

ACGME Program Requirements for Graduate Medical Education in Otolaryngology

Common Program Requirements are in BOLD

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Introduction

Int.A. Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.

The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident physician to assume personal responsibility for the care of individual patients. For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept—graded and progressive responsibility—is one of the core tenets of American graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident’s development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

Int.B. Definition and Scope of the Specialty

Residency programs in otolaryngology-head and neck surgery provide residents with education in the comprehensive evaluation, as well as medical and surgical management of patients of all ages having diseases and disorders of the ears, upper respiratory and upper alimentary systems and related structures, and the head and neck. The educational program should include core knowledge, skills, and understanding of the basic medical sciences relevant to the head, neck, the upper respiratory and upper alimentary systems; the communication sciences, including knowledge of audiology, speech pathology, rehabilitation, and the vestibular system; and the chemical senses, otolaryngic allergy, endocrinology, and neurology as they relate to the head and neck area. The educational program also should include clinical aspects of the diagnosis, medical and/or surgical therapy, and the prevention of and rehabilitation from diseases, neoplasms, deformities, disorders and/or injuries of the ears, upper respiratory and upper alimentary systems, the face, the jaws, and other head and neck systems; head and neck oncology; and facial plastic and reconstructive surgery.

Int.C. Duration and Scope of Education

- Int.C.1. The duration of residency programs in otolaryngology-head and neck surgery is five years with at least nine months of basic surgical, emergency and critical care, and anesthesia training within the first year. After this initial training, there must be at least 48 months of progressive education in the specialty, inclusive of vacation time. The final year of education must be a chief resident experience, and must be spent within sites approved as part of the program.
- Int.C.2. The otolaryngology program director is responsible for the design, implementation, and oversight of a PGY-1 year that will prepare residents for specialty education in otolaryngology-head and neck surgery. This year must allow residents to participate in clinical and didactic activities in which they:
- Int.C.2.a) assess, plan, and initiate treatment of adult and pediatric patients with surgical and/or medical problems;
 - Int.C.2.b) care for patients of all ages with surgical and medical emergencies, multiple organ system trauma, soft tissue wounds, nervous system injuries and diseases, and peripheral vascular and thoracic injuries;
 - Int.C.2.c) care for critically-ill surgical and medical patients in the intensive care unit and emergency room settings;
 - Int.C.2.d) participate in the pre-, intra-, and post-operative care of surgical patients; and,
 - Int.C.2.e) understand surgical anesthesia in hospital and ambulatory care settings, including anesthetic risks and the management of intra-operative anesthetic complications.
- Int.C.3. In order to meet these goals, the PGY-1 year should include (in no required order):
- Int.C.3.a) a minimum of five months of structured education in at least three of the following: general surgery, thoracic surgery, vascular surgery, pediatric surgery, plastic surgery, surgical oncology.
 - Int.C.3.b) one month of structured education in each of the following four clinical areas: emergency medicine, critical care unit (intensive care unit, trauma unit or similar), anesthesia, neurological surgery.
 - Int.C.3.b).(1) An additional maximum of three months of otolaryngology-head and neck surgery is optional, and any remaining months of the PGY-1 year may be taken on the clinical services listed in 3.a) or 3.b) above.
- Int.C.4. The program director is also responsible for the design, implementation, and oversight of years PGY-2 through PGY-5, which should include:

- Int.C.4.a) at least 36 months of rotations on otolaryngology-head and neck surgery and clinical services, and
- Int.C4.b) a structured research experience, with instruction in research methods and design that includes outcomes assessment.
- Int.C.4.b).(1) The program may further include rotations on related services such as neuroradiology, surgical pathology of the head and neck, audiology and vestibular assessment, speech pathology and rehabilitation, radiation oncology, pulmonary medicine, allergy/immunology, and oral and maxillo-facial surgery.

I. Institutions

I.A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating sites.

The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program.

- I.A.1. These responsibilities include the selection and evaluation of residents; didactic and clinical instruction, including patient management and scholarly activity; and the recruitment and evaluation of staff.
- I.A.2. There must, additionally, be sufficient operative time available to ensure adequate surgical experience for residents.

