

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

3
4 **Common Program Requirements are in BOLD**

5
6 Effective: July 1, 2011

7
8 Introduction

9
10 ~~Int.A. Duration and Scope of Training~~

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12 ~~Institutions offering residencies in colon and rectal surgery must provide the~~
13 ~~necessary education to qualify the resident as a colon and rectal specialist in the~~
14 ~~care of patients, in teaching, and in research. Surgeons admitted to each~~
15 ~~residency are required to have completed a minimum of five years of an~~
16 ~~accredited, graded program in general surgery. Thus, the residents should~~
17 ~~already have developed a satisfactory level of clinical maturity, technical skills,~~
18 ~~and surgical judgment which will enable them to begin a residency in colon and~~
19 ~~rectal surgery for the purpose of specializing in this field of surgery. The period of~~
20 ~~training must be one year and the program must comply with the institutional~~
21 ~~requirements for residency training.~~

22
23 Int.A. Colon and rectal surgery is the specialty that focuses on the medical, surgical,
24 endoscopic and perioperative management of disorders involving the colon,
25 rectum and anus, and related problems of the abdomen, pelvis and perineum.

26
27 Int.B. The educational program in colon and rectal surgery must be 12 months in
28 length.

29
30 **I Institutions**

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32 **I.A. Sponsoring Institution**

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34 **One sponsoring institution must assume ultimate responsibility for the**
35 **program, as described in the Institutional Requirements, and this**
36 **responsibility extends to resident assignments at all participating sites.**

37
38 **The sponsoring institution and the program must ensure that the program**
39 **director has sufficient protected time and financial support for his or her**
40 **educational and administrative responsibilities to the program.**

41
42 I.A.1. The sponsoring institution must provide at least 10% time protected to the
43 program director for administrative, non-teaching duties related to the
44 program.

45
46 I.A.2. Salary support for the program director's administrative time must be
47 provided by the sponsoring institution, foundation or practice, depending
48 on the institutional setting.

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

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I.B. Participating Sites

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

The PLA should:

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

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

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

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

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

~~I.B.3. Assignments at participating sites must be of sufficient length to ensure a quality educational experience and should provide sufficient opportunity for continuity of care. Although the number of participating sites may vary with the various specialties' needs, all participating sites must demonstrate the ability to promote the program goals and educational and peer activities. Exceptions must be justified and approved in advance by the Review Committee.~~

II Program Personnel and Resources

II.A. Program Director

II.A.1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.

~~II.A.1.a) The program director should be a member of the staff of the sponsoring or participating site.~~

~~II.A.1.b) There should be a minimum of two staff members, including the program director.~~

- 103
104 **II.A.2.** **The program director should continue in his or her position for a**
105 **length of time adequate to maintain continuity of leadership and**
106 **program stability.**
107
- 108 **II.A.3.** **Qualifications of the program director must include:**
109
- 110 **II.A.3.a)** **requisite specialty expertise and documented educational**
111 **and administrative experience acceptable to the Review**
112 **Committee;**
113
- 114 **II.A.3.b)** **current certification in the specialty by the American Board of**
115 **Colon and Rectal Surgery (ABCRS), or specialty qualifications**
116 **that are acceptable to the Review Committee; and,**
117
- 118 **II.A.3.c)** **current medical licensure and appropriate medical staff**
119 **appointment;**
120
- 121 **II.A.3.c).(1)** This must include membership on the medical staff of
122 either the sponsoring institution or a participating site.
123
- 124 **II.A.3.d)** at least three years of clinical practice in colon and rectal surgery;
125 and,
126
- 127 **II.A.3.e)** at least three years of prior experience as a faculty member in
128 either an ACGME-accredited general surgery or colon and rectal
129 surgery program.
130
- 131 **II.A.4.** **The program director must administer and maintain an educational**
132 **environment conducive to educating the residents in each of the**
133 **ACGME competency areas. The program director must:**
134
- 135 **II.A.4.a)** **oversee and ensure the quality of didactic and clinical**
136 **education in all sites that participate in the program;**
137
- 138 **II.A.4.b)** **approve a local director at each participating site who is**
139 **accountable for resident education;**
140
- 141 **II.A.4.c)** **approve the selection of program faculty as appropriate;**
142
- 143 **II.A.4.d)** **evaluate program faculty and approve the continued**
144 **participation of program faculty based on evaluation;**
145
- 146 **II.A.4.e)** **monitor resident supervision at all participating sites;**
147
- 148 **II.A.4.f)** **prepare and submit all information required and requested by**
149 **the ACGME, including but not limited to the program**
150 **information forms and annual program resident updates to**
151 **the ADS, and ensure that the information submitted is**
152 **accurate and complete;**
153

- 154 **II.A.4.g)** provide each resident with documented semiannual
155 evaluation of performance with feedback;
156
- 157 **II.A.4.h)** ensure compliance with grievance and due process
158 procedures as set forth in the Institutional Requirements and
159 implemented by the sponsoring institution;
160
- 161 **II.A.4.i)** provide verification of residency education for all residents,
162 including those who leave the program prior to completion;
163
- 164 **II.A.4.j)** implement policies and procedures consistent with the
165 institutional and program requirements for resident duty
166 hours and the working environment, including moonlighting,
167 and, to that end, must:
168
- 169 **II.A.4.j).(1)** distribute these policies and procedures to the
170 residents and faculty;
171
- 172 **II.A.4.j).(2)** monitor resident duty hours, according to sponsoring
173 institutional policies, with a frequency sufficient to
174 ensure compliance with ACGME requirements;
175
- 176 **II.A.4.j).(3)** adjust schedules as necessary to mitigate excessive
177 service demands and/or fatigue; and,
178
- 179 **II.A.4.j).(4)** if applicable, monitor the demands of at-home call and
180 adjust schedules as necessary to mitigate excessive
181 service demands and/or fatigue.
182
- 183 **II.A.4.k)** monitor the need for and ensure the provision of back up
184 support systems when patient care responsibilities are
185 unusually difficult or prolonged;
186
- 187 **II.A.4.l)** comply with the sponsoring institution's written policies and
188 procedures, including those specified in the Institutional
189 Requirements, for selection, evaluation and promotion of
190 residents, disciplinary action, and supervision of residents;
191
- 192 **II.A.4.m)** be familiar with and comply with ACGME and Review
193 Committee policies and procedures as outlined in the ACGME
194 Manual of Policies and Procedures;
195
- 196 **II.A.4.n)** obtain review and approval of the sponsoring institution's
197 GMC/DIO before submitting to the ACGME information or
198 requests for the following:
199
- 200 **II.A.4.n).(1)** all applications for ACGME accreditation of new
201 programs;
202
- 203 **II.A.4.n).(2)** changes in resident complement;
204

