ACGME
Common Program Requirements (Residency)
Sections I-V

Proposed major revision, posted for review and comment February 6, 2018
Upon final approval, the currently-in-effect Section VI will be added to this document
Common Program Requirements (Residency)  
Sections I-V (Tracked Changes)  
Proposed Major Revision

Where applicable, text in italics describes the underlying philosophy of the requirements in that section. These philosophic statements are not program requirements and are therefore not citable.

Note: Review Committees may further specify only where indicated by “The Review Committee may/must further specify.”

Introduction

Graduate medical education is the crucial step of professional development between medical school and autonomous clinical practice. It is in this vital phase of the continuum of medical education that residents learn to provide optimal patient care under the supervision of faculty members who not only instruct, but serve as role models of excellence, compassion, professionalism, and scholarship.

Graduate medical education transforms medical students into physician scholars who care for the patient, family, and a diverse community; create and integrate new knowledge into practice; and educate future generations of physicians to serve the public. Practice patterns established during graduate medical education persist many years later.

Graduate medical education has as a core tenet the graded authority and responsibility for patient care. The care of patients is undertaken with appropriate faculty supervision and conditional independence, allowing residents to attain the knowledge, skills, attitudes, and empathy required for autonomous practice. Graduate medical education results in the development of physicians who focus on excellence in delivery of safe, equitable, affordable, quality care; and the health of all members of the community. Graduate medical education values the strength that a diverse group of physicians brings to medical care.

Graduate medical education occurs in clinical settings that establish the foundation for practice-based and lifelong learning. The professional development of the physician, begun in medical school, continues through faculty modeling of the effacement of self-interest in a humanistic environment that emphasizes joy in curiosity, problem-solving, academic rigor, and discovery. This transformation is often physically, emotionally, and intellectually demanding and occurs in a variety of clinical learning environments committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.

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.

I. Oversight Institutions

I.A. Sponsoring Institution

The Sponsoring Institution is the organization or entity that assumes the ultimate
financial and academic responsibility for a program of graduate medical
education, consistent with the ACGME Institutional Requirements. The
Sponsoring Institution has the primary purpose of providing educational
programs and may provide health care services.

When the Sponsoring Institution is not a rotation site for the program, the major
site of clinical activity for the program is the primary clinical site.

Background and Intent: Participating sites will reflect the health care needs of the community
and the educational needs of the residents. A wide variety of organizations may provide a
robust educational experience and, thus, Sponsoring Institutions and participating sites may
encompass inpatient and outpatient settings including, but not limited to a university, a
medical school, a teaching hospital, a nursing home, a school of public health, a health
department, a public health agency, an organized health care delivery system, a medical
examiner’s office, a consortium (including OPTIs), a teaching health center, a physician group
practice, federally qualified health center, or an educational foundation.

I.A.1. The program must be sponsored by one ACGME-accredited Sponsoring
Institution. (Core)*

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.B. Participating Sites
A participating site is an organization providing educational experiences or educational assignments/rotations for residents.

I.B.1. The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)

I.B.2. There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)

I.B.2.a) The PLA should:

I.B.2.a).(1) be renewed at least every five years; and, (Core)

I.B.2.a).(2) be approved by the designated institutional official (DIO). (Core)

I.B.2.a).(3) identify the faculty who will assume both educational and supervisory responsibilities for residents; (Detail)

I.B.2.a).(4) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document; (Detail)

I.B.2.a).(5) specify the duration and content of the educational experience; and, (Detail)

I.B.2.a).(6) state the policies and procedures that will govern resident education during the assignment. (Detail)

I.B.3. The program must monitor the clinical learning and working environment at all participating sites. (Core)

I.B.3.a) There must be a director who is accountable for resident education at each participating site. (Core)

Background and Intent: While all residency programs must be sponsored by a single ACGME-accredited Sponsoring Institution, many programs will utilize other clinical settings to provide required or elective training experiences. At times it is appropriate to utilize community sites that are not owned by or affiliated with the Sponsoring Institution. Some of these sites may be remote for geographic, transportation, or communication issues. When utilizing such sites the program must ensure the quality of the educational experience. The requirements under I.B.3 are intended to ensure that this will be the case.

Suggested elements to be considered in PLAs will be found in the Program Director Guide.

I.B.4. 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).
I.C. The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse workforce inclusive of residents, fellows (if present), faculty members, senior administrative staff members, and other relevant members of its academic community. (Core)

Background and Intent: It is expected that the Sponsoring Institution will have developed policies and procedures related to recruitment and retention of underrepresented minorities in accordance with the Sponsoring Institution’s mission and aims. The program’s annual evaluation must include an assessment of the program’s efforts to recruit and retain a diverse workforce, as noted in V.C.2.a).(5).(c).

I.D. Resources

I.D.1. The institution and the program must jointly ensure The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education, as defined in the specialty program requirements. (Core) [Moved here from II.E.]

[The Review Committee must further specify] [As further specified by the Review Committee]

I.D.2. The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for: (Core)

I.D.2.a) access to food while on duty; (Core)

I.D.2.b) safe, quiet, clean, and private sleep/rest facilities available and accessible for residents with proximity appropriate for safe patient care; (Core)

Background and Intent: Care of patients within a hospital or health system occurs continually through the day and night. Such care requires that residents function at their peak abilities, which requires the work environment to provide them with the ability to meet their basic needs within proximity of their clinical responsibilities.

I.D.2.c) clean and private facilities for lactation that have refrigeration capabilities and that are in close proximity to the residents’ clinical responsibilities; and, (Core)

Background and Intent: Breastfeeding is important for the developing infant, providing the best nutritional support while decreasing illness. Sites must provide private and clean locations where residents may lactate and store the milk within a refrigerator. These locations should be in close proximity to clinical responsibilities. It would be helpful to have additional support within these locations that may assist the resident with the continued care of patients,
such as a computer and a phone. While space is important, the time required for lactation is also critical for the well-being of the resident and the resident's family, as outlined in VI.C.1.d).(1).

I.D.2.d) security and safety measures appropriate to the participating site. (Core)

I.D.3. Medical Information Access

Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text search capabilities should be available. (CoreDetail) [Moved here from II.F.]

