Accreditation Council for
Graduate Medical Education

ACGME Program Requirements for Graduate Medical Education in Colon and Rectal Surgery

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Common Program Requirements are in BOLD

Introduction

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

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

Int.B. Colon and rectal surgery is the specialty that focuses on the medical, surgical, endoscopic and perioperative management of disorders involving the colon, rectum and anus, and related problems of the abdomen, pelvis and perineum.

Int.C. The educational program in colon and rectal surgery must be 12 months in length. (Core)*

I. Institutions

I.A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating sites. (Core)

The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program. (Core)

I.A.1. The sponsoring institution must provide at least 10% protected time to the

program director for administrative, non-teaching duties related to the program. (Detail)

I.A.2. Salary support for the program director's administrative time must be provided by the sponsoring institution, foundation or practice, depending on the institutional setting. (Core)

I.A.3. The program director must not be required to generate clinical or other income to provide this administrative support. (Detail)

I.B. Participating Sites

I.B.1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years. (Core)

The PLA should:

I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for residents; (Detail)

I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document; (Detail)

I.B.1.c) specify the duration and content of the educational experience; and, (Detail)

I.B.1.d) state the policies and procedures that will govern resident education during the assignment. (Detail)

I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS). (Core)

II. Program Personnel and Resources

II.A. Program Director

II.A.1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. (Core)

II.A.1.a) The program director must submit this change to the ACGME via the ADS. (Core)

II.A.2. The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability. (Detail)

II.A.3. **Qualifications of the program director must include:**

II.A.3.a) **requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;** (Core)

II.A.3.b) **current certification in the specialty by the American Board of** Colon and Rectal Surgery (ABCRS)**, or specialty qualifications that are acceptable to the Review Committee;** (Core)

II.A.3.c) **current medical licensure and appropriate medical staff appointment;** (Core)

II.A.3.c).(1) This must include membership on the medical staff of either the sponsoring institution or a participating site.(Core)

II.A.3.d) at least three years of clinical practice in colon and rectal surgery; and, (Core)

II.A.3.e) at least three years of prior experience as a faculty member in either an ACGME-accredited general surgery or colon and rectal surgery program. (Core)

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

The program director must:

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

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

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

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

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

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

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

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

accurate and complete. (Core)

II.A.4.h) **ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;** (Detail)

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

II.A.4.j) **implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting,** (Core)

and, to that end, must:

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

II.A.4.j).(2) **monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;** (Core)

II.A.4.j).(3) **adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,** (Detail)

II.A.4.j).(4) **if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.** (Detail)

II.A.4.k) **monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;** (Detail)

II.A.4.l) **comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;** (Detail)

II.A.4.m) **be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;** (Detail)

II.A.4.n) **obtain review and approval of the sponsoring institution's GMEC/DIO before submitting information or requests to the ACGME, including:** (Core)

II.A.4.n).(1) **all applications for ACGME accreditation of new programs;** (Detail)

II.A.4.n).(2) **changes in resident complement;** (Detail)

II.A.4.n).(3) **major changes in program structure or length of training;** (Detail)

II.A.4.n).(4) **progress reports requested by the Review Committee;** (Detail)

II.A.4.n).(5) **requests for increases or any change to resident duty hours;** (Detail)

II.A.4.n).(6) **voluntary withdrawals of ACGME-accredited programs;** (Detail)

II.A.4.n).(7) **requests for appeal of an adverse action; and,** (Detail)

II.A.4.n).(8) **appeal presentations to a Board of Appeal or the ACGME.** (Detail)

II.A.4.o) **obtain DIO review and co-signature on all program application forms, as well as any correspondence or document submitted to the ACGME that addresses:** (Detail)

II.A.4.o).(1) **program citations, and/or,** (Detail)

II.A.4.o).(2) **request for changes in the program that would have significant impact, including financial, on the program or institution.** (Detail)

II.A.4.p) implement a policy that clearly defines the lines of authority between the program residents, other learners, the program faculty, other faculty, and the administration. This policy must be distributed to all residents, learners, and faculty members; (Detail)

II.A.4.q) ensure that a current, well-organized, written plan for rotation of residents among the various services and participating sites involved is maintained, is available to the residents and faculty, and is reviewed and updated at least annually; (Detail)

II.A.4.r) monitor resident stress, including mental or emotional conditions inhibiting performance or learning, and drug- or alcohol-related dysfunction; and, (Detail)

II.A.4.r).(1) Both the program director and the faculty should be sensitive to the need for timely provision of confidential counseling and psychological support services to residents. (Detail)

II.A.4.r).(2) Situations that demand excessive service or that consistently produce undesirable stress on residents must

be evaluated and modified. (Detail)

II.A.4.s) dedicate at least 10% of his or her time to directing the program, in addition to teaching. (Detail)

II.B. Faculty

II.B.1. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location. (Core)

The faculty must:

II.B.1.a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents; and, (Core)

II.B.1.b) administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas. (Core)

