver dissections, dissection lab

14:30 – The Frontal sinus: demonstrator prosections, dissection lab – **Martin Desrosiers and Marc Tewfik**

- Draft IIA procedures
- The axillary flap frontal recess dissection
- Frontal sinus mini-trephination

14:45 – The Frontal sinus: registrant cadaver dissections, dissection lab

16:00 – Course adjourns

Ancillary procedures (if time permits)

- Endoscopic septoplasty
- Sphenopalatine artery ligation
- Orbital decompression
- Lateral canthotomy and inferior cantholysis

## **LARYNGOLOGY COURSE: Director: Dr. Karen Kost**

This is a didactic and hands-on practical course for otolaryngology residents, who wish to improve their laryngology knowledge and phonosurgery skills. The course will cover common and uncommon voice disorders and their management. Participants will learn the basics of stroboscopy and the interpretation of stroboscopy findings so they can be incorporated into day-to-day practice. The techniques of thyroplasty, percutaneous injection, augmentation and transnasal esophagoscopy will be demonstrated and practiced.

The course content includes didactic lectures (with a minimum of 25% interactive question and answer sessions with each lecture) and hands-on practical skills sessions.

At the end of the course, participants will:

1. Understand the diagnosis and management of common vocal disorders.
2. Be able to perform stroboscopy and interpret the findings.
3. Have acquired the skills necessary for Type I thyroplasty and laryngeal injection techniques.
4. Appreciate the indications, contraindications and steps for percutaneous tracheotomy.

## **Other educational activities**

Review course for preparation of Royal College exam – sponsored by the Canadian Society of OTL-HNS for all **R5's yearly**, Halifax

Canadian Society of Otolaryngology – H&N Surgery – Endoscopic Sinus Course for **R3's yearly**.

**All residents** are encouraged to attend and to present at the Canadian Society of OTL-HNS and the American Academy of OTL-HNS

# **McGill Otolaryngology Double-program Master of Science**

## **Selection of Master's projects and supervisors**

Projects may be selected from the residency-training manual, or from projects described in Annual Grand Rounds session, "On-going research". Joint supervision by both a basic scientist and a clinician is required.

## **Double-program Master of Science**

Exceptional McGill OTL residents may be permitted to enter a double-program Master's, combining both normal residency and Master of Science activities. Double-program activities must start 6 months before the Enrichment year starts, and normally continue after the end of the Enrichment year.

## **MSc Degree requirements**

1. Course work (OTOL-602, OTOL-603, OTOL-612, OTOL-613, and 513-607 (Epidemiology))
2. Attendance at Research Topics seminars with Dr Segal
3. Presentation at Resident Research Day and at a national or international Scientific Meeting
4. Two seminars: (a) A *Progress seminar* during the first year, (b) A *Thesis seminar* about 2 months before submission of thesis. On request, the Research Committee may permit combination of these 2 seminars.
5. A thesis. It is expected that thesis material will be lead to at least one paper in a high-quality Journal

## **MSc course work**

The M.Sc. program comprises a minimum of 45 credits as follows:

Physiology, Histopathology and Clinical Otolaryngology 1 OTOL-602 - 3 credits;  
Physiology, Histopathology and Clinical Otolaryngology 2 OTOL-612 - 3 credits;  
Advanced Scientific Principles of Otolaryngology 1 OTOL-603 - 3 credits;  
Advanced Scientific Principles of Otolaryngology 2 OTOL-613 - 3 credits;  
Principles of Inferential Statistics in Medicine 513-607 - 3 credits or equivalent;  
Thesis 1 OTOL-690 - 3 credits  
Thesis 2 OTOL-691 - 3 credits;  
Thesis 3 OTOL-692 - 6 credits;  
Thesis 4 OTOL-693 - 6 credits;  
Thesis 5 OTOL-694 - 12 credits;

When appropriate, courses OTOL-602, OTOL-612, OTOL-603 or OTOL-613 may be replaced by other basic-science or clinical (500-level or higher) courses of relevance to Otolaryngology, as recommended or approved by the Department. Students aiming to acquire an interdisciplinary background will be expected to take additional elective courses, at the undergraduate level if necessary.

### **Courses**

**OTOL-602 PHYSIOLOGY, HISTOPATHOLOGY AND CLINICAL OTOLARYNGOLOGY 1** (3 credits). University and hospital rounds and seminars presenting various topics in Clinical Otolaryngology. Dr. S. Daniel (6 hr/wk).

**OTOL-603 ADVANCED SCIENTIFIC PRINCIPLES OF OTOLARYNGOLOGY 1** (3 credits). Lectures in advanced basic-science topics of relevance to the otolaryngologist. Dr. S. Daniel (1.5 hr/wk).

**OTOL-612 PHYSIOLOGY, HISTOPATHOLOGY AND CLINICAL OTOLARYNGOLOGY 2** (3 credits). University and hospital rounds and seminars presenting various additional topics in Clinical Otolaryngology. Dr. S. Daniel (6 hr/wk).

**OTOL-613 ADVANCED SCIENTIFIC PRINCIPLES OF OTOLARYNGOLOGY 2** (3 credits). Lectures in additional basic-science topics of relevance to the otolaryngologist. Dr. S. Daniel (1.5 hr/wk).

**EPIB-607 INFERENCE STATISTICS** (3 credits) Introduction to basic principles of statistical inference. An equivalent course may be substituted, in consultation with the supervisor.

**OTOL-690 THESIS 1** (3 credits). A literature search and research proposal under supervision of the research supervisor that leads to a written proposal.

**OTOL-691 THESIS 2** (3 credits) Supervised training and research in connection with the Master's thesis.

**OTOL-692 THESIS 3** (6 credits) Independent research in connection with the Master's thesis.

**OTOL-693 THESIS 4** (6 credits). A seminar and written report to be presented to an ad hoc committee describing appropriate progress at the end of the first year of training.

**OTOL-694 THESIS 5** (12 credits). Independent study in connection with the Master's thesis. Presentation of results at a departmental seminar, or at a scientific meeting. Presentation of *Thesis seminar* about 2 months before the student plans to submit the thesis. Completion and final acceptance of the M. Sc. Thesis by the Department and Faculty of Graduate Studies.

### **Suggested Timetable for Courses**

<b><u>Course Number</u></b>	<b><u>Course Title</u></b>	<b><u>Credits</u></b>
<u>First year: First semester (January-April)</u>		
OTOL-690	Thesis 1	3
OTOL-602	Physiology, Histopathology & Clinical Otolaryngology 1	3
OTOL-603	Advanced scientific principles of Otolaryngology 1	3
EPIB-607	Inferential statistics	4
<u>First year: Second semester (May-August)</u>		
OTOL-691	Thesis 2	3
OTOL-692	Thesis 3	6
<u>First year: Third semester (September-December)</u>		
OTOL-612	Physiology, Histopathology & Clinical Otolaryngology 2	3
OTOL-613	Advanced scientific principles of Otolaryngology 2	3
OTOL-693	Thesis 4	6
<u>Second year: Fourth semester (January-April;</u> possibly 5 <sup>th</sup> semester (May-Aug.) & 6 <sup>th</sup> (Sept.-Dec.)		
OTOL-694	Thesis 5	12
		Totals: 45 <sup>+</sup>

## Summary of Activities of Enrichment-year Double-Program-Master's Students

### Year preceding start of the Enrichment year

Jan-Jul	Find research project and two supervisors (Basic & Clinical).
Jan-Jul	Exceptional candidates consider applying for grant with proposed supervisor
May-Jun**	Attendance at May-June "On-going research" Rounds & May-June Research Topics lecture, "Planning your next clinical project"
<b>Jul</b>	<b>Apply for admission to Master's on Minerva (date for guaranteed consideration: Sept. 15 for Winter term)</b>
<b>Oct 30*</b>	<b>Submit <u>Preliminary version</u> of <i>Research Proposal Form</i> (see Dr Segal) to Research Committee</b>
Oct	Submit timetable for activities and courses to Research Committee
Nov-Dec	Present proposed research activities at Research Committee Meeting
Oct-Dec	Following project approval, obtain ethics approval, if required

### Enrichment-year & Double-program-Master's start

Jan	Progress tracking starts, using 6-month cycle (Jan-Jun; July-Dec)
Jan 1	Double-program 6-month intensive research block starts
<b>Jan 15*</b>	<b>Submit Progress Tracking Forms (resident &amp; supervisors: Form 1, Jan-Jun)</b>
Jan	Review literature & submit <u>Initial version</u> of <i>Research Proposal Form</i>
Jun 30	Double-program 6-month intensive research block ends
<b>Jun 30*</b>	<b>Deadline for submission of <u>Final version</u> of <i>Research Proposal Form</i> for OTOL-690 (Thesis 1)</b>
<b>Jul 5*</b>	<b>Submit Progress Tracking Form (resident: Form 2, Jan-Jun)</b>
<b>Jul 15*</b>	<b>Submit Progress Tracking Forms (supervisors: Form 3, Jan-Jun; resident &amp; supervisors: Form 1, Jul-Dec)</b>
Jul	Informal progress report to Research Committee
Aug	Start paper writing
Oct 1	Analysis & writing continues during clinical rotations
<b>Dec 15*</b>	<b>Submit Progress tracking Form (resident: Form 2, Jul-Dec)</b>
<b>Dec 15*</b>	<b>Submit <i>Final Report</i></b>
<b>Dec 30*</b>	<b>Submit Progress Tracking (supervisors: Form 3, Jul-Dec)</b>

### Enrichment-year ends; Double-program Master's continues

<b>May*</b>	<b>Presentation at Departmental Research Day and/or at National meeting for OTOL-693 (Thesis 4)</b>
Jan-Dec	Progress Tracking continues using 6-month cycle, as in previous year
Feb	<i>Thesis Seminar</i> (2 months before thesis submission) may be required
Mar	Submit advanced draft of thesis to Research Committee for Thesis-Submission Approval, <u>at least 1 month</u> before Graduate Faculty submission.
Apr	Submit acceptable thesis to Graduate Faculty for OTOL-694 (Thesis 5)
Jul-	Keep Research Committee informed of presentations, publications, awards, etc
<b>* denotes deadlines      ** Not implemented in 2008</b>	

# **McGILL OTOLARYNGOLOGY FELLOWSHIP**

## **PROGRAM**

**18/03/2013**

### **Fellowship Committee Members:**

Dr. Jamie Rappaport (Fellowship Director)

e-mail: [jrappapo@ent.jgh.mcgill.ca](mailto:jrappapo@ent.jgh.mcgill.ca)

Dr. Karen Kost, Dr. Saul Frenkiel, Dr. Bernard Segal, Dr. A. Katsarkas, Dr. Sam Daniel

### **Fellowships available:**

#### *Research:*

Laryngology

Dr. K. Kost

Neurotology:

Dr. J. Rappaport, Dr. A. Katsarkas, Dr. A. Zeitouni

Rhinology:

Dr. S. Frenkiel, Dr. M. Desrosiers, Dr. M. Samaha

Pediatrics:

Dr. M. Schloss, Dr. T. Tewfik, Dr. J. Manoukian, Dr. S. Daniel

Head & Neck (2yr)

Dr. M.J. Black, Dr. M. Hier, Dr. K. Kost

Vestibular:

Dr. A. Katsarkas

### **Fellowship requirements:**

Fellows will be directly responsible to the Director of the Fellowship Training Program and the Otolaryngologist-in-Chief of the hospital where the Fellow is based. The Fellowship will be classified as research or clinical, as determined by the Fellowship Committee and confirmed by the office of the Dean of the McGill Faculty of Medicine.

Fellows doing a research fellowship will follow similar research guidelines as Enrichment-year residents. This will include submission of a research proposal, implementation of the research project, presentations to the Research Committee (e.g., initial, mid-year progress, Grand rounds), and submission of a final report. Fellows must publish a minimum of one research-oriented paper during the fellowship year. Attendance at Research Topics seminars (Dr. Segal) is compulsory.

Clinical and teaching duties, as well as course work, will be determined by the fellow's supervisor, and by the Fellowship Committee. This may include rounds with the resident staff, lectures to medical students and residents, as well as supervision of resident consultations and discussion with attending staff.

Fellows will not compete with the residents for clinical or surgical case material, but will rather complement the training experience of the residents.

