

UNIVERSITY OF /MINNESOTA GRADUATE MEDICAL EDUCATION

2019-2020 EDUCATIONAL PROGRAM/CURRICULUM

Department of Otolaryngology **Otolaryngology Residency**

This Otolaryngology Residency Educational Program/Curriculum is intended for use together with the Graduate Medical Education Institution Policy Manual, available online at <http://z.umn.edu/gmeim>. The Institution Policy Manual contains information about benefits, policies and procedures that apply to all residents and fellows in a training program at the University of Minnesota. Should information in the Program Manual conflict with the Institution Manual, the Institution Manual takes precedence.

It is also intended for use with the Department of Otolaryngology Program Policy and Procedure Manual, available online at: <https://www.ent.umn.edu/education/otolaryngology-residency>. The Department Policy Manual contains information about policies and procedures that apply to all residents and fellows in a training program in the Department of Otolaryngology at the University of Minnesota.

Otolaryngology Residency Training Program Mission Statement

The goal of the Residency program at the University of Minnesota is first and foremost to provide excellent clinical training so that the finishing resident is competent to perform a wide variety of surgical procedures and to care for a wide variety of patient problems. It is also the philosophy of the Department that a thorough understanding of the basic sciences relevant to otolaryngology is crucial to the training of the resident and to the maintenance of clinical skills and expertise upon finishing the training program. Additionally, this Department is dedicated to training academic otolaryngologists who not only have excellent clinical skills but will also become teachers and researchers in the specialty.

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EDUCATIONAL PROGRAM/CURRICULUM

ACCREDITATION

The Otolaryngology Residency Training Program at University of Minnesota is accredited by the Accreditation Council for Graduate Medical Education (ACGME). Accreditation status is included in Appendix 1. Current requirements for accreditation are included in Appendix 2. For the most up-to-date information visit ACGME's web site, www.acgme.org.

ACGME Resident Case Log

All residents must maintain a record of their surgical procedures on the Resident Case Log System provided by the Accreditation Council for Graduate Medical Education (ACMGE) at www.acgme.org.

Include procedures performed in clinic as well as in the operating room.

ACGME's Otolaryngology Residency Review Committee highly recommends that residents log their cases on a weekly, or more frequent, basis, so that procedures don't become lost or forgotten. Residents are able to view their case logs at any time, and can correct entries as needed. The Program Director is able to, at any time, review the operative data submitted by each of the residents. A number of statistics regarding operative data are available on the ACGME web site (password protected) for access by residents and program directors, including cumulative national medians, means and standard deviations for each procedure category, subdivided by year of otolaryngology training. Program Directors are able to scan the case logs of each of their residents, tagged for procedure experiences 1 standard deviation or more below the national norms per resident year of training, so they can tailor resident rotations accordingly.

Residents will be able to print out their cumulative operative experiences.

ACGME will provide the American Board of Otolaryngology with the operative experience report it requires when the resident applies for examination.

Resident logging of procedures relies solely on the AMA's CPT coding system. The opportunity to use the CPT codes prepares the residents for coding procedures after the completion of residency training.

The one, and significant, deviation from CPT coding rules allows for "unbundling" so that all procedures or significant segments of such done by each resident can be captured. Ample samples of "unbundling" acceptable for resident reporting purposes have been placed as a link on the Resident Case Log web site.

Categories of resident involvement in a surgical procedure include "resident surgeon," "assistant surgeon" and "resident supervisor." Definitions of these categories are available on the resident case log web site.

AMERICAN BOARD OF OTOLARYNGOLOGY

This program is designed to prepare its graduates to sit for the certifying examinations offered by the American Board of Otolaryngology (ABOto). Requirements residents must fulfill for certification are listed in the American Board of Otolaryngology Booklet of Information. Residents should visit the ABOto web site at www.aboto.org for the most up-to-date requirements for certification.

American Board of Otolaryngology Resident Registry

All residents must be registered with the ABOto during the first year of otolaryngology training (PGY1 year) in order to subsequently apply to take the certification examination.

New Residents: A New Resident Form must be filed for each new resident by the Program Director by July 10 of the first year of otolaryngology-head and neck surgery training.

New residents then receive instructions on the procedure and deadline for submitting an official medical school transcript and documentation of previous training to the ABOto.

Returning Residents: The Program Director subsequently submits a Resident Evaluation Form for each returning resident by July 10 of each year, noting whether the previous year was successfully completed.

Resident Evaluation Forms become part of the individual's ABOto file, and are a prerequisite for application for the certification examination. Credit may not be granted by the ABOto for any year of training for which an Evaluation Form is not received.

EDUCATIONAL GOALS

ACGME Competencies

Otolaryngology residents are required to obtain competencies in the 6 areas below to the level expected of a new practitioner (see ACGME requirements for more information):

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, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care
3. *Practice-based learning and improvement* that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and continuous improvement in patient care based on constant self-evaluation and life-long learning
4. *Interpersonal and communication skills* that result in the effective exchange of information and collaboration with patients, their families and health professionals

5. *Professionalism*, as manifested through a commitment to carrying out professional responsibilities and adherence to ethical principles
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 effectively call on other resources in the system to provide optimal care

PGY1 Goals and Objectives (Developed and modified from the American College of Surgeons)

Locations: *University of Minnesota Medical Center (UMMC); HealthPartners/Regions Hospital, St. Paul (Regions); Hennepin County Medical Center, Minneapolis (HCMC), and Minneapolis VA Health Care System (VA)*

The Otolaryngology Program Director is responsible for the design, implementation and oversight of the PGY1 year. Scheduling of PGY1 rotations is done in conjunction with the Surgery Program Director at Hennepin County Medical Center, as permitted by ACGME.

Rotations are intended to meet ACGME requirements for the PGY1 year. Effective in 2016, ACGME requirements for the PGY-1 year include:

six months of structured education on non-otolaryngology rotations designed to foster proficiency in the perioperative care of surgical patients, inter-disciplinary care coordination, and airway management skills; and,

The total time a resident is assigned to any one non-otolaryngology rotation must be at least four weeks and must not exceed two months.

Rotations must be selected from the following: anesthesia, general surgery, neurological surgery, neuroradiology, ophthalmology, oral-maxillofacial surgery, pediatric surgery, plastic surgery, and radiation oncology.

This must include an intensive care rotation.

six months of otolaryngology rotations designed to develop proficiency in basic surgical skills, general care of otolaryngology patients both in the inpatient setting and in the outpatient clinics, management of otolaryngology patients in the emergency department, and cultivation of an otolaryngology knowledge base.

GENERAL SURGERY, TRAUMA, VASCULAR, THORACIC and PLASTIC ROTATIONS

Patient Evaluation, Assessment, and Management

By the completion of PGY-1, the resident should be knowledgeable in the following areas and be able to do:

History and Physical Examination, Documentation

- Obtain a detailed surgical history and obtain and review relevant medical records and reports
- Perform a detailed physical examination.
- Develop a complete differential diagnosis.
- Maintain a personal patient log.

- Write a succinct H&P, including a risk assessment evaluation.
- Obtain a written informed consent.
- Document the treatment plan in the medical record, including the indications for treatment.
- Dictate an operative note and discharge summary.
- Write daily patient progress notes by hand or electronically
- Understand and successfully use the electronic medical record system for notes, orders and X-rays

Patient Assessment and Perioperative Management

- Order and interpret basic laboratory tests and screening X-Rays, and evaluate the patient's cardiac, pulmonary, renal, and neurological status.
- Develop a preoperative assessment of risk factors.
- Review, prioritize, and order medications the patient is currently taking, as appropriate.
- Use and understand the nursing notes and patient data including by an electronic system.
- Prescribe activity level, management of medications, pain management, follow up appointments, and obtain urgent contact information.

Assessment of Basic Diagnostic Tests and X-Rays

- Recognize abnormalities in basic radiologic and laboratory tests and learn normal values and ranges.
- Choose the optimal imaging technique.
- Recognize:
 - pleural effusion on CXR
 - chest mass on CXR
 - pneumonitis on CXR
 - bowel gas patterns on flat plate abdomen
 - diaphragm abnormalities on CXR
 - spinal column fractures
 - cervical spine radiographs
- Interpret basic EKG findings
- Recognize ischemia & arrhythmia patterns on EKG.

Management of Fluid/Electrolyte and Acid Base Balance

- Understand acid-base balance and the applications of body composition to fluid, electrolyte, and acid-base balance in health and disease.
- Give fluid resuscitation, manage postoperative fluid requirements, and recognize and correctly manage acid-base disorders.
- Make adjustments in fluid administration for comorbid conditions, e.g. renal or cardiac insufficiency, diabetes, hypovolemia.
- Use CVP and urine flow rates for adjustments of fluid administration.
- Perform a saphenous cutdown.
- Recognize and treat calcium and magnesium imbalance.

Fever, Microbiology, and Surgical Infection

- Know the mediators of fever, differential diagnosis, evaluation and management of the febrile patient in order to initiate appropriate workup of fever and provide supportive treatment.
- Initiate definitive treatment with appropriate antibiotics.

- Be able to monitor antibiotic levels and recognize drug-related complications. Know the antibiotic of choice.
- Know and apply the principles of prevention of nosocomial infections, sterile technique and universal precautions.
- Order and interpret the appropriate imaging studies for localization of an infected focus.
- Know and apply the principles of incision and drainage.
- Know the proper use of prophylactic antibiotics.
- Know the classification of wounds (clean, clean-contaminated, contaminated, infected).
- Recognize the septic syndrome and initiate appropriate supportive treatment. Be familiar with the current literature concerning the causes and mediators of the sepsis syndrome and its pathophysiology.

Epidemiology and Public Health

- Be knowledgeable in AIDS diagnosis and prevention of HIV infection.
- Understand the epidemiology and treatment of sexually transmitted diseases and other communicable diseases.

Nutrition

- Perform a metabolic assessment of the surgical patient.
- Understand the metabolic implications of trauma and operation.
- Know the indications for nutritional support of the surgical patient.
- Know the methods of calculation of nutritional requirements in health and disease using the Harris-Benedict or similar formulae.
- Know the composition of various enteral and parenteral formulas and adjust appropriately.
- Calculate and order basic enteral or parenteral formulas.
- Recognize complications of enteral and parenteral feedings.
- Manage central IV lines.
- Manage gastrostomy or jejunostomy feeding tubes.
- Assess when a postoperative patient can be fed and assess adequacy of intake.
- Know and utilize comparative costs of nutritional support methods.

Perioperative Preparation

- Complete, document, and assess appropriate workup, write preoperative orders, and obtain required consultation from other specialists.

Surgical Skills

- Learn surgical site positioning, preparation and draping.
- Perform as first assistant. Know how to obtain hemostasis of small vessels and exposure of the operative field.
- Be familiar with common surgical instruments (scalpel, forceps, scissors, needle holders, hemostats, retractors, electrocautery) and suture materials and their proper uses.
- Perform basic maneuvers, e.g. suture of skin, soft tissues, fascia; tie knots; obtain simple hemostasis.
- Learn basic techniques of dissection and handling of tissues.
- Under supervision:
 - excise benign lesions of skin and subcutaneous tissues.
 - perform lymph node biopsy.
 - remove superficial foreign bodies.
 - incise and drain an abscess.

- repair simple lacerations.
- repair umbilical and type I and II inguinal hernias.
- perform appendectomy.

Sterile Technique

- Understand indications for and utilize appropriate methods of routine and reverse isolation procedures.
- Maintain appropriate sterile technique in the ER, at the bedside, in the ICU, and in the office.

Wound Management

- Differentiate between wound infection, hematoma, and seroma, and initiate therapy.
- Perform extensive debridement with supervision.
- Debride and pack wounds and apply dressings.
- Recognize and differentiate between wound infection and necrotizing fasciitis, and detect crepitus.
- Identify wound dehiscence and evisceration.
- Know and apply the specific recommendations for tetanus immunization (active and passive).
- Know the clinical manifestations of rabies in carrier and patient, and agents available to prevent development of the disease.
- Obtain proper wound specimen and perform and interpret Gram stain.

Prioritize and Manage Complications

- Assess and manage complications or change in health status, such as:
 - altered mental status.
 - fever.
 - hypotension.
 - hypovolemia, oliguria.
 - hypoxia.
 - pain .
 - vomiting, distention, nausea.
 - bleeding at the bedside & coagulopathy.
 - atelectasis, pneumonia, aspiration.
 - fecal impaction, constipation
 - chest pain,
 - dyspnea
 - pneumothorax
 - congestive heart failure, pulmonary edema
 - superficial phlebitis,
 - pulmonary embolus
 - urinary retention
 - diabetic ketoacidosis or hyperosmolar coma
 - peripheral ischemia or cyanosis
 - seizures, alcohol or drug withdrawal

Thoracic Surgery Rotation

The main goal of this rotation is to provide the PGY1 resident an organized experience to enable him/her to acquire the basic knowledge and skills in the evaluation and management of patients with common cardiac and pulmonary surgical problems.

At the completion of this rotation the PGY1 resident should be knowledgeable in the following areas and be able to do:

- Review applied cardiac physiology and applied pulmonary physiology
- Critical care and management of shock
- Basic surgical skills.
- Evaluation and management of chest masses
- Care for at least 15 ICU patients/month

ANESTHESIA, CRITICAL CARE, EMERGENCY MEDICINE, AND NEUROSURGERY ROTATIONS

Anesthesia Rotation

The main goal of this rotation is to provide the PGY1 resident an organized experience to enable him/her to acquire the basic knowledge and skills in preoperative care including preanesthetic evaluation, anesthetic risk assessment, airway evaluation and immediate postoperative care.

At the completion of this rotation the PGY 1resident should be knowledgeable in the following areas and be able to do:

- Basic laryngeal anatomy and physiology.
- Appropriate indications for general vs. local anesthesia.
- Appropriate preoperative evaluation including when to order a pre-operative chest x-ray, EKG, and laboratory tests based on the patient's age, past medical history and social habits.
- Write pre-anesthetic orders
- Obtain oropharyngeal control of airway and provide Ambu ventilation
- Be able to perform:
 - orotracheal intubation
 - nasotracheal intubation
 - laryngeal mask ventilation
 - jet ventilation
- Interpret the anesthesia record
- Position the patient properly for operative exposure, temperature control, and protection from pressure/traction.
- Be familiar with intraoperative monitoring.
- Insert arterial and venous lines.
- Know the dose range and complications (including pulmonary edema and malignant hyperthermia) of the following agents:
 - barbiturates
 - local anesthetics
 - paralyzing agents
 - reversing agents
 - inhalant anesthetics
- Know when and how to use epinephrine, hyaluronidase, in local anesthesia
- Under supervision:
 - administer a local block
 - administer general anesthesia
- Understand and use conscious sedation
- ACLS certification

Critical Care Rotation

The main goal of this rotation is to provide the PGY1 resident an organized experience to enable him/her to acquire the basic knowledge and skills in the evaluation and management of patients in the intensive care setting.

