ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology

Common Program Requirements are in BOLD

Effective: January 1, 2008

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. Program Goals and Objectives

Int.B.1. A residency program in obstetrics-gynecology must be a structured educational experience, planned in continuity with undergraduate and continuing medical education, in the health care area encompassed by this specialty. While such residency programs contain a patient-service component, they must be designed to provide education as a first priority and not function primarily to provide hospital service.

Int.B.2. An educational program in obstetrics-gynecology must provide an opportunity for resident physicians to achieve the knowledge, skills, and attitudes essential to the practice of obstetrics and gynecology and must also be geared toward the development of competence in the provision of ambulatory primary health care for women. The program must provide opportunity for increasing responsibility, appropriate supervision, formal instruction, critical evaluation, and counseling for the resident.

Int.C. Duration and Scope of Education

Resident education in obstetrics-gynecology must include four years of accredited, clinically oriented graduate medical education. This education must be focused on reproductive health care and ambulatory primary health care for women, including health maintenance, disease prevention, diagnosis, treatment, consultation, and referral.

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.A.1. The program director must have a minimum of 20 hours per week of administrative time (non-clinical), and must receive full financial support from the institution for this time. Administrative time should be sufficient to support the number of residents, the number of training sites, and other local factors.

I.A.2. The program must exist in an educational environment that should include at least two other relevant graduate medical education programs such as internal medicine, pediatrics, surgery, or family medicine. The program director must obtain teaching commitments from the other departments involved in the education of obstetrics-gynecology residents.

I.A.3. Participation by any site providing six months or more of training in a program of three or more years must be approved by the Review Committee.

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 Review Committee for Obstetrics-Gynecology uses the following categories for the purpose of monitoring the structure of residencies.

I.B.3.a) Independent--An independent program is conducted within a single educational site under a single program director. Extramural rotations for a total of no more than six months are permitted under the regulations applied to all programs (see I.B.3.d).

I.B.3.b) Integrated--An integrated program is conducted within multiple educational sites but under a single program director. Each educational site involved in an integrated program must provide the same quality of education and level of supervision required of an independent program and must formally acknowledge the authority of the program director and the role that the site will play in the overall program. Residents may rotate at any level, including the final year of the program. The program director must have authority over the educational program in each hospital, including the teaching appointments and assignments of all faculty and all residents, and must ensure the adequacy of the educational experience for each resident. Additional extramural rotations for a total of no more than six months are permitted under the regulations applied to all programs (see I.B.3.d). If a program includes rotations for a total of more than six months for any resident at sites other than those included in the integrated program, that program becomes a non-integrated program.

I.B.3.c) Non-integrated--A non-integrated program is one in which any resident spends a total of more than six months in extramural rotations outside the sponsoring institution (or sites, in the case of integrated programs).

I.B.3.d) Extramural Rotations--Extramural rotations may be arranged by the program director of either an independent or an integrated program to enhance the educational experience of the residents. The following requirements for the duration of extramural rotations must be observed:

I.B.3.d).(1) If the total time of extramural rotation from the parent program by any resident during the entire residency exceeds six months, the program is considered to be a non-integrated program, and the entire program must

receive prior approval by the Review Committee. Residents may not spend more than 18 months away from the sponsoring institution(s) without prior approval of the Review Committee.

I.B.3.d).(2) Rotations for a total of less than six months will not require that the program be designated as a non-integrated program, and these rotations may be arranged by the program director without prior Review Committee approval.

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 institution or integrated site.

II.A.1.b) The program director, together with the faculty, is responsible for recruitment, selection, instruction, supervision, counseling, evaluation, and advancement of residents and the maintenance of records related to program accreditation.

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 Obstetrics and Gynecology (ABOG)**, 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) experience in and commitment to ambulatory primary health care for women. There must be a minimum of five years' experience (postresidency/fellowship) in such activities.

II.A.3.e) unrestricted licensure to practice medicine in the state where the institution that sponsors the program is located. (Certain

physicians in federal programs are exempted.)

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 site;**

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).(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.**

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) be responsible for notifying the executive director of the Review Committee, in writing, within 30 days of any major change in the program that may significantly alter the educational experience for the residents, including:

II.A.4.p).(1) changes in leadership of the department or the program;

II.A.4.p).(2) changes in administrative structure, such as an alteration in the hierarchical status of the program/department within the institution; and

II.A.4.p).(3) substantial changes in volume and/or variety of the patient population.