**Fellows:**

1996-1997	Dr. Navin Prinja (Facial Plastics, Dr. N. Fanous)
1997-1998	Dr. Khalid Al-Ghamdi (Facial Plastics, Dr. N. Fanous) Dr. Youssef Al-Ghamdi (Facial Plastics, Dr. N. Fanous)
1998-1999	Dr. Shelly Browning (Neuro-otology) Dr. Ashraf Al-Benayan (Neuro-otology, until Dec. 1999) Dr. Ahmed Al-Ammar (Pediatrics, Dr. M. Schloss) Dr. Carolynne Tawile (Facial Plastics, Dr. N. Fanous) Dr. Khalid Al-Ghamdi (Facial Plastics – 6 months, Dr. N. Fanous) Dr. Max Sawaf (Facial Plastics – 6 months, Dr. N. Fanous)
1999-2000	Dr. Khalid Al-Sebeih (Facial Plastics: Dr. N. Fanous/ Head & Neck: Dr. M.J. Black) Dr. Abdul Bassas (Facial Plastics, Dr. N. Fanous) Dr. Walid Al-Ghamdi (Facial Plastics – 6 months, Dr. N. Fanous)
2000-2001	Dr. J. Bernardez (Rhinology/Otology: Dr. S. Frenkiel) Dr. Adul-Hadi Yamani (Facial Plastics , Dr. N. Fanous) Dr. Hanh H. Hugo (Facial Plastics – 6 months, Dr. N. Fanous)
2001-2002	Dr. M. Rowshani (Rhinology: Dr. S. Frenkiel)
2002-2003	Dr. A. Hussain (Rhinology: Dr. M. Desrosiers) Dr. Fardin Eghtedari (H&N: Drs. M. Black & Hier) Dr. Iman L. Salem (Facial Plastics, Dr. N. Fanous) Dr. Aman Obeid (Facial Plastics – 6 months, Dr. N. Fanous)
2003-2004	Dr. Udi Cinamon (H&N: Drs. M. Black & Hier) Dr. Walid Abou-Hadam (Rhinology: Dr. M. Desrosiers)
2004-2005	Dr. Mohammed Al-Garni (Pediatrics: Dr. J. Manoukian)
2005-2006	Dr. Mohammed Al-Garni (H&N: Drs. Kost, Hier, Black)
2006-2007	Dr. Jason Hwang (Rhinology: Drs. Desrosiers, Samaha) Dr. Basel Al-Sabah (Pediatrics: Dr. M. Schloss) Dr. Saleh Al-Ghamdi (Clinical/Research) Rhinology

2007-2008 Dr. Hasan Al-Shemari (Pediatrics: Drs. Schloss, Manoukian, Tewfik, Daniel and Nguyen)  
Dr. Saleh Al-Ghamdi (Rhinology: Drs. Desrosiers, Samaha)

2008-2009 Dr. Limor Muallem Kalmovich (H&N: Drs. M. Black & Hier)  
Dr. Fahad Al-Saab (Pediatrics: Drs. Schloss, Manoukian, Tewfik, Daniel and Nguyen)  
Dr. Hadi Hakami (H&N: Drs. Hier, Black, Kost)

2009-2010 Dr. Hadi Hakami (H&N: Drs. Hier, Black, Kost)  
Dr. Yayha Al-Badaai (Rhinology: Drs. Samaha, Frenkiel)  
Dr. Yaser Al-Rajhi (Pediatrics: Drs. Schloss, Manoukian, Tewfik, Daniel and Nguyen)

2010-2011 Dr. Eyal Sela (H&N: Drs. Hier, Black)  
Dr. Nadine Yammine (Laryngology: Dr. K. Kost)

2011-2012 Dr. Eyal Sela (H&N: Drs. Hier, Black)  
Dr. Koby Pitaro (Pediatrics: Dr. Sam Daniel)

2012-2013 Dr. Mandana Jeevanandam (H&N: Drs. Hier, Black)  
Dr. Constanza Valdes (Rhinology: Drs. Tewfik, Samaha)  
Dr. Alissa Kanaan (Pediatrics: Dr. Daniel)

# **Responsibilities and academic involvement of the Head and Neck Fellow**

**2013-03-18**

## **Preamble**

The head and neck oncology service at McGill is divided between the Jewish General Hospital and the McGill University Health Center that includes the Montreal General and the Royal Victoria Hospitals. The head and neck fellow will spend time both at the Jewish General Hospital and the McGill University Health Centre. He/she may go to any site as need be for special events. During the fellowship year, the fellow will be accountable to the site director for his activities that are clearly outlined below and the Director of Head and Neck Oncology at McGill.

The fellow is expected to be an asset to the program and become heavily involved in teaching residents and students during all their daily clinical activities. In addition, the fellow should expect to be involved in teaching in the operating room and to assist residents. The fellow will not compete with residents, but rather will be involved at a level suitable to his training. This means more active participation in difficult or revision cases that are unsuitable for chief residents, and more of a teaching role in cases that are in fact suitable for resident training. In addition, the fellow is expected to be actively involved in teaching and role modeling in all of the seven CanMEDS roles; medical expert, communicator, collaborator, manager, health advocate, scholar and professional. During the year, the fellow must produce at least one research project that is suitable for presentation either at the Canadian Society of Otolaryngology Annual Meeting in the late spring, or at the American Academy of Otolaryngology meeting in the fall. These papers will jointly be submitted for publication in the associated journal.

## **Pedagogical duties**

1. **Academic half day**: The academic half day is held every Tuesday afternoon from 3:00 to 6:00 p.m. The fellow is expected to teach at least 2 of these academic half days. He/she may be requested to provide additional small teaching sessions to the residents as requested.
2. **Grand rounds**: The fellow is expected to prepare and present a minimum of two grand rounds yearly. In addition, he/she will assist residents in their preparation of grand rounds on head and neck topics. Grand rounds are held at the Royal Victoria Hospital, JSL Browne Amphitheatre from September to December and at the Jewish General Hospital in the JGH Block Amphitheatre from January to June.
3. **Journal Clubs**. The fellow is expected to attend and to participate actively in the preparation of journal clubs. The fellow will be responsible for the presentation of a

minimum of three articles throughout the academic year and will be involved in helping and assisting junior and senior residents in their preparation for journal club. There are 4 journal clubs held at the Montreal Children's Hospital.

4. **Exams:** The head and neck fellow may be requested to actively participate in setting and giving both written and oral examinations and to assist chief residents in their graduating year in exam preparation. This may include the administration of mini-oral exams to the chief residents prior to the Royal College certification examination.
5. **On-Call:** Fellows will provide back-up call to the residents.
6. **Vacation/Academic time off:** This may be of 4-week duration but **not during the month of May or June.**

### **Clinical duties**

1. **Tumor Boards:** Tumor board rounds are held at the Jewish General Hospital every Monday from 3:00 to 4:00 p.m. and at the Royal Victoria Hospital every Thursday from 4:00 – 5:00 p.m. The fellow is expected to participate in the preparation of cases and to present cases as well as assist residents in presenting their own cases. He/She is to play an active role in the discussion. Tumor boards at both sites are multi-disciplinary in nature and involve the surgeons, the radiation oncologists, medical oncologists, nurses, and social workers.
2. **Ward rounds:** Ward rounds should be completed daily in the morning and in the evening with the residents and should be used as an opportunity for teaching, reviewing problems/complications, and reviewing the care of the patient.
3. **Emergency room/ward consults:** The fellow shall be actively involved with the residents in all pertinent emergency room and ward consults as they pertain to head and neck surgery. This provides an opportunity for teaching and interacting with the residents in terms of discussing and implementing a treatment plan. These consults should later be reviewed with the appropriate staff.
4. **Tumor Clinics:** Head and neck oncology clinics are held on Mondays and Thursday mornings at the Jewish General Hospital, on Tuesday at the Montreal General Hospital and Thursday afternoons at the Royal Victoria Hospital. All these clinics are multi-disciplinary in nature and provide ample opportunities for collaboration and interaction with colleagues and allied health personnel in other specialty areas. The fellow is expected to be present at the head and neck tumor clinics and to participate in seeing patients and in teaching residents during those clinics.
5. **Operating Room:** The fellow is expected to be present and to participate in as many head and neck cases as possible. For cases appropriate at a resident level, the fellow will assume more of a teaching and supervisory role while in complex and revision cases, the fellow will be more directly involved. Teaching during surgery includes guidance and instruction as to soft tissue handling, appropriate dissection techniques around vascular and neural structures, instruction of appropriate reconstruction, all in the context of head

and neck oncology. Head and neck cases are generally performed on Tuesday and Wednesday at the Royal Victoria Hospital and occasionally there is skull base surgery on Thursday at the Royal Victoria Hospital. Head and neck surgery at the Jewish General Hospital takes place every Wednesday, Thursday and Friday all day. The fellows will be completely supervised by attending staff in the operating room.

6. **Minor reconstructive procedures:** These are carried out on a weekly basis, Monday mornings, at the Montreal General Hospital, and include local and regional flaps and skin graft reconstruction for a variety of facial defects, post-MOHS surgery. Some of these reconstructive procedures are also done at the Royal Victoria Hospital.
7. **Surgical Exposure:** The head and neck fellow will be exposed to the full array of head and neck procedures, including: aerodigestive tract surgery, head and neck endocrine surgery, salivary gland surgery, laser surgery of the upper airway and complex head and neck reconstructions.

**It is mandatory that the fellow keep a complete log of his/her OR Cases**

<b>Overview of McGill Clinical Head and Neck Activities*</b>			
	<b>RVH</b>	<b>MGH</b>	<b>JGH</b>
<b><u>Monday</u></b>			AM Clinic & patient review PM Tumor board
<b>Tuesday</b>	+/- <b>OR</b>	Full day tumor clinic	<b>PM Academic half day</b>
<b>Wednesday</b>	<b><u>OR</u></b>		<b><u>OR</u></b>
<b>Thursday</b>	PM Tumor Clinic Tumor Board <b>**Grand Rounds</b>		<b><u>OR</u></b> AM Tumor Clinic PM Patient Review
<b>Friday</b>	+/- <b>OR</b>		<b><u>OR</u></b>

\* As of September 2004

**CanMEDS roles:**

**1. Medical Expert:**

The fellow is expected to have a solid knowledge of basic and clinical sciences as they pertain to otolaryngology in general and the subspecialty of head and neck in particular. He/she shall be actively involved in the teaching of the sciences; that includes performing a history and physical examination, carrying out appropriate diagnostic and therapeutic procedures and ordering appropriate investigations. He/she shall guide and supervise

residents as they become medical experts in the field of otolaryngology – head and neck surgery.

**2. Communicator:**

The role of communicator is essential and the fellow is expected to be a good role model as a communicator and to assist residents in developing and refining their skills as communicators. Throughout training, the role of communicator becomes more complex, particularly when dealing with difficult issues such as palliation and end of life issues.

**3. Collaborator:**

There is ample opportunity to collaborate during the many multi-disciplinary clinics, in the operating room and on the wards. The fellow is expected to exemplify this role and facilitate interaction between the various disciplines and aid the resident in refining their roles as collaborators.

**4. Manager:**

The fellow must have a good basic knowledge of the Canadian health care system as to available resources, and costs associated with them. He/she shall direct or assist the residents in understanding the nature of available resources and how they can best be used.

**5. Advocate:**

The fellow must have a clear understanding of the Canadian health care system, to use it in such a way as to maximally benefit the patient. In addition, the fellow will develop sound knowledge as to health issues particularly as they pertain to head and neck oncology, ex: life style issues such as smoking, alcohol, work exposure, occupational risks, etc. He/she must assist residents to actively seek out pertinent information relevant to these risk factors and offer tools to the patient in order to modify these behaviors or life style choices.

**6. Scholar:**

Fellows are expected to have acquired a solid background in self-directed learning and critical appraisal of the literature. They must pass on these skills to all residents in the

clinical and academic setting. They are expected to be involved in a research project and possibly assist residents who are also involved in research projects.

7. **Professional:**

Fellows must exemplify the highest standards in terms of professional responsibilities and attitude towards their work. Their approach to staff, colleagues, and allied health care professionals should be courteous, polite and respectful. In the multi-cultural diversity of Montreal, sensitivity for ethnic and cultural differences is crucial in establishing a strong relationship with patients and colleagues. Furthermore, fellows are expected to behave in an ethical manner at all times, both with residents, medical students, staff and colleagues. There is ample opportunity for discussion and teaching of ethics at journal clubs, grand rounds and during all clinical activities.

# **McGILL RHINOLOGY FELLOWSHIP GUIDELINES**

*2013-03-18*

## **Objective**

To develop specialised knowledge of medical and surgical management of nasal and paranasal sinus disease in individuals wishing to pursue a career in academic rhinology.

## **Justification:**

The McGill University rhinology group is well known for its expertise in sino-nasal disorders. The McGill Rhinology group offers a unique training opportunity for advanced training by the grouping of its three recognised experts in a common workgroup; the variety and number of procedures performed yearly, and the structured teaching.

## **Eligibility:**

Candidates will be individuals having successfully completed an accredited otolaryngology residency who are interested in pursuing a career in academic rhinology.

Candidate selection will be via a process of application, with selection based on letters of recommendation, academic achievements, and personal interview

Candidates will have to be eligible for a training card from the College des Medecins.

## **Specific objectives:**

At the end of training, the individual will have acquired skills and knowledge allowing him/her to develop and sustain an academic position in rhinology. This will be via the following means:

### **(iii) Medical Rhinology:**

Investigation and medical management of nasal and sinus disorders

Teaching will be through exposure to common nasal and sinus problems presenting for care in tertiary level rhinology clinics in the McGill University hospital network. Drs. Desrosiers, Frenkiel, and Samaha will act as preceptors. Exposure to multiple preceptors

will maximise exposure and allow the candidate to see different approaches. Having the fellow staff a clinic in rhinology will foster their professional development.

The fellow will attend specialized rhinology clinics at least two-half days per week. As well, he/she will be expected to staff one-half day clinic themselves, with attending supervision/consultation. This regular training will be complemented by exposures to allergy, radiology, and migraine clinics over the course of the year.

If possible, the fellow will attend specialized paediatric rhinology clinics at the MCH site.

**(iv) Surgical Rhinology:**

The candidate will participate in pre, per and post operative management of patients presenting for surgery. The candidate's exposure will be tailored to ensure exposure to a broad selection of cases, with a focus on tertiary procedures. Surgery will be performed at the MGH, JGH, and RVH sites. It is understood that priority will be given to residents and that for uncomplicated cases the fellow will primarily assist and teach the residents, rather than perform the cases.

It is expected that the candidate will be exposed to sufficient volume of the following cases to develop a facility with them:

- ESS for anatomic anomalies
- ESS for chronic rhinosinusitis
- ESS for sinonasal polyposis
- Frontal sinus outflow tract surgery
- Revision ESS
- ESS for benign tumours of the sinus and skull base

Endoscopic approaches to the skull base:

Pterygopalatine fossa  
Sphenoid sinus  
Mucocoeles

Orbital procedures:

Optic nerve decompression  
Orbital decompression  
Dacryocystorhinostomy (DCR)

Combined / Open approaches to the sinuses

Osteoplastic flap  
Lateral rhinotomy  
External rhinoplasty  
Caldwell-Luc  
Mid facial degloving

Image guided surgery for ESS

Complementing the above will be:

(v) **Selected readings program:**

The fellow will be furnished a list of selected readings, which will be maintained and kept up to date by the members of the rhinology group. Additional resources and access to the medical literature is available via the Internet from the McGill university libraries free of charge.

(vi) **Attendance at a national meeting**

The rhinology group will arrange to send the fellow to at least one major medical meeting during the fellowship year. This may be to present a paper or to attend a specialised conference.

(vii) **Teaching:**

The candidate will attend all normal activities of the department, including evaluation/follow up of hospitalised patients as required. He/she will also:

- Supervise residents in the OR
- Organise and supervise grand rounds when the subject is rhinology.
- Prepare and deliver lectures for rhinology day
- Teach medical students/residents/community ENT's during organised teaching activities held by the department

(viii) **Research:**

While the primary objective of the experience is not to develop researchers, development of academic skills is important in this fellowship. To this end the fellow will

- Write a review paper (on a topic to be determined with the preceptors) early in the training period to develop research/writing skills.
- Undertake and complete one clinical research project, which they will and present at a national meeting, and prepare the resulting article for publication

Participation in a collaborative project with a basic science effort will be according to orientation of the rhinology group at that time.

