ACGME Program Requirements for Graduate Medical Education in Otolaryngology

Common Program Requirements are in BOLD

Effective: ~~July 1, 2007~~

Introduction

Int.A. ~~Definition and Scope of the Specialty~~

~~Residency programs in o~~Otolaryngology-head and neck surgery programs ~~provide~~ educate residents to provide comprehensive medical and surgical care ~~with education in the comprehensive evaluation, as well as medical and surgical management of~~ to patients ~~of all ages having~~ with diseases and disorders ~~of~~ that affect the ears, the ~~upper~~ respiratory and upper alimentary systems, and related structures~~, and~~ of the head and neck. The educational program ~~should~~ includes the following areas: ~~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~~ allergy and immunology; facial plastic and reconstructive surgery; head and neck surgery; laryngology and communication disorders; neurotology as it pertains to primary otolaryngology; otology and audiology; pediatric otolaryngology; rhinology and chemical senses; and sleep medicine.

Int.B. The educational program in otolaryngology must be 60 months in length.

~~Int.B.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.B.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.B.2.a) assess, plan, and initiate treatment of adult and pediatric patients with surgical and/or medical problems;~~

~~Int.B.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.B.2.c) care for critically-ill surgical and medical patients in the intensive care unit and emergency room settings;~~

~~Int.B.2.d) participate in the pre-, intra-, and post-operative care of surgical patients; and,~~

~~Int.B.2.e) understand surgical anesthesia in hospital and ambulatory care settings, including anesthetic risks and the management of intra-operative anesthetic complications.~~

~~Int.B.3. In order to meet these goals, the PGY-1 year should include (in no required order):~~

~~Int.B.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.B.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.B.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.B.4. The program director is also responsible for the design, implementation, and oversight of years PGY-2 through PGY-5, which should include:~~

~~Int.B.4.a) at least 36 months of rotations on otolaryngology-head and neck surgery and clinical services, and~~

~~Int.B.4.b) a structured research experience, with instruction in research methods and design that includes outcomes assessment.~~

~~Int.B.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. The sponsoring institution must provide:

I.A.1.a) at least 10% salary support for protected time for the program director; and,~~ 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.1.b) salary support for a residency coordinator dedicated to the educational and administrative needs of the program.

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.

I.B.3. Rotations to foreign countries and non-participating sites used to meet minimum educational standards must adhere to the following requirements:

I.B.3.a) The program director must approve all rotations to foreign countries and non-participating sites.

I.B.3.b) The total time spent in rotations to foreign countries and non-participating sites should be no more than one month over the five -year program.

I.B.3.c) All institutional policies and procedures that govern the program at the sponsoring institution must continue to be in effect for residents during the foreign rotation and at non-participating sites.

I.B.3.d) Surgical procedures completed during the foreign rotation and non-participating sites must not be counted toward meeting the required minima of procedures.

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.

203 **II.A.2.** **The program director should continue in his or her position for a**
204 **length of time adequate to maintain continuity of leadership and**
205 **program stability.**
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207 **II.A.3.** **Qualifications of the program director must include:**
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209 **II.A.3.a)** **requisite specialty expertise and documented educational**
210 **and administrative experience acceptable to the Review**
211 **Committee;**
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213 **II.A.3.b)** **current certification in the specialty by the American Board of**
214 Otolaryngology (ABO)**, or specialty qualifications that are**
215 **acceptable to the Review Committee;**
216
217 II.A.3.c) **current medical licensure and appropriate medical staff**
218 **appointment; and,**
219
220 **II.A.3.d)** evidence of periodic updates of knowledge and skills to discharge
221 the roles and responsibilities for teaching, supervision, and formal
222 evaluation of residents.
223
224 **II.A.4.** **The program director must administer and maintain an educational**
225 **environment conducive to educating the residents in each of the**
226 **ACGME competency areas. The program director must:**
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228 **II.A.4.a)** **oversee and ensure the quality of didactic and clinical**
229 **education in all sites that participate in the program;**
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231 **II.A.4.b)** **approve a local director at each participating site who is**
232 **accountable for resident education;**
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234 II.A.4.b).(1) The director at each participating site must have major
235 clinical responsibilities at that site.
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237 **II.A.4.c)** **approve the selection of program faculty as appropriate;**
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239 **II.A.4.d)** **evaluate program faculty and approve the continued**
240 **participation of program faculty based on evaluation;**
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242 **II.A.4.e)** **monitor resident supervision at all participating sites;**
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244 **II.A.4.f)** **prepare and submit all information required and requested by**
245 **the ACGME, including but not limited to the program**
246 **information forms and annual program resident updates to**
247 **the ADS, and ensure that the information submitted is**
248 **accurate and complete;**
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250 **II.A.4.g)** **provide each resident with documented semiannual**
251 **evaluation of performance with feedback;**
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253 **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.~~ prepare and implement a supervision