II.A.4.q) be responsible for communicating to the Review Committee any change in the use of rotations to participating sites (including additions or deletions of sites) and any significant change in the number of patient cases available at the sponsoring and/or participating sites, if residency education would be adversely affected. The program director must describe the effect of these changes and corrective action taken to address them;

II.A.4.r) ensure that formal teaching activities in obstetrics-gynecology be structured and regularly scheduled. They generally should consist of patient rounds, case conferences, journal clubs, and protected time for didactic conferences covering all aspects of the specialty, including basic sciences pertinent to the specialty. In cross-disciplinary conferences such as perinatology, physicians from appropriate specialties should be invited to participate; and,

II.A.4.s) annually collect, compile, and retain the numbers and types of operative procedures performed by residents in the program, together with information describing the total resident experience in each institution and facility utilized in the clinical education of residents. This information must be provided in the format and form specified by the Review Committee.

II.A.5. If the program director judges that the size and nature of the patient population does not require a 24-hour presence of residents and faculty, this situation must be carefully defined and reviewed and should include information about the nature of the hospital, the patient population, the nature of attending staff, and the geographic and climatic situations. Exceptions require prior written approval from the Review Committee.

II.A.6. For the purpose of program review, accurate and complete documentation of each individual resident's experience for each year of

the program is mandatory. These records should indicate the level of participation of the resident and skills achieved. The program director must review the record of operative experience with individual residents at least semiannually for breadth and depth of experience as well as for evidence of continuing growth in technical achievements. These cumulative data will be reviewed in detail at the time of survey for program approval or continued program approval. For the purposes of these records, there is no distinction between private and service patients.

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.1.c) On an obstetrics and gynecology service, adequate supervision requires the 24-hour presence of faculty in the hospital except when residents are not assigned in-house call responsibilities. Faculty must be immediately available to the resident if clinical activity is taking place in the operating rooms and/or labor and delivery areas. Faculty must be within easy walking distance of patient care units. Clinical services provided in ambulatory (office) locations require on-site supervision. Open and generously used lines of two-way communication are important and should be encouraged.

II.B.2. The physician faculty must have current certification in the specialty by the American Board of Obstetrics and Gynecology (ABOG)**, or possess qualifications acceptable to the Review Committee.**

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) Documentation of scholarly activity on the part of the program and the faculty must be submitted at the time of program review.

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. At a minimum, a full-time program coordinator is required for all programs, and must receive full financial support from the institution.

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. Outpatient Facilities

The program must provide appropriate facilities and equipment, including patient medical and laboratory data retrieval capabilities to manage patients in a timely fashion, so that efficient and effective education ambulatory care can be accomplished.

II.D.2. Inpatient Facilities

The program must provide appropriate facilities and equipment, including patient medical and laboratory data retrieval capabilities, to manage critically ill patients and those undergoing obstetric or gynecologic

operative procedures.

II.D.3. Medical Records

The hospital should maintain a records room with adequate cross indexing and ready reference for study of patients' charts. Periodic summaries of department statistics are essential for the evaluation of results and usually will be requested at the time a program is reviewed by the Review Committee.

II.D.4. Resident Facilities and Support Services

The program must provide adequate facilities for residents to carry out their patient care and personal educational responsibilities. These include adequate on-call, sleep, lounge, and food facilities for residents while on duty and on call. Also required are clinical support services such as pathology and radiology, including laboratory and radiologic information retrieval systems that allow rapid access to results, intravenous (IV) services, phlebotomy services, and messenger/transporter services in sufficient number to meet reasonable demands at all times.

II.D.5. The patient population on which the educational program is based should be sufficient in size and composition so that the broad spectrum of experiences necessary to meet the educational objectives will be provided.

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 number of residents that can be adequately and responsibly educated depends on several interrelated factors. Clinical involvement alone does not constitute an educational experience. The provision of adequate supervision, education, individual evaluation, and administrative support is critical. With this, it is of utmost importance that each resident

have sufficient independent operative and clinical responsibilities to prepare for practice in the specialty.

III.B.2. The maximum number of residents in a program is linked to the number that can be accommodated within the framework of these requirements. One of the most important considerations is the clinical experience available to give each resident adequate primary responsibility. Because this usually centers on the senior resident year, the maximum number of residents in a program depends on how many senior residents the program can educate. Usually the maximum number of residents in a program is the number of senior residents the program can accommodate multiplied by four.

