AMERICAN **OSTEOPATHIC** ASSOCIATION

Basic Standards for Residency Training in Surgery and the Surgical Specialties

American Osteopathic Association and the American College of Osteopathic Surgeons

Adopted, BOT 7/2002
Revised, BOT 2/2003
Revised, BOT 7/2003
Revised, BOT 2/2004
Revised, BOT 7/2004
Revised BOT 2/2006, Effective, 7/2006
Revised BOT 7/2007, Effective, 7/2008
Revised BOT 9/2007, Effective, 7/2008

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SECTION II
INTRODUCTION

AUTHORITY AND PURPOSE

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

Residency program approval means action taken by the AOA assures that such programs have appropriately identified their mission, secured the resources necessary to accomplish that mission, accomplished their mission, and demonstrated that they may continue to accomplish their mission in the future. Approval signifies that a residency program has met or exceeded the AOA residency training standards for educational quality with respect to organization and administration; faculty; curriculum; instruction and evaluation; resident relations; and facilities. The standards for surgery and all surgical specialties may be found in Section III of this document.

The approval process for general surgery and surgical specialty 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 College of Osteopathic Surgeons (ACOS), the COPT, and the AOA Board of Trustees. The context and process used by the Board and COPT in approving programs may be located in the Approval Procedures for Residency Training Programs, (Reference Section IV). Supplementary statements may be found in the document, *Administrative Handbook of the COPT.*

A BRIEF HISTORY OF RESIDENCY PROGRAM APPROVAL

Since its earliest years, around 1900, the AOA has initiated approval of osteopathic postdoctoral training programs. Review was through the Council on Hospitals and approval was by the AOA Board of Trustees.

In 1968, the COPT 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, 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 education.

In 1946, the AOA Board of Trustees first authorized the establishment of osteopathic surgical training programs. By 1948, minimum requirements for postdoctoral surgical training were outlined in detail in conjunction with the hospital site visit function, and in 1950, a registry of training programs was established. The physician conducting a training program was then referred to as a preceptor and there were established requirements for the preceptor and the trainee.

Beginning in 1955, AOA requested that the specialty colleges develop an outline for training programs which was of "sufficient detail to adequately cover the specialty field." In 1956, a manual titled "Basic Documents of an Approved Residency in Surgery" was submitted to the AOA and received tentative approval. This tentative approval led to the AOA adopting recommendations in 1964 that made the training program four years in length beginning in 1967. At the same time, AOA adopted recommendations which required programs to be inspected at the time of inception and at interim periods thereafter and made the ACOS Residency Evaluation and Standards Committee (RESC) responsible for reviewing the programs and recommending elimination of programs inconsistent with effective teaching. The AOA also recommended exchange training programs, i.e., out-rotations, in certain training areas to add strength to those programs which were weak in those areas.

Today, the ACOS Residency Evaluation and Standards Committee (RESC) is composed of twelve (12) members, eleven (11) of whom are appointed by the Board of Governors of the ACOS to serve three (3)-year terms and one resident member who serves a one-year term. The RESC serves as an advisory body to the AOA COPT for the specialties of general surgery, general vascular surgery, neurological surgery, plastic and reconstructive surgery, surgical critical care, cardiothoracic surgery, and urological surgery. The RESC has two (2) primary functions: to develop standards which surgical training programs and residents must meet to be approved, and to review and make recommendations to the AOA to assure that residency programs and individual physicians seeking AOA approval have met and continue to meet the standards. By establishing standards that must be met, the AOA and the ACOS achieve their major purpose of assuring that programs are of acceptable quality and individuals have been adequately trained.

The approval process for postdoctoral surgical training is a public trust and its purposes are many. These include assuring:

1. *Students,* who are selecting among training programs, that the osteopathic programs have the necessary scope and meet the AOA and ACOS standards established for education and training in surgery;
2. *Residents in training programs*, who are the consumers of the educational process, that they are receiving education and training that is of high quality;
3. *Trainers,* other educational faculty, and staff, who are jointly responsible for the educational process, that the enterprise in which they are engaged is of high quality;
4. *Governing boards and administrators of training institutions*, that their sponsored programs meet acceptable national standards;
5. *Certifying boards*, that the standards they require are being met by individual programs;
6. *Funding agencies*, that the educational programs meet national standards and merit support; and,
7. *The public,* that residents are provided education and training of high quality in programs that are well supervised by competent teaching staffs.

SECTION III
STANDARDS FOR PROGRAM APPROVAL

Standard I. Institutional Support
The sponsoring institution must provide sufficient leadership and resources necessary to support and maintain an environment conducive for surgical education and to enable the programs to demonstrate compliance with approval criteria.

1.0 The sponsoring institution must meet the following organizational Requirements to be considered for approval to conduct a general surgery or surgical specialty residency program:

1.0.1 Approval by the American Osteopathic Association.

1.0.1.2 Be in operation not less than twelve months immediately preceding the date of the application for approval of residency education.

1.0.1.3 Confirm that education, in combination with quality patient care, will be the primary goal of the educational program.

1.0.1.4 Ensure that osteopathic principles and practices and their application to surgery are emphasized.

1.1 Provide the administrative, financial, educational, and support services for each educational program, such as:

1.1.1 The capability to provide residents with an education that demonstrates compliance with the AOA and ACOS standards.

1.1.2 Institutional facilities to accomplish the program's educational goals should include but not be limited to:

1.1.2.1 Classroom and office facilities for faculty and residents; sleeping, lounge, and food facilities accessible to residents on duty.

1.1.2.2 A medical library containing standard reference texts and journals and provision for electronic literature search capabilities and retrieval of information.

1.1.2.3 Support for research endeavors, including Ph.D. consultation and access to research facilities. Access to an animal laboratory or inanimate teaching laboratory is encouraged.

1.1.2.4 The maintenance of permanent educational records for the graduates of AOA-approved programs, to include resident annual reports.

1.1.2.5 The appointment of a director of medical education (DME) who is an osteopathic physician. (Reference - Section V, Appendix 1.)

1.2 Participation in an AOA-approved Osteopathic Postdoctoral Training Institution (OPTI).

1.3 Implementation of written policy(ies) regarding the process and criteria to select residents. The policies must contain the following minimums:

1.3.1 The specifics of contract renewal for residents who demonstrate competence and potential during each year of training.

1.3.2 The number of positions funded for each year.

1.3.3 A statement that admission to a residency program shall not be influenced by race, color, sex, religion, creed, national origin, age or handicap as defined by law and regulations.

1.4 To qualify for approval, the primary training institution must document the following minimum components:

1.4.1 An AOA-approved internship program and an AOA-approved training program.

1.4.2 Three organized clinical departments, including family practice, internal medicine, and surgery; an organized pathologic and radiologic service with full-time certified pathology and radiology physician staff.

1.4.3 A sufficient number of qualified faculty to provide quality patient care as well as resident supervision and instruction.

1.4.3.1 The faculty should be composed of general surgeons, surgical specialists, and other physicians engaged in the active practice of surgery.

1.4.4 Qualifications of the departmental chair, program director, and faculty:

1.4.4.1 The chair of the department of surgery must be certified in general surgery by the AOA through the American Osteopathic Board of Surgery (AOBS) or the American Board of Surgery (ABS) and must document at least two years of experience in general surgery.

1.4.4.2 Reference Standards VI - XII for additional specific qualifications for each specialty.

1.4.5 An osteopathic postdoctoral education committee must be constituted and active.

1.4.5.1 The Committee should be composed of the director of medical education, all program directors, and representatives of training faculty.

1.4.5.2 The Committee should meet at least monthly and minutes must be documented. (Reference Section V, Appendix 2.)

1.4.6 The surgical facilities at the primary training institution and affiliated sites should provide a sufficient scope, volume, and variety of operative experience to ensure that residents are provided with the necessary knowledge, technical skills, and judgement required for clinical practice.

1.4.6.1 The balance of education to service should be strictly monitored for all clinical assignments.

1.4.6.2 A sufficient experience with the continuity of patient care, i.e., pre-operative, intra-operative, and post-operative patient care, must be provided at both the primary training institution and at affiliated sites.

1.5 Affiliated training sites may be developed either to fulfill basic requirements or for elective experiences.

1.5.1 Affiliated training sites should offer educational experiences otherwise not available at the sponsoring institution and should be justified with an appropriate educational rationale.

1.5.2 Agreements with affiliated training sites must be current and documented.

1.5.3 Written evaluations of the resident, while assigned to affiliated training sites, must comply with the standards.

1.6 The sponsoring institution and the primary training site are responsible for implementing and documenting formal policies and procedures for the conduct of the residency (ies). These policies must be distributed to each resident at the time of admission. (Reference Standard IV.)

Standard II. The Educational Program

An organized, comprehensive, and effective curriculum must be documented and implemented, which meets or exceeds the model ACOS curriculum for general surgery and the applicable specialty, and which is based upon a philosophy of competence in practice and excellence in patient care.

2.0 The following components of the educational program should be well-documented and based upon the ACOS model curriculum:

2.0.1 The didactic program must include contemporary surgical knowledge with special emphasis on surgical science. Instruction in medial ethics, interpersonal skills, and practice management must be

I ncluded in the curriculum.

2.0.1.1 A variety of academic conferences and lectures should be documented, to include, for example, formal didactic conferences, morbidity and mortality meetings, and journal club, as well as seminars, workshops, and conferences that may be provided outside the program.

2.0.1.2 Each resident must complete the resident scientific and research component (Reference Appendix 3.)

2.0.2 The clinical component must include a sufficient scope, volume, and variety of operative experience complemented by sufficient pre-operative, intra-operative, and post-operative care of patients to ensure that residents are provided with the necessary knowledge, technical skills, and judgement required for clinical practice.

2.0.2.1 Written objectives for each clinical assignment and for each level in the program must be developed and implemented. Both the residents and the faculty should receive copies of the goals and objectives prior to each assignment.

2.0.2.2 The clinical component must include education and exposure to the evolving diagnostic and therapeutic methods, such as, laser, ultrasound, endoscopic and laparoscopic techniques and other applicable leading-edge technology.

2.0.2.3 The operative experience for each resident must be documented in a surgical operative log which reflects all assignments during the surgery or surgical specialty program. The AOA-approved form must be used. The adequacy of each resident's experience will be evaluated based upon the information submitted in these logs. (Reference the required minimum numbers for each surgical specialty in Standards VI - XII.)

2.0.2.4 The surgical competence of each resident must be evaluated based upon the number of surgeries performed gained through direct participation.

2.0.2.5 The program director and the faculty must ensure that each resident is provided with direct and progressively responsible patient management that will result in the demonstration of competence in technical skills and clinical decision-making upon successful completion of the program.

2.0.2.6 Outpatient clinics under supervision of the department of surgery, should be available for resident education. Alternatively, this activity may be accomplished by pre-operative and post-operative care in surgeon offices.

2.1 Resident work hours and supervision policies:
It is recognized that excessive numbers of hours worked by 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, director of medical education (DME) and residency 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.

2.1.1 Work hours:

The following work hours policy will apply to all residents in all specialties.

2.1.1.1. 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.

2.1.1.2. The resident shall not work in excess of twenty-four (24) consecutive hours exclusive of morning and noon educational programs. Allowance for, but not to exceed up to six (6) hours for inpatient and outpatient continuity, transfer of care, educational debriefing and formal didactic activities may occur. Residents may not assume responsibility for a new patient after twenty-four (24) hours.

2.1.1.3. If moonlighting is permitted, all moonlighting will be inclusive of the eighty (80) hour per week maximum work limit and must be reported. (See Moonlighting Policy.)

2.1.1.4. The resident shall have alternate week forty-eight (48) hour periods off or at least one (1) twenty-four (24) hour period off each week.

2.1.1.5. Upon conclusion of a twenty-four (24) hour duty shift, residents shall have a minimum of twelve (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.

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

2.1.1.7. Those rotations requiring the resident to be assigned to Emergency Department duty shall not be assigned longer than twelve (12) hour shifts.

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

2.1.1.9. The resident may not be assigned to call more often than every third night averaged over any consecutive four (4) week period.

2.1.2. The training institution shall provide an on-call room for residents, which is clean, quiet, safe 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.