II.B.1.b).(1) The physician faculty must maintain professional standards of clinical excellence and ethical behavior. (Core)

II.B.2. The physician faculty must have current certification in the specialty by the American Board of Colon and Rectal Surgery**, or possess qualifications judged acceptable to the Review Committee.** (Core)

II.B.3. The physician faculty must possess current medical licensure and appropriate medical staff appointment. (Core)

II.B.4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)

II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component. (Core)

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

II.B.5.b) Some members of the faculty should also demonstrate scholarship by one or more of the following:

II.B.5.b).(1) peer-reviewed funding; (Detail)

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

II.B.5.b).(3) publication or presentation of case reports or clinical series at local, regional, or national professional and

scientific society meetings; or, (Detail)

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

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

II.B.5.d) At least one faculty member must be actively involved in regional or national specialty societies. (Core)

II.B.5.e) At least one faculty member must be regularly active in scholarly inquiry. Research performed by a resident must not substitute for active faculty involvement. (Core)

II.B.6. There must be a minimum of three FTE ABCRS-certified faculty members active in the program, including the program director. (Core)

II.C. Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program. (Core)

II.C.1. The program must have a program coordinator with at least 10% of his or her time dedicated to the program. (Core)

II.C.1.a) Programs with more than one resident per year should provide an additional 5% of program coordinator time per additional resident. Therefore, if there is one resident per year, at least 10% of the program coordinator's time must be dedicated to the program. If there are two residents per year, at least 15% of the program coordinator's time must be dedicated to the program. If there are three residents per year, at least 20% of the program coordinator's time must be dedicated to the program. If there are four residents per year, at least 25% of the program coordinator's time must be dedicated to the program. If there are five residents per year, at least 30% of the program coordinator's time must be dedicated to the program. (Detail)

II.D. Resources

The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements. (Core)

II.D.1. The program must provide the volume and variety of colon and rectal patients and surgery necessary for residents to perform the required minimum case numbers and achieve all required outcomes. (Core)

II.D.2. Residents must be provided with office workspace and computer

hardware, software, support, Internet access, reference assistance, and statistical support. (Detail)

II.D.3. Residents must be provided with reliable systems for prompt communication with supervising faculty. (Core)

II.E. Medical Information Access

Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available. (Detail)

II.E.1. The major online, full-text journals relevant to the specialty for education and patient care must be conveniently available to residents at all participating sites. (Detail)

III. Resident Appointments

III.A. Eligibility Criteria

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

III.A.1. Eligibility Requirements – Residency Programs

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

III.A.1.a).(1) Prior to appointment in the program, residents must:

III.A.1.a).(1).(a) have successfully completed an ACGME- or Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited residency program in surgery of not less than five years of progressive education; and, (Core)

III.A.1.a).(1).(b) be certified by the American Board of Surgery (ABS) or have completed the educational requirements to sit for the ABS qualifying examinations. (Core)

III.A.1.a).(2) Prior to appointment in the program, residents should have

demonstrated a satisfactory level of clinical maturity, technical skills, and surgical judgment which will enable them to begin a residency in colon and rectal surgery for the purpose of specializing in this field of surgery. (Core)

III.A.1.b) **A physician who has completed a residency program that was not accredited by ACGME, RCPSC, or CFPC may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director at the ACGME-accredited program may be advanced to the PGY-2 level based on ACGME Milestones assessments at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry.** (Core)

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

III.A.1.c).(1) **The Review Committee for** Colon and Rectal Surgery **does not allow exceptions to the Eligibility Requirements. (Core)**

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

III.A.2. **Eligibility Requirements – Fellowship Programs**

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

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

III.A.2.b) **Fellow Eligibility Exception**

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

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

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

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

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

III.A.2.b).(4) **For an international graduate, verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification; and,** (Core)

III.A.2.b).(5) **Applicants accepted by this exception must complete fellowship Milestones evaluation (for the purposes of establishment of baseline performance by the Clinical Competency Committee), conducted by the receiving fellowship program within six weeks of matriculation. This evaluation may be waived for an applicant who has completed an ACGME International-accredited residency based on the applicant's Milestones evaluation conducted at the conclusion of the residency program.** (Core)

III.A.2.b).(5).(a) **If the trainee does not meet the expected level of Milestones competency following entry into the fellowship program, the trainee must undergo a period of remediation, overseen by the Clinical Competency Committee and monitored by the GMEC or a subcommittee of the GMEC. This period of remediation must not count toward time in fellowship training.** (Core)

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

III.B. Number of Residents

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

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

III.C. **Resident Transfers**

III.C.1. **Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident.** (Detail)

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

III.D. **Appointment of Fellows and Other Learners**

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' education. (Core)

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

IV. Educational Program

IV.A. **The curriculum must contain the following educational components:**

IV.A.1. **Overall educational goals for the program, which the program must make available to residents and faculty;** (Core)

IV.A.1.a) A comprehensive written curriculum covering all defined components of colon and rectal surgery must be used by the program as a guide for resident education. (Detail)

