

ACGME Program Requirements for Graduate Medical Education in Thoracic Surgery

Common Program Requirements are in **BOLD**

Effective: January 1, 2008

Introduction

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

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

Int.B. Definition and Scope of the Specialty

Thoracic Surgery encompasses the operative, perioperative, and critical care of patients with pathologic conditions within the chest. This includes the surgical care of coronary artery disease; diseases of the trachea, lungs, esophagus, and chest wall; abnormalities of the great vessels and heart valves; congenital anomalies of the chest and heart; tumors of the mediastinum; diseases of the diaphragm; and management of chest injuries.

Int.C. Duration and Scope of Education

Int.C.1. Education in thoracic surgery must be provided in one of these three formats:

Int.C.1.a) Independent Program (traditional format): Two years of thoracic surgery education, preceded by a successfully completed surgery residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME) or by the Royal College of Physicians and Surgeons of Canada.

Programs wishing to provide a three-year curriculum must document an educational rationale for the program which must be approved in advance by the Review Committee.

Int.C.1.b) Joint Surgery/Thoracic Surgery Program (the 4+3 program): All seven years of the program must be completed in the same institution, and all of the years must be accredited by the ACGME. Assuming successful completion of the programs, this format provides the graduate with the ability to apply for certification in both surgery and thoracic surgery.

Int.C.1.c) Integrated Program: Six years of thoracic surgery education (completed in one institution) following completion of an M.D. or D.O. degree from an institution accredited by the Liaison Committee of Medical Education (LCME). Graduates of medical schools from countries other than the United States or Canada must present evidence of final certification by the Education Commission for Foreign Medical Graduates (ECFMG).

Int.C.1.c).(1) The integrated curriculum must document six years of clinical thoracic surgery education under the authority and direction of the thoracic surgery program director. The sequencing of the thoracic surgery educational components must be integrated throughout the program in order to provide a cohesive, progressive, and longitudinal educational experience.

Int.C.1.c).(2) A minimum of 24 months and a maximum of 36 months of the program must include education in core surgical education, including pre- and post-operative evaluation and care. The remainder of the curriculum must include education in oncology; transplantation; basic and advanced laparoscopic surgery; surgical critical care and trauma management; thoracic surgery; and adult and congenital cardiac surgery.

Int.C.1.c).(3) The last year of the integrated program must comprise chief resident responsibility on the thoracic surgery service at the primary clinical site or at an integrated site.

I. Institutions

I.A. Sponsoring Institution

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

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

educational and administrative responsibilities to the program.

- I.A.1. The sponsoring institution must ensure an administrative and academic structure that provides for educational and financial resources dedicated to the needs of the program; i.e., the appointment of teaching faculty and residents, support for program planning and evaluation, the assurance of sufficient ancillary personnel, and the provision for patient safety and the alleviation of resident fatigue. The sponsoring institution must:
 - I.A.1.a) demonstrate commitment to education in thoracic surgery in their support of the residency program;
 - I.A.1.b) provide at least 25% salary support for the program director; and,
 - I.A.1.c) provide and document faculty development for the program director and the faculty in education and teaching.

I.B. Participating Sites

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

The PLA should:

- I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for residents;**
- I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;**
- I.B.1.c) specify the duration and content of the educational experience; and,**
- I.B.1.d) state the policies and procedures that will govern resident education during the assignment.**
- I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).**
 - I.B.2.a) Multiple abbreviated assignments among several sites or simultaneous assignments to more than one institution are not acceptable. Exceptions for physically-connected or geographically close sites require advance approval of the Review Committee.
 - I.B.2.b) Assignments of four months or more to any participating site must be approved in advance by the Review Committee.

I.B.2.c) Major changes in participating or integrated sites must be supported by submission of the institutional operative data.

I.B.3. Integrated Sites

A formal, written integration agreement is required that specifies, in addition to the points above, that the program director:

I.B.3.a) appoints the members of the teaching faculty at the integrated site;

I.B.3.b) appoints the chief or director of the teaching service in the integrated site;

I.B.3.c) appoints all residents in the program; and

I.B.3.d) determines all rotations and assignments of both residents and members of the teaching faculty.