2.1.3. 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 housestaff manual. Failure to report and receive approval by the program may be grounds for terminating a resident's contract.

2.1.4. Supervision of residents:
The residency is an educational experience and must be designed by the institution to offer structured and supervised exposure to promote learning rather than service. An opportunity must exist for residents to be supervised and evaluated throughout their training with availability of teaching staff scheduled within the program. During daytime hours, residents will be responsible to attending physicians for assignment, of responsibility.

2.2 AOA competencies: The residency program must require its residents to obtain competencies in the following areas to the level expected of a new practitioner. Toward this end, programs must define the specific knowledge, skills, and attitudes required and provide educational experiences as needed for their residents to demonstrate:

2.2.1 Patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

2.2.2 Medical knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

2.2.3 Practice-based learning and improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care.

2.2.4 Interpersonal and communication skills that result in effective information exchange and teaming with patients, their families, and other health professionals.

2.2.5 Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

2.2.6 Systems-based practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of healthcare and the ability to effectively call on system resources to provide care that is of optimal value.

2.2.7 Integration of osteopathic principles and osteopathic medical management.

Standard III. Faculty

The educational program must demonstrate a sufficient number of qualified faculty and support personnel to accomplish its stated purposes, to provide day-to-day continuity of leadership, and to fulfill all educational responsibilities inherent in meeting the goals of the program.

3.0 The program director and the physician faculty must be academically and professionally qualified and should maintain professional expertise appropriate to their educational and clinical responsibilities.

3.0.1 Both the program director and the faculty should affirm their commitment to the residency program by providing a quality education in all areas of the curriculum and by demonstrating active participation in the following educational activities:

3.0.1.1 Appropriate resident supervision and instruction in the operating room, at the bedside, and in ambulatory settings.

3.0.1.2 Participation and teaching in academic conferences.

3.0.1.3 Participation in resident and program evaluation activities.

3.0.2 Non-physician faculty must be qualified in their area of expertise.

3.0.3 The general qualifications for a general surgery or surgical specialty program director must include:

3.0.3.1 Membership in the American College of Osteopathic Surgeons.

3.0.3.2 An active staff member in the department of surgery of the sponsoring institution or the primary training institution.

3.0.3.3 Demonstrated clinical, educational, teaching, administrative, and leadership skills.

3.0.3.4 Fulfillment of continuing medical education, such as appropriate State Board, AOA, and other professional society activities, including continuing education in medical and surgical teaching skills and faculty development activities.

3.0.3.5 Participation in community and professional organizations.

3.0.3.6 Certification criteria. (Reference Standards VI – XII for specialty-specific certification criteria.)

3.0.4 Exceptions to the qualifications, such as the special circumstances of non-AOA certification, must be submitted to the ACOS RESC for review and approval.

3.0.5 Interim program directors may be approved by the ACOS RESC for a maximum of two (2) years. Failure of the Program to fill the program director vacancy may lead to a recommendation by the RESC for a site visit. An individual can be appointed as an interim program director of a program in transition when the individual is in compliance with the requirements in Section III, 3.0.3

3.1 A program director may serve as the director of medical education, but may not serve as program director of more than one residency program.

3.2 The general responsibilities of the program director must include, but are not limited to the following activities:

3.2.1 Administrative and educational responsibility for the conduct of the program consistent with the model AOA curriculum.

3.2.2 Arranging for affiliated training sites and electives to meet program objectives, consistent with approval of the DME.

3.2.3 Documenting compliance with the standards, policies, and procedures of the AOA.

3.2.4 Submitting reports as required by the AOA Approval Procedures. (Reference Section IV.)

3.2.5 Ensuring resident completion and submission of the resident annual reports to the ACOS.

3.2.6 Preparing the required documentation for, and participation in, the AOA site visit process.

3.2.7 Coordinating educational administrative activities of the training program to include resident schedules and resident assignments for educational activities.

3.2.8 Ensuring that all components of the training program are evaluated as required. (Reference Standard V.)

3.2.9 Encouraging residents to apply for ACOS resident membership status.

3.2.10 Attending the ACOS Osteopathic Surgical Educators' Seminar at least once every three years.

3.2.11 Registering program residents to utilize the ACOS electronic data collection/log system. Residents in general surgery, plastic and reconstructive surgery, neurological surgery, urological surgery, and general vascular surgery must utilize the ACOS electronic data

collection/log system to document and submit logs of procedures for the annual resident report. (Reference Section IV, 12.1.3.)

3.3 Procedural Requirements

3.3.1 Program director appointments must be approved by the ACOS RESC with subsequent registry by the AOA. (Reference Section IV, 9.5.)

3.3.2 Program directors may be dismissed for non-adherence to the AOA/ACOS Residency training standards. (Reference *AOA Basic Documents for Postdoctoral Training.*)

Standard IV. Residents

The following minimum resident-specific policies must be implemented and provided, as applicable, to residents admitted to the AOA-approved programs.

4.0 The following documentation must be available for review at the time of the site visit:

4.0.1 Each resident file must contain the following documentation attesting to their professional qualifications to matriculate for full-time study:

4.0.1.1 Graduation from an AOA-approved college of osteopathic medicine, documented by an official graduation transcript from the college of osteopathic medicine.

4.0.1.2 Completion of an AOA-approved internship, documented by a certificate and letter of recommendation from the director of medical education (DME) of the internship program of graduation.

4.0.1.3 Current licensure as a physician in the state(s) where the training program and clinical training site(s) are located.

4.0.1.4 Membership in the AOA, which must be maintained throughout the residency program.

4.0.1.5 A current, signed, contract between the resident and the sponsoring institution. (Reference Section IV,10.)

4.1 Each resident must be provided with a handbook, which should include, but is not limited to, the following policies and procedures:

4.1.1 Moonlighting and other extra-program activities: The resident must engage only in program director-approved outside activities which do not interfere with the resident performance in the training program.

4.1.2 Policies prohibiting the resident from acting as a consultant, engaging in a private specialty practice, or maintaining attending status during the residency program.

4.1.3 Resident-maintained educational records.

4.1.3.1 The resident is required to maintain and accurately complete records for their educational activities in the required surgical log form.

4.1.3.1.2 The logs must be submitted at the end of each rotation to the program director for review and

verification.

4.1.3.1.3 The logs should document the fulfillment of the requirements of the program, describing the scope, volume, and variety, progressive responsibility by the resident.

4.1.3.2 The resident is required to complete and submit the annual resident report to the ACOS RESC within 30 days of completion of each contract year. (Reference Section IV, 12.)
The ACOS does not review annual resident reports that are three or more years delinquent.

4.1.4 Resident duties and responsibilities: for example, clinical procedures and general orders; resident responsibilities for teaching and instruction of other residents, medical students, and other professional personnel.

4.1.5 Resident participation in professional staff activities: for example, patient care, department meetings, mortality and morbidity meetings.

4.1.6 Required participation of each general surgery resident in the annual ACOS general surgery in-service examination. General surgery emphasis interns may take the examination at the discretion of the program director.

4.1.7 Required completion of the scientific and research component of the curriculum. (Reference Section V, Appendix 3.)

4.1.8 The model ACOS Curriculum for Surgery and Surgical Specialties, including the program goals and objectives for the general surgery and the applicable surgical specialty training program for each assignment and for each level in the program.

4.1.9 All applicable policies and procedures of the sponsoring institution and the primary training institution, such as, work hours, call, and leave policies; financial arrangements, including housing, meals, and benefits; resident supervision and evaluation; specifics of contract renewal; and disciplinary, due process, and appeal policies.

4.2 Residency Training Evaluation

4.2.1 The RESC evaluates each year of a resident's training. Each year of training must be approved by the RESC before a resident will be considered to have successfully completed a residency training program approved by the ACOS and AOA. Successful completion is a prerequisite for eligibility for certification by the AOA through the American Osteopathic Board of Surgery (AOBS).

4.2.2 Annual resident reports must be received by the ACOS within 30 days of the completion of the resident's contract year. Incomplete annual resident reports submitted to the ACOS will not be reviewed by the RESC. (Reference Section IV, 12.)

4.2.3 Segregated totals submitted by the resident must demonstrate adequate scope, volume and variety. Residents must complete a minimum volume of cases:

General Surgery (See Section III, Standard VI, 6.3)
General Vascular Surgery (See Section III, Standard VII, 7.3)
Cardiothoracic Surgery - (See Section III, Standard VIII, 8.3)
Surgical Critical Care - (See Section III, Standard IX. 9.4)
Neurological Surgery - (See Section III, Standard X, 10.3 & 10.4.1)
Plastic and Reconstructive Surgery (See Section III, Standard XI, 11.4)

Urological Surgery (See Section III, Standard XII, 12.3)

4.2.4 Residents must meet the applicable requirements for scientific research for their specialty. The scientific research paper or other research project submitted for credit towards the annual resident report must be approved by the program director and adhere to *The ACOS Trainer's Evaluation Format for the Resident Original Scientific Research Paper*. Only one resident may receive credit for a paper or poster session submitted for the research project.

4.2.5 Residents must review and sign the Program Director's Annual Resident Evaluation Report for Surgery.

4.2.6 Residents must submit a satisfactory evaluation signed by their program director that recommends that the resident be advanced to the next year of training, or if applicable, for program completion.

4.2.7 Residents must evaluate their program director by completing and signing the Resident's Annual Evaluation Report of the Program Director.

4.2.8 Residents in general surgery training programs shall have completed the annual ACOS in-service examination.

Standard V. Evaluation

The program, with the support of the sponsoring institution, must document and implement an ongoing evaluation process that focuses upon improving the quality of osteopathic surgical education provided to their residents.

5.0 The program director, with faculty input, must complete written evaluations of resident performance at least quarterly. This must include evaluations from all affiliated training sites and elective assignments.

5.0.1 The evaluations should be learner-centered, developmental, improvement-oriented, and based upon educational objectives for each assignment and program activity, and reflect the AOA core competencies.

5.0.2 Completed evaluations must be signed by the program director and the resident as documentation that evaluation and counseling have occurred quarterly as required.

5.0.3 Copies of the quarterly evaluations should be filed, made available to the resident upon request, and submitted to the RESC as necessary or requested (Reference Section IV, 12.1.1.)

5.0.4 Residents requiring remediation or counseling should be evaluated more frequently.

5.0.5 A final evaluation of each resident's general and technical abilities which attests to their competence at graduation from the program, must be completed and filed with their permanent record.

5.1 The program director and the faculty should be peer evaluated annually with respect to their teaching abilities, commitment to the program, and scholarly activities.

5.2 The quality of the program should be evaluated at least annually by the program director, faculty, and residents, and the results should be used for program improvement.

5.2.1 Recommended methods include: program improvement and outcome results such as resident in-service examination scores and graduate performance on the certifying examination; postgraduate professional performance satisfaction surveys and records of the professional accomplishments of the program graduates; the resident attrition rate from the program and the percent of graduates completing the program on time.

5.3 Annual evaluation of the resident

The program director must submit the *Program Director's Annual Resident Evaluation Report for Surgery* with the resident annual reports (Reference Section IV, 12.1.1.)

Specialty-Specific Criteria

In addition to the stated educational criteria, the following specialty-specific criteria also apply to each specialty program.

Standard VI. General Surgery

Education in the specialty of general surgery reflects a core education in the basic sciences and cognitive and technical skills, as well as the development of mature surgical judgement in the diagnosis and management of surgical patients.

6.0 The general surgery residency program should provide a meaningful education that will provide residents with the opportunity to demonstrate the following competencies:

6.0.1 Cognitive

6.0.1.1 Integrate the sciences applicable to general surgery with clinical experiences in a progressive manner.

6.0.1.2 Develop critical thinking skills which result in making effective decisions for patient management.

6.0.1.3 Understand the relevance of research to the practice of general surgery.

6.0.1.4 Read, interpret, and participate in clinical research as appropriate.

6.0.2 Psychomotor and technical skills

6.0.2.1 Demonstrate osteopathic diagnoses and manipulative therapy, as appropriate, in the care of patients.

6.0.2.2 Demonstrate proficiency with the necessary technical skills required for the practice of general surgery.

6.0.2.3 Demonstrate the ability to provide progressive patient management responsibilities based upon knowledge of the basic and clinical sciences.