I.B. Participating Sites

- I.B.1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years.**

The PLA should:

- I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for residents;**
- I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;**
- I.B.1.c) specify the duration and content of the educational experience; and,**

- I.B.1.d) state the policies and procedures that will govern resident education during the assignment.**
- I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).**
- I.B.2.a) In programs involving two or more hospitals, the sponsoring institution must organize the program such that residents receive a progressive educational experience.**
- I.B.2.b) Each participating site must offer significant educational opportunities to the program. Resident education at each participating site must comply with the program requirements for otolaryngology. Assignments that dilute the education of residents or that do not provide proper supervision and coordination of educational activities, should not be established or maintained.**
- I.B.2.c) There must be a qualified otolaryngologist-head and neck surgeon appointed by and responsible to the program director in each geographically separate site. This individual must be responsible for the education of the residents, and supervise the educational activities of other faculty as they relate to resident education in that site. The program director at each participating site must have major clinical responsibilities at that site.**
- I.B.2.d) Any site providing education to residents for more than three months must have prior approval of the Review Committee.**

II. Program Personnel and Resources

II.A. Program Director

- II.A.1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.**
- II.A.2. The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.**
- II.A.3. Qualifications of the program director must include:**
- II.A.3.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;**

- II.A.3.b) current certification in the specialty by the American Board of Otolaryngology, or specialty qualifications that are acceptable to the Review Committee; and,**
- II.A.3.c) current medical licensure and appropriate medical staff appointment.**
- II.A.4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:**
 - II.A.4.a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;**
 - II.A.4.b) approve a local director at each participating site who is accountable for resident education;**
 - II.A.4.c) approve the selection of program faculty as appropriate;**
 - II.A.4.d) evaluate program faculty and approve the continued participation of program faculty based on evaluation;**
 - II.A.4.e) monitor resident supervision at all participating sites;**
 - II.A.4.f) prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;**
 - II.A.4.g) provide each resident with documented semiannual evaluation of performance with feedback;**
 - II.A.4.h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;**
 - II.A.4.i) provide verification of residency education for all residents, including those who leave the program prior to completion;**
 - II.A.4.j) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:**
 - II.A.4.j).(1) distribute these policies and procedures to the residents and faculty;**
 - II.A.4.j).(2) monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;**

- II.A.4.j).(3)** adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,
- II.A.4.j).(4)** if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.
- II.A.4.k)** monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;
- II.A.4.l)** comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;
- II.A.4.m)** be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;
- II.A.4.n)** obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:
- II.A.4.n).(1)** all applications for ACGME accreditation of new programs;
- II.A.4.n).(2)** changes in resident complement;
- II.A.4.n).(3)** major changes in program structure or length of training;
- II.A.4.n).(4)** progress reports requested by the Review Committee;
- II.A.4.n).(5)** responses to all proposed adverse actions;
- II.A.4.n).(6)** requests for increases or any change to resident duty hours;
- II.A.4.n).(7)** voluntary withdrawals of ACGME-accredited programs;
- II.A.4.n).(8)** requests for appeal of an adverse action;
- II.A.4.n).(9)** appeal presentations to a Board of Appeal or the ACGME; and,
- II.A.4.n).(10)** proposals to ACGME for approval of innovative educational approaches.

- II.A.4.o) obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:**
- II.A.4.o).(1) program citations, and/or**
- II.A.4.o).(2) request for changes in the program that would have significant impact, including financial, on the program or institution.**
- II.A.4.p) ensure that clinical conferences are held regularly, and should be attended by all residents and faculty. Grand rounds, mortality and morbidity conferences, tumor conferences, and conferences on other pertinent topics must be included in the educational program. Interdisciplinary conferences are also encouraged
- II.A.4.q) demonstrate that residents have essentially equivalent and adequate distribution of case categories and procedures. Significantly unequal experience in volume and/or complexity of cases managed by the residents will be considered serious noncompliance with these requirements. In some instances, the quality of care may require that case management be conducted with other specialties (e.g., hypophysectomy, cerebellopontine tumor).
- II.A.4.r) provide documentation of each individual resident's operative experience. The program director must review the cumulative operative experience of each resident at least semiannually to evaluate the balanced progress of the resident. The program director is responsible for compiling accurate information regarding the institutional operative records and the individual resident operative reports annually at the end of each academic year, and for submitting these records for review as requested by the Review Committee.
- II.A.4.s) ensure, direct, and document the implementation of and compliance with appropriate resident policies at all times.

