

1 **ACGME Program Requirements for Graduate Medical Education**
2 **in Orthopaedic Surgery**

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

5
6 Effective: July 1, 2012
7

8 **Introduction**
9

10 **Int.A. Residency is an essential dimension of the transformation of the medical**
11 **student to the independent practitioner along the continuum of medical**
12 **education. It is physically, emotionally, and intellectually demanding, and**
13 **requires longitudinally-concentrated effort on the part of the resident.**
14

15 **The specialty education of physicians to practice independently is**
16 **experiential, and necessarily occurs within the context of the health care**
17 **delivery system. Developing the skills, knowledge, and attitudes leading to**
18 **proficiency in all the domains of clinical competency requires the resident**
19 **physician to assume personal responsibility for the care of individual**
20 **patients. For the resident, the essential learning activity is interaction with**
21 **patients under the guidance and supervision of faculty members who give**
22 **value, context, and meaning to those interactions. As residents gain**
23 **experience and demonstrate growth in their ability to care for patients, they**
24 **assume roles that permit them to exercise those skills with greater**
25 **independence. This concept—graded and progressive responsibility—is**
26 **one of the core tenets of American graduate medical education.**
27 **Supervision in the setting of graduate medical education has the goals of**
28 **assuring the provision of safe and effective care to the individual patient;**
29 **assuring each resident’s development of the skills, knowledge, and**
30 **attitudes required to enter the unsupervised practice of medicine; and**
31 **establishing a foundation for continued professional growth.**
32

33 **Int.B. Orthopaedic surgery is the medical specialty that includes the study and**
34 **prevention of musculoskeletal diseases, disorders, and injuries, and their**
35 **treatment by medical, surgical, and physical methods.**
36

37 **Int.C. The educational program in orthopaedic surgery must be 60 months in length.**
38

39 **I. Institutions**
40

41 **I.A. Sponsoring Institution**
42

43 **One sponsoring institution must assume ultimate responsibility for the**
44 **program, as described in the Institutional Requirements, and this**
45 **responsibility extends to resident assignments at all participating sites.**
46

47 **The sponsoring institution and the program must ensure that the program**
48 **director has sufficient protected time and financial support for his or her**
49 **educational and administrative responsibilities to the program.**
50

51 **I.A.1. ~~One primary site must provide most of the residents’ basic science and~~**

- 52 ~~research education.~~
- 53
- 54 I.A.1.a) ~~Residents' clinical education at the primary site should include~~
55 ~~extensive experience in patient care. Preoperative evaluation and~~
56 ~~postoperative follow-up, as well as evaluation and treatment of~~
57 ~~patients not requiring surgery, must be included.~~
- 58
- 59 I.A.1.b) ~~Basic science education and the principal clinical conferences~~
60 ~~should be provided at the primary site. Supplemental conferences~~
61 ~~may also be provided at other locations, but the program's didactic~~
62 ~~activities should be provided at the program's primary site.~~
- 63
- 64 I.A.2. ~~In communities where the didactic programs of several residencies are~~
65 ~~combined, the staff of each accredited program must actively and~~
66 ~~consistently participate in the combined effort.~~
- 67
- 68 I.A.3. To provide an adequate interdisciplinary educational experience, the
69 institution that sponsors the orthopaedic program should also participate
70 in ACGME-accredited programs in general surgery, internal medicine,
71 and pediatrics.
- 72
- 73 **I.B. Participating Sites**
- 74
- 75 **I.B.1. There must be a program letter of agreement (PLA) between the**
76 **program and each participating site providing a required**
77 **assignment. The PLA must be renewed at least every five years.**
- 78
- 79 **The PLA should:**
- 80
- 81 **I.B.1.a) identify the faculty who will assume both educational and**
82 **supervisory responsibilities for residents;**
- 83
- 84 **I.B.1.b) specify their responsibilities for teaching, supervision, and**
85 **formal evaluation of residents, as specified later in this**
86 **document;**
- 87
- 88 **I.B.1.c) specify the duration and content of the educational**
89 **experience; and,**
- 90
- 91 **I.B.1.d) state the policies and procedures that will govern resident**
92 **education during the assignment.**
- 93
- 94 **I.B.2. The program director must submit any additions or deletions of**
95 **participating sites routinely providing an educational experience,**
96 **required for all residents, of one month full time equivalent (FTE) or**
97 **more through the Accreditation Council for Graduate Medical**
98 **Education (ACGME) Accreditation Data System (ADS).**
- 99
- 100 I.B.3. ~~Participating sites should be in close enough proximity to the primary site~~
101 ~~not be at such a distance from the sponsoring institution as to allow~~
102 ~~facilitate make-resident participation in program conferences and rounds.~~

- 103 ~~difficult, unless the participating sites provide comparable activities.~~
- 104
- 105 I.B.3.a) Residents at distant participating sites must attend and participate
- 106 in regularly scheduled and held teaching rounds, lectures and
- 107 conferences. On average, there must be at least four hours of
- 108 formal teaching activities each week.
- 109
- 110 **II. Program Personnel and Resources**
- 111
- 112 **II.A. Program Director**
- 113
- 114 **II.A.1. There must be a single program director with authority and**
- 115 **accountability for the operation of the program. The sponsoring**
- 116 **institution's GMEC must approve a change in program director.**
- 117 **After approval, the program director must submit this change to the**
- 118 **ACGME via the ADS.**
- 119
- 120 **II.A.2. The program director should continue in his or her position for a**
- 121 **length of time adequate to maintain continuity of leadership and**
- 122 **program stability.**
- 123
- 124 **II.A.3. Qualifications of the program director must include:**
- 125
- 126 **II.A.3.a) requisite specialty expertise and documented educational**
- 127 **and administrative experience acceptable to the Review**
- 128 **Committee;**
- 129
- 130 **II.A.3.b) current certification in the specialty by the American Board of**
- 131 **Orthopaedic Surgery (ABOS), or specialty qualifications that**
- 132 **are acceptable to the Review Committee; and,**
- 133
- 134 **II.A.3.c) current medical licensure and appropriate medical staff**
- 135 **appointment.**
- 136
- 137 **II.A.4. The program director must administer and maintain an educational**
- 138 **environment conducive to educating the residents in each of the**
- 139 **ACGME competency areas. The program director must:**
- 140
- 141 **II.A.4.a) oversee and ensure the quality of didactic and clinical**
- 142 **education in all sites that participate in the program;**
- 143
- 144 **II.A.4.b) approve a local director at each participating site who is**
- 145 **accountable for resident education;**
- 146
- 147 **II.A.4.c) approve the selection of program faculty as appropriate;**
- 148
- 149 **II.A.4.d) evaluate program faculty and approve the continued**
- 150 **participation of program faculty based on evaluation;**
- 151
- 152 **II.A.4.e) monitor resident supervision at all participating sites;**
- 153

