

ACGME Program Requirements for Graduate Medical Education in Emergency Medicine

Common Program Requirements are in BOLD

Effective: July 1, 2007

Introduction

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

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

Int.B. Definition and Scope of the Specialty

Residencies in emergency medicine 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. These programs provide progressive responsibility for and experience in these areas to enable effective management of clinical problems. Residents must have the opportunity, 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.

Int.C. Duration and Scope of Education

Int.C.1. 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. The Review Committee recognizes three educational formats: PGY 1-3, PGY 2-4, and PGY 1-4. The resident must complete all years of education for which the program is accredited. [Note: For information concerning the transfer of residents between emergency medicine residencies with differing educational formats and advanced placement credit for training in other specialties, contact the American Board of Emergency Medicine.]

Int.C.2. Programs that extend the residency beyond 36 months must present a clear educational rationale consonant with the program requirements and the objectives of the residency. The program director must obtain the approval of the sponsoring institution and the Review Committee prior to implementation and at each subsequent accreditation review of the program.

Int.C.3. 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.

Int.D. Guidelines

The Review Committee will publish guidelines on its website 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 committee evaluates some of these program requirements. The guidelines are assessed periodically by the committee to be consistent with the clinical practice of emergency medicine.

Int.E. Combined Programs

The Review Committee will review combined education program proposals only after the review and approval of the American Board of Emergency Medicine. Review by the committee will consider only whether the residency has sufficient resources to support combined education without diluting the experience of the regularly appointed residents. The Review Committee does not accredit combined education. The proposal must be submitted to the Review Committee prior to the implementation of required education.

I. Institutions

I.A. Sponsoring Institution

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

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

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. The program should be based at a primary hospital (hereafter referred to as the *primary clinical site*). More 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.

I.B.4. Programs using multiple hospitals must ensure the provision of a unified educational experience for the residents. Each participating site must offer significant educational opportunities to the overall program. The reasons for including each site must be stated.

I.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 participating sites that are geographically distant from the sponsoring institution are acceptable only if they offer special resources or a rural emergency medicine experience, unavailable locally, that significantly augment the overall educational experience of the program.

I.B.6. The number and geographic distribution of participating sites must not preclude the satisfactory participation by all residents in conferences and other educational exercises.

I.B.7. When there is a cooperative educational effort involving multiple sites, the commitment of each site to the program must be made explicit in an

affiliation agreement with each institution that conforms to ACGME Institutional Requirements.

- I.B.8. 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 faculty should have appropriate faculty appointments at the medical school.
- I.B.9. 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.

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 must not work more than 20 hours per week clinically, on average, or 960 clinical hours per year.
 - II.A.1.b) The program director must be active clinically and in full time emergency medicine.
- II.A.2. **The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.**
- II.A.3. **Qualifications of the program director must include:**
 - II.A.3.a) **requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;**
 - II.A.3.b) **current certification in the specialty by the American Board of Emergency Medicine, or specialty qualifications that are acceptable to the Review Committee; and,**
 - II.A.3.c) **current medical licensure and appropriate medical staff appointment.**
 - II.A.3.d) membership on the program's core teaching faculty;

- II.A.3.e) at least three years' experience as a clinician, administrator, and educator in emergency medicine; and,
- II.A.3.f) demonstration of active involvement in:
 - II.A.3.f).(1) continuing emergency medicine education,
 - II.A.3.f).(2) state, regional, or national societies; and,
 - II.A.3.f).(3) presentations, publications, and other scholarly activities.

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

- II.A.4.a) **oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;**
- II.A.4.b) **approve a local director at each participating site who is accountable for resident education;**
- II.A.4.c) **approve the selection of program faculty as appropriate;**
- II.A.4.d) **evaluate program faculty and approve the continued participation of program faculty based on evaluation;**
- II.A.4.e) **monitor resident supervision at all participating sites;**
- II.A.4.f) **prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;**
- II.A.4.g) **provide each resident with documented semiannual evaluation of performance with feedback;**
- II.A.4.h) **ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;**
- II.A.4.i) **provide verification of residency education for all residents, including those who leave the program prior to completion;**
- II.A.4.j) **implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:**
 - II.A.4.j).(1) **distribute these policies and procedures to the residents and faculty;**