II.B. Faculty

II.B.1. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location.

The faculty must:

II.B.1.a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents, and

- II.B.1.b) administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.**
- II.B.2. The physician faculty must have current certification in the specialty by the American Board of Otolaryngology, or possess qualifications acceptable to the Review Committee.**
- II.B.2.a) It is desirable that, in addition to the program director, there are at least two other members of the faculty with qualifications similar to those of the program director.
- II.B.2.b) The faculty is responsible for ensuring that the structure and content of the residency program reflect an appropriate education-to-service ratio. The resident should be recognized as a student, and should have sufficient experience in nonoperative management and preoperative, intraoperative, and postoperative care of patients with otolaryngologic disorders. Faculty responsibility must include on-site supervision of the resident in operative, inpatient, outpatient, and emergency cases, as well as participation in patient care conferences and other educational exercises
- II.B.3. The physician faculty must possess current medical licensure and appropriate medical staff appointment.**
- II.B.4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.**
- II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.**
- II.B.5.a) **The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.**
- II.B.5.b) **Some members of the faculty should also demonstrate scholarship by one or more of the following:**
- II.B.5.b).(1) **peer-reviewed funding;**
- II.B.5.b).(2) **publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;**
- II.B.5.b).(3) **publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,**
- II.B.5.b).(4) **participation in national committees or educational organizations.**
- II.B.5.c) **Faculty should encourage and support residents in scholarly activities.**

II.C. Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program.

II.D. Resources

The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements.

- II.D.1. There must be adequate space and equipment for the educational program, including meeting rooms, classrooms with audiovisual and other educational aids, office space for staff, pertinent library materials and current information technology readily available for clinical care, as well as diagnostic, therapeutic, and research facilities.
- II.D.2. Within each institution, beds sufficient for the needs of the service must be provided.
- II.D.3. Residents must have access to outpatient facilities, clinics, and office space for education in the regular preoperative evaluation and postoperative follow-up of cases for which the resident has responsibility.
- II.D.4. Technologically-current equipment considered necessary for diagnosis and treatment must be available.
- II.D.5. A patient-information system that facilitates both quality patient care and education must be available. It should be maintained to ensure easy and prompt access at all times, and be organized to permit the collection and evaluation of selected material from clinical records for investigative and review purposes.
- II.D.6. Residents should be provided with adequate office, sleeping, lounge, and food facilities during assigned duty hours.
- II.D.7. The sponsoring institution and participating sites approved for the program must collectively have a sufficient number and variety of adult and pediatric medical and surgical patients who are available for resident education.
- II.D.8. Recognizing the nature of the specialty of Otolaryngology-Head and Neck Surgery, there should be clinical resources, if not an approved training program, in the related fields of ophthalmology, neurological surgery, neurology, pathology, radiology, anesthesiology, internal medicine, pediatrics, and emergency medicine.
- II.D.9. Resources including space, equipment, personnel and funding for instruction and study of the basic sciences should be available to permit

satisfactory correlation between basic science knowledge and clinical application.

II.E. Medical Information Access

Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available.

III. Resident Appointments

III.A. Eligibility Criteria

The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements.

III.B. Number of Residents

The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program's educational resources must be adequate to support the number of residents appointed to the program.

III.B.1. Programs may not graduate more residents in any given year than the number of residents approved by the Review Committee, except in cases where a resident's educational program is extended because the program director has determined the need of additional education to meet minimum requirements for competency. The program director must request approval in writing from the Review Committee to extend a resident's educational program. Any increase in the number of residents in any year of the program, or in the total number of residents, must receive the prior approval of the Review Committee. Any such request for change in the approved resident complement must include a strong educational rationale.

III.B.2. A vacancy in a resident complement, if filled, must be at the same level in which the vacancy occurs, unless otherwise approved by the Review Committee. Violations of these requirements will result in an adverse accreditation action.

III.C. Resident Transfers

III.C.1. Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident.

