Frequently Asked Questions: Otolaryngology- Head and Neck Surgery
Review Committee for Otolaryngology- Head and Neck Surgery
ACGME

Question	Answer
Oversight	
What are some of the factors the Review Committee considers regarding adequate clinical volume when reviewing permanent complement increase requests? *[Program Requirement: I.D.4.a)]*	Various sources of information are utilized to make this determination. One important consideration is the aggregate volume of cases demonstrated by the existing complement of residents in each key indicator procedure (KIP), divisible by the proposed complement of residents. For example, a program takes three residents per year, and is requesting a complement increase to four per year. The KIP minimum for parotidectomy is 15. The three current graduating residents reported 27, 23, and 22 parotidectomies, respectively. The sum is 72 procedures; when that amount is divided by four, the result is 18, which remains above the KIP minimum. The Committee evaluates current surgical volume in the context of previous years, as such historical trends in activity also play a role in decisions regarding sufficient resources.
Personnel	
What activities are acceptable as evidence of the program director's periodic updates of knowledge and skills related to program responsibilities? *[Program Requirement: II.A.3.e)]*	Program directors can attend a variety of educational and/or continuing medical education (CME) venues relating to GME in otolaryngology – head and neck surgery, including the ACGME Annual Educational Conference, Society of University Otolaryngologists - Program Directors Organization meetings, the American Academy of Otolaryngology – Head and Neck Surgery Annual Meeting, and/or institutional courses.
What specialty expertise and documented educational and administrative experience is acceptable for the two required full-time equivalent (FTE) faculty members in addition to the program director? *[Program Requirement: II.B.1.a).(1)]*	Acceptable specialty expertise includes demonstrated clinical experience in otolaryngology – head and neck surgery or any subspecialty of otolaryngology – head and neck surgery. Examples of documented educational and administrative experience include didactic lectures, surgical instruction, resident evaluations, attendance at faculty meetings and conferences, preparation of manuscripts, and mentoring resident presentations.

Question	Answer
What would be considered appropriate medical staff appointment for the two required FTE faculty members in addition to the program director? *[Program Requirement: II.B.1.a).(2)]*	Both of these faculty members should have an academic appointment at the Sponsoring Institution. Appointment as a volunteer faculty member is not accepted by the Review Committee.
How does the Review Committee define "major" with regards to the clinical responsibilities of a site director? *[Program Requirement: II.B.2.g).(5)]*	"Major" is defined as adequate to have sufficient educational and administrative oversight of the program rotation. This generally would involve at least a 50 percent clinical effort at the site director's institution (participating site) and/or serving as the main educationally-contributing faculty member for the rotation.
What qualifications are acceptable for core physician faculty members in lieu of American Board of Otolaryngology-Head and Neck Surgery (ABOHNS) or American Osteopathic Board of Ophthalmology and Otorhinolaryngology Head and Neck Surgery (AOBOOHNS) certification? *[Program Requirements: II.B.3.b).(1) and II.B.4.c)]*	The Review Committee expects that all core faculty members will be either ABOHNS or AOBOOHNS certified or ABOHNS- or AOBOOHNS-eligible. The program director must send a letter to the Executive Director of the Review Committee at the ACGME explaining the reason for each core faculty member who is not certified by the ABOHNS or AOBOOHNS. The letter must provide a summary description of their board certification equivalency qualifications (i.e., other certification), prior GME teaching experience, a letter of support from the department chair, and a description of their effort to seek an alternative pathway to ABOHNS or AOBOOHNS certification. A curriculum vitae should be attached to the letter.
Educational Program	
Must the six months of non-otolaryngology – head and neck surgery rotations precede the six months of otolaryngology – head and neck surgery rotations for PGY-1 residents? *[Program Requirements: IV.C.4.a) and IV.C.4.b)]*	No. There is no obligatory sequencing of these requirements.