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

IV.A.2.a) Prior to the beginning of each rotation, each resident must review with the appropriate faculty the educational goals and objectives of that rotation. (Detail)

IV.A.2.b) As part of the evaluation of the resident, the faculty, the rotation, and the program, each resident must again review the educational goals and objectives for that rotation with the appropriate faculty at the end of the rotation to assess the degree to which they were attained. (Detail)

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

IV.A.3.a) There must be a structured, program-long series of didactic sessions with the residents and faculty that follows the written curriculum. These sessions must occur at least weekly. (Core)

IV.A.3.b) Regular colon and rectal conferences must be coordinated among program sites to allow attendance by a majority of faculty members and residents. (Detail)

IV.A.3.b).(1) A conference attendance record for both residents and faculty members must be maintained. (Detail)

IV.A.3.b).(2) Residents must attend a minimum of 70% of all conferences, excluding excused time away for meetings, vacation and illness. (Detail)

IV.A.3.c) Regular conferences must include:

IV.A.3.c).(1) morbidity and mortality conferences, held at least monthly, at which all complications occurring on the colon and rectal service(s) are presented for peer-review and follow-up; and, (Detail)

IV.A.3.c).(1).(a) Cases must be presented by the colon and rectal surgery resident(s). The involved faculty members must be present and other colon and rectal surgery faculty members should participate. (Detail)

IV.A.3.c).(2) a journal club conference, held at least quarterly, during which important articles from the current and past literature are presented by the resident(s) and any other learners on the service, and are discussed for content and study design. (Detail)

IV.A.3.d) Related pathology and radiology studies should be presented during these conferences. (Detail)

IV.A.3.e) Formal clinical teaching rounds with the responsible faculty must be conducted on each rotation on at least a weekly basis. (Detail)

IV.A.4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and, (Core)

IV.A.5. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum: (Core)

IV.A.5.a) Patient Care and Procedural Skills

IV.A.5.a).(1) Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. (Outcome)

IV.A.5.a).(2) Residents must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. Residents: (Outcome)

IV.A.5.a).(2).(a) must demonstrate proficiency in the evaluation and management of patients with all of the essential colon and rectal surgical disorders. (Outcome)

IV.A.5.a).(2).(a).(i) Proficiency in evaluation and management must include:

IV.A.5.a).(2).(a).(i).(a) pre-operative diagnosis, indications, alternatives, risks and preparation for operation; (Outcome)

IV.A.5.a).(2).(a).(i).(b) assessment of patient risk, nutritional status, co-morbidities, and need for pre-operative treatment and peri-operative prophylaxis; (Outcome)

IV.A.5.a).(2).(a).(i).(c) appropriate non-operative management; (Outcome)

IV.A.5.a).(2).(a).(i).(d) operative management, including all technical aspects, intra-operative decision-making, avoidance and management of intra-operative complications, and management of unexpected findings; and, (Outcome)

IV.A.5.a).(2).(a).(i).(e) post-operative management, including recognition and treatment of complications; and, appropriate follow-up and additional treatment. (Outcome)

IV.A.5.a).(2).(a).(ii) The essential colon and rectal surgery disorders must include:

IV.A.5.a).(2).(a).(ii).(a) abdominal and pelvic disorders, including: (Outcome)

IV.A.5.a).(2).(a).(ii).(a).(i) carcinoma of the colon, rectum, and anus; (Outcome)

IV.A.5.a).(2).(a).(ii).(a).(ii) colorectal infectious diseases, including sexually transmitted diseases (STDs) and other colidities, including clostridium difficile and HIV-related infection; (Outcome)

IV.A.5.a).(2).(a).(ii).(a).(iii) diverticular disease; (Outcome)

IV.A.5.a).(2).(a).(ii).(a).(iv) gastrointestinal obstruction, including those due to adhesions, malignancy, volvulus, hernias and pseudo obstruction; (Outcome)

IV.A.5.a).(2).(a).(ii).(a).(v) inflammatory bowel disease, including Crohn's disease and ulcerative colitis; (Outcome)

IV.A.5.a).(2).(a).(ii).(a).(vi) inherited colorectal disorders, including familial polyposis, hereditary cancer syndromes; other inherited polyposis syndromes and related genetic disorders; (Outcome)

IV.A.5.a).(2).(a).(ii).(a).(vii) lower gastrointestinal hemorrhage; (Outcome)

IV.A.5.a).(2).(a).(ii).(a).(viii) other neoplastic processes, including GIST tumors, lymphoma, carcinoid, desmoids, small bowel and mesenteric tumors; and, (Outcome)

IV.A.5.a).(2).(a).(ii).(a).(ix) radiation enteritis and the effects of ionizing radiation. (Outcome)

IV.A.5.a).(2).(a).(ii).(b) anorectal and perineal disorders, including: (Outcome)

IV.A.5.a).(2).(a).(ii).(b).(i) anal fissure; (Outcome)

IV.A.5.a).(2).(a).(ii).(b).(ii) anorectal stenosis; (Outcome)

