# BASIC STANDARDS FOR APPROVAL OF RESIDENCY TRAINING IN OTOLARYNGOLOGY/ FACIAL PLASTIC SURGERY

American Osteopathic Association
and the
American Osteopathic Colleges of
Ophthalmology and Otolaryngology-Head and Neck Surgery

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## STANDARDS FOR PROGRAM APPROVAL

Standards I through VIII of this document contain standards for residency training in Otolaryngology/Facial Plastic Surgery. The standards and prerequisites are used by the AOA and the AOCOO-HNS to evaluate the residency program on a continuing basis.

### STANDARD I MISSION

The mission of the residency training in Otolaryngology/ Facial Plastic Surgery is to develop an osteopathic physician, who is skilled in the specialty of otolaryngology/ facial plastic surgery and who will provide compassionate, quality care, continue lifelong learning and display integrity and professionalism, as an osteopathic otolaryngologist/facial plastic surgeon. Training shall be accomplished through meeting or exceeding educational goals and objectives outlined in this document.

Each residency program must provide a mission statement for their individual program and evidence that this statement is periodically reviewed and updated by the institution.

### STANDARD II EDUCATIONAL PROGRAM GOALS AND OBJECTIVES

A. Seven core competencies of the osteopathic profession:

Upon completion of the residency program, residents are required to attain and demonstrate competencies at the level expected of a new practitioner in the seven areas described below. The residency program is required to define specific knowledge, skills and attitudes required and provide educational experiences as needed in order for its residents to demonstrate competency in the following: (See Appendix II for details of instruction and evaluation methods).

1. Osteopathic philosophy and osteopathic manipulative medicine
2. Medical knowledge
3. Patient care
4. Interpersonal and communication skills
5. Professionalism
6. Practice based learning and improvement
7. Systems based practice

B. Program Design

The program director and faculty must prepare and implement written educational goals for the program.

1. All educational components of a residency program should be related to program goals and specialty content (Standard II, C. Specialty Content) with documentation of multiple measures to assess the residents performance (see Appendix II). The program design and/or structure must be approved by the AOCOO-HNS Council of Medical Education and AOA as part of the regular review process.

2. The program must have a comprehensive, well organized, and effective curriculum, including:

   a. The cyclical presentation of core specialty knowledge supplemented by the addition of current information.

   b. Indication of what competencies are needed to progress through each year of training.

   c. Evidence that the teaching is conducted in a variety of educational settings such as clinics, classrooms, operating rooms, bedsides, and laboratories, employing accepted educational principles.

3. The program director may arrange for required rotations with affiliated training sites, in order to fulfill requirements of the basic standards or to enhance training.

   a. A program seeking to fulfill its requirements through affiliations with other AOA or ACGME institutions shall sign formal affiliation agreements with these training sites. Affiliation agreements shall be signed by representatives of both the base institution and the affiliate training sites, and shall be maintained on file with the DME at the base institution. Affiliations shall be consistent with the guidelines of the AOA. There should be an appointed site director at the affiliated institution.

   b. Residents on rotation to affiliated training sites shall remain under contract to the base institution. Resident training logs shall reflect training and service to the affiliated training site and shall be included in the resident records at the base institution. The on-site faculty must submit written evaluation of the resident's performance at the affiliated training site to the program director at the base institution

   c. The base institution or organization may arrange for up to a total of six (6) consecutive months of training outside of the institution.

   d. In no case shall the maximum aggregate time on outside rotations be more than one-third the length of the program.

C. Specialty Content

The broad scope of the specialty of Otolaryngology/Facial Plastic Surgery requires that the program provide surgical and medical education in the following areas:

1. Osteopathic Management of Otolaryngic diseases with the ability to demonstrate knowledge of:

a. Basic concepts of structure-function relationships and the body's inherent healing ability

b. How to design a management plan, which promotes the body's ability to regulate itself toward health

1. Patient education regarding medication abuse, pollutants, humidification, and allergies.

2. Osteopathic manipulative treatment based on the musculoskeletal system's impact on circulation to and from all tissues, the autonomic nervous system and the promotion of lymphatic circulation and its role in reducing swelling and inflammation and stimulation of the immune system

3. Medical and surgical intervention combined with patient education and appropriate musculoskeletal treatment.

2. Morphology, physiology, pharmacology, pathology, microbiology biochemistry, genetics, and immunology relevant to the head and neck; the upper respiratory and upper alimentary systems; the communication sciences, including knowledge of audiology and speech-language pathology; the chemical senses and allergy, endocrinology, and neurology as they relate to the head and neck; and voice sciences as they relate to laryngology.

3. Diagnosis and diagnostic methods: audiologic and vestibular assessments, techniques in voice assessment, electrophysiological techniques, and other related laboratory procedures for diagnosing diseases and disorders of the ears, the upper respiratory and upper alimentary systems, and the head and neck.

4. Therapeutic and diagnostic radiology: the interpretation of medical imaging techniques relevant to the head and neck and the thorax, including studies of the temporal bone, skull, nose, paranasal sinuses, salivary and thyroid glands, larynx, neck, lungs, and esophagus.

5. Diagnostic evaluation and management of congenital anomalies, otolaryngic allergy, trauma, and diseases affecting the regions and systems mentioned above.

6. Management of congenital, inflammatory, endocrine, neoplastic, degenerative, and traumatic states, including operative intervention and preoperative and postoperative care of the following major categories:

a. General otolaryngology
b. Head and neck surgery
c. Plastic and reconstructive surgery
d. Otology
e. Endoscopy
f. Otolaryngic Allergy
g. General Medicine as it applies to otolaryngology

7. Habilitation and rehabilitation techniques and procedures including respiration, deglutition, chemoreception, balance, speech, and hearing.

8. Diagnostic and therapeutic techniques involving the application and utilization of lasers and flexible and rigid upper aerodigestive endoscopy.

D. Clinical Components

The volume and variety of clinical otolaryngic problems in children and adults must be sufficient to afford each resident a graduated supervised experience within the entire spectrum of otolaryngic diseases. This will allow the resident to develop diagnostic, therapeutic, and manual skills; and the judgment to use them appropriately.

During the course of training, residents should be responsible for the care of a panel of outpatients who represent a broad range of otolaryngic diseases. There must be appropriate faculty supervision of the residents in all outpatient visits. Appropriate faculty supervision occurs when the faculty is readily available to the resident(s) for consultation or assistance.

1. Outpatient experience

   a. There must be a well-organized and well-supervised outpatient service. This service must operate in relation to an inpatient service used in the program. Residents must have the opportunity to see patients, establish provisional diagnoses, and initiate preliminary treatment plans. An opportunity for follow-up care must be provided so that the results of surgical care may be evaluated by the responsible residents. These activities must be carried out under appropriate faculty supervision.

   b. If residents participate in preoperative and postoperative care in a private office, the program director must ensure that the resident functions with an appropriate degree of responsibility with adequate supervision. Experience should be provided in office practice procedures and management.

   c. Residents must have experience in the emergency care of critically ill and injured patients with otolaryngology-head and neck conditions.