- II.A.4.j).(2)** monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;
- II.A.4.j).(3)** adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,
- II.A.4.j).(4)** if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.
- II.A.4.k)** monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;
- II.A.4.l)** comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;
- II.A.4.m)** be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;
- II.A.4.n)** obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:
- II.A.4.n).(1)** all applications for ACGME accreditation of new programs;
- II.A.4.n).(2)** changes in resident complement;
- II.A.4.n).(2).(a)** 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.
- II.A.4.n).(3)** major changes in program structure or length of training;
- II.A.4.n).(4)** progress reports requested by the Review Committee;
- II.A.4.n).(5)** responses to all proposed adverse actions;
- II.A.4.n).(6)** requests for increases or any change to resident duty hours;
- II.A.4.n).(7)** voluntary withdrawals of ACGME-accredited

- programs;**
- II.A.4.n).(8) requests for appeal of an adverse action;**
- II.A.4.n).(9) appeal presentations to a Board of Appeal or the ACGME; and,**
- II.A.4.n).(10) proposals to ACGME for approval of innovative educational approaches.**
- Should the Review Committee determine that a significant alteration of the educational resources has occurred, an immediate resurvey of the program may be performed.
- II.A.4.o) obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:**
- II.A.4.o).(1) program citations, and/or**
- II.A.4.o).(2) request for changes in the program that would have significant impact, including financial, on the program or institution.**
- II.A.4.p) demonstrate leadership qualities and the capability to mentor emergency medicine residents;
- II.A.4.q) ensure 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;
- II.A.4.r) ensure that the program offers residents an average of at least five hours per week of planned educational experiences (not including change of shift report) developed by the emergency medicine residency program;
- II.A.4.s) 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 residents participate, on average, in at least 70% of the planned emergency medicine educational experiences offered (excluding vacations). Attendance should be monitored and documented;
- II.A.4.t) ensure that educational experiences in u) below 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.

- II.A.4.u) ensure that residents maintain a record of all major resuscitations and procedures performed by each resident (as delineated in IV.A.5.a.7. below). 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;
- II.A.4.v) verify the records described in u) above; these records 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 Review Committee; and,
- II.A.4.w) 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.

II.B. Faculty

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

The faculty must:

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

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

II.B.2. The physician faculty must have current certification in the specialty by the American Board of Emergency Medicine, or possess qualifications acceptable to the Review Committee.

II.B.2.a) This standard applies to all core physician program faculty and to other attending staff who provide supervision for emergency medicine residents.

II.B.2.b) 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.

- II.B.2.c) The definition of a core physician faculty member is a member of the program faculty 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.
- II.B.3. **The physician faculty must possess current medical licensure and appropriate medical staff appointment.**
- II.B.4. **The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.**
- II.B.5. **The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.**
 - II.B.5.a) **The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.**
 - II.B.5.b) **Some members of the faculty should also demonstrate scholarship by one or more of the following:**
 - II.B.5.b).(1) **peer-reviewed funding;**
 - II.B.5.b).(2) **publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;**
 - II.B.5.b).(3) **publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,**
 - II.B.5.b).(4) **participation in national committees or educational organizations.**
 - II.B.5.c) **Faculty should encourage and support residents in scholarly activities.**
 - II.B.5.d) The physician faculty for emergency medicine must be engaged in research and have protected time and adequate support services to accomplish these tasks.
 - II.B.5.e) All core faculty must be involved in continuing scholarly activity.
 - II.B.5.f) The faculty should participate in editorial review services, such as serving on editorial boards or serving as a reviewer for peer-reviewed publications.

- II.B.5.g) Each program should encourage the academic growth of its core faculty. Faculty development opportunities should be made available to each core faculty member.
- II.B.6. The chair/chief of emergency medicine shall:
 - II.B.6.a) be licensed to practice medicine in the state where the institution that sponsors the program is located. Certain federal programs are exempted;
 - II.B.6.b) be a member of the program's core teaching faculty;
 - II.B.6.c) qualified and have at least three years' experience as a clinician, administrator, and educator in emergency medicine;
 - II.B.6.d) certified in emergency medicine by the American Board of Emergency Medicine or have possess appropriate qualifications judged to be acceptable by the Review Committee;
 - II.B.6.e) demonstrate active involvement in emergency medicine through:
 - II.B.6.e).(1) continuing medical education;
 - II.B.6.e).(2) professional societies; and,
 - II.B.6.e).(3) scholarly activities.
 - II.B.6.f) demonstrate leadership qualities and be capable of mentoring faculty, residents, administrators, and other health care professionals.

II.C. Other Program Personnel

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

- II.C.1. 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 meetings.