IV.A.5.a).(2).(a).(ii).(b).(iii) fistulas, anorectal and rectovaginal; (Outcome)

IV.A.5.a).(2).(a).(ii).(b).(iv) hemorrhoids; (Outcome)

IV.A.5.a).(2).(a).(ii).(b).(v) hidradenitis; (Outcome)

IV.A.5.a).(2).(a).(ii).(b).(vi) meningocele, chordoma, and teratoma; (Outcome)

IV.A.5.a).(2).(a).(ii).(b).(vii) necrotizing fasciitis; (Outcome)

IV.A.5.a).(2).(a).(ii).(b).(viii) pilonidal disease; (Outcome)

IV.A.5.a).(2).(a).(ii).(b).(ix) presacral/retrorectal lesions including cysts; and (Outcome)

IV.A.5.a).(2).(a).(ii).(b).(x) pruritus ani. (Outcome)

IV.A.5.a).(2).(a).(ii).(c) pelvic floor disorders, including: (Outcome)

IV.A.5.a).(2).(a).(ii).(c).(i) constipation, including clinical and physiological evaluation, dysmotility, anismus and other forms of pelvic outlet obstruction; (Outcome)

IV.A.5.a).(2).(a).(ii).(c).(ii) fecal incontinence; and, (Outcome)

IV.A.5.a).(2).(a).(ii).(c).(iii) rectal and pelvic prolapse, rectocele, and solitary rectal ulcer syndrome. (Outcome)

IV.A.5.a).(2).(b) must demonstrate a high level of skill and dexterity in the performance of all essential colon and rectal surgical procedures. The essential procedures include: (Outcome)

IV.A.5.a).(2).(b).(i) abdominal procedures, including: (Outcome)

IV.A.5.a).(2).(b).(i).(a) abdominoperineal resection and total proctocolectomy; (Outcome)

IV.A.5.a).(2).(b).(i).(b) creation of stomas and surgical

	management of stoma complications; (Outcome)
IV.A.5.a).(2).(b).(i).(c)	ileal pouch-anal anastomosis; (Outcome)
IV.A.5.a).(2).(b).(i).(d)	laparoscopic abdominal and gastrointestinal surgery, including colon and rectal resections, ostomy construction and prolapse repair; (Outcome)
IV.A.5.a).(2).(b).(i).(e)	low anterior resection with colorectal and coloanal anastomosis; (Outcome)
IV.A.5.a).(2).(b).(i).(f)	procedures for rectal prolapse; (Outcome)
IV.A.5.a).(2).(b).(i).(g)	segmental colectomy, including ileocolic resection and colon resection; (Outcome)
IV.A.5.a).(2).(b).(i).(h)	small bowel resection; and, (Outcome)
IV.A.5.a).(2).(b).(i).(i)	stricturoplasty. (Outcome)
IV.A.5.a).(2).(b).(ii)	anorectal and perineal procedures, including: (Outcome)
IV.A.5.a).(2).(b).(ii).(a)	anoplasty; (Outcome)
IV.A.5.a).(2).(b).(ii).(b)	fistulotomies, including primary and staged advancement flap repairs of complex anorectal and rectovaginal fistulas; (Outcome)
IV.A.5.a).(2).(b).(ii).(c)	hemorrhoidectomy, including operative and non-operative treatment; (Outcome)
IV.A.5.a).(2).(b).(ii).(d)	internal sphincterotomy; (Outcome)
IV.A.5.a).(2).(b).(ii).(e)	perineal repairs of rectal prolapse; (Outcome)
IV.A.5.a).(2).(b).(ii).(f)	transanal excision of rectal neoplasms; (Outcome)
IV.A.5.a).(2).(b).(ii).(g)	treatment of hidradenitis; and, (Outcome)

IV.A.5.a).(2).(b).(ii).(h) treatment of pilonidal disease. (Outcome)

IV.A.5.a).(2).(b).(iii) endoscopic procedures, including: (Outcome)

IV.A.5.a).(2).(b).(iii).(a) anoscopy; (Outcome)

IV.A.5.a).(2).(b).(iii).(b) colonoscopy, including diagnostic and therapeutic; and, (Outcome)

IV.A.5.a).(2).(b).(iii).(c) sigmoidoscopy, including rigid and flexible. (Outcome)

IV.A.5.a).(2).(b).(iv) administration of conscious sedation and local analgesia; and, (Outcome)

IV.A.5.a).(2).(b).(v) pelvic floor procedures, including interpretation of clinical and laboratory study results to include anorectal manometry, anorectal ultrasound, pelvic magnetic resonance imaging (MRI), defecography, and transit time studies. (Outcome)

IV.A.5.b) Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents: (Outcome)

IV.A.5.b).(1) must demonstrate expertise in their knowledge of the anatomy, embryology and physiology of the colon, rectum, anus, and related structures; (Outcome)

IV.A.5.b).(2) must demonstrate competence in their knowledge of the essential colorectal disorders; (Outcome)