# **McGILL LARYNGOLOGY FELLOWSHIP GUIDELINES**

2013-03-18

Fellowship Director: Dr. Karen M Kost, MD, FRCSC, Director of the McGill University Voice and Dysphagia Laboratory.

## **Preamble**

Currently, otolaryngology residents are not eligible to write the certification exams for the American Board of Otolaryngology. As a direct consequence, American fellowships are largely unavailable to Canadian otolaryngology graduates wishing to pursue additional training. This situation has generated a demand, and need, to provide Canadian fellowships. At the present time, there is only one half-time laryngology fellowship available in Canada. McGill is uniquely positioned to offer a fellowship in laryngology.

## **Eligibility Criteria**

Eligible APPLICANTS must be certified otolaryngologists in practice in Canada wishing to undergo advanced training.

## **The McGill University Voice and Swallowing Laboratory**

The Voice and Swallowing Laboratory at the Montreal General Hospital is widely recognized as a center of excellence and provides services to almost 3000 referred patients annually. The Lab contains state of the art equipment complete with an integrated database and digitized recording system. There are clinics five days/week and one to two laryngology OR days per week. This volume is such that the residents have ample exposure to laryngology throughout their training and cannot attend more than a maximum of 2-3 clinics/week. As a result the majority of the clinics are run by the staff alone. Similarly, complex surgical cases are performed by the attending staff. As such, there is ample clinical material to provide excellent training for the residents and one fellow. A fellowship in laryngology would not, in any way, interfere with or compromise resident training in the subspecialty of laryngology.

## **Terms**

There will be a maximum of one available fellowship position per year. The fellowship will last one year and consist of clinical, teaching and research responsibilities. The division of activities will be roughly 50% clinical and 50% research.

Goals and objectives

1. Clinical and research conferences as well as journal clubs are, and will continue to be conducted regularly. These include laryngology rounds and research conferences in collaboration with a McGill basic scientist (Dr. L. Mongeau). The fellow will participate in the planning and conducting of these conferences.
2. The fellow will have supervised opportunities to develop skills in providing consultation and communicating with colleagues and referring physicians. The fellow is expected to teach medical students, residents, and other healthcare professionals. Teaching will occur at the bedside, in the Voice and Dysphagia Lab, as well as in the OR. Furthermore, the fellow will provide both interactive and didactic laryngology lectures to the Otolaryngology residents and Master's students. The fellow will also participate in the planning and execution of a 'Hands-on' Voice and Dysphagia Course for residents at the McGill Simulation centre.
3. The fellow will interact with related disciplines and engage in educational activities to further his/her role as an educator and communicator in the subspecialty of laryngology. There are ample such opportunities at McGill with the multidisciplinary dysphagia clinic (run with the occupational therapist and speech-language pathologist) as one example.
4. As an option a one month rotation at the Montreal Children's Hospital will be provided for pediatric voice and dysphagia exposure.

#### Clinical

- (a) The fellowship will provide structured clinical opportunities for fellows to develop advanced diagnostic, therapeutic and phonosurgical skills.
- (b) A sufficient number and variety of cases will be available for each fellow to assure adequate exposure to the broad range of conditions associated with the management of voice disorders and dysphagia, without in any way compromising the experience or exposure of residents.
- (c) At the end of the fellowship, the fellow will have had a cumulative experience as operating or teaching surgeon on at least 80-100 phonosurgery cases.
- (d) Lines of responsibility will be clearly delineated for trainees and other residents as related to areas of training and clinical duties.

#### Research

- (a) An active research component will enhance and compliment the educational experience. Although the clinical experience is essential, a supervised research experience is expected. The integrated database allows for almost unlimited clinical research possibilities. In addition, collaboration between the Dr Mongeau lab and the voice lab provides opportunities for basic science research.

### **Fundamental Components Of The Fellowship**

- (a) The fellow must participate in the evaluation, management, and care of a minimum of 200 cases of voice disorders/dysphagia.
- (b) Participation in 80-100 surgical procedures, representing the full scope of phonosurgery in voice and swallowing.
- (c) Participation in at least 50 outpatient phonosurgery procedures performed in the clinic. These include vocal fold augmentations and Botox injections.
- (d) Intensive exposure to the interdisciplinary management of patients with voice disorders/dysphagia.
  - (i) Multi-disciplinary clinic participation with Speech-Language Pathologists
  - (ii) Dysphagia management team
- (e) Participation in the development and implementation of research in Laryngology.
- (f) The above objectives will be attained in the context of the seven CanMEDS roles: medical expert, communicator, collaborator, manager, health advocate, scholar and professional.

### **Fellowship Clinical Curriculum**

The fellowship will provide clinical and/or didactic exposure to:

- (a) Videostrobolaryngoscopy
- (b) Full range of voice disorders
- (c) Vocal nodules, cysts, polyps
- (d) Laryngopharyngeal reflux
- (e) Functional voice disorders
- (f) Muscle tension dysphonias
- (g) Speech-Language vocal rehabilitation
- (h) Neurologic voice disorders, including dystonias
- (i) Benign neoplasms, including papillomatosis
- (j) Malignant neoplasms, including squamous cell carcinoma
- (k) Vocal fold paresis/paralysis
- (l) Vocal fold bowing/presbylarynx
- (m) Sulcus Vocalis
- (n) Vocal fold granulomas/ulcers
- (o) Vocal fold scarring
- (p) Glottic stenosis
- (q) Laryngeal manifestations of systemic disease
- (r) Vocal fold injection/augmentation/thyroplasty
- (s) Polypoidal degeneration
- (t) Laryngeal electromyography

- (u) Botox injection
- (v) Applications of CO2 laser
- (w) Microflap techniques
- (x) Endoscopic resection of early glottic cancers
- (y) Functional Endoscopic Evaluation of Swallowing
- (z) Morbidity and mortality conferences
- (aa) Journal clubs
- (bb) Clinical research protocols

### **Evaluation of the fellow and of the staff**

The fellow will be evaluated twice a year. An early informal assessment will be provided in the first 6 weeks. Evaluations will be based on the current CanMEDS roles and modified as appropriate to Laryngology. The fellow will be evaluated on clinical, teaching and research activities as set out in the fellowship curriculum. Evaluations will be performed online and reviewed with the fellow. The fellow will evaluate the staff and fellowship experience twice yearly anonymously online.

### **Summary**

The McGill Voice and Dysphagia Laboratory, with its large and varied clinical volume, is uniquely positioned to provide a much needed high-quality laryngology fellowship in Canada. This fellowship will not in any way compromise resident training and experience. On the contrary, it is expected to enhance resident training through additional clinical and didactic teaching.

# **MONTREAL CHILDREN'S HOSPITAL – PEDIATRIC FELLOWSHIP GUIDELINES**

2013-03-18

The fellow will be directly responsible to the Director of the Fellowship Training Program and the Otolaryngologist-in-Chief of the Montreal Children's Hospital. The fellow will be classified as research or clinical, as determined by the Fellowship Committee and confirmed by the office of the Dean of the Faculty of Medicine at McGill University.

The fellow will follow similar research guidelines as the enrichment year residents. This will include submission of a research proposal, implementation of a research project, presentations to the committee (initial, mid-year progress; fellowship grand rounds) and submission of a final report. The fellow must publish a minimum of one research-oriented paper during the fellowship year. Attendance at research topic lectures (Dr. Segal) is encouraged.

The pediatric fellow will be responsible for:

Rounds with resident staff

- Supervision of all in-patient consultations and discussion with attending staff
- On-call responsibilities for surgical cases he/she is involved with
- Organization of Monday A.M. rounds at the MCH
- Attending specialty clinics

Attending all educational activities in the Department of Otolaryngology at McGill University including university grand round

## 2011-2012 Lectures

Lectures: Lectures will be held every **Thursday afternoon 4pm**

Location: JGH E-711 **or as otherwise specified on monthly schedule**

Attendance: **Resident attendance is compulsory.** Attendance will be recorded and noted on in-training evaluation report.

**This is a tentative schedule. The final lectures are indicated and distributed on the monthly schedule. An e-mail will be sent to each hospital (departmental secretary) if there is a change in topic or location.**

Rev: March 14, 2012

Date	Topic	Lecturer (4:00pm)
Sept 8	Chronic ear disease	Dr Rappaport
Sept 11-14	AAO-HNS, San Francisco, CA	
Sept. 15	Facial nerve (anatomy and pathology ), temporal bone trauma	Dr Sweet
Sept. 22	Hearing loss( CHL ,SNHL ) /otosclerosis /ototoxicity	Dr Rappaport
Sept 29	Lateral Skull Base Lesions (Common CPA tumors )	Dr Zeitouni
Oct 6	TBA	
Oct. 13	Evaluation of the dizzy patient + Nystagmus	Dr Katsarkas
Oct. 20	McNally Lectureship	
Oct. 27	Testing the dizzy patient + ENG	Dr Zeitouni
Nov. 3	Congenital SNHL	Dr Daniel
Nov. 10	H.S. Birkett Memorial Lectureship	
Nov. 17	FMG Interviews ENT JGH all Day	
Nov 24	Congenital airway anomalies	Dr Nguyen
Dec 1	TBA	
Dec. 8	Pediatric neck masses	Dr Daniel
Dec 15	Subglottic stenosis	Dr Manoukian

## 2011-2012 Lectures

Lectures: Lectures will be held every **Thursday afternoon 4pm**

Location: JGH E-711 or as otherwise specified on monthly schedule

Attendance: **Resident attendance is compulsory.** Attendance will be recorded and noted on in-training evaluation report.

Date	Topic	Lecturer (4:00pm)
Jan. 5	Cleft lip and palate	Dr Lacroix
Jan. 12	Radiation for H&N CA <del>Laryngeal Cancer</del>	Dr. Sultanem <del>Dr Hier</del>
Jan. 19	Chemotherapy for H & N Carcinoma	Dr. Kavan
Jan. 26	Laryngeal cancer Radiation for H & N Cancer	Dr. Hier <del>Dr. Sultanem</del>
Feb 2	Melanoma	Dr. Mlynarek
Feb. 9	Oral Pathology diseases of the tongue	Dr Chauvin
Feb. 16	Salivary glands tumors	Dr Hier
Feb. 23	Lip and nose recon	Dr Mlynarek
March 1	Dental Tumors and Cysts	Dr. Lisbona
March 8	Thyroid /parathyroid tumors	Dr Payne
March 15-18	Update in OTL Course Tremblant	
March 22	Oral cavity tumors	Dr Kost
March 29	Voice Rehabilitation & laryngectomy	Gina Mills
<del>April 5</del>	<del>Vocal cords paralysis</del> Raymer Lectureship - JGH	<del>Dr Kost</del> Dr, Gerald Batist
April 12	Mini-orals	
<del>April 19</del>	<del>Benign laryngeal lesions</del>	<del>Dr Kost</del> - COSM meeting
April 26	Professional voice	Dr Chagnon
May 3	Benign voice disorders	Dr Young
May 10-11	20 <sup>th</sup> Annual Resident Research Day/James D. Baxter Lectureship	Dr. KJ Lee
May 17	TBA	
May 20-22	CSO-HNS, Toronto, May 20-22	
May 23-24	FESS Course	SIM Centre (our rhinologists)

## 2012-2013 Lectures

Lectures: Lectures will be held every **Thursday afternoon 4pm**

Location: JGH E-711 or as otherwise specified on monthly schedule

Attendance: **Resident attendance is compulsory.** Attendance will be recorded and noted on in-training evaluation report.

**This is a tentative schedule. The final lectures are indicated and distributed on the monthly schedule. An e-mail will be sent to each hospital (departmental secretary) if there is a change in topic or location.**

Date	Topic	Lecturer (4:00pm)	
Sept. 6	Neck Trauma	Dr. A. Al-Badr	
Sept. 9-12	AAO-HNS Annual Meeting	Washington DC	
Sept. 13	Frontal & Orbital Trauma	Dr. Forest	
Sept. 20	Head and Neck Radiology	Dr. Mark Leventhal	
Sept. 26	Airway Basics Course	Dr. Lily Nguyen – SIM Center	
Sept. 27	Laryngeal Trauma	Dr. Chagnon	
Oct. 4	Nasal Trauma and Epistaxis	Dr. Mark Samaha	
Oct. 11	Mandibular Trauma	Dr. Iera	
Oct. 18	McNally Lectureship	Dr. A. Katsarkas	
Oct. 25	Granulomatous Diseases of the H&N	Dr. Marc Tewfik	
Oct. 26-28	Congrès ORL	Chateau Frontenac	
Nov. 1	Maxillary & ZMC Trauma	Dr. Iera	
Nov. 8	H.S. Birkett Lectureship	Dr. M.J. Corsten (Ottawa)	
Nov. 15	Head and Neck Radiology	Dr. Mark Leventhal (Franca)	
Nov. 22	FMG interviews	Dr. Manoukian	
Nov. 29	Acute Rhinosinusitis	Dr. Marc Tewfik	
Dec. 6	Chronic Rhinosinusitis	Dr. Marc Tewfik	
Dec. 13	Complications of FESS	Dr. Mark Samaha	
Dec. 20	Mini-orals	Dr. A. Zeitouni	

## 2012-2013 Lectures

Lectures: Lectures will be held every **Thursday afternoon 4pm**

Location: JGH E-711 **or as otherwise specified on monthly schedule**

Attendance: **Resident attendance is compulsory.** Attendance will be recorded and noted on in-training evaluation report.

