

PROGRAM REQUIREMENTS for RESIDENCY EDUCATION in OTOLARYNGOLOGY.

COMMON PROGRAM REQUIREMENTS APPEAR IN BOLD. SECTIONS OF TEXT THAT ARE NOT BOLDED ARE SPECIALTY SPECIFIC REQUIREMENTS.

I. Introduction

A. Definition and Scope of the Specialty

Residency programs in otolaryngology-head and neck surgery are designed to provide residents with education in the comprehensive evaluation and medical and surgical management of patients of all ages with diseases and disorders that affect the ears, upper respiratory and upper alimentary systems and related structures, and the head and neck. The educational program should include the core knowledge, skills, and understanding of the basic medical sciences relevant to the head and neck, and the upper respiratory and upper alimentary systems; the communication sciences, including the 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 the 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.

B. Duration and Scope of Education

1. Residency programs in otolaryngology-head and neck surgery must be of 5 years' duration, with at least 9 months of basic surgical, emergency and critical care, and anesthesia training within the first year, thereafter including at least 48 months of progressive education in the specialty inclusive of vacation time. The final year of the specialty education must be a chief resident experience, and must be spent within institutions approved as part of the program.
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 include resident participation in clinical and didactic activities that will give them the opportunity to:
 - a) develop the knowledge and skills needed to assess, plan, and initiate treatment of adult and pediatric patients with surgical and/or medical problems;

- b) demonstrate the ability to 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;
- c) demonstrate the ability to care for critically-ill surgical and medical patients in the intensive care unit and emergency room settings;
- d) participate in the pre-, intra-, and post-operative care of surgical patients;
- e) and understand surgical anesthesia in hospital and ambulatory care settings, including anesthetic risks and the management of intra-operative anesthetic complications.

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

- a) a minimum of 5 months of structured education in at least 3 of the following: general surgery, thoracic surgery, vascular surgery, pediatric surgery, plastic surgery, surgical oncology.
- b) 1 month of structured education in each of the following 4 clinical areas: emergency medicine, critical care unit (intensive care unit, trauma unit or similar), anesthesia, neurological surgery.

An additional maximum of 3 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.

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

- a) at least 36 months of rotations on otolaryngology-head and neck surgery and clinical services;
- b) a structured research experience, with instruction in research methods and design that includes outcomes assessment;

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.

II. Institutions

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 institutions.

The sponsoring institution must provide sufficient faculty, financial resources, support space, clinical and research facilities, and library materials to meet the educational needs of the residents, and to enable the program to comply with the requirements for accreditation. The governing body of the sponsoring institution must grant the program director sufficient authority, financial support, and access to facilities to organize and supervise the following activities: the selection and evaluation of residents; didactic and clinical instruction, including patient management and scholarly activity; and the recruitment and evaluation of staff. There must, additionally, be sufficient operative time available to ensure adequate surgical experience for residents.

B. Participating Institutions

- 1. Assignment to an institution must be based on a clear educational rationale, integral to the program curriculum, with clearly-stated activities and objectives. When multiple participating institutions are used, there should be assurance of the continuity of the educational experience.**
- 2. Assignment to a participating institution requires a letter of agreement with the sponsoring institution. Such a letter of agreement should:**
 - a) identity the faculty who will assume both educational and supervisory responsibilities for residents;**
 - b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;**
 - c) specify the duration and content of the educational experience; and**
 - d) state the policies and procedures that will govern resident education during the assignment.**
- 3. In programs involving 2 or more hospitals, the sponsoring institution must organize the program in such a way to provide residents with a progressive educational experience.**

4. Each participating institution must offer significant educational opportunities to the program. Resident education at each participating institution 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.
5. There must be a qualified otolaryngologist-head and neck surgeon appointed by and responsible to the program director in each geographically separate institution. 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 institution. The program director at each participating institution must have major clinical responsibilities at that institution.
6. The educational program may not include assignments to any non-approved participating institutions for more than a total of 3 months without prior approval of the Residency Review Committee (RRC).

C. Facilities and Resources

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.

1. Within each institution, beds sufficient for the needs of the service must be provided.
2. 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.
3. Technologically-current equipment considered necessary for diagnosis and treatment must be available.
4. 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.
5. Residents should be provided with adequate office, sleeping, lounge, and food facilities during assigned duty hours. Adequate clerical support services also must be provided.

6. Library
 - a) Residents must have ready access to a major medical library, either at the institution where the residents are located or through arrangement with institutions located conveniently nearby.
 - b) Library services should include the electronic retrieval of information from medical databases.
 - c) There must be access to an on-site library or to a collection of appropriate texts and journals in each institution participating in the residency program. On-site libraries and/or collections of texts and journals must be readily available during nights and weekends.

