ACGME Program Requirements for Graduate Medical Education in General Surgery
Summary and Impact of Focused Requirement Revisions

Requirement #: II.A.4.w)

Requirement Revision (significant change only):

[The program director must] ensure that each resident has at least 750 850 major cases across the five years of training. This must include a minimum of 450 200 major cases in the resident’s chief year; (Core)

1. Describe the Review Committee’s rationale for this revision:

   The increase in major case requirements was a joint effort between the Review Committee, the American Board of Surgery (ABS), and the American College of Surgeons. The assembled task force took into consideration the ACGME national surgical Case Log data demonstrating the numbers of procedures completed by residents annually, responses to the aggregated specialty-specific questions pertaining to preparedness in the ACGME Resident Survey, and surveys of program directors’ perceptions of resident preparedness. In the Resident Survey, only approximately 60% of residents indicated they felt prepared to enter practice/fellowship at the end of residency, and program directors shared those concerns. The rationale behind the lack of perceived preparedness includes operative exposure for total cases for all residents, exposure to complex cases for chief residents, and a lack of appropriate supervised autonomy for all residents. It was felt that increasing the number of required total major cases and the number of chief cases per year would increase the general operative exposure with the goals of increasing proficiency/confidence, increasing the number of complex cases attended by chief residents, and increasing the opportunity for appropriate supervised autonomy as residents spent more time in the OR with faculty members. Review of the Case Log national data demonstrated that residents averaged 985 total major cases per year and 239 chief cases per year; very few residents did not achieve these numbers. The task force assessed the 10th and 20th percentile of the total cases, finding them to be 851 and 910 respectively for total major cases and 182 and 212 respectively for chief cases. After much discussion, it was determined that most programs could achieve the 10th percentile (851) of the major cases and 20th percentile (212) of chief cases, so the task force determined that an increase to 850 major cases and 200 chief cases would be attainable for most programs and their current resources. This recommendation was made to the Review Committee for Surgery and the ABS, and was accepted.

   The requirement revision is necessary to align with the new minimum operative requirements effective for the 2018 program graduates. These new minimum case requirements have been posted on the Surgery section of the ACGME website since July 2016.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?

   Increasing the number of total major cases and the number of chief cases per year will increase the general operative exposure with the intent of increasing the
residents' proficiency/confidence, increasing the number of complex cases attended by chief residents, and increasing the opportunity for appropriate supervised autonomy as residents spent more time in the OR with faculty members. Increased exposure to operative procedures increases proficiency, and in some cases, competency in operative procedures, which will in turn lead to improved patient safety and quality.

3. How will the proposed requirement or revision impact continuity of patient care?
   Residents will maintain continuity of care on all patients under their care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   In a limited number of programs, additional resources may be required to ensure that residents achieve the total major cases and chief cases. While this could be of concern to some programs, it was noted that programs that do not meet the current minimum requirements should be accessing additional resources in order to ensure that all residents achieve the minimum cases required for ABS certification.

5. How will the proposed revision impact other accredited programs?
   There is no anticipated impact on other ACGME-accredited programs.

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<th>Requirement #: IV.A.6.a).(2).(c).(i)</th>
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<tr>
<td>Requirement Revision (significant change only):</td>
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<tr>
<td>Knowledge of burn physiology, and experience with initial burn management is required. (Core)</td>
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1. Describe the Review Committee’s rationale for this revision:
   This revision serves only to clarify the expectation that residents will have clinical exposure to initial burn management.

2. How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?
   Increases resident’s understanding of burn management, including metabolic and fluid considerations that accompany these injuries.

3. How will the proposed requirement or revision impact continuity of patient care?
   There is no impact to the continuity of care.

4. Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?
   Programs that do not have a burn experience/rotation may have to establish a new rotation and/or site to allow residents to achieve this experience. This is already a requirement, so it should not pose a hardship.

5. How will the proposed revision impact other accredited programs?
   There is no anticipated impact on other ACGME-accredited programs.
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**Requirement Revision (significant change only):**

When justified by experience, a PG 5 (chief) resident may act as a teaching assistant (TA) to a more junior resident with appropriate faculty supervision. **Up to 50 cases listed by the chief resident as TA will be credited for the total requirement of 750 cases. TA cases may not count towards the 150-200 minimum cases needed to fulfill the operative requirements for the chief resident year. The junior resident performing the case will also be credited as surgeon for these cases.**

1. **Describe the Review Committee’s rationale for this revision:**
   *The Committee removed the reference to the total major cases, because that is not relevant to chief cases. It is the opinion of the Committee and the ABS that TA cases, where a senior resident is supervising a more junior resident, are not equivalent to a chief case wherein the chief resident is engaged in a complex procedure and therefore, prohibit the TA case from counting as a chief case. The ABS adopted this position and the Committee wishes to align with the Board, which now does not have a maximum for the number of TA cases that will count toward meeting the minimum requirement for total major cases.*

2. **How will the proposed requirement or revision improve resident/fellow education, patient safety, and/or patient care quality?**
   *This will reinforce the requirements for chief cases and maintains the requirement that chief residents teach/supervise more junior residents as a component of their training and professional growth.*

3. **How will the proposed requirement or revision impact continuity of patient care?**
   *The proposed requirement will not impact continuity of patient care.*

4. **Will the proposed requirement or revision necessitate additional institutional resources (e.g., facilities, organization of other services, addition of faculty members, financial support; volume and variety of patients), if so, how?**
   *The proposed requirement will not necessitate additional institutional resources.*

5. **How will the proposed revision impact other accredited programs?**
   *There is no anticipated impact on other ACGME-accredited programs.*