6.0.3 Communication skills

6.0.3.1 Demonstrate the ability to collaborate effectively with colleagues and allied healthcare professionals.

6.0.3.2 Educate patients and their families concerning healthcare needs.

6.0.3.3 Demonstrate the ability to teach medical students, interns, other residents, and allied healthcare staff within the context of residency education.

6.0.4 Practice management

6.0.4.1 Demonstrate leadership and management skills.

6.0.4.2 Provide cost-effective care to patients.

6.0.5 Professional attitudes and abilities

6.0.5.1 Demonstrate a broad understanding of the role of general surgery as it relates to other medical disciplines.

6.0.5.2 Appreciate the value of lifelong learning in medical education and as related to a professional career in the field.

6.0.5.3 Demonstrate the ability to provide sound ethical and legal judgments.

6.0.5.4 Participate in continuing education to promote personal and professional growth.

6.0.5.5 Participate in community and professional organizations.

6.0.5.6 Apply the principles of evidence-based medicine to their professional practice.

6.0.5.7 Upon successful completion of the program, the graduate should be prepared to meet certification requirements of the American Osteopathic Board of Surgery (AOBS).

6.1 The length of the general surgery residency program is **five (5)** years.

6.1.1 No more than a total of twelve (12) months of the **five**-year program may be scheduled away from the primary training institution. Short courses of two-weeks or less are accepted.

6.1.2 The final twelve months of the **five**-year program must be spent as chief resident in approved institutions, under appropriate supervision, demonstrating advanced-level responsibilities in patient care.

6.1.3 No more than a total of four months of the **final four years of the five**-year program may be allocated to non-surgical disciplines such as internal medicine, anesthesiology, or surgical pathology.

6.2 The program curriculum should meet or exceed the ACOS model curriculum and should include the following experiences:

6.2.1 The management of patients with severe and complex illnesses and major injuries in the emergency department and intensive care units.

6.2.2 Experience with evolving diagnostic and therapeutic measures such as rigid and flexible endoscopic techniques, the applications of laser therapy, and interventional techniques.

6.3 The program should provide each resident with a sufficient scope, volume, and variety of surgical experience in general surgery.

6.3.1 Each resident must document by program completion, participation, under appropriate supervision, a minimum of 500 major surgical procedures, as surgeon or first assistant.

6.3.2 Of these 500 procedures, each resident should average 125 cases per year.

6.3.3 During the chief year, at least 125 major surgical procedures of appropriate scope and variety with senior responsibility must be documented.

6.3.4 During each year of the program, progression of surgical responsibility should be demonstrated including an adequate scope, volume, and variety of surgical experience.

6.3.5 Excessive numbers of surgical procedures, either by category in total are unacceptable.

6.4 The program must provide clinical learning and experience in the pre-operative, operative and post-operative learning and surgical experience for patients with all diseases, which fall within the scope of practice of general surgery, to include:

6.4.1 Skin and soft tissue.

6.4.2 Diseases of the head and neck and the endocrine system.

6.4.3 Diseases of the gastrointestinal tract and other abdominal viscera, i.e., liver and spleen, and pancreatobiliary tract.

6.4.4 Diseases of the breast.

6.4.5 Disease of the abdominal wall.

6.4.6 Thoracic surgery and diseases of the vascular system.

6.4.7 Trauma, emergency surgery, surgical critical care.

6.4.8 Gynecological surgery.

6.4.9 Endoscopy.

6.4.10 Urological surgery.

6.4.11 Pediatric surgery.

6.5 Qualifications of the program director and the faculty

6.5.1 The program director must be certified in general surgery by the AOA through the American Osteopathic Board of Surgery (AOBS) or by the American Board of Surgery (ABS).

6.5.2 The program faculty must include at least two general surgeons, including the program director. At least one of these faculty must be AOA- certified in general surgery, the other faculty member must be at least board-eligible in general surgery.

6.6 General Surgery residency programs are required to administer the Annual ACOS General Surgery In-Service Examination to general surgery residents.

6.6.1 Residency training programs not adhering to the ACOS proctor instructions are subject to a fine set by the ACOS RESC and/or on-site inspection with a possibility of program probation. The penalty fee will be billed to the residency training program.

6.6.2 Program Directors must review a resident's in-service examination score results in consultation with the resident.

Standard VII. General Vascular Surgery

The specialty of general vascular surgery builds upon the core education of general surgery to provide the knowledge, skills, abilities to develop proficiency and mature surgical judgement in the diagnosis and management of diseases of the arterial, venous, and lymphatic circulatory systems, exclusive of the vessels of the heart and intra-cranial vessels.

7.0 The general vascular residency program should provide a meaningful education that provides residents with the opportunity to demonstrate these competencies:

7.0.1 Cognitive skills

7.0.1.1 Integrate the sciences applicable to general vascular surgery with clinical experiences in a progressive manner.

7.0.1.2 Develop critical thinking skills which result in making effective decisions for patient management.

7.0.1.3 Understand the relevance of research to the practice of general vascular surgery.

7.0.1.4 Read, interpret, and participate in clinical research as appropriate.

7.0.2 Psychomotor and technical skills

7.0.2.1 Demonstrate osteopathic diagnoses and manipulative therapy, as appropriate, in the care of patients.

7.0.2.2 Demonstrate proficiency with the necessary technical skills required for the practice of general vascular surgery.

7.0.2.3 Demonstrate the ability to provide progressive patient management responsibilities based upon knowledge of the basic and clinical sciences.

7.0.3 Communication skills

7.0.3.1 Demonstrate the ability to collaborate effectively with colleagues and allied healthcare professionals.

7.0.3.2 Educate patients and their families concerning healthcare needs.

7.0.3.3 Demonstrate the ability to teach medical students, interns, other residents, and allied healthcare staff within the context of residency education.

7.0.4 Practice management

7.0.4.1 Demonstrate leadership and management skills.

7.0.4.2 Provide cost-effective care to patients.

7.0.5 Professional attitudes and abilities

7.0.5.1 Demonstrate a broad understanding of the role of general surgery as it relates to other medical disciplines.

7.0.5.2 Appreciate the value of lifelong learning in medical education and as related to a professional career in the field.

7.0.5.3 Demonstrate the ability to provide sound ethical and legal judgments.

7.0.5.4 Participate in continuing education to promote personal and professional growth.

7.0.5.5 Participate in community and professional organizations.

7.0.5.6 Apply the principles of evidence-based medicine to their professional practice.

7.0.5.7 Upon successful completion of the program, the graduate should be prepared to meet the general vascular certification requirements of the AOA through the American Osteopathic Board of Surgery (AOBS).

7.1 The length of the general vascular surgery program is one year following completion of an AOA-approved general surgery residency program.

7.1.1.1 No more than a total of three months of the one-year program may be scheduled away from the primary training institution in a non-affiliated site.

7.2 The program curriculum should meet or exceed the ACOS curriculum for vascular surgery.

7.3 The program should ensure that each resident is provided with a sufficient scope, volume, and variety of clinical experience in general vascular surgery.

7.3.1 Each resident must document by program completion a minimum of 100 major vascular surgery procedures performed as surgeon or first assistant and under appropriate supervision.

7.4 The primary training institution must provide the following support resources:

7.4.1 At least 150 vascular procedures per resident annually.

7.4.2 Access to a critical care unit, coronary care unit, a pulmonary laboratory, and a vascular laboratory.

7.5 Qualifications of the program director

7.5.1 The program director must be a DO certified in general vascular surgery by the AOA through the AOBS or by an ABMS recognized certifying board.

7.5.2 The program faculty must include at least two general vascular or cardiothoracic surgeons, one of whom may be the program director. At least one of these faculty must be AOA-certified in general vascular or thoracic cardiovascular surgery, the other faculty member must be at least board- eligible in general vascular or thoracic cardiovascular surgery.

Standard VIII. Cardiothoracic Surgery

The specialty of cardiothoracic surgery encompasses the surgical care of patients with pathological conditions and trauma of the chest including the pulmonary, esophageal, mediastinal, chest wall, diaphragm, and cardiovascular disorders of patients in all age groups as well as the critical care management of patients with pathological conditions within the chest.

8.0 A cardiothoracic surgery residency program should provide a meaningful education that prepares the resident upon graduation to demonstrate the following competencies:

8.0.1 Cognitive

8.0.1.1 Integrate the sciences applicable to cardiothoracic vascular surgery with clinical experiences in a progressive manner.

8.0.1.2 Develop critical thinking skills which result in making effective decisions for patient management.

8.0.1.3 Understand the relevance of research to the practice of cardiothoracic surgery.

8.0.1.4 Read, interpret, and participate in clinical research as appropriate.

8.0.2 Psychomotor and technical skills

8.0.2.1 Demonstrate osteopathic diagnoses and manipulative therapy, as appropriate, in the care of patients.

8.0.2.2 Demonstrate proficiency with the necessary technical skills required for the practice of cardiothoracic surgery.

8.0.2.3 Demonstrate the ability to provide progressive patient management responsibilities based upon knowledge of the basic and clinical sciences.

8.0.3 Communication skills

8.0.3.1 Demonstrate the ability to collaborate effectively with colleagues and allied healthcare professionals.

8.0.3.2 Educate patients and their families concerning healthcare needs.

8.0.3.3 Demonstrate the ability to teach medical students, interns, other residents, and allied healthcare staff within the context of residency education.

8.0.4 Practice management

8.0.4.1 Demonstrate leadership and management skills.

8.0.4.2 Provide cost-effective care to patients.

8.0.5 Professional attitudes and abilities

8.0.5.1 Demonstrate a broad understanding of the role of cardiothoracic surgery as it relates to other medical disciplines.

8.0.5.2 Appreciate the value of lifelong learning in medical education and as related to a professional career in the field.

8.0.5.3 Demonstrate the ability to provide sound ethical, and legal judgments.

8.0.5.4 Participate in continuing education to promote personal and professional growth.

8.0.5.5 Participate in community and professional organizations.

8.0.5.6 Apply the principles of evidence-based medicine to their professional practice.

8.0.5.7 Upon successful completion of the program, the graduate should be prepared to meet certification requirements of the AOA through the American Osteopathic Board of Surgery (AOBS).

8.1 The length of the cardiothoracic residency program is two years following successful completion of an AOA-approved general surgery **residency** program.

8.1.1 Although clinical experiences may be achieved by formal affiliation with other institutions, no more than a total of six months may be assigned outside the primary training institution. Short courses of two weeks or less do not apply to the six-month limit.

8.1.2 The final twelve months of the two-year program must be spent as chief resident in approved institutions, under appropriate supervision, demonstrating advanced-level responsibilities for complete patient management.

8.2 The cardiothoracic surgery curriculum should meet or exceed the ACOS model curriculum and should include, for example, the following structured learning experiences:

8.2.1 Clinical learning experiences should be provided in the pre-operative, intra-operative, and post-operative care of patients with diseases of the heart and great vessels; lung, pleura and trachea; esophagus, mediastinum, diaphragm, and chest wall; and the peripheral vascular system.

8.2.2 Additional experiences include: cardiopulmonary bypass physiology and mechanics; pulmonary function examination; non-invasive peripheral vascular examination; chest x-ray, MRI and CT scan interpretation; cardiac catheterization interpretation; ventilator management; fluid and electrolyte management; clinical hematology, coagulation, and blood component replacement therapy; and cancer chemotherapy and radiation therapy.

8.2.3 Electives in organ transplantation and mechanical cardiac assist devices are highly desirable.

8.3 The program should provide each resident with a sufficient scope, volume, and variety of clinical experience in cardiothoracic surgery.