IV.A.5.b).(3) must demonstrate substantial familiarity with additional colon and rectal surgery-related issues, including: (Outcome)

IV.A.5.b).(3).(a) congenital disorders, including congenital pelvic and sacral neoplasms; Hirschsprung's disease; imperforate anus; and urogenital and sacral dysgenesis, including spina bifida; (Outcome)

IV.A.5.b).(3).(b) genetics and molecular biology as they apply to colorectal disorders; (Outcome)

IV.A.5.b).(3).(c) gynecological disorders, including endometriosis, considerations in managing the pregnant patient with colorectal disorders, and related intra-

operative findings such as ovarian lesions, fibroids, endometrial implants, and gynecological prolapse; (Outcome)

IV.A.5.b).(3).(d) other pediatric and congenital disorders, including childhood fissure, encopresis, juvenile polyposis, malrotation, Meckel's diverticulum, and prolapse; (Outcome)

IV.A.5.b).(3).(e) other pelvic disorders, including cystocele, enterocele, urinary incontinence, and vaginal and uterine prolapse; (Outcome)

IV.A.5.b).(3).(f) the pathology of colon and rectal disorders; (Outcome)

IV.A.5.b).(3).(g) radiological and other imaging modalities, including plain x-rays, contrast studies, computed tomography (CT), positron emission tomography (PET), CT colonography magnetic resonance imaging, nuclear medicine scans, angiography, defecography, abdominal ultrasound, evaluation for deep vein thrombosis and pulmonary embolism, fistulograms, and sinograms; (Outcome)

IV.A.5.b).(3).(h) related medical conditions; (Outcome)

IV.A.5.b).(3).(i) urological disorders, including urinary incontinence, fistulas to the urinary tract, involvement of the ureters, bladder and urethra in colorectal disease, and identifying and avoiding intraoperative injury to the ureters; and, (Outcome)

IV.A.5.b).(3).(j) vascular and mesenteric disorders affecting the colon and rectum. (Outcome)

IV.A.5.b).(4) must demonstrate substantial familiarity with additional colon and rectal surgery-related procedures, including: (Outcome)

IV.A.5.b).(4).(a) abdominal procedures, including continent ileostomy and pelvic exenteration; (Outcome)

IV.A.5.b).(4).(b) alternate pelvic pouch techniques, including colonic J-pouch and coloplasty; (Outcome)

IV.A.5.b).(4).(c) anastomotic techniques, including both sewn and stapled methods of colonic and anal anastomoses; (Outcome)

IV.A.5.b).(4).(d) anorectal procedures, including alternative methods of fistula repair, including fibrin glue and/or plug

placement; (Outcome)

IV.A.5.b).(4).(e) flaps and grafts for perineal reconstruction; (Outcome)

IV.A.5.b).(4).(f) management of colorectal trauma and foreign bodies; (Outcome)

IV.A.5.b).(4).(g) other procedures for fecal incontinence, including alternative methods of sphincter repair, augmentation and implantable devices; (Outcome)

IV.A.5.b).(4).(h) pelvic floor and gastrointestinal physiological assessment and procedures, their uses, and indications, including performance and interpretation of anorectal manometry, electromyography and pudendal nerve testing, defecography/dynamic MRI, transit time assessment, pelvic floor exercise, rehabilitation, and directed biofeedback; (Outcome)

IV.A.5.b).(4).(i) procedures for pelvic prolapse in addition to rectal prolapse, including rectocele and enterocele repairs; and, (Outcome)

IV.A.5.b).(4).(j) transanal endoscopic microsurgery. (Outcome)

IV.A.5.c) Practice-based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. (Outcome)

Residents are expected to develop skills and habits to be able to meet the following goals:

IV.A.5.c).(1) identify strengths, deficiencies, and limits in one's knowledge and expertise; (Outcome)

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

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

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

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

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

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

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

IV.A.5.c).(9) evaluate and analyze patient care outcomes; and, (Outcome)

IV.A.5.c).(10) utilize an evidence-based approach to patient care. (Outcome)

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

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

Residents are expected to:

IV.A.5.d).(1) **communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;** (Outcome)

IV.A.5.d).(2) **communicate effectively with physicians, other health professionals, and health related agencies;** (Outcome)

IV.A.5.d).(3) **work effectively as a member or leader of a health care team or other professional group;** (Outcome)

IV.A.5.d).(4) **act in a consultative role to other physicians and health professionals; and,** (Outcome)

IV.A.5.d).(5) **maintain comprehensive, timely, and legible medical records, if applicable.** (Outcome)

IV.A.5.e) **Professionalism**

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

Residents are expected to demonstrate:

IV.A.5.e).(1) **compassion, integrity, and respect for others;** (Outcome)

IV.A.5.e).(2) **responsiveness to patient needs that supersedes self-interest;** (Outcome)

IV.A.5.e).(3) **respect for patient privacy and autonomy;** (Outcome)

IV.A.5.e).(4) **accountability to patients, society and the profession;** (Outcome)

