

ACGME Program Requirements for Graduate Medical Education in Pediatric Rehabilitation Medicine

Common Program Requirements are in BOLD

Effective: July 1, 2007

Introduction

A. Definition

Pediatric Rehabilitation Medicine (PRM) is the subspecialty that utilizes an interdisciplinary approach to address the prevention, diagnosis, treatment, and management of congenital and childhood-onset physical impairments. These impairments include related or secondary medical, physical, functional, cognitive, psychosocial, and vocational limitations or conditions. Rehabilitation management of children with physical impairments requires the identification of functional capabilities and the selection of the best rehabilitation intervention strategies, with an understanding both of the life course of the disability and of the continuum of care.

B. Program Design

The director and teaching staff of a program must prepare and comply with written educational goals for the program.

All educational components of a residency program should be related to the program goals.

1. The Review Committee for Physical Medicine and Rehabilitation must approve the program design as part of the regular review process.
2. Participation by any site providing three months or more of training must be approved by the Review Committee.

C. Duration of Training

1. Training in PRM shall be 24 months in duration if it begins after satisfactory completion of an ACGME approved residency training program in PM&R. The program must ensure that the resident acquires knowledge and skills in general pediatrics, normal childhood development, normal neonatal development, and adolescent medicine including psychosocial issues.

2. Training in PRM shall be 12 months in duration if it begins after satisfactory completion of Accreditation Council for Graduate Medical Education (ACGME)-approved combined or consecutive residency training in both PM&R and Pediatrics.

D. Program Goals and Objectives

1. Goals

An approved subspecialty program must provide an educational experience to ensure that its graduates possess the advanced knowledge and competencies necessary to practice this subspecialty.

2. Objectives

The program must provide the resident opportunities to develop a specific set of attitudes, knowledge, and psychomotor skills in pediatric rehabilitation conditions to ensure their ability to enhance the quality of care available to those individuals and their families. The resident must become competent in:

- a) Defining aspects of growth and development in the context of children and adults with congenital and childhood onset disabilities, throughout the life course.
- b) Identifying age appropriate assessment and measurement tools to evaluate functional status or outcomes of interventions.
- c) Managing common medical issues in pediatric rehabilitation.
- d) Describing principles and techniques for general pediatric rehabilitative therapeutic management.
- e) Evaluating and prescribing age appropriate assistive devices and technologies to enhance function.
- f) Understanding and performing pediatric rehabilitation procedures.
- g) Outlining the clinical course of and functional prognosis for common pediatric disabilities.
- h) Identifying interventions to assist of children, adults, and their families to participate successfully in age-appropriate

education and other activities.

- i) Advocating for care needs, systems of care, and research to enhance the care and function of children and adults with congenital or childhood onset disabilities.
- j) Providing consultation to physiatrists, pediatricians and other clinicians regarding PRM issues.
- k) Participating in instruction and conducting research in PRM.
- l) Applying principles of management and administration

I. Institutions

A. Sponsoring Institution

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

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

1. The sponsoring institution must be a center for care of persons with pediatric rehabilitative diagnoses or be affiliated with such a center. Affiliation with an accredited medical school is desirable. The Joint Commission on Accreditation of Healthcare Organizations-Rehabilitation Section or the Commission on Accreditation of Rehabilitation Facilities should accredit the sponsoring institution.
2. Accreditation will be granted only when the program is affiliated with an ACGME-accredited residency program in PM&R.
3. There must be close cooperation between the core residency program and the subspecialty program. The lines of responsibility between residents in the core program and the subspecialty program must be clearly delineated.
4. There should be an institutional policy, reviewed at the time of regular institutional or internal review, governing the educational resources committed to the PRM program assuring cooperation of all involved disciplines.

5. The institution must provide for financial resources that include, but are not limited to, salaries, fringe benefits, and opportunities for residents' continuing education.

B. Participating Sites

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

The PLA should:

- 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.**
2. **The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).**
 3. Participating sites should be in the same geographic location and conveniently and safely accessible to residents.