Date	Topic	Lecturer (4:00pm)
Jan. 3	Microbiology of Head and Neck Infections	Dr. D. Vinh (TENTATIVE)
Jan. 10	Endoscopic Excision of Sinonasal Masses	Dr. Mark Samaha
Jan. 17	Free Flaps	Dr. Alex Mlynarek
Jan. 31	Local Flaps	Dr. Manish Khanna
Feb. 4	CARMS interviews	
Feb. 7	Facial Analysis	Dr. Mark Samaha
Feb. 14	Rhinoplasty	Dr. Mark Samaha
Feb. 21	Rhinology - Immunology/Allergy	Dr. Jaime Del Carpio
Feb. 28	Pathology	Dr. Kaglar
March 7	Benign Salivary Gland Lesions	Dr. Martin Black
March 14	COURSE – TREMBLANT	March 15-17, 2013
March 28	Cochlear Implants	Dr. Zeitouni
April 4	Benign Thyroid Diseases	Dr. Tamilya
April 11	Raymer Lecture	Not confirmed
April 18	Cleft Lip/Palate	Dr. Yolene Lacroix
April 25	OSA – Surgical	Dr. Veronique Forest
May 2	OSA – Medical	Dr. Kimmof
May 9	TBD	
May 16	21 <sup>st</sup> Annual Resident Research Day	Not confirmed
May 23	TBD	

May 30	Mini-orals	
June 2-4	CSO-HNS Annual Meeting	Banff, AB

Rev: Monday, 18 March 2013

**DEPARTMENT OF OTOLARYNGOLOGY**  
**UNIVERSITY GRAND ROUNDS**

ROYAL VICTORIA HOSPITAL

THURSDAYS - 5:15 p.m.

**September - December 2011**

AAO-HNS Annual Meeting, San Francisco Sept. 10-14<sup>th</sup>, 2011

Congres ORL 21-23 octobre 2011 Centre Mont Royal

CSO-H&NS Annual Meeting, Toronto, ON May 20-23, 2012

<b>Date</b>	<b>Presenter</b>	<b>Topic</b>
Sept. 10-14	AAO-HNS Annual Meeting	San Francisco, CA
Sept. 15	<b>Hani Al-Marzouki</b>	Otology
Sept. 23	Keith Richardson	H&N
Sept. 29	Jewish holiday Rosh Hashanah	
Oct. 6	Michael Chater	Rhinology
Oct. 13	Staff Rounds Dr. Sam Daniel	CPD Continuing Professional Development
Oct. 20	McNally Lectureship Merck	
Oct. 27	Staff Rounds Dr. Lily Nguyen Alcon	
Nov. 3	Journal Club Takeda	
Nov. 10	H.S. Birkett Memorial Lectureship (Merck)	Dr. John Niparko, Johns Hopkins,
Nov. 17	<del>Mini-Orals</del> FMG interviews ENT JGH all day	Zeitouni/Lily Nguyen
Nov. 24	Nathan Jowett	General ENT
Dec. 1	Yalon Dolev	Trauma/Reconstruction
Dec, 12-14	Annual Temporal Bone Course	Dr. Sam Daniel
Dec. 8	Dr. Tourain FMRQ Takeda	Resources for residents experiencing difficulties
Dec. 15	Rania Ywakim	H+N



# McGill

## DEPARTMENT OF OTOLARYNGOLOGY UNIVERSITY GRAND ROUNDS

THURSDAYS - 5:15 p.m.

### January – May 2012

JEWISH GENERAL HOSPITAL, BLOCK AMPH. Rev:Feb. 29, 2012

Date	Presenter	Topic
Jan. 5	Rickul Varshney	Peds
Jan. 12	Tamara Mijovic	Otology
Jan. 19	Yalon Dolev	Trauma
Jan. 26	Saud Al-Romaih	Rhinology Takeda
Feb. 2	Joseph Schwartz	Peds Alcon
Feb. 9	Yaseen Ali	H+N
Feb. 16	Alipasha Rassouli	General ENT or Rhinology Takeda
Feb. 23	<b>Yazeed Al-Ghonaim</b>	Laryngology
March 1	Faisal Al-Obaid	Otology Alcon
March 8	<del>Journal Club</del>	
March 15-18	Update in OTL – Mt. Tremblant Course	
March 22	Noah Sands	Plastics
March 29	Fellow Rounds Jacob Pitaro	Pediatrics
April 5 April POS	Raymer Lectureship <del>Fellow Rounds Eyal Sela</del>	Dr. Gerald Batiste <del>H+N</del>
April 12	Fellow rounds Dr. Eyal Sela – move to April 19 <sup>th</sup> , 2012.....	H&N

	Raymer Lectureship	
	COSM meeting April 19 <sup>th</sup> , 2012	
April 19	Faisal Zawawi	Otology (moved from Dec. 8 <sup>th</sup> ) Aleon
April 26	Mini-Orals	Zeitouni/Lily Nguyen
May 3	Dr. Frans Hilgers – Holland ATOS Medical	Laryngectomy rehabilitation
May 6&7 Sun&Monday	9 <sup>th</sup> Annual Melvin D. Schloss Pediatric Lectureship	Dr. Peter Koltai D-182 (MGH)
May 10-11 THURS-FRI.	20 <sup>TH</sup> Annual Resident Research Day/James D. Baxter Lectureship	
May 17	TBA	
May 20-23	CSO-HNS Annual Meeting	Toronto, ON

**DEPARTMENT OF OTOLARYNGOLOGY  
UNIVERSITY GRAND ROUNDS**

Jewish General Hospital - THURSDAYS - 5:15 p.m.

**September - December 2012 Version 2e**

AAO-HNS Annual Meeting, Washington DC Sept. 9-12, 2012  
Congrès ORL Le Chateau Frontenac QC, QC 26-28 octobre 2012  
CSO-H&NS Annual Meeting, Banff, AB June 2-4, 2013

<b>Date</b>	<b>Topic</b>	
Sept. 6	Pediatrics	Dr. F. Zawawi
Sept. 9-12	AAO-HNS Annual Meeting	Washington DC
Sept. 20	Rhinology	Dr. C. Valdes
Sept. 27	Otology	Dr. F. Al Obaid (Alcon)
Oct. 4	Plastics	Dr. N. Sands (GSK)
Oct. 11	Stress, distress/intimidation at training sites	Dr. Léon Tourian (ARM, FMRQ) Resident wellness committee lauchere@fmrq.qc.ca
Oct. 18	McNally Lectureship	Dr. A. Katsarkas
Oct. 23	Ethics Day	Dr. L. Nguyen
Oct. 25	Laryngology	Dr. Susan Thibeault U of Wisconsin
Oct. 30	Crisis resource management	PGY4's and PGY5's SIM Centre (Dr. L. Nguyen)
Nov. 1	Surgical Management of TMJ	Dr Jean-Philippe Frechette
Nov. 8	H.S. Birkett Memorial Lectureship	Dr. M. Corsten (GSK) UofOttawa
Nov. 15	Pediatrics	Dr. A. Kanaan (Merck)
Nov. 22	FMG Interviews	
Nov. 29	Journal Club	Dr. T. Mijovic (Takeda-Canada)
	Annual Temporal Bone Course	Dr. S. Daniel (coordinator)
Dec. 6	Rhinology	Dr. A. Al-Jarallah (GSK)
Dec. 13	Laryngology	Dr. A. Al-Bader
Dec. 20	Mini Orals	Dr. A. Zeitouni (coordinator)



# McGill

## DEPARTMENT OF OTOLARYNGOLOGY UNIVERSITY GRAND ROUNDS

THURSDAYS - 5:15 p.m.

### January – May 2013

JEWISH GENERAL HOSPITAL, BLOCK AMPH.

AAO-HNS Annual Meeting, Vancouver, BC Sept 29 – Oct 2, 2013

DATE	TOPIC	PRESENTER
Jan. 3	Pediatrics	Dr. A. Fanous
Jan. 10	Plastics/Reconstructive	Dr. Y. Dolev
Jan. 17	Staff grand rounds	Dr. Mark Samaha
Jan. 31	Rhinology	Dr. J. Schwartz (Merck)
Feb. 7	Trauma	Dr. M. Al-Dosari
Feb. 14	Rhinology	Dr. Y. Al-Ghonaim
Feb. 21	Journal Club	Dr. Y. Al-Ghonaim (Merck)
Feb. 28	Innovative techniques/technologies in otolaryngology	Dr. R. Ywakim (Alcon)
March 7	Otology	Dr. T. Mijovic
March 14	NO ROUNDS	OTL CME COURSE TREMBLANT, QC
March 21	Plastics	Dr. A. Rassouli
March 28	Journal Club	Dr. A. Rassouli
April 4	Head and Neck	Dr. J. Madana
April 11	Raymer Lecture	(Merck)
April 18	Laryngology	Dr. C. Nhan

<b>April 25</b>	<b>Pediatrics</b>	<b>Dr. R. Varshney (Alcon)</b>
<b>May 2</b>	<b>TBA</b>	
<b>May 9</b>	<b>Plastics &amp; Reconst.</b>	<b>Dr. Y. Ali</b>
<b>May 16</b>	<b>21ST ANNUAL RESIDENT RESEARCH DAY/JAMES D. BAXTER LECTURESHIP</b>	
<b>May 23</b>	<b>TBA</b>	
<b>May 30</b>	<b>Mini orals</b>	<b>Dr. A. Zeitouni</b>
<b>June 2-4</b>	<b>Annual CSO-HNS Meeting</b>	<b>Banff, AB</b>

**Pediatric Lectureship 2013** – Dr. Daniel  
(last year May 6-7, 2012)

**Facial Plastic Cadaver Course – Dr. Samaha**  
January 25, 2011  
March 30<sup>th</sup>, 2012

**FESS course:** Drs. Samaha and Tewfik  
(last year May 23-23, 2012)

**Facial Plastics Course** Dr. Fanous  
(last year April 13 & 30<sup>th</sup>, 2012)

**Laryngology Course** Dr. Kost  
(last year March 5-6, 2012)

## **JOURNAL CLUBS 2011-2012**

November 3, 2011  
Dr. Faisal Al-Obaid

November 24, 2011  
Dr. Saud Al-Romaih

March 15, 2012  
Dr. Yalon Dolev

## **JOURNAL CLUBS – 2012-2013**

November 29, 2012  
Dr. Tamara Mijovic  
Sponsored by Takeda-Canada

February 21, 2013  
Dr. Yazeed Al-Ghonaim  
Sponsored by Merck

March 28, 2013  
Dr. Alipasha Rassouli

Otolaryngology Head & Neck Surgery Division  
MCH Resident Teachings

**TUESDAYS**  
**12:00 – 1:00**

**ROOM B-240 OTL CONFERENCE ROOM**

**2012-2013**

**TOPIC TO BE DECIDED BY STAFF OR TRAINEE ONE WEEK PRIOR**

<b>Date</b>	<b>Speaker / Topic</b>
November 20, 2012	Dr. M. Schloss <b>CANCELLED</b>
November 27, 2012	Dr. L. Nguyen
December 4, 2012	Dr. T. Tewfik
December 11, 2012	Dr. A. Kanaan
December 18, 2012	Resident Led by <b>Dr. L. Nguyen</b>
<b>December 25, 2012</b>	<b>STAT HOLIDAY</b>
<b>January 1, 2013</b>	<b>STAT HOLIDAY</b>
January 8, 2013	Dr. M. Schloss <b>NEW ROTATION</b>
January 22, 2013	Dr. L. Nguyen
January 29, 2013	Dr. T. Tewfik
February 5, 2013	Dr. A. Kanaan
February 12, 2013	Resident Led by <b>Dr. M. Schloss</b>
February 19, 2013	Dr. L. Nguyen
February 26, 2013	Dr. M. Schloss
March 5, 2013	Dr. T. Tewfik
March 12, 2013	Dr. A. Kanaan
March 19, 2013	Resident Led by <b>Dr. T. Tewfik</b>
March 26, 2013	Dr. L. Nguyen
April 2, 2013	Dr. T. Tewfik <b>NEW ROTATION</b>
April 9, 2013	Dr. A. Kanaan
April 16, 2013	Resident Led by <b>Dr. L. Nguyen</b>
April 23, 2013	Dr. L. Nguyen
April 30, 2013	Dr. M. Schloss
May 7, 2013	Dr. L. Nguyen
May 14, 2013	Dr. T. Tewfik
May 21, 2013	Dr. A. Kanaan
May 28, 2013	Resident Led by <b>Dr. M. Schloss</b>
June 4, 2013	Dr. M. Schloss
June 11, 2013	Dr. L. Nguyen
June 18, 2013	Dr. T. Tewfik
June 25, 2013	Dr. A. Kanaan

# McNally Memorial Lectureship

## Royal Victoria Hospital LECTURERS

2013-03-18

<u>Year</u>	<u>Speaker</u>	<u>Topic</u>
May 29, 1997	David Tomlinson, Ph.D. University of Toronto	<i>Click-evoked EmG responses of sternocleidomasstoid muscle – A new tesst of otolith function</i>
May 21 1998	Dr. Geoffrey Melvin Jones University of Calgary	<i>An adaptive podokinetic system: Its interaction with the vestibular control of locomotor trajectory and compensatory eye movement</i>
May 27, 1999	Dora E. Engelaka, Ph.D. University of Mississippi	<i>Coding of translational movement in inertial space: Computational problems and neuronal strategies</i>
April 27, 2000	Dr. Richard R. Gacik	The three faces of vestibular gangliomitis
April 2, 2001	Dr. Saumil Merchant	<i>Pathology of the peripheral vestibular system with clinical implications</i>
May 16, 2002	Daniel Guitton, Ph.D.	<i>Scanning a visual scene with eye-head movements: keeping tabs on vestibular quick phases</i>

October 30, 2003	Henrietta Galiana, Ph.D. Department of Biomedical Engineering McGill University	<i>Unmasking clinical vestibular deficits with models and novel nystagmus analysis</i>
November 18, 2004	Dr. Kathleen Cullen Dept. of Physiology McGill University	<i>Discrimination of passive/active head movements by the vestibular system</i>
October 20, 2005	Dr. Lloyd Minor Prof. & Director, OTL H&NS Johns Hopkins, Baltimore, MD	<i>Superior semicircular canal dehiscence syndrome</i>
October 26, 2006	Dr. Aristides Sismanis Douglas G. Hayden Professor and Chairman Department of Otolaryngology – Head and Neck Surgery Richmond, Virginia	<i>Pulsatile Tinnitus: Advances in Diagnosis and Management</i>
October 18, 2007	Dr. Jay M. Goldberg University of Chicago	<i>The Type I Vestibular Hair Cell and its Calyx Ending</i>
October 23, 2008	Dr. David S. Zee John Hopkins University	<i>Disorders of the cerebellum: clues as to how the brain controls the vestibuloocular reflex</i>
November 5, 2009	Athanasios Katsarkas, M.D. Professor, Department of Otolaryngology McGill University and Henrietta Galiana, Ph.D. Professor, Department of Biomedical Engineering	<i>Dizziness, vestibular dysfunction and the engineering interpretation</i>