IV.A.5.e).(5) **sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation;** (Outcome)

IV.A.5.e).(6) a high standard of ethical behavior; and, (Outcome)

IV.A.5.e).(7) a commitment to continuity of care. (Outcome)

IV.A.5.f) **Systems-based Practice**

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

Residents are expected to:

IV.A.5.f).(1) **work effectively in various health care delivery settings and systems relevant to their clinical specialty;** (Outcome)

IV.A.5.f).(2) **coordinate patient care within the health care system relevant to their clinical specialty;** (Outcome)

IV.A.5.f).(3) **incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;** (Outcome)

IV.A.5.f).(4) **advocate for quality patient care and optimal patient care systems;** (Outcome)

IV.A.5.f).(5) **work in interprofessional teams to enhance patient safety and improve patient care quality; and,** (Outcome)

IV.A.5.f).(6) **participate in identifying system errors and implementing potential systems solutions.** (Outcome)

IV.A.6. Curriculum Organization and Resident Experiences

IV.A.6.a) The program must be organized so that residents participate in patient evaluation and care in each of the following settings: (Core)

IV.A.6.a).(1) ambulatory clinic/office; (Core)

IV.A.6.a).(2) emergency department; (Detail)

IV.A.6.a).(3) endoscopy suite/center; (Core)

IV.A.6.a).(4) inpatient care/hospital; and, (Core)

IV.A.6.a).(5) operating room, including in-patient and ambulatory. (Core)

IV.A.6.b) Residents must be exposed to basic and complex patients with the following conditions: (Core)

IV.A.6.b).(1) the broad spectrum of anorectal disease; (Detail)

IV.A.6.b).(2) colon, rectal and anal cancer; (Detail)

IV.A.6.b).(3) colorectal physiological disorders, including fecal incontinence, constipation, rectal and pelvic prolapse and intestinal dysmotility; (Detail)

IV.A.6.b).(4) diverticular disease; (Detail)

IV.A.6.b).(5) inflammatory bowel disease, including ulcerative colitis; and, (Detail)

IV.A.6.b).(6) relevant genetic disorders, including familial adenomatous polyposis (FAP) and hereditary non-polyposis colorectal cancer (HNPCC). (Detail)

IV.A.6.c) Residents must have a broad operative experience, including: (Core)

IV.A.6.c).(1) abdominal/pelvic, both open and laparoscopic; (Core)

IV.A.6.c).(2) anorectal; and, (Core)

IV.A.6.c).(3) endoscopic, including rigid proctoscopy, flexible sigmoidoscopy and colonoscopy. (Core)

IV.A.6.d) Residents must have exposure to testing methods, including: (Core)

IV.A.6.d).(1) anorectal manometry; (Detail)

IV.A.6.d).(2) defecography/dynamic MRI; (Detail)

IV.A.6.d).(3) electromyography and pudendal nerve testing; (Detail)

IV.A.6.d).(4) pelvic floor exercise, rehabilitation, and directed biofeedback; and, (Detail)

IV.A.6.d).(5) transit time assessment. (Detail)

IV.A.6.e) Residents must have formal instruction and clinical experiences in all essential disorders and procedures. (Core)

IV.A.6.f) Residents must participate in the evaluation and treatment of patients with the following diagnoses: (Core)

IV.A.6.f).(1) anorectal and physiologic disorders, including hemorrhoids, fistulas, abscesses, fissures, constipation, incontinence and pelvic floor problems (at least 110 patients); and, (Core)

IV.A.6.f).(2) abdominal disorders, including neoplasia of the colon, rectum and anus, inflammatory bowel disease, diverticular disease, and rectal prolapse (at least 215 patients). (Corel)

IV.A.6.g) Residents must document the following minimum overall case numbers~~, to include no more than 50% endoscopic procedures~~: (Core)

IV.A.6.g).(1) 120 abdominal operations, including: (Core)

IV.A.6.g).(1).(a) 30 laparoscopic resections; and, (Core)

IV.A.6.g).(1).(b) 30 pelvic dissections. (Core)

IV.A.6.g).(2) 60 anorectal operations; and, (Core)

IV.A.6.g).(3) 185 procedures evaluating the gastrointestinal tract and pelvic floor, including sigmoidoscopy/proctoscopy, anoscopy, rectal and anal ultrasound, pelvic floor evaluation and colonoscopies (at least 140 total procedures, including 30 interventional procedures). (Core)

IV.A.6.h) A colon and rectal surgery resident and a chief resident in general surgery or a fellow (whether the fellow is in an ACGME-accredited position or not) should not have primary responsibility for the same patient, except that a colon and rectal surgery resident and a critical care fellow may co-manage the non-operative care of the same patient. (Detail)

IV.A.6.i) Each colon and rectal surgery resident must continue to provide care for his or her post-operative patients until discharge, or until the patients' postoperative conditions are stable and only non-surgical issues remain. (Detail)