2. Surgical Experience

   a. Residents must perform and assist at a sufficient number of operative procedures to become skilled as comprehensive otolaryngology/facial plastic surgeons. That is, each resident must have major technical and patient care responsibilities in surgery (including laser surgery).

   b. The program director is responsible for verifying the surgical experiences of each resident, to include the number of cases in each category where the resident has served as the primary surgeon or the assistant surgeon (surgical logs). This documentation must be provided to the AOCOO-HNS Council of Medical Education and individual resident logs must be available at the time of the site visit.

c. While not all residents are expected to have operative experience in all surgical specialty procedures, the surgical procedures performed by the residents must be sufficient in number and variety to provide education in the entire scope of the specialty. There must be adequate distribution and sufficient complexity within the principal categories of the specialty.

d. Generally equivalent and adequate distribution of categories and procedures among the residents must be demonstrated. Significantly unequal experience in volume and/or complexity of cases managed by the residents will be considered serious noncompliance with these requirements.

3. Systemic Disease Consultation Experience

Each resident should receive experience in providing inpatient and outpatient consultation during the course of his/her education.

E. Resident Duty Hours and the Working Environment

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

1. Supervision of Residents

The residency is an educational experience and must be designed by the institution to offer structured and supervised exposure for the purpose of learning rather than service. The residents are to be supervised and evaluated throughout their training with availability of teaching staff. Residents will be responsible to attending physicians who will make appropriate educational assignments of responsibilities.

2. Work Hours must comply with AOA policy (See Appendix III)

3. Moonlighting Policy of the AOA (See Appendix III).

F. Progressive responsibilities

The program must provide the residents with experience in direct and progressively responsible patient management as they advance through the educational program. This education must culminate in sufficient independent responsibility for clinical decision making to reflect that the graduating resident has developed sound clinical judgment and possesses the ability to formulate and carry out appropriate management plans.

G. Research and Scholarly Activities

1. Graduate medical education must take place in an environment of inquiry and scholarship in which residents participate in the development of new knowledge, learn to evaluate research findings, and develop habits of inquiry as a continuing professional responsibility. Research offers an important opportunity for the application of the basic sciences to clinical problems and is an important part of the preparation of the resident for a lifetime of self-education after the completion of formal residency education.

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

3. The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the faculty. While not all members of the faculty must be investigators, the faculty as a whole must demonstrate broad involvement in scholarly activity. This activity should include:

   a. Participation of the faculty in clinical discussions, rounds, and conferences in a manner that promotes a spirit of inquiry and scholarship. Scholarship implies an in-depth understanding of basic mechanisms of normal and abnormal states and the application of current knowledge to practice.

   b. Participation in journal clubs and research conferences.

   c. Participation in regional or national professional and scientific societies, ideally through presentations at the organizations' meetings and publication in their journals.

   d. Participation in research, particularly in projects that are funded following peer review and/or result in publications or presentations at regional and national scientific meetings.

   e. Offering of guidance and technical support (e.g., research design, statistical analysis) for residents involved in research.

   f. Provision of support for resident participation in scholarly activities.

H. Conferences

1. Basic Science

   The resident must complete a minimum of 100 hours of basic science studies relating to Otolaryngology/Facial Plastic Surgery and presented in a structured format. Resident attendance must be monitored, education must be evaluated, and content must be integrated into the educational program.

The basic science education should include instruction in anatomy, biochemistry, cell biology, embryology, immunology, molecular genetics, pathology, pharmacology, physiology, and other basic sciences related to the head and neck. This should include cadaveric dissection, lectures and other formal sessions.

2. Clinical Conferences

Clinical conferences must be held regularly and should be attended by all residents and faculty. Grand rounds, mortality and morbidity conferences, tumor conferences, and conferences on other pertinent topics may be included in the educational program. Interdisciplinary conferences are encouraged.

3. The residency training program shall provide post-graduate courses in allergy, facial plastic surgery, head and neck surgery, laser surgery, and temporal bone surgery when sufficient clinical and didactic material is not available at the base institution.

## STANDARD III INSTITUTIONAL REQUIREMENTS FOR PROGRAM APPROVAL

A. An institution must meet the following institutional requirements to be considered for approval to conduct an Otolaryngology/Facial Plastic Surgery residency program:

1. Be accredited by the American Osteopathic Association/Healthcare Facilities Accreditation Program (HFAP) or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and affiliated with an Osteopathic Postdoctoral Training Institution (OPTI).

2. Have an AOA approved internship and document that the program meets the policies and procedures of the AOA and the OPTI with which it is affiliated.

3. Be in operation at least twelve (12) months immediately preceding the date of application for residency training.

4. Provide sufficient funding to meet the basic standards of the residency program.

B. Organizational Structure

The training institution shall have the following educational structure:

1. Director of Medical Education (DME) who is an osteopathic physician and meets AOA requirements for the position.

2. Postdoctoral education committee with membership and/or attendance of:

   a. Director of Medical Education

   b. Program directors of all specialty training programs at the institution.

c. Representatives of supporting specialty services.

C. Department or Section of Otolaryngology/Facial Plastic Surgery Requirements

To be considered for approval of a residency program in Otolaryngology/Facial Plastic Surgery, the department or section of Otolaryngology/Facial Plastic Surgery in conjunction with the base institution must:

1. Have a chairperson who is currently certified in Otolaryngology/Facial Plastic Surgery by the AOA through the American Osteopathic Board of Ophthalmology and Otolaryngology-Head and Neck Surgery (AOBOO-HNS) or the American Board of Otolaryngology (ABO); and must achieve re-certification within prescribed time frame by the certifying body.

2. Have all physicians who are clinically supervising Otolaryngology/Facial Plastic Surgery residents certified in Otolaryngology/Facial Plastic Surgery by the AOBOO-HNS or ABO or in the process of being certified. Significant clinical exposure to osteopathic otolaryngologists must be provided.

3. Have a minimum of one (1) core faculty member for every three (3) resident positions who is a physician certified in Otolaryngology/Facial Plastic Surgery by AOBOO-HNS or ABO who can provide adequate supervision for residents. However, there must be a minimum of two (2) core faculty members regardless of program size.

4. Have the volume, variety, scope and complexity of major surgical cases to support a residency program with a minimum of three (3) residents. There shall be a minimum volume of one hundred (100) major otolaryngology surgical cases per year for each resident in training that may consist of head and neck, intra-nasal and sinus, broncho-esophagology, and otologic procedures, combined with seventy-five (75) major facial plastic surgery cases per year for each resident in training. When the number of cases in an affiliated institution is to be included in the total procedures performed, a written affiliation agreement between the training institution and the affiliated institution must be established. The affiliated institution is then subject to inspection.

5. Provide supervised training and experience in the following:

   a. Operating room
   b. Outpatient care of patients
   c. Hospital units

6. Ensure that Osteopathic principles and practice and that their application to Otolaryngology/Facial Plastic Surgery are emphasized and employed.

7. The Otolaryngology/Facial Plastic Surgery residency program must adopt formal policies and the residents must be advised of these policies. There must be a resident manual that will include, but not be limited to:

   a. The institution's Otolaryngology/Facial Plastic Surgery residency curriculum.

b. The rules and regulations stating the resident's duties and responsibilities

c. Leave policies.

d. Financial arrangements, including housing, meals and other benefits, as may be determined by the institution and described in the resident contract.

e. Institutional policies and procedures for the supervision and evaluation of residents, due process, (e.g., grievances, disciplinary action, academic deficiencies or failure) and appeal processes.

f. Policies governing outside activities of a professional nature.

g. Institutional policies regarding contract renewal, contract interruption or cancellation, and the number of Otolaryngology/ Facial Plastic Surgery positions offered each year of training.

h. Resident work hours and supervision policies.

8. The institution shall provide a written selection policy to any osteopathic physician interested in its program. The selection of residents in the otolaryngology/facial plastic surgery program shall be under the jurisdiction of the department of otolaryngology/facial plastic surgery, reviewed by the appropriate educational committees and approved by the governing board of the institution.