II. Program Personnel and Resources

II.A. Program Director

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

II.A.1.a) The review committee will approve the qualifications of each program director prior to the appointment. A change in program director may result in a site visit and program review within 18 months of the approved change.

II.A.2. The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.

II.A.3. Qualifications of the program director must include:

II.A.3.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;

II.A.3.b) current certification in the specialty by the American Board of Thoracic Surgery, or specialty qualifications that are acceptable to the Review Committee; and,

II.A.3.c) current medical licensure and appropriate medical staff appointment.

- II.A.3.d) documented experience educating thoracic surgery residents and membership (in good standing) in the Thoracic Surgery Directors' Association, and
- II.A.3.e) documentation of formal faculty development activities in education and teaching, such as participation at local and national program director workshops and other educational activities.
- II.A.4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:**
 - II.A.4.a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;**
 - II.A.4.b) approve a local director at each participating site who is accountable for resident education;**
 - II.A.4.c) approve the selection of program faculty as appropriate;**
 - II.A.4.d) evaluate program faculty and approve the continued participation of program faculty based on evaluation;**
 - II.A.4.e) monitor resident supervision at all participating sites;**
 - II.A.4.f) prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;**
 - II.A.4.g) provide each resident with documented semiannual evaluation of performance with feedback;**
 - II.A.4.h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;**
 - II.A.4.i) provide verification of residency education for all residents, including those who leave the program prior to completion;**
 - II.A.4.j) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:**
 - II.A.4.j).(1) distribute these policies and procedures to the residents and faculty;**
 - II.A.4.j).(2) monitor resident duty hours, according to sponsoring**

- institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;**
- II.A.4.j).(3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,**
- II.A.4.j).(4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.**
- II.A.4.k) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;**
- II.A.4.l) comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;**
- II.A.4.m) be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;**
- II.A.4.n) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:**
- II.A.4.n).(1) all applications for ACGME accreditation of new programs;**
- II.A.4.n).(2) changes in resident complement;**
- II.A.4.n).(3) major changes in program structure or length of training;**
- II.A.4.n).(4) progress reports requested by the Review Committee;**
- II.A.4.n).(5) responses to all proposed adverse actions;**
- II.A.4.n).(6) requests for increases or any change to resident duty hours;**
- II.A.4.n).(7) voluntary withdrawals of ACGME-accredited programs;**
- II.A.4.n).(8) requests for appeal of an adverse action;**
- II.A.4.n).(9) appeal presentations to a Board of Appeal or the ACGME; and,**
- II.A.4.n).(10) proposals to ACGME for approval of innovative**

educational approaches.

- II.A.4.o) obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:**
 - II.A.4.o).(1) program citations, and/or**
 - II.A.4.o).(2) request for changes in the program that would have significant impact, including financial, on the program or institution.**
- II.A.4.p) provide evidence that faculty are actively engaged in the education and scholarly productivity of Thoracic Surgery residents, as well as participation in medical student education;
- II.A.4.q) provide separate and regularly-scheduled teaching conferences, mortality and morbidity conferences, rounds, and other educational activities in which both the thoracic surgery faculty and the residents attend and participate;
- II.A.4.r) provide an organized written plan and a block diagram for the clinical assignments to the various services and sites in the program;
- II.A.4.s) ensure that at the time of application to the program, each resident is notified in writing of the length of the program. Documentation must be maintained in each resident's file, including any required unaccredited years;
- II.A.4.t) submit a log, grouped by procedure, that details the operative experience of each trainee/fellow with the thoracic surgery resident logs at the time of the site visit;
- II.A.4.u) keep records of conference attendance which must be available for review by the site visitor; and,
- II.A.4.v) create opportunities for peer interaction with residents in related specialties at all participating sites.