III.C.2. A program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion.

III.D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' education. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.

IV. Educational Program

IV.A. The curriculum must contain the following educational components:

IV.A.1. Overall educational goals for the program, which the program must distribute to residents and faculty annually;

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation;

IV.A.3. Regularly scheduled didactic sessions;

IV.A.4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and,

IV.A.5. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum:

IV.A.5.a) Patient Care

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

IV.A.5.a).(1) will use diagnosis and diagnostic methods, including audiologic, vestibular, and vocal function testing; biopsy and fine needle aspiration techniques; and other clinical and laboratory procedures related to the diagnosis of diseases and disorders of the upper aerodigestive tract and the head and neck;

IV.A.5.a).(2) will be proficient in therapeutic and diagnostic imaging, specifically interpreting medical images of the head and neck and the thorax, including studies of the temporal bone, skull, nose, paranasal sinuses, salivary and thyroid

glands, larynx, necks, lungs, and esophagus;

- IV.A.5.a).(3) will diagnose, evaluate, and manage congenital anomalies, otolaryngic allergy, sleep disorders, pain and other conditions affecting the regions and systems mentioned above, and the chemical senses, endocrinology, and neurology as they relate to the head and neck;
- IV.A.5.a).(4) will manage congenital, degenerative, idiopathic, infectious, inflammatory, toxic, allergic, immunologic, vascular, metabolic, endocrine, neoplastic, foreign body and traumatic states through airway management, resuscitation, local/regional anesthesia, sedation and universal precaution techniques, operative intervention, and preoperative and postoperative care of the following major categories:
- IV.A.5.a).(4).(a) general otolaryngology, including pediatric otolaryngology, rhinology, bronchoesophagology and laryngology;
- IV.A.5.a).(4).(b) head and neck oncologic surgery;
- IV.A.5.a).(4).(c) facial plastic and reconstructive surgery of the head and neck; and,
- IV.A.5.a).(4).(d) otology and neurotology.
- IV.A.5.a).(5) will competently perform habilitation and rehabilitation techniques and procedures, including respiration, deglutition, chemoreception, balance, speech, as well as auditory measures such as hearing aids and implantable devices;
- IV.A.5.a).(6) will diagnose and apply therapeutic techniques involving endoscopy of the upper aerodigestive tract, including rhinoscopy, laryngoscopy, esophagoscopy, and bronchoscopy, as well as the associated application of stroboscopes, lasers, mechanical debriders, and computer-assisted guidance devices.
- IV.A.5.a).(7) will have experience with state-of-the-art advances and emerging technology in otolaryngology and head-and-neck surgery;
- IV.A.5.a).(8) should perform a sufficient number and variety of surgical procedures to ensure education in the entire scope of the specialty. There must be adequate distribution and sufficient complexity within the principal categories of the specialty;

- IV.A.5.a).(9) must work in a well-organized and well-supervised outpatient service. This service must operate in relation to an inpatient service used in the program. Residents must have the opportunity to see patients, establish provisional diagnoses, and initiate preliminary treatment plans. An opportunity for follow-up care must be provided so that the results of surgical care may be evaluated by the responsible residents. These activities must be carried out under the supervision of appropriate faculty;
- IV.A.5.a).(10) will function with an appropriate degree of responsibility, under adequate supervision, if they participate in preoperative and postoperative care in a private office. Experience should be provided in the procedures and management of office practice;
- IV.A.5.a).(11) must have experience in the emergency care of critically ill and injured patients with otolaryngology-head and neck conditions; and,
- IV.A.5.a).(12) should have patient care responsibility commensurate with the individual resident's knowledge, problem-solving ability, manual skills, experience, and the severity and complexity of each patient's status. The program must provide residents with experience in direct and progressively-responsible patient management, including surgical experience as assistant to the surgeon, as residents advance through the educational program. This education must culminate in sufficient independent responsibility for clinical decision-making to evidence the fact that the graduating resident has developed sound clinical judgment and possesses the ability to formulate and carry out appropriate management plans.