At the completion of this rotation the PGY 1 resident should be knowledgeable in the following areas and be able to do:

Critical Care and Management of Shock

- Differentiate types of shock (hemorrhagic, cardiogenic, septic, neurologic) and initiate appropriate therapy.
- Insert central venous and arterial catheters and obtain hemodynamic data; interpret data and initiate therapy.
- Recognize clinic presentation of a pneumothorax and insert chest tube
- Understand and utilize basic principles of mechanical ventilation.
- Recognize the indications for blood component therapy and initiate therapy.
- Recognize a transfusion reaction and initiate management.
- Institute measures to prevent upper GI bleeding in critically ill patients.

Coagulation and Anticoagulation

- Choose the appropriate tests for diagnosis of a coagulopathy, and have a working knowledge of factor analysis.
- Apply effective preventive measures for DVT and PE.
- Initiate and monitor therapeutic anticoagulation and its complications.
- Diagnose and manage acute deep venous thrombosis.
- Acutely manage a patient with a suspected acute pulmonary embolus, and provide a differential diagnosis.

Applied Cardiac Physiology

- Recognize rhythm disturbances, myocardial ischemia on EKG.
- Assess, formulate a differential diagnosis and initiate therapy for hypotension.
- Know and apply appropriate treatment for supraventricular tachycardia.
- Treat congestive failure and acute pulmonary edema.
- Manage hypertension in a surgical patient. Understand multidrug therapy and the toxic and side effects of antihypertensive drugs.

Applied Renal Physiology

- Know the pathophysiology of the development of acute renal failure; the differentiation of prerenal, renal, obstructive types of renal failure; and the general concepts of prevention and treatment of ARF.
- Recognize and treat simple electrolyte disturbances.
- Understand appropriate fluid replacement and balance.

Applied Pulmonary Physiology

- Know the manifestations—clinical and by laboratory testing—of obstructive pulmonary disease and pulmonary insufficiency, and their surgical perioperative management.
- Recognize bronchoconstrictive disorders and their perioperative management.

Applied Nutrition

- Learn to manage the nutritional needs of a critically ill patient.

- Placement of nasogastric tube and dophoff tube.

Surgical Skills

- Develop surgical skills in CPR, CVC placement, arterial catheter placement, and chest tube placement.
- Perform first assistant in bedside bronchoscopy, pulmonary lavage, and tracheotomy.
- Obtain oropharyngeal control of airway, provide Ambu ventilation and perform orotracheal intubation.

Emergency Medicine Rotation

The main goal of this rotation is to provide the PGY1 resident an organized experience to enable him/her to acquire the basic knowledge and skills in the evaluation and management of patients presenting to the emergency room with emphasis on patients presenting with head and neck complaints. The PGY1 resident should also gain a better appreciation of medical conditions often seen as co-morbidities in head and neck patients including, diabetes mellitus, hypertension, stroke, congestive heart disease, respiratory distress and myocardial infarction.

At the completion of this rotation the PGY 1resident should be knowledgeable in the following areas and be able to do:

- Conduct primary assessment and take appropriate steps to stabilize and treat patients with trauma (penetrating and blunt), respiratory distress, congestive heart failure, metabolic imbalances, myocardial infarction, and chronic pain.
- Establish the acuity level of patients in the ER, establish priorities and define the tasks necessary to manage the patients successfully.
- Monitor, observe, manage, and maintain the stability of one or more patients who are at different stages in their work-ups including fundamental lab tests and radiological studies.
- Recognize and initiate treatment for an acute anaphylactic reaction.
- Collaborate with physicians and other professionals to evaluate and treat patients, arrange appropriate placement and transfer if necessary, formulate a follow-up plan, and communicate effectively with patients, family, and involved health care members.
- Closure of simple and complex lacerations.
- Develop some familiarity with disaster management.

Neurosurgery Rotation

The main goal of this rotation is to provide the PGY1 resident an organized experience to enable him/her to acquire the basic knowledge and skills in the evaluation and management of patients presenting with neurosurgical complaints. The resident should gain an appreciation for the collaborative efforts between the ORL and NES specialties.

At the completion of this rotation the PGY-1 resident should be knowledgeable in the following areas and be able to do:

- Review basic cranial anatomy including cranial nerve origin and function.
- Perform neurosurgical patient evaluation, assessment and management.
- Learn evaluation and treatment of neurological trauma, critical care and emergencies.
- The indications for and basic interpretation of diagnostic tests and X-rays including basic head CT and MRI imaging studies.
- Basic neurosurgical skills, technique, and wound management including simple craniotomy, dural suturing and craniotomy closure.

- Recognition, diagnosis, and basic management of CSF leaks.
- Insertion and management of a lumbar drain.
- Management of common neurosurgical complications.
- Differentiate between stroke, TIA, and non-cerebrovascular events causing neurological symptoms and know the diagnostic techniques.
- Participate in at least 5 major procedures (cranial decompression, craniotomy, removal of pituitary adenoma)
- Understand neurosurgical procedures as it relates to Otolaryngology (suboccipital or retrosigmoid approaches).

Otolaryngology-Head and Neck Surgery Rotation

The main goal of this rotation is to provide the PGY-1 resident with an introduction to basic otolaryngology. At least 50% of the resident's time will be spent in the clinical evaluation of out-patients and the care of in-patients. Emphasis will be given on the management of Otolaryngology emergencies and office procedures, and introduction and development of basic surgical procedures:

- Understanding of the indications, risks, contraindications of a wide variety of Otolaryngologic surgical procedures for adult and pediatric patients.

Knowledge level demonstrated by above average performance, as compared to Program Year peers nationally, on annual in-service examination.

Clinical Skill development:

By the end of the first year of training, the resident should have been trained in the following skills and procedures:

- Medical histories and physical examinations of the head and neck
- Evaluation and treatment of common adult otolaryngologic problems [both inpatient and outpatient]
- Placement of IV's; drawing blood; performing ABG's
- Case presentations at morning and afternoon rounds
- Preoperative and postoperative evaluations of patients, admissions and discharges
- Management of the service with guidance from the chief residents and relevant Attendings, and/or Director of Resident Education
- Triaging and initiating care of otolaryngologic emergencies [both adult and pediatric] with supervision of Chief Residents and Attendings
- Performance of the following procedures: Tracheotomy, trach changes, tonsillectomy and adenoidectomy, closed reduction of nasal fractures, microscopic otoscopy and myringotomy and tube (M&T) insertion, fiberoptic laryngoscopy, flexible laryngoscopy, fine needle aspiration biopsies, oral biopsies, minor surgical procedures (ear lobe repair, incision and drainage, minor excisions, soft tissue trauma), microscopic ear examination with cerumen removal, treatment of epistaxis.

Development of personal style should include: self-assessment regarding work quality, ethical practice; ability to work as part of a team, and within a health care network; short-term planning, long-term planning; meticulous record keeping, including medical chart notes, informed consent, clinical administrative reports as assigned; efficient work habits.

Progression of responsibilities: By learning to evaluate inpatient and emergency consults, by contributing to the post-operative care of a wide variety of Otolaryngology patients, by operating

as outlined below the first resident acquires skills that prepare him/her for increasing responsibilities as a second year resident.

Research Skill Development

By the end of the first year of training, the resident should have visited the basic science laboratories and clinical research areas and met with individual faculty to learn about faculty research interests.

PGY-2 through PGY-5 Overview

Locations: University of Minnesota Medical Center, Fairview (UMMC); Children's Hospital and Clinic, Minneapolis and St. Paul (CH); Regions Hospital, St. Paul (Regions); Hennepin County Medical Center, Minneapolis (HCMC); Minneapolis VA Health Care System (VA)

Education Program overview for all Residents PGY 2 – PGY 5

All residents are expected to attend Grand Teaching Rounds Tuesday mornings at the Departmental conference room unless otherwise specified. The schedule is posted on the department website. All residents are expected to attend the Department-wide Morbidity and Mortality Conference the first Tuesday of the month as published on the department website. The expectation of attendance occurs throughout residency training and attendance is recorded.

In addition each hospital of rotation maintains its own weekly or monthly conferences and attendance is required while rotating at that hospital

University of Minnesota Medical Center, Fairview
Head & Neck Tumor Board (Friday)

Children's Hospital, Minneapolis
Pediatric Conference (monthly)

Regions
Maxillofacial Trauma Radiology Conference (Monday AM)
Maxillofacial Trauma Surgery Conference w/Plastics (monthly)

VA
Education Conference w/Dr. Gapany (Wednesday AM)
Tumor Board (Wednesday)

Hennepin County Medical Center
Citywide Otolaryngology Conference (once a month)
Otolaryngology Pathology Conference (once a month)
Otolaryngology Department Meeting, including case conference (once a month)
Journal Rounds (Friday)

Clinical program overview all residents (PGY2 – PGY-5)

All hospital rotations other than the University or Children's perform as a general Otolaryngology service where the chief resident assigns junior residents to cases and clinic.

HCMC service has faculty in head & neck (Odland, Goding), otology (Haberman), facial plastics / trauma (Odland, Walsh), pediatrics (Rimell), general and sinus (Schnitker, Skovlund, Boyer, Rosenberg), Laryngology (Goding).

Regions service has faculty in head & neck (Ondrey, Schmidt, Hamlar), facial plastics/trauma (Dresner, Hamlar), general and sinus (Janus, Schmidt), otology (Fina).

VA service has full time faculty (Caicedo-Granados and Gapany), and part time faculty in laryngology (Goding), otology (Fina and Huang), and sleep (Froyomovich).

University of Minnesota (UMMC) service is based on subspecialty assignments. PGY-2 is otology/neurotology and sinus (Levine, Huang, Adams, Boyer); PGY-3 is head & neck/reconstruction (Yueh, Lyford-Pike, Ondrey, Khaja, Khariwala); PGY-4 is pediatrics-3 months (Roby, Meyer) and Laryngology, Rhinology, Skullbase and Sleep-3 months (Boyer, Goding, Hsia, Misono); PGY-5 is allowed to participate in any area but must cover all endocrine cases (Evasovich).

Children's is for the PGY-2 resident and is all pediatrics as well as craniofacial and cleft palate where the Otolaryngology service runs the cleft palate clinic and does the cases (Lander, Tibesar).

PGY2 Goals and Objectives

The clinical training in the PGY2 year is spent working in four different three month rotations:

- Pediatrics at Children's Hospital (all residents);
- Otology at University of Minnesota (all residents);
- General otolaryngology-VA (all residents)
- General otolaryngology-HCMC (some residents)
- General otolaryngology-Regions (some residents)

All PGY-2 Residents are expected to attend the basic science curriculum that occurs throughout the PGY-2 year. The course includes head & neck anatomy (cadaver dissection offered by the Dept. of Anatomy, University of Minnesota), temporal bone anatomy dissection course, basic science audiology and speech pathology, and basic science otolaryngology. In addition lectures and guidance are given on the development of a research project.

Goals: The overall emphasis in this year at all hospital rotations is to develop comfortable in the clinic, inpatient areas and emergency room as well as develop a structured knowledge base to formulate a differential diagnosis and logical reasoning. Introduction to the operating theater will continue. The emphasis of training during this year is in Otology, Pediatric and General Otolaryngology.

1. Otology: Residents will complete three months of dedicated Otology training at the University of Minnesota Medical Center with fellowship trained and board certified neurotology staff. University of Minnesota Medical Center) is a tertiary care center that receives difficult referral cases from the contiguous five-state area. PGY2 residents will work with a specific staff or a team (head and neck, otology or pediatrics), and this will determine the type of problems they will see.

2. Pediatric Otolaryngology: Residents will complete three months of pediatrics otolaryngology at Children's Hospital taught by fellowship trained or recognized members of the American Society of Pediatric Otolaryngology. A strong exposure to cleft lip and palate surgery is provided.
3. General Otolaryngology--VA: In addition, exposure to general otolaryngology rounds out the PGY2 education. Exposure will occur to Head & Neck oncology at the VA.
4. General Otolaryngology—Regions or HCMC: Continued experience with general otolaryngology will occur either at Regions or HCMC. The focus of both of these rotations is on continued exposure to general otolaryngology as well as trauma and facial plastics supervised by the Department's board certified or board eligible Facial Plastic Surgeons. Since HCMC is a Level 1 Trauma Center, the greatest emphasis of the rotation will be on recognition and management of urgent problems.

Regions Hospital is also a Level 1 Trauma and Burn Center, and some of the emphasis at Regions will be the same as at HCMC. Additionally, resident will see a large number of patients from foreign countries (e.g., Hmong, Vietnamese, Hispanic, Somalian) as well as patients undergoing elective cosmetic reconstructive surgery.

PGY2 Objectives: The objectives for PGY2 ENT training follow. The learning objectives are organized by each ACGME core competency.

Medical Knowledge (MK): Upon completion of the PGY2 year of training the resident will be expected to demonstrate knowledge of relevant basic sciences as taught through the Basic Science Course, including:

- Principles of anatomy, physiology, embryology, pathology, and genetics.
- Neoplasms, deformities, and; plastic and reconstructive surgery; and allergy, endocrinology and neurology as they relate to the head and neck
- head & neck anatomy [through detailed dissections and lectures during the Head and Neck Anatomy course, given by the Department of Anatomy at the University of Minnesota to occur in July–August of the PGY-2]
- temporal bone anatomy [through detailed dissection during the temporal bone anatomy course during the winter of the PGY-2]
- Indications, risks, contraindications of a wide variety of Otolaryngologic surgical procedures for adult and pediatric patients.
- temporal bone anatomy, mastoid drilling technique, middle ear prostheses placement, implantable hearing devices [Temporal Bone Course]
- methods of treatment of maxillofacial trauma using plating techniques
- anatomy of upper aerodigestive tract.
- major principles of the communication sciences (including audiology and speech pathology and rehabilitation) as they apply to the practice of otolaryngology.
- physiology of the chemical senses
- pathophysiology of disorders of the ears, face, neck, and mandible
- major mechanisms of disease prevention

Resident's acquisition and application of medical knowledge will be demonstrated by above average performance, as compared to Program Year peers nationally, on annual in-service examination

Patient Care (PC): Upon completion of the PGY2 year of training the resident will be expected to:

- Obtain thorough and appropriate medical histories from patients presenting with disorders of the head and neck.
- Conduct appropriate physical examinations of the head and neck.
- Evaluate common adult otolaryngologic problems in both inpatient and outpatient settings.
- Develop and implement treatment plans for patients presenting with common adult otolaryngologic problems in both inpatient and ambulatory settings.
- Properly place IV's and draw blood.
- Perform ABG's in emergent situations
- Perform preoperative and postoperative evaluations of patients, admissions and discharges.
- Manage the service with guidance from the chief residents and relevant Attendings, and/or Director of Resident Education
- Appropriately triage and initiate care of adult otolaryngologic emergencies with supervision of Chief Residents and Attendings

Patient Care--Procedural Skills: Upon completion of the PGY2 year, residents are expected to demonstrate proficiency in the following procedures:

- Tracheotomy,
- trach changes,
- tonsillectomy and adenoidectomy,
- closed reduction of nasal fractures,
- microscopic otoscopy and
- myringotomy and tube (M&T) insertion,
- fiberoptic laryngoscopy,
- flexible laryngoscopy,
- fine needle aspiration biopsies,
- oral biopsies,
- minor surgical procedures (ear lobe repair, incision and drainage, minor excisions, soft tissue trauma of the face and neck),
- microscopic ear examination with cerumen removal,
- treatment of epistaxis,
- ability to assess the trauma patient,
- basic nasal and aerodigestive endoscopy

Communication Skills (CS): Upon completion of the PGY2 year, residents are expected to

- Effectively present cases at morning and afternoon rounds.
- Obtain thorough and appropriate medical histories from patients presenting with disorders of the head and neck.
- Communicate effectively with patients and their families.
- Complete medical and administrative documentation in an effective and timely manner.