- 205 **II.A.4.n).(3)** **major changes in program structure or length of**
206 **training;**
207
- 208 **II.A.4.n).(4)** **progress reports requested by the Review Committee;**
209
- 210 **II.A.4.n).(5)** **responses to all proposed adverse actions;**
211
- 212 **II.A.4.n).(6)** **requests for increases or any change to resident duty**
213 **hours;**
214
- 215 **II.A.4.n).(7)** **voluntary withdrawals of ACGME-accredited**
216 **programs;**
217
- 218 **II.A.4.n).(8)** **requests for appeal of an adverse action;**
219
- 220 **II.A.4.n).(9)** **appeal presentations to a Board of Appeal or the**
221 **ACGME; and,**
222
- 223 **II.A.4.n).(10)** **proposals to ACGME for approval of innovative**
224 **educational approaches.**
225
- 226 **II.A.4.o)** **obtain DIO review and co-signature on all program**
227 **information forms, as well as any correspondence or**
228 **document submitted to the ACGME that addresses:**
229
- 230 **II.A.4.o).(1)** **program citations, and/or**
231
- 232 **II.A.4.o).(2)** **request for changes in the program that would have**
233 **significant impact, including financial, on the program**
234 **or institution.**
235
- 236 **II.A.4.p)** implement a policy that clearly defines the lines of authority
237 between the program residents, other learners, the program
238 faculty, other faculty, and the administration. This policy must be
239 distributed to all residents, learners, and faculty members;
240
- 241 **II.A.4.q)** ensure that a current, well-organized, written plan for rotation of
242 residents among the various services and participating sites
243 involved is maintained, is available to the residents and faculty,
244 and is reviewed and updated at least annually;
245
- 246 **II.A.4.r)** monitor resident stress, including mental or emotional conditions
247 inhibiting performance or learning, and drug- or alcohol-related
248 dysfunction; and,
249
- 250 **II.A.4.r).(1)** Both the program director and the faculty should be
251 sensitive to the need for timely provision of confidential
252 counseling and psychological support services to
253 residents.
254
- 255 **II.A.4.r).(2)** Situations that demand excessive services or that

- 256 consistently produce undesirable stress on residents must
257 be evaluated and modified.
258
- 259 II.A.4.s) dedicate at least 10% of his or her time to directing the program,
260 in addition to teaching.
261
- 262 **II.B. Faculty**
263
- 264 **II.B.1. At each participating site, there must be a sufficient number of**
265 **faculty with documented qualifications to instruct and supervise all**
266 **residents at that location.**
267
- 268 **The faculty must:**
269
- 270 **II.B.1.a) devote sufficient time to the educational program to fulfill**
271 **their supervisory and teaching responsibilities; and to**
272 **demonstrate a strong interest in the education of residents,**
273 **and**
274
- 275 **II.B.1.b) administer and maintain an educational environment**
276 **conducive to educating residents in each of the ACGME**
277 **competency areas.**
278
- 279 II.B.1.b).(1) The physician faculty must maintain professional standards
280 of clinical excellence and ethical behavior.
281
- 282 **II.B.2. The physician faculty must have current certification in the specialty**
283 **by the American Board of Colon and Rectal Surgery, or possess**
284 **qualifications acceptable to the Review Committee.**
285
- 286 **II.B.3. The physician faculty must possess current medical licensure and**
287 **appropriate medical staff appointment.**
288
- 289 **II.B.4. The nonphysician faculty must have appropriate qualifications in**
290 **their field and hold appropriate institutional appointments.**
291
- 292 **II.B.5. The faculty must establish and maintain an environment of inquiry**
293 **and scholarship with an active research component.**
294
- 295 **II.B.5.a) The faculty must regularly participate in organized clinical**
296 **discussions, rounds, journal clubs, and conferences.**
297
- 298 **II.B.5.b) Some members of the faculty should also demonstrate**
299 **scholarship by one or more of the following:**
300
- 301 **II.B.5.b).(1) peer-reviewed funding;**
302
- 303 **II.B.5.b).(2) publication of original research or review articles in**
304 **peer-reviewed journals, or chapters in textbooks;**
305
- 306 **II.B.5.b).(3) publication or presentation of case reports or clinical**

- 307 series at local, regional, or national professional and
308 scientific society meetings; or,
309
310 **II.B.5.b).(4)** participation in national committees or educational
311 organizations.
312
- 313 **II.B.5.c)** Faculty should encourage and support residents in scholarly
314 activities.
315
- 316 **II.B.5.d)** At least one faculty member must be actively involved in regional
317 or national specialty societies.
318
- 319 **II.B.5.e)** At least one faculty member must be regularly active in scholarly
320 inquiry. Research performed by a resident must not substitute for
321 active faculty involvement.
322
- 323 **II.B.6.** There must be a minimum of three FTE ABCRS-certified faculty members
324 active in the program, including the program director.
325
- 326 **II.C. Other Program Personnel**
327
- 328 **The institution and the program must jointly ensure the availability of all**
329 **necessary professional, technical, and clerical personnel for the effective**
330 **administration of the program.**
331
- 332 **II.C.1.** The program must have a program coordinator with at least 10% of his or
333 her time dedicated to the program. Programs with more than one resident
334 per year should provide an additional 5% of program coordinator time per
335 additional resident. Therefore, if there is one resident per year, at least
336 10% of the program coordinator's time must be dedicated to the program.
337 If there are two residents per year, at least 15% of the program
338 coordinator's time must be dedicated to the program. If there are three
339 residents per year, at least 20% of the program coordinator's time must
340 be dedicated to the program. If there are four residents per year, at least
341 25% of the program coordinator's time must be dedicated to the program.
342 If there are five residents per year, at least 30% of the program
343 coordinator's time must be dedicated to the program.
344
- 345 **II.D. Resources**
346
- 347 **The institution and the program must jointly ensure the availability of**
348 **adequate resources for resident education, as defined in the specialty**
349 **program requirements.**
350
- 351 **II.D.1.** ~~The program should supply the necessary volume and variety of colon~~
352 ~~and rectal surgery to assure adequate training of residents. If there is~~
353 ~~insufficient volume or variety in the primary sites, arrangements should be~~
354 ~~made for an affiliation with a participating site to correct the inadequacy.~~
355 The program must provide the volume and variety of colon and rectal
356 patients and surgery necessary for residents to perform the required
357 minimum case numbers and achieve all required outcomes.

358
359 II.D.2. Adequate numbers of both diagnostic and therapeutic colonoscopies
360 must be available either at the colon and rectal training program or
361 through an appropriate institutional affiliation to satisfy this particular
362 need. Residents must be provided with office workspace with computer
363 hardware, software, support, Internet access, reference assistance, and
364 statistical support.