II.D. Resources

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

- II.D.1. 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.D.1.a) adequate space for patient care;
 - II.D.1.b) adequate space for clinical support services;
 - II.D.1.c) laboratory and diagnostic imaging results returned on a timely basis; (especially those required on a STAT basis);
 - II.D.1.d) adequate program support space, including office space for faculty and residents;
 - II.D.1.e) adequate and readily accessible instructional space;
 - II.D.1.f) information systems; and,
 - II.D.1.g) appropriate security services and systems to ensure a safe working environment.
- II.D.2. 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.D.3. The hospital must ensure 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.
- II.D.4. There must be sufficient patient population, of all ages and both sexes, having a wide variety of clinical problems to meet the educational needs of emergency medicine residents, as well as for other residents assigned training in emergency medicine. The primary clinical site and other emergency departments where residents rotate for four months or longer should have at least 30,000 emergency department visits in each annually. Educationally justifiable exceptions will be considered, such as clinical sites in a rural setting.

II.E. Medical Information Access

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

III. Resident Appointments

III.A. Eligibility Criteria

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

III.B. Number of Residents

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

III.B.1. The Review Committee will consider the number of core and total faculty, faculty clinical supervision, patient acuity, and clinical experience with procedures and resuscitations.

III.B.2. 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.

III.B.3. The program should request a number or range (minimum-maximum) of emergency medicine residents per year. The Review Committee will approve a range (minimum-maximum) or number of residents per year based on the educational resources of the program.

III.C. Resident Transfers

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

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

III.D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' education. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.

III.D.1. Programs must notify the Review Committee if they sponsor any emergency medicine-related fellowships within sites participating in the

program. Documentation must be provided describing the fellowship's relationship to and impact on the residency.

IV. Educational Program

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

IV.A.1. Overall educational goals for the program, which the program must distribute to residents and faculty annually;

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation;

IV.A.3. Regularly scheduled didactic sessions;

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

IV.A.5. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum:

IV.A.5.a) 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. Residents:

IV.A.5.a).(1) should have four months full time equivalent dedicated to the care of infants and children; or, should have 16% of all their emergency department encounters in pediatric experience (which is defined as the care of patients less than 18 years of age). 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 that a one-month rotation equals 4% of patients. Although this experience should include the critical care of infants and children, at least 50% of the four months should be in an emergency setting;

IV.A.5.a).(2) should treat a significant number of critically ill or critically injured patients at the primary clinical site, constituting at least 3% or 1,200 of the emergency department patients per year (whichever is greater). These patients should be those 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;
- IV.A.5.a).(3) must have at least two months of inpatient critical care rotations. During part of this experience, 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;
- IV.A.5.a).(4) should have no less than 50% of their clinical experience 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;
- IV.A.5.a).(5) must have experience in out-of-hospital care. 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;
- IV.A.5.a).(6) 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;
- IV.A.5.a).(7) are expected to gather accurate, essential information in a timely manner;
- IV.A.5.a).(8) are expected to generate an appropriate differential diagnosis;
- IV.A.5.a).(9) are expected to implement an effective patient management plan;
- IV.A.5.a).(10) are expected to competently perform the diagnostic and therapeutic procedures and emergency stabilization;

- IV.A.5.a).(11) are expected to prioritize and stabilize multiple patients and perform other responsibilities simultaneously;
- IV.A.5.a).(12) are expected to provide health care services aimed at preventing health problems or maintaining health; and,
- IV.A.5.a).(13) are expected to work with health care professionals to provide patient-focused care.

IV.A.5.b) Medical Knowledge

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

- IV.A.5.b).(1) must have a curriculum that includes didactic and clinical information to allow them 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);
- IV.A.5.b).(2) must have a curriculum that includes 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-emergency medicine rotation with assessment tools described;
- IV.A.5.b).(3) are expected to identify life-threatening conditions, the most likely diagnosis, synthesize acquired patient data, and identify how and when to access current medical information;
- IV.A.5.b).(4) are expected to properly sequence critical actions for patient care and generate a differential diagnosis for an undifferentiated patient; and,
- IV.A.5.b).(5) are expected to complete disposition of patients using available resources.

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;
- IV.A.5.c).(2) set learning and improvement goals;
- IV.A.5.c).(3) identify and perform appropriate learning activities;
- IV.A.5.c).(4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
- IV.A.5.c).(5) incorporate formative evaluation feedback into daily practice;
- IV.A.5.c).(6) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;
- IV.A.5.c).(7) use information technology to optimize learning; and,
- IV.A.5.c).(8) participate in the education of patients, families, students, residents and other health professionals.
- IV.A.5.c).(9) apply knowledge of study design and statistical methods to critically appraise the medical literature, and,
- IV.A.5.c).(10) use information technology to improve patient care.