Practice Based Learning and Improvement (PBLI): Upon completion of the PG 2 year, residents are expected to:

- Ask for feedback on performance
- Integrate relevant feedback into practice to improve performance
- Evaluate published literature in specialty and critically acclaimed journals and texts.
- Apply clinical trials data to patient management.
- Effectively access electronic information at point of care

Professionalism (P): Residents are expected to:

- Fulfill clinical and educational duties in an effective and timely manner
- Be receptive to feedback on performance.
- Be sensitive to gender, age, race, and cultural issues.
- Work effectively as a team member in all clinical settings.
- Respect patient confidentiality in all settings.

Systems-based Practice (SBP): Upon completion of the PG2 year residents are expected to:

- Work effectively as a team member.
- Recognize basic principles of patient safety
- Recognize basic issues of cost of care.
- Effectively serve as a consultant under the supervision of attending physicians and upper level residents.

Rotation Goals and Objectives:

Otology Rotation (University of Minnesota Medical Center): Upon completion of the general otology/ neurotology rotation at UMMC residents will be expected to:

- Perform an initial otology consultation (PC, MK).
- Write an appropriate consultation note, to communicate with the staff and the senior residents, and to communicate with other services as well (PC, CS, SBP).
- Evaluate patients with airway issues, chronic sinusitis, and other problems (MK, PC)
- Recognize differences when these diseases occur in patients who are immune-suppressed or have other multiple medical problems (MK, PC).
- Perform a thorough history and physical examination on patients who have had an organ transplant, bone marrow transplant, or who have been referred from an outstate hospital evaluating not only ENT problems, but multiple other medical problems (PC).
- Assess complex patients in clinic with supervising faculty (MK, PC).
- Know the indications for operative procedures in patients with multiple high-risk problems (MK, PC).
- Communicate effectively with multiple providers and staff in the care of complex patients (PC, CS).

VA General Otolaryngology Objectives: Upon completion of the general otolaryngology rotation at the VA residents will be expected to:

- Provide effective otolaryngology consults for patients on other medical services. (PC, SBP, CS)
- Effectively assess patients with long standing problems such as chronic hearing loss or vertigo (MK, PC).
- Offer treatment options for patients long standing problems such as chronic hearing loss and vertigo (MK, PC, SBP).
- Appropriately refer patients to other services, such as pulmonary for patients with chronic lung disease or endocrine for diabetic patients, as a part of patient assessment (PC, MK, SBP).
- Recognize indications and contraindications for ear surgery in patients with numerous other medical problems (MK, PC)
- Evaluate patients with long-standing chronic ear disease using audiometric assessment; scans and other laboratory testing when appropriate (MK, PC, SBP).
- Attend and present at weekly tumor conferences (MK, PC, CS, PBLI).
- Recognize which information is pertinent and critical for management of cancer including associated medical problems and co-morbid conditions (PC, MK)
- Assess what type of surgical procedure is indicated, and whether surgery is appropriate (MK, CS).

HCMC General Otolaryngology Objectives: Upon completion the general otolaryngology rotation at HCMC residents will be expected to:

- Perform appropriate initial assessment of patients with significant airway and facial injuries including evaluation of the airway, evaluation of the cervical spine, and evaluation of the need for immediate surgery (PC, MK).
- Effectively conduct assessment of airway issues in adults and children the emergency room (PC, MK).
- Perform evaluation of patients with suspected neoplastic disease will be using endoscopic procedures (PC, MK).
- Provide postoperative care of trauma patients in the intensive care unit or on the service (PC, MK).

Regions General Otolaryngology Objectives: Upon completion of the general otolaryngology rotation at Regions Hospital residents will be expected to:

- Perform appropriate initial assessment of patients with significant airway and facial injuries including evaluation of the airway, evaluation of the cervical spine, and evaluation of the need for immediate surgery (PC, MK).
- Effectively conduct assessment of airway issues in adults and children the emergency room (PC, MK).
- Perform evaluation of patients with suspected neoplastic disease will be using endoscopic procedures (PC, MK).
- Provide postoperative care of trauma patients in the intensive care unit or on the service (PC, MK).
- Effectively use the services of an interpreter to communicate with patients and families that do not speak English.
- Appreciate and understand the severity and complexity of cultural issues in assessment of patients (Prof, PC).

- Understand the principles of decision-making process for patients undergoing reconstructive procedures (PC, MK).

Pediatric Rotation Objectives: Upon completion of the Pediatrics rotation residents will be expected to:

- Perform an appropriate head and neck examination of the pediatric patient.
- Diagnose common pediatric otolaryngology conditions
- Perform treatment of pediatric otolaryngology conditions, building on the initial experience of the general otolaryngology rotations.
- Diagnose and manage pediatric airway, craniofacial, otologic, sinus and head and neck problems.
- Effectively use fiberoptic nasopharyngoscopy, indirect laryngoscopy, microscopic otoscopy, and pneumatic otoscopy and increase in the knowledge of abnormal anatomy.
- Describe the common and uncommon anomalies and conditions that may be encountered in the pediatric head and neck exam.
- Perform perioperative management of patients who present to the pediatric otolaryngology clinic
- Demonstrate basic proficiency in pediatric otolaryngology procedures:
 - myringotomy and tympanostomy tube placement
 - tympanoplasty
 - tracheotomy
 - laryngoscopy
 - bronchoscopy
 - esophagoscopy
 - endoscopic sinus surgery (FESS)
 - arytenoidectomy/arytenoidpexy
 - laryngotracheoplasty/cricoid split
 - excision of nasopharyngeal angiofibroma
- Understand the indicators of potential complications that arise in the perioperative period.
- Understand how to access additional services to provide care to children with otolaryngology conditions (audiology, speech therapy, social services, etc...) (PC, SBP)
- Provide accurate and appropriate explanations of clinical conditions, treatment options and risk/benefits to patient and their parents/guardians.
- Understand the process of obtaining informed consent for pediatric patients undergoing procedures.

PGY2: Research Skill Development

During the summer of the PGY2 year, the resident should complete the Head and Neck Anatomy dissection course.

During fall of the PGY2 year, the resident should complete the Physician Scientist/Thesis Development course. This should introduce issues such as research ethics, IRB, sample size/power, grant sources.

By October 1st of the PGY2 year, the resident should have identified an area of interest and selected a preceptor and an area of research.

By November 1st, the resident should have begun preparing an application to AAO-HNSF for a CORE grant, and should have discussed application requirements with both the preceptor and the financial accounting support staff in the Department.

By December 15th, the resident should submit a Letter of Intent to AAO-HNSF, and by January 15th, should submit the grant application to AAO-HNSF.

By February 1st of the PGY2 year, the resident should prepare a two- to three-page preliminary research proposal, including chosen advisor and tentative title, and should submit it to the Chair of the Department's Graduate Research Committee for approval. This proposal should provide a brief background of the research problem being considered, a brief description of the proposed study in general terms, and a budget page.

By June 1st of the PGY2 year, the resident should prepare a formal research proposal following the format used in NIH grants, and submit it to the Chair of the Department's Graduate Research Committee for approval. Once approval is obtained, the resident should prepare a budget with the help of the advisor, and submit the budget to an appropriate funding source.

By the end of the PGY2 year, in anticipation of research block time, the resident should have made arrangements to have the laboratory ready with appropriate equipment, calibration, and other measures to enable experimental procedures on the first block-time day.

Clinical Duties and Responsibilities: All residents are expected to fulfill their clinical and educational duties in an effective, timely and professional manner. The major duties and expectations of PGY2 residents are as follows:

- Responsible for the daily care of the adult and pediatric inpatient service
- Performs medical histories and physical examinations
- Identifies and treats common problems, i.e. place IV's, draw blood, perform ABG's, present at morning and afternoon rounds
- Performs preoperative and postoperative evaluations of patients, admissions and discharges
- Manages the service with guidance from the chief residents and relevant Attendings, and/or Director of Resident Education
- Required to be in clinic as assigned by the Program Director and/or Chief Resident
- Participates in the weekly basic science lecture series
- Attends all required courses and conferences
- Begins work on research requirement, above.
- As Pediatric First Year Resident, responsible for both the pediatric inpatient and consult service. Daily care of the pediatric otolaryngology patients.
- Responsible for emergency room consults (with the supervision of an Attending and Chief Resident)
- Organizes pediatric operations
- Mandatory attendance at pediatric and cleft clinic

Progression of Responsibilities: By learning to evaluate inpatient and emergency consults, by contributing to the post-operative care of a wide variety of Otolaryngology patients, by operating as outlined below, and by being in charge of the tracheotomy service, the first-year resident acquires skills that prepare him/her for increasing responsibilities as a second-year resident.

Clinical Skill Progression

Definitions used throughout this description regarding clinical procedures and operations:

- (1) General Supervision (the treatment/procedure is furnished under the Supervising Physician's overall direction and control, but the Supervising Physician's presence is not required during the performance of the procedure/treatment).
- (2) Direct supervision (the Supervising Physician must be present in the office suite or in the unit (as applicable), and immediately available to furnish assistance and direction throughout the performance of the treatment/procedure. It does not mean that the Supervising Physician must be present in the room when the treatment/procedure is being performed).
- (3) Direct Visual Supervision: (the Supervising Physician must be in attendance with the patient and the resident while supervising the performance of the treatment/procedure).
 - Procedures are performed under **direct visual supervision** of an Attending physician.
 - After a resident is duly assessed, the Attending will supervise directly the following procedures:
 - Tonsillectomy
 - Adenoidectomy
 - Tracheostomy
 - Arterial ligation
 - Uvulopharyngopalatoplasty
 - Direct laryngoscopy/microlaryngoscopy
 - Pediatric endoscopy
 - Cleft lip and palate (pediatric otolaryngology service is in charge of both the clinic and surgery)
 - Neck abscess drainage
 - Maxillary sinus surgery/Caldwell-Luc
 - Septoplasty
 - Turbinate surgery
 - Epistaxis management
 - Flexible fiberoptic laryngoscopy
 - Rigid nasal endoscopy
 - Otologic microscopy
 - Pneumatic otoscopy
 - Rigid esophagoscopy
 - Skin grafts
 - Fine needle aspiration
 - Peritonsillar abscess drainage
 - Excision of congenital cyst and sinuses
 - Tympanoplasty
 - Mastoidectomy
 - Cochlear implantation

PGY3 Goals and Objectives

Clinical training in the PGY3 year is spent working in two different three month rotations:

- Head and neck oncology at University of Minnesota (all residents)
- General otolaryngology/head and neck oncology-VA (all residents)

Research training: The remaining six months are spent in research. Flexibility is allowed in scheduling research, so that some residents will complete only 3 months of research during the PGY-3 year, with the remaining 3 months completed during the PGY4 year. If only 3 months of research occurs during this year then an additional clinical rotation is provided in general/trauma/plastics at Regions Hospital or Hennepin County Medical Center. Goals for that rotation are included with PGY4 year goals and objectives.

Clinical Goals: The overall emphasis continues on development and comfort with basic examination, evaluation and development of differential diagnosis. There is still an emphasis of time in the clinic compared to the operating theater, but gradual progression with increasing time spent in the operating theater will occur. The emphasis of training during this year is in head & neck oncology.

1. Head and Neck Oncology: Residents will complete three months of dedication Head and Neck Oncology training at the University of Minnesota Medical Center with fellowship trained head & neck oncology staff. In addition an introduction to advanced plastics will occur which includes microvascular and free tissue transfer as well as traditional pedicle flap reconstruction.

2. General Otolaryngology/Head and Neck Oncology—VA: Continued exposure to general otolaryngology will round out the PGY3 education. Exposure to Head and Neck Oncology will also occur at the VA in the Head and neck tumor conference and in the operating room.

PGY3 Objectives: The objectives for PGY3 ENT training follow. The learning objectives are organized by each ACGME core competency.

Medical Knowledge: Upon completion of the PGY3 year of training the resident will be expected to demonstrate knowledge of:

- Principles of radiologic oncology, laser physics, wound healing, laryngeal physics, voice measurement, language development, acoustics, auditory brainstem response, otoacoustic emissions, impact of hearing loss
- Physiology of small vessels (via microvascular surgery exposure)
- The rationale, content and implementation of diagnostic workup for neoplasms
- The rationale and methodology for fracture evaluation, and the dynamics of fracture reduction (at University or if rotating at HCMC / Regions)

Resident's acquisition and application of medical knowledge will be demonstrated by above average performance, as compared to Program Year peers nationally, on annual in-service examination.

Patient Care: Upon completion of the PGY3 year of training the residents will be expected to:

- Obtain thorough and appropriate medical histories from patients presenting with facial fractures or with head and neck cancer
- Present appropriate diagnostic workup for neoplasms, including literature review and case presentation at the interdisciplinary Head and Neck Tumor Board (University and VA)
- Present appropriate diagnostic workup for fracture reduction to the Facial Trauma attending on call (University or Regions / HCMC)

Patient Care--Procedural Skills: Upon completion of the PGY3 year, residents are expected to demonstrate proficiency in the following procedures:

- Improvement of procedural skills developed as a PGY-2 resident
- Repair techniques for small vessels
- Laser surgery including CO2, YAG and Argon beam after proper requirements are met (under direct visual supervision of Attendings).
- Submandibular gland excision
- Thyroglossal duct cyst excisions
- Septoplasty
- Turbinectomy
- Basic nasal endoscopy including minimal FESS as well as Caldwell Luc procedure
- Fracture management

Communication Skills: Upon completion of the PGY3 year, residents are expected to

- Establish and maintain professional and therapeutic relationships with patients and healthcare team members
- Consult appropriately with oncological services in the multidisciplinary care of head and neck cancer patients
- Effectively present cases, including literature review, to interdisciplinary head and neck tumor board
- Communicate effectively with cancer patients and their families, including discussion of end-of-life decisions
- Teach medical students and PGY2 residents

Practice Based Learning and Improvement: Upon completion of the PGY3 year, residents are expected to:

- Demonstrate behaviors that reflect an ongoing commitment to continuous professional development, ethical practice, sensitivity to diversity and responsible attitudes
- Systematically read to improve patient care
- Seek feedback from a variety of team members and integrate it into practice to improve performance

Professionalism: Residents are expected to:

- Be attentive to ethical issues.
- Accept responsibility for continuity of care;
- Be involved in end-of-life discussions and decisions.