365
366 II.D.3. Residents must be provided with reliable systems for prompt
367 communication with supervising faculty.
368

369 II.E. Medical Information Access

370
371 **Residents must have ready access to specialty-specific and other**
372 **appropriate reference material in print or electronic format. Electronic**
373 **medical literature databases with search capabilities should be available.**
374

375 II.E.1. The major online, full-text journals relevant to the specialty for education
376 and patient care must be conveniently available to residents at all
377 participating sites.
378

379 III Resident Appointments

380 381 III.A. Eligibility Criteria

382
383 **The program director must comply with the criteria for resident eligibility**
384 **as specified in the Institutional Requirements.**
385

386 III.A.1. Prior to appointment in the program, residents should have demonstrated
387 a satisfactory level of clinical maturity, technical skills, and surgical
388 judgment which will enable them to begin a residency in colon and rectal
389 surgery for the purpose of specializing in this field of surgery.
390

391 III.A.2. Prior to appointment in the program, residents must:
392

393 III.A.2.a) have successfully completed an ACGME- or Royal College of
394 Physicians and Surgeons of Canada (RCPSC)-accredited
395 residency program in surgery of not less than five years of
396 progressive education; and
397

398 III.A.2.b) be certified by the American Board of Surgery (ABS) or have
399 completed the educational requirements to sit for the ABS
400 qualifying examinations.
401

402 III.B. Number of Residents

403
404 **The program director may not appoint more residents than approved by the**
405 **Review Committee, unless otherwise stated in the specialty-specific**
406 **requirements. The program's educational resources must be adequate to**
407 **support the number of residents appointed to the program.**
408

- 409 **III.C. Resident Transfers**
410
411 **III.C.1.** Before accepting a resident who is transferring from another
412 program, the program director must obtain written or electronic
413 verification of previous educational experiences and a summative
414 competency-based performance evaluation of the transferring
415 resident.
416
417 **III.C.2.** A program director must provide timely verification of residency
418 education and summative performance evaluations for residents
419 who leave the program prior to completion.
420
421 **III.D. Appointment of Fellows and Other Learners**
422
423 The presence of other learners (including, but not limited to, residents from
424 other specialties, subspecialty fellows, PhD students, and nurse
425 practitioners) in the program must not interfere with the appointed
426 residents' education. The program director must report the presence of
427 other learners to the DIO and GMEC in accordance with sponsoring
428 institution guidelines.
429
430 **IV Educational Program**
431
432 **IV.A. The curriculum must contain the following educational components:**
433
434 **IV.A.1. Overall educational goals for the program, which the program must**
435 **distribute to residents and faculty annually.**
436
437 IV.A.1.a) A comprehensive written curriculum covering all defined
438 components of colon and rectal surgery must be used by the
439 program as a guide for resident education.
440
441 **IV.A.2. Competency-based goals and objectives for each assignment at**
442 **each educational level, which the program must distribute to**
443 **residents and faculty annually, in either written or electronic form.**
444 **These should be reviewed by the resident at the start of each**
445 **rotation.**
446
447 IV.A.2.a) Each resident and the faculty must jointly review the goals and
448 objectives at the beginning of each rotation.
449
450 IV.A.2.b) The rotation goals and objectives must also be reviewed at the
451 end of the rotation to assess the degree to which they were
452 attained as part of the evaluation of the resident, the teaching
453 faculty, the rotation, and the program.
454
455 **IV.A.3. Regularly scheduled didactic sessions.**
456
457 IV.A.3.a) There must be a structured, program-long series of didactic
458 sessions with the faculty that follows the written curriculum on at
459 least a weekly basis.

- 460
461 IV.A.3.b) Regular colon and rectal conferences must be coordinated among
462 program sites to allow attendance by a majority of faculty
463 members and residents.
464
465 IV.A.3.b).(1) A conference attendance record for both residents and
466 faculty members must be maintained.
467
468 IV.A.3.b).(2) Residents must attend a minimum of 70% of all
469 conferences, excluding excused time away for meetings,
470 vacation and illness.
471
472 IV.A.3.c) Regular conferences must include:
473
474 IV.A.3.c).(1) morbidity and mortality conferences, held at least monthly,
475 at which all complications occurring on the colon and rectal
476 service(s) are presented for peer-review and follow-up;
477 and.
478
479 IV.A.3.c).(1).(a) Cases must be presented by the colon and rectal
480 surgery resident(s). The involved faculty members
481 must be present, and other colon and rectal surgery
482 faculty members should participate.
483
484 IV.A.3.c).(2) a journal club conference, held at least quarterly, during
485 which important articles from the current and past literature
486 are presented by the resident(s) and any other learners on
487 the service, and are discussed for content and study
488 design.
489
490 IV.A.3.d) Related pathology and radiology studies should be presented
491 during these conferences.
492
493 IV.A.3.e) Formal clinical teaching rounds with the responsible faculty must
494 be conducted on each rotation on at least a weekly basis.
495
496 **IV.A.4. Delineation of resident responsibilities for patient care, progressive**
497 **responsibility for patient management, and supervision of residents**
498 **over the continuum of the program; and,**
499
500 **IV.A.5. ACGME Competencies**
501
502 **The program must integrate the following ACGME competencies**
503 **into the curriculum:**
504
505 **IV.A.5.a) Patient Care**
506
507 **Residents must be able to provide patient care that is**
508 **compassionate, appropriate, and effective for the treatment of**
509 **health problems and the promotion of health. Residents:**
510

511	IV.A.5.a).(1)	will have training in both diagnostic and therapeutic
512		colonoscopy. The objective is to develop the necessary
513		competence in the use of this procedure to qualify as an
514		expert in the field; <u>must demonstrate proficiency in the</u>
515		<u>evaluation and management of patients with all of the</u>
516		<u>essential colon and rectal surgical disorders.</u>
517		
518	IV.A.5.a).(1).(a)	<u>Proficiency in evaluation and management must</u>
519		<u>include:</u>
520		
521	IV.A.5.a).(1).(a).(i)	<u>pre-operative diagnosis, indications,</u>
522		<u>alternatives, risks and preparation;</u>
523		
524	IV.A.5.a).(1).(a).(ii)	<u>assessment of patient risk, nutritional</u>
525		<u>status, co-morbidities, and need for pre-</u>
526		<u>operative treatment and peri-operative</u>
527		<u>prophylaxis;</u>
528		
529	IV.A.5.a).(1).(a).(iii)	<u>appropriate non-operative management;</u>
530		
531	IV.A.5.a).(1).(a).(iv)	<u>operative management, including all</u>
532		<u>technical aspects, intra-operative decision-</u>
533		<u>making, avoidance and management of</u>
534		<u>intra-operative complications, and</u>
535		<u>management of unexpected findings; and,</u>
536		
537	IV.A.5.a).(1).(a).(v)	<u>post-operative management, including</u>
538		<u>recognition and treatment of complications;</u>
539		<u>and, appropriate follow-up and additional</u>
540		<u>treatment.</u>
541		
542	IV.A.5.a).(1).(b)	<u>The essential colon and rectal surgery disorders</u>
543		<u>must include:</u>
544		
545	IV.A.5.a).(1).(b).(i)	<u>abdominal and pelvic disorders, including:</u>
546		
547	IV.A.5.a).(1).(b).(i).(a)	<u>carcinoma of the colon, rectum, and</u>
548		<u>anus;</u>
549		
550	IV.A.5.a).(1).(b).(i).(b)	<u>colorectal infectious diseases,</u>
551		<u>including sexually transmitted</u>
552		<u>diseases (STDs) and other colidities,</u>
553		<u>including clostridium difficile and</u>
554		<u>HIV-related infection;</u>
555		
556	IV.A.5.a).(1).(b).(i).(c)	<u>diverticular disease;</u>
557		
558	IV.A.5.a).(1).(b).(i).(d)	<u>gastrointestinal obstruction,</u>
559		<u>including those due to adhesions,</u>
560		<u>malignancy, volvulus, hernias and</u>
561		<u>pseudo obstruction;</u>