policy that specifies resident and faculty lines of responsibility; and,

II.A.4.s) ~~ensure, direct, and document the implementation of and compliance with appropriate resident policies at all times.~~

II.A.4.t) notify the Review Committee in writing of any extension in a resident's educational program.

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~~ In addition to the program director, there ~~are~~ should be at least two other ~~members of the~~ FTE faculty members with qualifications ~~similar~~ comparable 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.C.1. This should include speech pathologists, audiologists, and/or balance therapists necessary for carrying out audiologic and vestibular testing and rehabilitation.

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 24-hour computer access with Internet, classrooms with audiovisual and other educational aids, meeting rooms, ~~classrooms with audiovisual and other educational aids,~~ and office space for residents ~~staff, pertinent library materials~~.

II.D.2. ~~and~~ There must be current information technology readily available for clinical care~~, as well as diagnostic, therapeutic, and research facilities~~.

II.D.3. ~~Within~~ Each clinical site must provide ~~institution,~~ beds and operating time sufficient for the needs of the service and resident education. ~~must be provided.~~

II.D.4. There must be a ~~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 to ensure resident competency in patient care ~~for resident education~~.

II.D.5. Residents must have access to outpatient facilities that provide clinics and office space for education in the regular preoperative evaluation and post-operative follow-up of cases for which ~~the~~ each resident has responsibility.

II.D.5.a) ~~Diagnostic, therapeutic and research facilities.~~

II.D.6. Technologically-current equipment considered necessary for diagnosis and treatment must be available.

II.D.7. ~~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.8. ~~Residents should be provided with adequate office, sleeping, lounge, and food facilities during assigned duty hours.~~

II.D.9. ~~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.10. ~~Recognizing the nature of the specialty of Otolaryngology-Head and Neck Surgery,~~ There should be clinical expertise ~~resources, if not an approved training program,~~ in the related fields of anesthesiology, emergency medicine, internal medicine, neurological surgery, neurology, ophthalmology, ~~neurological surgery, neurology,~~ pathology, pediatrics, and radiology, ~~anesthesiology, internal medicine, pediatrics, and emergency medicine~~.

II.D.11. Resources, including ~~space,~~ equipment, personnel, technical support, ~~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.~~

III.B.2. 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.3. 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.3.a) The didactic curriculum must include cyclical presentation of core specialty knowledge supplemented by the addition of breakthrough information.

IV.A.3.b) Educational conferences must include grand rounds, quality improvement conferences, mortality and morbidity conferences, tumor conferences, and conferences on other pertinent topics.

IV.A.3.b).(1) Faculty must participate in the preparation and presentation of educational conferences.

IV.A.3.b).(2) Residents must attend educational conferences.

IV.A.3.b).(2).(a) Resident attendance at educational conferences must be monitored.

IV.A.3.b).(2).(b) Educational conferences must be evaluated.

IV.A.3.b).(3) Didactic topics must include: basic sciences, as relevant to the head and neck and upper-aerodigestive system~~.~~; allergy and immunology, anatomy, biochemistry, cell biology, the communication sciences (including audiology and speech-language pathology and the voice sciences as they related to laryngology), embryology, genetics, microbiology, pathology, pharmacology, physiology, and rhinology, as well as the chemical senses, endocrinology, and neurology as they relate to the head and neck.~~;~~

IV.A.3.b).(3).(a) Anatomy should include the study and dissection of cadaver anatomic specimens, including the temporal bone, and procedural skills laboratories, along with appropriate lectures and other formal

sessions.