8.3.1 At the completion of the program, each resident must document participation in 250 major surgical procedures, 200 of which will be performed by the resident as surgeon under supervision in the following categories:

8.3.1.1	Lungs, Pleura, Chest Wall	50 TOTAL
	Pneumonectomy, Lobectomy, Segmentectomy	30
	Other	20
8.3.1.2	Esophageal, Mediastinum, Diaphragm	15 TOTAL
	Esophageal (At least 4 must be resections)	8
	Other (No more than 4 can be mediastinoscopy)	7
8.3.1.3	Congenital Cardiac (Exposure to 20 congenital cases with 10 for full credit)	20 TOTAL
	Full Credit	10
	First assist	10
8.3.1.4	Adult Cardiac	75 TOTAL
	Valvular Surgery	20
	Myocardial Revascularization	40
	Other	15
	Re-Operations (Any re-operation procedures for adult cardiac)	5 (are not counted toward the total 75)
8.3.1.5	Bronchoscopy and Esophagoscopy (At least 10 esophagoscopy)	30 TOTAL
8.3.1.6	Video Assisted Thoracic Surgery (VATS)	10 TOTAL

8.4 The primary training institution must serve as the primary clinical site and should document the capability to provide the required educational experiences in the specialty, including at minimum:

8.4.1 Institutional support for at least two (2) cardiothoracic residents.

8.4.2 125 major procedures per resident per year.

8.5 Qualifications of the program director and faculty:

8.5.1 The cardiothoracic program director must be certified in thoracic cardiovascular surgery by the AOA through the AOBS or American Board of Surgery.

8.5.2 The program faculty must include at least two cardiothoracic vascular surgeons, one of whom may be the program director. At least one of these faculty must be AOA-certified in thoracic cardiovascular surgery, the other must be at least board-eligible in thoracic cardiovascular surgery.

8.6 Directors of Medical Education of AOA-Approved Cardiothoracic residency training programs must provide the ACOS RESC with annual departmental segregated totals by July 31 of each year. These forms will be sent by the ACOS to Directors of Medical Education each January and shall reflect one year of surgical procedures performed at the institution. The year is to be determined by the institution's calendar/academic year.

Standard IX. Surgical Critical Care

The specialty of surgical critical care deals with the complex surgical and medical problems of the critically ill surgical patient, recognizing the complex pathophysiology of physical illness and the multidisciplinary approach necessary to the successful outcome for the patient.

9.0 A surgical critical care residency program should provide a meaningful education that prepares the resident upon graduation to demonstrate the following competencies:

9.0.1 Cognitive

9.0.1.1 Demonstrate the ability to develop a comprehensive plan of care for any critically ill patient, integrating the services of multidisciplinary team, including specialists and sub-specialists and directing the scope of their involvement to assure high quality of care for the patient without unnecessary duplication of services.

9.0.1.2 Demonstrate the ability to apply knowledge and understanding of each consultative specialty to provide competent patient care.

9.0.2 Psychomotor and technical skills

9.0.2.1 Integrate osteopathic principles and practices throughout the course of training, when indicated.

9.0.2.2 Demonstrate appropriate technical skills in surgical critical care.

9.0.2.3 Provide competent physiologic management of the critically ill surgical patient in the intensive care and intermediate care units.

9.0.3 Communications skills

9.0.3.1 Recognize the importance of problem-solving and conflict resolution among medical staff, resident staff, nursing staff, ancillary staff, and patients and their families.

9.0.4 Practice management

9.0.4.1 Demonstrate the ability to manage a surgical critical care unit.

9.0.4.2 Demonstrate the ability to cooperate with other healthcare professionals from a wide variety of different medical specialties in a multidisciplinary team. The role may be either team manager or team member based upon need to deliver quality care.

9.0.4.3 Demonstrate the ability to allocate scarce resources to include triage decisions both for admission and discharges as a provider and as the unit director.

9.0.5 Professional attitudes and abilities

9.0.5.1 Demonstrate the ability to treat the patient and family as beings and not just a disease entity.

9.0.5.2 Demonstrate an appreciation for the psychosocial aspects of critical surgical illness to prepare the resident to deal with the multifactorial impact of the illness on both the patient and the family.

9.0.5.3 Demonstrate the ability to initiate or withdraw physiologic support while understanding the needs and concerns of diverse cultures and traditions relating to death and to medical care.

9.0.5.4 Act as an educational resource for the institution and community.

9.0.5.5 Assume the role of educator as preparation for a career-long obligation as a surgical educator.

9.0.5.6 Publication of clinical or basic science research in recognized journals and periodicals is strongly encouraged.

9.0.5.7 Upon successful completion of the program, the graduate should be prepared to meet certification requirements of the AOA through the American Osteopathic Board of Surgery (AOBS).

9.1 The length of the surgical critical care residency program is twelve (12) months following successful completion of an AOA-approved general surgery **residency** program **which includes the completion of an AOA-approved common surgical OGME-1R year**.

9.1.1 Nine months of the twelve-month program must be dedicated exclusively to the management of adult critically ill surgical patients in the clinical setting.

9.1.2 No more than three-months of the twelve-month program may be assigned outside the program. Examples include: pediatric critical care, burn unit, transplant service, and research.

9.1.2.1 Elective assignments may be approved by the program director to permit the resident to pursue special interests.

9.2 The program curriculum should meet or exceed the ACOS model curriculum and should provide residents with an advanced education in critical care management, including the following:

9.2.1 The management of complicated critical care patients in a multi-disciplinary environment and to function as a unit director following completion of the program.

9.2.2 Knowledge of the physiology, pathophysiology, and pathology of diseases involving the cardiovascular, respiratory, renal, gastrointestinal, hepatic, central nervous, immune, endocrine, and hematologic systems, as well as in the therapy of appropriate diseases of each system; complex system interrelationships and single system failure.

9.2.3 The role of hypermetabolism, the various mediators, and the pathophysiology and therapy of multiple organ system failure.

9.2.4 Current treatment modalities and technologically current equipment used in the care of critically ill patients.

9.2.5 Physiologic support for the critically ill surgical patient, including:

9.2.5.1 Ventilatory management with and without assist devices including standard ventilatory modes, high frequency ventilatory modes, and extracorporeal oxygenation.

9.2.5.2 Pharmacological and mechanical cardiovascular support, for example, the intra-aortic balloon pump, left ventricular assist devices.

9.2.5.3 Renal support, for example, the various forms of dialysis, such as continuous arterial venous hemofiltration, peritoneal dialysis, and hemodialysis.

9.2.5.4 Immune system support, including pharmacological interventions aimed at understanding the immune consequences of various other therapies and the endocrine response to injury and illness.

9.2.5.5 Metabolic nutritional assessment and support including enteral and parenteral nutrition and nutritional assessment.

9.2.6 Pharmacologic intervention, including: inotropes, pressors, antibiotics, muscle paralyzing agents, sedatives and narcotics, and their role in assisting recovery or creating morbidity.

9.2.7 Knowledge of physiologic monitors and the technical skills to insert, calibrate, troubleshoot, and acquire data, for example: electrocardiogram, arterial lines, pulmonary artery catheters, oxymetric catheters, intracranial pressure monitors, compartment pressure monitors, indirect calorimetry.

9.2.8 The ability to evaluate data from multiple sources into a coherent picture of the pathophysiology of the disease.

9.3 Qualifications and duties of the program director and the faculty.

9.3.1 The program director's qualifications must include:

9.3.1.1 Certification in general surgery by the AOA through the AOBS or the ABS.

9.3.1.2 Successful completion an AOA or ACGME-approved residency program in critical care medicine.

9.3.1.3 Certification in critical care medicine by the AOBS or the ABS.

9.3.1.4 Active practice in surgical critical care as a major focus of their clinical practice.

9.3.2 The responsibilities of the program director must include:

9.3.2.1 Directing or delegating supervision of residents in the SICU.

9.3.2.2 Developing quality standards for the institution and for the periodic review and revisions of these standards.

9.3.2.3 Demonstrating active participation in the surgical education program.

9.3.3 The program faculty must include at least two surgeons, including the program director. At least one of these faculty must be AOA-certified in surgical critical care, the other faculty member must be at least board- eligible in surgical critical care.

9.4 The surgical critical care unit of the primary training institution must serve as the primary clinical site and should document the following:

9.4.1 A minimum of eight to ten beds dedicated to surgical critical care.

9.4.2 A sufficient volume of clinical experience to ensure an average daily census of five patients per resident per clinical day.

9.4.3 Institutional support for at least two (2) Surgical Critical Care residents.

9.5 DMES of AOA-Approved Surgical Critical Care residency training programs must provide the ACOS RESC with annual departmental segregated totals by July 31 of each year. These forms will be sent by the ACOS to the Director's of Medical Education each January and shall reflect one year of surgical procedures performed at the institution. The year is to be determined by the institution's calendar/academic year.

Standard X. Neurological Surgery
Neurological surgery is the surgical specialty that provides operative and non-operative care to patients of all ages with the management of disorders of the central, peripheral, and autonomic nervous systems, including their support structures and vascular supply.

10.0 The neurological surgery program should provide a meaningful education that prepares the resident upon graduation to demonstrate these competencies:

10.0.1 Cognitive

10.0.1.1 Demonstrate the ability to integrate the sciences applicable to neurological surgery with clinical experiences in a progressive manner.

10.0.1.2 Demonstrate critical thinking and problem-solving skills.

10.0.1.3 Demonstrate the ability to interpret and participate in clinical research.

10.0.2 Psychomotor and technical skills

10.0.2.1 Demonstrate osteopathic diagnoses and manipulative therapy, as appropriate, in the care of patients.

10.0.2.2 Demonstrate competent clinical patient care in a progressive manner which results in the ability to provide complete patient management.

10.0.2.3 Demonstrate proficient psychomotor skills required of a competent neurological surgeon.

10.0.3 Communication skills

10.0.3.1 Collaborate effectively, and share knowledge with colleagues and allied health professionals.

10.0.3.2 Educate patients and their families concerning healthcare needs.

10.0.4 Practice Management

10.0.4.1 Make sound, ethical, and legal judgments in the practice of neurological surgery.

10.0.4.2 Provide cost-effective care to neurological surgery patients.

10.0.5 Professional attitudes and abilities

10.0.5.1 Promote a broad understanding of the role of neurological surgery as it relates to other medical disciplines.

10.0.5.2 Develop professional leadership and management skills.

10.0.5.3 Foster lifelong learning in medical education which results in personal and professional growth.

10.0.5.4 Develop interest in and understanding of research in the specialty.

10.0.5.5 Provide residents with the knowledge, skills, and abilities to

meet certification requirements of the AOA through the American Osteopathic Board of Surgery (AOBS)

10.0.5.6 Participate in community and professional organizations

10.0.5.7 Upon successful completion of the program, the graduate should be prepared to meet certification requirements of the AOA through the American Osteopathic Board of Surgery.

10.1 The length of the neurological surgery residency program is **six** years **which includes an AOA-approved common surgical OGME-1R year.**

10.1.1 One educational format is recognized:

10.1.1.2 Completion of an AOA-approved internship year and five years of neurological surgery.

10.1.2 The neurological surgery program must include:

10.1.2.1 Three months of general surgery to be completed in the first year.

10.1.2.2 Three months of neurology, unless one year of neurology training was completed in the formal residency program.

10.1.2.3 Six months of assignments selected from: neurological surgery, critical care medicine, neurology, neuroradiology, neuropathology, neuroophthalmology.

10.1.2.4 Twelve months of electives which may be spent in clinical neurosurgery including the neurosurgery subspecialty areas arranged through affiliated training sites, or research (basic or clinical) as determined to be appropriate by the program director; and

10.1.2.5 Thirty-six months of clinical neurological surgery.

10.1.3 The final twelve months of the program should be spent as chief resident in the primary training institution, under appropriate supervision, and demonstrating advanced-level responsibilities.

10.1.4 The resident must be assigned periodically, and preferably during the chief year, to neurosurgeon offices for orientation to office practice.

10.1.5 Affiliated training sites are not permitted during the first neurosurgery year and may not exceed a total of fifteen months during the four-year period. Short courses of two weeks or less will not apply to the fifteen-month limit.

10.2 The program curriculum should meet or exceed the ACOS model curriculum and should include the following:

10.2.1 Medical and surgical neurology; pathology of the nervous system; surgical anatomy of the nervous system; neurological surgery, special procedures, and trauma; pediatric neurosurgery; and functional disease and pain related to neurosurgery.

10.2.2 Resident participation in all autopsies for the service. Additional experience in other autopsies is highly desirable.