562		
563	IV.A.5.a).(1).(b).(i).(e)	<u>inflammatory bowel disease, including Crohn's disease and ulcerative colitis;</u>
564		
565		
566		
567	IV.A.5.a).(1).(b).(i).(f)	<u>inherited colorectal disorders, including familial polyposis, hereditary cancer syndromes; other inherited polyposis syndromes and related genetic disorders;</u>
568		
569		
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572		
573	IV.A.5.a).(1).(b).(i).(g)	<u>lower gastrointestinal hemorrhage;</u>
574		
575	IV.A.5.a).(1).(b).(i).(h)	<u>other neoplastic processes, including GIST tumors, lymphoma, carcinoid, desmoids, small bowel and mesenteric tumors; and,</u>
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579		
580	IV.A.5.a).(1).(b).(i).(i)	<u>radiation enteritis and the effects of ionizing radiation.</u>
581		
582		
583	IV.A.5.a).(1).(b).(ii)	<u>anorectal and perineal disorders, including:</u>
584		
585	IV.A.5.a).(1).(b).(ii).(a)	<u>anal fissure;</u>
586		
587	IV.A.5.a).(1).(b).(ii).(b)	<u>anorectal stenosis;</u>
588		
589	IV.A.5.a).(1).(b).(ii).(c)	<u>fistulas, anorectal and rectovaginal;</u>
590		
591	IV.A.5.a).(1).(b).(ii).(d)	<u>hemorrhoids;</u>
592		
593	IV.A.5.a).(1).(b).(ii).(e)	<u>hidradenitis;</u>
594		
595	IV.A.5.a).(1).(b).(ii).(f)	<u>meningocele, chordoma, and teratoma;</u>
596		
597		
598	IV.A.5.a).(1).(b).(ii).(g)	<u>necrotizing fasciitis;</u>
599		
600	IV.A.5.a).(1).(b).(ii).(h)	<u>pilonidal disease;</u>
601		
602	IV.A.5.a).(1).(b).(ii).(i)	<u>presacral/retrorectal lesions including cysts; and</u>
603		
604		
605	IV.A.5.a).(1).(b).(ii).(j)	<u>pruritus ani.</u>
606		
607	IV.A.5.a).(1).(b).(iii)	<u>pelvic floor disorders, including:</u>
608		
609	IV.A.5.a).(1).(b).(iii).(a)	<u>constipation, including clinical and physiological evaluation, dysmotility, animus and other forms of pelvic outlet obstruction;</u>
610		
611		
612		

613		
614	IV.A.5.a).(1).(b).(iii).(b)	<u>fecal incontinence; and,</u>
615		
616	IV.A.5.a).(1).(b).(iii).(c)	<u>rectal and pelvic prolapse, rectocele,</u>
617		<u>and solitary rectal ulcer syndrome.</u>
618		
619	IV.A.5.a).(2)	will develop skills in patient evaluation, examination, office
620		treatment, and surgical aftercare. Where feasible, such
621		training should include work in the faculty member's office,
622		as well as in the out-patient clinic of the hospital; and, <u>must</u>
623		<u>demonstrate a high level of skill and dexterity in the</u>
624		<u>performance of all essential colon and rectal surgical</u>
625		<u>procedures. The essential procedures include:</u>
626		
627	IV.A.5.a).(2).(a)	<u>abdominal procedures, including:</u>
628		
629	IV.A.5.a).(2).(a).(i)	<u>abdominoperineal resection and total</u>
630		<u>proctocolectomy;</u>
631		
632	IV.A.5.a).(2).(a).(ii)	<u>creation of stomas and surgical</u>
633		<u>management of stoma complications;</u>
634		
635	IV.A.5.a).(2).(a).(iii)	<u>ileal pouch-anal anastomosis;</u>
636		
637	IV.A.5.a).(2).(a).(iv)	<u>laparoscopic abdominal and gastrointestinal</u>
638		<u>surgery, including colon and rectal</u>
639		<u>resections, ostomy construction and</u>
640		<u>prolapse repair;</u>
641		
642	IV.A.5.a).(2).(a).(v)	<u>low anterior resection with colorectal and</u>
643		<u>coloanal anastomosis;</u>
644		
645	IV.A.5.a).(2).(a).(vi)	<u>procedures for rectal prolapse;</u>
646		
647	IV.A.5.a).(2).(a).(vii)	<u>segmental colectomy, including ileocolic</u>
648		<u>resection and colon resection;</u>
649		
650	IV.A.5.a).(2).(a).(viii)	<u>small bowel resection; and,</u>
651		
652	IV.A.5.a).(2).(a).(ix)	<u>stricturoplasty.</u>
653		
654	IV.A.5.a).(2).(b)	<u>anorectal and perineal procedures, including:</u>
655		
656	IV.A.5.a).(2).(b).(i)	<u>anoplasty;</u>
657		
658	IV.A.5.a).(2).(b).(ii)	<u>fistulotomies, including primary and staged</u>
659		<u>advancement flap repairs of complex</u>
660		<u>anorectal and rectovaginal fistulas;</u>
661		
662	IV.A.5.a).(2).(b).(iii)	<u>hemorrhoidectomy, including operative and</u>
663		<u>office treatment;</u>

- 664
665 IV.A.5.a).(2).(b).(iv) internal sphincterotomy;
666
667 IV.A.5.a).(2).(b).(v) perineal repairs of rectal prolapse;
668
669 IV.A.5.a).(2).(b).(vi) transanal excision of rectal neoplasms;
670
671 IV.A.5.a).(2).(b).(vii) treatment of hidradenitis; and,
672
673 IV.A.5.a).(2).(b).(viii) treatment of pilonidal disease.
674
675 IV.A.5.a).(2).(c) endoscopic procedures, including:
676
677 IV.A.5.a).(2).(c).(i) anoscopy;
678
679 IV.A.5.a).(2).(c).(ii) colonoscopy, including diagnostic and
680 therapeutic; and,
681
682 IV.A.5.a).(2).(c).(iii) sigmoidoscopy, including rigid and flexible.
683
684 IV.A.5.a).(2).(d) administration of conscious sedation and local
685 analgesia; and,
686
687 IV.A.5.a).(2).(e) pelvic floor procedures, including interpretation of
688 clinical and laboratory study results to include
689 anorectal manometry, anorectal ultrasound/pelvic
690 magnetic resonance imaging (MRI), defecography,
691 and transit time studies.

