

**ACGME COMMON PROGRAM REQUIREMENTS APPEAR IN BOLD**  
SECTIONS OF TEXT THAT ARE NOT BOLDED ARE SPECIALTY SPECIFIC  
REQUIREMENTS

PROGRAM REQUIREMENTS for RESIDENCY EDUCATION in OBSTETRICS  
AND GYNECOLOGY

**Preface**

**The program requirements set forth here are to be considered common to all specialties, and are complete only when supplemented, where indicated and individually, by each specialty.**

**I. Introduction**

A. Program Goals and Objectives

1. A residency program in obstetrics-gynecology must constitute 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.
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.

B. Duration and Scope of Education

Resident education in obstetrics-gynecology must include 4 years of accredited, clinically oriented graduate medical education, which must be focused on reproductive health care and ambulatory primary health care for women, including health maintenance, disease prevention, diagnosis, treatment, consultation, and referral.

## II. Institutions

### A. Sponsoring Institution

1. **One sponsoring institution must assume the ultimate responsibility for the program as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating institutions.**
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 practice. The program director must obtain teaching commitments from the other departments involved in the education of obstetrics-gynecology residents.

### B. Participating Institutions

1. **Assignment to an institution must be based on a clear educational rationale, integral to the program curriculum, with clearly-stated activities and objectives, and should provide resources not otherwise available to the program.** Participation by any institution providing 6 months or more of training in a program of 3 or more years must be approved by the RRC. **When multiple participating institutions are used, there should be assurance of the continuity of the educational experience.**
2. **Assignment to a participating institution requires a letter of agreement with the sponsoring institution that provides an educational experience for a resident that is one month in duration or longer. Such a letter of agreement should:**
  - a. **identify the faculty who will assume both educational and supervisory responsibilities for residents;**
  - b. **specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;**
  - c. **specify the duration and content of the educational experience; and**

**d. state the policies and procedures that will govern resident education during the assignment.**

- C. The RRC for Obstetrics-Gynecology uses the following categories for the purpose of monitoring the structure of residencies.
1. Independent---An independent program is conducted within a single educational institution under a single program director. Extramural rotations for a total of no more than 6 months are permitted under the regulations applied to all programs (see II.C.4).
  2. Integrated---An integrated program is conducted within multiple educational institutions but under a single program director. Each educational institution 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 institution 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 6 months are permitted under the regulations applied to all programs (see II.C.4). If a program includes rotations for a total of more than 6 months for any resident at institutions other than those included in the integrated program, that program becomes an affiliated program.
  3. Affiliated---An affiliated program is one in which any resident spends a total of more than 6 months in extramural rotations outside the parent institution (or institutions, in the case of integrated programs).
  4. 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:

- a. If the total time of extramural rotation from the parent program by any resident during the entire residency exceeds 6 months, the program is considered to be an affiliated program, and the entire program must receive prior approval by the RRC. Residents may not spend more than 18 months away from the parent institution(s) without prior approval of the RRC.
- b. Rotations for a total of less than 6 months will not require that the program be designated as an affiliated program, and these rotations may be arranged by the program director without prior RRC approval.

### III. Program Personnel and Resources

#### A. Program Director

1. **There must be a single program director responsible for the program. The person designated with this authority is accountable for the operation of the program** and should be a member of the staff of the sponsoring or integrated institution. **In the event of a change of either program director or department chair, the program director should promptly notify the executive director of the Residency Review Committee (RRC) through the Web Accreditation Data System of the Accreditation Council for Graduate Medical Education (ACGME).**
2. **The program director, together with the faculty, is responsible for the general administration of the program,** including those activities related to the recruitment, selection, instruction, supervision, counseling, evaluation, and advancement of residents and the maintenance of records related to program accreditation, **and for the establishment and maintenance of a stable educational environment. Adequate lengths of appointment for both the program director and faculty are essential to maintaining such an appropriate continuity of leadership.**
3. **Qualifications of the program director are as follows:**
  - a. **The program director must possess the requisite specialty expertise, as well as documented educational and administrative abilities in his or**

**her field**, including experience in and commitment to ambulatory primary health care for women. There must be a minimum of 5 years' experience (postresidency/fellowship) in such activities.