III. Program Personnel and Resources

A. Program Director

1. **There must be a single program director responsible for the program. The person designated with this authority is accountable for the operation of the program. In the event of a change of either program director or department chair, the program director should promptly notify the executive director of the RRC through the Web Accreditation Data System of the ACGME.**
2. **The program director, together with the faculty, is responsible for the general administration of the program, and for the establishment and maintenance of a stable educational environment. Adequate lengths of appointment for both the program director and faculty are essential to maintaining such an appropriate continuity of leadership.**
3. **Qualifications of the program director are as follows:**
 - a) **The program director must possess the requisite specialty expertise, as well as documented educational and administrative abilities.**
 - b) **The program director must be certified in the specialty by the American Board of Otolaryngology, or possess qualifications judged to be acceptable by the RRC.**
 - c) **The program director must be appointed in good standing and based at the primary teaching site.**

4. Responsibilities of the program director are as follows:

- a) The program director must oversee and organize the activities of the educational program in all institutions that participate in the program. This includes selecting and supervising the faculty and other program personnel at each participating institution, appointing a local site director, and monitoring appropriate resident supervision at all participating institutions.**
- b) The program director is responsible for preparing an accurate statistical and narrative description of the program as requested by the RRC, as well as updating annually both program and resident records through the ACGME's Accreditation Data System.**
- c) The program director must ensure the implementation of fair policies, grievance procedures, and due process, as established by the sponsoring institution and in compliance with the Institutional Requirements.**
- d) The program director must seek the prior approval of the RRC for any changes in the program that may significantly alter the educational experience of the residents. Such changes, for example, include:
 - (1) the addition or deletion of a participating institution;**
 - (2) a change in the format of the educational program;**
 - (3) a change in the approved resident complement for those specialties that approve resident complement.****

On review of a proposal for any such major change in a program, the RRC may determine that a site visit is necessary.

B. Faculty

- 1. At each participating institution, there must be a sufficient number of faculty with documented qualifications to instruct and supervise adequately all residents in the program. It is desirable that, in addition to the program director, there be at least two other members of the faculty with qualifications similar to those of the program director.**
- 2. The faculty, furthermore, must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities. They must demonstrate a strong interest in the**

education of residents, and must support the goals and objectives of the educational program of which they are a member.

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 be provided with sufficient experience in nonoperative management and preoperative, intraoperative, and postoperative care of patients with otolaryngologic disorders. This 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.

3. Qualifications of the physician faculty are as follows:

- a) **The physician faculty must possess the requisite specialty expertise and competence in clinical care and teaching abilities, as well as documented educational and administrative abilities and experience in their field.**
- b) **The physician faculty must be certified in the specialty by the American Board of Otolaryngology or possess qualifications judged to be acceptable by the RRC.**
- c) **The physician faculty must be appointed in good standing to the staff of an institution participating in the program.**

4. The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the faculty, and an active research component must be included in each program. *Scholarship* is defined as the following:

- a) **the scholarship of *discovery*, as evidenced by peer-reviewed funding or by publication of original research in a peer-reviewed journal;**
- b) **the scholarship of *dissemination*, as evidenced by review articles or chapters in textbooks;**
- c) **the scholarship of *application*, as evidenced by the publication or presentation of, for example, case reports or clinical series at local, regional, or national professional and scientific society meetings.**

Complementary to the above scholarship is the regular participation of the teaching staff in clinical discussions, rounds, journal clubs, and research conferences in a manner that promotes a spirit of inquiry and scholarship (e.g., the offering of guidance and technical support

for residents involved in research such as research design and statistical analysis); and the provision of support for residents' participation, as appropriate, in scholarly activities.

5. Qualifications of the nonphysician faculty are as follows:

- a) Nonphysician faculty must be appropriately qualified in their field.**
- b) Nonphysician faculty must possess appropriate institutional appointments.**

C. Other Program Personnel

Additional necessary professional, technical, and clerical personnel must be provided to support the program.

D. Resources

The program must ensure that adequate resources (e.g., sufficient laboratory space and equipment, computer and statistical consultation services) are available.

IV. Resident Appointments

A. Eligibility Criteria

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

B. Number of Residents

The RRC will approve the number of residents based upon established written criteria that include the adequacy of resources for resident education (e.g., the quality and volume of patients and related clinical material available for education), faculty-resident ratio, institutional funding, and the quality of faculty teaching.

- 1. Programs may not graduate more residents in any given year than the number of residents approved by the RRC, 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 RRC 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 RRC. Any such request for change in the approved resident complement must include a strong educational rationale.

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 RRC. Violations of these requirements will result in an adverse accreditation action.

C. Resident Transfers

To determine the appropriate level of education for residents who are transferring from another residency program, the program director must receive written verification of previous educational experiences and a statement regarding the performance evaluation of the transferring resident prior to their acceptance into the program. A program director is required to provide verification of residency education for residents who may leave the program prior to completion of their education.