693 **IV.A.5.b)**

Medical Knowledge

694
695 **Residents must demonstrate knowledge of established and**
696 **evolving biomedical, clinical, epidemiological and social-**
697 **behavioral sciences, as well as the application of this**
698 **knowledge to patient care. Residents:**
699

- 700 IV.A.5.b).(1) will obtain sufficient knowledge of those aspects of
701 anesthesiology, radiology, and pathology that relate to
702 colon and rectal surgery to develop overall competence as
703 a specialist. Such training is best accomplished in
704 cooperation with the departments of anesthesiology,
705 radiology, and pathology. must demonstrate expertise in
706 their knowledge of the anatomy, embryology and
707 physiology of the colon, rectum, anus, and related
708 structures;
709
710 IV.A.5.b).(2) must demonstrate competence in their knowledge of the
711 essential colorectal disorders;
712
713 IV.A.5.b).(3) must demonstrate substantial familiarity with additional
714 colon and rectal surgery-related issues, including;

715		
716	IV.A.5.b).(3).(a)	<u>congenital disorders, including congenital pelvic and sacral neoplasms; Hirschsprung's disease; imperforate anus; and urogenital and sacral dysgenesis, including spina bifida;</u>
717		
718		
719		
720		
721	IV.A.5.b).(3).(b)	<u>genetics and molecular biology as they apply to colorectal disorders;</u>
722		
723		
724	IV.A.5.b).(3).(c)	<u>gynecological disorders, including endometriosis, considerations in managing the pregnant patient with colorectal disorders, and related intra-operative findings such as ovarian lesions, fibroids, endometrial implants, and gynecological prolapse;</u>
725		
726		
727		
728		
729		
730	IV.A.5.b).(3).(d)	<u>other pediatric and congenital disorders, including childhood fissure, encopresis, juvenile polyposis, malrotation, Meckel's diverticulum, and prolapse;</u>
731		
732		
733		
734	IV.A.5.b).(3).(e)	<u>other pelvic disorders, including cystocele, enterocele, urinary incontinence, and vaginal and uterine prolapse;</u>
735		
736		
737		
738	IV.A.5.b).(3).(f)	<u>the pathology of colon and rectal disorders;</u>
739		
740	IV.A.5.b).(3).(g)	<u>radiological and other imaging modalities, including plain x-rays, contrast studies, computed tomography (CT), positron emission tomography (PET), CT colonography magnetic resonance imaging, nuclear medicine scans, angiography, defecography, abdominal ultrasound, evaluation for deep vein thrombosis and pulmonary embolism, fistulograms, and sinograms;</u>
741		
742		
743		
744		
745		
746		
747		
748		
749	IV.A.5.b).(3).(h)	<u>related medical conditions;</u>
750		
751	IV.A.5.b).(3).(i)	<u>urological disorders, including urinary incontinence, fistulas to the urinary tract, involvement of the ureters, bladder and urethra in CRD, and identifying and avoiding intraoperative injury to the ureters; and,</u>
752		
753		
754		
755		
756		
757	IV.A.5.b).(3).(j)	<u>vascular and mesenteric disorders affecting the colon and rectum.</u>
758		
759		
760	IV.A.5.b).(4)	must have ample opportunity and responsibility for the care of patients with anorectal and colonic diseases. must <u>demonstrate substantial familiarity with additional colon and rectal surgery-related procedures, including:</u>
761		
762		
763		
764		
765	IV.A.5.b).(4).(a)	<u>abdominal procedures, including continent</u>

766		<u>ileostomy and pelvic exenteration;</u>
767		
768	IV.A.5.b).(4).(b)	<u>alternate pelvic pouch techniques, including colonic J-pouch and coloplasty;</u>
769		
770		
771	IV.A.5.b).(4).(c)	<u>anastomotic techniques, including both sewn and stapled methods of colonic and anal anastomoses;</u>
772		
773		
774	IV.A.5.b).(4).(d)	<u>anorectal procedures, including alternative methods of fistula repair, including fibrin glue and/or plug placement;</u>
775		
776		
777		
778	IV.A.5.b).(4).(e)	<u>flaps and grafts for perineal reconstruction;</u>
779		
780	IV.A.5.b).(4).(f)	<u>indications for and interpretation of CT colonography;</u>
781		
782		
783	IV.A.5.b).(4).(g)	<u>management of colorectal trauma and foreign bodies;</u>
784		
785		
786	IV.A.5.b).(4).(h)	<u>other procedures for fecal incontinence, including alternative methods of sphincter repair, augmentation and implantable devices;</u>
787		
788		
789		
790	IV.A.5.b).(4).(i)	<u>pelvic floor and gastrointestinal physiological assessment and procedures, their uses, and indications, including performance and interpretation of anorectal manometry, electromyography and pudendal nerve testing, defecography/dynamic MRI, transit time assessment, pelvic floor exercise, rehabilitation, and directed biofeedback;</u>
791		
792		
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798		
799	IV.A.5.b).(4).(j)	<u>procedures for pelvic prolapse in addition to rectal prolapsed, including rectocele and enterocele repairs; and,</u>
800		
801		
802		
803	IV.A.5.b).(4).(k)	<u>transanal endoscopic microsurgery.</u>
804		

IV.A.5.c)

Practice-based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:

IV.A.5.c).(1)

identify strengths, deficiencies, and limits in one's knowledge and expertise;