October 21, 2010	Brian Blakley, M.D. Professor, Dept. of OTL-HNS University of Manitoba	<i>Objective evaluation of vestibular function for clinical purposes</i>
October 20, 2011	Robert E. Kearney, Ph.D. Eng. Professor, Dept. of Biomedical Engineering, McGill University	<i>Dynamic ankle stiffness and the control of upright posture</i>
October 18, 2012	Athanasios Katsarkas, MD FRCS Professor, Dept. of OTL-HNS McGill University	<i>Doctor, I am dizzy</i>

**RAYMER LECTURESHIP**  
**Jewish General Hospital**  
**LECTURERS**

2013-03-18

<b>Year</b>	<b>Speaker</b>	<b>Topic</b>
May 15, 1998	Dr. Mark May <i>Clinical Professor of Otolaryngology Shadywide Hospital Pittsburgh, PA</i>	Facial re-animation – techniques that work- 12- anastomosis with tongue sparing
April 23, 1999	Dr. Marvin P. Fried <i>Beth Israel Deaconess Medical Center, Boston Director, Harvard Head and Neck Oncology Program</i>	Image guidance for otolaryngologic surgery
April 6, 2000	Dr. Robert Maisel <i>Chief, Department of Otolaryngology, Head and Neck Surgery Hennepin County Medical Center Professor, Department of Otolaryngology – H&amp;N Surgery University of Minnesota</i>	Sleep apnea – medical and surgical approaches
April 19, 2001	Dr. Jeremy L. Freeman <i>Professor, Department of Otolaryngology – H&amp;N Surgery University of Toronto Temmy Latner/Dynacare Chair in H&amp;N Oncology Mount Sinai Hospital</i>	Management of thyroid cancer in the 21 <sup>st</sup> century – What we have learned in the 20 <sup>th</sup> century
April 11, 2002	Dr. Peter Adamson <i>University of Toronto</i>	New treatment concepts in facial cosmetic surgery

2003	Cancelled (SARS in Ontario)	
April 5, 2004	Dr. Anthony Jahn <i>New York, NY</i>	Clinical approach to the professional voice patient. Otosclerosis: Clinical and histopathologic aspects
April 28, 2005	Dr. William Rea <i>University of Texas</i>	Sinusitis – environmental medicine perspective
April 27, 2006	Dr. Pierre Laverdu <i>Cleveland, OH</i>	Organ preservation – the last 20 years Management of the neck in organ preservation
April 26, 2007	Dr. Michael Tamilia <i>McGill</i>	The role of thyroglobulin in the management of thyroid cancer
April 17, 2008	Dr. Erin Wright <i>University of Edmonton</i>	Contemporary management of Inverted Papilloma
April 30, 2009	Dr. Dominique Dorion <i>University of Sherbrooke</i>	Anybody cares about the surgeon's QOL after surgery?
April 15, 2010	Dr. Richard Béliveau <i>Professor, Department of Chemistry, UQAM</i>	Preventing chronic diseases
April 14, 2011	Dr. Jimmy Gutman <i>Jewish General Hospital</i>	Glutathione: Essential Health AID – Antioxidant, immune booster, detoxifier
April 5, 2012	Dr. Gerald Batist <i>Professor of Oncology/McGill</i>	Personalized Medicine in Cancer: Our Contributions

**MELVIN D. SCHLOSS PEDIATRIC LECTURESHIP**  
**Montreal Children's Hospital**  
**LECTURERS**

2013-03-18

<u>Year</u>	<u>Speaker</u>	<u>Topic</u>
March 24, 2004	Dr. Fred Kozak, Director of Otolaryngology B.C. Children's Hospital	Hearing Loss
March 17, 2005	Dr. Christopher Hartnick Mass. Eye & Ear Inf. Harvard University	Pediatric laryngology – the past, the present and the future
April 12, 2006	Dr. Steven Sobol Emory University Atlanta	Airway problems in children
May 2, 2007	Dr. Paolo Campisi University of Toronto	Diagnosis and management of pediatric voice disorders
Feb. 4, 2008	Dr. Michael J. Rutter University of Cincinnati College of Medicine	Current advances in the management of laryngotracheal stenosis
Feb. 2, 2009	Dr. Vito Forté Professor, University of Toronto	Surgical Management of Thyroid Diseases in Children
May 10, 2010	Dr. Patrick Froehlich Professor, l'Hôpital Edouard Herriot of Lyon, France Chief, Pediatric Otolaryngology L'Hôpital de la Femme de la Mère et de l'Enfant de Lyon	Minimally-invasive surgery in pediatric otolaryngology
	Karen Gordon, Ph.D. Director of Research, Cochlear Implant Laboratory, Hospital for Sick Children, Toronto	Can cochlear implants reverse effects of deafness in the central auditory system?

May 2, 2011	Dr. Sylvie Lafrenaye	Post-operative analgesia: the tonsillectomy challenge
May 6-7, 2012	Dr. Peter J. Koltai, Chief Pediatric Otolaryngology Lucile Packard Children's Hospital, CA	Chevalier Jackson and the evolution of surgical instrumentation for airway foreign bodies

# **Herbert Stanley Birkett Memorial Lecture**

*2013-03-18*

The Birkett Memorial Lecture is held annually in October or November each year to commemorate Dr. Herbert S. Birkett, the first otolaryngologist-in-chief at McGill University. Renowned lecturers are invited from around the world to present papers. The lecture is given in the afternoon and is followed by a dinner in the evening. This event is sponsored by the Montreal Medico-Chirurgical Society - Section of Otolaryngology. All members of the Society are invited as well as residents from three Quebec training programs, McGill University, Université de Montréal and Université de Sherbrooke.

## **BIRKETT LECTURERS**

<b><u>Year</u></b>	<b><u>Speaker/Topic</u></b>
1934	Hector Mortimer Factors in the development and growth of the human paranasal sinuses
1935	Dr. E. Van Campenhout The origin of the acoustic ganglion Dr. P.E. Goldsmith Traps and pitfalls in otolaryngology
1936	Dr. A.C. Furstenberg Acute infections of the throat, mouth and cervical regions
1937	Dr. C.P. Martin The anatomy of the accessory sinuses and the eustachian tube
1938	Dr. Hayes Martin Cancer of the tongue
1939	Dr. F.M. Rackemann Asthma and sinus disease
1940	Dr. S.J. Crowe Prevention of deafness
1941	Dr. Whaley Some ear, nose and throat problems of aviation medicine
1942	Dr. Gabriel Tucker Tumours of the larynx, their diagnosis and treatment
1943	Dr. J.R. Lindsay

Recent progress in the management of acute middle ear suppuration

- 1944 Dr. Leroy A. Schall  
Personal experiences with cancer of the larynx
- 1945 Dr. O.E. Van Alyea  
A critical analysis of the management of chronic ear disease
- 1946 Major E.H. Van truex  
A kind of deafness
- 1947 Dr. Samuel Fomon  
Rhinoplasty as an adjunct to the armamentarium of the otolaryngologist a  
and its important bearing on the physiology of the upper respiratory tract
- 1948 Dr. James H. Maxwell  
Surgery of the parotid gland
- 1949 Dr. Baruch Silverman  
Hearing and speech, a challenge to the community
- 1950 Dr. Stacey R. Guild  
Nasopharyngeal irradiation and hearing acuity; a follow-up study
- 1951 Dr. G.E. Shambaugh  
Contributions of audiology to fenestration surgery
- 1952 Dr. D.E.S. Wishart  
Hearing test should benefit the deaf patient
- 1953 Dr. Stewart Nash  
The otolaryngological consultant in liability and compensation cases
- 1954 Dr. Hans Kobrac  
The function of the middle ear in health and disease
- 1955 Dr. H.R. Myklebust  
Deafness and related problems in young children
- 1956 Dr. Francis Lejeune  
Suspension laryngoscopy
- 1957 Dr. D. Baker  
Chronic lesions of the larynx

- 1958 Dr. P.E. Meltzer  
Recent trends in otological surgery
- 1959 Dr. J.J. Conley  
The significance of the lump in the neck
- 1960 Dr. Merle Lawrence  
The deafened, the otologist and the Zeitgeist
- 1961 Dr. Paul A. Campbell  
Space medical research in the USAF
- 1962 Dr. Paul A. Holinger  
The place of perioral endoscopy in present day medicine
- 1963 Dr. Harold Schuknecht  
Sensorineural hearing loss; pathology and diagnosis
- 1964 Dr. Milos Rasek  
The pitfalls of ultrasonic treatment of Meniere's Disease
- 1965 Dr. Francis Lederer  
The influence of environmental and medical progress in otolaryngology
- 1966 Dr. John Kirchner  
Carcinoma of the larynx
- 1967 Dr. Charles Morris  
Trends in the management of cancer of the larynx
- 1968 Dr. Franz Altman  
Surgical treatment of Meniere's Disease
- 1969 Dr. William J. McNally  
The labyrinth and the physician
- 1970 Dr. H. Rosenwasser  
Glomus tumours of the ear
- 1971 Dr. John Dickenson  
Reconstructive principles in head and neck surgery
- 1972 Dr. M. Stuart Strong  
Microscopic laryngoscopy. The laser in laryngology.
- 1973 Dr. David Austin  
Ossicular problems in chronic otitis media

- 1974 Dr. Burton Jaffe  
Congenital abnormality of the ear – surgery
- 1975 Dr. Max Som  
Hemilaryngectomy experience with 500 cases
- 1976 Dr. R. Bellucci  
Tympanoplasty
- 1977 Dr. H. Tucker  
Vocal cord paralysis
- 1978 Dr. G. Melvill-Jones  
The vestibular system
- 1979 Dr. Hugh Biller  
Conservation surgery of the larynx
- 1980 Dr. Mark Singer  
Voice rehabilitation after laryngectomy
- 1981 Dr. Malcolm Graham  
Chronic ear disease
- 1982 Dr. Mark May  
Facial nerve paralysis – management
- 1983 Dr. C. Krause  
Cancer of the head and neck
- 1984 Dr. William House  
Acoustic Neuroma
- 1985 Dr. William S. Crysedale  
The drooling child
- 1986 Dr. Murray Morrison  
Dysphonia and dysphagia
- 1987 Dr. Arnold M. Noyek  
Imaging of Head and Neck Structures
- 1988 Dr. P.W. Alberti  
Occupational hearing loss
- 1989 Dr. Donald F. Harrison

Surgical management of hypopharyngeal cancer using the Agastric pull-up

- 1990 Dr. Victor Schramm Jr.  
Skull base surgery
- 1991 Dr. Hugh Barber  
Careers: What shall I do after my residency?
- 1992 Dr. R. Gacek  
Differential diagnosis of otitis media  
Dr. D. Ellis  
Revision rhinoplasty: analysis and correction
- 1993 Dr. Robert Simons  
Rhinoplasty - personal techniques
- 1994 Dr. Robin Cotton  
The role of a special centre in pediatric laryngnology
- 1995 Dr. Rodney Lusk  
Pediatric chronic sinusitis - Surgical management and outcomes
- 1996 Dr. James D. Baxter  
The Legacy of Herbert Stanley Birkett
- 1997 Dr. Jack Gluckman  
Gene therapy for head and neck cancer - The future is now?
- 1998 Dr. Lauren Holinger  
Avoiding Tracheotomy: Alternative strategies in infants and children with severe upper airway obstruction
- 1999 Dr. Simon Parisier  
Individualized single operation management of Cholesteatoma
- 2000 Dr. Eugene Myers  
The management of tumors of the parapharyngeal space
- 2001 Dr. Steven Handler  
Parotid lesions in children  
Airway obstruction in children: Making the right decisions
- 2002 Dr. Richard Hayden  
Advances in head and neck reconstruction  
Pharyngo-esophageal reconstruction
- 2003 Dr. Lorne Parnes

The latest spin on BPPV  
Intratympanic pharmacotherapy for inner ear disorders

- 2004 Dr. Ricardo Bento  
Temporal Bone Fractures  
Cochlear Implants
- 2005 Dean Abraham Fuks, Faculty of Medicine  
Reframing Medicine
- 2006 Dr. Jeremy Freeman  
Re-operation for thyroid cancer
- 2007 Dr. Karen Calhoun  
Mechanisms of allergy immunology  
Reconstruction of facial skin defects
- 2008 Dr. Clark A. Rosen  
Vocal Fold Injection 2008  
12 steps to improved phonomicrosurgery
- 2009 Dr. Gary Clayman  
Management of thyroid cancer
- 2010 Dr. Patrick Gullane  
Thirty years of head and neck: Lesions learned – Imagine the future
- 2011 Dr. John K. Niparko  
Childhood development after cochlear implantation
- 2012 Dr. Martin Corsten  
Expanded endonasal approaches to the skull base

**Annual Resident Research Day**  
**James D. Baxter Lectureship**

2013-03-18

**LECTURERS**

<b><u>Year</u></b>	<b><u>Speaker</u></b>	<b><u>Topic</u></b>
1993	Dr. Howard Lampe <i>Chairman and Chief Department of Otolaryngology University of Western Ontario</i>	Use of Fine Needle Aspiration Biopsy in Head and Neck
1994	Dr. Martin J. Black <i>Director of Head and Neck Surgery and Oncology Sir Mortimer B. Davis Jewish General Hospital</i>	Head and Neck Surgery & Oncology in the 21 <sup>st</sup> Century
1995	Dr. Athanasios Katsarkas <i>Director, Department of Otolaryngology Royal Victoria Hospital</i>	Alternative Medicine - It is an alternative, but is it Medicine?
1996	Prof. Leonidas Manolidis <i>University of Thessaloniki Greece</i>	Congenital Dysplasias of the Ear
1997	Dr. Kevin Clarke <i>Division Head, Pediatric Otolaryngology Ass't Professor, Department of Otolaryngology, Dalhousie University</i>	Surgical Management of Choanal Atresia
1998	Dr. Mark May, <i>Clinical Professor of Otolaryngology- H&amp;N Surgery, Shadyside Hospital, Pittsburgh, PA</i>	Endonasal approach to the anterior base skull
1999	Dr. Joseph B. Nadol <i>Chief of Otolaryngology Massachusetts Eye and Ear Infirmary Professor and Chairman Department of Otology and Laryngology Harvard Medical School</i>	Cochlear Implants