II. Program Personnel and Resources

A. Program Director

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

- 2. The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.**
- 3. Qualifications of the program director must include:**
 - a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;**
 - b) current certification in the specialty by the American Board of Physical Medicine and Rehabilitation, or specialty qualifications that are acceptable to the Review Committee; and,**
 - c) current medical licensure and appropriate medical staff appointment.**
- 4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:**
 - a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;**
 - b) approve a local director at each participating site who is accountable for resident education;**
 - c) approve the selection of program faculty as appropriate;**
 - d) evaluate program faculty and approve the continued participation of program faculty based on evaluation;**
 - e) monitor resident supervision at all participating sites;**
 - f) prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;**
 - g) provide each resident with documented semiannual evaluation of performance with feedback;**

- h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;**
- i) provide verification of residency education for all residents, including those who leave the program prior to completion;**
- j) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:**
 - (1) distribute these policies and procedures to the residents and faculty;**
 - (2) monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;**
 - (3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,**
 - (4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.**
- k) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;**
- l) comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;**
- m) be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;**
- n) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:**

- (1) **all applications for ACGME accreditation of new programs;**
 - (2) **changes in resident complement;**
 - (3) **major changes in program structure or length of training;**
 - (4) **progress reports requested by the Review Committee;**
 - (5) **responses to all proposed adverse actions;**
 - (6) **requests for increases or any change to resident duty hours;**
 - (7) **voluntary withdrawals of ACGME-accredited programs;**
 - (8) **requests for appeal of an adverse action;**
 - (9) **appeal presentations to a Board of Appeal or the ACGME; and,**
 - (10) **proposals to ACGME for approval of innovative educational approaches.**
- 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:**
- (1) **program citations, and/or**
 - (2) **request for changes in the program that would have significant impact, including financial, on the program or institution.**
- p) should demonstrate active participation in research and scholarly activities in PRM;**
- q) be responsible for the supervision of residents through explicit written descriptions of supervisory lines of responsibility for care of patients. Such guidelines must be communicated to all members of the program staff. Residents must be provided with prompt, reliable systems for communications and interaction with supervisory**

- physicians;
- r) ensure documentation of staff and resident attendance at conferences;
 - s) monitor, in accord with written policies, on-duty assignments as well as activities outside the program;
5. The level of supervision of the residents should be determined by the program director based on formal and informal evaluations.
 6. The program director should assign a member of the faculty as supervisor to each resident. Written objectives for each clinical rotation must be provided to each resident.

B. Faculty

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

The faculty must:

- a) **devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents, and**
 - b) **administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.**
- 2. The physician faculty must have current certification in the specialty by the American Board of Physical Medicine and Rehabilitation, or possess qualifications acceptable to the Review Committee.**
 - a) In addition to the program director there must be at least one other faculty member with expertise in PRM who is dedicated to the program.
 - b) Educational activities must be carried out under the direct supervision of faculty members.
 - 3. The physician faculty must possess current medical licensure and appropriate medical staff appointment.**

4. **The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.**
5. **The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.**
 - a) **The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.**
 - b) **Some members of the faculty should also demonstrate scholarship by one or more of the following:**
 - (1) **peer-reviewed funding;**
 - (2) **publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;**
 - (3) **publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,**
 - (4) **participation in national committees or educational organizations.**
 - c) **Faculty should encourage and support residents in scholarly activities.**

C. Other Program Personnel

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

D. Resources

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

1. Education in PRM should include experience in both inpatient and outpatient facilities. The sponsoring institution and participating sites must operate or have access to a service delivery system dedicated to the care of persons with pediatric rehabilitative