10.2.3 Residents must be familiarized with the macroscopic and microscopic appearance of nervous system tissues.

10.3 The program should provide each resident with a sufficient volume, variety, and scope of clinical experience in neurological surgery.

10.3.1 Each resident must document by program completion, participation, under appropriate supervision, of a minimum of 400 major surgical procedures, 200 of which must be major neurological surgery procedures with an appropriate distribution of cranial, extracranial, peripheral nerve and spine cases.

10.4 The primary training institution should document the following educational support to provide the resident with the necessary progressive operative experience in the specialty.

10.4.1 Within the total clinical facilities available to the training program, there should be a minimum of 400 major neurological surgery procedures per year per finishing resident. It must be understood that achievement of this minimum number of clinical procedures will not ensure approval of a training program.

10.4.2 A minimum of 100 adult clinical beds.

10.4.3 A minimum of 100 neurosurgical admissions per resident per year.

10.4.4 Sufficient institutional resources, including patient volume, to train at least three (3) residents.

10.5 Qualifications of the program director and the faculty

10.5.1 The program director must be certified in neurological surgery by the AOA through the AOBS or ABNS.

10.5.2 There must be a minimum of two neurosurgery faculty, one of whom may be the program director. One faculty member must be AOA-certified or eligible in neurological surgery, the other faculty member must be at least board-eligible in neurological surgery.

10.5.3 Each neurological surgery faculty member must perform a minimum of 50 major neurological surgery procedures per year in the teaching institution.

Standard XI. Plastic and Reconstructive Surgery

The specialty of plastic and reconstructive surgery deals with the resection, repair, replacement and reconstruction of the integument and its underlying anatomic systems. Special knowledge and skill in the design and transfer of flaps, tissue transplantation, and the replantation of tissues and structures are also components of the specialty.

11.0 The plastic and reconstructive surgery program should provide a meaningful education that prepares the resident upon graduation to demonstrate these competencies:

11.0.1 Cognitive

11.0.1.1 Integrate the sciences applicable to plastic surgery with clinical experiences in a progressive manner.

11.0.1.2 Demonstrate critical thinking and problem-solving skills.

11.0.1.3 Demonstrate the ability to interpret and participate in clinical research.

11.0.2 Psychomotor and technical skills

11.0.2.1 Demonstrate osteopathic diagnoses and manipulative therapy, as appropriate, in the care of patients.

11.0.2.2 Demonstrate competent clinical patient care in a progressive manner, resulting in the ability to demonstrate complete patient management.

11.0.2.3 Demonstrate proficient psychomotor skills required of a competent plastic surgeon.

11.0.3 Communications skills

11.0.3.1 Collaborate effectively, and share knowledge with colleagues and allied healthcare professionals.

11.0.3.2 Educate patients and their families concerning healthcare needs.

11.0.4 Practice management

11.0.4.1 Make sound, ethical, and legal judgments in thepractice of plastic surgery.

11.0.4.2 Provide cost-effective care to plastic surgery patients.

11.0.5 Professional attitudes and abilities

11.0.5.1 Promote a broad understanding of the role of plastic and reconstructive surgery as it relates to other medical disciplines.

11.0.5.2 Develop professional leadership and management skills.

11.0.5.3 Foster lifelong learning in medical education which should result in personal and professional growth.

11.0.5.4 Develop interest in and understanding of research in the specialty.

11.0.5.5 Upon successful completion of the program, the graduate should be prepared to meet certification requirements of the AOA through the American Osteopathic Board of Surgery (AOBS).

11.1 The length of the plastic surgery residency program is two years following completion of one of the following prerequisites:

11.1.1 Completion of three AOA-approved years of general surgery **which includes an AOA-approved common surgical OGME-1R year**; or

11.1.2 Completion of an AOA-approved otolaryngology program; or

11.1.3 Completion of an AOA-approved orthopedic surgery program.

11.2 The program curriculum should meet or exceed the ACOS model curriculum and must include:

11.2.1 No more than a total of twenty-five per cent (25%) of the two-year plastic surgery program may be spent in non-affiliated training sites. Short courses of two weeks or less will not apply.

11.2.2 Advanced training in the basic sciences with structured learning and clinical experience in: musculoskeletal biomechanics, surgical physiology, and anatomy; fluids and electrolytes, shock, and resuscitation; wound healing; pathology, microbiology, immunology, and hematology; and nutrition.

11.2.3 Clinical learning and experience in the pre-operative, intra-operative, and post-operative care of patients with

11.2.3.1 Congenital deformities.

11.2.3.2 Malignancies and benign tumors of the head and neck, skin, and soft tissue.

11.2.3.3 Trauma and acquired deformities of the face, trunk, and lower extremity.

11.2.3.4 Aesthetic procedures.

11.2.3.5 Surgery of the breast.

11.2.3.6 Surgery of the hand.

11.2.3.7 Burns.

11.2.3.8 Microsurgery.

11.2.4 Subspecialty electives should include: anesthesiology, craniofacial surgery, urological surgery, laser techniques, orthopedic surgery, pediatric plastic surgery, and surgical oncology.

11.3 The primary training institution must serve as the primary training site and should document the following necessary educational experiences:

11.3.1 Support for at least three (3) plastic surgery resident positions.

11.3.2 Document at least 100 major plastic surgery procedures per resident per year.

11.4 The program should provide each resident with a sufficient scope, volume, and variety of clinical experience in plastic surgery.

11.4.1 Each resident must document by program completion, participation, under appropriate supervision, with a minimum of 200 major surgical procedures, as surgeon or first assistant.

11.4.2 The final twelve months of the program must be spent as a chief resident in approved institutions, under appropriate supervision, demonstrating advanced-level responsibilities and complete management of at least 100 cases during this year.

11.5 The program director must be a DO certified in plastic and reconstructive surgery by the AOA through the AOBS or by an ABMS recognized certifying board.

11.5.1 The program director must be a DO certified in plastic and reconstructive surgery by the AOA through the AOBS or by an ABMS recognized certifying board.

Standards XII. Urological Surgery
Urological surgery is the medical and surgical specialty involving diseases of the urological tract in both sexes, including the adrenal gland.

12.0 The urological surgery program should provide a meaningful education that prepares the resident upon graduation to demonstrate the following competencies:

12.0.1 Cognitive

12.0.1.1 Integrate the sciences applicable to urologic surgery with clinical experiences in a progressive manner.

12.0.2.2 Demonstrate critical thinking and problem-solving skills.

12.0.3.3 Demonstrate the ability to interpret and participate in clinical research.

12.0.2 Psychomotor and technical skills

12.0.2.1 Demonstrate osteopathic diagnoses and manipulative therapy, as appropriate, in the care of patients.

12.0.2.2 Demonstrate competent clinical patient care in a progressive manner, resulting in the ability to demonstrate complete patient management.

12.0.2.3 Demonstrate proficient psychomotor skills required of a competent urologic surgeon.

12.0.3 Communications skills

12.0.3.1 Collaborate effectively, and share knowledge with colleagues and allied healthcare professionals.

12.0.3.2 Educate patients and their families concerning healthcare needs.

12.0.4 Practice management

12.0.4.1 Make sound, ethical, and legal judgments in the practice of urologic surgery.

12.0.4.2 Provide cost-effective care to urologic surgery patients.

12.0.5 Professional attitudes and abilities

12.0.5.1 Promote a broad understanding of the role of urological surgery as it relates to other medical disciplines.

12.0.5.2 Develop professional leadership and management skills.

12.0.5.3 Foster lifelong learning in medical education which hould result in personal and professional growth.

12.0.5.4 Develop interest in and understanding of research in the specialty.

12.0.5.5 Upon successful completion of the program, the graduate should be prepared to meet certification requirements of the AOA through the American Board of Osteopathic Surgeons.

12.1 The minimum length of the urological surgery training program is five years **which includes an AOA-approved common surgical OGME-1R year and four years of urological surgery**.

12.1.1 Directors of Medical Education must notify the ACOS in writing of residents who have completed a specialty track internship and submit a copy of the specialty track internship certification of completion to the ACOS within thirty (30) days of the resident's OGME 2 training year. Resident must notify the ACOS RESC in writing of completion of a specialty-track internship and submit a copy of the specialty track internship certificate of completion to the ACOS with the OGME 2 Annual Report

12.2 The program curriculum must meet or exceed the model ACOS curriculum and must include the following experiences:

12.2.1 The program must provide pre-operative, intra-operative and post-operative learning and surgical experience for patients with all diseases which fall within the scope of urological surgery, including: laparoscopy, surgical oncology, pediatric surgery, urological lithotripsy, laser surgery, nephrology.

12.2.2 Educational electives should include urological trauma, critical care, urological endocrinology, renal transplantation, gynecological urological surgery, infertility, microsurgical techniques applied to urological surgery, interventional radiology, and urological research.

12.2.3 No more than twenty-five per cent (25%) of the urological surgery program may be spent in non-affiliated training sites.

12.2.4 The final twelve months of the urological surgery program must be spent as chief resident in approved institutions, under appropriate supervision, and demonstrating advanced-level responsibilities in the specialty.

12.3 The program should provide each resident with a sufficient scope, volume, and variety of clinical experience in urological surgery.

12.3.1 Each resident must document by program completion, participation, under appropriate supervision, an average of 125 major surgical procedures, as surgeon or first assistant.

12.4 The primary training institution must provide support for

12.4.1 A minimum of 200 major urological surgery procedures per resident per year.

12.4.2 At least three (3) urological surgery residency positions.

12.5 Qualifications of the program director and the faculty

12.5.1 The program director must be a DO certified in urological surgery by the AOA through the AOBS or by an ABMS recognized certifying board.

12.5.2 The program faculty must include at least two urologists, one of whom may be the program director. At least one of these faculty must be AOA-certified in urological surgery, the other faculty member must be at least board-eligible in urological surgery.

SECTION IV
APPROVAL PROCEDURES FOR
RESIDENCY TRAINING IN GENERAL SURGERY
AND THE SURGICAL SPECIALTIES

This section contains the policies and procedures manual used by the American Osteopathic Association (AOA) and its Bureau of Professional Education (BPE), Council on Postdoctoral Training (COPT), and the American College of Osteopathic Surgeons (ACOS) in approving residency training programs. The standards are located in Section III, "Standards for Program Approval."

The AOA, Bureau of Professional Education, Council on Postdoctoral Training, American College of Osteopathic Surgeons, and each approved program are required to adhere to the policies, procedures, and standards contained in these official AOA documents.

1. THE PHILOSOPHY AND CONTEXT OF APPROVAL OF RESIDENCY TRAINING PROGRAMS

1.1. Program approval assures the public, appropriate governmental jurisdictions, the osteopathic medical profession, colleges of osteopathic medicine, hospital administrators and governing boards, and interns and residents that approved residency training programs have met or exceeded acceptable levels of quality for postdoctoral training in osteopathic medicine, and comply with policies and procedures of the AOA.

2. APPROVING BODY

2.1. Approval of residency training is the responsibility of the American Osteopathic Association (AOA). The AOA has delegated much of the responsibility for assuring compliance with the standards of approval and overseeing the approval process to the evaluating committees of its specialty affiliates and to the Council on Postdoctoral Training (COPT).

Upon formal application from an institution and recommendation from an evaluating committee of a specialty affiliate, the COPT will consider a residency program for approval. For approval of residency training in general surgery and the surgery specialties, the Council on Postdoctoral Training acts only after receiving the recommendation of the Residency Evaluation and Standards Committee (RESC) of the American College of Osteopathic Surgeons (ACOS).

2.2. The ACOS and the COPT have the responsibility for developing and interpreting the standards for approval of surgical residency training.

2.3. Programs shall be notified of withdrawal of approval via certified mail from the Division of Postdoctoral Training.

3. NEW APPLICATION AND DEFINITION

3.1. New residency programs are initiated through the submission of an official application available through the Division of Postdoctoral Training of the American Osteopathic Association.