II.B. Faculty

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

The faculty must:

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

and

- II.B.1.b) **administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.**
- II.B.1.c) include one designated cardiothoracic faculty member who should be responsible for coordinating multidisciplinary clinical conferences and for organizing instruction and research in general thoracic surgery.
- II.B.1.d) include qualified thoracic surgeons and other faculty in related disciplines who should direct conferences.
- II.B.2. **The physician faculty must have current certification in the specialty by the American Board of Thoracic Surgery, or possess qualifications acceptable to the Review Committee.**
- II.B.3. **The physician faculty must possess current medical licensure and appropriate medical staff appointment.**
- II.B.4. **The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.**
- II.B.5. **The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.**
 - II.B.5.a) **The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.**
 - II.B.5.b) **Some members of the faculty should also demonstrate scholarship by one or more of the following:**
 - II.B.5.b).(1) **peer-reviewed funding;**
 - II.B.5.b).(2) **publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;**
 - II.B.5.b).(3) **publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,**
 - II.B.5.b).(4) **participation in national committees or educational organizations.**
 - II.B.5.c) **Faculty should encourage and support residents in scholarly activities.**
- II.C. **Other Program Personnel**

The institution and the program must jointly ensure the availability of all

necessary professional, technical, and clerical personnel for the effective administration of the program.

- II.C.1. The sponsoring institution must provide support for a coordinator who is designated to the thoracic surgery program.

II.D. Resources

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

- II.D.1. provide access to information services that include:
- II.D.1.a) the electronic retrieval of patient information;
 - II.D.1.b) a comprehensive data base for thoracic, adult cardiac, and congenital cardiac disease; and
 - II.D.1.c) an on-site library or electronic access to appropriate texts and journals;
- II.D.2. provide access to a learning resources laboratory for resident education and remediation;

II.E. Medical Information Access

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

III. Resident Appointments

III.A. Eligibility Criteria

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

III.B. Number of Residents

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

- III.B.1. A minimum of one thoracic surgery resident should be appointed in each year to provide for sufficient peer interaction.

III.C. Resident Transfers

- III.C.1. Before accepting a resident who is transferring from another**

program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident.

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

III.C.2.a) Documentation of the residents' operative experience must be included.

III.D. Appointment of Fellows and Other Learners

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

III.D.1. All trainees in both ACGME-accredited and non-accredited programs at the sponsoring and integrated sites which might affect the educational experience of the thoracic surgery residents, must be identified and their relationship to the thoracic surgery residents must be detailed.

III.D.1.a) Fellows in non-accredited positions must either be contracted with an ACGME-accredited thoracic surgery program or its equivalent, have completed their ACGME-accredited thoracic surgery educational program, or have requested and received an exception in advance from the Review Committee.

III.D.1.b) The program director must provide an impact statement addressing the goals and objectives, clinical responsibilities, duration of the educational program, and the interactions of these trainees/fellows as related to the thoracic surgery residents.

III.D.2. A chief thoracic surgery resident and a fellow (whether the fellow is in an ACGME-accredited position or not) must not have primary responsibility for the same patients.

IV. Educational Program

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

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

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form.

These should be reviewed by the resident at the start of each rotation;

IV.A.3. Regularly scheduled didactic sessions;

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

IV.A.5. ACGME Competencies

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

IV.A.5.a) Patient Care

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

IV.A.5.a).(1) will develop and execute patient care plans, demonstrate technical ability, use information technology, and evaluate diagnostic studies;

IV.A.5.a).(2) will under supervision of the thoracic surgery faculty:

IV.A.5.a).(2).(a) provide preoperative management, including the selection and timing of operative intervention and the selection of appropriate operative procedures;

IV.A.5.a).(2).(b) provide post-operative management of thoracic and cardiovascular patients;

IV.A.5.a).(2).(c) provide critical care of patients with thoracic and cardiovascular surgical disorders, including trauma patients, whether or not operative intervention is required;

IV.A.5.a).(2).(d) correlate the pathologic and diagnostic aspects of cardiothoracic disorders, demonstrating skill in diagnostic procedures (e.g., bronchoscopy and esophagoscopy), and to interpret appropriate imaging studies (e.g., ultrasound, computed tomography, roentgenographic, radionuclide, cardiac catheterization, pulmonary function, and esophageal function studies); and,

IV.A.5.a).(2).(e) demonstrate knowledge in the use of cardiac and respiratory support devices.

