

**RESIDENCY REVIEW COMMITTEE FOR EMERGENCY MEDICINE
REVIEWER'S CHECKLIST**

Name of Program _____ Program # _____

Reviewer's Name _____ Meeting Date _____

SECTION	REQUIREMENT	Check if NONcompliance
I.A	<p>INTRODUCTION <u>Definition and Scope of the Specialty</u></p> <p>Residencies in emergency medicine are designed to prepare physicians for the practice of emergency medicine. These programs must teach the fundamental skills, knowledge, and humanistic qualities that constitute the foundations of emergency medicine practice and provide progressive responsibility for and experience in the application of these principles to enable effective management of clinical problems. Equal opportunity must be provided for the residents, under the guidance and supervision of a qualified faculty, to develop a satisfactory level of clinical maturity, judgment, and technical skill. On completion of the program, residents should be capable of practicing emergency medicine, able to incorporate new skills and knowledge during their careers, and able to monitor their own physical and mental well being and that of others.</p>	
I.B.1	<p><u>Duration and Scope of Education</u></p> <p>The required length of an emergency medicine residency is 36 months in a curriculum under the control of the emergency medicine program director. Accreditation by the Accreditation Council for Graduate Medical Education (ACGME) is required for all years of the educational program.</p>	
I.B.2	<p>Before entry into the program, each resident must be notified in writing of the required length of the program. This period may not be changed for a particular resident during his or her program unless there is a significant break in his or her education, or the resident needs remedial education.</p>	
II.A	<p>INSTITUTIONS <u>Sponsoring Institution</u></p> <p>One sponsoring institution must assume the ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating institutions. The sponsoring institution must provide evidence of commitment to graduate medical education, including emergency medicine. While it is recognized that the practice of emergency medicine occurs within a variety of organizational structures, the administrative and academic structure must be organized in a way that facilitates the provision of an adequate educational experience. There must be evidence of an adequate financial commitment to the program.</p>	
II.B.1	<p><u>Participating Institutions</u></p> <p>Assignments to participating institutions must be based on a clear educational rationale, integral to the program curriculum, must have clearly-stated activities and objectives and should provide resources not otherwise available to the program. When multiple participating institutions are used, there should be assurance of the continuity of the educational experience.</p>	

II.B.2	Assignment to a participating institution requires a letter of agreement with the sponsoring institution. Such a letter of agreement should:	
II.B.2.a	identify the faculty who will assume both educational and supervisory responsibilities for residents;	
II.B.2.b	specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;	
II.B.2.c	specify the duration and content of the educational experience; and	
II.B.2.d	state the policies and procedures that will govern resident education during the assignment.	
II.B.2.e	such a letter of agreement for Emergency Medicine should also describe resources and facilities in the institution(s) that will be available to residents, including but not limited to library and medical records;	
II.B.2.f	explain the relationship that will exist between emergency medicine residents and residents and faculty in other programs;	
II.B.2.g	and, for emergency medicine rotations, identify the physician responsible under the authority of the program director for the teaching and supervision of emergency medicine residents.	
II.B.3	The program should be based at a primary hospital (hereafter referred to as the <i>primary clinical site</i>). More of the didactic and clinical experiences should take place at the primary clinical site than at any other single site. Educationally justified exceptions to this requirement will be considered.	
II.B.4	Programs using multiple hospitals must ensure the provision of a unified educational experience for the residents. Each affiliated institution must offer significant educational opportunities to the overall program. The reasons for including each institution must be stated.	
II.B.5	To maintain program cohesion, continuity, and critical mass, as well as to reduce stress on the residents and their families, mandated rotations to affiliated institutions that are geographically distant from the sponsoring institution are acceptable only if they offer special resources or a rural EM experience, unavailable locally, that significantly augment the overall educational experience of the program.	
II.B.6	The number and geographic distribution of participating institutions must not preclude the satisfactory participation by all residents in conferences and other educational exercises.	
II.C.1	<u>Affiliation Agreements</u> When there is a cooperative educational effort involving multiple institutions, the commitment of each institution to the program must be made explicit in an affiliation agreement with each institution that conforms to ACGME Institutional Requirements.	
II.D	<u>Medical School Affiliation</u> Medical school affiliation is desirable. When a medical school affiliation is present, there must be a written affiliation agreement or a letter of understanding which documents the duties and responsibilities of both the medical school and the program. Program core faculty should have appropriate faculty appointments at the medical school.	
II.E	<u>Facilities and Resources</u>	

