Rural and Private Practice Otolaryngology Residency Training Opportunities

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Take-home message: **Most otolaryngology residents train almost exclusively in academic, metropolitan settings; only 5.3% of programs offered rural rotations and 33.3% offered private practice rotations.**

Background & Objective

Rural communities face persistent specialty-care shortages and otolaryngology access gaps. Residency exposure is a modifiable factor that may shape future practice location, preparedness for nonacademic careers, and comfort serving underserved populations.

Objective **Assess the availability of rural and private practice training opportunities among U.S. ACGME-accredited otolaryngology residency programs.**

Methods

- Cross-sectional survey of all 132 ACGME-accredited otolaryngology residency programs.
- Four-question survey distributed to program coordinators/directors; nonresponders assessed via official websites and FREIDA.
- Rural opportunity defined by rural rotation reporting, FREIDA rural track, or rural program location using RUCA codes.
- Private practice opportunity defined as non-health-system-owned practice exposure listed or reported by the program.
- Resident totals were obtained from public sources as of June 2025.

Study Cohort

132	93	1,929
ACGME-accredited programs	survey responses (70.5%)	residents in June 2025

Program setting: 73% university-based; 16.9% community–university affiliated; 5.4% community-based; 4.6% military-based.

Definitions

- Rural designation: RUCA ZIP approximation codes 4.0–10.6, excluding commuting metropolitan-associated codes.
- Rural rotation: self-reported program rotation in a city with ≤50,000 people.
- Private practice rotation: rotation in a practice not owned by a health system.

Rural Rotation Programs

Program	State	Mand.	Weeks
NYU Grossman	NY	No	12
UIC	IL	No	2
Mount Sinai / NYEE	NY	No	12
Kaiser NorCal	CA	No	4
PCOM	PA	No	8
Nebraska	NE	Yes	16
Louisville	KY	No	4
UTMB*	TX	Yes	All
St. Elizabeth Boardman†	OH	unk	unk

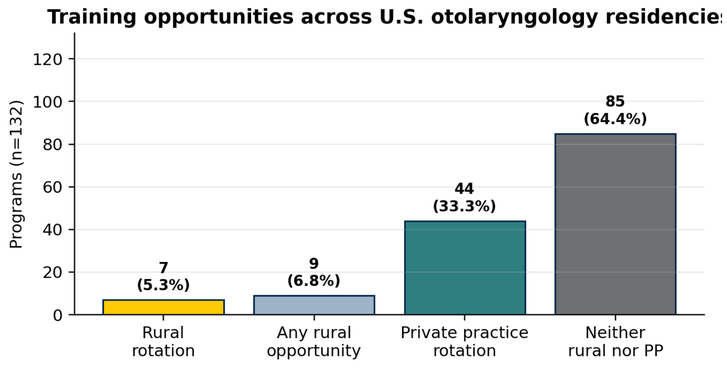
*Rural location by RUCA. †FREIDA rural-track designation; website did not confirm formal rotation. unk = unknown.

Key Results

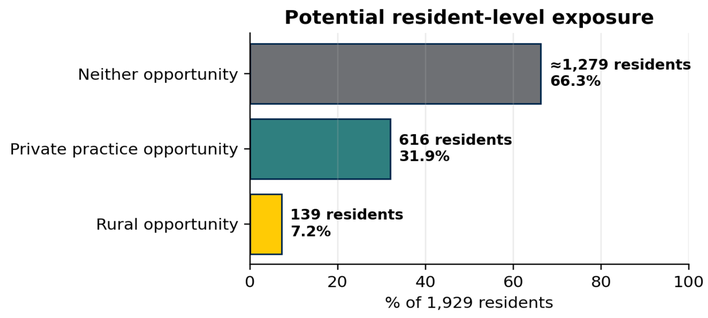
7/132	9/132	44/132
programs offered a rural rotation (5.3%)	programs had any rural opportunity (7.2% of residents)	programs offered private practice rotation (33.3%)

64.4% of programs and 66.3% of residents had neither rural nor private practice training exposure.