IV.A.5.a).(3) will have a minimum operative experience that must

include:

- IV.A.5.a).(3).(a) annually, a minimum of 125 major cases consistent with those listed in the program information forms;
- IV.A.5.a).(3).(b) an adequate volume of operative experience, distribution of categories, and complexity of procedures to ensure each resident a balanced and equivalent clinical education;
- IV.A.5.a).(3).(c) categories of procedures which must include but are not limited to the lungs, pleura, and chest wall; esophagus, mediastinum, and diaphragm; thoracic aorta and great vessels; congenital heart anomalies; valvular heart diseases; and myocardial revascularization;
- IV.A.5.a).(3).(d) these additional educational experiences: cardiac pacemaker implantation, mediastinoscopy, pleuroscopy, and flexible and rigid esophagoscopy and bronchoscopy; endoscopic ultrasound, endoscopic approaches to thoracic and esophageal diseases; and multidisciplinary approaches to the treatment of thoracic malignancy; and,
- IV.A.5.a).(3).(e) required experience in endovascular stents (for residents admitted on or after July 1, 2007).
- IV.A.5.a).(4) will have documented operative experience showing they:
 - IV.A.5.a).(4).(a) participated in the diagnosis, preoperative planning, and selection of the operation for the patient;
 - IV.A.5.a).(4).(b) performed those technical manipulations that constituted the essential parts of the patient's operation;
 - IV.A.5.a).(4).(c) were substantially involved in post-operative care; and,
 - IV.A.5.a).(4).(d) were supervised by responsible faculty/teaching staff.
- IV.A.5.a).(5) will have assignments to nonsurgical areas (i.e., cardiac catheterization and esophageal or pulmonary function labs) for a period of time not exceeding a total of three months during the clinical program, and this experience may not occur in the chief year.
- IV.A.5.a).(6) will spend their chief year in the sponsoring institute or integrated sites for the program. (Exceptions require

approval in advance by the Review Committee.) During this year, the resident must assume senior responsibility for the pre-, intra-, and post-operative care of patients with thoracic and cardiovascular disease.

IV.A.5.a).(7)

will have outpatient responsibilities which include the following:

IV.A.5.a).(7).(a)

The resident should have an opportunity to examine the patient pre-operatively, to consult with the attending surgeon regarding operative care, and to participate in the surgery and postoperative care;

IV.A.5.a).(7).(b)

Outpatient care activities include resident responsibility for seeing the patient personally in an outpatient setting and, as a minimum in some cases only, consulting with the attending surgeon regarding the follow-up care rendered to the patient in the doctor's office;

IV.A.5.a).(7).(c)

The policies and procedures governing pre-hospital and post-hospital involvement of the residents must be documented. Documentation of this process must be available to the site-visitor at the time of program review; and,

IV.A.5.a).(8)

perform clinical assignments that should be carefully structured to ensure that graded levels of responsibility, continuity in patient care, a balance between education and service, and progressive clinical experiences are achieved for each resident.

IV.A.5.b)

Medical Knowledge

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

IV.A.5.b).(1)

will know current medical information, and critically evaluate scientific information;

IV.A.5.c)

Practice-based Learning and Improvement

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

- IV.A.5.c).(1) **identify strengths, deficiencies, and limits in one's knowledge and expertise;**
- IV.A.5.c).(2) **set learning and improvement goals;**
- IV.A.5.c).(3) **identify and perform appropriate learning activities;**
- IV.A.5.c).(4) **systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;**
- IV.A.5.c).(5) **incorporate formative evaluation feedback into daily practice;**
- IV.A.5.c).(6) **locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;**
- IV.A.5.c).(7) **use information technology to optimize learning; and,**
- IV.A.5.c).(8) **participate in the education of patients, families, students, residents and other health professionals.**
- IV.A.5.c).(9) demonstrate the ability to practice lifelong learning, analyze personal practice outcomes, and use information technology to optimize patient care.