	In every hospital in which the emergency department is used as a training site, the following must be provided; exceptions for rotations in rural settings will be considered with appropriate educational justification:	
II.E.1	adequate space for patient care;	
II.E.2	adequate space for clinical support services;	
II.E.3	laboratory and diagnostic imaging results returned on a timely basis; (especially those required on a STAT basis)	
II.E.4	adequate program support space, including office space for faculty and residents;	
II.E.5	current medical library resources, including access to appropriate informational resources and medical databases in the emergency department. In addition, residents must have ready access to a major medical library either at the institution where the residents are located or through arrangement with convenient nearby institutions; these services should include the electronic retrieval of information from medical databases;	
II.E.6	adequate and readily accessible instructional space;	
II.E.7	information systems; and,	
II.E.8	appropriate security services and systems to ensure a safe working environment.	
II.F.1	<u>Clinical Services</u> Clinical support services must be provided on a 24-hour basis. These services must be adequate to meet reasonable and expected demands and must include nursing, clerical, intravenous, EKG, respiratory therapy, messenger/transporter, and phlebotomy services.	
II.F.2	The hospital must assure that all clinical specialty and subspecialty services are available in a timely manner for emergency department consultation and hospital admission. Clinical services should include, but are not limited to, internal medicine and its subspecialties, surgery and its subspecialties, pediatrics and its subspecialties, orthopedics, obstetrics and gynecology. If any clinical services are not available for consultation or admission, the hospital must have a written protocol for provision of these services elsewhere. This may include written agreements for the transfer of these patients to a designated hospital that provides the needed clinical service.	
III.A.1	PROGRAM PERSONNEL AND RESOURCES <u>Program Director</u> There must be a single program director responsible for the program. The person designated with this authority is accountable for the operation of the program and should be a member of the staff of the sponsoring or integrated institution. In the event of a change of either program director or department chair, the program director should promptly notify the executive director of the Residency Review Committee (RRC) through the Web Accreditation Data System of the Accreditation Council for Graduate Medical Education (ACGME).	
III.A.2	The program director together with the faculty, is responsible for the general administration of the program, and for the establishment and maintenance of a stable educational environment. Adequate lengths of appointment for both the program director and faculty are essential to maintaining such an environment. The length of appointment for the program director should provide continuity of leadership. Frequent changes in leadership or long periods of temporary leadership may adversely affect the accreditation status of the program.	

III.A.3.a	<p>Qualifications of the Program Director are as follows:</p> <p>The program director must possess the requisite specialty expertise, as well as documented educational and administrative abilities.</p>	
III.A.3.b	<p>The program director must be certified in the specialty by the American Board of Emergency Medicine, or possess qualifications judged to be acceptable by the RRC.</p>	
III.A.3.c	<p>The program director must be appointed in good standing and based at the primary teaching site.</p>	
III.A.3.d	<p>The program director must function within a sound administrative organizational framework, and have an effective program faculty; both are essential elements of an approved residency program.</p>	
III.A.3.e	<p>The program director must be a member of the program's core teaching faculty.</p>	
III.A.3.f	<p>The program director must have at least three years' experience as a clinician, administrator, and educator in emergency medicine.</p>	
III.A.3.g	<p>The program director must not work more than 20 hours per week clinically, on average, or 960 clinical hours per year.</p>	
III.A.3.h	<p>The program director must be active full time in emergency medicine, be clinically active, devote sufficient time and effort to the program to provide day-to-day continuity of leadership, and fulfill all of the responsibilities inherent in meeting the educational goals of the program.</p>	
III.A.3.i	<p>The program director must demonstrate leadership qualities and the capability to mentor emergency medicine residents.</p>	
III.A.3.j	<p>The program director must demonstrate active involvement in</p>	
III.A.3.j.1	<p>continuing emergency medicine education,</p>	
III.A.3.j.2	<p>state, regional, or national societies; and,</p>	
III.A.3.j.3	<p>presentations, publications, and other scholarly activities.</p>	
III.A.3.k	<p>The program director must have appropriate authority to oversee and to organize the activities of the educational program, including but not limited to:</p>	
III.A.3.k.1	<p>supervision, direction and administration of the educational activities;</p>	
III.A.3.k.2	<p>evaluation of the residents and residency program; and,</p>	
III.A.3.k.3	<p>participation in the evaluation of faculty.</p>	
III.A.4.a	<p>Responsibilities of the Program Director are as follows:</p> <p>The program director must oversee and organize the activities of the educational program in all institutions that participate in the program. This includes selecting and supervising the faculty and other program personnel at each participating institution, appointing a local site director, and monitoring appropriate resident supervision at all participating institutions.</p>	