III.B.3. The minimum number of residents in an accredited program is two per year. Accreditation is granted on the basis of a balance between the educational resources and the number of residents in the program. Appointment of residents in excess of the approved number may adversely affect the quality of the total experience of each resident. Therefore, changes in the educational resources should be reported to the Review Committee, and proposed increases in the number of residents must first be approved in writing by the Review Committee.

III.B.4. All requests for a change in the number of residents must demonstrate a distinct and substantial improvement in the educational opportunities for all residents in the program. Such requests must be based not only on the availability of an adequate patient population but also on adequate resources for supervision, education, and evaluation. A request for a permanent change in the number of residents must describe the predicted impact on the total experience of each of the senior residents under the new circumstances.

III.B.4.a) The request must be received within 18 months of the latest survey of the program; otherwise, a new survey will be necessary. The request will be considered incomplete if it lists only expansion in beds, hospitals, or overall clinical experience and does not address the question of the expansion of faculty and administrative support necessary to teach, supervise, and evaluate the additional residents.

III.B.4.b) Conversely, a reduction in beds or hospitals, or other changes in the program that may lead to an anticipated decrease in total experience for the residents, must be promptly called to the attention of the Review Committee to determine if a reduction in the number of resident positions in a given graduate medical program is necessary.

III.B.5. Residency programs may, with prior Review Committee approval, contain more residents in the first year than the number approved for subsequent years.

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.

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.2.a) One example of such objectives is set forth in the current "Educational Objectives for Residents in Obstetrics and Gynecology," produced under the auspices of the Council on Residency Education in Obstetrics and Gynecology (CREOG). Program directors must document that they review implementation of the educational objectives and that the residents are indeed accomplishing what is anticipated of them. Any program unable to demonstrate each resident's accomplishment (or not) of each educational aim and objective will be considered an inadequate program.

IV.A.2.b) It is neither essential nor desirable that all educational programs or individual resident experiences be identical in structure or function. Variations that provide creative solutions and opportunities or allow greater efficiency in the educational program may be implemented for a maximum of six months in an educational experience focused on women's health care. Such an experience of more than six months (and up to 12 months) would

need prior written approval of the Review Committee. This approval requires the assurance that the program provide quality education and experience for all of the residents completing the program. The program director must ensure that a resident completes the objectives and goals of the educational program. All educational experiences must have as a goal the enhancement of the quality of patient care.

IV.A.2.c) Growth in knowledge and experience in the primary and preventive care role is best provided to residents by maximizing their participation in an ambulatory environment designed to enable continuity of care over an extended period of time. Specific educational experiences for the primary and preventive care role should take place throughout the four years of residency and may be addressed in one or more of the following settings:

IV.A.2.c).(1) Continuity clinics

IV.A.2.c).(2) Obstetrical high-risk clinic

IV.A.2.c).(3) Family Medicine rotation.

IV.A.2.c).(4) Internal Medicine outpatient rotation

IV.A.2.c).(5) Emergency care rotation.

IV.A.2.d) No program or resident with a religious or moral objection shall be required to provide training in or to perform induced abortions. Otherwise, access to experience with induced abortion must be part of residency education. This education can be provided outside the institution. Experience with management of complications of abortion must be provided to all residents. If a residency program has a religious, moral, or legal restriction that prohibits the residents from performing abortions within the institution, the program must ensure that the residents receive satisfactory education and experience in managing the complications of abortion. Furthermore, such residency programs (1) must not impede residents in the programs who do not have religious or moral objections from receiving education and experience in performing abortions at another institution and (2) must publicize such policy to all applicants to those residency programs.

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) will prepare for their roles as providers of primary and preventive care. It is essential that the program provide a closely supervised experience by appropriately educated generalist faculty that ensures patients of continuity of care by an individual resident. Increasing responsibility should be given to residents under the supervision of a qualified, on-site, attending staff/faculty member. Residents should develop and maintain a continuing physician-patient relationship with a panel of patients, at least 1/2 day per week, for at least 30 months throughout the four years of education. The use of remote sites or institutions or clinical services must not interrupt continuity of care clinics for longer than two months in any of these four years. Residents should be provided opportunity on at least a weekly basis to return to the parent institution for their continuity clinic experience;

IV.A.5.a).(2) will develop measurable competencies as specified in the educational curriculum written and provided by the program for each resident. This education must include but not necessarily be limited to the following:

IV.A.5.a).(2).(a) Obstetrics

IV.A.5.a).(2).(a).(i) The full range of obstetrics, including the medical and surgical complications of pregnancy and experience in the management of critically ill patients;