IV.B. Residents' Scholarly Activities

IV.B.1. The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted,

evaluated, explained to patients, and applied to patient care. (Core)

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

IV.B.2.a) Each resident should participate in at least two of the following activities: (Detail)

IV.B.2.a).(1) one or more ongoing research studies with the faculty; (Detail)

IV.B.2.a).(2) one or more resident-initiated research project with faculty supervision; (Detail)

IV.B.2.a).(3) one or more scientific presentations at local, regional, national or international meetings; (Detail)

IV.B.2.a).(4) preparation/submission of one or more articles for peer-reviewed publications; or, (Detail)

IV.B.2.a).(5) writing one or more book chapters or current standards papers. (Detail)

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

IV.B.3.a) The program should provide support for residents involved in research, including research design, technical support and statistical analysis. (Detail)

IV.B.4. The program director must document each resident's scholarly activity annually. (Core)

V. Evaluation

V.A. Resident Evaluation

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

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

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

V.A.1.a).(1).(a) **These additional members must be physician faculty members from the same program or other programs, or other health professionals who have extensive contact and experience**

with the program's residents in patient care and other health care settings. (Core)

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

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

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

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

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

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

V.A.2. **Formative Evaluation**

V.A.2.a) **The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.** (Core)

V.A.2.a).(1) The program director must formally discuss each resident's evaluation(s) with him or her in person and on a quarterly basis. (Detail)

V.A.2.a).(1).(a) This discussion must include the resident's performance related to the six competencies, clinical experiences, and duty hours. (Detail)

V.A.2.a).(1).(b) This evaluation must be documented, signed by the program director and the resident, and maintained for review by the faculty, resident, institution and site visitor. (Detail)

V.A.2.a).(2) The ACGME Case Log System must be used to assess resident experience with both diagnoses and procedures. (Core)

V.A.2.a).(2).(a) The program director must ensure regular and accurate completion of the Case Log System, and

that each resident completes his or her case logs in the system in their entirety prior to completing the program. (Core)

V.A.2.a).(2).(b) The program director must review the Case Log results at least quarterly to assess each resident's progress and to ensure completion of each rotation's goals and objectives. (Detail)

V.A.2.a).(2).(c) The program director must review case distribution regularly, and if a deficit is identified, specific plans must be made to remedy the problem. (Detail)

V.A.2.a).(2).(c).(i) These plans must be documented and shared with each resident and with the faculty. (Detail)

V.A.2.a).(2).(c).(ii) Review of these plans must be performed at each resident's next quarterly evaluation to assess results. (Detail)

V.A.2.a).(2).(d) The program director must ensure minimum case numbers for each resident and assess resident technical competence. (Core)

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

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

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

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

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

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

V.A.2.d) The Colon and Rectal Surgery In-Training Examination (CARSITE) or a similar, specialty-specific examination should be used as one method of resident evaluation. (Core)

V.A.2.d).(1) The results should be reviewed in a debriefing session with each resident in which the program director or delegated faculty member provides feedback regarding identified gaps in knowledge and helps the resident develop strategies to resolve these deficiencies. (Detail)

V.A.2.e) The American Board of Surgery In-Service Training Examination (ABSITE) must not be used for specialty-specific evaluation of resident knowledge in colon and rectal surgery. (Core)

V.A.3. Summative Evaluation

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

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

This evaluation must:

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

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

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

V.B. Faculty Evaluation

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

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

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

V.C. Program Evaluation and Improvement

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

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

V.C.1.a).(1) **must be composed of at least two program faculty members and should include at least one resident;** (Core)

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

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

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

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

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

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

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

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

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

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

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

V.C.2.c).(1) At least 70% of a program's graduates from the preceding ten years must enter the certifying examination process for colon and rectal surgery offered by the ABCRS within three years of completing their residency program. (Outcome)

V.C.2.c).(2) At least 70% of a program's graduates from the preceding five years taking the ABCRS qualifying and certifying examinations for the first time must pass. (Outcome)

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

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

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

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

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

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

VI. Resident Duty Hours in the Learning and Working Environment

VI.A. Professionalism, Personal Responsibility, and Patient Safety

VI.A.1. **Programs and sponsoring institutions must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.** (Core)

VI.A.2. **The program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment.** (Core)

VI.A.3. **The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.** (Core)

VI.A.4. **The learning objectives of the program must:**

VI.A.4.a) **be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,** (Core)

VI.A.4.b) **not be compromised by excessive reliance on residents to fulfill non-physician service obligations.** (Core)

VI.A.5. **The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility.** (Core)

VI.A.6. **Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following:**

VI.A.6.a) **assurance of the safety and welfare of patients entrusted to their care;** (Outcome)

VI.A.6.b) **provision of patient- and family-centered care;** (Outcome)

VI.A.6.c) **assurance of their fitness for duty;** (Outcome)

VI.A.6.d) **management of their time before, during, and after clinical assignments;** (Outcome)

VI.A.6.e) **recognition of impairment, including illness and fatigue, in themselves and in their peers;** (Outcome)