disorders. Necessary resources include

- a) Inpatient pediatric rehabilitation beds;
 - b) A designated outpatient clinic or examination area for persons with pediatric rehabilitative disorders; and,
 - c) Transitional services for home care, community entry, schooling, etc.
2. The sponsoring institution must have the equipment, electrodiagnostic devices, radiology services, laboratory services, and clinical facilities necessary to provide appropriate care to persons with pediatric rehabilitative disorders. Facilities for teaching services must be available as well as a medical records system that allows for efficient case retrieval.
 3. The sponsoring institution must have specialty consulting services essential to the care of persons with pediatric rehabilitative disorders. These services include anesthesia, emergency medicine, family medicine, genetics, neurological surgery, neurology, orthopedic surgery, pathology, pediatrics (including the relevant subspecialties), plastic surgery, psychiatry, radiology, surgery, urology, and other relevant health care professionals.
 4. Availability of home care and specialized schooling.
 5. The patient population must be of sufficient size and diversity of pediatric age groups to allow residents to care for an adequate number of persons, in both inpatient and outpatient settings, in all pediatric rehabilitative diagnostic categories.

E. Medical Information Access

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

III. Resident Appointments

A. Eligibility Criteria

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

1. The applicant must be licensed for unrestricted practice in a state or province of the United States or Canada.

B. Number of Residents

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

1. The program shall establish written policies and procedures regarding selection and appointment of residents. There should be at least one resident in the program at all times.
2. The program shall have and implement written policies and procedures, based on the clinical and educational resources available, for determining the number of resident positions.
3. The program shall have and implement written policies and procedures, based on the clinical and educational resources available, regarding changes in resident complement or filling vacant positions.

C. Resident Transfers

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

D. Appointment of Fellows and Other Learners

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

1. The resident must have the opportunity to meet and share experience with residents in the core program and in other specialties. It is desirable for the resident to interact with peers in primary care and relevant subspecialties. Residents should have the opportunity to teach other residents, medical students, and other health care professionals.
2. Rotation to the PRM program by medical students, and residents from other specialties or subspecialties is desirable.

IV. Educational Program

A. The curriculum must contain the following educational components:

1. **Overall educational goals for the program, which the program must distribute to residents and faculty annually;**
2. **Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation;**
3. **Regularly scheduled didactic sessions;**
4. **Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and,**
5. **ACGME Competencies**

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

a) Patient Care

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents:

- (1) must have a sufficient variety, depth, and volume of clinical experiences. The educational program should take into consideration the resident's documented past educational and patient care experiences. The

training program must provide for the resident to spend a significant amount of time with responsibility for the direct care of hospitalized as well as non-hospitalized patients. Residents must devote at least 1/3 of their clinical experience to the care of hospitalized patients and at least 1/3 to non-hospitalized patients;

- (2) must attain knowledge and competency in the following areas of PRM:
 - (a) normal growth and development, including, physical growth, developmental skills attainment (language and communication skills, physical skills, cognitive skills, emotional skills and maturity, academic achievement/learning skills), transitional issues, metabolic status, biomechanics, the effects of musculoskeletal development on function, sexuality, avocational interest development, wellness and health promotion, and aging issues for adults with congenital or childhood onset disabilities;
 - (b) applications, efficacy, and selection of PRM assessment tools, including enabling/disabling process, general health measures, developmental attainment measures, general functional measures, and specific outcomes measures;
 - (c) identification and management of common pediatric rehabilitation medical conditions and complications, including nutrition, bowel management, bladder management, gastroesophageal reflux, skin protection, pulmonary hygiene and protection, sensory impairments, sleep disorders, spasticity, DVT prophylaxis, congenital and acquired lymphedema, feeding disorders, swallowing dysfunction, seizure management, and behavioral problems;
 - (d) principles and techniques for general pediatric rehabilitative therapeutic management, including early intervention, age appropriate

functional training, programs of therapy, play (avocation), therapeutic exercise, electrical stimulation and other modalities, communication strategies, oral motor interventions, discharge planning, educational and vocational planning, transitional planning, adjustment to disability support, and prevention strategies;