- Practice patient-centered care that encompasses confidentiality, respect for privacy and autonomy through appropriate informed consent and shared decision-making

Systems-based practice: Upon completion of the PGY3 year residents are expected to:

- Coordinate care within the health care system
- Work in interprofessional teams to improve patient care quality

Rotation goals and objectives:

Head and Neck Oncology Rotation (University of Minnesota Medical Center): Upon completion on the head and neck oncology rotation at UMMC residents will be expected to:

- Develop medical and surgical management plans for diseases of the major and minor salivary glands.
- Explain mechanisms of carcinogenesis of upper aerodigestive cancers in the context of abnormalities of the critical elements of cell cycle regulation.
- Appropriately assess (e.g., staging endoscopy, CT and MRI imaging, and FNA) and apply staging parameters of squamous cell and non-squamous cell neoplasms of the head and neck in presentation of patients to Head and Neck Tumor Board, understanding of the relationship between clinical stage, treatment recommendation, and prognosis. .
- Use of diagnostic procedures for diseases of the esophagus including the identification of abnormalities involving manometry, ph monitoring, and esophagoscopy.
- Apply knowledge of multi-organ system risk factors towards the management of postoperative complications in patients undergoing OHNS surgical treatment.

VA General Otolaryngology Objectives: Upon completion of the PGY3 general otolaryngology rotation at the VA residents will be expected to:

- Demonstrate expertise in the complete office-based physical exam of the head and neck, including teaching medical students and PGY2 residents
- Demonstrate advanced skills in the performance of indirect mirror flexible and rigid laryngoscopy.
- Discuss the measures of immune suppression in head and neck cancer and their biologic basis
- Create a treatment plan including assessment and management for the patient with thyroid nodule / goiter / cancer.
- Establish guidelines for the surgical and medical management of patients with hyperthyroidism.
- Describe criteria for the surgical management of Grave's ophthalmopathy, and the ocular complications.

PGY3 Research Skill Development:

As part of the program structure, residents are provided with six months of time for conducting research. Beginning in the PGY3 year, the resident should spend 6 months conducting basic science or applied clinical research with guidance and supervision by qualified faculty. The

resident should participate in the development of new knowledge, learn to evaluate research findings, and develop habits of inquiry as a continuing professional responsibility.

By April 15th, the PGY3 resident should submit a written research progress report to the Chair of the Department's Graduate Research Committee.

Clinical Duties and Responsibilities: All residents are expected to fulfill their clinical and educational duties in an effective, timely and professional manner. The major duties and expectations of PGY3 residents are as follows:

- Performs all responsibilities under direct visual supervision; progressively adds additional procedures and responsibilities to armamentarium.
- As Tumor Resident, presents tumor cases at tumor conferences. Under guidance of Attendings, organizes the content of presentations for this conference.
- Performs Panendoscopy (direct laryngoscopy, esophagoscopy and bronchoscopy) in the operating room.
- Performs laser procedures of the head and neck
- Assists in all tumor surgical cases at the University.
- As a Consulting Resident, is responsible for seeing and following adult consults service, as well as tending to adult ER consultations. This resident should formulate a plan and institute it after discussing the cases with the chief and/or Attending.
- Carries out mandible, trimalar and other basic fracture cases.
- Other surgeries include laryngectomies, neck dissections of all types, pharyngeal resections, laryngeal sparing procedures, parotidectomies, submandibular gland excision, thyroid surgery, thyroglossal duct cyst excisions, septoplasty, turbinectomy, and basic nasal endoscopy including minimal FESS as well as Caldwell Luc procedures.
- Assists on major surgical procedures.
- Develops skill with lasers including CO2, YAG and Argon beam after proper requirements are met. These surgeries should be performed under direct visual supervision
- Attends rounds every AM & PM and is expected to take night call from home.
- Attends all required courses and Grand Rounds.

Progression of Responsibilities

- By being in charge of the adult and ER consults, formulating diagnoses and treatment plans with the Attending and Chief Resident, organizing the multidisciplinary Tumor Board conference, and by operating, the PGY3 resident acquires skills that prepare him/her for the increasing responsibilities as a PGY4 resident.
- Permitted to perform medical histories and physical examinations and to record such in patient charts. Also, formulation regarding diagnosis, treatment plans, progress notes and doctor's orders may be recorded in patient charts.
- Permitted to perform all the above and all procedures that a PGY-2 resident may perform, plus the following additional procedures listed below.
- These procedures are performed under the direct visual supervision of an attending physician.

Procedures

- Submandibular gland resection
- Parotid gland resection
- Incision and drainage of neck abscess
- Neck dissections of all types
- Local resection of mouth malignancy
- Laser resection of head & neck malignancy
- Endoscopy (bronchoscopy [rigid & flexible])
- Esophagoscopy (rigid & flexible)
- Laryngoscopy (rigid & flexible)
- Endoscopic sinus surgery
- Laryngectomy (total and modified)
- Mandibular resection
- Pharyngeal resection
- Thyroid surgery
- Local and regional reconstruction
- Free tissue transfer
- Laryngeal resections (total / partial)
- Parotidectomies

PGY4 Goals and Objectives

Clinical training in the PGY4 year is spent working in four different three-month rotations:

- Pediatric otolaryngology at University of Minnesota (all residents)
- General otolaryngology-VA (all residents) (focus on head and neck oncology)
- General otolaryngology-HCMC (all residents)
- General otolaryngology-Regions (all residents)

Goals: An increased emphasis on operative skills is placed on this year. More independence of thought in the clinic as well as inpatient management occurs in this year.

1. Pediatric Otolaryngology: Residents will complete three months of dedicated pediatric otolaryngology training at University of Minnesota Medical Center with fellowship trained pediatric otolaryngology staff. This will include tertiary pediatric otolaryngology and craniofacial surgery, with continued exposure to pediatric endoscopy, otology and airway reconstruction,
2. General Otolaryngology—VA: At the VA, the emphasis will continue to be on head and neck oncology.
3. General Otolaryngology-Regions: At Regions Hospital, the emphasis will continue to be on trauma as well as facial plastic and reconstructive surgery. This rotation will include more exposure to facial plastic procedures, i.e. rhinoplasty, blepharoplasty, and facial enhancement.
4. General Otolaryngology—HCMC: HCMC will also provide continued experience in trauma, as well as in sinonasal surgery and laryngology. This rotation will also include continued exposure to laryngology cases, sinus surgery, and a strong emphasis on adult otology.

PGY4 Objectives: The objectives for PGY4 ENT training follow. Learning objectives are organized by each ACGME core competency.

Medical Knowledge: Upon completion of the PGY4 year of training the resident will be expected to demonstrate an evolving mastery of Otolaryngology/Head and Neck Surgery, including:

- Medical and surgical aspects of otology and neurotology
- Medical and surgical aspects of head and neck oncology
- Medical and surgical aspects of sinonasal problems
- Medical and surgical aspects of plastic and reconstructive cases
- Medical and surgical aspects of advanced cases in pediatric otolaryngology, including congenital defects and airway problems.

Knowledge level demonstrated by above average performance, as compared to Program Year peers nationally, on annual in-service examination.

Patient Care: Upon completion of the PGY4 year of training the resident will be expected to:

- Obtain thorough and appropriate medical histories from patients presenting with congenital defects
- Develop and implement treatment plans for adult and pediatric patients presenting with complex problems in both inpatient and ambulatory settings

Patient Care—Procedural Skills: Upon completion of the PGY4 year, residents are expected to demonstrate proficiency in the following procedures:

Major head and neck procedures including:

- Parotidectomy
- Thyroidectomy
- Radical neck dissection
- Major vessel surgery
- Nerve grafting
- Craniofacial resection and other ablative procedures

Plastic procedures including:

- Myocutaneous flaps
- Rhinoplasty
- Rhytidectomy
- Blepharoplasty
- Facial reanimation

Management of craniofacial trauma

Communication Skills: Upon completion of the PGY4 year, residents are expected to:

- Effectively supervise more junior residents in the clinic as well as in the operating room
- Work effectively as leader of the health care team by substituting for the Chief Resident when the Chief Resident is absent

Practice-Based Learning and Improvement: Upon completion of the PGY4 year, residents are expected to:

- Participate in the education of patients, families, students, residents and other health professionals
- Set appropriate learning and improvement goals based on self-identification of strengths, deficiencies, and limits in knowledge and expertise

Professionalism: Upon completion of the PGY4 year, residents are expected to:

- Demonstrate a commitment to excellence by engaging in activities that foster personal and professional growth as a physician

Systems-Based Practice: Upon completion of the PGY4 year, residents are expected to:

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

PGY4 Research Skill Development:

During the PGY4 year, the resident should begin data analysis and drafting a publication.

The resident may participate with a faculty member in submission for grant funding, learning the method of grant preparation for various funding sources, and IRB requirement.

Presents findings of required project or other research at local, regional or national meeting.

Submits article for publication.

Carries out other guided research projects with faculty (may be other than research mentor).

By April 15th, the PGY4 resident should submit a written research progress report to the Chair of the Department's Graduate Research Committee.

Clinical Duties and Responsibilities: All residents are expected to fulfill their clinical and educational duties in an effective, timely and professional manner. The major duties and expectations of the PGY4 residents are as follows:

- Supervise PGY-1, -2, and -3 residents
- Observe PGY3 residents and instruct them in clinic as well as in the operating room.
- Supervises PGY3 residents in the operating room for the following cases: panendoscopy, tracheotomy, septoplasty, turbinectomy, and basic facial fractures.
- Participate in major otologic surgery including middle ear exploration, acoustic, stapedectomy, mastoidectomy, tympanoplasty, excision and reconstruction of aural atresia.
- As plastics resident, participate in all plastic procedures performed.
- Participate in major head and neck as well as other major cases.
- Substitute for the chief resident while the chief is absent.
- Participate in all major Otolaryngological surgeries in all realms of the specialty, including Plastics, Otology, Head and Neck surgery and Pediatric otolaryngology. Major head and neck procedures include parotidectomy, thyroidectomy, radical neck dissection, major vessel surgery, nerve grafting, craniofacial resection and other

- ablative procedures. Plastic procedures include myocutaneous flaps, free grafts, rhinoplasty, rhytidectomy, blepharoplasty, and facial reanimation.
- Perform endoscopic sinus surgery under staff supervision.
 - Perform medical histories and physical examinations and record them in patient charts. Formulate diagnosis and treatment plans.
 - Write progress notes and doctor's orders in electronic medical record.

Progression of Responsibilities

- By functioning as a senior Resident, by serving as the Pediatric Senior in charge of the Pediatric Otolaryngology service, by substituting when the Chief is away, and by taking back-up call overseeing more junior residents, the third year resident acquires skills that prepare him/her for the increasing responsibilities as a year four resident.
- May assume some administrative duties as delegated by the Program Director.
- May act for Chief Resident in their absence.
- Permitted to perform all the above and all procedures that a PGY-3 resident may perform, plus the following additional procedures listed below.
- These procedures are performed under the direct visual supervision of an attending physician.

Clinical Skill Progression

- Middle ear exploration
- Acoustic
- Stapedectomy
- Mastoidectomy
- Tympanoplasty
- Cochlear implantation
- Excision and reconstruction of aural atresia
- Parotidectomy
- Thyroidectomy
- Radical neck dissection
- Major vessel surgery
- Nerve grafting
- Craniofacial resection and other ablative procedures
- Myocutaneous flaps
- Free grafts
- Rhinoplasty
- Rhytidectomy
- Blepharoplasty
- Facial reanimation
- Endoscopic sinus surgery (adult and pediatric)
- Pediatric airway endoscopy
- Laryngotracheal reconstruction
- Surgery of complex pediatric head and neck tumors (i.e. lymphangioma / hemangioma)

PGY5 Goals and Objectives

Clinical training in the PGY5 year is spent in four different approximately three-month rotations:

- Chief Resident Rotation, University of Minnesota (all residents)
- Chief Resident Rotation, VA (all residents)
- Chief Resident Rotation, HCMC (all residents)
- Chief Resident Rotation, Regions (all residents)

Additionally, the Chief Resident at Regions Hospital has the opportunity to accompany Dr. Peter Hilger to his private cosmetic practice, Facial Plastic and Reconstructive Surgery Specialists at the Centennial Lakes Building in Edina, approximately once a week. Aesthetic surgery is only practiced at select outpatient surgery centers, so this experience allows the resident access to a broader range of the training in facial plastic surgery that is required by the American Board of Otolaryngology. At the completion of this experience, the resident will have gained knowledge, skills, and understanding and will demonstrate competence regarding:

- The financial difference between a private physician's practice and a hospital based practice
- The role of ancillary aesthetic office services
- Patient assessment and evaluation techniques of aesthetic surgical patients
- How to ensure patient safety in outpatient office surgery
- Assisting and performing primary aesthetic procedures

Goals: The goal of the PGY5 year at all rotations is for the resident to build on clinical skills developed in prior years, to demonstrate maturity in approach to patient care and follow-up; and to demonstrate mastery of surgical techniques and medical management in Otolaryngology/Head and Neck Surgery.

University of Minnesota: At the U of M site the chief resident is not assigned a particular rotation but allowed to choose an area of concentration or further skill refinement in Head & Neck, Neurotology or Pediatrics. The chief resident can also choose to rotate among the three blocks depending on the case being done that day. This allows the chief resident to set appropriate learning and improvement goals based on self-identification of strengths, deficiencies, and limits in knowledge and expertise.

PGY5 Objectives: The objectives for PGY5 training follow. The learning objectives are organized by each ACGME core competency.

Medical Knowledge: Upon completion of the PGY5 year of training residents will have:

- Demonstrated mastery of the course content in Otolaryngology/Head and Neck Surgery
- Displayed maturity in approach to patient care and follow-up
- Explored advanced techniques and adapted them to personal style

Resident's acquisition and application of medical knowledge will be demonstrated by above average performance, as compared to Program Year peers nationally, on annual in-service examination.

Patient Care: Upon completion of the PGY5 year residents will have:

- Demonstrated the ability to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

Patient Care—Procedural Skills: Upon completion of the PGY5 year residents will have:

- Performed a sufficient number and variety of surgical procedures to ensure education in the entire scope of the specialty

Communication Skills: Upon completion of the PGY5 year residents will have:

- Effectively presented cases at Morbidity and Mortality Conference
- Demonstrated interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.

Practice Based Learning and Improvement: Upon completion of the PGY5 year residents will have:

- Engaged in quality improvement projects based on cases brought to Morbidity and Mortality Conference
- Demonstrated 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

Professionalism: Upon completion of the PGY5 year residents will have:

- Demonstrated a commitment to carrying out professional responsibilities and an adherence to ethical principles that would be expected in a staff physician.