3.1.1. An application packet shall consist of:

3.1.1.1 The Policies and Standards for Program Approval;

3.1.1.2. A cover memo describing the approval process and a copy of the basic standards for the specific specialty;

3.1.1.3. A segregated total form for the specific specialty, if available, or other information for determining scope, volume and variety of patient load;

3.3.1.4 The curriculum documents for the specialty;

3.1.1.5. A sample affiliation agreement;

3.1.1.6. Instructions on the submission of fees; and

3.1.1.7. A checklist to assist the applicant in preparing this application.

3.2. A residency training program shall commence only after it has received the recommendation of the Council on Postdoctoral Training.

4. NEW PROGRAM APPLICATION PROCEDURES

4.1. Applications are obtained from the AOA Division of Postdoctoral Training.

4.2. Applications are returned to the AOA Division of Postdoctoral Training with the following required information:

4.2.1. Curriculum vitae of program director;

4.2.2. Written program description to include a mission statement, goals and objectives, curriculum, summary of the academic and clinical experience, resident-patient care responsibilities, rules and regulations.

4.2.3. A list of faculty, with certification status of each faculty member, where appropriate, and

4.2.4. If there is no AOA-approved intern program at the institution, the curriculum vitae of the director of medical education.

4.2.5. Each application is reviewed by staff of the Division of Postdoctoral Training and the applicant is notified of deficiencies apparent to staff or of inconsistencies with AOA basic standards. Corrections are requested prior to the initiation of an on-site visit.

4.3. Upon receipt of the completed documentation, program materials will be reviewed in preparation for an on-site visit. A site visitor is identified from the listing of site visitors recommended by the specialty affiliate and approved by the COPT.

4.3.1. The site visitor shall review material to determine whether additional documentation is necessary. If further information is required, the consultant shall request additional information. When materials received are complete, the site visitor will arrange for a mutually agreeable date for the site visit with the program director, in conjunction with the director of medical education and the administrator of the institution. The site visitor must inform the AOA of the site-visit date.

4.3.2. The site visitor shall submit a written report to the AOA Division of Postdoctoral Education, to be forwarded to the specialty affiliate and the COPT. These reports shall contain the findings on the quality of professional practice, educational programs, and patient care.

4.4. The completed site visitor report is forwarded to the evaluating committee of the specialty affiliate for review, in concert with the application material.

4.4.1. The evaluating committee of the specialty affiliate shall review and make a recommendation of approval, deferral or denial of the program application. Deferral or denial of recommendations must be accompanied by reasons for these recommendations, which are cross-referenced to this basic standard document.

4.5. The Council on Postdoctoral Training shall review the application material in concert with the recommendation from the specialty affiliate. The COPT shall recommend approval, denial or deferral of action.

4.5.1. Applications for new residency programs which comply with the AOA standards, shall be recommended for approval with re-inspection within one year of the commencement date of a resident in training.

4.5.2. Applications for new residency programs that do not comply with AOA standards, shall be recommended for denial. Recommendations for denial shall be accompanied by a description of areas of non-compliance which are cross-referenced to the basic standards document for that specialty.

4.5.3. Applications for new residency programs that do not contain correct information or are deemed incomplete, shall have action deferred for a period of thirty (30) days to allow the program to correct the application. Failure to do so will result in a recommendation for denial.

4.6. The AOA Board of Trustees shall take final action on all applications for new programs. Such action shall be based on recommendations of the COPT and the educational evaluation committee of the individual specialty affiliate.

4.7. For residency training in surgery, the following special procedures will be followed:

4.7.1. The ACOS shall review segregated totals prior to the on-site visit, and other submitted program information prior to scheduling of an on-site review. The ACOS may recommend denial of a program if the institutional requirements for patient volume are not met.

5. PROCEDURES FOR CONTINUING APPROVAL OF ESTABLISHED PROGRAMS

5.1. A continuing residency program shall be evaluated through an on-site inspection, conducted by an AOA-certified specialist.

5.2. The Division of Postdoctoral Training shall arrange for an on-site inspection of the program by an inspector approved by the COPT, on recommendation of the specialty affiliate.

5.2.1. The site visitor shall arrange for a mutually agreeable date for the on-site inspection with the program director, in conjunction with the director of medical education and the administrator of the institution. The site visitor will inform the AOA of the on-site visit date.

5.2.2. The site visitor shall submit a written report to the COPT. This report shall contain the findings on the quality of professional practice; educational programs, and patient care.

5.2.3 Timely completion of site visits

5.2.3.1 Written correspondence from the AOA will notify both the site visitor and the program director of the agreed upon time/date established for the site visit. This correspondence will state the date by which the visit must be completed – 30 days before or after the AOA inspection due date. A copy of the correspondence also will be forwarded to the DME of the institution and to the OPTI.

5.2.3.2 If the site visit and training program review is not performed by the 120 day deadline because of a request for deferral by the program director, the ACOS staff will respond in writing notifying the program director that the RESC may take action to administratively withdraw the program's approval at the next scheduled RESC meeting. This correspondence will be copied to the DME and to the OPTI.

5.3. The completed inspection report is forwarded by the AOA to the evaluating committee of the specialty affiliate for review.

5.3.1. The evaluating committee of the specialty affiliate shall review and make a recommendation to the COPT for approval or denial of the program. The evaluating committee shall specify all reasons for recommendations for denial.

5.4. The COPT shall review the inspection report in concert with the recommendation from the specialty affiliate. The COPT shall recommend approval or denial of action.

5.4.1. An existing osteopathic postdoctoral program may be recommended for:

5.4.1.1. Approval with re-inspection within three (3) to five (5) years from the date of action of the COPT. This recommendation is to be used for programs which meet or AOA standards and have no major deficiencies noted in the inspection.

5.4.1.2. Approval with re-inspection within two (2) years from the date of action of the COPT. This recommendation is to be used for programs which have correctable deficiencies or document in a transition which may affect the quality of training, but require an early re-visit to evaluate the correction of deficiencies.

5.4.1.3. Approval with re-inspection within one (1) year from the date of action of the COPT. This recommendation is to be used for programs which are not in compliance with one or more major AOA or specialty affiliate standard, which must be corrected immediately.

Any existing osteopathic residency program recommended for re-inspection within one (1) year, ***may not*** contract with new or residents until such time as the program receives a recommendation of approval with re-inspection within two (2) or more years.

5.5. Withdrawal of approval for violation of standards will be made only after on-site inspection of the program.

5.5.1. Approval status of residency training may be recommended for withdrawal if the program or sponsoring institution:

5.5.1.1. Refuses to undergo an on-site inspection.

5.5.1.2. After a recommendation of "deferral" by the COPT or its Executive Committee, refuses to supply adequate documentation of corrective action within thirty (30) days of notification of deferral of approval.

5.5.1.3. Fails to follow directives associated with the approval system, or other directives from the AOA regarding the program.

5.5.2. The AOA or its specialty affiliate may recommend re-inspection of a program at any time. Reasons for such re-inspection include, but are not limited to, the following:

5.5.2.1. Change in program director.

5.5.2.2. Sale or other change in hospital administration.

5.5.2.3. Substantial change in patient base or volume.

5.5.3. An institution may voluntarily discontinue its residency program at any time. If a program closes, the AOA and the specialty affiliate will assist with re-assignment of existing residents.

5.6. Deferral of approval may be conferred for lack of sufficient information that precludes an informed and reasonable decision. When approval is deferred, the program retains its current status until a final decision is conferred at the next meeting.

5.7 Administrative withdrawal of program approval for non-compliance with AOA/ACOS standards and procedures

5.7.1 A program director of a currently AOA-approved program may be deemed to have withdrawn from the voluntary process of re-approval and the RESC may recommend that the COPT administratively withdraw the approval of the program if that director refuses to comply with the following:

5.7.1.1 To undergo a site visit of the program within the required time period;

5.7.1.2 To follow directives for remediation associated with a prior approval action;

5.7.1.3 To provide the RESC with requested information in atimely manner.

5.7.2 Administrative withdrawal of program approval for non-compliance with AOA/ACOS standards and procedures is an administrative action that is not subject to the appeals process.

5.8. The AOA Board of Trustees shall take final action on all continuing postdoctoral programs. Such action shall be based on the recommendation of the COPT and the specialty affiliate.

6. PROCEDURES FOR RESIDENT INCREASES IN ESTABLISHED PROGRAMS

6.1. Institutions seeking to increase the number of positions in a specific program may contact the AOA Division of Postdoctoral Education and request an application packet.

6.1.1. An application packet shall consist of:

6.1.1.1. A segregated total form for the specific specialty, for determining scope, volume and variety of patient load;

6.1.1.2. Affiliation agreements;

6.1.1.3 Letter of support from the OPTI officer or DME of the sponsoring institution.

6.1.1.4 The educational rationale for the increase.

6.1.1.5 A revised clinical rotation schedule for the clinical assignments.

6.1.1.6 An updated curriculum vitae for the program director.

6.2. If the requested increase is based on use of an affiliated site, the application must include the affiliation agreement, a listing of faculty at the affiliated site and their certification, and a clear statement regarding the proposed nature of the teaching and supervision to be done at the affiliated site.

6.2.1 Each application is forwarded to the evaluating committee of the specialty affiliate for review. The evaluating committee of the specialty affiliate shall then review and make a recommendation of approval, deferral or denial of the increase application.

6.3. The COPT shall review the application material in concert with the recommendation from the specialty affiliate. The COPT shall recommend approval, deferral of action, or denial.

6.3.1. Applications for increases in established residency programs that do not comply with AOA standards, shall be recommended for denial. Recommendations for denial shall be accompanied by a description of areas of non-compliance which are cross-referenced to the basic standard documents for that specialty.

6.3.2. Applications for increases in established residency programs that do not contain correct information or are deemed incomplete, shall have action deferred for a period of thirty days to allow the program to correct the application. Failure to do so will result in a recommendation for denial at the next meeting.

6.4. The AOA Board of Trustees shall take final action on all applications for increases in established residency programs. Such action shall be based on the recommendation of the COPT and the specialty affiliate.

6.4.1 The AOA application for the increase must be approved by the AOA COPT prior to programs accepting residents to fill those positions. Annually, the AOA will confirm the number of resident contracts does not exceed the number of approved positions. Under no circumstances will contracts be offered prior to approval of the additional position.

6.5. **Temporary Program Expansion**: A residency program may apply to the ACOS RESC for a temporary increase in residency positions. After review, the RESC may recommend to the AOA PTRC that the program be approved for a temporary increase in resident positions for one year. The resident for which the temporary increase was requested may not be accepted into the residency training program without written notification of the approval by the AOA of the temporary increase. Permanent retention of that temporary position will require the submission of a formal application for an increase in resident positions. The consideration of a formal application for an increase may require an on-site review of the program.

7. PROCEDURES FOR APPEAL

7.1. Any program that receives a recommendation of approval with re-inspection within one year, may request to have the recommendation reconsidered by the COPT.

7.1.1. To be considered for reconsideration an institution must submit a written request describing the basis for reconsideration, and must submit to the AOA Division of Postdoctoral Training documentation of the changes or discrepancies between reported deficiencies and fact. This request must be received within thirty (30) days of the date of the letter of notification.

7.1.2. Upon receipt of the written request, the Division shall forward this documentation to the appropriate specialty affiliate for immediate review and recommendation to the Executive Committee of the COPT.

7.1.3. A formal ballot shall be prepared for Executive Committee action within five (5) working days of receipt of the recommendation from the specialty affiliate. Material shall be forwarded to the Executive Committee for review and action.

7.1.4. All actions on reconsidered issues shall be reported to the full Council in the Secretary's Report and forwarded with recommendation to the Board of Trustees for their review and action.

7.2. An institution notified by the COPT secretary of a recommendation of denial may request an appeal to the Bureau of Professional Education within thirty (30) days of receipt of the certified letter of notification.

7.2.1. A request for an appeal shall be made in writing and must state the basis for the appeal.

7.2.2. If an appeal is granted, the Bureau of Professional Education shall schedule a hearing at its next meeting in accordance with its appeal protocol.

7.3 An AOA-approved institution which may experience negative effects by the establishment of a training program sponsored by an osteopathic institution in its patient service area, and has expressed this impact by letter to the COPT, and wishes to appeal the approval recommendation of the COPT for approval of a sponsored residency training program, may request such an appeal before the Bureau of Professional Education. The request for appeal must be filed within thirty (30) days of receipt of the COPT's letter and in accordance with the appeal protocol.