III.A.4.b	The program director is responsible for preparing an accurate statistical and narrative description of the program as requested by the RRC, as well as updating annually both program and resident records through the ACGME's Accreditation Data System.	
III.A.4.c	The program director must ensure the implementation of fair policies, grievance procedures, and due process, as established by the sponsoring institution and in compliance with the Institutional Requirements.	
III.A.4.d	The program director must seek the prior approval of the RRC for any changes in the program that may significantly alter the educational experience of the residents. On review of a proposal for any such major change in a program, the RRC may determine that a site visit is necessary. Such changes, for example, include:	
III.A.4.d.1	the addition or deletion of a participating institution to which residents rotate for 4 months or longer;	
III.A.4.d.2	a change in the format of the educational program;	
III.A.4.d.3	a change in the approved resident complement (prior approval is not required for temporary changes in resident numbers due to makeup or remedial time for currently enrolled residents or to fill vacancies at the same level of education in which the vacancy occurs);	
III.A.4.e	Selection of residents for appointment to the program in accordance with institutional and departmental policies and procedures.	
III.A.4.f	The supervision of residents through explicit written descriptions of supervisory lines of responsibility for the care of patients. Such guidelines must be communicated to all members of the program staff. Residents must be provided with prompt, reliable systems for communication and interaction with supervisory physicians.	
III.A.4.g	Regular evaluation of the residents' knowledge, skill and overall performance.	
III.A.4.h	Provision of a written final evaluation for each resident who completes the program. The evaluation must include a review of the resident's performance during the final period of training and should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. This final evaluation should be part of the resident's permanent record maintained by the institution.	
III.B.1	<u>Faculty</u> At each participating institution, there must be a sufficient number of faculty with documented qualifications to instruct and supervise adequately all residents in the program. Members of the faculty of the emergency medicine program must be able to devote sufficient time to meet their supervisory and teaching responsibilities. To ensure a sufficient number of faculty to provide adequate on-line 24-hour emergency department attending staff supervision and participation in ongoing scholarly activity and research in support of the emergency medicine residents, there must be a minimum of one core physician faculty member for every three residents in the program. When the total resident complement exceeds 30, the faculty-resident ratio of one core faculty member for every three residents may be altered with appropriate educational justification.	
III.B.2	The faculty, furthermore, must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities. They must demonstrate a strong interest in the education of residents, and must support the goals and objectives of the educational program of which they are a member. A core physician faculty member, a member of the program faculty, is one who provides clinical service and teaching, devotes the majority of his or her professional efforts to the program and has sufficient time protected from direct service responsibilities to meet the educational requirements of the program. To this end, core faculty should not average more than 28 clinical hours per	

	week, or 1344 clinical hours per year.	
III.B.3.a	Qualifications of the physician faculty are as follows: The physician faculty must possess the requisite specialty expertise and competence in clinical care and teaching abilities, as well as documented educational and administrative abilities and experience in their field.	
III.B.3.b	The physician faculty must be certified in the specialty by the American Board of Emergency Medicine or possess qualifications judged to be acceptable by the RRC. <i>This standard applies to all core physician program faculty and to other attending staff hired to provide resident supervision in any emergency department where emergency medicine residents rotate.</i>	
III.B.3.c	The physician faculty must be appointed in good standing to the staff of an institution participating in the program.	
III.B.3.d	The physician faculty for emergency medicine must show evidence of participation in a spectrum of professional activities within the institution, as well as within local, state, regional, and national associations.	
III.B.3.e	The physician faculty for emergency medicine must be engaged in research and have protected time and adequate support services to accomplish these tasks.	
III.B.3.f	Offering of guidance and technical support (e.g., research design, statistical analysis) for residents involved in research.	
III.B.4	The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the faculty, and an active research component must be included in each program. Graduate medical education must take place in an environment of inquiry and scholarship in which residents participate in the development of new knowledge, learn to evaluate research findings, and develop habits of inquiry as a continuing professional responsibility. Adequate resources for scholarly activities for faculty and residents must be available. The program as a whole must demonstrate broad involvement in scholarly activities. All core faculty must be involved in continuing scholarly activity. <i>Scholarship is defined as the following:</i>	
III.B.4.a	the scholarship of <i>discovery</i> , as evidenced by peer-reviewed funding or by publication of original research in a peer-reviewed journal;	
III.B.4.b	the scholarship of <i>dissemination</i> , as evidenced by review articles or chapters in textbooks;	
III.B.4.c	the scholarship of <i>application</i> , as evidenced by the publication or presentation of, for example, case reports or clinical series at local, regional, or national professional and scientific society meetings;	
III.B.4.d	Active participation in regional or national professional and scientific societies;	
III.B.4.e	Editorial review services, such as serving on editorial boards or serving as a reviewer for peer-reviewed publications;	
III.B.4.f	Abstract or grant review services;	
III.B.5	Qualifications of nonphysician faculty are as follows:	
III.B.5.a	Nonphysician faculty must be appropriately qualified in their field.	

III.B.5.b	Nonphysician faculty must possess appropriate institutional appointments.	
III.B.6	Core Faculty Development Each program should encourage the academic growth of its core faculty. Faculty development opportunities should be made available to each core faculty member.	
III.B.7	Chair/Chief of Emergency Medicine The chair/chief of emergency medicine shall	
III.B.7.a	be licensed to practice medicine in the state where the institution that sponsors the program is located. (Certain federal programs are exempted.);	
III.B.7.b	be a member of the program's core teaching faculty;	
III.B.7.c	be qualified and have at least three years' experience as a clinician, administrator, and educator in emergency medicine;	
III.B.7.d	be certified in emergency medicine by the American Board of Emergency Medicine or have possess appropriate qualifications judged to be acceptable by the RRC;	
III.B.7.e	demonstrate active involvement in emergency medicine through:	
III.B.7.e.1	continuing medical education,	
III.B.7.e.2	professional societies, and	
III.B.7.e.3	scholarly activities, and	
III.B.7.f	demonstrate leadership qualities and be capable of mentoring faculty, residents, administrators, and other health care professionals.	
III.C	<u>Other Program Personnel</u> Additional necessary professional, technical, and clerical must be provided to support the program.	
III.C.1	A member of the program faculty of each participating institution must be designated to assume responsibility for the day-to-day activities of the program at that institution, with overall coordination by the program director.	
III.C.2	The program faculty must be organized and have regular documented meetings in order to review program goals and objectives as well as program effectiveness in achieving them. At least one resident representative should participate in these reviews.	
III.C.3	The program faculty members should periodically evaluate the utilization of the resources available to the program, the contribution of each institution participating in the program, the financial and administrative support for the program, the volume and variety of patients available to the program for educational purposes, the performance of members of the teaching staff, and the quality of supervision of residents.	
III.D	<u>Resources</u>	