- 817 **IV.A.5.c).(2)** set learning and improvement goals;
818
819 **IV.A.5.c).(3)** identify and perform appropriate learning activities;
820
821 **IV.A.5.c).(4)** systematically analyze practice using quality
822 improvement methods, and implement changes with
823 the goal of practice improvement;
824
825 **IV.A.5.c).(5)** incorporate formative evaluation feedback into daily
826 practice;
827
828 **IV.A.5.c).(6)** locate, appraise, and assimilate evidence from
829 scientific studies related to their patients' health
830 problems;
831
832 **IV.A.5.c).(7)** use information technology to optimize learning;
833
834 **IV.A.5.c).(8)** participate in the education of patients, families,
835 students, residents and other health professionals;
836
837 ~~IV.A.5.c).(9)~~ teach to contribute to the educational process. Teaching
838 should be a regular part of the training program. The
839 resident should assist when possible in the instruction of
840 general surgical residents, and medical students, as well
841 as nurses, and other allied health professionals. It is
842 important to include instruction in the care of intestinal
843 stomas, especially in institutions that do not have
844 enterostomal therapists.
845
846 **IV.A.5.c).(10)** evaluate and analyze patient care outcomes; and,
847
848 **IV.A.5.c).(11)** utilize an evidence-based approach to patient care.
849
850 **IV.A.5.d)** **Interpersonal and Communication Skills**
851
852 **Residents must demonstrate interpersonal and**
853 **communication skills that result in the effective exchange of**
854 **information and collaboration with patients, their families,**
855 **and health professionals. Residents are expected to:**
856
857 **IV.A.5.d).(1)** communicate effectively with patients, families, and
858 the public, as appropriate, across a broad range of
859 socioeconomic and cultural backgrounds;
860
861 **IV.A.5.d).(2)** communicate effectively with physicians, other health
862 professionals, and health related agencies;
863
864 **IV.A.5.d).(3)** work effectively as a member or leader of a health care
865 team or other professional group;
866
867 **IV.A.5.d).(4)** act in a consultative role to other physicians and

868		health professionals; and,
869		
870	IV.A.5.d).(5)	maintain comprehensive, timely, and legible medical records, if applicable.
871		
872		
873	IV.A.5.e)	Professionalism
874		
875		Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:
876		
877		
878		
879	IV.A.5.e).(1)	compassion, integrity, and respect for others;
880		
881	IV.A.5.e).(2)	responsiveness to patient needs that supersedes self-interest;
882		
883		
884	IV.A.5.e).(3)	respect for patient privacy and autonomy;
885		
886	IV.A.5.e).(4)	accountability to patients, society and the profession;
887		
888	IV.A.5.e).(5)	sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation;
889		
890		
891		
892		
893	IV.A.5.e).(6)	<u>a high standard of ethical behavior; and,</u>
894		
895	IV.A.5.e).(7)	<u>a commitment to continuity of care.</u>
896		
897	IV.A.5.f)	Systems-based Practice
898		
899		Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:
900		
901		
902		
903		
904		
905	IV.A.5.f).(1)	work effectively in various health care delivery settings and systems relevant to their clinical specialty;
906		
907		
908		
909	IV.A.5.f).(2)	coordinate patient care within the health care system relevant to their clinical specialty;
910		
911		
912	IV.A.5.f).(3)	incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
913		
914		
915		
916	IV.A.5.f).(4)	advocate for quality patient care and optimal patient care systems;
917		
918		

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

921
922 **IV.A.5.f).(6)** **participate in identifying system errors and**
923 **implementing potential systems solutions.**

924
925 IV.A.6. Curriculum Organization and Resident Experiences

926
927 IV.A.6.a) The program must be organized so that residents participate in
928 patient evaluation and care in each of the following settings:

929
930 IV.A.6.a).(1) ambulatory clinic/office;

931
932 IV.A.6.a).(2) emergency department;

933
934 IV.A.6.a).(3) endoscopy suite/center;

935
936 IV.A.6.a).(4) inpatient care/hospital; and,

937
938 IV.A.6.a).(5) operating theater, including in-patient and ambulatory.

939
940 IV.A.6.b) Residents must be exposed to basic and complex patients with
941 the following conditions:

942
943 IV.A.6.b).(1) the broad spectrum of anorectal disease;

944
945 IV.A.6.b).(2) colon, rectal and anal cancer;

946
947 IV.A.6.b).(3) colorectal physiological disorders, including fecal
948 incontinence, constipation, rectal and pelvic prolapse and
949 intestinal dysmotility;

950
951 IV.A.6.b).(4) diverticular disease;

952
953 IV.A.6.b).(5) inflammatory bowel disease, including ulcerative colitis;
954 and,

955
956 IV.A.6.b).(6) relevant genetic disorders, including familial adenomatous
957 polyposis (FAP) and hereditary non-polyposis colorectal
958 cancer (HNPCC).

959
960 IV.A.6.c) Residents must have a broad operative experience, including:

961
962 IV.A.6.c).(1) abdominal/pelvic, both open and laparoscopic;

963
964 IV.A.6.c).(2) anorectal; and,

965
966 IV.A.6.c).(3) endoscopic, including rigid proctoscopy, flexible
967 sigmoidoscopy and colonoscopy.

968
969 IV.A.6.d) Residents must have exposure to testing methods, including:

970		
971	IV.A.6.d).(1)	<u>anorectal manometry;</u>
972		
973	IV.A.6.d).(2)	<u>defecography/dynamic MRI;</u>
974		
975	IV.A.6.d).(3)	<u>electromyography and pudendal nerve testing;</u>
976		
977	IV.A.6.d).(4)	<u>pelvic floor exercise, rehabilitation, and directed</u>
978		<u>biofeedback; and,</u>
979		
980	IV.A.6.d).(5)	<u>transit time assessment.</u>
981		
982	IV.A.6.e)	<u>Residents must have formal instruction and clinical experiences in</u>
983		<u>all essential disorders and procedures.</u>
984		
985	IV.A.6.f)	<u>Residents must participate in the evaluation and treatment of</u>
986		<u>patients with the following diagnoses:</u>
987		
988	IV.A.6.f).(1)	<u>anorectal and physiologic disorders, including</u>
989		<u>hemorrhoids, fistulas, abscesses, fissures, constipation,</u>
990		<u>incontinence and pelvic floor problems (at least 110</u>
991		<u>patients); and,</u>
992		
993	IV.A.6.f).(2)	<u>abdominal disorders, including neoplasia of the colon,</u>
994		<u>rectum and anus, inflammatory bowel disease, diverticular</u>
995		<u>disease, and rectal prolapse (at least 215 patients).</u>
996		
997	IV.A.6.g)	<u>Residents must document the following minimum overall case</u>
998		<u>numbers, to include no more than 50% endoscopic procedures:</u>
999		
1000	IV.A.6.g).(1)	<u>120 abdominal operations, including:</u>
1001		
1002	IV.A.6.g).(1).(a)	<u>30 laparoscopic resections; and,</u>
1003		
1004	IV.A.6.g).(1).(b)	<u>30 pelvic dissections.</u>
1005		
1006	IV.A.6.g).(2)	<u>60 anorectal operations; and,</u>
1007		
1008	IV.A.6.g).(3)	<u>185 procedures evaluating the gastrointestinal tract and</u>
1009		<u>pelvic floor, including sigmoidoscopy/proctoscopy,</u>
1010		<u>anoscopy, rectal and anal ultrasound, pelvic floor</u>
1011		<u>evaluation and colonoscopies (at least 140 total</u>
1012		<u>procedures, including 30 interventional procedures).</u>
1013		
1014	IV.A.6.h)	<u>A colon and rectal surgery resident and a chief resident in general</u>
1015		<u>surgery or a fellow (whether the fellow is in an ACGME-accredited</u>
1016		<u>position or not) should not have primary responsibility for the</u>
1017		<u>same patient, except that a colon and rectal surgery resident and</u>
1018		<u>a critical care fellow may co-manage the non-operative care of the</u>
1019		<u>same patient.</u>
1020		