IV.A.5.d)

Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:

- IV.A.5.d).(1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
- IV.A.5.d).(2) communicate effectively with physicians, other health professionals, and health related agencies;
- IV.A.5.d).(3) work effectively as a member or leader of a health care team or other professional group;
- IV.A.5.d).(4) act in a consultative role to other physicians and health professionals; and,
- IV.A.5.d).(5) maintain comprehensive, timely, and legible medical records, if applicable.

- IV.A.5.d).(6) develop effective written communication skills;
- IV.A.5.d).(7) demonstrate the ability to handle situations unique to the practice of emergency medicine; and,
- IV.A.5.d).(8) effectively communicate with out-of-hospital personnel as well as non-medical personnel.

IV.A.5.e) Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:

- IV.A.5.e).(1) compassion, integrity, and respect for others;**
- IV.A.5.e).(2) responsiveness to patient needs that supersedes self-interest;**
- IV.A.5.e).(3) respect for patient privacy and autonomy;**
- IV.A.5.e).(4) accountability to patients, society and the profession; and,**
- 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.**
- IV.A.5.e).(6) ability to discuss death honestly, sensitively, patiently, and compassionately, and
- IV.A.5.e).(7) openness and responsiveness to the comments of other team members, patients, families, and peers.

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

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

- IV.A.5.f).(1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;**
- IV.A.5.f).(2) coordinate patient care within the health care system relevant to their clinical specialty;**
- IV.A.5.f).(3) incorporate considerations of cost awareness and**

- risk-benefit analysis in patient and/or population-based care as appropriate;**
- IV.A.5.f).(4) advocate for quality patient care and optimal patient care systems;**
- IV.A.5.f).(5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,**
- IV.A.5.f).(6) participate in identifying system errors and implementing potential systems solutions.**
- IV.A.5.f).(7) understand different medical practice models and delivery systems and how to best utilize them to care for the individual patient, and
- IV.A.5.f).(8) actively participate in emergency department continuous performance quality improvement (PI) programs. Program components should include:
 - IV.A.5.f).(8).(a) basic principles and application of PI;
 - IV.A.5.f).(8).(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; and,
 - IV.A.5.f).(8).(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.

IV.B. Residents' Scholarly Activities

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

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

IV.B.2.a) 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,

IV.B.2.b) The program must teach residents to have an understanding of basic research methodologies, statistical analysis, and critical analysis of current medical literature.

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

V. Evaluation

V.A. Resident Evaluation

V.A.1. Formative Evaluation

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

V.A.1.b) The program must:

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;

V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);

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

V.A.1.b).(4) provide each resident with documented semiannual evaluation of performance with feedback.

V.A.1.c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.

V.A.1.d) 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.

V.A.1.e) Residents on non-emergency medicine rotations should be evaluated based on defined competency expectations.

V.A.1.f) Residents should be advanced to positions of higher responsibility on the basis of evidence of their satisfactory progressive scholarship and professional growth.

V.A.1.g) A plan to remedy deficiencies must be in writing and on file. Progress and improvement must be monitored at a minimum of every three months if a resident has been identified as needing a

remediation plan.

V.A.2. Summative Evaluation

V.A.2.a) The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. This evaluation must:

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

V.A.2.c) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.

V.B. Faculty Evaluation

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

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

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

V.B.4. Faculty evaluations should include administrative and interpersonal skills, and participation in and contributions to resident conferences. A summary of the evaluations should be communicated in writing to each faculty member.

V.C. Program Evaluation and Improvement

V.C.1. The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:

V.C.1.a) resident performance;

V.C.1.b) faculty development;

V.C.1.c) graduate performance, including performance of program graduates on the certification examination; and,

V.C.1.d) program quality. Specifically:

V.C.1.d).(1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at

least annually, and

V.C.1.d).(2) The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.

V.C.2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.

V.C.3. The Review Committee will consider program graduates' performance over a period of several years.

V.C.4. The program faculty members should periodically evaluate the utilization of the resources available to the program. This should include the contribution of each site participating in the program, the program's financial and administrative support, the volume and variety of patients available to the program for educational purposes, teaching staff performance, and the quality of resident supervision.