	<p>The program must ensure that adequate resources (e.g., sufficient laboratory space and equipment, computer and statistical consultation services) are available.</p> <p>The sponsoring institution for emergency medicine education must have a major educational commitment as evidenced by training programs in other major specialties. The program must demonstrate the availability of educational resources in other specialties for the training of emergency medicine residents. A lack of such resources will adversely affect the accreditation status of the program.</p>	
IV.A	<p>RESIDENT APPOINTMENT</p> <p><u>Eligibility Criteria</u></p> <p>The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements.</p>	
IV.B	<p><u>Number of Residents</u></p> <p>The RRC will approve the number of residents based upon established written criteria that include the adequacy of resources for resident education such as quality and volume of patients and related clinical material available for education, faculty to resident ratio, institutional funding, and the quality of faculty teaching. In addition, the RRC will consider the number of core and total faculty, faculty clinical supervision, patient acuity, and clinical experience with procedures and resuscitations.</p>	
IV.B.1	<p>There should be a minimum of six residents per year of training to achieve a major impact in the emergency department, to ensure meaningful attendance at emergency medicine conferences, to provide for progressive responsibility, and to foster a sense of residency program and departmental identity. Exceptions to these standards will require justification based on sound educational principles and must demonstrate substantial compliance with the intent of this requirement.</p>	
IV.B.2	<p>The program should request a number or range (minimum-maximum) of emergency medicine residents per year. The RRC will approve a range (minimum-maximum) or number of residents per year based on the educational resources of the program.</p>	
IV.C	<p><u>Resident Transfers</u></p> <p>To determine the appropriate level of education for a resident who is transferring from another residency program, the program director must receive written verification of the previous educational experiences and a statement regarding the performance evaluation of the transferring resident, including an assessment of competence in the six core areas described in the Program Requirements, prior to acceptance into the program. A program director is required to provide verification of residency education for any residents who may leave the program prior to completion of their education.</p>	
IV.D	<p><u>Appointment of Fellows and Other Students</u></p> <p>The appointment of fellows and other specialty residents or students must not dilute or detract from the educational opportunities of the regularly appointed specialty residents.</p>	
V.A.1	<p>PROGRAM CURRICULUM</p> <p><u>Program Design</u></p> <p>Format</p> <p>The program design and sequencing of educational experiences will be approved by the RRC as part of the review process.</p>	
V.A.2	<p>Goals and Objectives</p>	

	The program must possess a written statement that outlines its educational goals with respect to the knowledge, skills, and other attributes of residents for each major assignment and for each level of the program. This statement must be distributed to residents and faculty, and must be reviewed with residents prior to their assignments.	
V.A.3	<p>Role of Program Director and Faculty</p> <p>The program director, with assistance of the faculty, is responsible for developing and implementing the academic and clinical program of resident education by preparing and implementing a written statement outlining the educational goals of the program with respect to the knowledge, skills, and other attributes of residents for each major assignment and each level of the program. The statement must be distributed to residents and faculty and reviewed with residents prior to the assignment.</p>	
V.B	<p><u>Specialty Curriculum</u></p> <p>The program must possess a well-organized and effective curriculum, both academic and clinical, which includes the presentation of core specialty knowledge supplemented by the addition of current information. The curriculum must also provide residents with direct experience in progressive responsibility for patient management.</p>	
V.B.1.a.1	<p>Organization and Structure</p> <p>Patient Population</p> <p>There must be an adequate number of patients of all ages and both sexes with a wide variety of clinical problems to provide a patient population sufficient to meet the educational needs of emergency medicine residents and other residents who are assigned for training in emergency medicine. The primary clinical site and other emergency departments where residents rotate for 4 months or longer should have at least 30,000 emergency department visits annually. Educationally justifiable exceptions will be considered, such as clinical sites in a rural setting.</p>	
V.B.1.a.2	<p>Pediatric experience, defined as the care of patients less than 18 years of age, should be at least 16% of all resident emergency department encounters, or 4 months of full-time-equivalent experience dedicated to the care of infants and children. The program can balance a deficit of patients by offering dedicated rotations in the care of infants and children. The formula for achieving this balance is a 1-month rotation equals 4% of patients. Although this experience should include the critical care of infants and children, at least 50% of the 4 months should be in an emergency setting.</p>	
V.B.1.a.3	<p>The number of critically ill or critically injured patients treated in aggregate by the residents at the primary clinical site should be significant, constituting at least 3% or 1,200 of the emergency department patients per year (whichever is greater) who are admitted to monitored care settings, operative care or the morgue following treatment in the emergency department. Additional critical care experience is required during off-service rotations.</p>	
V.B.2.a	<p>Curriculum</p> <p>The program director must provide each resident and member of the faculty, in writing and in advance of the experience, a comprehensive curriculum specific to the educational needs of the emergency medicine resident and designed to accomplish the defined goals and core competencies of the emergency medicine training program. The curriculum shall be readily available for review.</p>	
V.B.2.b	<p>The curriculum must include didactic and clinical information to enable the residents to achieve the goals and competencies of the training program. These include knowledge and skill-based competencies as listed in the Model of the Clinical Practice of Emergency Medicine (www.acgme.org) that include, but are not limited to, signs, symptoms, and presentations; abdominal and gastrointestinal disorders; cardiovascular disorders; cutaneous disorders; endocrine, metabolic and nutritional disorders; environmental disorders; head, ear, eye, nose, throat disorders; hematologic disorders; immune system disorders; systemic infectious disorders; musculoskeletal disorders (nontraumatic); nervous system disorders; obstetrics and gynecology; psychobehavioral disorders; renal and urogenital disorders; thoracic-respiratory disorders;</p>	