IV.A.5.d) Interpersonal and Communication Skills

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

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

IV.A.5.e)

Professionalism

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

IV.A.5.e).(1)

compassion, integrity, and respect for others;

IV.A.5.e).(2)

responsiveness to patient needs that supersedes self-interest;

IV.A.5.e).(3)

respect for patient privacy and autonomy;

IV.A.5.e).(4)

accountability to patients, society and the profession; and,

IV.A.5.e).(5)

sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

IV.A.5.e).(6)

high standards of ethical behavior; demonstrate continuity of care (pre-operative, operative, and post-operative); demonstrate sensitivity to age, gender, culture, and other differences; and demonstrate honesty, dependability, and commitment.

IV.A.5.f)

Systems-based Practice

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

IV.A.5.f).(1)

work effectively in various health care delivery settings and systems relevant to their clinical specialty;

IV.A.5.f).(2)

coordinate patient care within the health care system relevant to their clinical specialty;

IV.A.5.f).(3)

incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;

IV.A.5.f).(4)

advocate for quality patient care and optimal patient care systems;

IV.A.5.f).(5)

work in interprofessional teams to enhance patient safety and improve patient care quality; and,

- IV.A.5.f).(6)** **participate in identifying system errors and implementing potential systems solutions.**
- IV.A.5.f).(7) practice cost-effective care without compromising quality, promote disease prevention, demonstrate risk-benefit analysis, and know how different practice systems operate to deliver care.
- IV.B. Residents' Scholarly Activities**
- IV.B.1. The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.**
- IV.B.2. Residents should participate in scholarly activity.**
- IV.B.2.a) A protected research assignment is not permitted during the program. Resident participation in scholarly activities, however, should be encouraged.
- IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.**
- IV.B.3.a) The sponsoring institution and program should provide support for residents' attendance at national professional meetings.
- V. Evaluation**
- V.A. Resident Evaluation**
- V.A.1. Formative Evaluation**
- V.A.1.a) The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.**
- V.A.1.b) The program must:**
- V.A.1.b).(1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;**
- V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);**
- V.A.1.b).(3) document progressive resident performance**

- improvement appropriate to educational level; and,
- V.A.1.b).(4) provide each resident with documented semiannual evaluation of performance with feedback.
- V.A.1.c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.
- V.A.2. **Summative Evaluation**
- The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. This evaluation must:
- V.A.2.a) document the resident's performance during the final period of education, and
- V.A.2.b) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.
- V.B. **Faculty Evaluation**
- V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program.
- V.B.2. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.
- V.B.3. This evaluation must include at least annual written confidential evaluations by the residents.
- V.B.4. Because of the small resident cohort in each program, assurance that the content of resident evaluations of the faculty does not adversely affect resident progression is required.
- V.C. **Program Evaluation and Improvement**
- V.C.1. The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:
- V.C.1.a) **resident performance**; (e.g., educational activities that document improved resident cognitive performance, technical skills, and professional behaviors);
- V.C.1.b) **faculty development**;

- V.C.1.c) **graduate performance, including performance of program graduates on the certification examination; and,**
- V.C.1.d) **program quality. Specifically:**
 - V.C.1.d).(1) **Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and**
 - V.C.1.d).(2) **The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.**
 - V.C.1.d).(3) **Program improvement (e.g., quality of the didactic and clinical curriculum, and the use of educational tools such as skills labs and other activities);**
 - V.C.1.d).(4) **Faculty improvement (e.g., development activities to improve the faculty's teaching and evaluation skills, continuing education activities related to education, the development of new skills in their specialty to improve patient care, and scholarly activities); and,**
 - V.C.1.d).(5) **The program must document its active participation in clinical databases that are used to assess and improve patient outcomes.**
- V.C.2. **If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.**

VI. Resident Duty Hours in the Learning and Working Environment

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

- VI.A.1. **Programs and sponsoring institutions must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.**
- VI.A.2. **The program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment.**
- VI.A.3. **The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.**
- VI.A.4. **The learning objectives of the program must:**