VI. Resident Duty Hours in the Learning and Working Environment

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

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

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

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

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

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

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

VI.A.5. The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Residents and faculty members must demonstrate an

understanding and acceptance of their personal role in the following:

- VI.A.5.a) assurance of the safety and welfare of patients entrusted to their care;**
- VI.A.5.b) provision of patient- and family-centered care;**
- VI.A.5.c) assurance of their fitness for duty;**
- VI.A.5.d) management of their time before, during, and after clinical assignments;**
- VI.A.5.e) recognition of impairment, including illness and fatigue, in themselves and in their peers;**
- VI.A.5.f) attention to lifelong learning;**
- VI.A.5.g) the monitoring of their patient care performance improvement indicators; and,**
- VI.A.5.h) honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.**

- VI.A.6. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.**

- VI.B. Transitions of Care**
 - VI.B.1. Programs must design clinical assignments to minimize the number of transitions in patient care.**
 - VI.B.2. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.**
 - VI.B.3. Programs must ensure that residents are competent in communicating with team members in the hand-over process.**
 - VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.**

- VI.C. Alertness Management/Fatigue Mitigation**
 - VI.C.1. The program must:**

- VI.C.1.a)** educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;
- VI.C.1.b)** educate all faculty members and residents in alertness management and fatigue mitigation processes; and,
- VI.C.1.c)** adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.
- VI.C.2.** Each program must have a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties.
- VI.C.3.** The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home.
- VI.D. Supervision of Residents**
- VI.D.1.** In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.
- VI.D.1.a)** This information should be available to residents, faculty members, and patients.
- VI.D.1.b)** Residents and faculty members should inform patients of their respective roles in each patient's care.
- VI.D.2.** The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.
- Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care.
- VI.D.3. Levels of Supervision**
- To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:

- VI.D.3.a) Direct Supervision – the supervising physician is physically present with the resident and patient.**
- VI.D.3.b) Indirect Supervision:**
- VI.D.3.b).(1) with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.**
- VI.D.3.b).(2) with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.**
- VI.D.3.c) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.**
- VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.**
- VI.D.4.a) The program director must evaluate each resident’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.**
- VI.D.4.b) Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.**
- VI.D.4.c) Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.**
- VI.D.5. Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.**
- VI.D.5.a) Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.**
- VI.D.5.a).(1) In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision**

immediately available.

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

VI.E. Clinical Responsibilities

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

VI.E.1. When emergency medicine residents are on emergency medicine rotations, the following standards apply:

VI.E.1.a) 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; and,

VI.E.1.b) 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 residency program, including all on-call hours.

VI.F. Teamwork

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

VI.F.1. Interprofessional teams must be used to ensure effective and efficient communication for appropriate patient care for emergency medicine department admissions, transfers, and discharges.

VI.G. Resident Duty Hours

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

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

VI.G.1.a) Duty Hour Exceptions

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

The Review Committee for Emergency Medicine will not consider requests for exceptions to the 80-hour limit to the residents' work week.

- VI.G.1.a).(1)** In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.
- VI.G.1.a).(2)** Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.
- VI.G.2.** **Moonlighting**
- VI.G.2.a)** Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
- VI.G.2.b)** Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.
- VI.G.2.c)** PGY-1 residents are not permitted to moonlight.
- VI.G.3.** **Mandatory Time Free of Duty**
- Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.
- VI.G.4.** **Maximum Duty Period Length**
- VI.G.4.a)** Duty periods of PGY-1 residents must not exceed 16 hours in duration.
- VI.G.4.b)** Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.
- VI.G.4.b).(1)** It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.
- VI.G.4.b).(2)** Residents must not be assigned additional clinical

responsibilities after 24 hours of continuous in-house duty.

VI.G.4.b).(3)

In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

VI.G.4.b).(3).(a)

Under those circumstances, the resident must:

VI.G.4.b).(3).(a).(i)

appropriately hand over the care of all other patients to the team responsible for their continuing care; and,

VI.G.4.b).(3).(a).(ii)

document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

VI.G.4.b).(3).(b)

The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

VI.G.5.

Minimum Time Off between Scheduled Duty Periods

VI.G.5.a)

PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.

VI.G.5.b)

Intermediate-level residents should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

PGY-2 residents are considered to be at the intermediate-level.

VI.G.5.c)

Residents in the final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

Residents who are in the PGY-3 or beyond are considered to be in the final years of education.

VI.G.5.c).(1)

This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight

hours free of duty between scheduled duty periods, there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

VI.G.5.c).(1).(a) Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.

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

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

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

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

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

VI.G.8. At-Home Call

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

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

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

VII. Innovative Projects

Requests for innovative projects that may deviate from the institutional, common and/or specialty specific program requirements must be approved in advance by

the Review Committee. In preparing requests, the program director must follow Procedures for Approving Proposals for Innovative Projects located in the ACGME Manual on Policies and Procedures. Once a Review Committee approves a project, the sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.

ACGME Approved: June 2005 Effective: September 2005
Revised Common Program Requirements Effective: July 1, 2007
Editorial revision: October 1, 2007
Revised Common Program Requirements Effective: July 1, 2011