IV.A.5.b) Medical Knowledge

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

- IV.A.5.b).(1) must learn within a comprehensive, well-organized, and effective curriculum, including the cyclical presentation of core specialty knowledge supplemented by the addition of current information. Residents must learn in a variety of educational settings, such as clinics, classrooms, operating rooms, bedsides, and laboratories, employing accepted educational principles.
- IV.A.5.b).(2) must have a structured educational experience in basic science. Ordinarily, this should be provided within the

participating sites of the residency program. Any program that provides the requisite basic science experience outside the approved participating sites must demonstrate that the educational experience provided meets these designated criteria. Faculty must participate in basic science education, resident attendance must be monitored, education must be evaluated, and content must be integrated into the educational program.

IV.A.5.b).(3)

will become familiar with the broad scope of otolaryngology-head and neck surgery. This requires that the program provide basic science, medical, and surgical education in the following areas:

IV.A.5.b).(3).(a)

basic sciences, as relevant to the head and neck and upper-aerodigestive system: anatomy, embryology, physiology, pharmacology, pathology, microbiology, biochemistry, genetics, cell biology, immunology, the communication sciences (including a knowledge of audiology and speech-language pathology and the voice sciences as they relate to laryngology), as well as the chemical senses, endocrinology, and neurology as they relate to the head and neck;

IV.A.5.b).(3).(b)

basic science education which should include instruction in anatomy, biochemistry, cell biology, embryology, immunology, molecular genetics, pathology, pharmacology, physiology, and other basic sciences related to the head and neck;

IV.A.5.b).(3).(c)

communication sciences as they relate to otology and laryngology, including audiology, speech-language pathology, and voice science;

IV.A.5.b).(3).(d)

anatomy which should include the study and dissection of cadaver anatomic specimens, including the temporal bone, with appropriate lectures and other formal sessions; and,

IV.A.5.b).(3).(e)

pathology which should include formal instruction in correlative pathology in which gross and microscopic pathology relating to the head and neck area are included. The resident should study and discuss with the pathology service tissues removed at operations and autopsy material. It is desirable to have residents assigned to the Department of Pathology.

IV.A.5.c)

Practice-based Learning and Improvement

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

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

IV.A.5.d) Interpersonal and Communication Skills

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

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

records, if applicable.

IV.A.5.e)

Professionalism

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

IV.A.5.e).(1)

compassion, integrity, and respect for others;

IV.A.5.e).(2)

responsiveness to patient needs that supersedes self-interest;

IV.A.5.e).(3)

respect for patient privacy and autonomy;

IV.A.5.e).(4)

accountability to patients, society and the profession; and,

IV.A.5.e).(5)

sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

IV.A.5.f)

Systems-based Practice

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

IV.A.5.f).(1)

work effectively in various health care delivery settings and systems relevant to their clinical specialty;

IV.A.5.f).(2)

coordinate patient care within the health care system relevant to their clinical specialty;

IV.A.5.f).(3)

incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;

IV.A.5.f).(4)

advocate for quality patient care and optimal patient care systems;

IV.A.5.f).(5)

work in interprofessional teams to enhance patient safety and improve patient care quality; and,

IV.A.5.f).(6)

participate in identifying system errors and implementing potential systems solutions.

IV.A.5.f).(7) be familiar with ethical, socioeconomic, and medico-legal issues that affect the provision of quality and cost-effective care and the utilization of resources within the health care system; the provision of quality and cost-effective otolaryngology care within the context of the health care system; and the use of the resources of that health care system, other medical specialists, information technology, continuing medical education, and the ongoing analysis of clinical outcomes to ensure such care.

IV.B. Residents' Scholarly Activities

IV.B.1. The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.

IV.B.2. Residents should participate in scholarly activity.

IV.B.2.a) The educational program should provide a structured research experience for the residents, sufficient to result in an understanding of the basic principles of study design, performance, analysis, and reporting. The research experience may be clinical or basic in nature, and should reflect careful advice by and planning with the faculty. Facilities and protected time for research by the residents should also be provided, with guidance and supervision by qualified faculty.

IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.

V. Evaluation

V.A. Resident Evaluation

V.A.1. Formative Evaluation

V.A.1.a) The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.

V.A.1.b) The program must:

V.A.1.b).(1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;

V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients,

self, and other professional staff);

V.A.1.b).(3) document progressive resident performance improvement appropriate to educational level; and,

V.A.1.b).(4) provide each resident with documented semiannual evaluation of performance with feedback.