	toxicologic disorders; and traumatic disorders.	
V.B.2.c	The curriculum must include measurable competency objectives for each year of training, a description of how the objectives will be assessed and remediated when necessary. Measurable objectives should also be developed for each non-EM rotation with assessment tools described.	
V.C	<u>Resident Scholarly Activities:</u> Provision of support for resident participation in scholarly activities	
V.C.1	Each program must provide an opportunity for residents to participate in research or other scholarly activities, and residents must participate actively in such scholarly activities.	
V.C.2	The curriculum should include resident experience in scholarly activity prior to completion of the program. Some examples of suitable resident scholarly activities are the preparation of a scholarly paper such as a collective review or case report, active participation in a research project, or formulation and implementation of an original research project; and,	
V.C.3	Residents must be taught an understanding of basic research methodologies, statistical analysis, and critical analysis of current medical literature. Complementary to the above scholarship is the regular participation of the teaching staff in clinical discussions, rounds, journal clubs, and research conferences in a manner that promotes a spirit of inquiry and scholarship (e.g., the offering of guidance and technical support for residents involved in research such as research design and statistical analysis); and the provision of support for residents' participation, as appropriate, in scholarly activities.	
V.D	<u>ACGME Core Competencies</u> The residency program must require that its residents obtain competence in the six areas listed below to the level expected of a new practitioner. Programs must define the specific knowledge, skills, behaviors, and attitudes required and provide educational experiences as needed in order for their residents to demonstrate the following competency objectives are met:	
V.D.1	Patient Care: 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. Among other things, residents are expected to:	
V.D.1.a	Gather accurate, essential information in a timely manner.	
V.D.1.b	Generate an appropriate differential diagnosis	
V.D.1.c	Implement an effective patient management plan.	
V.D.1.d	Competently perform the diagnostic and therapeutic procedures and emergency stabilization.	
V.D.1.e	Prioritize and stabilize multiple patients and perform other responsibilities simultaneously.	
V.D.1.f	Provide health care services aimed at preventing health problems or maintaining health.	
V.D.1.g	Work with health care professionals to provide patient-focused care.	
V.D.2	Medical Knowledge: Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Among other things, residents are expected to:	
V.D.2.a	Identify life-threatening conditions, the most likely diagnosis, synthesize acquired patient data, and identify how and when to access current medical information	

V.D.2.b	Properly sequence critical actions for patient care and generate a differential diagnosis for an undifferentiated patient	
V.D.2.c	Complete disposition of patients using available resources	
V.D.3	Practice-Based Learning: Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Among other things, residents are expected to:	
V.D.3.a	Analyze and assess their practice experience and perform practice-based improvement	
V.D.3.b	Locate, appraise and utilize scientific evidence related to their patient's health problems	
V.D.3.c	Apply knowledge of study design and statistical methods to critically appraise the medical literature	
V.D.3.d	Utilize information technology to enhance their education and improve patient care	
V.D.3.e	Facilitate the learning of students and other health care professionals	
V.D.4	Interpersonal and Communication Skills: Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families and professional associates. Among other things, residents are expected to:	
V.D.4.a	Develop an effective therapeutic relationship with patients and their families, with respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences	
V.D.4.b	Demonstrate effective participation in and leadership of the health care team	
V.D.4.c	Develop effective written communication skills	
V.D.4.d	Demonstrate the ability to handle situations unique to the practice of emergency medicine	
V.D.4.e	Effectively communicate with out-of-hospital personnel as well as non-medical personnel	
V.D.5	Professionalism: Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to demonstrate a set of model behaviors that include but are not limited to:	
V.D.5.a	Treats patients/family/staff/paraprofessional personnel with respect	
V.D.5.b	Protects staff/family/patient's interests/confidentiality	
V.D.5.c	Demonstrates sensitivity to patient's pain, emotional state, and gender/ethnicity issues,	
V.D.5.d	Able to discuss death honestly, sensitively, patiently, and compassionately	
V.D.5.e	Unconditional positive regard for the patient, family, staff, and consultants	
V.D.5.f	Accepts responsibility/accountability	
V.D.5.g	Openness and responsiveness to the comments of other team members, patients, families, and peers	
V.D.6	Systems-Based Practice: Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the	