IV.A.3.b).(3).(b) Pathology should include formal instruction in correlative pathology, including gross and microscopic pathology relating the head and neck area. Residents should study and discuss with the pathology service tissues removed at operations as well as autopsy material.

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) must demonstrate proficiency in data gathering and interpretation in areas including: ~~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).(1).(a) allergy testing;

IV.A.5.a).(1).(b) audiology testing;

IV.A.5.a).(1).(c) clinical history and exam;

IV.A.5.a).(1).(d) facial analysis;

IV.A.5.a).(1).(e) histopathology studies;

IV.A.5.a).(1).(f) imaging studies of the head and neck;

IV.A.5.a).(1).(g) laboratory testing;

IV.A.5.a).(1).(h) sleep studies;

IV.A.5.a).(1).(i) smell and taste testing; and,

IV.A.5.a).(1).(j) vestibular testing.

IV.A.5.a).(2) must demonstrate proficiency in formulating differential diagnoses of conditions affecting the head and neck;~~ 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) must demonstrate proficiency in surgical (including peri-operative) and non-surgical management and treatment of conditions affecting ~~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, including:

IV.A.5.a).(3).(a) aerodigestive foreign body obstruction;

IV.A.5.a).(3).(b) allergic and immunologic disorders;

IV.A.5.a).(3).(c) chemoreceptive disorders;

IV.A.5.a).(3).(d) communicative and swallowing disorders;

IV.A.5.a).(3).(e) disorders related to the geriatric population;

IV.A.5.a).(3).(f) endocrine disorders related to the thyroid and parathyroid;

IV.A.5.a).(3).(g) facial plastic and reconstructive disorders;

IV.A.5.a).(3).(h) idiopathic disorders;

IV.A.5.a).(3).(i) infectious and inflammatory disorders;

IV.A.5.a).(3).(j) metabolic disorders;

IV.A.5.a).(3).(k) neoplastic disorders;

IV.A.5.a).(3).(l) neurologic disorders related to the head and neck;

IV.A.5.a).(3).(m) pain;

IV.A.5.a).(3).(n) pediatric and congenital disorders;

IV.A.5.a).(3).(o) sleep disorders;

IV.A.5.a).(3).(p) traumatic disorders;

712 IV.A.5.a).(3).(q) vascular disorders; and,
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714 IV.A.5.a).(3).(r) vestibular and hearing disorders.
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716 IV.A.5.a).(4) should demonstrate competency in performing
717 otolaryngologic procedures, including:
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719 IV.A.5.a).(4).(a) will manage congenital, degenerative, idiopathic,
720 infectious, inflammatory, toxic, allergic,
721 immunologic, vascular, metabolic, endocrine,
722 neoplastic, foreign body and traumatic states
723 through airway management;
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725 IV.A.5.a).(4).(b) computer-assisted navigation.
726 operative intervention, and preoperative and
727 postoperative care of the following major
728 categories:
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730 IV.A.5.a).(4).(c) endoscopy of the upper aerodigestive tract;
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732 IV.A.5.a).(4).(d) laser usage;
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734 IV.A.5.a).(4).(e) local and regional anesthesia;
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736 IV.A.5.a).(4).(f) resuscitation;
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738 IV.A.5.a).(4).(g) stroboscopy; and
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740 IV.A.5.a).(4).(h) sedation and universal precautions. techniques;
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742 IV.A.5.a).(4).(i) general otolaryngology, including pediatric
743 otolaryngology, rhinology, bronchoesophagology,
744 and laryngology;
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746 IV.A.5.a).(4).(j) head and neck oncologic surgery;
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748 IV.A.5.a).(4).(k) facial plastic and reconstructive surgery of the head
749 and neck; and,
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751 IV.A.5.a).(4).(l) otology and neurotology.
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753 IV.A.5.a).(5) will competently perform habilitation and rehabilitation
754 techniques and procedures, including respiration,
755 deglutition, chemoreception, balance, speech, as well as
756 auditory measures such as hearing aids and implantable
757 devices;
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759 IV.A.5.a).(6) will diagnose and apply therapeutic techniques involving
760 endoscopy of the upper aerodigestive tract, including
761 rhinoscopy, laryngoscopy, esophagoscopy, and
762 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 demonstrate knowledge appropriate for unsupervised practice of otolaryngology as defined by the ABO curriculum~~.~~; and, ~~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 demonstrate knowledge of anatomy~~,~~ through procedural skills demonstrated in cadaver dissection, temporal bone lab, and/or surgical simulator labs. ~~understanding of~~ the ~~basic principles of study design, performance, analysis, and reporting~~