I.E. The program’s educational and clinical resources must be adequate to support the number of residents appointed to the program. (Core) [Moved here from III.B.1.]

[The Review Committee may further specify] [As further specified by the Review Committee]

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

I.F. Appointment of Fellows and Other Learners

The presence of other learners and other care providers, (including, but not limited to, residents from other specialties, subspecialty fellows, and advanced practice care providers, PhD students, and nurse practitioners), in the program must not interfere with the appointed residents’ education. (Core) [Moved here from III.D.]

I.F.1. The program director must report the presence of other learners to the DIO and Graduate Medical Education Committee (GMEC) in accordance with Sponsoring Institution guidelines. (CoreDetail) [Moved here from III.D.1.]

[As further specified by the Review Committee]

Background and Intent: The clinical learning environment has become increasingly complex and often includes care providers, students, and post-graduate residents and fellows from multiple disciplines. The presence of these practitioners and their learners enriches the learning environment. Programs have a responsibility to monitor the learning environment to ensure that residents’ education is not compromised by the presence of other providers and learners.

II. Program Personnel and Resources

II.A. Program Director

II.A.1. There must be one faculty member appointed as a single program
Background and Intent: While the ACGME recognizes the value of input from numerous individuals in the management of a residency, a single individual must be designated as program director and made responsible for the residency. This individual will have dedicated time for the leadership of the residency, and it is this individual’s responsibility to communicate with the residents, faculty members, DIO, GMEC, and the ACGME. The program director’s nomination is reviewed and approved by the GMEC. Final appointment of program directors resides with the Review Committee.

II.A.1.a) The program must demonstrate retention of the program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability. (CoreDetail)

[The Review Committee may further specify]

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

[As further specified by the Review Committee]

II.A.2. At a minimum, the program director must be provided with the salary support required to devote 20 percent FTE (at least eight hours) per week of non-clinical time to the administration of the program. (Core)

[The Review Committee may further specify]

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

II.A.3.a) must include requisite specialty expertise and at least three years of documented educational and/or administrative experience or qualifications acceptable to the Review Committee; (Core)

Background and Intent: Leading a program requires knowledge and skills that are established during residency and subsequently further developed. The time period from completion of residency until assuming the role of program director allows the individual to cultivate leadership abilities while becoming professionally established. The three-year period is intended for the individual's professional maturation.

The broad allowance for educational and/or administrative experience recognizes that strong leaders arise through diverse pathways. These areas of expertise are important when...
identifying and appointing a program director. The choice of a program director should be informed by the mission of the program and the needs of the community.

In certain circumstances, the program and Sponsoring Institution may propose and the Review Committee may accept a candidate for program director who fulfills these goals but does not meet the three-year minimum.

II.A.3.b) must include current certification in the specialty for which they are the program director by the American Board of _____ or by the American Osteopathic Board of _____, or specialty qualifications that are acceptable to the Review Committee; and. (Core)

[The Review Committee may further specify acceptable specialty qualifications]

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

[As further specified by the Review Committee]

II.A.3.d) must include ongoing clinical activity. (Core)

Background and Intent: A program director is a role model for faculty members and residents. The program director must participate in clinical activity consistent with the specialty. This activity will allow the program director to role model the core competencies for the faculty members and residents.

[The Review Committee may further specify additional program director qualifications]-[As further specified by the Review Committee]

II.A.4. Program Director Responsibilities

The program director must have responsibility, authority, and accountability for administration, operations, teaching, scholarly activity, and resident education in the context of patient care. (Core)

II.A.4.a) The program director must:

II.A.4.a).(1) be a role model of professionalism; (Core)

Background and Intent: The program director, as the leader of the program, must serve as a role model to residents in addition to fulfilling the technical aspects of the role. As residents are expected to demonstrate compassion, integrity, and respect for others, they must be able to look to the program director as an exemplar. It is of utmost importance, therefore, that the program director model outstanding professionalism, high quality patient care, educational excellence, and a scholarly approach to work. The program director creates an environment where respectful discussion is welcome, with the goal of continued improvement of the educational experience.

II.A.4.a).(2) design and conduct the program in a fashion consistent
Background and Intent: The mission of institutions participating in graduate medical education is to improve the health of the public. Each community has health needs that vary based upon location and demographics. Programs must understand the social determinants of health of the populations they serve and incorporate them in the design and implementation of the program curriculum, with the ultimate goal of addressing these needs and health disparities.

II.A.4.a).(3) administer and maintain a learning environment conducive to educating the residents in each of the ACGME competency domains; (Core)

II.A.4.a).(4) develop and oversee a process to evaluate candidates prior to appointment as program faculty members and at least annually thereafter, as outlined in V.B.; (Core)

II.A.4.a).(5) have the authority to appoint program faculty members at all sites; approve the selection of program faculty as appropriate; (Core)

II.A.4.a).(6) have the authority to remove program faculty members from participation in the educational program at all sites; approve the continued participation of program faculty based on evaluation; (Core)

II.A.4.a).(7) have the authority to remove residents from supervising interactions that do not meet the standards of the program; (Core)

II.A.4.a).(8) prepare and submit accurate and complete all information required and requested by the DIO, GMEC, and ACGME; (Core)

II.A.4.a).(8).(a) 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.a).(9) provide applicants with information related to eligibility for the relevant specialty Board examination(s); (Core)

II.A.4.a).(10) provide a learning and working environment in which residents have the opportunity to raise concerns and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; (Core)

II.A.4.a).(11) ensure the program’s compliance with the Sponsoring Institution’s policies and procedures on probation, dismissal, grievance, and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution; (Core)

Background and Intent: A program does not operate independently of its Sponsoring Institution. It is expected that the program director will be aware of the Sponsoring Institution’s policies and procedures, and will ensure they are followed by the program’s leadership, faculty members, support personnel, and residents.

II.A.4.a).(12) ensure the program’s compliance with the Sponsoring Institution’s policies and procedures on employment and non-discrimination; (Core)

II.A.4.a).(12).(a) The program, in partnership with its Sponsoring Institution, must not require residents to sign a non-competition guarantee or restrictive covenant. (Core)

II.A.4.a).(13) document and provide upon request verification of residency education for all residents within 30 days of program completion, including those who leave the program prior to completion; (Core)

II.A.4.a).(14) document and provide upon request summative evaluation of residency education for all residents, and; (Core)

Background and Intent: Primary verification of graduate medical education training is important to credentialing of physicians for further training and practice. Such verification must be accurate and timely. Sponsoring Institution and program policies for record retention are important to facilitate timely documentation of residents who have previously completed the program. Residents who leave the program prior to completion also require timely documentation of their summative evaluation.