- (e) evaluation and prescription for assistive devices technology, including orthotics, prosthetics, wheelchairs and positioning, ADL aids, interfaces and environmental controls, augmentative/ alternative communication, environmental accessibility, electrical stimulation, and dynamic splinting;
- (f) principles and techniques of PRM procedures, including spasticity management and electrodiagnosis;
- (g) interpretation of diagnostic studies commonly ordered in PRM;
- (h) rehabilitation management of:
 - (i) musculoskeletal disorders and trauma, including sports injuries;
 - (ii) cerebral palsy;
 - (iii) spinal dysraphism, and other congenital anomalies;
 - (iv) pediatric spinal cord injury;
 - (v) pediatric traumatic brain injury;
 - (vi) limb deficiency/ amputation;
 - (vii) neuromuscular disorders;
 - (viii) rheumatologic and connective tissue disorders, including but not limited to specific conditions, such as juvenile rheumatoid arthritis,

spondyloarthropathies, dermatomyositis, and Lyme disease;

- (ix) burns in the pediatric patient; and,
 - (x) peripheral nerve injuries.
- (i) administration, including principles of organizational behaviors and leadership, quality assurance, cost efficiency, knowledge of health care systems, community resources, and support services regulations pertaining to service provision (external reviews, inpatient services, outpatient services, home care, school based programs and capabilities), skills for effective advocacy, medical legal aspects, (child protective services, guardianship, liability), professionalism, and ethics;
 - (j) psychological, social and behavioral aspects of rehabilitation management, including family-centered care; and,
 - (k) requesting appropriate medical/surgical consultations from other specialties.
- (3) should follow individual patients longitudinally as well as the ability to encounter a wide variety of patient problems.
 - (4) should have progressive responsibility with lesser degrees of supervision as they advance and demonstrate additional competencies. The program should be flexible but sufficiently structured to allow for such graded responsibility.

b) Medical Knowledge

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

- (1) should have basic science didactic curriculum taught by faculty and a self-directed learning program to address the theoretical and clinical principles that

form the fundamentals for managing patients with pediatric medicine disorders. Pathophysiology, discussion and knowledge of clinical manifestations, and management problems should constitute the major topics for study;

- (2) should have specialty content including faculty in anesthesiology, emergency medicine, family medicine, genetics, neurology, neurosurgery, orthopedic surgery, pediatrics (including the relevant subspecialties), plastic surgery, psychiatry, radiology, surgery, and urology taking an active role in providing instruction in the areas of their practices relevant to PRM;
- (3) must have conferences that include case-oriented multidisciplinary conferences, journal clubs, and quality management seminars relevant to clinical care in PRM; and,
- (4) must have Conferences of sufficient quality and frequency to provide in-depth coverage of the major topics in PRM.

c) Practice-based Learning and Improvement

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

- (1) identify strengths, deficiencies, and limits in one's knowledge and expertise;**
- (2) set learning and improvement goals;**
- (3) identify and perform appropriate learning activities;**
- (4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;**

- (5) **incorporate formative evaluation feedback into daily practice;**
- (6) **locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;**
- (7) **use information technology to optimize learning; and,**
- (8) **participate in the education of patients, families, students, residents and other health professionals.**

The resident should have the opportunity to:

- (a) Teach other hospital personnel and health care providers, patients, and patient support systems about the rehabilitation and longitudinal needs in PRM.
 - (b) Teach medical students, residents, and other health care professionals.
- (9) Understand and utilize learning theory, including assessment of learning needs, development of objectives and curriculum plans, effective use of audiovisual aids and other teaching materials, and evaluation of teaching outcomes.
 - (10) Participate in educational activities within the interdisciplinary PRM care team.

d) Interpersonal and Communication Skills

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

- (1) **communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;**

- (2) **communicate effectively with physicians, other health professionals, and health related agencies;**
- (3) **work effectively as a member or leader of a health care team or other professional group;**
- (4) **act in a consultative role to other physicians and health professionals; and,**
- (5) **maintain comprehensive, timely, and legible medical records, if applicable.**
- (6) learn, understand, and apply principles of organizational and group behavior, leadership and management styles, evaluation and modification of performance, labor management issues, cost accounting containment, and quality assurance techniques. The resident should gain an understanding and some proficiency in the areas of budget planning and presentation, preparation of management briefings, information systems, and external reviews such as the Commission for the Accreditation of Rehabilitation Facilities.