- 154 **II.A.4.f)** prepare and submit all information required and requested by
155 the ACGME, including but not limited to the program
156 information forms and annual program resident updates to
157 the ADS, and ensure that the information submitted is
158 accurate and complete;
159
- 160 **II.A.4.g)** provide each resident with documented semiannual
161 evaluation of performance with feedback;
162
- 163 **II.A.4.h)** ensure compliance with grievance and due process
164 procedures as set forth in the Institutional Requirements and
165 implemented by the sponsoring institution;
166
- 167 **II.A.4.i)** provide verification of residency education for all residents,
168 including those who leave the program prior to completion;
169
- 170 **II.A.4.j)** implement policies and procedures consistent with the
171 institutional and program requirements for resident duty
172 hours and the working environment, including moonlighting,
173 and, to that end, must:
174
- 175 **II.A.4.j).(1)** distribute these policies and procedures to the
176 residents and faculty;
177
- 178 **II.A.4.j).(2)** monitor resident duty hours, according to sponsoring
179 institutional policies, with a frequency sufficient to
180 ensure compliance with ACGME requirements;
181
- 182 **II.A.4.j).(3)** adjust schedules as necessary to mitigate excessive
183 service demands and/or fatigue; and,
184
- 185 **II.A.4.j).(4)** if applicable, monitor the demands of at-home call and
186 adjust schedules as necessary to mitigate excessive
187 service demands and/or fatigue.
188
- 189 **II.A.4.k)** monitor the need for and ensure the provision of back up
190 support systems when patient care responsibilities are
191 unusually difficult or prolonged;
192
- 193 **II.A.4.l)** comply with the sponsoring institution's written policies and
194 procedures, including those specified in the Institutional
195 Requirements, for selection, evaluation and promotion of
196 residents, disciplinary action, and supervision of residents;
197
- 198 **II.A.4.m)** be familiar with and comply with ACGME and Review
199 Committee policies and procedures as outlined in the ACGME
200 Manual of Policies and Procedures;
201
- 202 **II.A.4.n)** obtain review and approval of the sponsoring institution's
203 GMEC/DIO before submitting to the ACGME information or
204 requests for the following:

205		
206	II.A.4.n).(1)	all applications for ACGME accreditation of new programs;
207		
208		
209	II.A.4.n).(2)	changes in resident complement;
210		
211	II.A.4.n).(3)	major changes in program structure or length of training;
212		
213		
214	II.A.4.n).(4)	progress reports requested by the Review Committee;
215		
216	II.A.4.n).(5)	responses to all proposed adverse actions;
217		
218	II.A.4.n).(6)	requests for increases or any change to resident duty hours;
219		
220		
221	II.A.4.n).(7)	voluntary withdrawals of ACGME-accredited programs;
222		
223		
224	II.A.4.n).(8)	requests for appeal of an adverse action;
225		
226	II.A.4.n).(9)	appeal presentations to a Board of Appeal or the ACGME; and,
227		
228		
229	II.A.4.n).(10)	proposals to ACGME for approval of innovative educational approaches.
230		
231		
232	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:
233		
234		
235		
236	II.A.4.o).(1)	program citations, and/or
237		
238	II.A.4.o).(2)	request for changes in the program that would have significant impact, including financial, on the program or institution.
239		
240		
241		
242	II.A.4.p)	<u>prepare and implement a supervision policy including lines of responsibility for faculty members, residents, and other learners in the program; and,</u>
243		
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245		
246	II.A.4.q)	ensure the provision of adequate facilities, teaching staff, resident staff, teaching beds, educational resource materials, outpatient facilities, and research facilities;
247		
248		
249		
250	II.A.4.r)	maintain a file of current, written institutional and interinstitutional agreements, resident agreements, patient care statistics, the operative experience of individual residents, policies on duty hours and supervision, and regular assessments of resident performance. These documents must be provided on request to the Review Committee or to the site visitor;
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256		
257	II.A.4.s)	ensure that faculty and residents attend and participate in
258		regularly scheduled and held teaching rounds, lectures, and
259		conferences. Treatment indications, clinical outcomes,
260		complications, morbidity, and mortality must be critically reviewed
261		and discussed on a regular basis. Subjects of mutual interest and
262		the changing practice of medicine should be discussed at
263		interdisciplinary conferences. On average, there must be at least
264		four hours of formal teaching activities each week; and,
265		
266	II.A.4.t)	maintain a current record of research activity by residents and
267		faculty <u>members</u> .
268		
269	II.B.	Faculty
270		
271	II.B.1.	At each participating site, there must be a sufficient number of
272		faculty with documented qualifications to instruct and supervise all
273		residents at that location.
274		
275		The faculty must:
276		
277	II.B.1.a)	devote sufficient time to the educational program to fulfill
278		their supervisory and teaching responsibilities; and to
279		demonstrate a strong interest in the education of residents,
280		and
281		
282	II.B.1.b)	administer and maintain an educational environment
283		conducive to educating residents in each of the ACGME
284		competency areas.
285		
286	II.B.2.	The physician faculty must have current certification in the specialty
287		by the American Board of Orthopaedic Surgery, or possess
288		qualifications acceptable to the Review Committee.
289		
290	II.B.2.a)	<u>All programs</u> There must have <u>be a minimum of</u> at least three
291		faculty members, <u>including the program director, who each of</u>
292		<u>whom</u> devotes at least 20 hours <u>each per</u> week to the program.
293		<u>These faculty members must have current ABOS certification in</u>
294		<u>the specialty.</u>
295		
296	II.B.2.b)	There must be at least one <u>full-time</u> FTE physician faculty member
297		<u>equivalent</u> (one FTE equals 45 hours per week devoted to the
298		<u>residency program</u>), <u>who has current ABOS certification in the</u>
299		<u>specialty</u> , for every four residents in the program (excluding
300		<u>residents in nonorthopaedic education</u>).
301		
302	II.B.2.c)	The teaching staff must ensure that the structure and content of
303		the residency reflect an education-to-service ratio that identifies
304		residents as students and provides adequate experience in
305		preoperative and postoperative, as well as intraoperative, patient
306		care.