II.A.4.a).(15) obtain review and approval of the Sponsoring Institution’s GMEC/DIO before submitting information or requests to the ACGME, as required in the Institutional Requirements and outlined in the Program Director Guide, including.

II.A.4.a).(15).(a) all applications for ACGME accreditation of new programs; (Detail)
II.A.4.a).(15).(b) changes in resident complement; (Detail)
II.A.4.a).(15).(c) major changes in program structure or length of training; (Detail)
II.A.4.a).(15).(d) progress reports requested by the Review Committee; (Detail)
II.A.4.a).(15).(e) requests for increases or any change to resident duty hours; (Detail)
II.A.4.a).(15).(f) voluntary withdrawals of ACGME-accredited programs; (Detail)
II.A.4.a).(15).(g) requests for appeal of an adverse action; and, (Detail)
II.A.4.a).(15).(h) appeal presentations to a Board of Appeal or the ACGME. (Detail)
II.A.4.a).(16) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program; (Core)
II.A.4.a).(17) approve a local director at each participating site who is accountable for resident education; (Core)
II.A.4.a).(18) evaluate program faculty; (Core)
II.A.4.a).(19) monitor resident supervision at all participating sites; (Core)
II.A.4.a).(20) 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.a).(20).(a) distribute these policies and procedures to the residents and faculty; (Detail)
II.A.4.a).(20).(b) monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements; (Core)
II.A.4.a).(20).(c) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and, (Detail)
II.A.4.a).(20).(d) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate
II.A.4.a).(21) 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.a).(22) 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.a).(23) 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.a).(24) 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.a).(24).(a) program citations, and/or, (Detail)

II.A.4.a).(24).(b) request for changes in the program that would have significant impact, including financial, on the program or institution. (Detail)

[As further specified by the Review Committee]

II.B. Faculty

Faculty are a foundational element of graduate medical education – faculty members teach residents how to care for patients. Faculty members provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.

Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves.

Background and Intent: “Faculty” refers to the entire teaching force responsible for educating residents. The term faculty, including core faculty, does not imply or require an academic
II.B.1. At each participating site, there must be a sufficient number of faculty members with competence documented qualifications to instruct and supervise all residents at that location. (Core)

The Review Committee may further specify

II.B.2. The faculty members must:

II.B.2.a) demonstrate commitment to the delivery of safe, quality, cost-effective, patient-centered care; (Core)

Background and Intent: Patients have the right to expect quality, cost-effective care with patient safety at its core. The foundation for meeting this expectation is formed during residency and fellowship. Faculty members model these goals and continually strive for improvement in care and cost, embracing a commitment to the patient and the community they serve.

II.B.2.b) demonstrate a strong interest in the education of residents; (Core)

II.B.2.c) 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,

II.B.2.d) administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas; and,

II.B.2.e) at least annually pursue formal faculty development designed to enhance their skills: (Core)

Background and Intent: Formal faculty development is intended to describe structured programming developed for the purpose of enhancing transference of knowledge, skill, and behavior from the educator to the learner. Formal faculty development may occur in a variety of configurations (lecture, workshop, etc.) using internal and/or external resources. Programming is typically needs-based (individual or group) and associated with defined learning objectives.

II.B.2.e).(1) as educators; (Core)

II.B.2.e).(2) in quality improvement and patient safety; (Core)

II.B.2.e).(3) in fostering their own and their residents’ well-being; and,

II.B.2.e).(4) in patient care based on their practice-based learning and improvement efforts. (Core)

Background and Intent: Practice-based learning serves as the foundation for the practice of
Through a systematic analysis of one's practice and review of the literature, one is able to make adjustments that improve patient outcomes and care. Thoughtful consideration to practice-based analysis improves quality of care, as well as patient safety. This allows faculty members to serve as role models for residents in practice-based learning.

The Review Committee may further specify additional faculty responsibilities

II.B.3. Faculty Qualifications

II.B.3.a) The Physician faculty members must:

II.B.3.a).(1) have current certification in the specialty by the American Board of _____ or American Osteopathic Board of _____, or possess qualifications judged acceptable to the Review Committee. (Core)

II.B.3.a).(2) The physician faculty must possess current medical licensure and appropriate medical staff appointment. (Core)

The Review Committee may further specify additional qualifications - As further specified by the Review Committee

II.B.3.b) The Non-physician faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)

The Review Committee may further specify

II.B.3.b).(1) Any non-physician faculty members who interact with residents must be designated by the program director. (Core)

The Review Committee may further specify

Background and Intent: The provision of optimal and safe patient care requires a team approach. The education of the residents by the non-physician educators enables the resident to better manage patient care and provides valuable advancement of the knowledge by the resident. Furthermore, other individuals contribute to the education of the resident in the basic science of the specialty or in research methodology. If the program director determines that the contribution of a non-physician individual is significant to the education of the residents, the program director may designate the individual as a program faculty member or a program core faculty member.

II.B.4. Core Faculty

Core faculty members must have a significant role in the education and supervision of residents and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents. (Core)
Background and Intent: Core faculty members are critical to the success of resident education. They support the program leadership in developing, implementing, and assessing curriculum and in assessing residents’ progress toward achievement of competence in the specialty. Core faculty members should be selected for their broad knowledge of and involvement in the program, permitting them to effectively evaluate the program, including completion of the annual ACGME Faculty Survey.

II.B.4.a) At a minimum, the core faculty must include the program faculty who are members of the Clinical Competency Committee and Program Evaluation Committee. (Core)

II.B.4.a).(1) Any additional core faculty members must be designated by the program director. (Core)

II.B.4.b) Core faculty members must complete the annual ACGME Faculty Survey. (Core)

[The Review Committee may specify the minimum number of core faculty and/or the core faculty-resident ratio]

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.6. Faculty should encourage and support residents in scholarly activities. (Core)

[As further specified by the Review Committee]

II.C. Program Coordinator

II.C.1. There must be a program coordinator. (Core)

II.C.2. At a minimum, the program coordinator must be supported at 50% FTE
Background and Intent: Each program requires a lead administrative person, frequently referred to as a program coordinator, administrator, or as titled by the institution. This person will frequently manage the day-to-day operations of the program and serve as an important liaison with learners, faculty and other staff members, and the ACGME. Individuals serving in this role are recognized as program coordinators by the ACGME.