9. The institution shall execute a contract with each resident in accordance with AOA policy.

10. The institution must provide resources sufficient to maintain a quality training program, particularly in the area of faculty development, curriculum, and evaluation methodology. In addition the institution must commit to an equitable and reasonable balance between education and service.

11. Upon satisfactory completion of the training program, the institution shall award the resident an appropriate certificate. The certificate shall confirm the fulfillment of the program requirements, starting and completion dates of the program and the name(s) of the training institution(s) and the program director.

## STANDARD IV FACULTY REQUIREMENTS AND RESPONSIBILITIES

The sponsoring institution, in conjunction with the program director shall designate a minimum of two (2) core faculty who shall participate in the Otolaryngology/Facial Plastic Surgery residency program. One of these shall be designated as Program Director.

A. Program Director

The sponsoring institution shall designate an osteopathic ENT/FPS physician as program director. This individual shall have leadership abilities, and sufficient clinical time for program administration and clinical instruction. Appointments are subject to

the approval by the AOCOO-HNS Council of Medical Education after review of curriculum vitae and subsequent registration by the AOA.

1. The program director of the Otolaryngology/Facial Plastic Surgery residency program must possess the following qualifications:

   a. Be a graduate of an AOA-approved college of osteopathic medicine.

   b. Have completed an AOA-approved OGME 1 training program.

   c. Be certified by the AOA through the American Osteopathic Board of Ophthalmology and Otolaryngology/Head and Neck Surgery and be recertified as required within the prescribed time frame of the certifying body.

   d. Membership in the American Osteopathic Association.

   e. Membership in the American Osteopathic Colleges of Otolaryngology/Facial Plastic Surgery and Otolaryngology-Head and Neck Surgery (AOCOO-HNS).

   f. Active staff membership within the department or section of Otolaryngology/Facial Plastic Surgery.

   g. Active clinical practice of Otolaryngology/Facial Plastic Surgery at the base or an affiliated institution.

   h. Fulfill the qualifications of a faculty member of an Otolaryngology/ Facial Plastic Surgery residency program including completion of AOA continuing medical education requirement and attendance at faculty development programs.

   i. Minimum of three (3) years of clinical experience in Otolaryngology/Facial Plastic Surgery following certification by the AOA or three (3) years experience as a faculty member of an Otolaryngology/Facial Plastic Surgery residency program or request special consideration by the AOCOO-HNS Council of Medical Education.

   j. Be educationally and attitudinally suited to conduct a training program.

   k. Understand and fulfill the basic requirements of the AOA and AOCOO-HNS.

   l. Active participation in AOCOO-HNS, other professional organizations appropriate to Otolaryngology/Facial Plastic Surgery, and in community affairs.

   m. Involvement in research and academic pursuits. Examples may include, but are not limited to publication in peer-reviewed journals, textbooks, local or specialty publications, formal lectures and visiting professorships.

n. May only function as the program director of one (1) AOA approved residency program.

2. The program director shall have the following responsibilities:

a. Direction of the Otolaryngology/Facial Plastic Surgery residency program to ensure that the resident has received, the training outlined in the written program description,

b. Arrange formal affiliation agreements and/or outside rotations necessary or advantageous to meet the program objectives.

c. Evaluation of residents, faculty, and the Otolaryngology/Facial Plastic Surgery residency program; and submission of required reports.

d. In coordination with the DME, have responsibility for all schedules, and appropriate time for resident training, including lectures, educational sessions, and study time.

e. Work with the DME to support the predoctoral and postdoctoral education and training at the institution.

f. Notify the AOCOO-HNS of all residents in training on an annual basis.

g. Participation in the annual AOCOO-HNS Program Director Workshop. Attendance at this annual workshop held during the ACA is mandatory, at minimum, alternate years for the program director and in the intervening years his/her designee who is actively involved in the training program.

h. Faculty Development Program. Attendance at this annual program held during the mid-winter meetings is mandatory and will require the program director to attend two (2) out of three (3) programs. Others who are actively involved in the training program will be required to attend one (1) out of five (5) annual faculty development programs.

i. Ensuring that the program complies with the standards, policies and procedures of the AOA and AOCOO-HNS.

j. Preparation for and participation in the AOA inspection of the program in cooperation with the Division of Postdoctoral Training and the designated evaluator.

k. Inform the AOA, OPTI and AOCOO-HNS Council of Medical Education of major changes in the program, including but not limited to changes in program directors; institutional ownership and affiliations, or other major administrative changes.

l. Arrange for the residents to take the Otolaryngology/Facial Plastic Surgery in-service examination on an annual basis and to provide, each year, the test results to the AOCOO-HNS Council of Medical Education.

m. Approve the residents' scientific project and certify documentation of the work completed by the resident.

n. Provide the resident with all documents pertaining to the training program, as well as, the requirements for satisfactory completion of the program.

o. Submit quarterly program reports, including reports for outside rotations, to the director of medical education and administration of the institution.

p. Submit Annual Reports, for each resident to the AOCOO-HNS within thirty (30) days of the completion of each training year.

q. Develop goals and objectives for each rotation featured in the program and maintain these through periodic updating.

r. Development of supplemental rotations as needed to meet the goals and objectives of the program. It will be necessary to describe these areas in the program description and to follow the protocol of the program in arranging the rotations. While it may be necessary to change the institution at which the outside rotations will occur, it should still be within the framework of the structured program description as to sequence as well as duration of the program.

s. Encourage the resident to apply for candidate in training status with the AOCOO-HNS.

t. In the event there is documented evidence that a program director is not adhering to one or more of the qualifications of a program director, the AOCOO-HNS Council of Medical Education will provide a copy of the evidence to the program director and will inform the program director that his/her status as a trainer is under review by the AOCOO-HNS Council of Medical Education. A copy of the evidence will be sent to the Director of Medical Education, The institution's Chief Operating Officer, and the OPTI. The program director will have 60 days to provide the AOCOO-HNS Council of Medical Education with documentation of compliance. The AOCOO-HNS Council of Medical Education has 60 days after receipt of documentation of compliance before making a decision regarding continuing program approval.

B. Core faculty members

1. Must be certified or an active candidate in the process of certification by the AOBOO-HNS or ABO.

2. Must be qualified by training and experience to perform their teaching role, including recertification within the prescribed time frame of the certifying body. Faculty must demonstrate sufficient scholarly activity. Faculty credentials must be on file and available at the time of inspection.

3. Core faculty must provide sufficient time to the instruction of residents in the outpatient clinics, surgical suites and hospital units or other sites where

Ophthalmology is practiced. Furthermore, faculty must participate in the academic educational program, such as formal lectures, case conferences and journal clubs and other requirements of the core curriculum.

4. The institution shall have administrative and other non-physician staff committed to the program to support teaching in the Otolaryngology/ Facial Plastic Surgery residency program.

## STANDARD V RESIDENTS REQUIREMENTS AND RESPONSIBILITIES

A. An applicant for Otolaryngology/Facial Plastic Surgery residency training must:

1. Be a graduate of an AOA-accredited college of osteopathic medicine.

2. Be a member of the AOA and maintain membership in the AOA throughout the term of training.

3. Be licensed in the State(s) when required where the training program and affiliated sites are located.

4. Arrange to provide letters of recommendation and official transcripts from the college of osteopathic medicine and hospital administration of internship and/or previous residency training.