8. CONFIDENTIALITY OF THE APPROVAL PROCESS

8.1. The inspection report for a residency program is confidential between the COPT, the evaluating committee, and board of governors of the specialty affiliate. Premature and/or unauthorized disclosure of information reflecting official inspector recommendations is not permitted and will result in dismissal of the inspector from the site visit list.

8.2. The program director of each residency must make the inspection report available to the director of medical education, the faculty of the training program, and the program residents.

8.3. It is the obligation of the AOA Division of Postdoctoral Training to maintain confidentiality of the recommendations of the specialty affiliate concerning possible action on and/or status of individual programs.

9. COMMUNICATION PROCEDURES

9.1. The AOA must be notified, in writing, of any recommendations or actions of the ACOS which impact approved and/or proposed general surgery and surgery specialty residency programs and/or residents in these programs.

9.2. Program directors are required to submit reports in a timely manner.

9.3. The institution must respond to AOA requests for program information and submit all contracts and other required materials by established deadlines.

9.4. The institution must notify the AOA and the ACOS within thirty (30) days of any requested change in program director. Such notification must be in writing, from the appropriate administrator of the sponsoring institution, and be accompanied by the curriculum vitae of the new program director, verifying that the new program director is certified by the AOA in general surgery and otherwise meets the requirements of a program director in this specialty.

9.4.1. The RESC *will prior approve* all program director appointments for educational qualifications and may request additional documentation regarding the credentials of the new program director, and advise the institution of any apparent deficiencies in credentials. The specialty college may also direct that an immediate re-inspection be conducted of the program. (See Section IV, 5.5.2.1)

9.4.2. Results of site visits resulting from changes in program directors may receive expedited action by the ACOS RESC and/or the AOA PTRC.

9.5. Institutions shall immediately notify the AOA of any change in faculty of the surgical residency program.

9.6. Any decision for termination of a resident must be reported to the AOA and ACOS. Upon request, the institution shall provide supporting documentation regarding the termination and attempts at remediation.

9.7. The American Osteopathic Board of Surgery (AOBS) will be notified by the ACOS RESC of actions relating to individual residency training permitting the resident to take the written portion of the AOBS certification examination given each spring.

10. RESIDENT CONTRACT PROCEDURES

10.1. Resident contracts shall be executed between residents and osteopathic institutions approved for residency training. (*Refer to the AOA Accreditation Document for Osteopathic Postdoctoral Training Institutions and the Basic Document for Postdoctoral Training Programs.).*

10.2 Any contract violation shall be reported immediately to the AOA Division of Postdoctoral Training.

11. OTHER OPERATING PROCEDURES

11.1. **Leave policies:** Institutions should comply with each calendar year for sick leave, vacation and military leave. If additional maternity leave, sick leave, or other personal or professional leave is granted, the program must be extended to meet all time and rotation requirements of the program. A training year shall consist of a minimum of 48 weeks of documented training, irrespective of the length of the leave time.

11.2. **Advanced standing:** Residents may petition the AOA for advanced standing based on training in previous years. Such requests are granted only for 12-month periods, and are submitted through the AOA Division of Postdoctoral Training to the ACOS for recommendation to the COPT and AOA Board of Trustees. However, when considering advanced placement, the AOA and ACOS do not recognize allopathic OGME -1 training in general surgery as equivalent to the first year of an osteopathic residency training. Furthermore, residents who were required to repeat a training year cannot utilize the repeated year towards the fulfillment of their primary or secondary programs. The training program and resident position must be AOA-approved or ACGME-accredited prior to commencement of the resident's training. Documentation, which must be submitted for consideration of advanced standing, must include the following:

11.2.1. Evaluations and verification by the director of the previous program that the training was successfully completed;

11.2.2. A resident report, on the appropriate report form, documenting procedures performed;

11.2.3. A written description of the program, and a schedule of rotations completed; and

11.2.4. A scientific paper 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 paper shall be at least 1500 words, double spaced, paginated, with references required for all material derived from the work of others.

11.3. **Affiliations:** To be considered as part of the basic institutional program, any affiliation must meet the following guidelines:

11.3.1. Staff membership in participating institutions by the program director.

11.3.2. Actual participation by the resident and the program director on all educational committees and programs such as mortality review, quality review, tissue committee and journal club.

11.3.3. Under these circumstances, the institutional segregated totals from the affiliation/consortium may be used in the formula to determine the number of resident slots. Such affiliation/consortium must be formally documented and must be part of the program description to be inspected and approved by the AOA. Out-rotations for any other purpose do not qualify except for the specific experience, and the institution's statistics cannot be used in calculation of meeting program requirements.

11.4. **Outside rotations:** Outside rotations are permissible when included in the basic residency program as approved by the Council on Postdoctoral Training. The purpose of such rotations is for the enhancement of the basic program. The parent institution or organization is responsible for the outside rotations.

11.4.1. The resident shall remain under contract or agreement to the parent institution or organization throughout the outside rotation.

11.4.2. The resident's training log at the training site shall be included in the resident's log at the parent institution or organization.

11.4.3. Written evaluation of the resident's performance must be submitted by the onsite program director to the parent institution or organization.

11.4.4. The parent institution or organization may arrange for up to a total of six (6) consecutive months of training as an outside rotation to supplement the residency program. Such training must meet the approved requirements for that specialty. Outside rotations in excess of six (6) months must receive prior approval by the COPT.

11.4.5. The total number of outside rotations in a residency program shall be determined by the specialty affiliate and shall be a part of its basic requirements as approved by the AOA. In no case shall that maximum aggregate time in outside rotations be more than one half of the time of the program.

11.5. **Continuity of training**: To achieve approval/program completion by the ACOS RESC, a resident must spend the final two years of residency training in the same program. Resident transfers resulting from participation in a residency program that has been discontinued will be exempt from the continuity of training policy for the final two years of residency training.

11.6. **Residency Transfers:** Residents who transfer from one surgical training program to another surgical training program during an OGME training year will only be able to seek approval of their training after submission of the following documentation to the RESC: a copy of a mutual agreement to be released from the residency contract; a copy of a mutual agreement for acceptance into the new residency program; resident's surgical logs documenting scope, volume and variety from the former residency program and the new program; evaluations of the resident from the former program director and the new program director for the training completed in each program; and a written justification for the transfer. The combined training must be equivalent to and meet the same standards as an OGME year of training in a single program. ACOS files should include the documentation of this transfer.

11.7. **Research Sabbatical:** General surgery residents may participate in 12 months of research at the approval of the program director. The sabbatical year may be taken following an OGME 2 or OGME 3 general surgery training year. The research training year may not count towards the minimum number of years that must be AOA-approved for program completion nor may it conflict with the continuity of training policy that requires the last two years at the same training institution.

12. COMPONENTS OF THE ANNUAL RESIDENT REPORT

12.1 Annual resident reports are required for each training year and are reviewed by the RESC. Residents must submit an annual report within thirty (30) days of completion of each contract year. Residents not submitting their appropriate forms (Resident's Annual Evaluation Report of the Program Director, original research paper, segregated totals on AOA/ACOS form) within 60 days will be required to pay a late fee accrued annually before their training will be approved. The late fee applies to residents seeking AOA or ACGME training approval and is determined by the RESC and the ACOS Board of Governors. The annual resident report consists of the following documents:

12.1.1 ***Program Director's Annual Resident Evaluation Report for Surgery.*** This AOA/ACOS report form is completed by the program director. The program director must include a narrative progress report **on the resident's competency in each year of training. The narrative must summarize the resident's progress in achieving the core competencies and provide a description and an evaluation of the resident's scholarly activity**. Both the resident signature and the program director signature are required to document that the resident has been counseled concerning progress. Quarterly evaluations must be submitted with this annual report form if the promotion section of the form includes a recommendation from the program director that the training year not receive approval and/or that the resident not be advanced to the next level of training.

12.1.2 ***Resident's Annual Evaluation Report of the Program Director.*** This AOA/ACOS report form is completed by the resident and is held in strict confidence by the RESC. The RESC utilizes this form to evaluate the program director. ACOS staff notifies the RESC when a trend of negative evaluations develops for a particular residency program.

12.1.3 ***Resident's Annual Report for Surgery*** (segregated totals). This AOA/ACOS form is completed by the resident and signed by both the resident and the program director to verify that the information reported is accurate. This report form documents the resident's surgical experience for the residency year. There is a different report form for each surgical specialty reviewed by the RESC. Segregated totals must reflect adequate scope, volume, and variety of procedures as defined by the ACOS/AOA standards. Residents in General Surgery, Plastic and Reconstructive Surgery, Neurological Surgery, Urological Surgery, and General Vascular Surgery must utilize the ACOS electronic data collection/log system to document and submit log data for the annual resident report. (To be implemented July 1, 2004)

12.1.4 ***Original Scientific Research Paper.*** (Reference Section V, Appendix Three.)

12.2 Non-Member ACOS residents seeking approval of AOA or ACGME training are required to pay a non-member processing fee, as determined by the RESC and the ACOS Board of Governors, for each year of their training to be evaluated by the RESC.

SECTION V
APPENDICES

APPENDIX ONE
POSITION DESCRIPTION AND DUTIES OF THE DIRECTOR OF MEDICAL EDUCATION (DME)

The duties of the DME should include, but not be limited to:

Monitoring the quality of the residency program (s) to ensure that the program meets the standards of the AOA and of the sponsoring institution.

Providing programs with effective administrative and educational support services to include assistance with evaluations and program self-study.

Executing affiliation agreements for all educational assignments.

Assisting the program director (s) with resident recruitment, faculty development, and faculty recruitment.

Assisting the program director with the implementation of policies and procedures, such as, resident disciplinary actions, academic probation, or dismissal.

Ensuring that the AOA and ACOS reports are submitted by required deadlines and in accordance with ACOS procedures.

Ensuring, along with the sponsoring institution and the program director, retention of permanent resident records to include operative logs and resident evaluations in the office of the DME at the primary training institution.

Reviewing inspection reports of all surgery and specialty surgery programs.

Submittal of the annual departmental segregated totals for each AOA-approved surgical residency program to the ACOS/RESC: Directors of medical education must provide the ACOS Residency Evaluation and Standards Committee with annual departmental segregated totals for each AOA-approved surgical residency training program by July 31 of each year. These forms will be sent by the ACOS to directors of medical education each January. Completed forms shall reflect one year of surgical procedures performed at the institution for each surgical specialty. The calendar/academic year is to be determined by the institution. Departmental segregated totals must be submitted with the annual resident reports.

APPENDIX TWO
GUIDELINES FOR THE OSTEOPATHIC POSTDOCTORAL COMMITTEE

The recommended committee duties and responsibilities include, but are not limited to:

Coordinating the intern and residency educational programs.

Establishing and implementing policies affecting all surgical educational programs regarding educational quality and the resident work environment.

Adjudicating complaints and grievances of the residents and faculty.

Developing evaluation procedures.

APPENDIX THREE
GUIDELINES FOR THE RESIDENT SCIENTIFIC RESEARCH PAPER

3.1 General Surgery

The ACOS Residency Evaluation and Standards Committee (RESC) requires all residents to demonstrate the ability to synthesize and apply medical research data by writing an original scientific research paper. Through this process, the resident should improve cognitive skills, and learn to manage and communicate medical information.

This requirement is met by:

OGME 2 Submission of a literature review or a poster presentation or a scientific paper.

OGME 3 Submission of a case report or a poster presentation or a scientific paper.

OGME 4 Evidence of original research and data collection, and a progress report prepared in the format of a scientific paper by completion of OGME 4, approved by the program director, on an original research topic.

OGME 5 Additional evidence of original research and data collection, and completion and submission of an original research paper approved by the program director.

All documents listed above must be submitted with the resident's annual report to the ACOS RESC and should relate to general surgery. All documents must meet the criteria outlined in *The ACOS Trainer's Evaluation Format for the Resident Scientific Research Paper*.

3.2 Urological Surgery

The ACOS Residency Evaluation and Standards Committee (RESC) requires all residents to demonstrate the ability to synthesize and apply medical research data by writing an original scientific research paper. Through this process, the resident should improve cognitive skills, and learn to manage and communicate medical information.