- VI.A.4.a) **be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,**
- VI.A.4.b) **not be compromised by excessive reliance on residents to fulfill non-physician service obligations.**
- VI.A.5. **The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following:**
 - VI.A.5.a) **assurance of the safety and welfare of patients entrusted to their care;**
 - VI.A.5.b) **provision of patient- and family-centered care;**
 - VI.A.5.c) **assurance of their fitness for duty;**
 - VI.A.5.d) **management of their time before, during, and after clinical assignments;**
 - VI.A.5.e) **recognition of impairment, including illness and fatigue, in themselves and in their peers;**
 - VI.A.5.f) **attention to lifelong learning;**
 - VI.A.5.g) **the monitoring of their patient care performance improvement indicators; and,**
 - VI.A.5.h) **honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.**
- VI.A.6. **All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.**
- VI.B. **Transitions of Care**
 - VI.B.1. **Programs must design clinical assignments to minimize the number of transitions in patient care.**
 - VI.B.2. **Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.**
 - VI.B.3. **Programs must ensure that residents are competent in**

communicating with team members in the hand-over process.

VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.

VI.C. Alertness Management/Fatigue Mitigation

VI.C.1. The program must:

VI.C.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;

VI.C.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; and,

VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.

VI.C.2. Each program must have a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties.

VI.C.3. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home.

VI.D. Supervision of Residents

VI.D.1. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.

VI.D.1.a) This information should be available to residents, faculty members, and patients.

VI.D.1.b) Residents and faculty members should inform patients of their respective roles in each patient's care.

VI.D.2. The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.

Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately

supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care.

VI.D.3. Levels of Supervision

To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:

- VI.D.3.a) Direct Supervision – the supervising physician is physically present with the resident and patient.**
 - VI.D.3.b) Indirect Supervision:**
 - VI.D.3.b).(1) with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.**
 - VI.D.3.b).(2) with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.**
 - VI.D.3.c) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.**
- VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.**
- VI.D.4.a) The program director must evaluate each resident’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.**
 - VI.D.4.b) Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.**
 - VI.D.4.c) Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.**

VI.D.5. Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.

VI.D.5.a) Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

VI.D.5.a).(1) In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.

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

VI.E. Clinical Responsibilities

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

VI.F. Teamwork

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

VI.G. Resident Duty Hours

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

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

VI.G.1.a) Duty Hour Exceptions

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

VI.G.1.a).(1) In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.

VI.G.1.a).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval

of the institution's GMEC and DIO.

VI.G.2. Moonlighting

VI.G.2.a) Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

VI.G.2.b) Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.

VI.G.2.c) PGY-1 residents are not permitted to moonlight.

VI.G.3. Mandatory Time Free of Duty

Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

VI.G.4. Maximum Duty Period Length

VI.G.4.a) Duty periods of PGY-1 residents must not exceed 16 hours in duration.

VI.G.4.b) Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.

VI.G.4.b).(1) It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.

VI.G.4.b).(2) Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

VI.G.4.b).(3) In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

VI.G.4.b).(3).(a) Under those circumstances, the resident must:

VI.G.4.b).(3).(a).(i) appropriately hand over the care of all other patients to the team responsible for their continuing care; and,

VI.G.4.b).(3).(a).(ii) document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

VI.G.4.b).(3).(b) The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

VI.G.5. Minimum Time Off between Scheduled Duty Periods

VI.G.5.a) PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.

VI.G.5.b) Intermediate-level residents should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

For independent programs, Y-1, -2, and -3 residents are considered to be in the final years of education.

For integrated programs, Y-2 and -3 fellows are considered to be at the intermediate level.

VI.G.5.c) Residents in the final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

For independent programs, Y-1, -2, and -3 residents are considered to be in the final years of education.

For integrated programs, Y-4, -5, and -6 level residents are considered to be in the final years of education.

VI.G.5.c).(1) This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

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

ACGME Approved: June 12, 2007 Effective: January 1, 2008
Editorial Revision: July 1, 2009
Revised Common Program Requirements Effective: July 1, 2011