IV.A.5.a).(2).(a).(ii) Genetics, including experience with genetic amniocentesis and patient counseling;

IV.A.5.a).(2).(a).(iii) Learning and performing operative vaginal deliveries, including the use of obstetric forceps and/or the vacuum extractor;

IV.A.5.a).(2).(a).(iv) Performing breech and multifetal deliveries;

IV.A.5.a).(2).(a).(v) Performing vaginal births after previous cesarean delivery;

IV.A.5.a).(2).(a).(vi) Learning the principles of general and

conduction anesthesia, together with the management and the complications of these techniques;

IV.A.5.a).(2).(a).(vii) Immediate care of the newborn (Every resident must have experience in resuscitation of the newborn and understanding of the principles of general neonatal complications);

IV.A.5.a).(2).(a).(viii) The full range of commonly employed obstetrical diagnostic procedures, including ultrasonography and other relevant imaging techniques;

IV.A.5.a).(2).(a).(ix) The emotional and psychosocial impact of pregnancy or pregnancy loss on an individual and her family;

IV.A.5.a).(2).(a).(x) The counseling of women regarding nutrition, exercise, health maintenance, high-risk behaviors, and preparation for pregnancy and childbirth; and,

IV.A.5.a).(2).(a).(xi) Obstetric pathology.

IV.A.5.a).(2).(b) Gynecology

IV.A.5.a).(2).(b).(i) The full range of medical and surgical gynecology for all age groups, including experience in the management of critically ill patients;

IV.A.5.a).(2).(b).(ii) Diagnosis and management of pelvic floor dysfunction, including experience with various operations for its correction;

IV.A.5.a).(2).(b).(iii) Diagnosis and medical and surgical management of urinary incontinence;

IV.A.5.a).(2).(b).(iv) Oncology, including prevention, diagnosis, and treatment;

IV.A.5.a).(2).(b).(v) Diagnosis and nonsurgical management of breast disease;

IV.A.5.a).(2).(b).(vi) Reproductive endocrinology and infertility;

IV.A.5.a).(2).(b).(vii) Clinical skills in family planning;

IV.A.5.a).(2).(b).(viii) Psychosomatic and psychosexual

counseling;

IV.A.5.a).(2).(b).(ix)	The full range of commonly employed gynecologic diagnostic procedures, including ultrasonography and other relevant imaging techniques;
IV.A.5.a).(2).(b).(x)	Counseling and educating patients about the normal physiology of the reproductive tract and about high-risk behaviors that may compromise reproductive function; and,
IV.A.5.a).(2).(b).(xi)	Gynecologic pathology.
IV.A.5.a).(2).(c)	Primary and preventive care
IV.A.5.a).(2).(c).(i)	Comprehensive history taking, including medical, nutritional, sexual, family, genetic, and social behavior data, and the ability to assess health risks;
IV.A.5.a).(2).(c).(i).(a)	Complete physical examination
IV.A.5.a).(2).(c).(ii)	Appropriate use of laboratory studies and diagnostic techniques;
IV.A.5.a).(2).(c).(iii)	Patient education and counseling;
IV.A.5.a).(2).(c).(iv)	Screening appropriate to patients of various ages and risk factors;
IV.A.5.a).(2).(c).(v)	Immunizations needed at specific ages and under specific circumstances;
IV.A.5.a).(2).(c).(vi)	Diagnosis and treatment of the common nonreproductive illnesses affecting women;
IV.A.5.a).(2).(c).(vii)	Continuous management of the health care of women of all ages;
IV.A.5.a).(2).(c).(viii)	Appropriate use of community resources and other physicians through consultation when necessary;
IV.A.5.a).(2).(c).(ix)	Appropriate awareness and knowledge of the behavioral and societal factors that influence health among women of differing socioeconomic and cultural backgrounds;
IV.A.5.a).(2).(c).(x)	Behavioral medicine and psychosocial problems, including domestic violence,

sexual assault, and substance abuse;

IV.A.5.a).(2).(c).(xi) Emergency care;

IV.A.5.a).(2).(c).(xii) Ambulatory primary care problems of the geriatric patient;

IV.A.5.a).(2).(c).(xiii) Basics of epidemiology, statistics, data collection and management, and use of medical literature and assessment of its value;

IV.A.5.a).(2).(c).(xiv) Ethics and medical jurisprudence;

IV.A.5.a).(2).(c).(xv) Community medicine, including health promotion and disease prevention;

IV.A.5.a).(2).(c).(xvi) Health care delivery systems and practice management;