5. Sign an annual residency contract with the institution.

B. The resident is legally, morally, and ethically responsible to pursue the agreed upon program of training. The resident shall not engage in any outside activities of a professional nature during residency training except those approved by the program director and designated institutional authorities. Such activities must not interfere with the resident's participation in the training program. The resident may not act as an unsupervised consultant in the specialty and must be designated in such a manner to retain his/her identity as a resident.

C. The resident shall progressively assume increasing responsibility for patient care during the residency program, so that by the senior year, the resident must be able to assume complete management of all assigned cases.

D. Increased competency in Otolaryngology/Facial Plastic Surgery is based on experience and number and variety of cases managed in the operating room and in the outpatient setting. Such experience is gained through participation in highly specialized rotations as deemed necessary by the program director.

E. Each resident shall adhere to established policies and procedures for residency training, as outlined in this document, and in the resident manual.

F. The resident shall maintain formal records of all activities related to the educational program. These records shall be submitted monthly to the program director and DME for review and verification. Copies of these records shall be kept on permanent file by the administration at the base institution and shall be available at the time of the inspection. These records should document the fulfillment of the requirements of the program, describing the volume, variety and scope, and progressive

responsibility on the part of the resident for Otolaryngology/Facial Plastic Surgery cases and procedures performed under supervision.

G. Annual Report

The resident must submit an annual resident report to the AOCOO-HNS within thirty (30) days of completion of each training year. (Documents not received on time may incur a monetary penalty). The annual report consists of: the resident's segregated totals (logs), the program directors report, the professional paper, the home study verification and in-service-exam scores.

The resident shall prepare an annual professional paper during the 2nd, 3rd, and 4th years of training that is either an original contribution or a case report. Original contributions will document original clinical or applied research. Case reports will document ***unusual*** clinical presentations with newly recognized or rarely reported features. The length of the annual professional paper shall be at least 1500 words, double-spaced, paginated, with references required for all material derived from the works of others. The annual paper shall be submitted to the AOCOO-HNS Council of Medical Education within thirty (30) days of the completion date of each contract year.

In lieu of one (1) paper, the resident may submit one (1) of the following alternatives:

1. Poster presentation at the annual clinical assembly, which has been reviewed and approved by the program director. The poster must be submitted to the AOCOO-HNS Council of Medical Education with picture(s) of the poster and an outline of the contents.

2. Provide documentation of satisfactory completion of a university level statistics course taken in the current or prior year**.** The statistics course must be approved by the AOCOO-HNS Council of medical education in order to qualify as a substitution for the professional paper, as well as meet the minimum of 1 university-based course credit.

Or In place of three annual papers, residents may do a substantive research project during the four-year training period. To participate in such research, the resident must submit an outline of the research project with the first year annual report; a progress report of the research project with the second year annual report, and the completed research project with the third year annual report. The completed research project must be submitted to the AOCOO-HNS Council of Medical Education in a publishable format. In all instances research projects must be approved by the program director.

Institutional Review Board (IRB) approval for any research involving human or animal subjects must be obtained prior to the institution of research. Additionally, all research must meet all local, state and federal regulations.

H. The resident shall be required to participate in professional staff activities as directed by the program director.

I. The resident must participate, annually, in the Otolaryngology/Facial Plastic Surgery in service examination.

J. The resident must be certified as a provider in advanced cardiac life support (ACLS).

K. Time spent away from the base institution.

1. Extracurricular activities: The training program is a full-time responsibility; activities outside the educational program may not be mandated nor interfere with the resident's performance in the educational process as defined in the agreement between the institution and the resident.

2. Outside rotations: Outside rotations are permissible when included in the basic residency program as approved by the AOCOO-HNS Council of Medical Education and AOA. The purpose of such rotations is for the enhancement of the basic program. The parent institution or organization is responsible for the outside rotations.

L. The resident must complete a minimum of 100 hours of basic science studies relating to Otolaryngology/Facial Plastic Surgery. These studies refer to anatomy, physiology, microbiology, pharmacology, etc.

M. Complete a suitable home study course approved by the program director during the 2nd, 3rd, and 4th years of training. Documentation of the entire home study course is required by the end of the fourth year of training. The resident is strongly encouraged to review the home study course in a group fashion, and to review it twice during the training program.

N. The resident is strongly encouraged to apply for and maintain Candidate status in the AOCOO-HNS.

O. It is recommended that the resident attend at least one Annual Clinical Assembly of the AOCOO-HNS prior to the final year of training.

## STANDARD VI CURRICULUM AND INSTRUCTION

A. The Otolaryngology/Facial Plastic Surgery program shall adhere to a curriculum that meets or exceeds the requirements listed within this document.

B. The program shall create and implement a core curriculum for Otolaryngology/ Facial Plastic Surgery residency training that prepares the resident for specialty certification in Otolaryngology/Facial Plastic Surgery.

1. The five year curriculum in Otolaryngology/Facial Plastic Surgery must begin with an approved OGME Year 1 and include the following core curriculum components:

a. Utilization of osteopathic principles and practice relating to Otolaryngology/Facial Plastic Surgery.

b. Development of a growing competence on the part of the resident in the surgical and medical practice of Otolaryngology/Facial Plastic Surgery.

c. Development of a philosophy of Otolaryngology/Facial Plastic Surgery directed toward delivery of the best possible patient care.

d. Advanced training in the basic sciences, which shall include structured learning and clinical experience in the basic sciences and clinical skills in Otolaryngology/Facial Plastic Surgery.

e. Exposure to issues which, the resident will face as a practicing clinician, including health policy, managed care, health administration, medical ethics, medical liability, practice management and interpersonal skills.

f. Participation in required OPTI educational programs.

g. Structure of OGME Year 1

4 months hospital-based general surgery
1 month medical pediatrics
1 month anesthesia
1 month intensive care unit
1 month emergency room
1 month surgical subspecialty (neurological, vascular, maxillofacial, plastic, cardiovascular, general)
1 month medical subspecialty (pulmonary, neurology, ophthalmology, family medicine, gastroenterology, dermatology, internal medicine)
2 months Elective (from surgical subspecialty or medical subspecialty lists above)

2. By the completion of the Otolaryngology/Facial Plastic Surgery residency program, each resident shall demonstrate competency in the basic sciences, medical and surgical knowledge and skills in the following areas:

Medical, surgical and laser training in head and neck surgery, including basic sciences, otology, rhinology, laryngology, and otolayngic allergy. Surgical exposure to procedures of the nose, maxilla, salivary glands, lips, oral cavity, neck, larynx, thyroid, middle ear, facial nerve, inner ear, nasal endoscopy, bronchoscopy, esophagoscopy, and congenital anomaly. It will also include exposure to otoplasty, rhinoplasty, blepharoplasty, facial trauma, flaps and grafts in their application to head and neck surgery, and general medicine as it applies to otolaryngology.

3. The program must provide an environment that is conducive to resident~~s~~ education. This environment must include exposure to the clinical applications of Otolaryngology/Facial Plastic Surgery as well as surgery and the skills necessary to develop the proper attitudes towards patients, professional staff, and administration of the institution.

4. The program must ensure that the resident demonstrates increasing competence in Otolaryngology/Facial Plastic Surgery skills and techniques in the use of its diagnostic and therapeutic modalities. Progression through the

residency program must be based on documented achievement of education goals and objectives. This shall be done through:

a. Documentation of educational outcomes through multiple measures. Faculty input is required.

b. Observation, assistance, and supervised participation leading toward greater responsibility for diagnosis, care, and treatment of patients.

c. Attendance and participation in teaching and training inside and outside of the parent institution.

d. Participation in available seminars, divisional society meetings, workshops in other institutions, programs provided by universities, and clinical activities in affiliated outpatient clinics or specialty institutions.