The program coordinator is a member of the leadership team and is critical to the success of the program. As such, the program coordinator must possess skills in leadership and personnel management. Program coordinators are expected to develop unique knowledge of the ACGME and Program Requirements, policies, and procedures. Program coordinators assist the program director in accreditation efforts, educational programming, and support of residents.

Programs, in partnership with their Sponsoring Institutions, should encourage the professional development of their program coordinators and avail them of opportunities for both professional and personal growth. Programs with fewer residents may not require a full-time coordinator; one coordinator may support more than one program.
III.A. Eligibility Criteria Requirements

III.A.1. The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements. An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program:

III.A.1.a) graduation from a medical school in the United States or Canada, accredited by the Liaison Committee on Medical Education (LCME) or, graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA);

III.A.1.b) graduation from a medical school outside of the United States or Canada, and meeting one of the following additional qualifications:

III.A.1.b.(1) holds a currently-valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment;

III.A.1.b.(2) holds a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located.

III.A.2. 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, or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation.

III.A.2.a) Residency programs must receive verification of each applicant's resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones assessments from the prior training program after acceptance but prior to matriculation.

Background and Intent: Programs with ACGME-I Foundational Accreditation or from institutions with ACGME-I accreditation do not qualify unless the program has also achieved ACGME-I Advanced Specialty Accreditation. To ensure entrants into ACGME-accredited programs from ACGME-I programs have attained the prerequisite milestones for this training, they must be from programs that have ACGME-I Advanced Specialty Accreditation.

III.A.3. A physician who has completed a residency program that was not
accredited by ACGME, RCPSC, CFPC, or ACGME-I (with Advanced Specialty Accreditation) 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 and with approval by the GMEC, may be advanced to the PGY-2 level based on ACGME Milestones evaluations 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.4. Resident Eligibility Exception

The Review Committee for ______ will allow the following exception to the resident eligibility requirements: (Core)

[Note: A Review Committee may permit the eligibility exception if the specialty requires completion of a prerequisite residency program prior to admission. If this language is not applicable, this section will not appear in the specialty-specific requirements.]

III.A.4.a) An ACGME-accredited residency program may accept an exceptionally qualified international graduate applicant who does not satisfy the eligibility requirements listed in III.A.1. – III.A.3., but who does meet all of the following additional qualifications and conditions: (Core)

III.A.4.a).(1) evaluation by the program director and residency selection committee of the applicant’s suitability to enter the program, based on prior training and review of the summative evaluations of this training; and, (Core)

III.A.4.a).(2) review and approval of the applicant’s exceptional qualifications by the GMEC; and, (Core)

III.A.4.a).(3) verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification. (Core)

III.A.4.b) Applicants accepted through this exception must have an evaluation of their performance by the Clinical Competency Committee within 12 weeks of matriculation. (Core)

III.A.4.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.4.d) Review Committees will grant no other exceptions to these eligibility requirements for residency education. (Core)

III.A.5. Eligibility Requirements – Fellowship Programs [Section moved to Common Program Requirements (Fellowship)]
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)

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)

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)

Review and approval of the applicant’s exceptional qualifications by the GMEC or a subcommittee of the GMEC; and. (Core)

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

For an international graduate, verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification; and. (Core)

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)

If the trainee does not meet the expected level of fellowship 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.

[Each Review Committee will decide no later than December 31, 2013 whether the exception specified above will be permitted. If the Review Committee will not allow this exception, the program requirements will include the following statement]:

III.A.5.d) The Review Committee for _____ does not allow exceptions to the Eligibility Requirements for Fellowship Programs in Section III.A.2. (Core)

III.B. Number of Residents

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

[The Review Committee may further specify] [As further specified by the Review Committee]

III.B.1. The program’s educational resources must be adequate to support the number of residents appointed to the program. (Core) [Moved to I.E.]

Background and Intent: Temporary complement increases of less than eight weeks are automatically approved by the Review Committee for programs with a status of Continued Accreditation. If residents are not full-time with the program, the resident complement should reflect the FTE.

III.C. Resident Transfers

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 prior to acceptance of a transferring resident, and Milestones evaluations after acceptance, but prior to matriculation. (Core) [Detail]

[The Review Committee may further specify]
III.C.1. A program director must provide timely verification of residency education and summative performance evaluations for residents who may leave the program prior to completion.  

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.  

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

IV. Educational Program

The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.

The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.

In addition, the program is expected to define its specific program aims consistent with the overall mission of its Sponsoring Institution, the needs of the community it serves, and the distinctive capabilities of physicians it intends to graduate. While programs must demonstrate substantial compliance with the Common and specialty-specific Program Requirements, it is recognized that within this framework, programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-specific goals for it and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from one focusing on community health.

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

IV.A.1. a set of program aims consistent with the Sponsoring Institution’s mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates;  

IV.A.1.a) The program’s aims must be made Overall educational goals for the program, which the program must make available to program applicants, residents, and faculty members.  

IV.A.1.b) A program with additional ACGME recognition status must demonstrate how requirements associated with such recognition are integrated into the curriculum.
IV.A.2. competency-based goals and objectives for each assignment at each educational level experience designed to promote progress on a trajectory to practice without supervision, which the program must distribute. These must be distributed, reviewed, and available to residents and faculty members at least annually, in either written or electronic form.

Background and Intent: The trajectory to autonomous practice is documented by Milestones evaluation. The Milestones detail the progress of a resident in attaining skill in each competency domain. They are developed by each specialty group and allow evaluation based on observable behaviors. Milestones are considered formative and should be used to identify learning needs. This may lead to focused or general curricular revision in any given program or to individualized learning plans for any specific resident.