- b. The program director must be certified in the specialty by the American Board of Obstetrics and Gynecology (ABOG) or possess qualifications judged to be acceptable by the RRC.**
  - c. The program director must be appointed in good standing and based at the primary teaching site.**
  - d. The program director must have unrestricted licensure to practice medicine in the state where the institution that sponsors the program is located. (Certain physicians in federal programs are exempted.)
- 4. Responsibilities of the program director are as follows:**
- a. The program director must oversee and organize the activities of the educational program in all institutions that participate in the program. This includes selecting and supervising the faculty and other program personnel at each participating institution, appointing a local site director, selecting residents for appointment to the program in accordance with institutional and departmental policies and procedures, and monitoring appropriate resident supervision at all participating institutions.**
  - b. The program director is responsible for preparing an accurate statistical and narrative description of the program as requested by the RRC, as well as updating annually both program and resident records through the ACGME's Accreditation Data System.**
  - c. The program director must ensure the implementation of fair policies, grievance procedures, and due process, as established by the sponsoring institution and in compliance with the Institutional Requirements.**

d. **The program director must seek the prior approval of the RRC for any changes in the program that may significantly alter the educational experience of the residents. Such changes, for example, include:**

- 1) **the addition or deletion of a participating institution;**
- 2) **a change in the format of the educational program;**
- 3) **a change in the approved resident complement for those specialties that approve resident complement.**

**On review of a proposal for any such major change in a program, the RRC may determine that a site visit is necessary.**

e. The program director is responsible for notifying the executive secretary of the RRC, in writing, within 30 days of any major change in the program that may significantly alter the educational experience for the residents, including

- 1) changes in leadership of the department or the program;
- 2) changes in administrative structure, such as an alteration in the hierarchical status of the program/department within the institution; and
- 3) substantial changes in volume and/or variety of the patient population.

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

## **B. Faculty**

- 1. At each participating institution, there must be a sufficient number of faculty with documented qualifications to instruct and supervise adequately all residents in the program.** The faculty complement should include appropriately educated generalist obstetrics-gynecology faculty.
- 2. The faculty, furthermore, must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities. They must demonstrate a strong interest in the education of residents, and must support the goals and objectives of the educational program of which they are a member.**
- 3. Qualifications of the physician faculty are as follows:**
  - a. The physician faculty must possess the requisite specialty expertise and competence in clinical care and teaching abilities, as well as documented educational and administrative abilities and experience in their field.**
  - b. The physician faculty must be certified in the specialty by the American Board of Obstetrics and Gynecology (ABOG), or possess qualifications judged to be acceptable by the RRC.**
  - c. The physician faculty must be appointed in good standing to the staff of an institution participating in the program.**
- 4. The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the faculty, and an active research component must be included in each program. *Scholarship* is defined as the following:**
  - a. the scholarship of *discovery*, as evidenced by peer-reviewed funding or by publication of original research in a peer-reviewed journal;**
  - b. the scholarship of *dissemination*, as evidenced by review articles or chapters in textbooks;**

- c. **the scholarship of *application*, as evidenced by the publication or presentation of, for example, case reports or clinical series at local, regional, or national professional and scientific society meetings.**

**Complementary to the above scholarship is the regular participation of the teaching staff in clinical discussions, rounds, journal clubs, and research conferences in a manner that promotes a spirit of inquiry and scholarship (e.g., the offering of guidance and technical support for residents involved in research such as research design and statistical analysis); and the provision of support for residents' participation, as appropriate, in scholarly activities.**

Documentation of scholarly activity on the part of the program and the faculty must be submitted at the time of program review. The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the teaching staff. While not all members of a teaching staff must be investigators, the staff as a whole must demonstrate broad, ongoing involvement in scholarly activity.