1021 IV.A.6.i) Each colon and rectal surgery resident must continue to provide
1022 care for his or her post-operative patients until discharge, or until
1023 the patients' postoperative conditions are stable and only non-
1024 surgical issues remain.
1025

1026 **IV.B. Residents' Scholarly Activities**

1027
1028 **IV.B.1. The curriculum must advance residents' knowledge of the basic**
1029 **principles of research, including how research is conducted,**
1030 **evaluated, explained to patients, and applied to patient care.**
1031

1032 **IV.B.2. Residents should participate in scholarly activity.**

1033
1034 IV.B.2.a) Each resident should participate in at least two of the following
1035 activities:
1036

1037 IV.B.2.a).(1) one or more ongoing research studies with the faculty;

1038
1039 IV.B.2.a).(2) one or more resident-initiated research project with faculty
1040 supervision;

1041
1042 IV.B.2.a).(3) one or more scientific presentations at local, regional,
1043 national or international meetings;

1044
1045 IV.B.2.a).(4) preparation/submission of one or more articles for peer-
1046 reviewed publications; or,

1047
1048 IV.B.2.a).(5) writing one or more book chapters or current standards
1049 papers.
1050

1051 **IV.B.3. The sponsoring institution and program should allocate adequate**
1052 **educational resources to facilitate resident involvement in scholarly**
1053 **activities.**

1054
1055 IV.B.3.a) The program should provide support for residents involved in
1056 research, including research design, technical support and
1057 statistical analysis.
1058

1059 IV.B.4. The program director must document each resident's scholarly activity
1060 annually.
1061

1062 **V Evaluation**

1063
1064 **V.A. Resident Evaluation**

1065
1066 **V.A.1. Formative Evaluation**

1067
1068 **V.A.1.a) The faculty must evaluate resident performance in a timely**
1069 **manner during each rotation or similar educational**
1070 **assignment, and document this evaluation at completion of**
1071 **the assignment.**

1072		
1073	V.A.1.a).(1)	<u>The program director must formally discuss each resident's evaluation with him or her in person and on a quarterly basis.</u>
1074		
1075		
1076		
1077	V.A.1.a).(1).(a)	<u>This discussion must include the resident's performance related to the six competencies, clinical experiences, and duty hours.</u>
1078		
1079		
1080		
1081	V.A.1.a).(1).(b)	<u>This evaluation must be documented, signed by the program director and the resident, and maintained for review by the faculty, resident, institution and site visitor.</u>
1082		
1083		
1084		
1085		
1086	V.A.1.a).(2)	<u>The ACGME Case Log System must be used to assess resident experience with both diagnoses and procedures.</u>
1087		
1088		
1089	V.A.1.a).(2).(a)	<u>The program director must ensure regular and accurate completion of the Case Log System, and that each resident completes his or her case logs in the system in their entirety prior to completing the program.</u>
1090		
1091		
1092		
1093		
1094		
1095	V.A.1.a).(2).(b)	<u>The program director must review the Case Log results at least quarterly to assess each resident's progress and to ensure completion of each rotation's goals and objectives.</u>
1096		
1097		
1098		
1099		
1100	V.A.1.a).(2).(c)	<u>The program director must review case distribution regularly, and if a deficit is identified, specific plans must be made to remedy the problem.</u>
1101		
1102		
1103		
1104	V.A.1.a).(2).(c).(i)	<u>These plans must be documented and shared with each resident and with the faculty.</u>
1105		
1106		
1107		
1108	V.A.1.a).(2).(c).(ii)	<u>Review of these plans must be performed at each resident's next quarterly evaluation to assess results.</u>
1109		
1110		
1111		
1112	V.A.1.a).(2).(d)	<u>The program director must ensure minimum case numbers for each resident and assess resident technical competence.</u>
1113		
1114		
1115		
1116	V.A.1.b)	The program must:
1117		
1118	V.A.1.b).(1)	provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;
1119		
1120		
1121		
1122		

1123		
1124	V.A.1.b).(2)	use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);
1125		
1126		
1127	V.A.1.b).(3)	document progressive resident performance
1128		improvement appropriate to educational level; and,
1129		
1130	V.A.1.b).(4)	provide each resident with documented semiannual
1131		evaluation of performance with feedback.
1132		
1133	V.A.1.c)	The evaluations of resident performance must be accessible
1134		for review by the resident, in accordance with institutional
1135		policy.
1136		
1137	V.A.1.d)	<u>The Colon and Rectal Surgery In-Training Examination</u>
1138		<u>(CARSITE) or a similar, specialty-specific examination should be</u>
1139		<u>used as one method of resident evaluation.</u>
1140		
1141	V.A.1.d).(1)	<u>The results should be reviewed in a debriefing session with</u>
1142		<u>each resident in which the program director or delegated</u>
1143		<u>faculty member provides feedback regarding identified</u>
1144		<u>gaps in knowledge and helps the resident develop</u>
1145		<u>strategies to resolve these deficiencies.</u>
1146		
1147	V.A.1.e)	<u>The American Board of Surgery In-Service Training Examination</u>
1148		<u>(ABSITE) must not be used for specialty-specific evaluation of</u>
1149		<u>resident knowledge in colon and rectal surgery.</u>
1150		
1151	V.A.2.	Summative Evaluation
1152		
1153		The program director must provide a summative evaluation for each
1154		resident upon completion of the program. This evaluation must
1155		become part of the resident's permanent record maintained by the
1156		institution, and must be accessible for review by the resident in
1157		accordance with institutional policy. This evaluation must:
1158		
1159	V.A.2.a)	document the resident's performance during the final period
1160		of education, and
1161		
1162	V.A.2.b)	verify that the resident has demonstrated sufficient
1163		competence to enter practice without direct supervision.
1164		
1165	V.B.	Faculty Evaluation
1166		
1167	V.B.1.	At least annually, the program must evaluate faculty performance as
1168		it relates to the educational program.
1169		
1170	V.B.2.	These evaluations should include a review of the faculty's clinical
1171		teaching abilities, commitment to the educational program, clinical
1172		knowledge, professionalism, and scholarly activities.
1173		