- 307
308 II.B.2.d) ~~The teaching staff must provide direct supervision appropriate to a~~
309 ~~resident's competence and level of training in all patient care~~
310 ~~settings, including operative, inpatient, outpatient, and emergency.~~
311
- 312 **II.B.3. The physician faculty must possess current medical licensure and**
313 **appropriate medical staff appointment.**
314
- 315 **II.B.4. The nonphysician faculty must have appropriate qualifications in**
316 **their field and hold appropriate institutional appointments.**
317
- 318 **II.B.5. The faculty must establish and maintain an environment of inquiry**
319 **and scholarship with an active research component.**
320
- 321 **II.B.5.a) The faculty must regularly participate in organized clinical**
322 **discussions, rounds, journal clubs, and conferences.**
323
- 324 **II.B.5.b) Some members of the faculty should also demonstrate**
325 **scholarship by one or more of the following:**
326
- 327 **II.B.5.b).(1) peer-reviewed funding;**
328
- 329 **II.B.5.b).(2) publication of original research or review articles in**
330 **peer-reviewed journals, or chapters in textbooks;**
331
- 332 **II.B.5.b).(3) publication or presentation of case reports or clinical**
333 **series at local, regional, or national professional and**
334 **scientific society meetings; or,**
335
- 336 **II.B.5.b).(4) participation in national committees or educational**
337 **organizations.**
338
- 339 **II.B.5.c) Faculty should encourage and support residents in scholarly**
340 **activities.**
341
- 342 **II.C. Other Program Personnel**
343
- 344 **The institution and the program must jointly ensure the availability of all**
345 **necessary professional, technical, and clerical personnel for the effective**
346 **administration of the program.**
347
- 348 **II.D. Resources**
349
- 350 **The institution and the program must jointly ensure the availability of**
351 **adequate resources for resident education, as defined in the specialty**
352 **program requirements.**
353
- 354 These resources must include:
355
- 356 **II.D.1. workspace for residents that includes ready access to computers at all**
357 **clinical sites; and,**

358		
359	II.D.2.	<u>current technological resources for production of presentations, manuscripts, or portfolios.</u>
360		
361		
362	II.E.	Medical Information Access
363		
364		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.
365		
366		
367		
368	II.E.1.	<u>Residents must have Internet access to appropriate full-text journals and electronic medical reference resources for education and patient care at all participating sites.</u>
369		
370		
371		
372	III.	Resident Appointments
373		
374	III.A.	Eligibility Criteria
375		
376		The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements.
377		
378		
379	III.A.1.	Programs are encouraged to <u>It is strongly suggested that the program policies for resident selection recognize the value and importance of recruiting qualified women and minority students.</u>
380		
381		
382		
383	III.B.	Number of Residents
384		
385		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.
386		
387		
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389		
390	I.A.1.	The Review Committee will approve both the total number of residents to be educated in the program and at each level of the program.
391		
392		
393	III.C.	Resident Transfers
394		
395	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.
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400		
401	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.
402		
403		
404		
405	III.D.	Appointment of Fellows and Other Learners
406		
407		The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse
408		

409 practitioners) in the program must not interfere with the appointed
410 residents' education. The program director must report the presence of
411 other learners to the DIO and GMEC in accordance with sponsoring
412 institution guidelines.
413

414 **IV. Educational Program**

415
416 **IV.A. The curriculum must contain the following educational components:**
417

418 **IV.A.1. Overall educational goals for the program, which the program must**
419 **distribute to residents and faculty annually;**
420

421 **IV.A.2. Competency-based goals and objectives for each assignment at**
422 **each educational level, which the program must distribute to**
423 **residents and faculty annually, in either written or electronic form.**
424 **These should be reviewed by the resident at the start of each**
425 **rotation;**
426

427 **IV.A.3. Regularly scheduled didactic sessions;**
428

429 IV.A.3.a) Basic science education and the principal clinical conferences
430 should be provided at the primary clinical site.
431

432 IV.A.3.b) Conferences and didactic sessions should be scheduled to permit
433 resident attendance on a regular basis.
434

435 IV.A.3.c) Faculty members and residents must attend and participate in
436 regularly scheduled and held teaching rounds, lectures, and
437 conferences.
438

439 IV.A.3.c).(1) On average, there must be at least four hours of formal
440 teaching activities each week.
441

442 IV.A.3.c).(2) Treatment indications, clinical outcomes, evidence-based
443 guidelines, complications, morbidity, and mortality must be
444 critically reviewed and discussed on a regular basis.
445

446 IV.A.3.d) The didactic curriculum must include:
447

448 IV.A.3.d).(1) ~~basic sciences education anatomy, including~~ biochemistry,
449 biomechanics, embryology, immunology, microbiology,
450 pathology, pharmacology, and physiology;
451

452 IV.A.3.d).(2) ~~instruction in anatomy, including that includes~~ study and
453 dissection of anatomic specimens by the residents and
454 lectures or other formal sessions;
455

456 IV.A.3.d).(3) ~~instruction in pathology that includes~~ pathology, including
457 correlative pathology in which gross and microscopic
458 pathology are related to clinical and roentgenographic
459 findings;