V.A.1.c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.

V.A.2. Summative Evaluation

The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. This evaluation must:

V.A.2.a) document the resident's performance during the final period of education, and

V.A.2.b) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.

V.B. Faculty Evaluation

V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program.

V.B.2. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.

V.B.3. This evaluation must include at least annual written confidential evaluations by the residents.

V.C. Program Evaluation and Improvement

V.C.1. The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:

V.C.1.a) resident performance;

V.C.1.b) faculty development;

V.C.1.c) graduate performance, including performance of program graduates on the certification examination; and,

- V.C.1.d) program quality. Specifically:**
- V.C.1.d).(1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and**
- V.C.1.d).(2) The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.**
- V.C.2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.**
- V.C.2.a) Residents who fail to demonstrate appropriate industry, competence, responsibility, learning abilities, or ethics should be successively counseled and, after due process, dismissed if remediation has not occurred.**
- V.C.2.b) It is essential that residents participate in existing national examinations. The annual Otolaryngology Training Examination (OTE), offered by the American Board of Otolaryngology, is one example of an objective test that may be used by the program. An analysis of the results of these testing programs should guide the faculty in assessing the strengths and weaknesses of individual residents and the program. The program director should also monitor the performance of program graduates on the examinations of the American Board of Otolaryngology.**

VI. Resident Duty Hours in the Learning and Working Environment

VI.A. Professionalism, Personal Responsibility, and Patient Safety

- VI.A.1. Programs and sponsoring institutions must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.**
- VI.A.2. The program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment.**
- VI.A.3. The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.**
- VI.A.4. The learning objectives of the program must:**
- VI.A.4.a) be accomplished through an appropriate blend of supervised**

patient care responsibilities, clinical teaching, and didactic educational events; and,

VI.A.4.b) not be compromised by excessive reliance on residents to fulfill non-physician service obligations.

VI.A.5. The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following:

VI.A.5.a) assurance of the safety and welfare of patients entrusted to their care;

VI.A.5.b) provision of patient- and family-centered care;

VI.A.5.c) assurance of their fitness for duty;

VI.A.5.d) management of their time before, during, and after clinical assignments;

VI.A.5.e) recognition of impairment, including illness and fatigue, in themselves and in their peers;

VI.A.5.f) attention to lifelong learning;

VI.A.5.g) the monitoring of their patient care performance improvement indicators; and,

VI.A.5.h) honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.

VI.A.6. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.

VI.B. Transitions of Care

VI.B.1. Programs must design clinical assignments to minimize the number of transitions in patient care.

VI.B.2. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.

VI.B.3. Programs must ensure that residents are competent in communicating with team members in the hand-over process.

VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.

VI.C. Alertness Management/Fatigue Mitigation

VI.C.1. The program must:

VI.C.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;

VI.C.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; and,

VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.

VI.C.2. Each program must have a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties.

VI.C.3. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home.

VI.D. Supervision of Residents

VI.D.1. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.

VI.D.1.a) This information should be available to residents, faculty members, and patients.

VI.D.1.b) Residents and faculty members should inform patients of their respective roles in each patient's care.

VI.D.2. The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.

Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means

of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care.

VI.D.3. Levels of Supervision

To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:

- VI.D.3.a) Direct Supervision – the supervising physician is physically present with the resident and patient.**
- VI.D.3.b) Indirect Supervision:**
 - VI.D.3.b).(1) with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.**
 - VI.D.3.b).(2) with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.**
- VI.D.3.c) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.**
- VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.**
 - VI.D.4.a) The program director must evaluate each resident’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.**
 - VI.D.4.b) Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.**
 - VI.D.4.c) Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.**
- VI.D.5. Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising**

faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.