5. Residents in the program will learn teaching skills by actively participating in the process of instructing interns, medical students and other residents.

6. The curriculum is to be evaluated annually by faculty and residents as a method for revision and updating the document. Documentation of this annual evaluation must be available during on-site inspection.

7. The curriculum will provide for annual evaluation by faculty and residents as a method for revision and updating of the document.

8. Institutions that lack an adequate amount of clinical material in certain areas of training, the curriculum may be supplemented through outside rotations. It is necessary to describe these areas in the program description and to follow the protocol of the program in arranging the rotations.

## STANDARD VII FACILITIES AND OTHER RESOURCES

A. Institutional facilities and resources must be adequate to provide educational opportunities to the resident. The institution is responsible for assuming the financial, technical and educational support for the program. The institution must provide the necessary space, facilities and learning environment for the establishment and maintenance of an AOA-approved training program.

1. The institution shall have the following facilities:

a. A medical library that is properly staffed and maintained by a qualified librarian. This library shall provide access to standard medical reference texts and current medical journals, and computer-assisted literature search capabilities, e.g., Medline.

b. Conference room(s) that are available for formal instruction.

c. The training institution shall provide an on-call room for residents, which is clean, quiet and comfortable, so to permit rest during call. A telephone shall be present in the on-call room. Toilet and shower facilities should be present in or convenient to the room. Nourishment shall be available during the on-call hours of the night.

d. Faculty and administrative office space.

e. Adequate space for residents to pursue educational activities.

2. Otolaryngology/Facial Plastic Surgery facilities

a. The institution shall have supervised outpatient clinics or a formal arrangement for rotations in an outpatient facility. Institutional clinics or Otolaryngologist's offices may be used.

b. The institution shall be properly equipped, appropriately staffed and properly organized to give adequate training in Otolaryngology/Facial Plastic Surgery.

c. The institution must provide ample working area and study space for its residents, and the instrumentation and equipment essential to the conduct of the specialty.

d. Access to a properly equipped temporal bone lab facility, appropriately staffed, and properly organized to give adequate otolaryngology training.

## STANDARD VIII EVALUATION

The program must implement and document a method of evaluation that includes, at minimum, the following measures and other related measures as necessary.

A. Resident evaluation

1. Evaluations of residents' abilities and competencies must be completed and filed with their permanent record. These competencies should be in concert with AOA defined core competencies in patient care, interpersonal and communications skills, systems-based practice, medical knowledge, practice-based learning and improvement, professionalism, and osteopathic manipulative theory.

   The results of the in-service examination should not be used as the only criterion of resident performance. An analysis of these tests should guide the faculty in assessing the strengths and weaknesses of individual residents and the program. Other tools are to be used to measure residents' competence, such as, faculty and staff evaluations, patient surveys, faculty review of video-taped surgical procedures, review of medical records, evaluation of surgical and non-surgical outcomes, and evaluation of research manuscripts or presentations and literature reviews.

2. The program director, with faculty input, must complete written quarterly evaluations of resident performance. This should include evaluations from all affiliated training sites and supplemental rotation sites.

3. Evaluations should be learner-centered, developmental, foster continuous improvement, and be based upon educational objectives for each assignment and program activity.

4. Completed evaluations must be shared with the resident in consultation for improvement. They must be signed by the program director and resident to document that evaluation and counseling have occurred, at least, quarterly as required. Copies of evaluations should be made available to the resident.

5. The program director must document that residents needing remediation or counseling as a result of evaluation are provided with this information in a timely manner. There must be documentation of follow up evaluations of these residents.

B. Program Evaluation

1. Program assessments and measured outcomes for continuous quality improvement should be done on an ongoing basis, with an annual summative evaluation of the quality of the program. Evaluative information should be used for program improvement, and documentation of it should be on file.

2. Multiple measures should be used for program review and evaluation to obtain a comprehensive view of program quality. Recommended methods include outcome results of resident in-service examination scores; performance on certifying examination; post graduate professional performance satisfaction surveys; resident completion rate in the program; percent of graduates completing the program on time; placement of graduates; professional accomplishments of program graduates.

3. The curriculum will be evaluated annually by faculty and residents as a method for revising and updating of the document.

4. The program director and program faculty shall undergo annual, internal review for teaching, and scholarly activities, and development of the program.

5. The faculty must be evaluated, annually, by the residents. Residents must be allowed to conduct this evaluation anonymously.

6. The program must undergo a mid-cycle evaluation by the base institution, as required by the AOA.

## APPENDIX I

## STANDARDS TO APPROVE RESIDENCY TRAINING PROGRAMS IN OTOLARYNGOLOGY/FACIAL PLASTIC SURGERY

### AUTHORITY AND PURPOSE

The Bureau of Professional Education of the American Osteopathic Association (AOA) is the only accrediting agency recognized by federal and state authorities in the United States, for osteopathic medical education. Postdoctoral training is approved by the American Osteopathic Association through its Council of Postdoctoral Training (COPT), a component of the Bureau of Professional Education.

Residency program approval implies the following: that a program has appropriately identified its mission, has secured the resources necessary to accomplish that mission, shown evidence of accomplishing its mission, and demonstrates its ability to carry its mission into the future.

Approval signifies that a residency program has met or exceeded the AOA standards for educational quality with respect to organization and administration: faculty, curriculum, instruction and evaluation; as well as resident relations, and facilities.

The process of Otolaryngology/Facial Plastic Surgery residency program approval is a cooperative activity calling for continuing self-assessment on the part of each residency program, periodic peer evaluation through site visits, and review by the American Osteopathic Colleges of Ophthalmology and Otolaryngology- Head and Neck Surgery (AOCOO-HNS), the Council of Postdoctoral Training, and the AOA Board of Trustees.

### A BRIEF HISTORY OF RESIDENCY PROGRAM APPROVAL

The organization of ophthalmologists and otorhinolaryngologists in the osteopathic profession began in 1908, with the establishment of the Eye, Ear, Nose and Throat Section of the American Osteopathic Association. This group has continued through the years to conduct an educational program in Ophthalmology and Otorhinolaryngology in connection with the programs of the American Osteopathic Association.

In 1916 an independent organization was formed to provide organized sponsorship for the Section, and an enlarged scope of activity in the training and development of specialists in this field of practice. This organization began the American Osteopathic Society of Ophthalmology and Otorhinolaryngology.

In 1928, the need became apparent for an organization composed solely of those in the profession who devoted their entire time to Ophthalmology and/or Otorhinolaryngology, and whose qualifications were to be determined by examination, written, oral and practical, for advanced study, research and highly technical programs in this field. This organization became the International Society of Ophthalmology and Otorhinolaryngology, which represented the then “approved” group of specialists in this field. The International Society later became the nucleus for the “Certified” group of ophthalmologists and otorhinolaryngologists in the American Osteopathic Association.

In 1944, the American Society and the International Society officially disbanded, and joined in a coalition organization known as the Osteopathic College of Ophthalmology and

Otorhinolaryngology, with a graduated membership which consisted of Fellows, Seniors and Juniors and provision for Associates who were guests without membership status.

This organization assumed all professional and financial obligations of its predecessor organizations, including sponsorship of the Eye, Ear, Nose and Throat Section of the American Osteopathic Association and became, and continues to be, the official organization of ophthalmologists and otolaryngologist-head and neck surgeons in the osteopathic profession.