460
461 IV.A.3.d).(4) ~~instruction in biomechanics, presented in seminars or~~
462 ~~conferences emphasizing principles, terminology, and~~
463 ~~application to orthopaedics;~~
464
465 IV.A.3.d).(5) ~~organized instruction in the basic medical sciences~~
466 ~~integrated into the daily clinical activities by clearly linking~~
467 ~~the pathophysiologic process and findings to the diagnosis,~~
468 ~~treatment, and management of clinical disorders;~~
469
470 IV.A.3.d).(6) ~~organized instruction in the appropriate use and~~
471 ~~interpretation of radiographic and other imaging~~
472 ~~techniques;~~
473
474 IV.A.3.d).(7) ~~education that includes orthopaedic oncology,~~
475 ~~rehabilitation of neurologic injury and disease, orthotics~~
476 ~~and prosthetics, and the ethics of medical practice; and,~~
477
478 IV.A.3.d).(8) basic motor skills, including proper and safe use of surgical
479 instruments and operative techniques.
480
481 IV.A.3.d).(8).(a) The application of basic motor skills must be
482 integrated into daily clinical activities, especially in
483 the operating room.
484
485 IV.A.3.e) Organized instruction in the basic medical sciences must be
486 integrated into the daily clinical activities by clearly linking the
487 pathophysiologic process and findings to the diagnosis, treatment,
488 and management of clinical disorders.
489
490 **IV.A.4. Delineation of resident responsibilities for patient care, progressive**
491 **responsibility for patient management, and supervision of residents**
492 **over the continuum of the program; and,**
493
494 **IV.A.5. ACGME Competencies**
495
496 **The program must integrate the following ACGME competencies**
497 **into the curriculum:**
498
499 **IV.A.5.a) Patient Care**
500
501 **Residents must be able to provide patient care that is**
502 **compassionate, appropriate, and effective for the treatment of**
503 **health problems and the promotion of health. Residents:**
504
505 IV.A.5.a).(1) must demonstrate competence in the pre-admission care,
506 hospital care, operative care, and follow-up care (including
507 rehabilitation) of patients. ~~Opportunities for resident~~
508 ~~involvement in all aspects of care of the same patient~~
509 ~~should be maximized;~~
510

511	IV.A.5.a).(2)	must demonstrate competence in their ability to:
512		
513	IV.A.5.a).(2).(a)	communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families;
514		
515		
516		
517	IV.A.5.a).(2).(b)	gather essential and accurate information about their patients;
518		
519		
520	IV.A.5.a).(2).(c)	make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment;
521		
522		
523		
524		
525	IV.A.5.a).(2).(d)	develop and carry out patient management plans, and;
526		
527		
528	IV.A.5.a).(2).(e)	counsel and educate patients and their families;
529		
530	IV.A.5.a).(2).(f)	demonstrate the ability to practice culturally competent medicine;
531		
532		
533	IV.A.5.a).(2).(g)	use information technology to support patient care decisions and patient education;
534		
535		
536	IV.A.5.a).(2).(h)	provide health care services aimed at preventing health problems or maintaining health; and,
537		
538		
539	IV.A.5.a).(2).(i)	work with health care professionals, including those from other disciplines, to provide patient-focused care.
540		
541		
542		
543	IV.A.5.a).(3)	<u>Residents must demonstrate competence in the diagnosis and management of adult and pediatric orthopaedic disorders.</u>
544		
545		
546		
547	IV.A.5.a).(4)	Resident clinical experience volume in procedures that are tracked in ACGME case logs must be no less than 1.5 standard deviations below the mean or 2 standard deviations above the mean for graduating residents PGY-2 PGY-5.
548		
549		
550		
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552		
553	IV.A.5.b)	Medical Knowledge
554		
555		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:
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557		
558		
559		
560	IV.A.5.b).(1)	must demonstrate expertise in their knowledge of those areas appropriate for an orthopaedic <u>surgeon</u> surgery
561		

562		specialist; <u>and</u> ,
563		
564	IV.A.5.b).(2)	must demonstrate an investigatory and analytic thinking
565		approach to clinical situations.
566		
567	IV.A.5.c)	Practice-based Learning and Improvement
568		
569		Residents must demonstrate the ability to investigate and
570		evaluate their care of patients, to appraise and assimilate
571		scientific evidence, and to continuously improve patient care
572		based on constant self-evaluation and life-long learning.
573		Residents are expected to develop skills and habits to be able
574		to meet the following goals:
575		
576	IV.A.5.c).(1)	identify strengths, deficiencies, and limits in one’s
577		knowledge and expertise;
578		
579	IV.A.5.c).(2)	set learning and improvement goals;
580		
581	IV.A.5.c).(3)	identify and perform appropriate learning activities;
582		
583	IV.A.5.c).(4)	systematically analyze practice using quality
584		improvement methods, and implement changes with
585		the goal of practice improvement;
586		
587	IV.A.5.c).(5)	incorporate formative evaluation feedback into daily
588		practice;
589		
590	IV.A.5.c).(6)	locate, appraise, and assimilate evidence from
591		scientific studies related to their patients’ health
592		problems;
593		
594	IV.A.5.c).(7)	use information technology to optimize learning;
595		
596	IV.A.5.c).(8)	participate in the education of patients, families,
597		students, residents and other health professionals;
598		and,
599		
600	IV.A.5.c).(9)	obtain and use information about their own population of
601		patients and the larger population from which their patients
602		are drawn, and
603		
604	IV.A.5.c).(10)	apply knowledge of study designs and statistical methods
605		to the appraisal of clinical studies and other information on
606		diagnostic and therapeutic effectiveness.
607		
608	IV.A.5.d)	Interpersonal and Communication Skills
609		
610		Residents must demonstrate interpersonal and
611		communication skills that result in the effective exchange of
612		information and collaboration with patients, their families,

- 613 and health professionals. Residents are expected to:
- 614
- 615 **IV.A.5.d).(1)** **communicate effectively with patients, families, and**
- 616 **the public, as appropriate, across a broad range of**
- 617 **socioeconomic and cultural backgrounds;**
- 618
- 619 **IV.A.5.d).(2)** **communicate effectively with physicians, other health**
- 620 **professionals, and health related agencies;**
- 621
- 622 **IV.A.5.d).(3)** **work effectively as a member or leader of a health care**
- 623 **team or other professional group;**
- 624
- 625 **IV.A.5.d).(4)** **act in a consultative role to other physicians and**
- 626 **health professionals;**
- 627
- 628 **IV.A.5.d).(5)** **maintain comprehensive, timely, and legible medical**
- 629 **records, if applicable;**
- 630
- 631 **IV.A.5.d).(6)** **create and sustain a therapeutic and ethically sound**
- 632 **relationship with patients, and,**
- 633
- 634 **IV.A.5.d).(7)** **use effective listening skills, and elicit and provide**
- 635 **information using effective nonverbal, explanatory,**
- 636 **questioning, and writing skills.**