IV.A.3. delineation of resident responsibilities for patient care, progressive responsibility for patient management, and graded supervision of residents over the continuum of the program;

Background and Intent: These responsibilities may generally be described by PGY level and specifically by Milestones progress as determined by the Clinical Competency Committee. This approach encourages the transition to competency-based education. An advanced learner may be granted more responsibility independent of PGY level and a learner needing more time to accomplish a certain task may do so in a focused rather than global manner.

IV.A.4. a broad range of structured didactic activities regularly scheduled didactic sessions; and,

Background and Intent: It is intended that residents will participate in structured didactic activities. It is recognized that there may be circumstances in which this is not possible. Programs should define core didactic activities for which time is protected and the circumstances in which residents may be excused from these didactic activities. Didactic activities may include, but are not limited to, lectures, conferences, courses, labs, asynchronous learning, simulations, drills, case discussions, grand rounds, didactic teaching, and education in critical appraisal of medical evidence.

IV.A.4.a) Residents must be provided with protected time to participate in core didactic activities.

IV.A.5. advancement in the residents’ knowledge of the basic principles of research, including how research is designed, conducted, evaluated, explained to patients, and applied to patient care.

Background and Intent: The Competencies provide a conceptual framework describing the required domains for a trusted physician to enter autonomous practice. These Competencies are core to the practice of all physicians, although the specifics are further defined by each specialty. The developmental trajectories in each of the Competencies are articulated through the Milestones for each specialty.

IV.B. ACGME Competencies

Background and Intent: The Competencies provide a conceptual framework describing the required domains for a trusted physician to enter autonomous practice. These Competencies are core to the practice of all physicians, although the specifics are further defined by each specialty. The developmental trajectories in each of the Competencies are articulated through the Milestones for each specialty.
IV.B.1. The program must integrate the following ACGME Competencies, including sub-competencies associated with additional ACGME recognition status, into the curriculum. (Core)

IV.B.1.a) Professionalism

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

IV.B.1.a).(1) Residents must be expected to demonstrate competence in:

IV.B.1.a).(1).(a) compassion, integrity, and respect for others; (Outcome Core)

IV.B.1.a).(1).(b) responsiveness to patient needs that supersedes self-interest; (Outcome Core)

Background and Intent: This includes the recognition that under certain circumstances, the interests of the patient may be best served by transitioning care to another provider. Examples include fatigue, conflict or duality of interest, not connecting well with a patient, or when another physician would be better for the situation based on skill set or knowledge base.

IV.B.1.a).(1).(c) respect for patient privacy and autonomy; (Outcome Core)

IV.B.1.a).(1).(d) accountability to patients, society, and the profession; (Outcome Core)

IV.B.1.a).(1).(e) respect for sensitivity and responsiveness to a broad diverse patient population, including all manifestations of human diversity but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation; (Outcome Core)

IV.B.1.a).(1).(f) ability to recognize and develop a plan for one’s own personal and professional well-being; and, (Core)

IV.B.1.a).(1).(g) appropriately disclosing and addressing conflict or duality of interest. (Core)

[As further specified by the Review Committee]

IV.B.1.b) Patient Care and Procedural Skills

Background and Intent: Quality patient care is safe, effective, timely, efficient, patient-centered, equitable, and designed to improve population health, while reducing per capita
These organizing principles inform the Common Program Requirements across all Competency domains. Specific content is determined by the Review Committees with input from the appropriate professional societies, certifying boards, and the community.

IV.B.1.b).(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. Residents: (OutcomeCore)

[The Review Committee must further specify] [As further specified by the Review Committee]

IV.B.1.b).(2) Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. Residents: (OutcomeCore)

[The Review Committee may further specify] [As further specified by the Review Committee]

IV.B.1.c) 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: (OutcomeCore)

[The Review Committee must further specify] [As further specified by the Review Committee]

IV.B.1.d) 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 lifelong learning. (OutcomeCore)

Background and Intent: Practice-based learning and improvement is one of the defining characteristics of being a physician. It is the ability to investigate and evaluate the care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning.

The intention of this Competency is to help a physician develop the habits of mind required to continuously pursue quality improvement, well past the completion of residency.

IV.B.1.d).(1) Residents must demonstrate competence in...
to develop skills and habits to be able to meet the following goals:

IV.B.1.d).(1).(a) identifying identify strengths, deficiencies, and limits in one’s knowledge and expertise; (OutcomeCore)

IV.B.1.d).(1).(b) setting set learning and improvement goals; (OutcomeCore)

IV.B.1.d).(1).(c) identifying identify and performing perform appropriate learning activities; (OutcomeCore)

IV.B.1.d).(1).(d) systematically analyzing analyze practice using quality improvement methods, and implementing implement changes with the goal of practice improvement; (OutcomeCore)

IV.B.1.d).(1).(e) incorporating incorporate feedback and formative evaluation feedback into daily practice; (OutcomeCore)

IV.B.1.d).(1).(f) locating, appraising, and assimilating locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems; and. (OutcomeCore)

IV.B.1.d).(1).(g) using use information technology to optimize learning. (OutcomeCore)

IV.B.1.d).(1).(h) participate in the education of patients, families, students, residents and other health professionals. (Outcome)

[The Review Committee may further specify by adding to the list of sub-competencies] [As further specified by the Review Committee]

IV.B.1.e) 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. (OutcomeCore)

IV.B.1.e).(1) Residents must demonstrate competence in are expected to:

IV.B.1.e).(1).(a) communicating communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; (OutcomeCore)
IV.B.1.e).(1). (b) communicating communicate effectively with physicians, other health professionals, and health-related agencies; (OutcomeCore)

IV.B.1.e).(1). (c) working work effectively as a member or leader of a health care team or other professional group; (OutcomeCore)

IV.B.1.e).(1). (d) educating patients, families, students, residents, and other health professionals; (Core)

IV.B.1.e).(1). (e) acting act in a consultative role to other physicians and health professionals; and, (OutcomeCore)

IV.B.1.e).(1). (f) maintaining maintain comprehensive, timely, and legible medical records, if applicable. (OutcomeCore)

IV.B.1.e).(2) Residents must learn to communicate with patients and families to partner with them to assess their care goals, including, when appropriate, end-of-life goals. (Core)

[The Review Committee may further specify by adding to the list of sub-competencies] [As further specified by the Review Committee]

Background and Intent: When there are no more medications or interventions that can achieve a patient’s goals or provide meaningful improvements in quality or length of life, a discussion about the patient’s goals, values, and choices surrounding the end of life is one of the most important conversations that can occur. Residents must learn to participate effectively and compassionately in these meaningful human interactions, for the sake of their patients and themselves.