Question	Answer
Must PGY-1 rotations be scheduled as two six-month blocks, or can otolaryngology – head and neck surgery rotations and non-otolaryngology – head and neck surgery rotations be interspersed? *[Program Requirements: IV.C.4.a) and IV.C.4.b)]*	No, there is no obligatory sequencing of rotations. The program has flexibility in scheduling the various rotations during the PGY-1 so as to best meet the educational needs of the residents.
What clinical services other than otolaryngology – head and neck surgery can be used for resident education during the PGY2-5? *[Program Requirement: IV.C.5.]*	While the bulk of this time should be spent on the otolaryngology – head and neck service, the program director may wish to include other rotations for resident education, possibly including allergy and immunology, audiology and vestibular assessment, neuroradiology, oral and maxillofacial surgery, radiation oncology, sleep medicine, speech pathology and rehabilitation, and surgical pathology of the head and neck.
Must the chief year occur during the final year of education? *[Program Requirement: IV.C.6.]*	No. The chief year can occur during either PGY-4 or PGY-5 but must take place on the otolaryngology – head and neck surgery clinical service at the primary clinical site or at participating sites of the Sponsoring Institution. The Review Committee believes this will provide programs with greater flexibility in meeting the educational needs of each individual resident. For example, some residents may be ready to begin a focus on their anticipated subspecialty area during their final year, and thus would complete their chief year during the PGY-4, while others may need the PGY-4 to focus on specific milestones before beginning as chief resident during the PGY-5.
What information is needed when a program seeks approval from the Review Committee for research rotations less than one month in length? *[Program Requirement: IV.C.7.a).(1)]*	Programs may use an outline similar to an Advancing Innovation in Residency Education (AIRE) proposal (see https://acgme.org/What-We-Do/Accreditation/Advancing-Innovation-in-Residency-Education-AIRE for more) to include the following elements: • Program and Sponsoring Institution demographics • Rationale for the request • Detailed description of the proposed research rotations • Anticipated impacts on the clinical learning environment (potential positives and negatives) • Methods and metrics for tracking anticipated impacts and achievement of goals and objectives • Current and proposed block schedules

Question	Answer
Why must all residents in a program have essentially equivalent distributions of case categories and procedures? *[Program Requirement: IV.C.10.b).(1)]*	The Review Committee expects that residents' educational experience be fairly equivalent within a program, so that all graduates have had a sufficient volume and variety of educational experiences to prepare them for practice as a general otolaryngologist. The Committee sees a significant parity issue if one resident has had an insufficient experience in a particular clinical area, while peers have had an excess experience in the same area. Generally, disparities in case numbers between graduating chief residents are not seen as significant if there are no areas of clinical deficiency.
What are the Review Committee's expectations for entering operative procedures into the Case Log System? *[Program Requirement: IV.C.10.f).(2)]*	Expectations are described in detail in the document Case Log Coding Guidelines that is available on the Documents and Resources page of the Otolaryngology – Head and Neck Surgery section of the ACGME website. This document is regularly updated.
What qualifies as an international rotation? *[Program Requirement: IV.C.11.]*	"Rotations to international countries" are rotations and/or mission trips of short duration at medical institutions outside of the US and Canada. The only rare exception to this rule would be required military program rotations that involve transportation of program personnel and infrastructure to an international location. This exception would require prior Review Committee approval to be eligible to count towards ACGME Case Log procedure totals.
Why are there limits on international rotations? *[Program Requirements: IV.C.11.b)]*	While the Review Committee acknowledges that international rotations may be important, they are fraught with circumstances that may not be in compliance with ACGME requirements, such as potential clinical and educational work hour violations, inadequate supervision, inadequate opportunities for pre-, peri-, and post-operative care, and questionable continuity of care.
The Learning and Working Environment	
Who can supervise residents in the clinical environment? *[Program Requirement: VI.A.2.a).(1)]*	Appropriately-credentialed and privileged attending physicians in the surgical clinical environment may include appropriately-credentialed American Board of Medical Specialties (ABMS)-certified surgeons from other surgical specialties (e.g., general surgery, pediatric surgery, plastic surgery). In the critical care clinical environment, procedures must be supervised by appropriately-credentialed ABMS-certified critical care physicians (e.g., anesthesiologists, critical internists, critical care pediatricians). While other care providers are expected to be part of interprofessional teams that provide patient care, only appropriately-credentialed and privileged attending physicians may supervise residents.
What are examples of defined tasks for which PGY-1 residents may be	Indirect supervision is allowed for:

Question	Answer
supervised indirectly and of those for which PGY-1 residents should have direct supervision until competence is demonstrated? *[Program Requirements: VI.A.2.c).(1).-VI.A.2.c).(2)]*	1) Patient Management Competencies a) evaluation and management of a patient admitted to the hospital, including initial history and physical examination, formulation of a plan of therapy, and necessary orders for therapy and tests b) pre-operative evaluation and management, including history and physical examination, formulation of a plan of therapy, and specification of necessary tests c) evaluation and management of postoperative patients, including the conduct of monitoring, specifying necessary tests to be carried out, and preparing orders for medications, fluid therapy, and nutrition therapy d) transfer of patients between hospital units or hospitals e) discharge of patients from the hospital f) interpretation of laboratory results 2) Procedural Competencies a) carry-out basic venous access procedures, including establishing intravenous access placement and removal of nasogastric tubes and Foley catheters arterial puncture for blood gases Direct supervision is required until competence is demonstrated for: 1) Patient Management Competencies a) initial evaluation and management of patients in the urgent or emergent situation, including urgent consultations, trauma, and emergency department consultations (ATLS required) b) evaluation and management of post-operative complications, including hypotension, hypertension, oliguria, anuria, cardiac arrhythmias, hypoxemia, change in respiratory rate, change in neurologic status, and compartment syndromes c) evaluation and management of critically-ill patients, either immediately post-operatively or in the intensive care unit, including monitoring, ventilator management, specification of necessary tests, and orders for medications, fluid therapy, and enteral/parenteral nutrition therapy d) management of patients in cardiac arrest (ACLS required) 2) Procedural Competencies

Question	Answer
	a) carry-out of advanced vascular access procedures, including central venous catheterization, temporary dialysis access, and arterial cannulation b) repair of surgical incisions of the skin and soft tissues c) repair of skin and soft tissue lacerations d) excision of lesions of the skin and subcutaneous tissues e) tube thoracostomy f) paracentesis g) joint aspiration h) advanced airway management i) endotracheal intubation ii) tracheostomy
Who comprises the “care team?” *[Program Requirement: IV.E.2.]*	The care team is defined as those individuals who are formally part of the otolaryngology – head and neck surgery program, including OHNS residents and attending physicians, advanced practice providers, patient care coordinators, etc., who fall under the governance of the otolaryngology – head and neck surgery department/division. This requirement does not refer to the numerous other people (ward nurses, hospital respiratory therapists, etc.) who might provide health care to the patient but who are not expected to be knowledgeable regarding residency program requirements.

Question	Answer
What skills should members of the caregiver team have and how should these be ensured across the team? *[Program Requirement: VI.E.2.]*	Recommended skills for all team members include: 1) recognition of and sensitivity to the experience and competence of other team members; 2) time management; 3) prioritization of tasks as the dynamics of a patient's needs change; 4) recognizing when an individual becomes overburdened with responsibilities that cannot be accomplished within an allotted time period; 5) communication, so that if all required tasks cannot be accomplished in a timely fashion, appropriate methods are established to hand off the remaining task(s) to another team member at the end of a clinical and educational work period; 6) signs and symptoms of fatigue not only in oneself, but in other team members; 7) compliance with work hours limits imposed at the various levels of education; and, 8) team development. Team development is a component of systems-based practice and is used to develop improved communication and teamwork among members. Programs may utilize simulated operative emergencies (e.g. airway fire), Team STEPPES (Strategies and Tools to Enhance Performance and Patient Safety) or simulated airway codes to assess team members' knowledge, preparedness and performance. Instruction may be provided in a variety of ways, such as workshops, grand rounds, lectures, or individual learning modules provided by the department, division, hospital, institution, societies, or online resource providers.