D. Appointment of Fellows and Other Students

The appointment of fellows and other specialty residents or students must not dilute or detract from the educational opportunities available to regularly appointed residents.

V. Program Curriculum

A. Program Design

1. Format

The program design and sequencing of educational experiences will be approved by the RRC as part of the review process.

2. Goals and Objectives

The program must possess a written statement that outlines its educational goals with respect to the knowledge, skills, and other attributes of residents for each major assignment and for each level of the program. This statement must be distributed to residents and faculty, and must be reviewed with residents prior to their assignments. This statement must be distributed to residents and faculty, and reviewed with residents prior to the assignment.

B. Specialty Curriculum

The program must possess a well-organized and effective curriculum, both didactic and clinical. The curriculum must also provide residents with direct

experience in progressive responsibility for patient management.

The program must, further, have a comprehensive, well-organized, and effective curriculum, including the cyclical presentation of core specialty knowledge supplemented by the addition of current information. There must be evidence that the teaching is conducted in a variety of educational settings—such as clinics, classrooms, operating rooms, bedsides, and laboratories—employing accepted educational principles.

1. Basic Science

There must be a structured educational experience in basic science. Ordinarily, this should be provided within the participating institutions of the residency program. Any program that provides the requisite basic science experience outside the approved participating institutions 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.

The broad scope of the specialty of otolaryngology-head and neck surgery requires that the program provide basic science, medical, and surgical education in the following areas:

- 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.

Basic science education 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.

- b) Sufficient 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.
- c) Communication sciences as they relate to otology and laryngology, including audiology, speech-language pathology, and voice science.

- d) Resident instruction in anatomy should include the study and dissection of cadaver anatomic specimens, including the temporal bone, with appropriate lectures and other formal sessions.
- e) Resident instruction in pathology 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.
- f) 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 assure such care.

2. Clinical Conferences

Clinical conferences must be 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.

3. Clinical Components

a) Clinical Experiences

- i. 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.
- ii. Therapeutic and diagnostic imaging; the interpretation of medical imaging techniques relevant to 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.
- iii. Diagnostic evaluation and management of 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. Management of 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:
 - (a) General otolaryngology, including pediatric otolaryngology, rhinology, bronchoesophagology and laryngology;
 - (b) Head and neck oncologic surgery;
 - (c) Facial plastic and reconstructive surgery of the head and neck;
 - (d) Otology and neurotology.
- v. Habilitation and rehabilitation techniques and procedures, including respiration, deglutition, chemoreception, balance, speech, as well as auditory measures such as hearing aids and implantable devices.
- vi. Diagnostic and 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.
- vii. Exposure to state-of-the-art advances and emerging technology in Otolaryngology and Head-and-Neck Surgery.

b) Surgical Experience

- i. The sponsoring and participating institutions 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. While not all residents are expected to have operative experience in all surgical specialty procedures, the surgical procedures residents do perform must be sufficient in number and variety to provide education in the entire scope of the specialty. There must be adequate distribution and sufficient complexity within the principal categories of the specialty.
- iii. Equivalent and adequate distribution of categories and procedures among the residents must generally be demonstrated. 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).
- iv. Documentation of each individual resident's operative experience must be provided. The cumulative operative experience of each resident must be reviewed at least semiannually by the program director as part of his or her responsibility for evaluation of the balanced progress of individual residents. 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 RRC.

c) Outpatient Experience

- i. There must be 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.

- ii. If residents participate in preoperative and postoperative care in a private office, the program director must ensure that the resident functions with an appropriate degree of responsibility with adequate supervision. Experience should be provided in the procedures and management of office practice.
- iii. Residents must have experience in the emergency care of critically ill and injured patients with otolaryngology-head and neck conditions.

C. Residents Scholarly Activities

Each program must provide an opportunity for residents to participate in research or other scholarly activities, and residents must participate actively in such scholarly activities.

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.

D. ACGME Competencies

The residency program must require its residents to obtain competence in the six areas listed below to the level expected of a new practitioner. Programs must define the specific knowledge, skills, behaviors, and attitudes required, and provide educational experiences as needed in order for their residents to demonstrate the following:

1. ***Patient care* that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health;**
2. ***Medical Knowledge* about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care;**
3. ***Practice-based learning and improvement* that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements in patient care;**

4. ***Interpersonal and communication skills*** that result in the effective exchange of information and collaboration with patients, their families, and other health professionals;
5. ***Professionalism***, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds;
6. ***Systems-based practice***, as manifested by actions that 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.