In 1995, in order to meet the needs of the individual specialty colleges, the College was redefined and renamed to be the American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery (AOCOO-HNS). This has allowed the separate functioning of the individual Colleges under the combined umbrella. The individuality of the Colleges has been ensured in order to allow them to participate more fully in the highly specialized areas of interest. The Board of Governors of the American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery are composed of the Officers of the individual Colleges. The overall fiscal responsibility for the combined Colleges is shared at this level, as is the general organizational structure. Each individual College is responsible for its own administrative duties and its interprofessional relationships.

Early in the 20$^{th}$ Century, the AOA initiated approval of osteopathic postdoctoral training programs, with review through the Committee on Hospitals and approval by the AOA Board of Trustees. In 1968, the Committee on Postdoctoral Training was established as a representative body composed of members from AOA affiliate organizations created to assure the Bureau of Professional Education, AOA Board of Trustees, the osteopathic profession and general public that postdoctoral training programs are operating within approved standards, rules and regulations, and are providing educational training resulting in high quality patient care. The COPT also has the obligation to deliberate and recommend policy revisions to the Bureau of Professional Education and the AOA Board of Trustees for improvements in postdoctoral training.

Presently, the Council of Medical Education (COME) is composed of members appointed by the Board of Governors of the AOCOO-HNS. The AOCOO-HNS Council of Medical Education (COME) serves as an advisory body to the AOA Council of Postdoctoral Training for Ophthalmology and Otolaryngology-Head and Neck Surgery. The Committee has two functions: (1) develop standards which training programs and residents must meet to be approved, and (2) review and make recommendations to the AOA to assure that residency programs and individual physicians seeking AOA approval have met the training standards. By maintaining these required standards, the AOA and the AOCOO-HNS assure that graduates of residency programs achieve expertise in their specialty.

The approval process for postdoctoral Ophthalmology training is a public trust. Its purposes are many and include assuring that:

(1) Osteopathic training programs meet AOA and AOCOO-HNS standards.
(2) Residents in training programs, receive education and training consistent with AOA and AOCOO-HNS standards.
(3) Those responsible for resident education are competent.
(4) Sponsored programs meet acceptable national standards.
(5) Educational programs merit support from funding agencies.

## APPENDIX II

Core competencies of the osteopathic profession

Note: Complete descriptions of the various evaluation methods can be found at: http://www.acgme.org/Outcome/assess/Toolbox.pdf

1. *Osteopathic philosophy and osteopathic manipulative medicine*

   Residents are expected to demonstrate and apply knowledge of accepted standards in osteopathic manipulative treatment (OMT) appropriate to the specialty. The educational goal is to train a skilled and competent osteopathic practitioner who remains dedicated to life-long learning.

   a. Demonstrate competency in the understanding and application of OMT appropriate to Otolaryngology/Facial Plastic Surgery.

      1. Provide opportunities for active participation for residents in hospital and ambulatory sites for OMT training.
      2. Teach residents to perform a critical appraisal of medical literature related to OMT.
      3. Observe and credential residents in the performance of OMT by assessing their diagnostic skills, medical knowledge, and problem solving abilities.

      Evaluation methods appropriate to this standard: (See Appendix for discussion of evaluation methods).
      1. Simulations and models.
      2. Objective structured clinical examinations (OSCE)
      3. Record reviews.
      4. Standardized oral examination.
      5. Competency cards.

   b. Integrate osteopathic concept and OMT into the medical care provided to patients as appropriate.

      1. Have residents assume increasing responsibility for the incorporation of osteopathic concepts in patient management.
      2. Participate in activities that provide educational programs at the student and intern levels.
      3. Participate in CME programs provided by COMS, the AAO, and specialty colleges.

      Evaluation methods appropriate to this standard:
      1. Simulations and models.
      2. Procedures or case logs.
      3. Global rating of live or recorded performance.
      4. Standardized patient examination.

   c. Understand and integrate osteopathic principles and philosophy into all clinical and inpatient care activities.

1. Utilize caring, compassionate behavior with patients.
2. Demonstrate the treatment of people rather than symptoms.
3. Demonstrate understanding of somato-visceral relationships and the role of the musculoskeletal system in Otolaryngic disease.

Evaluation methods appropriate to this standard:
1. Direct observation.
2. Global rating of live or recorded performance.
3. 360 degree evaluation.
4. Standardized patient examination.
5. Peer review.

2. *Medical knowledge*

Residents are expected to demonstrate and apply knowledge of accepted standards of clinical medicine, remain current with new developments in medicine, and participate in lifelong learning activities, including research with special emphasis on the specialty of Otolaryngology/Facial Plastic Surgery.

a. Demonstrate competency in the understanding and application of clinical medicine to patient care.

1. Performance on COMLEX Part III and in-service examinations.
2. Supervised observation of the clinical decision-making abilities of residents.
3. Attendance at seminars and/or CME.
4. Participation in a directed readings program and Journal club.
5. Periodic assessment of resident critical thinking and problem solving abilities.

Evaluation methods appropriate to this standard:
1. Chart simulated recall oral examinations (CSR).
2. Simulations and models.
3. 360 degree evaluation instrument.
4. Written examinations.

b. Know and apply the foundations of clinical and behavioral medicine as appropriate to the discipline.

1. Participate in research activities that critically evaluate current medical information and scientific evidence.

2. Develop as medical educator by having residents give presentations before peers, faculty and participate in the instruction of medical students.
3. Routinely assess the skill and outcomes of residents in their performance of medical procedures.
4. Develop programmatic education in lifelong learning.

Evaluation methods appropriate to this standard:

1. Chart simulated recall oral examinations (CSR).
2. Written examination.
3. 360 degree evaluation instrument.
4. Direct observation.
5. Simulations and models.

3. *Patient care*

Residents must demonstrate the ability to effectively treat patients, provide medical care that incorporates the osteopathic philosophy, patient empathy, awareness of behavioral issues, the incorporation of preventive medicine, and health promotion.

a. Gather accurate, essential information for all sources, including medical interviews, physical examinations, medical records, and diagnostic/therapeutic plans and treatments.

1. Supervise the performance of medical interviewing techniques to assess the resident skill and ability.
2. Provide instruction on the development and implementation of effective patient management plans.
3. Teach residents the proper methods for requesting and sequencing diagnostic tests and consultative services.
4. Instill in residents the need to provide a caring attitude that is mindful of cultural sensitivities, patient apprehensions, and accuracy of information.

Evaluation methods appropriate to this standard:
1. Checklist evaluation.
2. Standardized patient examination.
3. Objective structured clinical examination (OSCE).
4. Standardized oral examination.
5. Record review.
6. 360 degree evaluation instrument.

b. Validate competency in the performance of diagnosis, treatment and procedures appropriate to the specialty.

1. Provide instructional programs for the performance of medical procedures where appropriate.
2. Develop a credentialing program for residents to validate their competency in the performance of medical procedures where appropriate.
3. Instruct residents in the performance of the medical procedure, any potential complications and known risks to the patient (informed consent).

Evaluation methods appropriate to this standard:
1. Checklist evaluation.
2. Global rating of live or recorded performance.
3. Simulations and models.
4. Procedure in case logs.

c. Provide health-care services consistent with osteopathic philosophy, including preventive medicine and health

promotion that are based on current scientific evidence and understanding of behavioral medicine.