VI.A.6.f) **attention to lifelong learning;** (Outcome)

VI.A.6.g) **the monitoring of their patient care performance improvement indicators; and,** (Outcome)

VI.A.6.h) **honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.** (Outcome)

VI.A.7. **All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. They must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.** (Outcome)

VI.B. Transitions of Care

VI.B.1. **Programs must design clinical assignments to minimize the number of transitions in patient care.** (Core)

VI.B.2. **Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.** (Core)

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

VI.B.4. **The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.** (Detail)

VI.C. Alertness Management/Fatigue Mitigation

VI.C.1. **The program must:**

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

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

VI.C.1.c) **adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.** (Detail)

VI.C.2. **Each program must have a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties.** (Core)

VI.C.3. **The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home.** (Core)

VI.D. Supervision of Residents

VI.D.1. **In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.** (Core)

VI.D.1.a) **This information should be available to residents, faculty members, and patients.** (Detail)

VI.D.1.b) **Residents and faculty members should inform patients of their respective roles in each patient's care.** (Detail)

VI.D.2. **The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.** (Core)

Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care. (Detail)

VI.D.3. **Levels of Supervision**

To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision: (Core)

VI.D.3.a) **Direct Supervision – the supervising physician is physically**

present with the resident and patient. (Core)

VI.D.3.b) **Indirect Supervision:**

VI.D.3.b).(1) **with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.** (Core)

VI.D.3.b).(2) **with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.** (Core)

VI.D.3.c) **Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.** (Core)

VI.D.4. **The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.** (Core)

VI.D.4.a) **The program director must evaluate each resident's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.** (Core)

VI.D.4.b) **Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.** (Detail)

VI.D.4.c) **Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.** (Detail)

VI.D.5. **Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.** (Core)

VI.D.5.a) **Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.** (Outcome)

VI.D.5.a).(1) **In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.** (Core)

VI.D.6. **Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.** (Detail)

VI.E. Clinical Responsibilities

The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services. (Core)

VI.F. Teamwork

Residents must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty. (Core)

VI.F.1. Each resident must have the opportunity to interact with other providers, such as enterostomal therapists, mid-level providers, nurses, other specialists, and social workers. (Detail)

VI.G. Resident Duty Hours

VI.G.1. Maximum Hours of Work per Week

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting. (Core)

VI.G.1.a) Duty Hour Exceptions

A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale. (Detail)

The Review Committee for Colon and Rectal Surgery will not consider requests for exceptions to the 80-hour limit to the residents' work week.

VI.G.1.a).(1) In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures. (Detail)

VI.G.1.a).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO. (Detail)

VI.G.2. Moonlighting

VI.G.2.a) **Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.** (Core)

VI.G.2.b) **Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.** (Core)

VI.G.2.c) **PGY-1 residents are not permitted to moonlight.** (Core)

VI.G.2.c).(1) Colon and rectal surgery residents are not permitted to moonlight. (Core)

VI.G.3. **Mandatory Time Free of Duty**

Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days. (Core)

VI.G.4. **Maximum Duty Period Length**

VI.G.4.a) **Duty periods of PGY-1 residents must not exceed 16 hours in duration.** (Core)

VI.G.4.b) **Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital.** (Core)

VI.G.4.b).(1) **Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.** (Detail)

VI.G.4.b).(2) **It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.** (Core)

VI.G.4.b).(3) **Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.** (Core)

VI.G.4.b).(4) **In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events**

transpiring, or humanistic attention to the needs of a patient or family. (Detail)

VI.G.4.b).(4).(a) **Under those circumstances, the resident must:**

VI.G.4.b).(4).(a).(i) **appropriately hand over the care of all other patients to the team responsible for their continuing care; and,** (Detail)

VI.G.4.b).(4).(a).(ii) **document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.** (Detail)

VI.G.4.b).(4).(b) **The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.** (Detail)

VI.G.5. **Minimum Time Off between Scheduled Duty Periods**

VI.G.5.a) **PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.** (Core)

VI.G.5.b) **Intermediate-level residents should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.** (Core)

Colon and rectal surgery residents are considered to be in the final years of education.

VI.G.5.c) **Residents in the final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.** (Outcome)

Colon and rectal surgery residents are considered to be in the final years of education.

VI.G.5.c).(1) **This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.** (Detail)

VI.G.5.c).(1).(a) **Circumstances of return-to-hospital activities**

with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director. (Detail)

VI.G.5.c).(1).(b) The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. (Detail)

VI.G.6. Maximum Frequency of In-House Night Float

Residents must not be scheduled for more than six consecutive nights of night float. (Core)

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

PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period). (Core)

VI.G.8. At-Home Call

VI.G.8.a) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks. (Core)

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

VI.G.8.b) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period". (Detail)

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

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

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

Osteopathic Recognition

For programs seeking Osteopathic Recognition for the entire program, or for a track within the program, the Osteopathic Recognition Requirements are also applicable. (http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/Osteopathic_Recogniton_Requirements.pdf)