2000	Dr. William H. Novick <i>Associate Professor Dept. of OTL-H&amp;NS McGill University</i>	General otolaryngology in the academic setting - past, present, and future
2001	Dr. André Lamothe <i>Assistant Profess/Program Director Department of OTL-H&amp;NS University of Ottawa</i>	Oropharyngeal carcinoma: What Is realistic to expect from salvage Surgery
2002	Dr. Melvin Mendelsohn <i>Associate Professor Dept. of Otolaryngology/McGill</i>	Stapes Surgery at McGill - Then and Now
2003	Dr. William Potsic <i>Head, Pediatric Otolaryngology Children's Hospital of Philadelphia</i>	Congenital cholesteatomas
2004	Dr. David Eibling <i>Professor, Otolaryngology University of Pittsburgh, PA VA Hospital, PA</i>	Some guys and gals have all the luck! Assessment and management of dysphagia
2005	Dr. Jason Frank, <i>Royal College of Physicians &amp; Surgeons of Canada</i>	The CanMeds Project and the competencies of the 21 <sup>st</sup> Century surgeon
2006	Dr. Ian Witterick <i>Associate Professor, Department of Otolaryngology, University of Toronto</i>	Skull base surgery
2007	Dr. Nabil Fanous <i>McGill University</i>	My personal philosophy on how to manage time, work...and life!
2008	Dr. Michael McKenna <i>Harvard University</i>	Etiology of otosclerosis Superior Canal Dehiscence Syndrome
2009	Joseph Chen <i>Associate Professor, Department of Otolaryngology – H&amp;N Surgery University of Toronto</i>	The management of the facial nerve in skull base surgery
2010	Dr. Nader Sadeghi <i>Associate Professor, Surgery</i>	Evidence-based evaluation & treatment of the neck in head & neck

	<i>Director, H&amp;N Surgery George Washington University</i>	cancer
2011	<i>Dr. Manohar Bance, Professor, Acting Head, Div. of Otolaryngology, Dalhousie Nova Scotia</i>	Future trends in otology
2012	<i>Dr. K.J. Lee, Southern New England, Ear, Nose &amp; Facial Plastic Group LLP</i>	What kind of doctor – person will you be? Potpourri of thoughts Pointer & pitfalls of stapedectomy

# **ROYAL COLLEGE OF PHYSICIANS AND SURGEONS** **REQUIREMENTS FOR TRAINING**

## **OBJECTIVES OF SURGICAL FOUNDATION AND TRAINING (version 1.1 2011)**

**please go to this link:**

[http://rcpsc.medical.org/residency/certification/objectives/surgical\\_foundations\\_otr\\_e.pdf](http://rcpsc.medical.org/residency/certification/objectives/surgical_foundations_otr_e.pdf)

## **OBJECTIVES OF TRAINING IN THE SPECIALTY OF OTOLARYNGOLOGY – HEAD AND NECK SURGERY (version 1.0 2011)**

**Please go to this link:**

[http://rcpsc.medical.org/residency/certification/objectives/otolaryngology\\_e.pdf](http://rcpsc.medical.org/residency/certification/objectives/otolaryngology_e.pdf)

## **SPECIALITY TRAINING REQUIREMENTS IN OTOLARYNGOLOGY – HEAD AND NECK SURGERY (version 1.0 2011)**

**Please go to this link:**

[http://rcpsc.medical.org/residency/certification/training/otolaryngology\\_e.pdf](http://rcpsc.medical.org/residency/certification/training/otolaryngology_e.pdf)

**Evaluation and Promotion  
in Postgraduate Training Programs**  
*July 1, 2012*

[http://www.medicine.mcgill.ca/postgrad/welcometopostgrad\\_evaluationpromotions.htm](http://www.medicine.mcgill.ca/postgrad/welcometopostgrad_evaluationpromotions.htm)

**Office of Postgraduate Medical Education  
Faculty of Medicine  
McGill University**

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## **PREAMBLE**

This document "Evaluation and Promotion in Postgraduate Training Programs" contains the rules and regulations governing the evaluation and promotion of all Residents and Fellows in postgraduate training programs at McGill University. It is the personal responsibility of each Resident and Fellow to read this document and to be familiar with its content. The Faculty of Medicine at McGill University uses the Medical Rotation Evaluation System (MRES – one45 software), an on-line web-based evaluation system, to provide residents and faculty with formal evaluations of clinical rotations.

July 2012

1. **TERMINOLOGY:** This section defines the terms used throughout the present document.
  - 1.1 **Academic Year:** The academic year commences July 1 and finishes on June 30. On occasion a resident will be out of phase, e.g. have a starting date other than July 1.
  - 1.2 **Period (or Block):** A period or block is of 4-weeks duration. There are 13 periods in each academic year.
  - 1.3 **Rotation:** A rotation refers to the "content" of the experience, and may be of any duration (e.g. 2 weeks to 3 months). In some programs, a rotation may be a "longitudinal" experience, e.g. half-day a week for 6 months.
  - 1.4 **REPEAT (rotation):** This refers to a rotation that is being repeated because of a BORDERLINE or UNSATISFACTORY assessment. A Resident undertaking a REPEAT rotation is evaluated by the usual methods.
  - 1.5 **REMEDIAL (rotation):** This term refers to a rotation that has been designed to address specific weaknesses of a Resident who has performed poorly. A REMEDIAL rotation will only occur during a Probationary Period and the Resident is not formally evaluated during a REMEDIAL rotation.
  - 1.6 **FACULTY POSTGRADUATE PROMOTIONS COMMITTEE:** This Committee is a standing Committee which reports to the Associate Dean for Postgraduate Medical Education, and has the primary responsibility of monitoring the evaluation and promotion of Residents.
  - 1.7 **RESIDENTS:** Residents refers to all Residents and Fellows registered as students at McGill University in Postgraduate training programs.
  - 1.8 **ADVISOR:** An advisor is an individual chosen by a resident or a Faculty member. The advisor must be a member of the University Community, but is not a member of the legal profession and is not paid for his or her services. In all hearings under these guidelines, the resident and the Faculty member are entitled to have an advisor present. The Advisor's role is to provide support to the resident or Faculty member; he/she is not a witness or participant in the proceedings.

## 2. GENERAL PRINCIPLES

The Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada and the Collège des médecins du Québec, all require satisfactory final evaluations before a resident is admitted to the certification examinations:

- 2.1 Each training program will have written learning objectives, and the Residents will be provided with these objectives upon entering the program.
- 2.2 The evaluation process is based on these training objectives.
- 2.3 The Program Director ensures that Residents are familiar with the rules and regulations governing evaluation and promotion.
- 2.4 All Residents will receive a copy of the document: "Evaluation and Promotion in Postgraduate Training Programs".
- 2.5 The evaluations are confidential documents. Access should be restricted to the Program Director (or delegate), any individual or Committee responsible for making Promotion decisions, external certification and licensing bodies, and the Resident him/herself. Evaluation information on a Resident should not be transmitted from one supervisor to another. Under exceptional circumstances, such as those which might relate to issues of patient safety, information might be transmitted by the Program Director, but then only with the utmost discretion.
- 2.6 **Improper Conduct:** In addition to being students of the University, the Residents and Fellows are physicians, and therefore must be governed by the policies of the professional bodies, such as the Collège des médecins du Québec, the Canadian Medical Association (Code of Ethics) and others, and by policies of the Faculty of Medicine, including the Faculty of Medicine Code of Appropriate Conduct and Disciplinary Procedures as outlined in the McGill University Student and Responsibilities Handbook. Violation of any of these standards or policies may constitute improper conduct.

### **3. THE EVALUATION PROCESS**

- 3.1 A Resident will receive a written evaluation at the end of each rotation, usually after a 4-week period.
- 3.2 In some programs a rotation may be longer than 4 weeks (2, 4 or even 6 blocks). If a resident is doing a 4 block rotation, the Resident will receive 2 formal evaluations, each bearing a Global Evaluation. Each evaluation will cover an 8 week period, and each is considered separate for promotion rules. As an exception, if a resident is doing a 3 block rotation, the Resident will receive 1 (one) formal evaluation.
- 3.3 If at any point a Resident gets into difficulty (i.e. obtains a Borderline or Unsatisfactory evaluation), it is advisable that evaluations then be done after each 4 week period. The Resident must be informed that he/she will be evaluated at these more frequent intervals.
- 3.4 The evaluation at the end of each rotation is written by the Faculty Supervisor responsible for the Resident during that rotation. If more than one faculty member is involved in the supervision of a Resident during a rotation, information from all faculty may be written

on the evaluation form, or the information may be summarized by one of the supervisors, but in all cases the **global evaluation** should represent a consensus opinion.

- 3.5 If a rotation evaluation is submitted to a Program Director or to the Dean's office without the global evaluation being filled in, it will be returned to the supervisor for completion even if the Resident has already signed the evaluation.
- 3.6 Ongoing verbal feedback is important for all residents, and is of particular importance to residents experiencing difficulty. Supervisors will make every effort to provide such feedback.
- 3.7 At the completion of each rotation, the Resident should be given feedback and must sign the evaluation. The Resident may indicate that he/she disagrees with the evaluation.
- 3.8 The Resident bears some personal responsibility for ensuring that the evaluations are completed in a timely fashion, and that he/she has received feedback and has signed the evaluation.
- 3.9 Successful completion of a rotation is defined as obtaining a SATISFACTORY global evaluation.
- 3.10 A BORDERLINE evaluation anywhere on the evaluation form indicates that weaknesses have been identified.
- 3.11 A BORDERLINE **global evaluation** on any evaluation is not considered a passing grade.
- 3.12 A Resident with an UNSATISFACTORY or BORDERLINE global evaluation for any rotation, must be notified immediately.
- 3.13 In order to meet pedagogical requirements, a Resident should not miss more than 1/4 of a rotation due to illness, conference leave, vacation, etc. A rotation which includes less than 3/4 of the expected time commitment, may be considered INCOMPLETE.
- 3.14 An INCOMPLETE rotation should be completed, the duration of which is determined by the nature of the experience and the need for continuity: e.g. a 2-week illness during an Emergency rotation could be made up by 2 weeks in the Emergency room, whereas a 2-week illness during an ICU rotation might require a 4-week ICU rotation to be considered complete.
- 3.15 For any clinical interaction, it is the Faculty Supervisor who determines whether or not the contact with the resident was sufficient for meaningful evaluation.
- 3.16 At least twice during the ACADEMIC YEAR, the Program Director (or designate) will meet with each Resident in the Program, and review all the evaluations and the Resident's progress in the program.

## **4. PROMOTION**

### **4.1 Specific Promotion Regulations:**

- 4.1.a Promotion of a Resident to the next academic level occurs if all rotation periods during the year have been completed with SATISFACTORY or higher global evaluations.
- 4.1.b When it is recognized that a Resident is in academic difficulty, the Program Director (or delegate) will identify the areas of weakness, and will attempt to support and assist the Resident in addressing those weaknesses.
- 4.1.c During the academic year, an UNSATISFACTORY in one rotation period, with SATISFACTORY completion of all others, requires the Resident to complete a REPEAT rotation of the same duration.
- 4.1.d During the academic year, a BORDERLINE evaluation in one rotation period with SATISFACTORY completion of all others may require a REPEAT rotation. This is left to the discretion of the Program Director, and the decision should be made towards the end of the academic year.
- 4.1.e A REPEAT rotation is not to be undertaken until completion of the academic year, and must be completed before promotion to the subsequent academic year.
- 4.1.f REPEAT rotations, whenever possible, should be undertaken in a different hospital/setting.
- 4.1.g An UNSATISFACTORY or BORDERLINE evaluation in a REPEAT rotation period will require that a Resident be placed on PROBATION.
- 4.1.h During the academic year, an UNSATISFACTORY and/or BORDERLINE Global Evaluation in two rotation periods, will require the Resident to be placed on PROBATION.
- 4.1.i In some programs, there is an additional requirement for promotion, often related to performance on standardized written exams or clinical exams, usually given annually to all residents in training. These requirements must be identified to the resident at the beginning of the academic year. Failure to successfully comply with these requirements may require the resident to be placed on PROBATION.

### **4.2 Probation:**

- 4.2.a A resident will be placed on PROBATION for any of the following reasons:
  - i) UNSATISFACTORY or BORDERLINE in a REPEAT rotation period

- ii) UNSATISFACTORY and/or BORDERLINE in two rotation periods in one academic year.
  - iii) Upon recommendation by the Program Promotions Committee (as per 4.3.g), and with appropriate supporting documentation.
  - iv) Upon recommendation by the Faculty Postgraduate Promotions Committee (as per 4.4.f), and with appropriate supporting documentation.
- 4.2.b The PROBATIONARY period should start immediately, once the conditions listed in 4.2.a have been met.
- 4.2.c If a resident is appealing an evaluation to an Ad Hoc Departmental Appeal Committee, this process must be completed within 4 weeks from the date of the written request.
- 4.2.d The duration of the probationary period will be from 6 to 10 blocks, as determined by the Program Director. Four blocks during the Probationary period will be 'evaluated' blocks.
- 4.2.e The **evaluated** blocks of the probationary period should not be interrupted by a leave of absence, vacation, conference or study leave.
- 4.2.f In the event a trainee requires a Sick Leave or a Vacation Leave during the REMEDIAL period, this will extend the PROBATION by an equivalent number of blocks.
- 4.2.g A trainee may choose to take an unpaid leave of absence prior to starting the probationary period. This request must be made in writing to the Associate Dean for Postgraduate Education and will delay the start of the probationary period. There may be a restriction placed on the duration of the requested leave.
- 4.2.h The terms of the Probationary Period must be outlined in writing to the Resident, with copies to the Associate Dean for Postgraduate Education.
- 4.2.i During the Probationary Period, efforts will be made to assist the Resident in addressing areas of weakness.
- 4.2.j Anywhere from 2 to 6 blocks of the probationary period may be considered REMEDIAL rotations, whereby a program is set up to address specific areas of weakness. The duration of REMEDIAL time will be determined by the Program Director at the outset. The Resident is given feedback and evaluated, but the evaluations are not used in a formal manner.
- 4.2.k Four periods of the Probationary Period will include clinical experiences that are appropriate for the resident's level of training. These constitute the evaluated component of the Probationary Period, and an evaluation will be provided at the end of each period.