637

638 **IV.A.5.e)**

Professionalism

639

640 **Residents must demonstrate a commitment to carrying out**

641 **professional responsibilities and an adherence to ethical**

642 **principles. Residents are expected to demonstrate:**

- 643
- 644 **IV.A.5.e).(1)** **compassion, integrity, and respect for others;**
- 645
- 646 **IV.A.5.e).(2)** **responsiveness to patient needs that supersedes self-**
- 647 **interest;**
- 648
- 649 **IV.A.5.e).(3)** **respect for patient privacy and autonomy;**
- 650
- 651 **IV.A.5.e).(4)** **accountability to patients, society and the profession;**
- 652
- 653 **IV.A.5.e).(5)** **sensitivity and responsiveness to a diverse patient**
- 654 **population, including but not limited to diversity in**
- 655 **gender, age, culture, race, religion, disabilities, and**
- 656 **sexual orientation;**
- 657
- 658 **IV.A.5.e).(6)** **~~commitment to excellence and ongoing professional~~**
- 659 **~~development;~~**
- 660
- 661 **IV.A.5.e).(7)** **commitment to ethical principles pertaining to provision or**
- 662 **withholding of clinical care, confidentiality of patient**
- 663 **information, informed consent, and business practices;**

664		and,
665		
666	IV.A.5.e).(8)	sensitivity and responsiveness to fellow health care professionals' culture, age, gender, and disabilities.
667		
668		
669	IV.A.5.f)	Systems-based Practice
670		
671		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:
672		
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674		
675		
676		
677	IV.A.5.f).(1)	work effectively in various health care delivery settings and systems relevant to their clinical specialty;
678		
679		
680		
681	IV.A.5.f).(2)	coordinate patient care within the health care system relevant to their clinical specialty;
682		
683		
684	IV.A.5.f).(3)	incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
685		
686		
687		
688	IV.A.5.f).(4)	advocate for quality patient care and optimal patient care systems;
689		
690		
691	IV.A.5.f).(5)	work in interprofessional teams to enhance patient safety and improve patient care quality; and,
692		
693		
694	IV.A.5.f).(6)	participate in identifying system errors and implementing potential systems solutions.
695		
696		
697	IV.A.5.f).(7)	understand how their patient care and other professional practices affect other healthcare professionals, the healthcare organization, and the larger society and how these elements of the system affect their own practice, and
698		
699		
700		
701		
702	IV.A.5.f).(8)	know how types of medical practice and delivery systems differ from one another, including methods of controlling healthcare costs and allocating resources.
703		
704		
705		
706	IV.A.6.	<u>Curriculum Organization and Resident Experiences</u>
707		
708	IV.A.6.a)	The PGY-1 year must be organized to provide (in no required order) include:
709		
710		
711	IV.A.6.a).(1)	a minimum of six months of structured education in <u>general surgery</u>, to include (but does not require an equal distribution of) multi-system trauma, plastic surgery/burn care, surgical intensive care, and vascular surgery;
712		
713		
714		

- 715
716 IV.A.6.a).(2) a minimum of ~~one month~~ three months of structured
717 education, with at least one month each in at least three or
718 more of the following: anesthesiology, emergency
719 medicine, internal medicine, medical/cardiac intensive
720 care, musculoskeletal imaging, neurological surgery,
721 neurology, ~~pediatric surgery or pediatrics~~, rehabilitation,
722 rheumatology, and pediatric surgery, if not already
723 included in general surgery; and,
724
- 725 IV.A.6.a).(3) a maximum of three months of orthopaedic surgery.
726
- 727 IV.A.6.b) The PGY-2 through ~~PGY-5~~ years must ~~be organized to include~~ at
728 least ~~three years~~ 36 months of rotations on orthopaedic services;
729 rotations on related services such as plastic surgery, physical
730 medicine and rehabilitation, rheumatology, or neurological surgery
731 are suggested but not required.
732
- 733 IV.A.6.b).(1) The final 24 months of education must be obtained in a
734 single program.
735
- 736 IV.A.6.c) The PGY-1 year must include residents' participation in ~~clinical~~
737 ~~and didactic~~ activities that will give them the opportunity to:
738
- 739 IV.A.6.c).(1) ~~develop the knowledge, attitudes, and skills needed to~~
740 formulate principles and assess, plan, and initiate
741 treatment of adult and pediatric patients with surgical
742 and/or medical problems;
743
- 744 IV.A.6.c).(2) ~~be involved in the care of~~ for patients with surgical and
745 medical emergencies, multiple organ system trauma, soft
746 tissue wounds, nervous system injuries and diseases,
747 peripheral vascular injuries and diseases, and
748 rheumatologic and other medical diseases;
749
- 750 IV.A.6.c).(3) ~~gain experience in the care of~~ for critically-ill surgical and
751 medical patients;
752
- 753 IV.A.6.c).(4) participate in the pre-, intra- and post-operative care of
754 surgical patients; and,
755
- 756 IV.A.6.c).(5) develop an understanding of surgical anesthesia, including
757 anesthetic risks and the management of intra-operative
758 anesthetic complications.
759
- 760 IV.A.6.d) ~~Each resident's clinical education at the primary site should~~
761 ~~include extensive experience in patient care. Preoperative~~
762 ~~evaluation and postoperative follow-up, as well as evaluation and~~
763 ~~treatment of patients not requiring surgery, must be included.~~
764
- 765 IV.A.6.e) Each resident's experiences must include:

766		
767	IV.A.6.e).(1)	the diagnosis and management of adult and pediatric
768		orthopaedic disorders, including:
769		
770	IV.A.6.e).(1).(a)	adult orthopaedics including joint reconstruction;
771		
772	IV.A.6.e).(1).(b)	pediatric orthopaedics, including pediatric trauma;
773		
774	IV.A.6.e).(1).(c)	trauma, including multisystem trauma;
775		
776	IV.A.6.e).(1).(d)	surgery of the spine, including disk surgery, spinal
777		trauma, and spinal deformities;
778		
779	IV.A.6.e).(1).(e)	hand surgery;
780		
781	IV.A.6.e).(1).(f)	foot surgery; in adults and children;
782		
783	IV.A.6.e).(1).(g)	athletic injuries, including arthroscopy; metastatic
784		disease; and
785		
786	IV.A.6.e).(1).(h)	orthopaedic rehabilitation, including amputations
787		and postamputation care;
788		
789	IV.A.6.e).(1).(i)	<u>orthopaedic oncology, including metastatic disease;</u>
790		<u>and,</u>
791		
792	IV.A.6.e).(1).(j)	<u>amputations and post-amputation care.</u>
793		
794	IV.A.6.e).(2)	Experience in non-operative outpatient diagnosis and care,
795		including all orthopaedic anatomic areas; and, patients of
796		all age groups.
797		
798	IV.A.6.e).(2).(a)	<u>Each resident Residents</u> must have at least one
799		half-day per week and should have two half-days
800		per week of outpatient clinical experience in
801		physician offices or hospital clinics with a minimum
802		of 10 patients per session on all clinical rotations.
803		
804	IV.A.6.e).(2).(b)	<u>Each resident Residents</u> must be supervised by
805		faculty and instructed in pre- and post-operative
806		assessment as well as the operative and non-
807		operative care of general and subspecialty
808		orthopaedic patients.
809		
810	IV.A.6.e).(2).(c)	Opportunities for resident involvement in all aspects
811		of outpatient care of the same patient should be
812		maximized.
813		
814	IV.A.6.e).(3)	The opportunity to assume increasing responsibility for
815		patient care, under faculty supervision (as appropriate for
816		each resident's ability and experience), as <u>they</u> or <u>she</u>

817		progresses through the program.
818		
819	IV.A.6.e).(3).(a)	Residents must have inpatient and outpatient experience with all age groups.
820		
821		
822	IV.A.6.e).(4)	Instruction in basic motor skills, including proper and safe use of surgical instruments and operative techniques. The application of basic motor skills must be integrated into daily clinical activities, especially in the operating room.
823		
824		
825		
826		
827	IV.A.6.f)	<u>Clinical experience for PGY-2-5 residents must be tracked in the ACGME Case Log System.</u>
828		
829		
830	IV.A.6.f).(1)	<u>Each graduating resident must log between 1000 and 3000 procedures.</u>
831		
832		
833	IV.B.	Residents' Scholarly Activities
834		
835	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.
836		
837		
838		
839	IV.B.1.a)	Resident education must include instruction in experimental design, hypothesis testing, and other current research methods, as well as participation in clinical or basic research. so that residents may develop their abilities to critically evaluate medical literature, research, and other scholarly activity.
840		
841		
842		
843		
844		
845	IV.B.2.	Residents should participate in scholarly activity.
846		
847	IV.B.2.a)	Each resident must demonstrate scholarship through at least one of the following activities:
848		
849		
850	IV.B.2.a).(1)	participation in sponsored research;
851		
852	IV.B.2.a).(2)	preparation of an article for a peer-reviewed publication;
853		
854	IV.B.2.a).(3)	presentation of research at a regional or national meeting;
855		or,
856		
857	IV.B.2.a).(4)	participation in a structured literature review of an important topic.
858		
859		
860	IV.B.3.	The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.
861		
862		
863		
864	V.	Evaluation
865		
866	V.A.	Resident Evaluation
867		

868	V.A.1.	Formative Evaluation
869		
870	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.
871		
872		
873		
874		
875	V.A.1.b)	The program must:
876		
877	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;
878		
879		
880		
881		
882		
883	V.A.1.b).(2)	use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);
884		
885		
886	V.A.1.b).(3)	document progressive resident performance improvement appropriate to educational level; and,
887		
888		
889	V.A.1.b).(4)	provide each resident with documented semiannual evaluation of performance with feedback.
890		
891		
892	V.A.1.c)	The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.
893		
894		
895		
896	V.A.1.d)	Semiannual assessment must include a review of case volume <u>and</u> breadth, and must ensure that residents are entering cases into the <u>ACGME Case Log System</u> in a timely manner.
897		
898		
899		
900	V.A.2.	Summative Evaluation
901		
902		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:
903		
904		
905		
906		
907		
908	V.A.2.a)	document the resident's performance during the final period of education, and
909		
910		
911	V.A.2.b)	verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.
912		
913		
914	V.B.	Faculty Evaluation
915		
916	V.B.1.	At least annually, the program must evaluate faculty performance as it relates to the educational program.
917		
918		

- 919 **V.B.2.** These evaluations should include a review of the faculty’s clinical
920 teaching abilities, commitment to the educational program, clinical
921 knowledge, professionalism, and scholarly activities.
922
- 923 **V.B.3.** This evaluation must include at least annual written confidential
924 evaluations by the residents.
925
- 926 **V.C.** Program Evaluation and Improvement
927
- 928 **V.C.1.** The program must document formal, systematic evaluation of the
929 curriculum at least annually. The program must monitor and track
930 each of the following areas:
931
- 932 **V.C.1.a)** resident performance;
933
- 934 **V.C.1.b)** faculty development;
935
- 936 **V.C.1.c)** graduate performance, including performance of program
937 graduates on the certification examination; and,
938
- 939 **V.C.1.c).(1)** 75% of a program’s graduates should take both Part I
940 and Part II of the American Board of Orthopaedic
941 Surgery ABOS examinations, and
942
- 943 **V.C.1.c).(2)** Program graduates should take both Part I and Part II of
944 the American Board of Orthopaedic Surgery examinations
945 and at least 75% of those who take the exams for the first
946 time should pass. 75% of a program’s eligible graduates
947 from the preceding five years taking Part I and Part II of the
948 ABOS certifying examination for the first time should pass.
949
- 950 **V.C.1.d)** program quality. Specifically:
951
- 952 **V.C.1.d).(1)** Residents and faculty must have the opportunity to
953 evaluate the program confidentially and in writing at
954 least annually, and
955
- 956 **V.C.1.d).(2)** The program must use the results of residents’
957 assessments of the program together with other
958 program evaluation results to improve the program.
959
- 960 **V.C.2.** If deficiencies are found, the program should prepare a written plan
961 of action to document initiatives to improve performance in the
962 areas listed in section V.C.1. The action plan should be reviewed
963 and approved by the teaching faculty and documented in meeting
964 minutes.
965
- 966 **VI.** Resident Duty Hours in the Learning and Working Environment
967
- 968 **VI.A.** Professionalism, Personal Responsibility, and Patient Safety
969