1. Counsel patients and their families on health-care promotion and lifestyle activities related to good health maintenance.
2. Refer patients to not-for-profit and community service organizations that support health promotion and behavior modification programs.
3. Work with professionals from varied disciplines as a team to provide effective medical care to patients that address their diverse health-care needs.

Evaluation methods appropriate to this standard:
1. Checklist evaluation.
2. Global rating of live record performance.
3. Simulations and models.
4. Patient surveys.
5. Objectives structured clinical examination (OSCE).
6. Standardized patient examination (SP).
7. Procedure case logs.

4. *Interpersonal and communication skills*

Residents are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health-care teams.

a. Demonstrate effectiveness in developing appropriate doctor-patient relationships.

1. Demonstrate patient interviewing techniques.
2. Demonstrate ability to assess the health of non English-speaking and deaf patients.
3. Involve patients and families in decision-making.
4. Illustrate the use of appropriate verbal and nonverbal skills when communicating with patients, families and faculty.
5. Demonstrate an understanding of cultural and religious issues and sensitivities in the doctor-patient relationship.

Evaluation methods appropriate to this standard:
1. Checklist evaluation.
2. Objectives structured clinical examination (OSCE).
3. 360 degree evaluation instrument.
4. Patient surveys.
5. Standardized patient examination.
6. Videotaping.

b. Exhibit effective listing, written and oral communications skills in professional interactions with patients and health-care professionals.

1. Communicate medical problems and patient options at appropriate levels of understanding.
2. Maintain comprehensive, timely, and legible medical records.
3. Demonstrate respectful interactions with health-care practitioners, patients, and families of patients.
4. Elicit medical information in effective ways.
5. Demonstrate an understanding of resources available to physicians to assist with appropriate assessment of communication-impaired patients.
6. Work effectively with others as a member or leader of a health-care team.

Evaluation methods appropriate to this standard:

1. Standardized patient examination.
2. Objectives structured clinical examination (OSCE).
3. 360 degree evaluation instrument.
4. Patient surveys.
5. Checklist evaluation.

5. *Professionalism*

Residents are expected to uphold the Osteopathic Oath in the conduct of their professional activities that promote advocacy of patient welfare, adherence to ethical principles, and collaboration with health-care professionals, lifelong learning, and sensitivity to a diverse patient population. Residents should be cognizant of their own physical and mental health in order to effectively care for patients.

a. Demonstrate respect for patients and families and advocate for the primacy of patient's welfare and autonomy.

1. Present an honest representation of a patient's medical status and the implications of informed consent to medical treatment plans.
2. Maintain the patient's confidentiality and demonstrate proper fulfillment of the physician's role in the doctor-patient relationship.
3. Commitment to an appropriate and non-exploitative relationship with patients.
4. Inform patients, accurately, of the risks associated with medical research projects, the potential consequences of treatment plans, and the realities of medical errors in medicine.
5. Treat the terminally ill with compassion in the management of pain, palliative care, and preparation for death.
6. Participate in courses and programs (compliance and end of life).

Evaluation methods appropriate to this standard:

1. Checklist evaluation.
2. Objective structured clinical examination (OSCE).
3. 360 degree evaluation instrument.
4. Patient surveys.

5. Standardized patient examination.
6. Videotaping.

b. Demonstrate adherence to ethical principles in the practice of medicine.

1. Understand conflicts of interest inherent in medicine and the appropriate responses to societal, community, and health-care industry pressures.
2. Use limited medical resources effectively and avoid the utilization of unnecessary tests and procedures.
3. Recognize the inherent vulnerability and trust accorded by patients to physicians and uphold the highest moral principles that avoid exploitation for sexual, financial, or other private gain.
4. Pursue life-long learning goals in clinical medicine, humanism, ethics, and gain insight into the understanding of patient concerns and the proper relationship with the medical industry.

Evaluation methods appropriate to this standard:
1. Standardized patient examination.
2. Objectives structured clinical examination (OSCE).
3. 360 degree evaluation instrument.
4. Patients survey.
5. Checklist evaluation.
6. Lectures/seminars.

c. Demonstrate awareness and proper attention to issues of culture, religion, age, gender, sexual orientation, and mental and physical disabilities.

1. Become knowledgeable and responsive to the special needs and cultural origins of patients.
2. Advocate for continuous quality of care for all patients.
3. Prevent the discrimination of patients based on defined characteristics.
4. Understand the legal obligations of physicians in the care of patients.

Evaluation methods appropriate to this standard:
1. Standardized oral examination.
2. Objectives structured clinical examination (OSCE).
3. Checklist evaluation.
4. 360 degree evaluation.
5. Portfolios.
6. Patient surveys.
7. Competency cards.
8. Sensitivities seminars and programs.

6. *Practice based learning and improvement*

Residents must demonstrate the ability to critically evaluate their methods of clinical practice, integrate evidence-based medicine into

patient care, show an understanding of research methods, and improve patient care practices.

a. Treat patients in a manner consistent with the most up-to-date information on diagnostic and therapeutic effectiveness.

   1. Use reliable and current information in diagnosis and treatment.
   2. Understand how to use the medical library and electronically mediated resources to discover pertinent medical information.
   3. Demonstrate the ability to extract and apply evidence from scientific studies to patient care.

   Evaluation methods appropriate to this standard:
   1. Written examinations.
   2. Objectives structured clinical examination (OSCE).
   3. Portfolios.
   4. Record review.
   5. Standardized patient examination.
   6. Chart simulated recall oral examination (CSR).

b. Perform self-evaluations of clinical practice patterns and practice based improvement activities using a systematic methodology.

   1. Understand and participate in quality assurance activities at the hospital and at ambulatory sites.
   2. Apply the principles of evidence-based medicine in the diagnosis and treatment of patients.
   3. Measured the effectiveness of resident practice patterns against results obtained with other population groups in terms of effectiveness and outcomes.

   Evaluation methods appropriate to this standard:
   1. Standardized patient examinations.
   2. Objectives structured clinical examination (OSCE).
   3. Record reviews.
   4. Chart simulated recall oral examinations (CSR).
   5. Portfolios.
   6. Self-study.

c. Understand research methods, medical informatics, and the application of technology as applied to medicine.

   1. Participate in research activities as required by the AOCOO-HNS.
   2. Demonstrate computer literacy, information retrieval skills, and understanding of computer technology applied to patient care and hospital systems.
   3. Apply study designs and statistical methods to the appraisal of clinical studies.

   Evaluation methods:

1. Objectives structured clinical examination (OSCE).
2. Standardized patient examination is.
3. Portfolios.
4. Procedure case logs.
5. Residents initiated research.
6. Information technology research related review/development.
7. Self-study.

7. *Systems based practice*

Residents are expected to demonstrate an understanding of health-care delivery systems, provide effective and qualitative patient care within the system, and practice cost-effective medicine.

a. Understand national and local health-care delivery systems and how they impact on patient care and professional practice.

1. Attend instruction in matters of health-care policy in structure.
2. Understand business applications in the medical practice.
3. Show operational knowledge of health-care organizations, state and federal programs.
4. Understand the role of the resident as a member of the health-care team in the hospital, ambulatory clinic, and community.
5. Attend guest lectures and seminars with policymakers.

Evaluation methods:
1. Portfolios.
2. Objectives Structured Clinical Examination (OSCE).
3. 360 degree evaluation.
4. Chart Simulated Recall Oral Examination (CSR).
5. Seminars.

b. Advocate for quality health-care behalf of patients and assist them in their interactions with the complexities of the medical system.