e) Professionalism

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

- (1) **compassion, integrity, and respect for others;**
- (2) **responsiveness to patient needs that supersedes self-interest;**
- (3) **respect for patient privacy and autonomy;**
- (4) **accountability to patients, society and the profession; and,**
- (5) **sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.**

f) Systems-based Practice

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

- (1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;**
- (2) coordinate patient care within the health care system relevant to their clinical specialty;**
- (3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;**
- (4) advocate for quality patient care and optimal patient care systems;**
- (5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,**
- (6) participate in identifying system errors and implementing potential systems solutions.**
- (7) develop a management style compatible with an interdisciplinary team process.**

B. Residents' Scholarly Activities

- 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.**
- 2. Residents should participate in scholarly activity.**
- 3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.**

V. Evaluation

A. Resident Evaluation

1. Formative Evaluation

- 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.**
- b) **The program must:**
 - (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;**
 - (2) **use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);**
 - (3) **document progressive resident performance improvement appropriate to educational level; and,**
 - (4) **provide each resident with documented semiannual evaluation of performance with feedback.**
- c) **The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.**
- d) Remedial objectives may be established.
- e) Evaluation should be based on the program objectives and on the objectives of the resident's individualized program. These include resident knowledge, skills, and overall performance, including the development of professional attitudes consistent with being a physician.
- f) Residents should be advanced to positions of higher responsibility only on the basis of evidence of their satisfactory progressive scholarship and professional growth.

- g) The following areas should be evaluated:
 - (1) Acquisition of competencies outlined in IV.A.5.V.
 - (2) Problem solving skills
 - (3) Interpersonal relationship skills
 - (4) Ability to access, retrieve, and critically evaluate the literature.
 - (5) Information management.
 - (6) Quality and cost-effectiveness measures of patient care.
 - (7) Research and other scholarly accomplishments.

2. Summative Evaluation

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

- a) **document the resident's performance during the final period of education, and**
- b) **verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.**

B. Faculty Evaluation

- 1. **At least annually, the program must evaluate faculty performance as it relates to the educational program.**
- 2. **These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.**
- 3. **This evaluation must include at least annual written confidential evaluations by the residents.**

C. Program Evaluation and Improvement

- 1. The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:**
 - a) resident performance;**
 - b) faculty development;**
 - c) graduate performance, including performance of program graduates on the certification examination; and,**
 - d) program quality. Specifically:**
 - (1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and**
 - (2) The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.**
- 2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.**
- 3. 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. Resident satisfaction at the completion of training should also be assessed. 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.**

VI. Resident Duty Hours in the Learning and Working Environment

A. Principles

- 1. The program must be committed to and be responsible for promoting patient safety and resident well-being and to providing a supportive educational environment.**
- 2. The learning objectives of the program must not be compromised by excessive reliance on residents to fulfill service obligations.**
- 3. Didactic and clinical education must have priority in the allotment of residents' time and energy.**
- 4. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.**

B. Supervision of Residents

The program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities.

- 1. The supervisor is responsible for the educational experience according to the written plan developed at the beginning of the training. The supervisor must meet regularly with the program director and resident for appropriate monitoring and feedback.**

C. Fatigue

Faculty and residents must be educated to recognize the signs of fatigue and sleep deprivation and must adopt and apply policies to prevent and counteract its potential negative effects on patient care and learning.

D. Duty Hours (the terms in this section are defined in the ACGME Glossary and apply to all programs)

Duty hours are defined as all clinical and academic activities related to the 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.

1. **Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.**
2. **Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call.**
3. **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.**

E. On-call Activities

1. **In-house call must occur no more frequently than every third night, averaged over a four-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 six 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.**
4. **At-home call (or pager call)**
 - a) **The frequency of at-home call is not subject to the every-third-night, or 24+6 limitation. However at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident.**
 - b) **Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.**
 - c) **When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.**

F. Moonlighting

1. **Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.**

2. **Internal moonlighting must be considered part of the 80-hour weekly limit on duty hours.**

G. Duty Hours Exceptions

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

1. **In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.**
2. **Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.**

VII. Experimentation and Innovation

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

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