- 970 VI.A.1. Programs and sponsoring institutions must educate residents and
971 faculty members concerning the professional responsibilities of
972 physicians to appear for duty appropriately rested and fit to provide
973 the services required by their patients.
974
- 975 VI.A.2. The program must be committed to and responsible for promoting
976 patient safety and resident well-being in a supportive educational
977 environment.
978
- 979 VI.A.3. The program director must ensure that residents are integrated and
980 actively participate in interdisciplinary clinical quality improvement
981 and patient safety programs.
982
- 983 VI.A.4. The learning objectives of the program must:
984
- 985 VI.A.4.a) be accomplished through an appropriate blend of supervised
986 patient care responsibilities, clinical teaching, and didactic
987 educational events; and,
988
- 989 VI.A.4.b) not be compromised by excessive reliance on residents to
990 fulfill non-physician service obligations.
991
- 992 VI.A.5. The program director and institution must ensure a culture of
993 professionalism that supports patient safety and personal
994 responsibility. Residents and faculty members must demonstrate an
995 understanding and acceptance of their personal role in the
996 following:
997
- 998 VI.A.5.a) assurance of the safety and welfare of patients entrusted to
999 their care;
1000
- 1001 VI.A.5.b) provision of patient- and family-centered care;
1002
- 1003 VI.A.5.c) assurance of their fitness for duty;
1004
- 1005 VI.A.5.d) management of their time before, during, and after clinical
1006 assignments;
1007
- 1008 VI.A.5.e) recognition of impairment, including illness and fatigue, in
1009 themselves and in their peers;
1010
- 1011 VI.A.5.f) attention to lifelong learning;
1012
- 1013 VI.A.5.g) the monitoring of their patient care performance improvement
1014 indicators; and,
1015
- 1016 VI.A.5.h) honest and accurate reporting of duty hours, patient
1017 outcomes, and clinical experience data.
1018
- 1019 VI.A.6. All residents and faculty members must demonstrate
1020 responsiveness to patient needs that supersedes self-interest.

1021		Physicians must recognize that under certain circumstances, the
1022		best interests of the patient may be served by transitioning that
1023		patient's care to another qualified and rested provider.
1024		
1025	VI.B.	Transitions of Care
1026		
1027	VI.B.1.	Programs must design clinical assignments to minimize the number
1028		of transitions in patient care.
1029		
1030	VI.B.2.	Sponsoring institutions and programs must ensure and monitor
1031		effective, structured hand-over processes to facilitate both
1032		continuity of care and patient safety.
1033		
1034	VI.B.3.	Programs must ensure that residents are competent in
1035		communicating with team members in the hand-over process.
1036		
1037	VI.B.4.	The sponsoring institution must ensure the availability of schedules
1038		that inform all members of the health care team of attending
1039		physicians and residents currently responsible for each patient's
1040		care.
1041		
1042	VI.C.	Alertness Management/Fatigue Mitigation
1043		
1044	VI.C.1.	The program must:
1045		
1046	VI.C.1.a)	educate all faculty members and residents to recognize the
1047		signs of fatigue and sleep deprivation;
1048		
1049	VI.C.1.b)	educate all faculty members and residents in alertness
1050		management and fatigue mitigation processes; and,
1051		
1052	VI.C.1.c)	adopt fatigue mitigation processes to manage the potential
1053		negative effects of fatigue on patient care and learning, such
1054		as naps or back-up call schedules.
1055		
1056	VI.C.2.	Each program must have a process to ensure continuity of patient
1057		care in the event that a resident may be unable to perform his/her
1058		patient care duties.
1059		
1060	VI.C.3.	The sponsoring institution must provide adequate sleep facilities
1061		and/or safe transportation options for residents who may be too
1062		fatigued to safely return home.
1063		
1064	VI.D.	Supervision of Residents
1065		
1066	VI.D.1.	In the clinical learning environment, each patient must have an
1067		identifiable, appropriately-credentialed and privileged attending
1068		physician (or licensed independent practitioner as approved by each
1069		Review Committee) who is ultimately responsible for that patient's
1070		care.
1071		

1072		A licensed independent practitioner may include non-physician faculty working in conjunction with the orthopaedic surgery department.
1073		
1074		
1075	VI.D.1.a)	This information should be available to residents, faculty members, and patients.
1076		
1077		
1078	VI.D.1.b)	Residents and faculty members should inform patients of their respective roles in each patient's care.
1079		
1080		
1081	VI.D.2.	The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.
1082		
1083		
1084		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.
1085		
1086		
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1090		
1091		
1092		
1093		
1094		
1095	VI.D.3.	Levels of Supervision
1096		
1097		To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:
1098		
1099		
1100		
1101	VI.D.3.a)	Direct Supervision – the supervising physician is physically present with the resident and patient.
1102		
1103		
1104	VI.D.3.b)	Indirect Supervision:
1105		
1106	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.
1107		
1108		
1109		
1110		
1111	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.
1112		
1113		
1114		
1115		
1116		
1117		
1118	VI.D.3.c)	Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.
1119		
1120		
1121		
1122	VI.D.4.	The privilege of progressive authority and responsibility, conditional

1123		independence, and a supervisory role in patient care delegated to
1124		each resident must be assigned by the program director and faculty
1125		members.
1126		
1127	VI.D.4.a)	The program director must evaluate each resident’s abilities
1128		based on specific criteria. When available, evaluation should
1129		be guided by specific national standards-based criteria.
1130		
1131	VI.D.4.b)	Faculty members functioning as supervising physicians
1132		should delegate portions of care to residents, based on the
1133		needs of the patient and the skills of the residents.
1134		
1135	VI.D.4.c)	Senior residents or fellows should serve in a supervisory role
1136		of junior residents in recognition of their progress toward
1137		independence, based on the needs of each patient and the
1138		skills of the individual resident or fellow.
1139		
1140	VI.D.5.	Programs must set guidelines for circumstances and events in
1141		which residents must communicate with appropriate supervising
1142		faculty members, such as the transfer of a patient to an intensive
1143		care unit, or end-of-life decisions.
1144		
1145	VI.D.5.a)	Each resident must know the limits of his/her scope of
1146		authority, and the circumstances under which he/she is
1147		permitted to act with conditional independence.
1148		
1149	VI.D.5.a).(1)	In particular, PGY-1 residents should be supervised
1150		either directly or indirectly with direct supervision
1151		immediately available.
1152		
1153	VI.D.6.	Faculty supervision assignments should be of sufficient duration to
1154		assess the knowledge and skills of each resident and delegate to
1155		him/her the appropriate level of patient care authority and
1156		responsibility.
1157		
1158	VI.E.	Clinical Responsibilities
1159		
1160		The clinical responsibilities for each resident must be based on PGY-level,
1161		patient safety, resident education, severity and complexity of patient
1162		illness/condition and available support services.
1163		
1164	VI.F.	Teamwork
1165		
1166		Residents must care for patients in an environment that maximizes
1167		effective communication. This must include the opportunity to work as a
1168		member of effective interprofessional teams that are appropriate to the
1169		delivery of care in the specialty.
1170		
1171	VI.G.	Resident Duty Hours
1172		
1173	VI.G.1.	Maximum Hours of Work per Week