1. Understand local medical resources available to patients for treatment and referral.
2. Participate in advocacy activities that enhance the quality of care provided to patients.
3. Practice clinical decision-making in the context of cost, allocation of resources, and outcomes.

Evaluation methods appropriate to this standard:
1. Record review.
2. Objectives Structured Clinical Examination (OSCE).
3. 360 degree evaluation.
4. Patient surveys.
5. Checklist evaluation.
6. Portfolios.

## APPENDIX III

***AOA WORK HOUR PREAMBLE:*** IT IS RECOGNIZED THAT EXCESSIVE NUMBERS OF HOURS WORKED BY INTERN AND RESIDENT PHYSICIANS CAN LEAD TO ERRORS IN JUDGMENT AND CLINICAL DECISION-MAKING. THESE CAN IMPACT ON PATIENT SAFETY THROUGH MEDICAL ERRORS, AS WELL AS THE SAFETY OF THE PHYSICIAN TRAINEES THROUGH INCREASED MOTOR VEHICLE ACCIDENTS, STRESS, DEPRESSION AND ILLNESS RELATED COMPLICATIONS. THE TRAINING INSTITUTION AND, DIRECTOR OF MEDICAL EDUCATION (DME) AND RESIDENT PROGRAM DIRECTOR MUST MAINTAIN A HIGH DEGREE OF SENSITIVITY TO THE PHYSICAL AND MENTAL WELL BEING OF RESIDENTS AND MAKE EVERY ATTEMPT TO AVOID SCHEDULING EXCESSIVE WORK HOURS LEADING TO SLEEP DEPRIVATION, FATIGUE OR INABILITY TO CONDUCT PERSONAL ACTIVITIES.

AOA Work Hours Policy

a. The resident shall not be assigned to work physically on duty in excess of eighty hours (80) per week averaged over a four (4) week period, inclusive of in-house night call.

b. The trainee shall not work in excess of 24 consecutive hours inclusive of morning and noon educational programs. Allowances for inpatient and outpatient continuity, transfer of care, educational debriefing and formal didactic activities may occur, but may not exceed 6 hours. Residents may not assume responsibility for a new patient after working 24 hours.

c. The trainee shall have on alternate weeks 48-hour periods off, or at least one 24-hour period off each week.

d. Upon conclusion of a 24-hour duty shift, trainees shall have a minimum of 12 hours off before being required to be on duty again. Upon completing a lesser hour duty period, adequate time for rest and personal activity must be provided.

e. All off-duty time must be totally free from assignment to clinical or educational activity.

f. Rotations in which trainee is assigned to Emergency Department duty shall ensure that trainees work no longer than 12 hour shifts.

g. The trainee and training institution must always remember the patient care responsibility is not precluded by the work hour policy. In cases where a trainee is engaged in patient responsibility which cannot be interrupted, additional coverage should be provided as soon as possible to relieve the resident involved.

h. The trainee may not be assigned to call more often than every third night averaged over any consecutive four-week period.

MOONLIGHTING POLICY

Any professional clinical activity (moonlighting) performed outside of the official residency program may only be conducted with the permission of the program administration (DME/Program Director). A written request by the resident must be approved or disapproved by the Program Director and DME and be filed in the institution's resident file. All approved hours are included in the total allowed work hours under AOA policy and are monitored by the institution's graduate medical education committee. This policy must be published in the institution's house staff manual. Failure to report and receive approval by the program may be grounds for terminating a resident's contract.

If moonlighting is permitted, all moonlighting will be inclusive of the 80 hour per week maximum work limit and must be reported.

Interns are prohibited from moonlighting.

## APPENDIX IV

## GUIDELINES FOR PREPARATION AND SUBMISSION OF MEDICAL MANUSCRIPTS, RESEARCH PAPERS and PROGRESS REPORTS

I All manuscripts must be submitted in appropriate format acceptable for publication as outlined by the Journal of the American Osteopathic Association (JAOA). An abstract must accompany each manuscript.

II One original manuscript signed by the program director plus two copies shall be submitted. By signing the manuscript cover sheet the program director acknowledges that he/she has read the manuscript and that it fulfills the requirements of an adequate paper.

III Manuscripts will be reviewed by a subcommittee prior to submission for final approval at the C.O.M.E.

IV Manuscripts that require revision will be returned to the resident. Once the revisions have been completed, the manuscript may be resubmitted for final approval.

V Timely submission of manuscripts is advised in order to allow adequate time for revisions.

VI Manuscripts will only be accepted in the following format:

A. A case presentation of a first reported case or other unusual manifestations of a disease. Length is limited to a minimum of 1500 words. A review of literature and discussion must be included. Literature review without personal case material will not be accepted.

B. A report of an original clinical research study approved by the program director and the institutional review committee of the hospital.

VII Residents should submit the proposal to the program director for review and approval as fulfilling the paper requirements. All projects must be completed under the supervision the program director or another physician approved by the program director.

VIII Residents may work jointly on an original clinical research project, provided a progress report and written approval of program director is included in the resident's annual report. Residents may not work jointly on case reports. Co-authorship between residents may be considered when pre-approved by the Council of Medical Education of the AOCOO-HNS.

IX Manuscripts shall be submitted within thirty (30) days of completion of the second and third year of training.

X Clinical research projects, which are prospective in nature, may require ongoing recruitment of patients to provide sufficient numbers to assure statistical validity. Patient recruitment, performance of the study, data analysis and writing of the paper may represent a long-term project of more than two years. In this situation with the approval of the program director, residents may submit a substantive progress report of the project with a summary of the data collected so far and indicate the ongoing nature of the study. This progress report shall be accepted in lieu of the required final manuscript for the second-year of the three-year program.

# APPENDIX V

## MODEL HOSPITAL POLICY ON ACADEMIC AND DISCIPLINARY DISMISSALS

In July 1993, the Board of Trustees of the American Osteopathic Association adopted the following policy:

The hospital and department have clearly defined procedures for academic and disciplinary action. Academic dismissals result from a failure to attain a proper level of scholarship or non-cognitive skills, including clinical abilities, interpersonal relations, and/or personal and professional characteristics. Institutional standards of conduct include such issues as cheating, plagiarism, falsifying records, stealing, alcohol and/or substance abuse, or any other inappropriate actions or activities.

In case of academic dismissal, the hospital and department will inform trainees, orally and in writing, of inadequacies and their effects on academic standing. The trainee will be provided a specified period in which to implement specified actions required to resolve academic deficiencies.

Following this period, if academic deficiencies persist, the trainee may be placed on probation for a period of three (3) to six (6) months. The trainee may be dismissed following this period, if deficiencies remain and are judged to be irremediable. In accordance with institutional policy, the trainee will be provided an opportunity to meet with evaluators to appeal decisions regarding probation or dismissal. Legal counsel at hearings concerning academic issues will not be allowed.

In cases of disciplinary infractions that are judged irremediable, the hospital and department will provide the trainee with adequate notice, in writing, of specific ground(s) and the nature of the evidence on which the disciplinary action is based. The trainee will be given an opportunity for a hearing in which the disciplinary authority will provide a fair opportunity for the trainee's position, explanations and evidence. Finally, no disciplinary action will be taken on grounds which are not supported by substantial evidence. The department and/or hospital intern training committee, or house staff education committee, or other appropriate committees will act as the disciplinary authority. Trainees may be allowed counsel at hearings concerning disciplinary issues. Pending proceedings on such disciplinary action, the hospital in its sole discretion may suspend the trainee, when it is believed that such suspension is in the best interests of the hospital or of patient care.