- 5. **Qualifications of the nonphysician faculty are as follows:**
  - a. **Nonphysician faculty must be appropriately qualified in their field.**
  - b. **Nonphysician faculty must possess appropriate institutional appointments.**

**C. Other Program Personnel**

**Additional necessary professional, technical, and clerical personnel must be provided to support the program.**

**D. Facilities and Resources**

**The program must ensure that adequate resources (e.g., sufficient laboratory space and equipment, computer and statistical consultation services) are available.**

1. Outpatient Facilities

Appropriate facilities and equipment including patient medical and laboratory data retrieval capabilities to manage patients in a timely fashion must be provided so that efficient and effective education in the ambulatory care aspects of the discipline can be accomplished.

2. Inpatient Facilities

Appropriate facilities and equipment including patient medical and laboratory data retrieval capabilities must be provided to achieve the educational objectives, including the management of critically ill patients and those undergoing obstetric or gynecologic operative procedures.

3. Medical Records

The fundamentals of good medical history taking and thoughtful, meticulous physical examination must be taught. 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. 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 RRC.

4. Medical Library

The medical library is an important resource to the obstetrics-gynecology education program. The library may be sponsored by the hospital or the department, but it must be readily accessible to staff and residents, both during the day and in the evening, including weekends. In addition, there must be access to an on-site library or to a collection of appropriate texts and journals in each institution participating in the residency program. The textbooks should be kept up to date, and there should be an ample supply of current journals devoted to obstetrics-gynecology and related subjects. When a comprehensive library is not available in the hospital, an active reference system should be provided through ready access to larger medical libraries. Programs

must provide instruction in retrieval and assessment of medical literature, and library services should include the electronic retrieval of information from medical databases.

5. Resident Facilities and Support Services

Adequate facilities for residents to carry out their patient care and personal educational responsibilities are required. 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.

**IV. Resident Appointments**

**A. Eligibility Criteria**

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

**B. Number of Residents**

**The RRC will approve the number of residents based upon established written criteria that include the adequacy of resources for resident education (e.g., the quality and volume of patients and related clinical material available for education), faculty-resident ratio, institutional funding, and the quality of faculty teaching.**

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.
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.

3. The minimum number of residents in an accreditable 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 RRC, and proposed increases in the number of residents must first be approved in writing by the RRC.
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.

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.

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 RRC to determine if a reduction in the number of resident positions in a given graduate medical program is necessary.

5. Residency programs may, with prior RRC approval, contain

more residents in the first year than the number approved for subsequent years.

**C. Resident Transfers**

**To determine the appropriate level of education for residents who are transferring from another residency program, the program director must receive written verification of previous educational experiences and a statement regarding the performance evaluation of the transferring resident prior to their acceptance into the program. A program director is required to provide verification of residency education for residents who may leave the program prior to completion of their education.**

**D. Appointment of Fellows and Other Students**

**The appointment of fellows and other specialty residents or students must not dilute or detract from the educational opportunities available to regularly appointed residents.**

**V. Program Curriculum**

**A. Program Design**

**1. Format**

**The program design and sequencing of educational experiences will be approved by the RRC as part of the review process.**

**2. Goals and Objectives**

**The program must possess a written statement that outlines its educational goals with respect to the knowledge, skills, and other attributes of residents for each major assignment and for each level of the program. This statement must be distributed to residents and faculty, and must be reviewed with residents prior to their assignments.**

- 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). Directors of

programs must be able to document that they are reviewing the implementation of the educational objectives and that the residents are indeed accomplishing what is anticipated of them. Any program that does not establish a system that clearly demonstrates that each resident has or has not successfully accomplished each of the items indicated in the program's statement of educational aims and objectives cannot be considered an adequate program.

- 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 up to 6 months of an educational experience focused on women's health care; an experience of more than 6 months and up to 12 months for an individual or a program would need prior written approval of the RRC. This approval requires the assurance that each residency program provides quality education and experience for all of the residents completing the program. The program director has the responsibility to assure that a resident completes the objectives and goals of the specific educational program. All educational experiences must have as a goal the enhancement of the quality of patient care.