Systems-based Practice: Upon completion of the PGY5 year residents will have:

- Participated in identifying system errors and implementing potential systems solutions.
- Demonstrated 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.

PGY5 Research Skill Development:

- The resident may participate with a faculty member in submission for grant funding, learning the method of grant preparation for various funding sources, and IRB requirements
- Presents findings of required project or other research at local, regional or national meeting
- Submits article for publication

Resident Duties

1. Clinical

- Under the supervision of the Attendings, manages the service and is responsible for all patients on the otolaryngology service
- Makes final decisions regarding management under Attending supervision
- Can operate with direct visual supervision when he/she feels comfortable with a particular case.
- Runs the clinics under Attending supervision
- Supervises the ward service under Attending supervision

2. Administrative:

- Serves as a the administrative chief while on rotation at all hospital sites
- Develops the resident call schedule
- Assigns caseloads
- Administers the service under Attending supervision
- Forms the link for resident feedback to the Attending surgeons

3. Educational:

- Participates in the education and evaluation of junior residents
- Teaches and evaluates the medical students
- Instructs junior residents in clinic and in the operating room.
- Presents all Morbidity and Mortality cases to the monthly meeting

Progression of Responsibilities

- Acts in a supervisory role within the operating room setting and when performing procedures outside the OR when the responsible Attending is immediately available by telephone and readily available onsite when needed.
- The Attending physician must be present for the key portion of the procedure. In an emergency situation, when a supervising physician is not present, the resident shall document the emergency treatment provided by said resident. This shall include the nature of the emergency, the treatment provided, and the contact of the supervising physician. With arrival of the supervising physician, he/she will concur with the resident and contact the Attending physician for appropriate management decisions.
- As Chief Resident, is fostered in development of skills in supervisory and administrative skills.
- Has an increased supervisory role over other residents (with Attending coverage) and instructs them in clinic.
- Supervises (with Attending coverage) in the operating room for any case that is approved by the attending and would not be considered a fellow level case. This would include all general cases as well as neck dissections, facial trauma, endoscopic sinus surgery, neck masses congenital or other, general otology including mastoidectomy and tympanoplasty, tracheotomy, septoplasty, turbinectomy.

CONFERENCES

Orientation

New residents are required to attend University of Minnesota Medical School Resident/Fellow Orientation.

An orientation to the Department of Otolaryngology is scheduled at the beginning of July.

Otolaryngology Core Curriculum

PGY 2 through PGY5 residents, as well as PGY1 residents on Otolaryngology rotation, are required to attend Tuesday Morning Core Curriculum Conference except during approved leave time. Attendance is verified by a sign-in sheet. Conferences begin at 6:30 a.m. Be sure to allow time in your schedule to be at the University promptly. The core curriculum is taught on a two-year cycle. Outline for the curriculum was derived from the COCLIA program available on American Academy of Otolaryngology's web site.

Conferences require some basic preparation by all residents. Residents are assigned to prepare written answers to COCLIA questions to be circulated to all residents and the faculty moderator in advance of conference. In addition, individual residents are assigned to lecture. These assignments appear in the conference schedule, which is posted on the web. Begin at www.ent.umn.edu and choose "Info for Residents" and then "Conference Schedules" from right menu.

Residents are expected to:

- Discuss their presentation in advance with the conference moderator(s).

- Prepare PowerPoint or slide presentation.

- Provide a typed outline of their lecture, with references, to everyone present at the conference.

Morbidity and Mortality Conference

Morbidity and Mortality Conference is held once a month, usually on the first Tuesday of the month, at 6:30AM. Resident attendance is required. The chief resident at each hospital (or PGY2 resident at Children's) is responsible for preparing a report in PowerPoint on each complication, even those that appear to be minor, and presenting it at conference.

Guest Speakers/Special Conferences

Distinguished visiting otolaryngologists will be scheduled to present at several evening conferences per year. Residents are required to attend these conferences. Other special conferences will be scheduled which require resident attendance. Recent examples include Dr. Hilger's AO-ASIF Maxillofacial Course for Surgeons and Sinus/Skull Base course given by Drs. Boyer and Caicedo-Granados.

Rotation-Specific Conferences

Each hospital has regularly scheduled conferences, and residents assigned to that hospital are required to participate. Some of these conferences are listed below. Residents on research

rotation are assigned to a hospital, and are expected to attend conferences at that hospital during their research rotation (see "Research Rotation," page 57).

UMMC

Head and Neck Oncology Conference, every Friday. Coordinated by Dr. Khariwala.

CH

Pediatric Otolaryngology Conference, third Wednesdays. Coordinated by Dr. James Sidman.

HCMC

Otolaryngology-Head and Neck Surgery (Citywide) Conference, first Monday each month.

HCMC Otolaryngology Department Meeting, monthly. Coordinated by Dr. Robert Maisel.

Tumor Conference, third Tuesday each month. Coordinated by Dr. Emiro Caicedo-Granados

Journal Rounds, every Friday. Coordinated by Dr. Rick Odland.

RH

Maxillofacial Trauma Radiology Conference, every Monday. Coordinated by Drs. David Hamlar and Warren Schubert.

Maxillofacial Trauma Conference, first Thursday each month. Coordinated by Dr. Warren Schubert.

VA

Educational Conference with Dr. Gapany, every Wednesday

Tumor Conference, every Wednesday. Coordinated by Dr. Markus Gapany.

Otology Conference, every Friday. Coordinated by Dr. Manuela Fina.

COURSES

ANAT 7999: Head and Neck Anatomy for Residents

PGY2 residents are required to complete Anatomy 7999, a comprehensive review of the anatomy of the head and neck with dissection. Course usually meets Tuesday, Wednesday and Thursday evenings at 6:00 p.m. for one month near the beginning of the PGY2 year.

Home Study Course (American Academy of Otolaryngology-HNS)

The Home Study Course is designed for both residents and practitioners in otolaryngology-head and neck surgery or related specialties. This is an excellent supplement to formal training for residents and a valuable tool for continuing medical education.

Temporal Bone Dissection

The Temporal Bone Dissection course is a hands-on course in dissection of the ear. This course is coordinated by Drs. Samuel Levine, Meredith Adams, and Tina Huang.

Topics include:

- Surface anatomy of the temporal bone
- Simple mastoidectomy
- Identification of the facial nerve
- Endolymphatic sac
- Facial recess
- Middle ear anatomy, ossicular reconstruction
- Wall down mastoidectomy
- Labyrinthectomy
- Internal auditory canal
- Middle fossa approach
- Petrous apex

RESEARCH

Every resident is required to conduct and publish research during the four-year residency. The department will not consider a resident to be board-eligible until this is accomplished. A research component is required by the Accreditation Council for Graduate Medical Education (ACGME) for all otolaryngology residency training programs.

Research Rotation

All residents have 6 months of research-dedicated block time, or two 3-month blocks, beginning in the PGY3 year. By ACGME rules, additional research time cannot be accomplished within the four years of residency training. Residents may complete non-accredited block time as a part of the educational contract; however, the required length of training would be extended accordingly. Questions about this should be taken up with the Program Director.

Scheduling of the resident's research block is determined, first and foremost, by the resident's proficiency in clinical skills. Faculty will determine which clinical rotation an individual resident could best afford to miss. Next, the needs of the resident's research are taken into account.

In anticipation of block time, students should arrange to have lab "ready" with appropriate equipment, calibration, and other measures to enable experimental procedures on the first block-time day.

Residents on research will round Monday through Friday at the hospital responsible for their stipend (indicated on the rotation schedule), either in the morning (preferable) or the afternoon. During your six-month research rotation, there are expectations for your involvement in department activities, as well as those at your specific hospital:

- All residents on research block time are required to attend Tuesday Morning Conferences (Core Conferences, Morbidity and Mortality) Pediatric ENT Conferences, as well as special conferences.

Residents on block time who are assigned to Hennepin County Medical Center are required to attend clinically at least three times a week, complete a rounds list, and participate in all conferences at HCMC. During this period at HCMC, you are second call for otolaryngology and will be assigned in-house first call as needed.

Residents on block time who are assigned to the Veterans' Affairs Medical Center are required to attend the weekly Tumor Conference and other requirements as directed by the staff.

TEACHING

Teaching Medical Students

Residents are an essential part of the teaching of medical students. It is critical that any resident who supervises or teaches medical students must be familiar with the educational objectives of the course or clerkship and be prepared for their roles in teaching and evaluation. Therefore, we've included in this manual the URL to the objectives for the Clerkship(s).

<https://www.med.umn.edu/md-students/academics/course-directory>

Search for:

OTOL 7200, two-week Introduction to Otolaryngology:

OTOL 7501, four-week Otolaryngology Acting Internship:

SURG 7500, Two weeks of ENT as part of required 8-week surgery clerkship

EVALUATION

See Also Institution Policy Manual,

<http://www.gme.umn.edu/InstitutionPolicyManual2013/index.htm>, *Evaluation Policy.*

The Clinical Competency Committee

The Clinical Competency Committee is appointed by the Program Director. In addition to Dr. Janus, members of the committee include Drs. Holly Boyer, Christopher Hilton, Jennifer Hsia, Samir Khariwala, and Bill Walsh.

The Clinical Competency Committee will review all resident evaluations at least semi-annually; will prepare and assure the reporting of Milestone evaluations of each resident semi-annually to ACGME; and will advise the program director regarding resident progress, including promotion, remediation, and dismissal.

Semi-Annual Performance Review

The Program Director conducts a private, semi-annual performance review with each resident based on the Clinical Competency Committee meeting. A written summary of the semi-annual review is maintained in the permanent record of each resident.

Resident Portfolio

Each resident is encouraged to maintain a portfolio to serve as an archive of educational and research activities. Portfolios can include such documents as:

- Curriculum vitae
- Up-to-date operative experience report from ACGME web site
- Handouts prepared for M & M conferences
- Documentation of quality assurance activities
- Grand rounds presentations
- Research proposals
- Annual research progress reports
- Patient presentations
- Reprints of published scholarly work, including clinical studies, scientific articles, clinical reviews, editorials, or letters to the editor
- Unpublished manuscripts of clinical studies, scientific articles, or clinical reviews
- Evaluations of oral presentations
- Documentation of coding meetings
- Teaching experience
- Administrative experience, including participation in department/medical school/hospital committees

The following information is from the ACGME/ABMS Joint Initiative Toolbox of Assessment Methods, Version 1.1, September 2000, Page 11:

Description - A portfolio is a collection of products prepared by the resident that provides evidence of learning and achievement related to a learning plan. A portfolio typically contains written documents but can include video- or audio-recordings, photographs, and other forms of information. Reflecting upon what has been learned is an important part of constructing a portfolio. In addition to products of learning, the portfolio can include statements about what has been learned, its application, remaining learning needs, and how they can be met. In graduate medical education, a portfolio might include a log of clinical procedures performed; a summary of the research literature reviewed when selecting a treatment option; a quality improvement project plan and report of the results; ethical dilemmas faced and how they were handled; a computer program that tracks patient care outcomes; or a recording or transcript of counseling provided to patients.

Suggested Reference – Challis M. Amee medical education guide no. 11 (revised): Portfolio-based learning and assessment in medical education. *Med Teach.* 1991; 21:370-86.”

Components/Principles of the Review

All relevant aspects of resident progress are considered by the Resident Review Committee at the time of the review. Review will consider progress toward the goals listed on pages 2 through 30, and will include:

Clinical and surgical performance and progress: Faculty submit written evaluations of each clinical rotation using the online system.

ACGME Case Log / Progress compared to ACGME minimum numbers and American Board of Otolaryngology Core Surgical Competency

Progress compared to ACGME Milestones for Otolaryngology

Research progress

Administrative skill and experience

Teaching skill and experience: Medical students submit written evaluations of resident teaching using the E*Value system.

Publication progress

Otolaryngology Training Examination scores: The American Board of Otolaryngology offers the Otolaryngology Training Examination in the spring of each year (usually the first Saturday in March, so probably March 2, 2019). All residents are required to take the Training Exam. The exam provides an opportunity for residents in training to monitor their acquisition of knowledge. It is an opportunity to compare individual proficiency against the national norm of residents at the same level of training. Results are reported by category: head and neck, otology, plastic and reconstructive, etc. This allows individual areas of strength and weakness to be determined and allows the individual to improve in those areas which require it. Residents are encouraged to be well prepared for these examinations. Scores on the test are considered by the faculty at the time of the residents' review.

Attitude

Punctuality

Conference attendance, participation and presentation

The faculty assume a resident's performance will mature as the resident gains greater education and experience. Therefore, expectations for the PGY5 resident are very different from those for the PGY2 resident.

Possible Outcomes

Positive outcomes of the Resident Review include:

Affirmation of good clinical progress

Advancement to the next year of training

Recommendation for graduation from the program

Information becomes part of the residents' permanent file

Negative outcomes of the Resident Review include:

A reprimand related to concern about performance

Meetings at six-week intervals to evaluate improved performance until the next scheduled evaluation

Probation for a period of six months to allow performance to improve

Expulsion, conducted according to the University of MN appeals process

Information becomes part of the residents' permanent file

Resident Evaluation of Faculty and of Rotations/Training Program

At the end of each clinical rotation, residents have the opportunity to evaluate the rotation and the faculty using the confidential, online system available through New Innovations Residency Management Suite (RMS). Residents will receive email reminders when evaluations are due. This information is valuable to improving our program and residents are encouraged to complete it.

Residents can also review evaluations of their own progress submitted by faculty and medical students through RMS.

RMS is located on the web at www.new-innov.com (choose "Client Login").

If you don't know your user name or password, contact Faith Courchane, 612-625-7692 or courc002@umn.edu. You may use the "NET" (not enough time) feature to delete evaluations that have been inappropriately assigned to you. Department contact for E*Value for the Medical Student Clerkships is also Faith Courchane, 612-625-7692 or courc002@umn.edu.

Exit Interview

In June the Program Director invites the graduating residents to an informal dinner, after they have received their graduation certificates, and asks them to candidly describe to a small group of faculty areas for improvement and suggestions for strengthening the educational experience.