IV.A.5.a).(2).(c).(xvii) Information processing and decision making; and,

IV.A.5.a).(2).(c).(xviii) Patient safety

IV.A.5.a).(3) must be able to personally evaluate a patient's complaint, provide an accurate examination, employ appropriate diagnostic tests, arrive at a correct diagnosis, and recommend the appropriate treatment;

IV.A.5.a).(4) will complete management of a patient's care under adequate supervision and should be considered the highest level of residency education. There are, however, circumstances under which the resident may not assume complete management:

IV.A.5.a).(4).(a) When the program director or his/her designee does not believe the resident's expertise or understanding is adequate to ensure the best care of the patient;

IV.A.5.a).(4).(b) When the attending physician is unable to delegate the necessary degree of responsibility; and,

IV.A.5.a).(4).(c) When the resident, for religious or moral reasons, does not wish to participate in proposed procedures.

IV.A.5.a).(5) will have a significant number of staff support the principle of delegation of complete management under supervision as an essential feature of resident education; and,

IV.A.5.a).(6) will have increasing responsibility that must progress in an orderly fashion, culminating in a chief resident year. The chief resident year consists of 12 months of clinical experience 10 months of which must be spent in the parent and/or integrated site(s) that occur within the last 24 months of the resident's program. The chief resident must have sufficient independent operating experience to become technically competent and have enough total responsibility for management of patients to ensure proficiency in the diagnostic and treatment skills that are required of a specialist in obstetrics-gynecology in office and hospital practice.

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) will have wise judgment regarding the need for a surgical procedure and recognition and management of complications as well as proficiency in technical aspects of obstetrics and gynecology. The program must, therefore, ensure that residents' clinical experience emphasizes appropriate involvement in the process that leads to selection of the surgical option, the preoperative assessment, and the postoperative care of the patients for whom they share surgical responsibility. Continuity of care of these patients must be documented. A residency program in obstetrics-gynecology must be able to provide substantial, diverse, and appropriate surgical experience after residents have mastered the basic skills;

IV.A.5.b).(2) will have a structured didactic and clinical educational experience in all methods of family planning that is provided or coordinated by the program. Topics must include all reversible methods of contraception, including natural methods, as well as sterilization. This must include experience in management of complications as well as training in the performance of these procedures. This education can be provided outside the institution, in an appropriate facility, under the supervision of appropriately educated faculty;

IV.A.5.b).(3) will have appropriate didactic instruction about and sufficient clinical management of post-reproductive age women, as an increasing percentage of women seeking their medical care from obstetrician-gynecologists are postmenopausal; and,

IV.A.5.b).(4) will have appropriate didactic instruction regarding the ambulatory care of the patient, which requires both knowledge and skills in the areas of health maintenance, disease prevention, risk assessment, counseling, and the use of consultants and community resources. These experiences should be evident in the residents' exposure to continuity of care, general gynecology, general obstetrics, prevention or control of disease (e.g., sexually transmitted disease), substance abuse, or prevention of pregnancy. In addition to rotations in obstetrics-gynecology, general medical management experience may also be obtained during rotations in internal medicine and/or family medicine, emergency medicine, and geriatric medicine. If rotations outside the department of obstetrics-gynecology are used, the residents' role and experience in these rotations should be sufficiently similar to those of residents on these services and relevant to the health care of women. These experiences should be strongly oriented toward ambulatory care. Residents must have adequate experience in menopausal healthcare and geriatric medicine.

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.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) have the fundamentals of good medical history taking and thoughtful, meticulous physical examination. Information gained by these procedures must be carefully recorded in the medical record. A reliable measure of the quality of a program is the quality of hospital records. These records should include daily appropriate progress notes by residents, together with a discharge summary.

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.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.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.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) These evaluations of performance should include the knowledge, skills, and professional growth of the residents, using appropriate criteria and procedures.

V.A.1.e) One example of an acceptable mechanism helpful in evaluating cognitive knowledge is the CREOG in-training examination.

V.A.2. **Summative Evaluation**

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.a) **document the resident's performance during the final period of education, and**

V.A.2.b) **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.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.**

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.

Any health professional with appropriate certification, e.g., Certified Nurse Midwife, Nurse Practitioner, Physician Assistant, can be listed as faculty.

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.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.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 Obstetrics and Gynecology 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 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.**

PGY-3 and PGY-4 residents 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 12, 2007   Effective: January 1, 2008
Revised Common Program Requirements Effective: July 1, 2011