~~IV.A.5.b).(3) 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).(4) 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).(4).(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).(4).(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).(4).(c)~~ ~~communication sciences as they relate to otology and laryngology, including audiology, speech-language pathology, and voice science;~~

~~IV.A.5.b).(4).(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).(4).(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.**

916 **IV.A.5.d)** **Interpersonal and Communication Skills**
917
918 **Residents must demonstrate interpersonal and**
919 **communication skills that result in the effective exchange of**
920 **information and collaboration with patients, their families,**
921 **and health professionals. Residents are expected to:**
922
923 **IV.A.5.d).(1)** **communicate effectively with patients, families, and**
924 **the public, as appropriate, across a broad range of**
925 **socioeconomic and cultural backgrounds;**
926
927 **IV.A.5.d).(2)** **communicate effectively with physicians, other health**
928 **professionals, and health related agencies;**
929
930 **IV.A.5.d).(3)** **work effectively as a member or leader of a health care**
931 **team or other professional group;**
932
933 **IV.A.5.d).(4)** **act in a consultative role to other physicians and**
934 **health professionals;**
935
936 **IV.A.5.d).(5)** **maintain comprehensive, timely, and legible medical**
937 **records, if applicable; and,**
938
939 IV.A.5.d).(6) develop and present educational materials.
940
941 **IV.A.5.e)** **Professionalism**
942
943 **Residents must demonstrate a commitment to carrying out**
944 **professional responsibilities and an adherence to ethical**
945 **principles. Residents are expected to demonstrate:**
946
947 **IV.A.5.e).(1)** **compassion, integrity, and respect for others;**
948
949 **IV.A.5.e).(2)** **responsiveness to patient needs that supersedes self-**
950 **interest;**
951
952 **IV.A.5.e).(3)** **respect for patient privacy and autonomy;**
953
954 **IV.A.5.e).(4)** **accountability to patients, society and the profession;**
955 **and,**
956
957 **IV.A.5.e).(5)** **sensitivity and responsiveness to a diverse patient**
958 **population, including but not limited to diversity in**
959 **gender, age, culture, race, religion, disabilities, and**
960 **sexual orientation.**
961
962 **IV.A.5.f)** **Systems-based Practice**
963
964 **Residents must demonstrate an awareness of and**
965 **responsiveness to the larger context and system of health**
966 **care, as well as the ability to call effectively on other**