Program-Level Availability



Resident-Level Exposure



Private Practice Rotation Characteristics

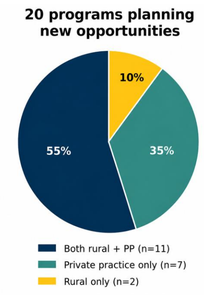
- 44 programs (33.3%) reported or listed private practice rotations.
- 616 residents (31.9%) were enrolled in programs with potential private practice exposure.
- About half were mandatory: 23/44 rotations (52.3%).
- Median rotation duration was 8 weeks; five programs reported continuous exposure across all 5 years.

Interpretation There is a mismatch between training environments and the workforce: most otolaryngologists ultimately practice outside traditional academic centers, while most residency programs remain university-based.

Why This Matters

- Rural and underserved communities have fewer specialists and greater barriers to head and neck, otologic, laryngology, pediatric, and general ENT care.
- Exposure to rural and private practice settings may build autonomy, practice-management skills, and comfort with nonacademic care delivery models.
- Academic centers may see rural patients, but that does not reproduce the operational constraints and access barriers of rural practice.

Future Directions Reported by Programs



- 20 programs without current opportunities reported plans to develop rural and/or private practice experiences.
- Potential models include rural track partnerships, community faculty exchange, structured private practice operations curricula, telemedicine, and outreach clinics.

Limitations

- Survey responses may be subject to reporting bias.
- Website review likely underestimates informal or developing rotations.
- Cross-sectional design captures a single moment in a changing training landscape.
- Rotation quality, resident competency, and eventual practice location were not assessed.

Conclusions

Rural and private practice training opportunities remain limited in otolaryngology residency. Only a small fraction of programs provide rural rotations, and one-third include private practice experiences. Expanding structured exposure, mentorship, and practice-management curricula may better prepare future otolaryngologists for diverse career paths and underserved care delivery.

Actionable Implementation Ideas

- Create 2–12 week elective rural rotations with defined case-log and competency goals.
- Pair private practice rotations with billing, staffing, ambulatory operations, and ancillary-service didactics.
- Track outcomes: resident confidence, career intent, practice location, access metrics, and community benefit.

Proposed Academy-Level Implementation Framework

A practical pathway for expanding nonacademic exposure without requiring every program to build a full rural track.

1. Map opportunities

Start with what already exists

- Inventory rural, community, private practice, outreach, and telehealth sites.
- Identify interested community faculty and define supervision expectations.
- Use standardized language for rural and private practice exposure.

2. Build rotations

Keep pilots small and measurable

- Begin with 2–4 week electives or longitudinal clinic days.
- Use focused goals: autonomy, access barriers, procedural breadth, referral patterns.
- Create shared templates for affiliation agreements and resident evaluation.

3. Teach practice operations

Prepare residents for real-world systems

- Add didactics on billing, coding, staffing, ambulatory flow, call models, and ancillaries.
- Pair private practice exposure with reflection and faculty debriefs.
- Include rural access, telemedicine, and policy topics in didactic curricula.

4. Measure impact

Move beyond availability counts

- Track resident confidence, career intent, and practice location after graduation.
- Measure case mix, continuity, autonomy, and community benefit.
- Study whether exposure improves access to otolaryngology care.

Potential Program Models

- Rural elective: short, competency-based rotation with a community preceptor.
- Private practice block: ambulatory surgery, clinic workflow, business operations, and community call.
- Hybrid track: repeated rural/community exposure across PGY years.
- Outreach + telemedicine: academic-specialty support linked to a community site.

These models may be easier to implement than full rural tracks and can be scaled by program size and geography.

Future Research Questions

- What rotation features meaningfully change resident confidence or career plans?
- Do rural/private rotations increase procedural autonomy or breadth of general otolaryngology exposure?
- Which partnerships are sustainable for community faculty and residency programs?
- Can structured exposure improve workforce distribution or patient access?

Policy implication: professional societies and accrediting bodies can accelerate adoption through recognition, shared curricula, pilot grants, and implementation toolkits.

Selected References

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