2802631055 - UNIVERSITY OF MINNESOTA PROGRAM

Otolaryngology - Minneapolis, MN

[← Back To Search](#)

Accreditation Council for Graduate Medical Education (ACGME) - Public

University of Minnesota Medical School

Mayo Mail Code 396

420 Delaware St SE

Minneapolis, MN 55455

<https://www.ent.umn.edu> [↗](#)

Specialty:

Otolaryngology

Sponsoring Institution:

[269501] University of Minnesota Medical School

Related Programs:

[2862631019] University of Minnesota Program (Neurotology)

[2882631016] University of Minnesota Program (Pediatric otolaryngology)

Phone:

(651) 254-3860

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(612) 625-2101

Email:

courc002@umn.edu

Director Information

Sophia Lyfor-Pike MD,

MS Program Director

Director First Appointed:

July 01, 2019

Coordinator Information

Sacha Brueggemann

Program Education

Coordinator

Phone:

(612) 625-7692

Email:

brueg015@umn.edu

Accreditation And General Information

Original Accreditation Date:

March 27, 1952

Accreditation Status:

Continued Accreditation

Effective Date:

January 26, 2018

Legend



Clinical Site

Primary Clinical Site

Accredited Length of Training:
5 years

Osteopathic Recognition:

No Information Currently Present

Osteopathic Recognition Effective Date:

No Information Currently Present

Director of Osteopathic-Focused Education:

No Information Currently Present

Last Site Visit Date:

February 16, 2011

Date of Next Site Visit (Approximate):

No Information Currently Present

Self Study Due Date (Approximate):

August 01, 2020

10 Year Site Visit (Approximate):

February 01, 2022

Positions

Total Approved Resident Positions:

20

Total Filled Resident Positions*:

20

Complement Breakdown: Approved						
Years:	1	2	3	4	5	Total
Approved:	4.0	4.0	4.0	4.0	4.0	20.0

Complement Breakdown: Filled						
Years:	1	2	3	4	5	Total
Filled:	4.0	4.0	4.0	4.0	4.0	20.0

*Total filled will reflect the previous academic year until the annual update is completed for the current academic year. Totals may vary from year to year due to off cycle residents.

Participating Site Information									
#	ID	Site Name	Required Rotation	Rotation Months					
				Y1	Y2	Y3	Y4	Y5	
1	260254	University of Minnesota Medical Center	Yes	3	3	3	6	3	
2	260119	Minneapolis VA Health Care System	Yes	3	0	3	0	3	
3	260184	Regions Hospital	Yes	2	3	0	3	3	
4	260402	Hennepin County Medical Center	Yes	4	3	3	0	3	
5	260740	Children's Hospitals and Clinics of Minnesota - Minneapolis	Yes	0	3	0	0	0	

Showing 1 to 5 of 5 entries



**Accreditation Council for
Graduate Medical Education**

ACGME Program Requirements for Graduate Medical Education in Otolaryngology

ACGME-approved: June 10, 2012; effective: July 1, 2013

ACGME approved categorization: June 9, 2013; effective: July 1, 2014

Revised Common Program Requirements effective: July 1, 2015

Revised Common Program Requirements effective: July 1, 2016

ACGME approved focused revision: September 28, 2014; effective: July 1, 2016

ACGME approved focused revision: September 27, 2015; effective: July 1, 2016

ACGME approved focused revision: February 6, 2017; effective: July 1, 2017

Revised Common Program Requirements effective: July 1, 2017

ACGME Program Requirements for Graduate Medical Education in Otolaryngology

Common Program Requirements are in BOLD

Where applicable, text in italics describes the underlying philosophy of the requirements in that section. These philosophic statements are not program requirements and are therefore not citable.

Introduction

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

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

Int.B. Otolaryngologists provide comprehensive medical and surgical care to patients with diseases and disorders that affect the ears, the respiratory and upper alimentary systems, and related structures of the head and neck.

Int.C. The educational program in otolaryngology must be 60 months in length. (Core)*

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.

*(Core)**

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. ^(Core)

- I.A.1. The sponsoring institution must provide salary support or equivalent protected time for the program director as follows: ^(Core)
- I.A.1.a) a minimum of 10 percent for programs with an approved complement of five or fewer residents; ^(Detail)
- I.A.1.b) a minimum of 15 percent for programs with an approved complement of six to 15 residents; and, ^(Detail)
- I.A.1.c) a minimum of 20 percent for programs with an approved complement of 16 or more residents. ^(Detail)
- I.A.2. The sponsoring institution must provide salary support for a residency coordinator dedicated to the educational and administrative needs of the program. ^(Core)

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.** ^(Core)

The PLA should:

- I.B.1.a) **identify the faculty who will assume both educational and supervisory responsibilities for residents;** ^(Detail)
- I.B.1.b) **specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;** ^(Detail)
- I.B.1.c) **specify the duration and content of the educational experience; and,** ^(Detail)
- I.B.1.d) **state the policies and procedures that will govern resident education during the assignment.** ^(Detail)
- 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).** ^(Core)

I.B.3. International Rotations

- I.B.3.a) International rotations must be approved by the program director. ^(Core)
- I.B.3.b) The total time spent in international rotations should be no more

than one month over the five-year program. ^(Detail)

- 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 an international rotation. ^(Core)
- I.B.3.d) Surgical procedures completed during an international rotation must not be counted toward meeting the required minima of procedures. ^(Core)

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.** ^(Core)
 - II.A.1.a) **The program director must submit this change to the ACGME via the ADS.** ^(Core)
- II.A.2. **The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.** ^(Detail)
- II.A.3. **Qualifications of the program director must include:**
 - II.A.3.a) **requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;** ^(Core)
 - II.A.3.b) **current certification in the specialty by the American Board of Otolaryngology (ABOto), or specialty qualifications that are acceptable to the Review Committee;** ^(Core)
 - II.A.3.b).(1) **The Review Committee accepts only ABOto certification.** ^(Core)
 - II.A.3.c) **current medical licensure and appropriate medical staff appointment; and,** ^(Core)
 - II.A.3.d) **a minimum of three years of clinical practice in the specialty post-residency/fellowship;** ^(Core)
 - II.A.3.e) **a minimum of one year of experience as an associate program director of an ACGME-accredited Otolaryngology program or three years of participation as an active faculty member of an ACGME-accredited Otolaryngology program; and,** ^(Core)
 - II.A.3.f) **evidence of periodic updates of knowledge and skills to discharge the roles and responsibilities for teaching, supervision, and formal**

evaluation of residents. ^(Detail)

II.A.4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. ^(Core)

The program director must:

II.A.4.a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program; ^(Core)

II.A.4.b) approve a local director at each participating site who is accountable for resident education; ^(Core)

II.A.4.b).(1) The director at each participating site must have major clinical responsibilities at that site. ^(Core)

II.A.4.c) approve the selection of program faculty as appropriate; ^(Core)

II.A.4.d) evaluate program faculty; ^(Core)

II.A.4.e) approve the continued participation of program faculty based on evaluation; ^(Core)

II.A.4.f) monitor resident supervision at all participating sites; ^(Core)

II.A.4.g) prepare and submit all information required and requested by the ACGME. ^(Core)

II.A.4.g).(1) This includes but is not limited to the program application forms and annual program updates to the ADS, and ensure that the information submitted is accurate and complete. ^(Core)

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; ^(Detail)

II.A.4.i) provide verification of residency education for all residents, including those who leave the program prior to completion; ^(Detail)

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, ^(Core)

and, to that end, must:

II.A.4.j).(1) distribute these policies and procedures to the residents and faculty; ^(Detail)

- II.A.4.j).(2)** monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements; ^(Core)
- II.A.4.j).(3)** adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and, ^(Detail)
- 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. ^(Detail)
- 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; ^(Detail)
- 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; ^(Detail)
- 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; ^(Detail)
- II.A.4.n)** obtain review and approval of the sponsoring institution's GMEC/DIO before submitting information or requests to the ACGME, including: ^(Core)
- II.A.4.n).(1)** all applications for ACGME accreditation of new programs; ^(Detail)
- II.A.4.n).(2)** changes in resident complement; ^(Detail)
- II.A.4.n).(3)** major changes in program structure or length of training; ^(Detail)
- II.A.4.n).(4)** progress reports requested by the Review Committee; ^(Detail)
- II.A.4.n).(5)** requests for increases or any change to resident duty hours; ^(Detail)
- II.A.4.n).(6)** voluntary withdrawals of ACGME-accredited programs; ^(Detail)
- II.A.4.n).(7)** requests for appeal of an adverse action; and, ^(Detail)
- II.A.4.n).(8)** appeal presentations to a Board of Appeal or the ACGME. ^(Detail)

- II.A.4.o) **obtain DIO review and co-signature on all program application forms, as well as any correspondence or document submitted to the ACGME that addresses:** ^(Detail)
- II.A.4.o).(1) **program citations, and/or,** ^(Detail)
- II.A.4.o).(2) **request for changes in the program that would have significant impact, including financial, on the program or institution.** ^(Detail)
- II.A.4.p) **prepare and implement a supervision policy that specifies resident and faculty member lines of responsibility.** ^(Core)
- 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.** ^(Core)

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,** ^(Core)
- II.B.1.b) **administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.** ^(Core)
- II.B.2. **The physician faculty must have current certification in the specialty by the American Board of Otolaryngology, or possess qualifications judged acceptable to the Review Committee.** ^(Core)
- II.B.2.a) **In addition to the program director, there should be at least two other FTE faculty members with qualifications to include:** ^(Detail)
- II.B.2.a).(1) **specialty expertise and documented educational and administrative experience acceptable to the Review Committee; and,** ^(Detail)
- II.B.2.a).(2) **appropriate medical staff appointment.** ^(Detail)
- II.B.3. **The physician faculty must possess current medical licensure and appropriate medical staff appointment.** ^(Core)
- II.B.4. **The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.** ^(Core)
- II.B.5. **The faculty must establish and maintain an environment of inquiry**

and scholarship with an active research component. ^(Core)

II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. ^(Detail)

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; ^(Detail)

II.B.5.b).(2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks; ^(Detail)

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, ^(Detail)

II.B.5.b).(4) participation in national committees or educational organizations. ^(Detail)

II.B.5.c) Faculty should encourage and support residents in scholarly activities. ^(Core)

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. ^(Core)

II.C.1. This should include speech pathologists, audiologists, and/or balance therapists necessary for carrying out audiologic and vestibular testing and rehabilitation. ^(Detail)

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. ^(Core)

II.D.1. There must be space and equipment for the educational program, including 24-hour computer access with Internet, classrooms with audiovisual and other educational aids, meeting rooms, and office space for residents. ^(Detail)

II.D.2. There must be current information technology readily available for clinical care. ^(Detail)

II.D.3. Each participating site must provide beds and operating time sufficient for the needs of the service and for resident education. ^(Core)

II.D.4. There must be a variety of adult and pediatric medical and surgical

patients available to allow development of resident competency in patient care. ^(Core)

- II.D.5. Residents must have access to outpatient facilities that provide clinics and office space for education in the regular pre-operative evaluation and postoperative follow-up of cases for which each resident has responsibility. ^(Core)
- II.D.6. Technologically-current equipment considered necessary for diagnosis and treatment must be available. ^(Core)
- II.D.7. There should be clinical services in the related fields of anesthesiology, emergency medicine, internal medicine, neurological surgery, neurology, ophthalmology, pathology, pediatrics, and radiology. ^(Detail)

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.
^(Detail)

III. Resident Appointments

III.A. Eligibility Criteria

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

III.A.1. Eligibility Requirements – Residency Programs

III.A.1.a) All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, or in Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada. Residency programs must receive verification of each applicant's level of competency in the required clinical field using ACGME or CanMEDS Milestones assessments from the prior training program. ^(Core)

III.A.1.a).(1) The Review Committee for Otolaryngology does not allow transfer into an ACGME-accredited otolaryngology program at the PGY2 level or above from a RCPSC-accredited program. ^(Core)

III.A.1.b) A physician who has completed a residency program that was not accredited by ACGME, RCPSC, or CFPC may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the

program director at the ACGME-accredited program may be advanced to the PGY-2 level based on ACGME Milestones assessments at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry. ^(Core)

III.A.1.c) A Review Committee may grant the exception to the eligibility requirements specified in Section III.A.2.b) for residency programs that require completion of a prerequisite residency program prior to admission. ^(Core)

III.A.1.d) Review Committees will grant no other exceptions to these eligibility requirements for residency education. ^(Core)

III.A.2. Eligibility Requirements – Fellowship Programs

All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, or in an RCPSC-accredited or CFPC-accredited residency program located in Canada. ^(Core)

III.A.2.a) Fellowship programs must receive verification of each entering fellow's level of competency in the required field using ACGME or CanMEDS Milestones assessments from the core residency program. ^(Core)

III.A.2.b) Fellow Eligibility Exception

A Review Committee may grant the following exception to the fellowship eligibility requirements:

An ACGME-accredited fellowship program may accept an exceptionally qualified applicant**, who does not satisfy the eligibility requirements listed in Sections III.A.2. and III.A.2.a), but who does meet all of the following additional qualifications and conditions: ^(Core)

III.A.2.b).(1) Assessment by the program director and fellowship selection committee of the applicant's suitability to enter the program, based on prior training and review of the summative evaluations of training in the core specialty; and ^(Core)

III.A.2.b).(2) Review and approval of the applicant's exceptional qualifications by the GMEC or a subcommittee of the GMEC; and ^(Core)

III.A.2.b).(3) Satisfactory completion of the United States Medical Licensing Examination (USMLE) Steps 1, 2, and, if the applicant is eligible, 3, and; ^(Core)

- III.A.2.b).(4)** For an international graduate, verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification; and, ^(Core)
- III.A.2.b).(5)** Applicants accepted by this exception must complete fellowship Milestones evaluation (for the purposes of establishment of baseline performance by the Clinical Competency Committee), conducted by the receiving fellowship program within six weeks of matriculation. This evaluation may be waived for an applicant who has completed an ACGME International-accredited residency based on the applicant's Milestones evaluation conducted at the conclusion of the residency program. ^(Core)
- III.A.2.b).(5).(a)** If the trainee does not meet the expected level of Milestones competency following entry into the fellowship program, the trainee must undergo a period of remediation, overseen by the Clinical Competency Committee and monitored by the GMEC or a subcommittee of the GMEC. This period of remediation must not count toward time in fellowship training. ^(Core)

**** An exceptionally qualified applicant has (1) completed a non-ACGME-accredited residency program in the core specialty, and (2) demonstrated clinical excellence, in comparison to peers, throughout training. Additional evidence of exceptional qualifications is required, which may include one of the following: (a) participation in additional clinical or research training in the specialty or subspecialty; (b) demonstrated scholarship in the specialty or subspecialty; (c) demonstrated leadership during or after residency training; (d) completion of an ACGME-International-accredited residency program.**

- III.A.2.c)** The Review Committee for Otolaryngology does not allow exceptions to the Eligibility Requirements for Fellowship Programs in Section III.A.2. ^(Core)

III.B. Number of Residents

The program's educational resources must be adequate to support the number of residents appointed to the program. ^(Core)

- III.B.1.** The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. ^(Core)

- III.B.2.** If a vacancy in a program's resident complement is filled, it should be

filled at the same level in which it occurs. Exceptions must be approved by the Review Committee. ^(Detail)

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. ^(Detail)

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

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. ^(Core)

III.D.1. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines. ^(Detail)

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 make available to residents and faculty; ^(Core)

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty at least annually, in either written or electronic form; ^(Core)

IV.A.3. Regularly scheduled didactic sessions; ^(Core)

IV.A.3.a) The didactic curriculum must include cyclical presentation of core specialty knowledge supplemented by the addition of breakthrough information. ^(Core)

IV.A.3.b) Educational conferences must include grand rounds, quality improvement conferences, morbidity and mortality conferences, and tumor conferences. ^(Core)

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

- IV.A.3.b).(2) Residents must attend educational conferences. ^(Core)
- IV.A.3.b).(2).(a) Each resident should attend at least 75 percent of the scheduled and held educational conferences. ^(Detail)
- IV.A.3.b).(2).(b) Educational conferences must be evaluated. ^(Detail)
- 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, speech and language pathology, and the voice sciences, as they related to laryngology; embryology; genetics; microbiology; pathology; pharmacology; physiology; rhinology; and the chemical senses, endocrinology, and neurology, as they relate to the head and neck. ^(Detail)
- IV.A.3.b).(3).(a) Anatomy should include the study and dissection of anatomic specimens, including the temporal bone, and procedural skills laboratories, along with appropriate lectures and other formal sessions. ^(Detail)
- IV.A.3.b).(3).(b) Pathology should include formal instruction in correlative pathology, including gross and microscopic pathology relating to the head and neck. ^(Detail)
- IV.A.3.b).(3).(b).(i) Residents should study and discuss with the pathology service tissues removed at operations and autopsy material. ^(Detail)
- 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,** ^(Core)
- IV.A.5. ACGME Competencies**
- The program must integrate the following ACGME competencies into the curriculum:** ^(Core)
- IV.A.5.a) Patient Care and Procedural Skills**
- IV.A.5.a).(1) 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:** ^(Outcome)
- IV.A.5.a).(2) Residents must be able to competently perform all medical, diagnostic, and surgical procedures**

considered essential for the area of practice.