	ability to effectively call on system resources to provide care that is of optimal value. Among other things, residents are expected to:	
V.D.6.a	Understand, access, appropriately utilize, and evaluate the effectiveness of the resources, providers, and systems necessary to provide optimal emergency care	
V.D.6b	Understand different medical practice models and delivery systems and how to best utilize them to care for the individual patient	
V.D.6.c	Practice cost-effective health care and resource allocation that does not compromise quality of care	
V.D.6.d	Advocate for and facilitates patients' advancement through the health care system.	
V.E.1	<u>Planned Educational Experiences</u> Each program must offer its residents an average of at least 5 hours per week of planned educational experiences (not including change of shift report) developed by the emergency medicine residency program.	
V.E.2	The program should ensure that residents are relieved of clinical duties to attend these planned educational experiences. Although release from some off-service rotations may not be possible, the program should require that each resident participate in at least 70% of the planned emergency medicine educational experiences offered (excluding vacations). Attendance should be monitored and documented.	
V.E.3	These educational experiences should include presentations based on the defined curriculum, morbidity and mortality conferences, journal review, administrative seminars, and research methods. They may include but are not limited to problem-based learning, evidence-based learning, laboratories, and computer-based instruction, as well as joint conferences cosponsored with other disciplines. The Committee will consider the use of alternative methods of education, such as interactive teleconferencing, with appropriate educational justification.	
V.E.4	Emergency medicine faculty are expected to attend and meaningfully participate in these planned educational experiences. Participation in resident conferences should be one component in the annual evaluation of the core emergency medicine faculty.	
V.E.5	The curriculum must include at least 2 months of inpatient critical care rotations, during which the residents should have decision-making experience that allows them to develop the skills and judgment necessary to manage critically ill and injured patients who present to the emergency department.	
V.E.6	The program must assure that the residents follow-up on a representative sample of patients so as to learn about the results of diagnostic studies, the outcome of interventions, and the final patient diagnosis.	
V.E.7	Of the total educational experience, no less than 50% should take place under the supervision of emergency medicine faculty. Such experiences can include emergency medical services, toxicology, pediatric emergency medicine, sports medicine, emergency medicine administration, and research in emergency medicine.	
V.E.8	<u>Out-of-Hospital Care</u> Since out-of-hospital care is an integral and vital part of emergency medicine, there must be a formal, structured resident experience. This should include: participation in paramedic base station communications; emergency transportation and care in the field, including ground units and if possible air ambulance units; teaching and oversight of out-of-hospital personnel; and disaster planning and drills. If residents are required to ride in ground or air ambulance units, they must be notified of this requirement during the resident recruitment process.	
V.E.9	<u>Resuscitations and Procedures</u> Each resident must have sufficient opportunities to perform invasive procedures, monitor unstable patients and direct major resuscitations of all types on all age groups. A major resuscitation is patient care for which prolonged physician attention is needed and interventions such as defibrillation, cardiac pacing, treatment of shock, intravenous use of drugs (e.g., thrombolytics, vasopressors, neuromuscular blocking agents), or	

	invasive procedures (e.g., cut downs, central line insertion, tube thoracostomy, endotracheal intubations) that are necessary for stabilization and treatment. The resident must have the opportunity to make admission recommendations and direct resuscitations.	
V.E.9.a	Programs must maintain a record of all major resuscitations and procedures performed by each resident. The record must document their role, i.e., participant or director; the type of procedure(s); and age of patient. Only one resident may be credited with the direction of each resuscitation and the performance of each procedure.	
V.E.9.b	These records should be verified by the residency director and should be the basis for documenting the total number of resuscitations and procedures in the program. They should be available for review by the site visitor and the Residency Review Committee.	
V.E.10	Systems-Based Practices and Performance Improvement Each resident must actively participate in emergency department continuous performance quality improvement (PI) programs. Program components should include	
V.E.10.a	basic principles and application of PI;	
V.E.10.b	formal regular clinical discussions, rounds, and conferences that provide critical review of patient care and promote PI and quality care, such as mortality and morbidity conferences that analyze system factors in medical errors. Efforts should be made to gain permission for postmortem examinations to review the results of these examinations;	
V.E.10.c	evidence of development, implementation and assessment of a project to improve care, such as a clinical pathway, a patient satisfaction survey, or improvement of a recognized problem area.	
VI	RESIDENT DUTY HOURS AND THE WORKING ENVIRONMENT Providing residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energies. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.	
VI.A.1	<u>Supervision of Residents</u> All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of residents at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty.	
VI.A.2	Faculty schedules must be structured to provide residents with continuous supervision and consultation.	
VI.A.3	Faculty and residents must be educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects.	
VI.A.4	All residents within the emergency department must be under the supervision of qualified emergency medicine faculty in the emergency department at all times, except when residents from other services provide supervised care to patients on their service. In such circumstances, they must be supervised by emergency medicine faculty or by faculty from their services.	
VI.A.5	Sufficient faculty must be present to provide supervision appropriate to the care of each patient.	
VI.A.6	All residents assigned to the emergency department must have supervision commensurate to their level of training.	
VI.A.7	Allied health professionals, such as physician assistants and nurse practitioners must not compromise the educational objectives of the emergency	