Programs may teach this skill through direct clinical experience, simulation, or other means of active learning.

IV.B.1.f) Systems-based Practice

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

IV.B.1.f).(1) Residents must demonstrate competence in are expected to:

IV.B.1.f).(1). (a) working work effectively in various health care delivery settings and systems relevant to their clinical specialty; (OutcomeCore)

Background and Intent: Medical practice occurs in the context of an increasingly complex...
clinical care environment where optimal patient care requires attention to compliance with external and internal administrative and regulatory requirements. Examples might include attention to hand hygiene, timely completion of medical records, etc.

IV.B.1.f).(1).(b) coordinating patient care across within the health care system continuum and beyond as relevant to their clinical specialty; *(OutcomeCore)*

Background and Intent: Every patient deserves to be treated as a whole person. Therefore it is recognized that any one component of the health care system does not meet the totality of the patient's needs. An appropriate transition plan requires coordination and forethought by an interdisciplinary team. The patient benefits from proper care and the system benefits from proper use of resources.

IV.B.1.f).(1).(c) advocating for quality patient care and optimal patient care systems; *(OutcomeCore)*

IV.B.1.f).(1).(d) working in interprofessional teams to enhance patient safety and improve patient care quality; *(OutcomeCore)*

IV.B.1.f).(1).(e) participating in identifying system errors and implementing potential systems solutions; *(OutcomeCore)*

IV.B.1.f).(1).(f) incorporating considerations of value, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate; and, *(OutcomeCore)*

IV.B.1.f).(1).(g) understanding health care finances and its impact on individual patients' health decisions. *(Core)*

IV.B.1.f).(2) Residents must learn to advocate for patients within the health care system to achieve the patient's and family's care goals, including, when appropriate, end-of-life goals. *(Core)*

[The Review Committee may further specify by adding to the list of sub-competencies] [As further specified by the Review Committee]

IV.C. Curriculum Organization and Resident Experiences

IV.C.1. The curriculum must be structured to optimize resident educational experiences, the length of these experiences, and supervisory continuity. *(Core)*

[The Review Committee may further specify]

[The Review Committee may specify required didactic and clinical experiences]
Background and Intent: In some specialties, frequent rotational transitions, inadequate continuity of faculty member supervision, and dispersed patient locations within the hospital have adversely affected optimal resident education and effective team-based care. The need for patient care continuity varies from specialty to specialty and by clinical situation, and may be addressed by the individual Review Committee.

IV.D. Scholarship

Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through resident participation in scholarly activities. Scholarly activities may include discovery, integration, application, and teaching.

The ACGME recognizes the diversity of residencies and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program’s scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.

IV.D.1. Program Responsibilities

IV.D.1.a) The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)

IV.D.1.b) The sponsoring institution and program must allocate adequate educational resources to facilitate resident and faculty involvement in scholarly activities. (Core)

[The Review Committee may further specify]

IV.D.1.c) The curriculum must advance residents’ knowledge and practice of the scholarly approach to evidence-based patient care. (Core)

Background and Intent: The scholarly approach can be defined as a synthesis of teaching, learning, and research with the aim of encouraging curiosity and critical thinking based on an understanding of physiology, pathophysiology, differential diagnosis, treatments, treatment alternatives, efficiency of care, and patient safety. While some faculty members are responsible for fulfilling the traditional elements of scholarship through research, integration, and teaching, all faculty members are responsible for advancing residents’ scholarly approach to patient care.

Elements of a scholarly approach to patient care include:

- Asking meaningful questions to stimulate residents to utilize learning resources to create a differential diagnosis, a diagnostic algorithm, and treatment plan.
Challenging the evidence that the residents use to reach their medical decisions so that they understand the benefits and limits of the medical literature

When appropriate, dissemination of scholarly learning in a peer-reviewed manner (publication or presentation)

Improving resident learning by encouraging them to teach using a scholarly approach

The scholarly approach to patient care begins with curiosity, is grounded in the principles of evidence-based medicine, expands the knowledge base through dissemination, and develops the habits of life-long learning by encouraging residents to be scholarly teachers.

IV.D.2. Faculty Scholarly Activity

IV.D.2.a) Among their scholarly activity, programs must have efforts in at least three of the following domains: (Core)

- Research in basic science, education, translational science, patient care, or population health
- Peer-reviewed grants
- Quality improvement and/or patient safety initiatives
- Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports
- Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials
- Contribution to professional committees, educational organizations, or editorial boards
- Innovations in education

IV.D.2.b) The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:

[Review Committee will choose to require either IV.D.2.b).(1) or both IV.D.2.b).(1) and IV.D.2.b).(2)]

Background and Intent: For the purposes of education, metrics of scholarly activity represent one of the surrogates for the program’s effectiveness in the creation of an environment of inquiry that advances the residents’ scholarly approach to patient care. The Review Committee will evaluate the dissemination of scholarship for the program as a whole, not for individual faculty members, with the goal of assessing the effectiveness of the creation of such an environment. The ACGME recognizes that there may be differences in scholarship requirements between different specialties and between residencies and fellowships in the same specialty.
IV.D.2.b)(2) peer-reviewed publication. (Outcome)

IV.D.3. Residents' Scholarly Activity

IV.D.3.a) Residents must should participate in scholarship and scholarly activity. Each graduating resident should have a scholarly activity that is disseminated as further described in IV.D.2.b)(1) or IV.D.2.b)(2). (Core)

[The Review Committee may further specify] [As further specified by the Review Committee]

Background and Intent: While some Review Committees may accept local dissemination of resident scholarship, others may require external dissemination.

IV.D.3.b) 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)

[Moved to IV.A.5.]

V. Evaluation

V.A. Resident Evaluation

V.A.1. Feedback, and Evaluation Formative Evaluation

Background and Intent: Feedback is ongoing information provided regarding aspects of one's performance or understanding. The faculty empower residents to provide much of that feedback themselves in a spirit of continuous learning and self-reflection. Feedback from faculty members in the context of routine clinical care should be frequent, and need not always be formally documented.