Residents: (Outcome)

- IV.A.5.a).(2).(a) must demonstrate proficiency in data gathering and interpretation in areas including: (Outcome)
- IV.A.5.a).(2).(a).(i) allergy testing; (Outcome)
- IV.A.5.a).(2).(a).(ii) audiology testing; (Outcome)
- IV.A.5.a).(2).(a).(iii) clinical history and exam; (Outcome)
- IV.A.5.a).(2).(a).(iv) facial analysis; (Outcome)
- IV.A.5.a).(2).(a).(v) histopathology studies; (Outcome)
- IV.A.5.a).(2).(a).(vi) imaging studies of the head and neck; (Outcome)
- IV.A.5.a).(2).(a).(vii) laboratory testing; (Outcome)
- IV.A.5.a).(2).(a).(viii) sleep studies; (Outcome)
- IV.A.5.a).(2).(a).(ix) smell and taste testing; and, (Outcome)
- IV.A.5.a).(2).(a).(x) vestibular testing. (Outcome)
- IV.A.5.a).(2).(b) must demonstrate proficiency in formulating differential diagnoses of conditions affecting the head and neck; (Outcome)
- IV.A.5.a).(2).(c) must demonstrate proficiency in surgical (including peri-operative) and non-surgical management and treatment of conditions affecting the head and neck, including: (Outcome)
- IV.A.5.a).(2).(c).(i) aerodigestive foreign body obstruction; (Outcome)
- IV.A.5.a).(2).(c).(ii) allergic and immunologic disorders; (Outcome)
- IV.A.5.a).(2).(c).(iii) chemoreceptive disorders; (Outcome)
- IV.A.5.a).(2).(c).(iv) voice, speech, and swallowing disorders; (Outcome)
- IV.A.5.a).(2).(c).(v) disorders related to the geriatric population; (Outcome)
- IV.A.5.a).(2).(c).(vi) endocrine disorders related to the thyroid and parathyroid; (Outcome)

IV.A.5.a).(2).(c).(vii)	facial plastic and reconstructive disorders; (Outcome)
IV.A.5.a).(2).(c).(viii)	idiopathic disorders; (Outcome)
IV.A.5.a).(2).(c).(ix)	infectious and inflammatory disorders; (Outcome)
IV.A.5.a).(2).(c).(x)	metabolic disorders; (Outcome)
IV.A.5.a).(2).(c).(xi)	neoplastic disorders; (Outcome)
IV.A.5.a).(2).(c).(xii)	neurologic disorders related to the head and neck; (Outcome)
IV.A.5.a).(2).(c).(xiii)	pain; (Outcome)
IV.A.5.a).(2).(c).(xiv)	pediatric and congenital disorders; (Outcome)
IV.A.5.a).(2).(c).(xv)	sleep disorders; (Outcome)
IV.A.5.a).(2).(c).(xvi)	traumatic disorders; (Outcome)
IV.A.5.a).(2).(c).(xvii)	vascular disorders; and, (Outcome)
IV.A.5.a).(2).(c).(xviii)	vestibular and hearing disorders. (Outcome)
IV.A.5.a).(2).(d)	should demonstrate competency in performing otolaryngologic procedures, including; (Outcome)
IV.A.5.a).(2).(d).(i)	airway management; (Outcome)
IV.A.5.a).(2).(d).(ii)	computer-assisted navigation; (Outcome)
IV.A.5.a).(2).(d).(iii)	endoscopy of the upper aerodigestive tract; (Outcome)
IV.A.5.a).(2).(d).(iv)	laser usage; (Outcome)
IV.A.5.a).(2).(d).(v)	local and regional anesthesia; (Outcome)
IV.A.5.a).(2).(d).(vi)	resuscitation; (Outcome)
IV.A.5.a).(2).(d).(vii)	stroboscopy; and, (Outcome)
IV.A.5.a).(2).(d).(viii)	universal precautions. (Outcome)

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: (Outcome)

IV.A.5.b).(1) must demonstrate knowledge appropriate for unsupervised practice of otolaryngology as defined by the ABOto curriculum; and, (Outcome)

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. (Outcome)

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.
(Outcome)

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;** (Outcome)

IV.A.5.c).(2) **set learning and improvement goals;** (Outcome)

IV.A.5.c).(3) **identify and perform appropriate learning activities;**
(Outcome)

IV.A.5.c).(4) **systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;** (Outcome)

IV.A.5.c).(5) **incorporate formative evaluation feedback into daily practice;** (Outcome)

IV.A.5.c).(6) **locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;** (Outcome)

IV.A.5.c).(7) **use information technology to optimize learning; and,**
(Outcome)

IV.A.5.c).(8) **participate in the education of patients, families, students, residents and other health professionals.**
(Outcome)

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

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Outcome)

Residents are expected to:

- IV.A.5.d).(1)** communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; (Outcome)
- IV.A.5.d).(2)** communicate effectively with physicians, other health professionals, and health related agencies; (Outcome)
- IV.A.5.d).(3)** work effectively as a member or leader of a health care team or other professional group; (Outcome)
- IV.A.5.d).(4)** act in a consultative role to other physicians and health professionals; (Outcome)
- IV.A.5.d).(5)** maintain comprehensive, timely, and legible medical records, if applicable; and, (Outcome)
- IV.A.5.d).(6)** develop and present educational materials to the public. (Outcome)

IV.A.5.e)

Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. (Outcome)

Residents are expected to demonstrate:

- IV.A.5.e).(1)** compassion, integrity, and respect for others; (Outcome)
- IV.A.5.e).(2)** responsiveness to patient needs that supersedes self-interest; (Outcome)
- IV.A.5.e).(3)** respect for patient privacy and autonomy; (Outcome)
- IV.A.5.e).(4)** accountability to patients, society and the profession; and, (Outcome)
- IV.A.5.e).(5)** sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation. (Outcome)

IV.A.5.f)

Systems-based Practice

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

(Outcome)

Residents are expected to:

- IV.A.5.f).(1)** work effectively in various health care delivery settings and systems relevant to their clinical specialty; (Outcome)
- IV.A.5.f).(2)** coordinate patient care within the health care system relevant to their clinical specialty; (Outcome)
- IV.A.5.f).(3)** incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate; (Outcome)
- IV.A.5.f).(4)** advocate for quality patient care and optimal patient care systems; (Outcome)
- IV.A.5.f).(5)** work in interprofessional teams to enhance patient safety and improve patient care quality; and, (Outcome)
- IV.A.5.f).(6)** participate in identifying system errors and implementing potential systems solutions. (Outcome)

IV.A.6. Curriculum Organization and Resident Experiences

- IV.A.6.a) PGY-1 residents must participate in clinical and didactic activities in which they: (Core)
- IV.A.6.a).(1) assess, plan, and initiate treatment of adult and pediatric patients with surgical and/or medical problems; (Core)
- IV.A.6.a).(2) 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; (Core)
- IV.A.6.a).(3) care for critically-ill surgical and medical patients in the intensive care unit and emergency room settings; (Core)
- IV.A.6.a).(4) participate in the pre-, intra-, and post-operative care of surgical patients; and, (Core)
- IV.A.6.a).(5) participate in surgical anesthesia in hospital and ambulatory care settings, including evaluation of anesthetic risks and the management of intra-operative anesthetic complications. (Core)

- IV.A.6.b) The PG-1 year must include:
- IV.A.6.b).(1) six months of structured education on non-otolaryngology rotations designed to foster proficiency in the peri-operative care of surgical patients, inter-disciplinary care coordination, and airway management skills; and, ^(Core)
- IV.A.6.b).(1).(a) The total time a resident is assigned to any one non-otolaryngology rotation must be at least four weeks and must not exceed two months. ^(Core)
- IV.A.6.b).(1).(b) Rotations must be selected from the following: anesthesia, emergency medicine, general surgery, neurological surgery, neuroradiology, ophthalmology, oral-maxillofacial surgery, pediatric surgery, plastic surgery, radiation oncology, and vascular surgery. ^(Core)
- IV.A.6.b).(1).(b).(i) This must include a surgical or medical intensive care rotation. ^(Core)
- IV.A.6.b).(1).(b).(ii) A one month or 4-week night float rotation is permitted but must have structured educational goals and objectives, and the resident must be evaluated during and at the end of the rotation. ^(Core)
- IV.A.6.b).(2) six months of otolaryngology rotations designed to develop proficiency in basic surgical skills, general care of otolaryngology patients both in the inpatient setting and in the outpatient clinics, management of otolaryngology patients in the emergency department, and cultivation of an otolaryngology knowledge base. ^(Core)
- IV.A.6.c) The PG-2-5 years must include 48 months of progressive education in otolaryngology. ^(Core)
- IV.A.6.d) Each resident must spend a 12-month period as chief resident on the otolaryngology clinical service at the primary clinical site or one of the participating sites of the sponsoring institution during the last 24 months of the educational program. ^(Core)
- IV.A.6.e) Resident Supervision and Patient Care Experiences
- IV.A.6.e).(1) Residents must have experience with state-of-the-art advances and emerging technology in otolaryngology. ^(Detail)
- IV.A.6.e).(2) Residents must perform a sufficient number, variety, and complexity of surgical procedures to ensure education in the entire scope of the specialty. ^(Core)

- IV.A.6.e).(2).(a) Residents must have essentially equivalent distributions of case categories and procedures. (Core)
- IV.A.6.e).(3) Residents' must have a broad range of experience in otolaryngology through outpatient care. (Core)
- This must include:
- IV.A.6.e).(3).(a) exposure to clinical aspects of diagnosis, medical and/or surgical therapy, and prevention of and rehabilitation from diseases, neoplasms, deformities, disorders, and/or injuries of the ears, upper respiratory and upper alimentary systems, face, jaws, and other head and neck systems; to head and neck oncology; and to facial plastic and reconstructive surgery; (Core)
- IV.A.6.e).(3).(b) evaluating patients, establishing provisional diagnoses, and initiating preliminary treatment plans; and, (Core)
- IV.A.6.e).(3).(c) providing follow-up care and evaluating the results of surgical care. (Core)
- IV.A.6.e).(4) Residents should have experience in the management of office practice. (Detail)
- IV.A.6.e).(5) Residents must have experience in the emergency care of critically-ill and injured patients with otolaryngologic conditions. (Core)
- 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. (Core)
- IV.A.6.e).(6).(a) This must include experience as assistant surgeon and resident supervisor. (Core)
- IV.A.6.e).(6).(b) All levels of surgical intervention must be recorded in the ACGME Case Log System. (Core)

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. (Core)**
- IV.B.2. Residents should participate in scholarly activity. (Core)**

IV.B.2.a) The educational program must provide at least three months of a structured research experience for residents. ^(Core)

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

IV.B.2.a).(2) The research experience should result in a completed manuscript suitable for publication in a peer-reviewed journal. ^(Outcome)

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

V. Evaluation

V.A. Resident Evaluation

V.A.1. The program director must appoint the Clinical Competency Committee. ^(Core)

V.A.1.a) At a minimum the Clinical Competency Committee must be composed of three members of the program faculty. ^(Core)

V.A.1.a).(1) The program director may appoint additional members of the Clinical Competency Committee.

V.A.1.a).(1).(a) These additional members must be physician faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents in patient care and other health care settings. ^(Core)

V.A.1.a).(1).(b) Chief residents who have completed core residency programs in their specialty and are eligible for specialty board certification may be members of the Clinical Competency Committee. ^(Core)

V.A.1.b) There must be a written description of the responsibilities of the Clinical Competency Committee. ^(Core)

V.A.1.b).(1) The Clinical Competency Committee should:

V.A.1.b).(1).(a) review all resident evaluations semi-annually; ^(Core)

V.A.1.b).(1).(b) prepare and ensure the reporting of Milestones evaluations of each resident semi-annually to ACGME; and, ^(Core)

V.A.1.b).(1).(c) advise the program director regarding resident progress, including promotion, remediation, and dismissal. ^(Detail)

V.A.2. Formative Evaluation

V.A.2.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. ^(Core)

V.A.2.b) The program must:

V.A.2.b).(1) provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones; ^(Core)

V.A.2.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff); ^(Detail)

V.A.2.b).(3) document progressive resident performance improvement appropriate to educational level; and, ^(Core)

V.A.2.b).(4) provide each resident with documented semiannual evaluation of performance with feedback. ^(Core)

V.A.2.c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy. ^(Detail)

V.A.2.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. ^(Core)

V.A.2.e) The program director must meet with each resident in person to review his or her cumulative operative experience at least semiannually to ensure balanced progress towards achieving experience with a variety and complexity of surgical procedures. ^(Core)

V.A.2.f) Residents must participate in existing national examinations. ^(Core)

V.A.2.f).(1) Use of the annual Otolaryngology Training Examination is

strongly suggested.