VI. Resident Duty Hours and the Working Environment

Providing residents with a sound didactic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energy. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

A. Supervision of Residents

1. **All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of residents at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty.**
2. **Faculty schedules must be structured to provide residents with continuous supervision and consultation.**
3. **Faculty and residents must be educated to recognize the signs of fatigue, and adopt and apply policies to prevent and counteract its potential negative effects.**
4. **The program director must ensure, direct, and document the implementation of and compliance with appropriate resident policies at all times.**

B. Duty Hours

1. **Duty hours are defined as all clinical and academic activities related to the residency program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the**

provision for transfer of patient care, time spent in-house during call activities, and scheduled activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

- 2. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.**
- 3. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties.**
- 4. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.**

C. On-call Activities

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. *In-house call* is defined as those duty hours beyond the normal work day, when residents are required to be immediately available in the assigned institution.

- 1. In-house call must occur no more frequently than every third night, averaged over a 4-week period.**
- 2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care. During this time, residents may assist in surgery.**
- 3. No new patients may be accepted after 24 hours of continuous duty. A new patient is defined as any patient for whom the otolaryngology service or department has not previously provided care. The resident should evaluate the patient before participating in surgery.**
- 4. *At-home call* (or *pager call*) is defined as a call taken from outside the assigned institution.**
 - a) The frequency of at-home call is not subject to the every-third-night limitation. At-home call, however, must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided**

with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.

- b) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.**
- c) The program director and the faculty must monitor the demands of at-home call in their programs, and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.**

5. Graded Responsibility

The responsibility given to residents in patient care should depend upon an 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.

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.

D. Moonlighting

- 1. Because residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.**
- 2. The program director must comply with the sponsoring institution's written policies and procedures regarding moonlighting, in compliance with the ACGME Institutional Requirements.**
- 3. Any hours a resident works for compensation at the sponsoring institution or any of the sponsor's primary clinical sites must be considered part of the 80-hour weekly limit on duty hours. This refers to the practice of *internal moonlighting*.**

E. Oversight

- 1. Each program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment. These policies must be distributed to the residents and the faculty. Duty hours must be monitored with a frequency sufficient to ensure an appropriate balance between education and service.**
- 2. Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.**

F. Duty Hours Exceptions

An RRC may grant exceptions for up to 10% of the 80-hour limit to individual programs based on a sound educational rationale. Prior permission of the institution's GMEC, however, is required.

VII. Evaluation

A. Resident

1. Formative Evaluation

The faculty must evaluate in a timely manner the residents whom they supervise. In addition, the residency program must demonstrate that it has an effective mechanism for assessing resident performance throughout the program, and for utilizing the results to improve resident performance.

- a) Assessment should include the use of methods that produce an accurate assessment of residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.**
- b) Assessment should include the regular and timely performance feedback to residents that includes at least semiannual written evaluations. Such evaluations are to be communicated to each resident in a timely manner, and maintained in a record that is accessible to each resident.**
- c) Assessment should include the use of assessment results, including evaluation by faculty, patients, peers, self, and other**

professional staff, to achieve progressive improvements in residents' competence and performance.

- d) 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.
- e) 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.

2. Final Evaluation

The program director must provide a final evaluation for each resident who completes the program. This evaluation must include a review of the resident's performance during the final period of education, and should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. The final evaluation must be part of the resident's permanent record maintained by the institution.

B. Faculty

The performance of the faculty must be evaluated by the program no less frequently than at the midpoint of the accreditation cycle, and again prior to the next site visit. The evaluations should include a review of their teaching abilities, commitment to the educational program, clinical knowledge, and scholarly activities. This evaluation must include annual written confidential evaluations by residents.

C. Program

The educational effectiveness of a program must be evaluated at least annually in a systematic manner.

- 1. **Representative program personnel (i.e., at least the program director, representative faculty, and one resident) must be organized to review program goals and objectives, and the effectiveness with which they are achieved. This group must conduct a formal documented meeting at least annually for this purpose. In the evaluation process, the**

group must take into consideration written comments from the faculty, the most recent report of the GMEC of the sponsoring institution, and the residents' confidential written evaluations. If deficiencies are found, the group should prepare an explicit plan of action, which should be approved by the faculty and documented in the minutes of the meeting.

- 2. The program should use resident performance and outcome assessment in its evaluation of the educational effectiveness of the residency program. Performance of program graduates on the certification examination should be used as one measure of evaluating program effectiveness. The program should maintain a process for using assessment results together with other program evaluation results to improve the residency program.**

VIII. Experimentation and Innovation

Since responsible innovation and experimentation are essential to improving professional education, experimental projects along sound educational principles are encouraged. Requests for experimentation or innovative projects that may deviate from the program requirements must be approved in advance by the RRC, and must include the educational rationale and method of evaluation. The sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.

IX. Certification

Residents who plan to seek certification by the American Board of Otolaryngology should communicate with the office of the board or consult its web site (www.aboto.org) regarding the full requirements for certification.

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Common Program Requirements:

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