	medicine program by diluting the training experience or preventing appropriate progressive responsibility for the emergency medicine residents.	
VI.A.8	The program director should ensure that all emergency medicine residents, while on rotation on other services, are appropriately supervised and are provided with an educational experience equivalent to that of an ACGME-approved residency in that specialty.	
VI.A.9	The program director must ensure that the degree of professional responsibility accorded to a resident is progressively increased through the course of training commensurate with skill and experience. Included should be opportunities to develop clinical and administrative judgment in the areas of patient care, teaching, administration, and leadership.	
VI.A.10	Fellowships Programs must notify the RRC if they sponsor any emergency medicine-related fellowships within institutions participating in the program. Documentation must be provided describing the fellowship's relationship to and impact on the residency.	
VI.A.10.a	The appointment of other individuals for special training or education, such as fellows, must not dilute or detract from the educational opportunities of regularly appointed emergency medicine residents.	
VI.A.10.b	Addition or integration of such individuals into an existing residency program requires a clear statement of the areas of education, clinical responsibilities, duration of training, and overall impact on the educational needs of existing emergency medicine residents.	
VI.B.1	<u>Duty Hours</u> Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.	
VI.B.2.a	Emergency medicine rotations As a minimum, residents shall be allowed an average of 1 full day in 7 days away from the institution and free of any clinical or academic responsibilities, including planned educational experiences.	
VI.B.2.b	While on duty in the emergency department, residents may not work longer than 12 continuous scheduled hours. There must be at least an equivalent period of continuous time off between scheduled work periods.	
VI.B.2.c	A resident should not work more than 60 scheduled hours per week seeing patients in the emergency department and no more than 72 duty hours per week. Duty hours comprise all clinical duty time and conferences, whether spent within or outside the educational program, including all on-call hours.	
VI.B.3.a	Non-Emergency Department Rotations For rotations on other services, duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.	
VI.B.3.b	Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.	
VI.B.3.c	Adequate time for rest and personal activities must be provided. This should consist of a 10 hour time period provided between all daily duty periods and after in-house call.	

VI.C	<u>On-Call Activities</u> The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal work day when residents are required to be immediately available in the assigned institution.	
VI.C.1	In-house call must occur no more frequently than every third night, averaged over a four-week period.	
VI.C.2	Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care as defined in Specialty and Subspecialty Program Requirements.	
VI.C.3	No new patients, as defined in Specialty and Subspecialty Program Requirements, may be accepted after 24 hours of continuous duty.	
VI.C.4	At-home call (pager call) is defined as call taken from outside the assigned institution.	
VI.C.4.a	The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.	
VI.C.4.b	When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.	
VI.C.4.c	The program director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.	
VI.C.5	Extracurricular activities Activities that fall outside the educational program may not be mandated, nor may they interfere with the resident's performance in the educational process as defined in the agreement between the institution and the resident.	
VI.D.1	<u>Moonlighting</u> Because residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.	
VI.D.2	The program director must comply with the sponsoring institution's written policies and procedures regarding moonlighting, in compliance with the Institutional Requirements.	
VI.D.3	Any hours a resident works for compensation at the sponsoring institution or any of the sponsor's primary clinical sites must be considered part of the 80 hour weekly limit on duty hours. (72-hour weekly total limit for emergency medicine.) This refers to the practice of <i>internal moonlighting</i> .	
VI.E.1	<u>Oversight</u> Each program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment. These policies must be distributed to the residents and the faculty. Monitoring of duty hours is required with frequency sufficient to ensure an appropriate balance between education and service.	
VI.E.2	Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.	
VI.F	<u>Duty Hour Exception</u> The RRC will not grant an exception to the applicable duty limits described above.	