## **B. Specialty Curriculum**

**The program must possess a well-organized and effective curriculum, both didactic and clinical. The curriculum must also provide residents with direct experience in progressive responsibility for patient management.**

- a. Complete management of a patient's care under adequate supervision should be considered the highest level of residency education. There are, however, circumstances under which the resident may not assume complete management:
  - 1) 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

- 2) When the attending physician is unable to delegate the necessary degree of responsibility
  - 3) When the resident, for religious or moral reasons, does not wish to participate in proposed procedures
- b. An essential feature of resident education is that a significant number of staff support the principle of delegation of complete management under supervision.
  - c. Increasing responsibility 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 institution(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.

#### **C. Residents Scholarly Activities**

**Each program must provide an opportunity for residents to participate in research or other scholarly activities, and residents must participate actively in such scholarly activities.**

#### **D. ACGME Competencies**

**The residency program must require its residents to obtain competence in the six areas listed below to the level expected of a new practitioner. Programs must define the specific knowledge, skills, behaviors, and attitudes required, and provide educational experiences as needed in order for their residents to demonstrate the following:**

1. ***Patient care* that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health;**
2. ***Medical Knowledge* about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care;**

3. ***Practice-based learning and improvement*** that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements in patient care;
4. ***Interpersonal and communication skills*** that result in the effective exchange of information and collaboration with patients, their families, and other health professionals;
5. ***Professionalism***, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds;
6. ***Systems-based practice***, as manifested by actions that 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.

E. Educational Components

1. The resident's ability 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 is of paramount importance.
2. Formal teaching activities in obstetrics-gynecology should 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.
3. Wise judgment regarding the need for a surgical procedure and recognition and management of complications are as important as the technical aspects of residency education. 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.

4. The program must provide a structured didactic and clinical educational experience in all methods of family planning. 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.
5. 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.
6. Because an increasing percentage of women seeking their medical care from obstetrician-gynecologists are postmenopausal, there must be appropriate didactic instruction and sufficient clinical experience in the management of the problems of women in the postreproductive age.

## F. Clinical Components

### 1. Organization and structure

- a. 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:

1. Continuity clinics
2. Obstetrical high-risk clinic
3. Family Practice rotation.
4. Internal Medicine outpatient rotation
5. Emergency care rotation.

The emphasis should be on 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 practice, 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.

- b. 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.
- c. The ambulatory care experiences of residents preparing for their roles as providers of primary and preventive care require the same attention, supervision, and guidance as those experiences in specialty clinics. It is essential to provide a closely supervised experience by appropriately educated generalist faculty that assures 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 one-half day per week, for at least 30 months throughout the 4 years of education. The use of remote sites or institutions or clinical services must not interrupt continuity of care clinics for longer than 2 months in any of these 4 years. Residents should be provided opportunity on at least a weekly basis to return to the parent institution for their continuity clinic experience.

## 2. Specific Educational Experiences

The educational curriculum must be written and implemented for the comprehensive development of measurable competencies for each resident. This education must include but not necessarily be limited to the following:

- a. Obstetrics
  - 1) The full range of obstetrics, including the medical and surgical complications of pregnancy and experience in the management of critically ill patients
  - 2) Genetics, including experience with genetic amniocentesis and patient counseling
  - 3) Learning and performing operative vaginal

deliveries, including the use of obstetric forceps and/or the vacuum extractor

- 4) Performing breech and multifetal deliveries
- 5) Performing vaginal births after previous cesarean delivery
- 6) Learning the principles of general and conduction anesthesia, together with the management and the complications of these techniques
- 7) Immediate care of the newborn (Every resident must have experience in resuscitation of the human newborn and understanding of the principles of general neonatal complications.)
- 8) The full range of commonly employed obstetrical diagnostic procedures, including ultrasonography and other relevant imaging techniques
- 9) The emotional and psychosocial impact of pregnancy or pregnancy loss on an individual and her family
- 10) The counseling of women regarding nutrition, exercise, health maintenance, high-risk behaviors, and preparation for pregnancy and childbirth
- 11) Obstetric pathology