- 1174 **V.B.3.** This evaluation must include at least annual written confidential
 1175 evaluations by the residents.
 1176
- 1177 **V.C.** Program Evaluation and Improvement
 1178
- 1179 **V.C.1.** The program must document formal, systematic evaluation of the
 1180 curriculum at least annually. The program must monitor and track
 1181 each of the following areas:
 1182
- 1183 **V.C.1.a)** resident performance;
 1184
- 1185 **V.C.1.b)** faculty development;
 1186
- 1187 **V.C.1.c)** graduate performance, including performance of program
 1188 graduates on the certification examination; and,
 1189
- 1190 **V.C.1.d)** program quality. Specifically:
 1191
- 1192 **V.C.1.d).(1)** Residents and faculty must have the opportunity to
 1193 evaluate the program confidentially and in writing at
 1194 least annually.
 1195
- 1196 **V.C.1.d).(2)** The program must use the results of residents'
 1197 assessments of the program together with other
 1198 program evaluation results to improve the program.
 1199
- 1200 **V.C.1.d).(3)** Within three years of completing their residency education,
 1201 at least 70% of a program's graduates from the preceding
 1202 five years must take both the qualifying and certifying
 1203 examinations for colon and rectal surgery offered by the
 1204 ABCRS.
 1205
- 1206 **V.C.1.d).(4)** At least 70% of a program's graduates from the preceding
 1207 five years taking the ABCRS qualifying and certifying
 1208 examinations for the first time must pass.
 1209
- 1210 **V.C.2.** If deficiencies are found, the program should prepare a written plan
 1211 of action to document initiatives to improve performance in the
 1212 areas listed in section V.C.1. The action plan should be reviewed
 1213 and approved by the teaching faculty and documented in meeting
 1214 minutes.
 1215
- 1216 **VI** Resident Duty Hours in the Learning and Working Environment
 1217
- 1218 **VI.A.** Principles
 1219
- 1220 **VI.A.1.** The program must be committed to and be responsible for
 1221 promoting patient safety and resident well-being and to providing a
 1222 supportive educational environment.
 1223
- 1224 **VI.A.2.** The learning objectives of the program must not be compromised by

- 1225 excessive reliance on residents to fulfill service obligations.
1226
- 1227 **VI.A.3.** Didactic and clinical education must have priority in the allotment of
1228 residents' time and energy.
1229
- 1230 **VI.A.4.** Duty hour assignments must recognize that faculty and residents
1231 collectively have responsibility for the safety and welfare of patients.
1232
- 1233 **VI.B.** **Supervision of Residents**
1234
- 1235 The program must ensure that qualified faculty provide appropriate
1236 supervision of residents in patient care activities.
1237
- 1238 **VI.C.** **Fatigue**
1239
- 1240 Faculty and residents must be educated to recognize the signs of fatigue
1241 and sleep deprivation and must adopt and apply policies to prevent and
1242 counteract its potential negative effects on patient care and learning.
1243
- 1244 **VI.D.** **Duty Hours (the terms in this section are defined in the ACGME Glossary
1245 and apply to all programs)**
1246
- 1247 Duty hours are defined as all clinical and academic activities related to the
1248 program; i.e., patient care (both inpatient and outpatient), administrative
1249 duties relative to patient care, the provision for transfer of patient care,
1250 time spent in-house during call activities, and scheduled activities, such as
1251 conferences. Duty hours do *not* include reading and preparation time spent
1252 away from the duty site.
1253
- 1254 **VI.D.1.** Duty hours must be limited to 80 hours per week, averaged over a
1255 four-week period, inclusive of all in-house call activities.
1256
- 1257 **VI.D.2.** Residents must be provided with one day in seven free from all
1258 educational and clinical responsibilities, averaged over a four-week
1259 period, inclusive of call.
1260
- 1261 **VI.D.3.** Adequate time for rest and personal activities must be provided.
1262 This should consist of a 10-hour time period provided between all
1263 daily duty periods and after in-house call.
1264
- 1265 **VI.E.** **On-call Activities**
1266
- 1267 **VI.E.1.** In-house call must occur no more frequently than every third night,
1268 averaged over a four-week period.
1269
- 1270 **VI.E.2.** Continuous on-site duty, including in-house call, must not exceed 24
1271 consecutive hours. Residents may remain on duty for up to six
1272 additional hours to participate in didactic activities, transfer care of
1273 patients, conduct outpatient clinics, and maintain continuity of
1274 medical and surgical care.
1275

- 1276 **VI.E.3. No new patients may be accepted after 24 hours of continuous duty.**
 1277
 1278 VI.E.3.a) A new patient is defined as any patient for whom the ~~resident~~
 1279 service has not previously provided care.
 1280
 1281 **VI.E.4. At-home call (or pager call)**
 1282
 1283 **VI.E.4.a) The frequency of at-home call is not subject to the every-**
 1284 **third-night, or 24+6 limitation. However at-home call must not**
 1285 **be so frequent as to preclude rest and reasonable personal**
 1286 **time for each resident.**
 1287
 1288 **VI.E.4.b) Residents taking at-home call must be provided with one day**
 1289 **in seven completely free from all educational and clinical**
 1290 **responsibilities, averaged over a four-week period.**
 1291
 1292 **VI.E.4.c) When residents are called into the hospital from home, the**
 1293 **hours residents spend in-house are counted toward the 80-**
 1294 **hour limit.**
 1295
 1296 **VI.F. Moonlighting**
 1297
 1298 **VI.F.1. Moonlighting must not interfere with the ability of the resident to**
 1299 **achieve the goals and objectives of the educational program.**
 1300
 1301 **VI.F.2. Internal moonlighting must be considered part of the 80-hour weekly**
 1302 **limit on duty hours.**
 1303
 1304 VI.F.3. Moonlighting is not permitted during a colon and rectal surgery residency.
 1305
 1306 **VI.G. Duty Hours Exceptions**
 1307
 1308 **A Review Committee may grant exceptions for up to 10% or a maximum of**
 1309 **88 hours to individual programs based on a sound educational rationale.**
 1310
 1311 **VI.G.1. In preparing a request for an exception the program director must**
 1312 **follow the duty hour exception policy from the ACGME Manual on**
 1313 **Policies and Procedures.**
 1314
 1315 **VI.G.2. Prior to submitting the request to the Review Committee, the**
 1316 **program director must obtain approval of the institution's GMEC and**
 1317 **DIO.**
 1318
 1319 **VII Experimentation and Innovation**
 1320
 1321 **Requests for experimentation or innovative projects that may deviate from the**
 1322 **institutional, common and/or specialty specific program requirements must be**
 1323 **approved in advance by the Review Committee. In preparing requests, the**
 1324 **program director must follow Procedures for Approving Proposals for**
 1325 **Experimentation or Innovative Projects located in the ACGME Manual on Policies**
 1326 **and Procedures. Once a Review Committee approves a project, the sponsoring**

1327 **institution and program are jointly responsible for the quality of education offered**
1328 **to residents for the duration of such a project.**

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