- V.A.2.f).(2) An analysis of the results of these testing programs must be limited to guiding the faculty in assessing the strengths and weaknesses of the program and individual residents.
(Core)

V.A.3. Summative Evaluation

- V.A.3.a) **The specialty-specific Milestones must be used as one of the tools to ensure residents are able to practice core professional activities without supervision upon completion of the program.** (Core)

- V.A.3.b) **The program director must provide a summative evaluation for each resident upon completion of the program.** (Core)

This evaluation must:

- V.A.3.b).(1) **become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy;** (Detail)

- V.A.3.b).(2) **document the resident's performance during the final period of education; and,** (Detail)

- V.A.3.b).(3) **verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.** (Detail)

V.B. Faculty Evaluation

- V.B.1. **At least annually, the program must evaluate faculty performance as it relates to the educational program.** (Core)

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

- V.B.3. **This evaluation must include at least annual written confidential evaluations by the residents.** (Detail)

V.C. Program Evaluation and Improvement

- V.C.1. **The program director must appoint the Program Evaluation Committee (PEC).** (Core)

- V.C.1.a) **The Program Evaluation Committee:**

- V.C.1.a).(1) **must be composed of at least two program faculty**

members and should include at least one resident;
(Core)

V.C.1.a).(2) must have a written description of its responsibilities; and, (Core)

V.C.1.a).(3) should participate actively in:

V.C.1.a).(3).(a) planning, developing, implementing, and evaluating educational activities of the program; (Detail)

V.C.1.a).(3).(b) reviewing and making recommendations for revision of competency-based curriculum goals and objectives; (Detail)

V.C.1.a).(3).(c) addressing areas of non-compliance with ACGME standards; and, (Detail)

V.C.1.a).(3).(d) reviewing the program annually using evaluations of faculty, residents, and others, as specified below. (Detail)

V.C.2. The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written, annual program evaluation. (Core)

The program must monitor and track each of the following areas:

V.C.2.a) resident performance; (Core)

V.C.2.b) faculty development; (Core)

V.C.2.c) graduate performance, including performance of program graduates on the certification examination; (Core)

V.C.2.c).(1) 85 percent of the program's eligible graduates from the preceding five years taking the ABOto Qualifying Examination for the first time must pass. (Outcome)

V.C.2.c).(2) 95 percent of the program's eligible graduates from the preceding five years taking the ABOto Oral Certification Examination for the first time must pass. (Outcome)

V.C.2.c).(3) 75 percent of the program's eligible graduates from the preceding five years taking the American Osteopathic Boards of Ophthalmology and Otolaryngology-Head & Neck Surgery (AOBOO-HNS) otolaryngology written qualifying examination for the first time must pass. (Outcome)

V.C.2.c).(4) 70 percent of the program's eligible graduates from the

preceding five years taking the AOBOO-HNS otolaryngology oral certifying examination for the first time must pass. ^(Outcome)

V.C.2.d) program quality; and, ^(Core)

V.C.2.d).(1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and ^(Detail)

V.C.2.d).(2) The program must use the results of residents' and faculty members' assessments of the program together with other program evaluation results to improve the program. ^(Detail)

V.C.2.e) progress on the previous year's action plan(s). ^(Core)

V.C.3. The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section V.C.2., as well as delineate how they will be measured and monitored. ^(Core)

V.C.3.a) The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes. ^(Detail)

VI. The Learning and Working Environment

Residency education must occur in the context of a learning and working environment that emphasizes the following principles:

- *Excellence in the safety and quality of care rendered to patients by residents today*
- *Excellence in the safety and quality of care rendered to patients by today's residents in their future practice*
- *Excellence in professionalism through faculty modeling of:*
 - *the effacement of self-interest in a humanistic environment that supports the professional development of physicians*
 - *the joy of curiosity, problem-solving, intellectual rigor, and discovery*
- *Commitment to the well-being of the students, residents, faculty members, and all members of the health care team*

VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability

VI.A.1. Patient Safety and Quality Improvement

All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Graduate medical education must prepare residents to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by residents who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.

Residents must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating residents will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

It is necessary for residents and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.

VI.A.1.a) Patient Safety

VI.A.1.a).(1) Culture of Safety

A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.

VI.A.1.a).(1).(a) The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)

VI.A.1.a).(1).(b) The program must have a structure that promotes safe, interprofessional, team-based care. (Core)

VI.A.1.a).(2) Education on Patient Safety

Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)

VI.A.1.a).(3) Patient Safety Events

Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are

essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.

VI.A.1.a).(3).(a) Residents, fellows, faculty members, and other clinical staff members must:

VI.A.1.a).(3).(a).(i) know their responsibilities in reporting patient safety events at the clinical site; (Core)

VI.A.1.a).(3).(a).(ii) know how to report patient safety events, including near misses, at the clinical site; and, (Core)

VI.A.1.a).(3).(a).(iii) be provided with summary information of their institution's patient safety reports. (Core)

VI.A.1.a).(3).(b) Residents must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)

VI.A.1.a).(4) Resident Education and Experience in Disclosure of Adverse Events

Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for residents to develop and apply.

VI.A.1.a).(4).(a) All residents must receive training in how to disclose adverse events to patients and families. (Core)

VI.A.1.a).(4).(b) Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated. (Detail)

VI.A.1.b) Quality Improvement

VI.A.1.b).(1) Education in Quality Improvement

A cohesive model of health care includes quality-

related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.

VI.A.1.b).(1).(a)

Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities. ^(Core)

VI.A.1.b).(2)

Quality Metrics

Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.

VI.A.1.b).(2).(a)

Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. ^(Core)

VI.A.1.b).(3)

Engagement in Quality Improvement Activities

Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.

VI.A.1.b).(3).(a)

Residents must have the opportunity to participate in interprofessional quality improvement activities. ^(Core)

VI.A.1.b).(3).(a).(i)

This should include activities aimed at reducing health care disparities. ^(Detail)

VI.A.2.

Supervision and Accountability

VI.A.2.a)

Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.

Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

VI.A.2.a).(1)

Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as

specified by the applicable Review Committee) who is responsible and accountable for the patient's care.
(Core)

- VI.A.2.a).(1).(a) This information must be available to residents, faculty members, other members of the health care team, and patients. (Core)
- VI.A.2.a).(1).(b) Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. (Core)
- VI.A.2.b) *Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member, fellow, or senior resident physician, either on site or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.*
- VI.A.2.b).(1) The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)
- VI.A.2.c) **Levels of Supervision**
- To promote oversight of resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision: (Core)
- VI.A.2.c).(1) **Direct Supervision – the supervising physician is physically present with the resident and patient.** (Core)
- VI.A.2.c).(2) **Indirect Supervision:**
- VI.A.2.c).(2).(a) **with Direct Supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.** (Core)
- VI.A.2.c).(2).(b) **with Direct Supervision available – the supervising physician is not physically present**

within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision. ^(Core)

- VI.A.2.c).(3) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. ^(Core)**
- VI.A.2.d) The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. ^(Core)**
- VI.A.2.d).(1) The program director must evaluate each resident’s abilities based on specific criteria, guided by the Milestones. ^(Core)**
- VI.A.2.d).(2) Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. ^(Core)**
- VI.A.2.d).(3) Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. ^(Detail)**
- VI.A.2.e) Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). ^(Core)**
- VI.A.2.e).(1) Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. ^(Outcome)**
- VI.A.2.e).(1).(a) Initially, PGY-1 residents must be supervised either directly, or indirectly with direct supervision immediately available. ^(Core)**
- VI.A.2.e).(1).(a).(i) Each program must define those physician tasks for which PGY-1 residents may be supervised indirectly with direct supervision available, and must define “direct supervision” in the context of the individual program. ^(Core)**
- VI.A.2.e).(1).(a).(ii) Each program must define those physician tasks for which PGY-1 residents must be**

supervised directly until they have demonstrated competence as defined by the program director, and must maintain records of such demonstrations of competence. ^(Core)

VI.A.2.f) Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. ^(Core)

VI.B. Professionalism

VI.B.1. Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients. ^(Core)

VI.B.2. The learning objectives of the program must:

VI.B.2.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; ^(Core)

VI.B.2.b) be accomplished without excessive reliance on residents to fulfill non-physician obligations; and, ^(Core)

VI.B.2.c) ensure manageable patient care responsibilities. ^(Core)

VI.B.3. The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. ^(Core)

VI.B.4. Residents and faculty members must demonstrate an understanding of their personal role in the:

VI.B.4.a) provision of patient- and family-centered care; ^(Outcome)

VI.B.4.b) safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; ^(Outcome)

VI.B.4.c) assurance of their fitness for work, including: ^(Outcome)

VI.B.4.c).(1) management of their time before, during, and after clinical assignments; and, ^(Outcome)

VI.B.4.c).(2) recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team. ^(Outcome)

- VI.B.4.d) commitment to lifelong learning; (Outcome)
- VI.B.4.e) monitoring of their patient care performance improvement indicators; and, (Outcome)
- VI.B.4.f) accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data. (Outcome)
- VI.B.5. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider. (Outcome)
- VI.B.6. Programs must provide a professional, respectful, and civil environment that is free from mistreatment, abuse, or coercion of students, residents, faculty, and staff. Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)
- VI.C. Well-Being
- In the current health care environment, residents and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician. Self-care is an important component of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of residency training. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as they do to evaluate other aspects of resident competence.*
- VI.C.1. This responsibility must include:
- VI.C.1.a) efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; (Core)
- VI.C.1.b) attention to scheduling, work intensity, and work compression that impacts resident well-being; (Core)
- VI.C.1.c) evaluating workplace safety data and addressing the safety of residents and faculty members; (Core)
- VI.C.1.d) policies and programs that encourage optimal resident and faculty member well-being; and, (Core)

VI.C.1.d).(1) Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core)

VI.C.1.e) attention to resident and faculty member burnout, depression, and substance abuse. The program, in partnership with its Sponsoring Institution, must educate faculty members and residents in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must: (Core)

VI.C.1.e).(1) encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence; (Core)

VI.C.1.e).(2) provide access to appropriate tools for self-screening; and, (Core)

VI.C.1.e).(3) provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)

VI.C.2. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. Each program must have policies and procedures in place that ensure coverage of patient care in the event that a resident may be unable to perform their patient care responsibilities. These policies must be implemented without fear of negative consequences for the resident who is unable to provide the clinical work. (Core)

VI.D. Fatigue Mitigation

VI.D.1. Programs must:

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

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

- VI.D.1.c) encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. (Detail)**
- VI.D.2. Each program must ensure continuity of patient care, consistent with the program’s policies and procedures referenced in VI.C.2, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue. (Core)**
- VI.D.3. The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. (Core)**
- VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care**
- VI.E.1. Clinical Responsibilities**
- The clinical responsibilities for each resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services. (Core)**
- VI.E.1.a) The workload associated with optimal clinical care of surgical patients is a continuum from the moment of admission to the point of discharge. (Detail)
- VI.E.1.b) During the residency education process, surgical teams should be made up of attending surgeons, residents at various PGY levels, medical students (when appropriate), and other health care providers. (Detail)
- VI.E.1.c) The work of the caregiver team should be assigned to team members based on each resident’s level of education, experience, and competence. (Detail)
- VI.E.2. Teamwork**
- Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty and larger health system. (Core)**
- VI.E.2.a) Effective surgical practices entail the involvement of members with a mix of complementary skills and attributes (physicians, nurses, and other staff members). Success requires both an unwavering mutual respect for those skills and contributions, and a shared commitment to the process of patient care. (Detail)
- VI.E.2.b) Residents must collaborate with fellow surgical residents, and especially with faculty members, other physicians outside of their specialty, and non-traditional health care providers, to best formulate treatment plans for an increasingly diverse patient

population. ^(Detail)

VI.E.2.c) Residents must assume personal responsibility to complete all tasks to which they are assigned (or which they voluntarily assume) in a timely fashion. These tasks must be completed in the hours assigned, or, if that is not possible, residents must learn and utilize the established methods for handing off remaining tasks to another member of the resident team so that patient care is not compromised. ^(Detail)

VI.E.2.d) Lines of authority should be defined by programs, and all residents must have a working knowledge of these expected reporting relationships to maximize quality care and patient safety. ^(Detail)

VI.E.3. Transitions of Care

VI.E.3.a) **Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure.** ^(Core)

VI.E.3.b) **Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.** ^(Core)

VI.E.3.c) **Programs must ensure that residents are competent in communicating with team members in the hand-over process.** ^(Outcome)

VI.E.3.d) **Programs and clinical sites must maintain and communicate schedules of attending physicians and residents currently responsible for care.** ^(Core)

VI.E.3.e) **Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency.** ^(Core)

VI.F. Clinical Experience and Education

Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.

VI.F.1. Maximum Hours of Clinical and Educational Work per Week

Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all

in-house clinical and educational activities, clinical work done from home, and all moonlighting. ^(Core)

VI.F.2. Mandatory Time Free of Clinical Work and Education

VI.F.2.a) The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being. ^(Core)

VI.F.2.b) Residents should have eight hours off between scheduled clinical work and education periods. ^(Detail)

VI.F.2.b).(1) There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements. ^(Detail)

VI.F.2.c) Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. ^(Core)

VI.F.2.d) Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. ^(Core)

VI.F.3. Maximum Clinical Work and Education Period Length

VI.F.3.a) Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. ^(Core)

VI.F.3.a).(1) Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. ^(Core)

VI.F.3.a).(1).(a) Additional patient care responsibilities must not be assigned to a resident during this time. ^(Core)

VI.F.4. Clinical and Educational Work Hour Exceptions

VI.F.4.a) In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:

VI.F.4.a).(1) to continue to provide care to a single severely ill or unstable patient; ^(Detail)

- VI.F.4.a).(2) **humanistic attention to the needs of a patient or family; or,** ^(Detail)
- VI.F.4.a).(3) **to attend unique educational events.** ^(Detail)
- VI.F.4.b) **These additional hours of care or education will be counted toward the 80-hour weekly limit.** ^(Detail)
- VI.F.4.c) **A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.**
- The Review Committee for Otolaryngology will not consider requests for exceptions to the 80-hour limit to the residents' work week.
- VI.F.4.c).(1) **In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the *ACGME Manual of Policies and Procedures.*** ^(Core)
- VI.F.4.c).(2) **Prior to submitting the request to the Review Committee, the program director must obtain approval from the Sponsoring Institution's GMEC and DIO.** ^(Core)
- VI.F.5. **Moonlighting**
- VI.F.5.a) **Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety.** ^(Core)
- VI.F.5.b) **Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit.** ^(Core)
- VI.F.5.c) **PGY-1 residents are not permitted to moonlight.** ^(Core)
- VI.F.6. **In-House Night Float**
- Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements.** ^(Core)
- VI.F.6.a) **Night float rotations cannot exceed two consecutive months in duration, and residents can have no more than three months of night float assignments per year.** ^(Core)
- VI.F.6.b) **There must be at least two months between each night float rotation.** ^(Core)

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

Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core)

VI.F.8. At-Home Call

VI.F.8.a) Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. (Core)

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

VI.F.8.b) Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit. (Detail)

***Core Requirements:** Statements that define structure, resource, or process elements essential to every graduate medical educational program.

Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.

Osteopathic Recognition

For programs seeking Osteopathic Recognition for the entire program, or for a track within the program, the Osteopathic Recognition Requirements are also applicable.

http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/Osteopathic_Recognition_Requirements.pdf