b. Gynecology

- 1) The full range of medical and surgical gynecology for all age groups, including experience in the management of critically ill patients
- 2) Diagnosis and management of pelvic floor dysfunction, including experience with various operations for its correction
- 3) Diagnosis and medical and surgical

management of urinary incontinence

- 4) Oncology, including prevention, diagnosis, and treatment
- 5) Diagnosis and nonsurgical management of breast disease
- 6) Reproductive endocrinology and infertility
- 7) Clinical skills in family planning
- 8) Psychosomatic and psychosexual counseling
- 9) The full range of commonly employed gynecologic diagnostic procedures, including ultrasonography and other relevant imaging techniques
- 10) Counseling and educating patients about the normal physiology of the reproductive tract and about high-risk behaviors that may compromise reproductive function
- 11) Gynecologic pathology

c. Primary and preventive care

- 1) Comprehensive history taking, including medical, nutritional, sexual, family, genetic, and social behavior data, and the ability to assess health risks
- 2) Complete physical examination
- 3) Appropriate use of laboratory studies and diagnostic techniques
- 4) Patient education and counseling
- 5) Screening appropriate to patients of various ages and risk factors
- 6) Immunizations needed at specific ages and under specific circumstances

- 7) Diagnosis and treatment of the common nonreproductive illnesses affecting women
- 8) Continuous management of the health care of women of all ages
- 9) Appropriate use of community resources and other physicians through consultation when necessary
- 10) Appropriate awareness and knowledge of the behavioral and societal factors that influence health among women of differing socioeconomic and cultural backgrounds
- 11) Behavioral medicine and psychosocial problems, including domestic violence, sexual assault, and substance abuse
- 12) Emergency care
- 13) Ambulatory primary care problems of the geriatric patient
- 14) Basics of epidemiology, statistics, data collection and management, and use of medical literature and assessment of its value
- 15) Ethics and medical jurisprudence
- 16) Community medicine, including health promotion and disease prevention
- 17) Health care delivery systems and practice management
- 18) Information processing and decision making
- 19) Patient safety

## **VI. Resident Duty Hours and the Working Environment**

**Providing residents with a sound didactic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by**

**excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energy. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.**

**A. Supervision of Residents**

- 1. All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of residents at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty.**

The program director must provide for 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.

Supervision of residents in obstetrics and gynecology is required to ensure proper (1) quality of care, (2) education, (3) patient safety, and (4) fulfillment of responsibility of the attending physicians to their patients. These considerations must be integrated with the goal of independent competence in the full range of obstetrics and gynecology at the completion of residency. This implies a graduated and increasing level of independent resident action. Each program director must balance quality assurance for patient care, resident education, and independent resident action. The level of resident supervision should be commensurate with the amount of independent function that is designated at each resident level. Residents, as well as faculty, may provide supervision.

- 2. Faculty schedules must be structured to provide residents with continuous supervision and consultation.**
  - a. 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.

- b. If the program director judges that the size and nature of the patient population does not require the 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 RRC.
3. **Faculty and residents must be educated to recognize the signs of fatigue, and adopt and apply policies to prevent and counteract its potential negative effects.**

## **B. Duty Hours**

1. **Duty hours are defined as all clinical and academic activities related to the residency program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities such as conferences. Duty hours do *not* include reading and preparation time spent away from the duty site.**
2. **Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.**
3. **Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. *One day* is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties.**
4. **Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.**

### **C. On-call Activities**

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. *In-house call* is defined as those duty hours beyond the normal work day, when residents are required to be immediately available in the assigned institution.