VII.A	EVALUATION <u>Resident</u> There must be effective, ongoing evaluation of all components of the residency program. This evaluation process must relate to the educational objectives of the program and provide a mechanism to effect change.	
VII.A.1	Formative Evaluation The faculty must evaluate in a timely manner the residents whom they supervise. In addition, the residency program must demonstrate that it has an effective mechanism for assessing resident performance throughout the program, and for utilizing the results to improve resident performance.	
VII.A.1.a	Assessment should include the use of methods that produce an accurate assessment of residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.	
VII.A.1.b	Assessment should include the regular and timely performance feedback to residents that includes at least semiannual written evaluations. Such evaluations are to be communicated to each resident in a timely manner, and maintained in a record that is accessible to each resident.	
VII.A.1.c	Assessment should include the use of assessment results, including evaluation by faculty, patients, peers, self, and other professional staff, to achieve progressive improvements in residents' competence and performance.	
VII.A.2	Final Evaluation The program director must provide a final evaluation for each resident who completes the program. This evaluation must include a review of the resident's performance during the final period of education, and should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. The final evaluation must be part of the resident's permanent record maintained by the institution.	
VII.A.3	At least annually, there must be a formal evaluation of each resident's competency to progress to the next year of training. The competency evaluation tools should be defined prospectively and take into account the core competencies.	
VII.A.4	At least yearly, competency in chief complaint assessment, procedures and resuscitations must be formally evaluated by the program with remediation plans put in place as needed.	
VII.A.5	Residents on non-EM rotations should be evaluated based on defined competency expectations.	
VII.A.6	Residents should be advanced to positions of higher responsibility on the basis of evidence of their satisfactory progressive scholarship and professional growth.	
VII.A.7	A plan to remedy deficiencies must be in writing and on file. Progress and improvement must be monitored at a minimum of every 3 months if a resident has been identified as needing a remediation plan.	
VII.A.8	A permanent record of evaluation for each resident must be maintained and must be accessible to the resident and other authorized personnel.	
VII.B	<u>Faculty</u> The performance of the faculty must be evaluated by the program no less frequently than at the midpoint of the accreditation cycle and again prior to the next site visit. The evaluations should include a review of their teaching abilities, commitment to the educational	

	program, clinical knowledge, and scholarly activities. This evaluation must include annual written confidential evaluations by the residents.	
VII.B.1	At least annually, individual faculty members must be formally evaluated by the chair/chief of emergency medicine, which should include information from the program director and the emergency medicine residents. A mechanism for preserving resident confidentiality in the evaluation process must be implemented.	
VII.B.2	Faculty evaluations should include documentation of teaching ability, clinical knowledge, administrative and interpersonal skills, participation and contributions to resident conferences, and scholarly contributions. A summary of the evaluations should be communicated in writing to each faculty member.	
VII.C	<u>Program Evaluation</u> The educational effectiveness of a program must be evaluated at least annually in a systematic manner.	
VII.C.1	Representative program personnel, i.e., at least the program director, representative faculty, and at least one resident, must be organized to review program goals and objectives and the effectiveness with which they are achieved. This group must conduct a formal meeting at least annually for this purpose. In the evaluation process, the group must take into consideration written comments from the faculty, the most recent report of the GMEC of the sponsoring institution (see Institutional Requirements I.B.3.d), and the residents' confidential written evaluations. If deficiencies are found, the group should prepare an explicit plan of action, which should be approved by the faculty and documented in the minutes of the meeting.	
VII.C.2	The program should use resident performance and outcome assessment in its evaluation of the educational effectiveness of the residency program. Performance of program graduates on the certification examination should be used as one measure of evaluating program effectiveness. The program should maintain a process for using assessment results together with other program evaluation results to improve the residency program. The RRC will take into consideration performance of program graduates over a period of several years.	
VIII	EXPERIMENTATION AND INNOVATION Since responsible innovation and experimentation are essential to improving professional education, experimental projects supported by sound educational principles are encouraged. Requests for experimentation or innovative projects that may deviate from the program requirements must be RRC prior-approved and must include the educational rationale and a method for evaluating the project. The sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.	
IX.	CERTIFICATION Residents who plan to seek certification by the American Board of Emergency Medicine should communicate with the office of the board regarding the full requirements for certification.	
X.	OTHER <u>Notice of Changes in the Program</u>	
X.A.1	The program leadership is responsible for notifying the Executive Director of the RRC within 30 days, in writing, of any major changes in the program that may significantly alter the educational experience for the residents, including the following:	
X.A.1.a	changes in leadership of the department or the program	
X.A.1.b	changes in administrative structure, such as an alteration in the hierarchical status of the program/department within the institution	
X.A.1.c	a drop in the core faculty complement below the required minimum number or if one-third or more of the core faculty leave within 1 year	
	a drop below the minimum approved number of residents in the program for 2 consecutive years	

X.A.1.d		
X.A.1.e	Should the RRC determine that a significant alteration of the educational resources has occurred; an immediate resurvey of the program may be performed.	
X.B	<u>Guidelines</u> – The RRC will publish guidelines on its Web site for interpretation of some of these requirements, such as minimum numbers of procedures and resuscitations expected. These guidelines are provided for program directors to understand how the RRC evaluates some of the Program Requirements. The guidelines are assessed yearly by the RRC to be consistent with the clinical practice of emergency medicine.	
XI	<p>COMBINED PROGRAMS</p> <p>The RRC will review combined education program proposals only after the review and approval of the American Board of Emergency Medicine. Review by the RRC will consider only whether the residency has sufficient resources to support combined education without diluting the experience of the regularly appointed residents. The RRC does not accredit combined education. The proposal must be submitted to the RRC prior to the implementation of required education.</p>	

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