If the resident begins the urological surgery residency in OGME 3, the requirement is met by:

OGME 3 Submission of a literature review or a poster presentation or a scientific paper.

OGME 4 Submission of a case report or a poster presentation or a scientific paper.

OGME 5 Evidence of original research and data collection, and a progress report prepared in the format of a scientific paper by completion of OGME 5, approved by the program director, on an original research topic.

OGME 6 Additional evidence of original research and data collection, and completion and submission of an original research paper approved by the program director.

If the resident begins the urological surgery residency in OGME 4, the requirement is met by:

OGME 4 Submission of a case report or a poster presentation or a scientific paper.

OGME 5 Evidence of original research and data collection, and a progress report prepared in the format of a scientific paper by completion of OGME 5, approved by the program director, on an original research topic.

OGME 6 Additional evidence of original research and data collection, and completion and submission of an original research paper approved by the program director.

All documents listed above must be submitted with the resident's annual report to the ACOS RESC and should relate to urological surgery. All documents must meet the criteria outlined in *The ACOS Trainer's Evaluation Format for the Resident Scientific Research Paper*.

3.3 General Vascular Surgery and Surgical Critical Care

The ACOS Residency Evaluation and Standards Committee (RESC) requires all residents to demonstrate the ability to synthesize and apply medical research data by writing an original scientific research paper. Through this process, the resident should improve cognitive skills, and learn to manage and communicate medical information.

After completing the OGME 5 program in general surgery, the program director will require one of the following to be submitted to the ACOS RESC for the OGME 6 year:

- Technique description
- Essay suitable for publication in a referenced journal
- Symposium presentation
- Poster presentation
- Original research project
  - Retrospective study
  - Prospective study

The document(s) must be submitted with the resident's annual report to the ACOS RESC and should relate to the resident's specialty (general vascular surgery or surgical critical care, respectively). The document(s) submitted for approval must meet the criteria outlined in *The ACOS Trainer's Evaluation Format for the Resident Scientific Research Paper*.

3.4 Plastic and Reconstructive Surgery

The ACOS Residency Evaluation and Standards Committee (RESC) requires all residents to demonstrate the ability to synthesize and apply medical research data by writing an original scientific research paper. Through this process, the resident should improve cognitive skills and learn to manage and communicate medical information.

The program director will require one of the following to be submitted to the ACOS RESC for each plastic and reconstructive surgery residency training year:

- Technique description
- Essay suitable for publication in a referenced journal
- Symposium presentation
- Poster presentation
- Original research project
  - Retrospective study

- Prospective study

All documents listed above must be submitted with the resident's annual report to the ACOS RESC and should relate to plastic and reconstructive surgery. Documents must meet the criteria outlined in *The ACOS Trainer's Evaluation Format for the Resident Scientific Research Paper.*

3.5 Cardiothoracic Surgery

The ACOS Residency Evaluation and Standards Committee (RESC) requires all residents to demonstrate the ability to synthesize and apply medical research data by writing an original scientific research paper. Through this process, the resident should improve cognitive skills and learn to manage and communicate medical information.

The program director will require one of the following to be submitted to the ACOS RESC for each cardiothoracic surgery residency training year:

- Technique description
- Essay suitable for publication in a referenced journal
- Symposium presentation
- Poster presentation
- Original research project
  - Retrospective study
  - Prospective study

All documents listed above must be submitted with the resident's annual report to the ACOS RESC and should relate to cardiothoracic surgery. Documents must meet the criteria outlined in *The ACOS Trainer's Evaluation Format for the Resident Scientific Research Paper.*

3.6 Neurological Surgery

The ACOS Residency Evaluation and Standards Committee (RESC) requires all residents to demonstrate the ability to synthesize and apply medical research data by writing an original scientific research paper. Through this process, the resident should improve cognitive skills, and learn to manage and communicate medical information.

This requirement is met by:

OGME 2 Submission of a literature review or a poster presentation or a scientific paper.

OGME 3 Submission of a literature review or a poster presentation or a scientific paper.

OGME 4 Submission of a case report or a poster presentation or a scientific paper.

OGME 5 Evidence of original research and data collection, and a progress report prepared in the format of a scientific paper by completion of OGME 4, approved by the program director, on an original research topic.

OGME 6 Additional evidence of original research and data collection, and completion and submission of an original research paper approved by the program director.

All documents listed above must be submitted with the resident's annual report to the ACOS RESC and should relate to neurological surgery. All documents must meet the criteria outlined in *The ACOS Trainer's Evaluation Format for the Resident Scientific Research Paper.*

APPENDIX FOUR
COMPETENCIES FOR OSTEOPATHIC MEDICINE

The residency program must require and document that its residents develop the competencies in the seven areas below to the level expected of a new surgeon beginning practice after completion of training. Toward this end, programs must define the specific knowledge, skill, and attitudes required and provide educational experiences as needed for residents to demonstrate the competencies.

1) <u>Osteopathic Principles and Practices (OPP)</u>

Residents should be able to demonstrate competency in the understanding and application of osteopathic principles and practices (OPP) appropriate to the care of surgical patients.
Residents are expected to:

- Recognize and treat each patient as a whole person integrating body, mind, and spirit; and,
- Use the relationship between structure and function to help the body move toward wellness.

<u>Suggested Methodologies to Achieve Compliance</u>

- Encourage opportunities for active participation of surgical residents in clinical rounds with OPP practitioners at training sites.
- Teach residents to perform a critical appraisal of medical literature related to OPP.
- Encourage computer hosted educational modules.
- Encourage opportunities for residents to participate in OPP continuing medical education programs.

<u>Suggested Methods for Evaluation</u>

- Encourage performance of OPP with patients.
- Observation of application of Osteopathic Principles.
- Written examinations to demonstrate knowledge.

2) <u>Patient Care</u>

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
Residents are expected to:

- Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families;
- Gather essential and accurate information about their patients;
- Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment;
- Develop and carry out patient management plans;
- Counsel and educate patients and their families;
- Use information technology to support patient care decisions and patient education;
- Competently perform all medical and invasive procedures considered essential for the area of practice surgical specialty;

2) <u>Patient Care (Cont'd)</u>

- Provide healthcare services aimed at preventing health problems or maintaining health; and,
- Work with healthcare professionals, including those from other disciplines, to provide patient-focused care.

3) Medical Knowledge

Suggested Methodologies to Achieve Compliance

- Provide a formal didactic program.
- Design opportunity to provide education for critical appraisal of literature.
- Provide for resident participation in continuing medical education courses.
- Provide for resident participation in clinical activities (Patient Care) of the surgery department.
- Simulations and models.

Suggested Methods for Evaluation

- Simulations and models.
- Monthly service rotation evaluations.
- Evaluations completed by faculty.
- Written examinations – i.e., ACOS General Surgery In-Service examination.

Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Residents are expected to:

- demonstrate an investigator and analytic thinking approach to clinical situations; and,
- know and apply the basic and clinically supportive sciences which are appropriate to their discipline.

4) Practice-Based Learning and Improvement

Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents are expected to:

- analyze practice experience and perform practice-based improvement activities using a systematic methodology;
- locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;
- obtain and use information about their own population of patients and the larger population from which their patients are drawn;
- apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness;
- use information technology to manage information, access on-line medical information, and support their own education; and,
- facilitate the learning of students and other healthcare professionals.

5) Interpersonal and Communication Skills

Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates. Residents are expected to:

- create and sustain a therapeutic and ethically sound relationship with patients;
- use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills; and,
- work effectively with others as a member or leader of a healthcare team or other professional group.

6) Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to:

- demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supercedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development;
- demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices; and,
- demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities.

7) Systems-Based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. Residents are expected to:

- Understand how their patient care and other professional practices affect other healthcare professionals, the healthcare organization, and the larger society and how these elements of the system affect their own practice;
- know how types of medical practice and delivery systems differ from one another; including methods of controlling healthcare costs and allocating resources;
- practice cost-effective healthcare and resource allocation that does not compromise quality of care;
- advocate for quality patient care and assist patients in dealing with system complexities; and,
- know how to partner with healthcare managers and healthcare providers to assess, coordinate, and improve healthcare and know how these activities can affect system performance.

APPENDIX FIVE
OGME-1R (FIRST YEAR RESIDENCY) REQUIREMENTS – GENERAL SURGERY, NEUROLOGICAL SURGERY AND UROLOGICAL SURGERY

First-Year Rotation in General Surgery (OGME-1R)

The following **rotations are required for OGME-1R** in general surgery, **neurological surgery, and urological surgery**:

1. **Rotations for** ½ day for 46 weeks of **a primary care outpatient clinic** in an out-patient clinic or office
2. Two months of general internal medicine
3. One month of ICU
4. One month of emergency medicine
5. One month of **female reproductive medicine**
6. One month of pediatrics, **if available, or another primary care specialty at the discretion of the training institution**
7. Four months of general surgery
8. Two months of electives to include any of the following areas:
   a. Urology
   b. Orthopedics
   c. Anesthesia
   d. ENT
   e. General Surgery
   f. Vascular Surgery
   g. Neurosurgery
   h. **Cardiovascular Thoracic** Surgery
   i. Plastic and Reconstructive Surgery
   j. **Radiology**

APPENDIX SIX
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 cases 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 that 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.

SECTION VI
ACOS GLOSSARY and ACRONYMS

GLOSSARY

Affiliation: An approved healthcare facility that provides a required educational experience for resident training. An institutional agreement is required for all affiliations.

Affiliated Training Site: The hospital or other medical facility providing clinical experiences in a residency program.

Approved-Program/Institution: The program has been approved by the AOA (includes primary training institution and affiliations).

Board eligibility: A physician who has successfully completed an AOA-approved osteopathic educational program and who has been found eligible for the AOA certification process, as a time-limited designation.

Chief resident: A resident who is in the final year of training and who has been assigned senior responsibility/ies.

Compliance: A term that connotes a program that has demonstrated conformance with published standards in the AOA/ACOS basic standards. (The opposite term is non-compliant.)

Curriculum: The sum total of learning activities for a subject or discipline which should include the cognitive, psychomotor, and affective components; recommended learning activities for the student; goals and objectives; measurement parameters; and recommended educational resources.

Desirable, highly desirable, encourage/d: Terminology used to describe aspects of a training program that may be suggested or recommended, but are not mandatory for program approval.

Effective: An educational term used to describe those elements of a training program that are meaningful and achieve educational purpose(s), e.g., effective curriculum, effective teaching, and effective evaluation.

Faculty: Physicians and other healthcare professionals who provide didactic or clinical education for resident training.

Program Director: The certified osteopathic physician who is responsible for the administration of a residency program.

Full time: A term used to describe the totality of faculty commitment to resident training and educational activities.

Must, shall or essential: Approval terms used to describe a standard or criterion that is mandatory or required.

Osteopathic institution: A college of osteopathic medicine or an osteopathic hospital.

Primary training institution: The primary clinical training site responsible for, and providing the majority of, required clinical experience for an approved training program.

Should: An approval term used to describe a standard or criterion that is so important that its absence must be justified by a program. The use of this term provides programs with the opportunity to develop alternative methods to demonstrate compliance with the referenced standard. It should not be interpreted as permissive.

Sponsoring institution: The legal entity responsible for the support and conduct of training programs, i.e.,

generally defined as a College of Osteopathic Medicine, an AOA-approved hospital, or a consortium of healthcare facilities.

Sufficient or adequate: A term which connotes that an approval standard or criterion meets compliance as judged by their peers, e.g., sufficient operative experience.

ACRONYMS

AOA	American Osteopathic Association
AOBS	American Osteopathic Board of Surgery
ACOS	American College of Osteopathic Surgeons (ACOS), the AOA's specialty affiliate for surgical training
ABS	American Board of Surgery
Board	Board of Trustees of the AOA
BPE	Bureau of Professional Education of the AOA
COPT	Council on Postdoctoral Training
Division	Division of Postdoctoral Training
DME	Director of Medical Education
PTRC	Program and Trainee Review Council
OPTI	Osteopathic Postdoctoral Training Institution
RESC	Residency Evaluation and Standards Committee