1. **In-house call must occur no more frequently than every third night, averaged over a 4-week period.**
2. **Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.**
3. **No new patients may be accepted after 24 hours of continuous duty, except in outpatient continuity clinics.**
4. ***At-home call (or pager call)* is defined as a call taken from outside the assigned institution.**
  - a. **The frequency of at-home call is not subject to the every-third-night limitation. At-home call, however, must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.**
  - b. **When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.**
  - c. **The program director and the faculty must monitor the demands of at-home call in their programs, and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.**

**D. Moonlighting**

- 1. Because residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.**
- 2. The program director must comply with the sponsoring institution's written policies and procedures regarding moonlighting, in compliance with the ACGME Institutional Requirements.**
- 3. Any hours a resident works for compensation at the sponsoring institution or any of the sponsor's primary clinical sites must be considered part of the 80-hour weekly limit on duty hours. This refers to the practice of *internal moonlighting*.**

**E. Oversight**

- 1. Each program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment. These policies must be distributed to the residents and the faculty. Duty hours must be monitored with a frequency sufficient to ensure an appropriate balance between education and service.**
- 2. Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.**

**F. Duty Hours Exception**

**An RRC may grant exceptions for up to 10% of the 80-hour limit to individual programs based on a sound educational rationale. Prior permission of the institution's GMEC, however, is required.**

**VII. Evaluation**

**A. Resident**

- 1. Formative Evaluation**

**The faculty must evaluate in a timely manner the residents whom they supervise. In addition, the residency program must demonstrate that it has an effective mechanism for assessing resident performance throughout the program, and for utilizing the results to improve resident performance.**

- a. Assessment should include the use of methods that produce an accurate assessment of residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.**
- b. Assessment should include the regular and timely performance feedback to residents that includes at least semiannual written evaluations of the knowledge, skills, and professional growth of the residents, using appropriate criteria and procedures. Such evaluations are to be communicated to each resident in a timely manner, and maintained in a record that is accessible to each resident.**
- c. Assessment should include the use of assessment results, including evaluation by faculty, patients, peers, self, and other professional staff, to achieve progressive improvements in residents' competence and performance. One example of an acceptable mechanism helpful in evaluating cognitive knowledge is the CREOG in-training examination.**

## **2. Final Evaluation**

**The program director must provide a final evaluation for each resident who completes the program. This evaluation must include a review of the resident's performance during the final period of education, and should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. The final evaluation must be part of the resident's permanent record maintained by the institution.**

**B. Faculty**

**The performance of the faculty must be evaluated by the program no less frequently than at the midpoint of the accreditation cycle, and again prior to the next site visit. The evaluations should include a review of their teaching abilities, commitment to the educational program, clinical knowledge, and scholarly activities. This evaluation must include annual written confidential evaluations by residents.**

**C. Program**

**The educational effectiveness of a program must be evaluated at least annually in a systematic manner.**

- 1. Representative program personnel (i.e., at least the program director, representative faculty, and one resident) must be organized to review program goals and objectives, and the effectiveness with which they are achieved. This group must conduct a formal documented meeting at least annually for this purpose. In the evaluation process, the group must take into consideration written comments from the faculty, the most recent report of the GMEC of the sponsoring institution, and the residents' confidential written evaluations. If deficiencies are found, the group should prepare an explicit plan of action, which should be approved by the faculty and documented in the minutes of the meeting.**
  - a. 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.
  - b. Annually, the program director must 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 RRC.

2. **The program should use resident performance and outcome assessment in its evaluation of the educational effectiveness of the residency program. Performance of program graduates on the certification examination should be used as one measure of evaluating program effectiveness. The program should maintain a process for using assessment results together with other program evaluation results to improve the residency program.**

#### **VIII. Experimentation and Innovation**

**Since responsible innovation and experimentation are essential to improving professional education, experimental projects along sound educational principles are encouraged. Requests for experimentation or innovative projects that may deviate from the program requirements must be approved by the RRC, and must include the educational rationale and method of evaluation. The sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.**

#### **IX. Certification**

**Residents who plan to seek certification by the American Board of Obstetrics and Gynecology should communicate with the office of the board regarding the full requirements for certification.**

ACGME: February 15, 2005  
Effective Date: July 1, 2005