1174		
1175		Duty hours must be limited to 80 hours per week, averaged over a
1176		four-week period, inclusive of all in-house call activities and all
1177		moonlighting.
1178		
1179	VI.G.1.a)	Duty Hour Exceptions
1180		
1181		A Review Committee may grant exceptions for up to 10% or a
1182		maximum of 88 hours to individual programs based on a
1183		sound educational rationale.
1184		
1185	VI.G.1.a).(1)	In preparing a request for an exception the program
1186		director must follow the duty hour exception policy
1187		from the ACGME Manual on Policies and Procedures.
1188		
1189	VI.G.1.a).(2)	Prior to submitting the request to the Review
1190		Committee, the program director must obtain approval
1191		of the institution's GMEC and DIO.
1192		
1193	VI.G.2.	Moonlighting
1194		
1195	VI.G.2.a)	Moonlighting must not interfere with the ability of the resident
1196		to achieve the goals and objectives of the educational
1197		program.
1198		
1199	VI.G.2.b)	Time spent by residents in Internal and External Moonlighting
1200		(as defined in the ACGME Glossary of Terms) must be
1201		counted towards the 80-hour Maximum Weekly Hour Limit.
1202		
1203	VI.G.2.c)	PGY-1 residents are not permitted to moonlight.
1204		
1205	VI.G.3.	Mandatory Time Free of Duty
1206		
1207		Residents must be scheduled for a minimum of one day free of duty
1208		every week (when averaged over four weeks). At-home call cannot
1209		be assigned on these free days.
1210		
1211	VI.G.4.	Maximum Duty Period Length
1212		
1213	VI.G.4.a)	Duty periods of PGY-1 residents must not exceed 16 hours in
1214		duration.
1215		
1216	VI.G.4.b)	Duty periods of PGY-2 residents and above may be
1217		scheduled to a maximum of 24 hours of continuous duty in
1218		the hospital. Programs must encourage residents to use
1219		alertness management strategies in the context of patient
1220		care responsibilities. Strategic napping, especially after 16
1221		hours of continuous duty and between the hours of 10:00
1222		p.m. and 8:00 a.m., is strongly suggested.
1223		
1224	VI.G.4.b).(1)	It is essential for patient safety and resident education

1225		that effective transitions in care occur. Residents may
1226		be allowed to remain on-site in order to accomplish
1227		these tasks; however, this period of time must be no
1228		longer than an additional four hours.
1229		
1230	VI.G.4.b).(2)	Residents must not be assigned additional clinical
1231		responsibilities after 24 hours of continuous in-house
1232		duty.
1233		
1234	VI.G.4.b).(3)	In unusual circumstances, residents, on their own
1235		initiative, may remain beyond their scheduled period
1236		of duty to continue to provide care to a single patient.
1237		Justifications for such extensions of duty are limited
1238		to reasons of required continuity for a severely ill or
1239		unstable patient, academic importance of the events
1240		transpiring, or humanistic attention to the needs of a
1241		patient or family.
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1243	VI.G.4.b).(3).(a)	Under those circumstances, the resident must:
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1245	VI.G.4.b).(3).(a).(i)	appropriately hand over the care of all
1246		other patients to the team responsible
1247		for their continuing care; and,
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1249	VI.G.4.b).(3).(a).(ii)	document the reasons for remaining to
1250		care for the patient in question and
1251		submit that documentation in every
1252		circumstance to the program director.
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1254	VI.G.4.b).(3).(b)	The program director must review each
1255		submission of additional service, and track
1256		both individual resident and program-wide
1257		episodes of additional duty.
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1259	VI.G.5.	Minimum Time Off between Scheduled Duty Periods
1260		
1261	VI.G.5.a)	PGY-1 residents should have 10 hours, and must have eight
1262		hours, free of duty between scheduled duty periods.
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1264	VI.G.5.b)	Intermediate-level residents should have 10 hours free of
1265		duty, and must have eight hours between scheduled duty
1266		periods. They must have at least 14 hours free of duty after 24
1267		hours of in-house duty.
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1269		PGY-2 and PGY-3 residents are considered to be at the
1270		intermediate level.
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1272	VI.G.5.c)	Residents in the final years of education must be prepared to
1273		enter the unsupervised practice of medicine and care for
1274		patients over irregular or extended periods.
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1276		PGY-4 and PGY-5 residents and fellows (PGY-6 and above) are considered to be in the final years of education.
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1279	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.
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1288	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.
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1294	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.
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1301	VI.G.6.	Maximum Frequency of In-House Night Float
1302		
1303		Residents must not be scheduled for more than six consecutive nights of night float.
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1306	VI.G.6.a)	Night float may not exceed three months per year.
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1308	VI.G.7.	Maximum In-House On-Call Frequency
1309		
1310		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).
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1314	VI.G.8.	At-Home Call
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1316	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.
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1322	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.
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1326	VI.G.8.b)	Residents are permitted to return to the hospital while on at-

1327 home call to care for new or established patients. Each
1328 episode of this type of care, while it must be included in the
1329 80-hour weekly maximum, will not initiate a new “off-duty
1330 period”.

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1332 **VII. Innovative Projects**

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1334 **Requests for innovative projects that may deviate from the institutional, common**
1335 **and/or specialty specific program requirements must be approved in advance by**
1336 **the Review Committee. In preparing requests, the program director must follow**
1337 **Procedures for Approving Proposals for Innovative Projects located in the**
1338 **ACGME Manual on Policies and Procedures. Once a Review Committee approves**
1339 **a project, the sponsoring institution and program are jointly responsible for the**
1340 **quality of education offered to residents for the duration of such a project.**

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1344 ACGME-approved: October 1, 2011; Effective: July 1, 2012