967 **resources in the system to provide optimal health care.**
968 **Residents are expected to:**
969
970 **IV.A.5.f).(1)** **work effectively in various health care delivery**
971 **settings and systems relevant to their clinical**
972 **specialty;**
973
974 **IV.A.5.f).(2)** **coordinate patient care within the health care system**
975 **relevant to their clinical specialty;**
976
977 **IV.A.5.f).(3)** **incorporate considerations of cost awareness and**
978 **risk-benefit analysis in patient and/or population-**
979 **based care as appropriate;**
980
981 **IV.A.5.f).(4)** **advocate for quality patient care and optimal patient**
982 **care systems;**
983
984 **IV.A.5.f).(5)** **work in interprofessional teams to enhance patient**
985 **safety and improve patient care quality; and,**
986
987 **IV.A.5.f).(6)** **participate in identifying system errors and**
988 **implementing potential systems solutions.**
989
990 IV.A.5.f).(7) ~~be familiar with ethical, socioeconomic, and medico-legal~~
991 ~~issues that affect the provision of quality and cost-effective~~
992 ~~care and the utilization of resources within the health care~~
993 ~~system; the provision of quality and cost-effective~~
994 ~~otolaryngology care within the context of the health care~~
995 ~~system; and the use of the resources of that health care~~
996 ~~system, other medical specialists, information technology,~~
997 ~~continuing medical education, and the ongoing analysis of~~
998 ~~clinical outcomes to assure such care.~~
999
1000 IV.A.6. Curriculum Organization and Resident Experiences
1001
1002 IV.A.6.a) PGY-1 residents must participate in clinical and didactic activities
1003 in which they:
1004
1005 IV.A.6.a).(1) assess, plan, and initiate treatment of adult and pediatric
1006 patients with surgical and/or medical problems;
1007
1008 IV.A.6.a).(2) care for patients of all ages with surgical and medical
1009 emergencies, multiple organ system trauma, soft tissue
1010 wounds, nervous system injuries and diseases, and
1011 peripheral vascular and thoracic injuries;
1012
1013 IV.A.6.a).(3) care for critically-ill surgical and medical patients in the
1014 intensive care unit and emergency room settings;
1015
1016 IV.A.6.a).(4) participate in the pre-, intra-, and post-operative care of
1017 surgical patients; and,

1018
1019 IV.A.6.a).(5) participate in surgical anesthesia in hospital and
1020 ambulatory care settings, including evaluation of
1021 anesthetic risks and the management of intra-operative
1022 anesthetic complications.
1023
1024 IV.A.6.b) In order to meet these goals, the PGY-1 must include:
1025
1026 IV.A.6.b).(1) a minimum of five months of structured education in at
1027 least three of the following: general surgery, pediatric
1028 surgery, plastic surgery, surgical oncology, thoracic
1029 surgery, transplantation surgery, and vascular surgery;
1030 and,
1031
1032 IV.A.6.b).(2) one month of structured education in each of the following
1033 four clinical areas: emergency medicine, critical care unit
1034 (intensive care unit, trauma unit or similar), anesthesia,
1035 and neurological surgery.
1036
1037 IV.A.6.b).(2).(a) These requirements should be fulfilled in the PGY-1
1038 year.
1039
1040 IV.A.6.c) PGY--2-5 must include 48 months of progressive education in
1041 otolaryngology and clinical services.
1042
1043 IV.A.6.d) The final year of education must be a chief resident experience
1044 and must be spent within sites approved as part of the program.
1045
1046 IV.A.6.e) Resident Supervision and Patient Care Experiences
1047
1048 IV.A.6.e).(1) Residents must have experience with state-of-the-art
1049 advances and emerging technology in otolaryngology.
1050
1051 IV.A.6.e).(2) Residents must perform a sufficient number, variety and
1052 complexity of surgical procedures to ensure education in
1053 the entire scope of the specialty.
1054
1055 IV.A.6.e).(2).(a) Residents must have essentially equivalent
1056 distributions of case categories and procedures.
1057
1058 IV.A.6.e).(3) Residents' experiences in the outpatient service must
1059 include:
1060
1061 IV.A.6.e).(3).(a) exposure to clinical aspects of the diagnosis,
1062 medical and/or surgical therapy, and the prevention
1063 of and rehabilitation from diseases, neoplasms,
1064 deformities, disorders and/or injuries of the ears,
1065 upper respiratory and upper alimentary systems,
1066 the face, the jaws, and other head and neck
1067 systems, head and neck oncology, and facial
1068 plastic and reconstructive surgery;

IV.A.6.e).(3).(b) evaluating patients, establishing provisional diagnoses, and initiating preliminary treatment plans; and

IV.A.6.e).(3).(c) providing follow-up care and evaluating the results of surgical care.

IV.A.6.e).(4) Residents should have experience in the procedures and management of office practice.

IV.A.6.e).(5) Residents must have experience in the emergency care of critically-ill and injured patients with otolaryngology conditions.