- VI.D.5.a) Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.**
- VI.D.5.a).(1) In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.**
- VI.D.5.a).(2) Each program must define those physician tasks for which PGY-1 residents may be supervised indirectly with direct supervision available, and must define “direct supervision” in the context of the individual program.**
- VI.D.5.a).(3) Each program must define those physician tasks for which PGY-1 residents must be supervised directly until they have demonstrated competence as defined by the program director, and must maintain records of such demonstrations of competence.**
- VI.D.6. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.**
- VI.E. Clinical Responsibilities**
- The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services.**
- VI.E.1. The workload associated with optimal clinical care of surgical patients is a continuum from the moment of admission to the point of discharge.**
- VI.E.2. During the residency education process, surgical teams should be made up of attending surgeons, residents at various PGY levels, medical students (when appropriate), and other health care providers.**
- VI.E.3. The work of the caregiver team should be assigned to team members based on each resident’s level of education, experience, and competence.**
- VI.F. Teamwork**
- Residents must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty.**

- VI.F.1. Effective surgical practices entail the involvement of members with a mix of complementary skills and attributes (physicians, audiologists, nurse practitioners, nurses, otolaryngology physician assistants, speech and language pathology personnel, and vestibular lab personnel). Success requires both an unwavering mutual respect for those skills and contributions, and a shared commitment to the process of patient care.
- VI.F.2. Residents must collaborate with fellow surgical residents, and especially with faculty members and other physicians outside of the specialty to best formulate treatment plans for an increasingly diverse patient population.
- VI.F.3. Residents must assume personal responsibility to complete all tasks to which they are assigned (or which they voluntarily assume) in a timely fashion. These tasks must be completed within the hours assigned, or, if that is not possible, residents must learn and utilize the established methods for handing off remaining tasks to another member of the resident team so that patient care is not compromised.
- VI.F.4. Lines of authority should be defined by programs, and all residents must have a working knowledge of expected reporting relationships to maximize quality care and patient safety.

VI.G. Resident Duty Hours

VI.G.1. Maximum Hours of Work per Week

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

VI.G.1.a) Duty Hour Exceptions

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

The Review Committee for Otolaryngology will not consider requests for exceptions to the 80-hour limit to the residents' work week.

VI.G.1.a).(1) In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.

VI.G.1.a).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.

VI.G.2. Moonlighting

VI.G.2.a) Moonlighting must not interfere with the ability of the resident

to achieve the goals and objectives of the educational program.

VI.G.2.b) Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.

VI.G.2.c) PGY-1 residents are not permitted to moonlight.

VI.G.3. **Mandatory Time Free of Duty**

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

VI.G.4. **Maximum Duty Period Length**

VI.G.4.a) Duty periods of PGY-1 residents must not exceed 16 hours in duration.

VI.G.4.b) Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.

VI.G.4.b).(1) It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.

VI.G.4.b).(2) Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

VI.G.4.b).(3) In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

VI.G.4.b).(3).(a) Under those circumstances, the resident must:

VI.G.4.b).(3).(a).(i) appropriately hand over the care of all other patients to the team responsible

for their continuing care; and,

VI.G.4.b).(3).(a).(ii)

document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

VI.G.4.b).(3).(b)

The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

VI.G.5.

Minimum Time Off between Scheduled Duty Periods

VI.G.5.a)

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

VI.G.5.b)

Intermediate-level residents should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

PGY-2 and PGY-3 residents are considered to be at the intermediate level.

VI.G.5.c)

Residents in the final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

PGY-4 and PGY-5 residents are considered to be in the final years of education.

VI.G.5.c).(1)

This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

VI.G.5.c).(1).(a)

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

VI.G.5.c).(1).(b)

The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved; events

of exceptional educational value; or, humanistic attention to the needs of a patient or family.

VI.G.6. Maximum Frequency of In-House Night Float

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

VI.G.6.a) Night float rotations cannot exceed two months in duration, and residents can have no more than three months of night float assignments per year.

VI.G.6.b) There must be at least two months between each night float rotation.

VI.G.7. Maximum In-House On-Call Frequency

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

VI.G.8. At-Home Call

VI.G.8.a) **Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.**

VI.G.8.a).(1) **At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.**

VI.G.8.b) **Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”.**

VII. Innovative Projects

Requests for innovative projects that may deviate from the institutional, common and/or specialty specific program requirements must be approved in advance by the Review Committee. In preparing requests, the program director must follow Procedures for Approving Proposals for Innovative Projects located in the ACGME Manual on Policies and Procedures. Once a Review Committee approves a project, the sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.

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