- 4.2.l During the Probationary Period, the resident should complete any of the BORDERLINE or UNSATISFACTORY rotations that led to being placed on Probation.
- 4.2.m One UNSATISFACTORY or BORDERLINE global evaluation during the evaluated component of the Probationary Period will require the Resident to withdraw from the Program.
- 4.2.n A Resident will be placed on PROBATION on only one occasion during postgraduate training. If, at any time, a Resident meets the criteria for PROBATION a second time, the Resident must withdraw from the program. This regulation applies even when a Resident changes from one program to another.
- 4.2.o Successful completion of a Probationary Period requires SATISFACTORY global evaluations on all evaluated rotations. Under usual circumstances, the Resident will not receive academic credit for a successful Probationary Period but will continue in the program out of phase. Under exceptional circumstances, a Program Promotions Committee might recommend that credit be given for the Probationary Period but this must be approved by the Faculty Postgraduate Promotions Committee.
- 4.2.p After successful completion of a Probationary Period, for the purposes of promotion regulations, the remainder of that academic year and the subsequent academic year are considered as one.
- 4.2.q A resident may be placed on CONDUCT PROBATION by a Program Promotions Committee or by the Faculty Postgraduate Promotions Committee in cases where the trainee exhibited unprofessional or unethical behaviour. CONDUCT PROBATION may occur in conjunction with a standard Probationary Period, or CONDUCT PROBATION may be applied to reflect unprofessional behaviour when the academic performance is otherwise satisfactory. In the first situation, residents who are placed on CONDUCT PROBATION must successfully complete an initial evaluated Probationary Period as per article 4.2.b, following which the status of CONDUCT PROBATION will be maintained until training is complete (i.e. at the end of a residency and/or fellowship). For a resident on CONDUCT PROBATION, any recurrence of unprofessional or unethical behaviour will result in dismissal from the Faculty of Medicine.
- 4.2.r A decision taken to place a resident on Probation must be approved by the Faculty Postgraduate Promotions Committee. The Associate Dean can approve a Probation decision pending approval by the Faculty Postgraduate Promotions Committee.

#### **4.3 Program Promotions Committee:**

- 4.3.a Within each training program, there must exist a Program Promotions Committee which monitors the evaluation and promotion of Residents in the program. This committee must be set-up separately from the Residency Training Committee, with promotion as its specific objective. There must not be a resident on the Program Promotions Committee.
- 4.3.b The membership of the Program Promotions Committee should include the Program Director [may chair the committee or designate a chair], the Chair of the department [or designate] and 1 or 2 Faculty involved in Resident education. There must not be a resident on this committee.
- 4.3.c The principle of confidentiality must be strictly respected. Discussions held and decisions taken with respect to the evaluation and promotion of residents are confidential and should never be shared with other faculty or residents.
- 4.3.d The Program Promotions Committee should meet at least twice yearly (December and June), to review the progress of the Residents in the Program.
- 4.3.e The entire record of a Resident who has received a BORDERLINE or UNSATISFACTORY global evaluation during any rotation must be reviewed by the Committee.
- 4.3.f The Associate Dean for Postgraduate Education must be informed in writing immediately of any Resident who is in academic or non-academic difficulty.
- 4.3.g The overall performance of any Resident can be reviewed by the Program Promotions Committee, at the discretion of the Program Director. This may occur even in the absence of BORDERLINE or UNSATISFACTORY global evaluations.
- 4.3.h The Program Director can recommend the suspension or withdrawal of a resident from a training program for academic or non-academic reasons, pending subsequent approval by the Program Promotions Committee.
- 4.3.i The Program Promotions Committee can recommend the withdrawal of a resident from a training program for academic or non-academic reasons.

#### **4.4 Faculty Postgraduate Promotions Committee:**

- 4.4.a The Faculty Postgraduate Promotions Committee is a standing Committee which reports to the Associate Dean for Postgraduate Education and includes 1 resident representative from the ARM. The Associate Dean sits as a non-voting member. The Chair is appointed by the Dean.
- 4.4.b The Faculty Postgraduate Promotions Committee will monitor the overall process of evaluation and promotion to ensure that the standards are being maintained.

- 4.4.c The Faculty Postgraduate Promotions Committee ensures that the regulations and guidelines have been adhered to, and that the resident has been treated fairly.
- 4.4.d All promotion and probation decisions must be approved by the Faculty Postgraduate Promotions Committee.
- 4.4.e No promotion decision is considered final until it has been approved by the Faculty Postgraduate Promotions Committee.
- 4.4.f The Faculty Postgraduate Promotions Committee can review the entire record of any Resident who is in academic or non-academic difficulty. This Committee can place a resident on Probation.
- 4.4.g The Faculty Postgraduate Promotions Committee can require the withdrawal of a Resident from a training program for academic reasons including inappropriate physician/patient interactions, unethical behaviour, or unprofessional behaviour.
- 4.4.h The Faculty Postgraduate Promotions Committee can require the withdrawal of a Resident from a training Program for non-academic reasons, such as: drug or substance abuse, criminal activity.
- 4.4.i The Associate Dean of Postgraduate Medical Education can approve promotion and probation decisions, pending subsequent ratification by the Faculty Postgraduate Promotions Committee.
- 4.4.j The Associate Dean of Postgraduate Medical Education may require the suspension or withdrawal of a Resident from a training program for academic or non-academic reasons, pending subsequent review/approval by the Faculty Postgraduate Promotions Committee.
- 4.4.k A resident has the right to appear before the Faculty Postgraduate Promotions Committee if one of the options is to require withdrawal from the Program.
- 4.4.l A resident who appears before the Faculty Postgraduate Promotions Committee will have access to all relevant written evaluations/correspondence in his/her record. Medical Records and Patient Records are not admissible in these proceedings.
- 4.4.m All relevant and admissible written evaluations, correspondence and/or documentation must be made available to the Secretary of the Faculty Postgraduate Promotions Committee at least five (5) working days **prior** to the meeting, for distribution to all parties prior to the meeting.
- 4.4.n The Faculty Postgraduate Promotions Committee may request the presence of the Program Director.

- 4.4.o The Faculty member and the resident may be accompanied by an advisor (as per Article 1.8).
- 4.4.p Both parties will appear before the Committee and withdraw simultaneously. The meeting is informal and non-confrontational.
- 4.4.q The parties are informed verbally by the Associate Dean or delegate as soon as the decision has been made, and in writing, as soon as possible. If the decision requiring the resident to withdraw is upheld, the resident's registration and training are terminated effective that date, including the training card.

## **5. RECONSIDERATION OF A ROTATION EVALUATION**

- 5.1 A resident who is not in agreement with a rotation evaluation should first discuss that evaluation with the Faculty Supervisor who wrote it. The resident might provide additional information or suggest other supervisors who could speak positively on his/her behalf. They are only to discuss the rotation in question and they must not discuss the promotion implications of the evaluation. The supervisor then has two options;
  - i) The supervisor may revise the evaluation and the 'revised' evaluation becomes the official one, or
  - ii) The original evaluation is not revised
- 5.2 If a resident wishes to formally contest a rotation evaluation, this request must be submitted in writing to the Program Director within 28 days of receiving the evaluation, and an Ad Hoc Division or Departmental Appeal Committee will be set up. This Committee is usually set up in the Division or Department where the evaluation took place.
- 5.3 The Ad Hoc Departmental Appeal Committee;
  - 5.3.a The Chair of the Department [or delegate] will appoint the Chair of the committee.
  - 5.3.b There will be 3 or 4 committee members who ideally should not have been involved in the evaluation of the resident in the past. The membership may include faculty members from another department and this is often helpful for small departments.
  - 5.3.c Whether or not to include a Resident as a member of this committee should be a decision made by the resident contesting the evaluation. He/she cannot choose a particular resident, but will decide whether or not to have a resident as a committee member. In small programs, the resident member should be from another training program. The Resident selected should have had no previous contact or link with the resident requesting the appeal.

- 5.3.d The resident must have access to any written evaluations/correspondence on his/her performance during that rotation. Medical Records and Patient Records are not admissible in these proceedings.
- 5.3.e The resident must ensure that any relevant and admissible correspondence or documentation they wish to present is made available to the Chair of the committee at least 5 working days **prior** to the meeting.
- 5.3.f Both the faculty supervisor and the resident may be accompanied by an advisor [as per Article 1.8].
- 5.3.g The Faculty supervisor may bring additional supervisors from that rotation who contributed to the resident's evaluation.
- 5.3.h The faculty supervisor and the resident appear before the committee and withdraw simultaneously. The meeting is informal and non-confrontational.
- 5.3.i The mandate of this committee is to review only the specific rotation being contested and the other evaluations in the resident's dossier should not be discussed. It is not the mandate of this committee to discuss the 'promotion implications' of the given evaluation. The future status of the resident in the training program as a result of the negative evaluation should not be discussed. Any attempt on the part of the resident to discuss promotion issues must be curtailed.
- 5.3.j. The committee determines that the evaluation given was accurate and fair based on the following guidelines.
- A BORDERLINE Global Evaluation means that the supervisor[s] identified weaknesses in the resident's performance. In comparison to other residents at the same level of training, the supervisor believes that this resident is weak;
  - An UNSATISFACTORY global evaluation means that the overall performance of the resident or some aspect of that performance was below the minimal standard accepted for a resident at that level.
  - The supervisor was aware of the training level of the resident;
  - In the supervisor's opinion, there was adequate time and exposure to evaluate performance;
  - The evaluator had input from other sources if appropriate.
- 5.3.k. The Ad Hoc Departmental Appeal Committee has several options:
- i) The evaluation can remain unchanged;
  - ii) An Unsatisfactory Global Evaluation can be changed to Borderline or to Satisfactory;

iii) A Borderline Global Evaluation can be changed to Satisfactory or Unsatisfactory.

5.3.l Minutes should be kept of the meeting. The minutes and all written communication should be sent to the Associate Dean for Postgraduate Medical Education.

5.3.m The parties are informed verbally by the Chair or delegate as soon as the decision has been made, and in writing, as soon as possible.

## **6. APPEAL OF A REQUIREMENT TO WITHDRAW**

6.1 If a resident is required by the Faculty Postgraduate Promotions Committee to withdraw from a program and wishes to appeal that decision, he/she must make the request in writing within 14 working days to the Dean of the Faculty who will then appoint an Ad Hoc Promotions Review Committee.

6.1.a The committee will consist of four (4) members of the Faculty's academic staff and one (1) senior trainee who is registered in a McGill University residency training program. All members will be knowledgeable about the postgraduate training process but must have had no previous knowledge of the Resident or the case under appeal. One member will be designated as Chair.

6.1.b One representative from the Collège des médecins du Québec may be substituted for an academic staff.

6.1.c In order to give the Resident time to prepare for the meeting, there will be a minimum two-week notice period. It may be scheduled earlier if the Resident requests it or agrees in advance to the shorter notice period.

6.1.d The Secretary will call for a dossier from each party which will be circulated to the Committee members and all parties prior to the meeting. The dossier must be made available to all parties at least five (5) working days prior to the meeting so they have time to become acquainted with the issues.

6.1.e The Ad Hoc Promotions Review Committee has the right to review the entire record of the Resident.

6.1.f The Chair of the Faculty Postgraduate Promotions Committee, or delegate, represents the Faculty Postgraduate Promotions Committee.

6.1.g Either party may be accompanied by an advisor (as per Article 1.8). Witnesses may be called if needed. The Secretary must be informed of the names of witnesses and advisors at least five (5) working days prior to the hearing.

- 6.1.h Both parties will appear before the Committee and withdraw simultaneously. The meeting is informal and non-confrontational.
- 6.1.i The Chair of the Faculty Postgraduate Promotions Committee will present the Faculty Postgraduate Promotions Committee position, and the Resident will then have the opportunity to present his/her position. The Committee members may ask questions of each party. The parties may also question each other in order to clarify points.
- 6.1.j The Secretary to the Faculty (or delegate) acts as a technical advisor and secretary to the Committee.
- 6.1.k All members of the Committee including the Chair, have a vote.
- 6.1.l The parties are informed verbally by the Secretary as soon as the decision has been made, and in writing, as soon as possible.
- 6.1.m Grounds for overturning the decision of the Faculty Postgraduate Promotions Committee should be limited to the following:
  - i) Faculty regulations and procedures were not followed or
  - ii) All relevant evidence was not taken into consideration when a decision affecting the resident was taken.
- 6.1.n The Ad Hoc Promotions Review Committee may refuse to give formal hearing to an appeal, after considering the written submissions of the resident, if by unanimous consent of the members present, there is no basis for the appeal.
- 6.1.o Within the Faculty of Medicine, decisions of the Ad Hoc Promotions Review Committee are final

# **Postgraduate Medical Education &** **McGill Health Care Facility** **Resident Health & Safety Policy**

## **PREAMBLE**

The Postgraduate Medical Education (PGME) Office and the McGill Health Care Facilities recognize that residents have the right to a safe environment during their residency training. The responsibility for promoting a culture and environment of safety for residents rests with the Faculty of Medicine, regional health authorities, health care establishments, clinical departments, and residents themselves. The concept of resident safety includes physical, emotional, and professional security.

The Postgraduate Medical Education (PGME) & McGill Health Care Establishment Resident Health & Safety Policy provides a central faculty mechanism for residents to use when faced with a health and safety issue during the course of their training which cannot be resolved at the local training site level.

On occasion residents/fellows may be confronted with a situation for which they are not sufficiently trained. It is expected that they, like other physicians, will deal with such situations as practicing professionals to the best of their ability. The word “resident” in the present document refers to all Residents and Fellows registered as students at McGill University in Postgraduate training programs.