Formative and summative evaluation have distinct definitions. Formative evaluation is monitoring resident learning and providing ongoing feedback that can be used by residents to improve their learning in the context of provision of patient care or other educational opportunities. More specifically, formative evaluations help:

- residents identify their strengths and weaknesses and target areas that need work
- program directors and faculty members recognize where residents are struggling and address problems immediately

Summative evaluation is evaluating a resident's learning by comparing the residents against the goals and objectives of the rotation and program, respectively. Summative evaluation is utilized to make decisions about promotion to the next level of training, or program completion.

End-of-rotation and end-of-year evaluations have both summative and formative components. Information from a summative evaluation can be used formatively when residents or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the residency program.
Feedback, formative evaluation, and summative evaluation compare intentions with accomplishments, enabling the transformation of a neophyte physician to one with growing expertise.

V.A.1.a) Faculty must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. 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)

Background and Intent: Faculty members should provide feedback frequently throughout the course of each rotation. Residents require feedback from faculty members to reinforce well-performed duties and tasks, as well as to correct deficiencies. This feedback will allow for the development of the learner as they strive to achieve the Milestones. More frequent feedback is strongly encouraged for residents who have deficiencies that may result in a poor final rotation evaluation.

V.A.1.b) Evaluation must be documented at the completion of the assignment. (Core)

V.A.1.b).(1) For rotations of greater than two months in duration, evaluation must be documented at least every two months. (Core)

V.A.1.b).(2) Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion. (Core)

V.A.1.c) The program must be organized to provide an objective assessment-performance evaluation based on the Competencies and 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, and must: (Core)

V.A.1.c).(1) use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, (CoreDetail)

V.A.1.c).(2) provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. (Core)

V.A.1.c).(3) document progressive resident performance improvement appropriate to educational level; and, (Core)

V.A.1.c).(4) provide each resident with documented semiannual evaluation of performance with feedback. (Core)
V.A.1.d) The program director or their designee, with input from the Clinical Competency Committee, must:

meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones; (Core)

V.A.1.d).(1)

assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and, (Core)

V.A.1.d).(2)

develop plans for residents failing to progress, following institutional policies and procedures. (Core)

V.A.1.d).(3)

Background and Intent: Learning is an active process that requires effort from the teacher and the learner. Faculty members evaluate a resident's performance at least at the end of each rotation. The program director or their designee will review those evaluations, including their progress on the Milestones, at a minimum of every six months. Residents should be encouraged to reflect upon the evaluation, using the information to reinforce well-performed tasks or knowledge or to modify deficiencies in knowledge or practice. Working together with the faculty members, residents should develop an individualized learning plan.

Residents who are experiencing difficulties with achieving progress along the Milestones may require intervention to address specific deficiencies. Such intervention, documented in an individual remediation plan developed by the program director or a faculty mentor and the resident, will take a variety of forms based on the specific learning needs of the resident. However, the ACGME recognizes that there are situations which require more significant intervention that may alter the time course of resident progression. To ensure due process, it is essential that the program director follow institutional policies and procedures.

V.A.1.e) At least annually, there must be a summative evaluation of each resident's readiness to progress to the next year of the program. (Core)

V.A.1.f) The evaluations of resident performance must be accessible for review by the resident. (CoreDetail)

[The Review Committee may further specify under any requirement in V.A.1.-V.A.1.f]

V.A.2. Final Summative Evaluation

V.A.2.a) The program director must provide a final summative evaluation for each resident upon completion of the program. (Core)

V.A.2.a).(1) The specialty-specific Milestones, and when applicable the specialty-specific Case Logs, must be used as one of the tools to ensure residents are able to engage in autonomous practice core professional activities without supervision upon completion of the program. (Core)
The final evaluation must:

V.A.2.a).(2).a) 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.

V.A.2.a).(2).b) verify that the resident has demonstrated sufficient competence to enter practice without supervision.

V.A.2.a).(2).c) consider recommendations from the Clinical Competency Committee; and,

V.A.2.a).(2).d) be shared with the resident upon completion of the program.

V.A.2.a).(2).e) document the resident’s performance during the final period of education.

V.A.3. A Clinical Competency Committee must be appointed by the program director. The program director must appoint the Clinical Competency Committee.

V.A.3.a) At a minimum the Clinical Competency Committee must be composed of three members of the program faculty.

V.A.3.a).(1) The program director may appoint additional members of the Clinical Competency Committee. These additional members must be 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.

Background and Intent: The requirements regarding the Clinical Competency Committee do not preclude or limit a program director’s participation on the Clinical Competency Committee. The intent is to leave flexibility for each program to decide the best structure for its own circumstances, but a program should consider: its program director’s other roles as resident advocate, advisor, and confidante; the impact of the program director’s presence on the other Clinical Competency Committee members’ discussions and decisions; the size of the program faculty; and other program-relevant factors. The program director has final responsibility for resident evaluation and promotion decisions.

Program faculty may include more than the physician faculty members, such as other physicians and non-physicians who teach and evaluate the program’s residents. There may be additional members of the Clinical Competency Committee. 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.
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)

There must be a written description of the responsibilities of the Clinical Competency Committee. (Core) The Clinical Competency Committee should:

- review all resident evaluations at least semi-annually; (Core)
- determine each resident’s progress on achievement of the specialty-specific Milestones prepare and ensure the reporting of Milestones evaluations of each resident semi-annually to ACGME; and, (Core)

- meet prior to the resident’s semi-annual evaluation and advise the program director regarding each resident’s progress, including promotion, remediation, and dismissal. (CoreDetail)

At least annually, the program must evaluate each faculty member’s performance as it relates to the educational program. (Core)

This evaluation must include a review of the faculty member’s clinical teaching abilities, engagement with commitment to the educational program, participation in faculty development related to skills as an educator, clinical performance knowledge, professionalism, and scholarly activities. (CoreDetail)

This evaluation must include at least annual written, anonymous, and confidential evaluations by the residents. (CoreDetail)

Faculty members must receive feedback on their evaluations at least annually. (Core)

Results of the faculty evaluation should be used as a basis for faculty development plans. (Core)

Background and Intent: The quality of the faculty’s teaching and clinical care is a determinant of the quality of the program and the quality of the residents’ future clinical care. Therefore, the program has the responsibility to evaluate and improve the program faculty members’ teaching, scholarship, professionalism, and quality care. This section mandates annual review of the program’s faculty for this purpose.