IV.A.6.e).(6) Each resident must have patient care responsibility commensurate with his or her knowledge, problem-solving ability, manual skills, and experience, as well as with the severity and complexity of each patient's status.

IV.A.6.e).(6).(a) This must include experience as assistant surgeon and resident supervisor.

IV.A.6.e).(6).(b) All levels of surgical intervention must be recorded in the ACGME Case Log System.

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~~ for a minimum of three months.

IV.B.2.a).(1) This must include instruction in research methods and design, as well as outcome assessment.

IV.B.2.a).(2) The research experience should result in a completed manuscript suitable for publication.~~ 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.1.d) The faculty must meet annually to provide collective evaluation of each resident, including surgical competency, and must provide an annual summative report for each resident.

V.A.1.e) The program director must review, in person, each resident's cumulative operative experience at least semiannually to ensure balanced progress of each resident towards achieving experience with a variety and complexity of surgical procedures.

V.A.1.f) Residents who fail to demonstrate appropriate industry, competence, responsibility, learning abilities, or ethics should be successively counseled and, after due process and remediation, dismissed if remediation is not successful.

V.A.2. Summative Evaluation

1171 **The program director must provide a summative evaluation for each**
1172 **resident upon completion of the program. This evaluation must**
1173 **become part of the resident's permanent record maintained by the**
1174 **institution, and must be accessible for review by the resident in**
1175 **accordance with institutional policy. This evaluation must:**
1176
1177 **V.A.2.a) document the resident's performance during the final period**
1178 **of education, and**
1179
1180 **V.A.2.b) verify that the resident has demonstrated sufficient**
1181 **competence to enter practice without direct supervision.**
1182
1183 **V.B. Faculty Evaluation**
1184
1185 **V.B.1. At least annually, the program must evaluate faculty performance as**
1186 **it relates to the educational program.**
1187
1188 **V.B.2. These evaluations should include a review of the faculty's clinical**
1189 **teaching abilities, commitment to the educational program, clinical**
1190 **knowledge, professionalism, and scholarly activities.**
1191
1192 **V.B.3. This evaluation must include at least annual written confidential**
1193 **evaluations by the residents.**
1194
1195 **V.C. Program Evaluation and Improvement**
1196
1197 **V.C.1. The program must document formal, systematic evaluation of the**
1198 **curriculum at least annually. The program must monitor and track**
1199 **each of the following areas:**
1200
1201 **V.C.1.a) resident performance;**
1202
1203 **V.C.1.b) faculty development;**
1204
1205 **V.C.1.c) graduate performance, including performance of program**
1206 **graduates on the certification examination; and,**
1207
1208 **V.C.1.d) program quality. Specifically:**
1209
1210 **V.C.1.d).(1) Residents and faculty must have the opportunity to**
1211 **evaluate the program confidentially and in writing at**
1212 **least annually, and**
1213
1214 **V.C.1.d).(2) The program must use the results of residents'**
1215 **assessments of the program together with other**
1216 **program evaluation results to improve the program.**
1217
1218 V.C.1.d).(3) Residents must participate in existing national
1219 examinations. Use of the annual Otolaryngology Training
1220 Examination (OTE) is strongly suggested. An analysis of
1221 the results of these testing programs must be limited to

guiding the faculty in assessing the strengths and weaknesses of the program.

V.C.1.d).(4) 75% of the program's graduates from the preceding five years taking the ABO certifying examination for the first time must pass.

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. Principles

VI.A.1. The program must be committed to and be responsible for promoting patient safety and resident well-being and to providing a supportive educational environment.

VI.A.2. The learning objectives of the program must not be compromised by excessive reliance on residents to fulfill service obligations.

VI.A.3. Didactic and clinical education must have priority in the allotment of residents' time and energy.

VI.A.4. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

VI.B. Supervision of Residents

The program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities.