## **KEY RESPONSIBILITIES:**

### **For Residents**

- Provide information and communicate safety concerns to the program and to comply with safety policies.

### **For Residency Training Programs**

- To act promptly to address identified safety concerns and incidents and to be proactive in providing a safe learning environment.
- Individual residency programs must develop policies to deal with issues specific to their discipline. These may include concerns related to physical safety, psychological safety and professional safety. Examples of such concerns include:
  - **Physical safety:** Travel, working in isolated locations, electronic communication with patients, dealing with violent patients, body substance exposure, immunizations, call rooms, radiation exposure, pregnancy.
  - **Psychological safety:** Intimidation and harassment, psychological illness,

substance abuse, inequity in the workplace.

- **Professional safety:** Conflict in ethical/religious beliefs, adverse event/critical incident support, confidentiality of personal information, medico-legal coverage and threat of legal action.

## I. PHYSICAL SAFETY

**These policies apply only during residents' activities that are related to the execution of residency duties:**

- Residents should familiarize themselves with the location and services offered by the Occupational Health and Safety Office of the health care facility in which they are training. This includes familiarity with policies and procedures for infection control and protocols following exposure to contaminated fluids, needle stick injuries, and reportable infectious diseases.
- Residents who are infected by a blood borne pathogen must declare their condition to the Associate Dean's office and to the SERTIH (Service d'Évaluation des Risques de Transmission d'Infections Hématogènes), especially if they may be involved in exposure-prone procedures.
- Residents must observe routine practices and additional precautions when indicated.
- Residents must keep their immunizations up to date. Overseas travel immunizations and advice should be sought well in advance when traveling abroad for electives or meetings. Consult the Tropical Medicine Clinic at the MGH or other similar facility (fees may apply).
- Call rooms and lounges provided for residents must be clean, smoke free, located in safe locations, and have adequate lighting, a phone, fire alarms, and smoke detectors. Any appliances supplied are to be in good working order. There must be adequate locks on doors.
- Residents working in areas of high and long term exposure to radiation must follow radiation safety policies and minimize their exposure according to current guidelines.
- Radiation protective garments (aprons, gloves, neck shields) should be used by all residents using fluoroscopic techniques.
- Pregnant residents should be aware of specific risks to themselves and their fetus in the training environment and request accommodations where indicated. Residents should consult the Occupational Health and Safety Office of the health care facility for information.
- Residents should not work alone after hours in health care or academic facilities without adequate support from Security Services.
- Residents are not expected to work alone at after-hours clinics.
- Residents are not expected to make unaccompanied home visits.
- Residents should only telephone patients using caller blocking and should use the health care facility phones and not their personal cellular phone or pda.
- Residents should not be expected to walk alone for any major or unsafe distances at night.

- Residents should not drive home after call if they have not had adequate rest.
- Residents should not assess violent or psychotic patients without the backup of security and an awareness of accessible exits and buzzers.
- The physical space requirements for management of violent patients must be provided where appropriate.
- Special training should be provided to residents who are expected to encounter aggressive patients, for example Crisis Management courses are available in some health care facilities – please contact your local residency office for information.
- Site orientations should include a review of local safety procedures.
- For long distance travel for clinical or other academic assignments, residents should ensure that a colleague or the home residency program is aware of their itinerary.
- Residents going on International Electives should consult the Global Health web site on the following link: <http://www.mcgill.ca/globalhealth/internationalelectives/>. <http://www.mcgill.ca/globalhealth/internationalelectives/> In general, the PGME Office will not approve electives in regions for which the Canadian government has issued a [Travel Warning](#).
- Residents should not be on call the day before long distance travel for clinical or other academic assignments by car. When long distance travel is required in order to begin a new rotation, the resident should request that they not be on call on the last day of the preceding rotation. If this cannot be arranged then there should be a designated travel day on the first day of the new rotation before the start of any clinical activities.
- Residents are not to be expected to travel long distances during inclement weather for clinical or other academic assignments. If such weather prevents travel, the resident is expected to contact the program office promptly. Assignment of an alternative activity is at the discretion of the Program Director.

## II. PSYCHOLOGICAL SAFETY

- Learning environments must be free from intimidation, harassment, and discrimination.
- When a resident's performance is affected or threatened by poor health or psychological conditions, the resident should be placed on a leave of absence and receive appropriate support. These residents should not return to work until an appropriate assessor has declared them ready to assume all of their resident duties, including call.
- Residents must be aware of the mechanisms and resources in place to manage issues of perceived lack of resident safety, intimidation, harassment and abuse.

## III. PROFESSIONAL SAFETY

- Some physicians may experience conflicts between their ethical or religious beliefs and the training requirements and professional obligations of physicians. Resources should be made available to residents to deal with such conflicts via the PGME Office.
- Programs are bound by FMRQ contract allowances for religious and other statutory holidays.
- The PGME Office should promote a culture of safety in which residents are able to report and discuss adverse events, critical incidents, ‘near misses’, and patient safety concerns without fear of punishment.
- Residency program committee members must not divulge information regarding residents. It is the responsibility of the residency Program Directors to make the decision and to disclose information regarding residents (e.g. personal information and evaluations) outside of the residency program committee and to do so only when there is reasonable cause. The resident file is confidential.
- With regard to resident files, programs must be aware of and comply with the Freedom of Information and Privacy (FOIP) Act. Programs can obtain guidance about FOIP issues from the McGill Access and Privacy Coordinator. Contact information is found on the McGill Secretariat web site.
- Resident feedback and complaints must be handled in a manner that ensures resident anonymity, unless the resident explicitly consents otherwise. However, in the case of a complaint that must be dealt with due to its severity or threat to other residents, staff or patients, a Program Director may be obliged to proceed, against the complainant’s wishes. In that case the Faculty of Medicine’s Residency Affairs Office or the main campus Harassment Office or the McGill Ombudsperson should be consulted immediately. Depending on the nature of the complaint, the Collège des médecins du Québec may need to be informed and involved. In general, the Program Director may serve as a resource and advocate for the resident in the complaints process.
- Residents are insured for professional liability by the Association québécoise d’établissements de santé et de services sociaux (AQESSS) automatically when they have a valid training card.
- The Role of Residents during Medivac/Ambulance Transports:

- In many programs, participation in patient transport is a valuable learning experience for residents. There must be clear educational objectives underlying the resident's participation in patient transport.
- Residents must have appropriate training with demonstrated competency in the circumstances relevant to the transport experience.
- Communication and supervision between the resident and his/her designated supervising physician must be available at all times.
- Resident well-being should be considered in all transports

## **CROSS REFERENCES TO RELATED POLICIES:**

FMRQ Collective Agreement: <http://www.fmrq.qc.ca/formation-medicale/info.cfm?noPageSiteInternet=12&cfgsection=affairessyndicales&cfgsoussection=entente-collective>

Health Care Facility Safety Policies

Health Care Facility Workplace Hazardous Material Information System WHMIS

McGill Student & Resident Affairs web site: <http://www.mcgill.ca/medwell>

Medicine Code of Appropriate Conduct: <http://www.mcgill.ca/medwell/professionalism>

## **CONTACT INFORMATION:**

FMRQ: 514) 282-0256

Health Care Facility Security Offices

MGH	48282 (internal)
RVH	38282 (internal)
MCH	28282 (internal)
MNI	88-5542 (internal)
JGH	(514) 340-8222 ext. 5000
SMH	(514) 345-3511 switchboard
Verdun General Hospital (514) 362-1000 switchboard	
Lakeshore Hospital (514) 630-2225 switchboard	

**MUHC Occupational Health and Safety Office Policy on Violence and the Complaint Resolution Process / McGill Harassment, Sexual Harassment and Discrimination Office**

<http://ww2.mcgill.ca/harass/> (514)398-4911

McGill Ombudsperson: 514-398-7059

Programme d'aide aux médecins du Québec : (514) 397-0888 or 1-800-387-4166

For resources on environmental, climate, health, and safety information in many countries: Public Health Agency of Canada: <http://www.phac-aspc.gc.ca/tmp-pmv/index-eng.php>

Another resource for up-to-date health and safety information abroad: Centers for Disease Control and Prevention: <http://wwwnc.cdc.gov/travel/default.aspx>.

## **DEPARTMENTAL TEACHING STAFF**

### **Montreal Children's Hospital (Pediatrics)**

Dr. Melvin Schloss, Professor	Clinical, teaching, research
Dr. Ted Tewfik, Professor	Clinical, teaching, research
Dr. John Manoukian, Assoc. Prof/Program Director	Clinical, teaching, research
Dr. Robert Shapiro, Assoc. Prof.	Clinical, teaching, research
Dr. Sam Daniel, Assoc. Prof.	Clinical, teaching, research
Dr. Lily Nguyen, Ass't Prof.	Clinical, teaching, research
Dr. Yolene Lacroix, Ass't Prof.	Clinical, teaching, research
Dr. Jack Rothstein, Lecturer	Clinical, teaching, research
Dr. Lyne Picard, Lecturer	Clinical, teaching
Dr. Vlad Iordanescu, Lecturer	Clinical, teaching

### **Montreal General Hospital**

Dr. Karen Kost, Assoc. Prof.	Laryngology/H&N Onco./Clinical, teaching, research
Dr. Robert Sweet, Ass't Prof. Gen.	General otol/otology-neurotology/Clinical, teaching, research
Dr. Veronique Forest, Ass't Prof (pt)	H&N Oncology/Sleep apnea/Clinical, teaching, research
Dr. George Sejean, Ass't Prof.	General otol/Clinical, teaching
Dr. Jonathan Young, Lecturer	Laryngology/Clinical, teaching, research

### **Jewish General Hospital**

Dr. Saul Frenkiel, Professor/Chair	Rhinology/Clinical, teaching, research
Dr. Martin Black, Ass't Prof.	H&N Oncology/Clinical, teaching, research
Dr. Michael Hier, Assoc. Prof.	H&N Oncology/Clinical, teaching, research
Dr. Jamie Rappaport, Assoc. Prof.	Otology/neurotology/Clinical, teaching, research
Dr. Richard Payne, Ass't Prof.	H&N Oncology/Sleep Apnea/Clinical, teaching, research
Dr. Alex Mlynarek, Ass't Prof.	H&N Oncology/Clinical, teaching, research
Dr. Marc Tewfik, Ass't Prof.	Rhinology/Skull Base/Clinical, teaching, research
Dr. Véronique Forest Adj. prof. (pt)	H&N Oncology/Sleep Apnea/Clinical, teaching, research
Dr. Alan Finesilver, Lecturer	General otol/Clinical, teaching
Dr. Melissa Henry, Assoc. Member	Psychology/Clinical, teaching
Dr. Bernard Segal, Assoc. Prof. (PhD)	Engineering/Research

### **Royal Victoria Hospital**

Dr. Athanasios Katsarkas, Prof.	Vestibular (Neurotology)/Clinical, teaching, research
Dr. Nabil Fanous, Assoc. Prof.	Facial plastic & recons. Surgery/Clinical, teaching, research
Dr. William H. Novick, Assoc. Prof.	General otolaryngology/Clinical, teaching
Dr. Anthony Zeitouni, Assoc. Prof.	Otology/Neurotol.H&N Oncology/ Clinical, teaching, research
Dr. Mark Samaha, Ass't Prof.	Rhinology/Clinical, teaching, research
Dr. Marc Tewfik, Ass't Prof.	Rhinology/Skull Base/Clinical, teaching, research
Dr. Kathleen Cullen, Assoc. Member	Physiology/Research

### **Verdun General Hospital (Pediatrics)**

Dr. Melvin Schloss, Prof.	Clinical, teaching, research
Dr. Ted Tewfik, Prof.	Clinical, teaching, research
Dr. John Manoukian, Assoc. Prof.	Clinical, teaching, research

Dr. Robert Shapiro, Assoc. Prof.	Clinical, teaching, research
Dr. Sam Daniel, Assoc. Prof.	Clinical, teaching, research
Dr. Lily Nguyen, Ass't Prof.	Clinical, teaching, research
Dr. Yolene Lacroix, Ass't Prof.	Clinical, teaching, research
Dr. Jack Rothstein, Lecturer	Clinical, teaching, research
Dr. Lyne Picard, Lecturer	Clinical, teaching
Dr. Vladimir Iordanescu, Lecturer	Clinical, teaching

**Lakeshore General Hospital**

Dr. John Manoukian, Assoc. Prof.	Pediatrics/Clinical, teaching
Dr. Sam Daniel, Assoc. Prof.	Pediatrics/Clinical, teaching
Dr. Robert Shapiro, Assoc. Prof.	Pediatrics/Clinical, teaching
Dr. Lily Nguyen, Ass't Prof.	Pediatrics/Clinical, teaching
Dr. Richard Lafleur, Ass't Prof.	General otolaryngology/otology/Clinical, teaching
Dr. Gilles-Michel Belisle	General otolaryngology/Clinical, teaching
Dr. Vi Vu, Lecturer	General otolaryngology/Clinical, teaching
Dr. Roger Lebel	General otolaryngology/Clinical, teaching

**LaSalle General Hospital**

Dr. Saul Frenkiel, Prof./Chair	Rhinology/Clinical, teaching
Dr. Marc Tewfik, Ass't Prof.	Rhinology/Clinical, teaching

**Lachine General Hospital**

Dr. Saul Frenkiel, Prof./Chair	Rhinology/Clinical, teaching
Dr. Marc Tewfik, Prof./Chair	Rhinology/Clinical, teaching

**Quebec North Community Hospital**

Dr. Karen Kost, Assoc. Prof.	General otolaryngology/otology/Clinical, teaching
Dr. Jamie Rappaport, Assoc. Prof.	General otolaryngology/otology/Clinical, teaching
Dr. Robert Sweet, Ass't Prof.	General otolaryngology/otology/Clinical, teaching

**Research Associates**

Luc Mongeau (Ph.D.)	Biomedical Engineering/Research
Henrietta Galiana (Ph.D.)	Biomedical Engineering/Research
Robert Funnell (Ph.D.)	Biomedical Engineering/Research
Dr. Kathleen Cullen (Ph.D.)	Physiology/Research
Dr. Q. Hamid	Medicine/Pathology/Research