The program director must appoint the Program Evaluation Committee. (Core)
V.C.1.a) The Program Evaluation Committee must be composed of at least two program faculty members and at least one resident. (Core)

V.C.1.b) Program Evaluation Committee must have a written description of its responsibilities must include:

V.C.1.b).(1) should participate actively in: planning, developing, implementing, and evaluating educational activities of the program; (Detail)

V.C.1.b).(2) reviewing and making recommendations for revision of competency-based curriculum goals and objectives; and, (Detail)

V.C.1.b).(3) addressing areas of non-compliance with ACGME requirements. (Detail)

V.C.1.b).(4) reviewing the program annually using evaluations of faculty, residents, and others, as specified below. (Detail)

V.C.2. The Program Evaluation Committee must conduct and document the Annual Program Evaluation, including the plan for improvement. 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)

Background and Intent: In order to achieve its mission and train the highest quality physicians, a program must evaluate its performance and plan for improvement in the Annual Program Evaluation. Performance of residents and faculty members is a reflection of program quality, and can use metrics that reflect the goals that a program has set for itself. The Program Evaluation Committee must include the following elements in its assessment of the program The program must monitor and track each of the following areas:

V.C.2.a).(1) curriculum; (Core)

V.C.2.a).(2) outcomes from prior Annual Program Evaluation(s); (Core)

V.C.2.a).(3) ACGME letters of notification, including citations, Areas for Improvement, and comments; (Core)

V.C.2.a).(4) quality and safety of patient care; (Core)

V.C.2.a).(5) aggregate resident and faculty:

V.C.2.a).(5).(a) well-being; (Core)

V.C.2.a).(5).(b) recruitment and retention; (Core)
V.C.2.a).(5).(c) workforce diversity; (Core)

V.C.2.a).(5).(d) engagement in quality improvement and patient safety; (Core)

V.C.2.a).(5).(e) scholarly activity; (Core)

V.C.2.a).(5).(f) ACGME Resident and Faculty Surveys; and, (Core)

V.C.2.a).(5).(g) written evaluations of the program. (Core)

V.C.2.a).(6) aggregate resident:

V.C.2.a).(6).(a) achievement of Milestones; (Core)

V.C.2.a).(6).(b) in-training examinations (where applicable); (Core)

V.C.2.a).(6).(c) Board pass and certification rates graduate performance, including performance of program graduates on the certification examination; and, (Core)

V.C.2.a).(6).(d) graduate clinical resident performance. (Core)

V.C.2.a).(7) aggregate faculty:

V.C.2.a).(7).(a) faculty performance; and, (Core)

V.C.2.a).(7).(b) professional faculty development. (Core)

V.C.2.a).(8) program quality; and, (Core)

Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and (Detail)

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.a).(9) progress on the previous year’s action plan(s). (Core)

V.C.2.b) The Program Evaluation Committee must evaluate the program’s mission and aims, strengths, areas for improvement, and threats. (Core)

V.C.2.c) The annual review, including the action plan, must:

V.C.2.c).(1) be distributed to and discussed with the members of the teaching faculty and the residents; and, (Core)
V.C.2.c).(2) **be reviewed by the GMEC.** (Core)

V.C.2.d) **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.2.d).(1) The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes. (Detail)

V.C.3. **The program must complete a Self-Study prior to its 10-year accreditation site visit.** (Core)

Background and Intent: Outcomes of the documented Annual Program Evaluation can be integrated into the 10-year Self-Study process. The Self-Study is an objective, comprehensive evaluation of the residency program, with the aim of improving it. Underlying the Self-Study is this longitudinal evaluation of the program and its learning environment, facilitated through sequential Annual Program Evaluations that focus on the required components, with an emphasis on program strengths and self-identified areas for improvement. Details regarding the timing and expectations for the Self-Study and the 10-year accreditation site visit are provided in the ACGME Manual of Policies and Procedures. Additionally, a description of the Self-Study process, as well as information on how to prepare for the 10-year accreditation site visit is available on the ACGME website.

V.C.4. **One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.**

V.C.4.a) The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board. (Core)

V.C.4.b) **For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, aggregate pass rate of program graduates taking the examination for the first time must be above the fifth percentile.** (Outcome)

V.C.4.c) **For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, aggregate pass rate of program graduates taking the examination for the first time must be above the fifth percentile for pass rate.** (Outcome)

V.C.4.d) **For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, aggregate pass rate of program graduates taking the examination for the first time must be above the fifth percentile.**
V.C.4.e) For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, aggregate pass rate of program graduates taking the examination for the first time must be above the fifth percentile for pass rate. (Outcome)

V.C.4.f) For each of the exams referenced in V.C.4.b)-e), any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program. (Outcome)

Background and Intent: Setting a single standard for pass rate that works across specialties is not supportable based on the heterogeneity of the psychometrics of different examinations. By using a percentile rank, the performance of the lower five percent (fifth percentile) of programs can be identified and set on a path to curricular and test preparation reform.

There are specialties where there is a very high Board pass rate that could leave successful programs in the bottom five percent (fifth percentile) despite admirable performance. These high-performing programs should not be cited, and V.C.4.f) is designed to address this.

V.C.4.g) Programs must report in the Accreditation Data System (ADS) board certification rates annually for the cohort of residents that graduated seven years earlier. (Core)

Background and Intent: It is essential that residency programs demonstrate knowledge and skill transfer to their residents. One measure of that is the qualifying or initial certification exam pass rate. Another important parameter of the success of the program is the ultimate board certification rate of its graduates. Graduates are eligible for up to seven years from residency graduation for initial certification. The ACGME will calculate a rolling three-year average of the ultimate board certification rate at seven years post-graduation, and the Review Committees will monitor it.

The Review Committees will track the rolling seven-year certification rate as an indicator of program quality. Programs are encouraged to monitor their graduates’ performance on board certification examinations.

In the future, the ACGME may establish parameters related to ultimate board certification rates.

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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.