VI.C. Fatigue

1273
1274 **Faculty and residents must be educated to recognize the signs of fatigue**
1275 **and sleep deprivation and must adopt and apply policies to prevent and**
1276 **counteract its potential negative effects on patient care and learning.**
1277
1278 **VI.D. Duty Hours (the terms in this section are defined in the ACGME Glossary**
1279 **and apply to all programs)**
1280
1281 **Duty hours are defined as all clinical and academic activities related to the**
1282 **program; i.e., patient care (both inpatient and outpatient), administrative**
1283 **duties relative to patient care, the provision for transfer of patient care,**
1284 **time spent in-house during call activities, and scheduled activities, such as**
1285 **conferences. Duty hours do *not* include reading and preparation time spent**
1286 **away from the duty site.**
1287
1288 **VI.D.1. Duty hours must be limited to 80 hours per week, averaged over a**
1289 **four-week period, inclusive of all in-house call activities.**
1290
1291 **VI.D.2. Residents must be provided with one day in seven free from all**
1292 **educational and clinical responsibilities, averaged over a four-week**
1293 **period, inclusive of call.**
1294
1295 **VI.D.3. Adequate time for rest and personal activities must be provided.**
1296 **This should consist of a 10-hour time period provided between all**
1297 **daily duty periods and after in-house call.**
1298
1299 **VI.E. On-call Activities**
1300
1301 **VI.E.1. In-house call must occur no more frequently than every third night,**
1302 **averaged over a four-week period.**
1303
1304 **VI.E.2. Continuous on-site duty, including in-house call, must not exceed 24**
1305 **consecutive hours. Residents may remain on duty for up to six**
1306 **additional hours to participate in didactic activities, transfer care of**
1307 **patients, conduct outpatient clinics, and maintain continuity of**
1308 **medical and surgical care.**
1309
1310 VI.E.2.a) ~~During this six hour time period, residents may assist in surgery.~~
1311
1312 **VI.E.3. No new patients may be accepted after 24 hours of continuous duty.**
1313
1314 VI.E.3.a) A new patient is defined as any patient for whom the
1315 otolaryngology service or department has not previously provided
1316 care~~. The resident should evaluate the patient before participating~~
1317 ~~in surgery.~~
1318
1319 **VI.E.4. At-home call (or pager call)**
1320
1321 **VI.E.4.a) The frequency of at-home call is not subject to the every-**
1322 **third-night, or 24+6 limitation. However at-home call must not**
1323 **be so frequent as to preclude rest and reasonable personal**

1324 **time for each resident.**
1325
1326 **VI.E.4.b) Residents taking at-home call must be provided with one day**
1327 **in seven completely free from all educational and clinical**
1328 **responsibilities, averaged over a four-week period.**
1329
1330 **VI.E.4.c) When residents are called into the hospital from home, the**
1331 **hours residents spend in-house are counted toward the 80-**
1332 **hour limit.**
1333
1334 **VI.F. Moonlighting**
1335
1336 **VI.F.1. Moonlighting must not interfere with the ability of the resident to**
1337 **achieve the goals and objectives of the educational program.**
1338
1339 **VI.F.2. Internal moonlighting must be considered part of the 80-hour weekly**
1340 **limit on duty hours.**
1341
1342 **VI.G. Duty Hours Exceptions**
1343
1344 **A Review Committee may grant exceptions for up to 10% or a maximum of**
1345 **88 hours to individual programs based on a sound educational rationale.**
1346
1347 **VI.G.1. In preparing a request for an exception the program director must**
1348 **follow the duty hour exception policy from the ACGME Manual on**
1349 **Policies and Procedures.**
1350
1351 **VI.G.2. Prior to submitting the request to the Review Committee, the**
1352 **program director must obtain approval of the institution's GMEC and**
1353 **DIO.**
1354
1355 **VII. Experimentation and Innovation**
1356
1357 **Requests for experimentation or innovative projects that may deviate from the**
1358 **institutional, common and/or specialty specific program requirements must be**
1359 **approved in advance by the Review Committee. In preparing requests, the**
1360 **program director must follow Procedures for Approving Proposals for**
1361 **Experimentation or Innovative Projects located in the ACGME Manual on Policies**
1362 **and Procedures. Once a Review Committee approves a project, the sponsoring**
1363 **institution and program are jointly responsible for the quality of education offered**
1364 **to residents for the duration of such a project.**
1365
1366 ***
1367