

ACGME Program Requirements for Graduate Medical Education in Urology

Common Program Requirements are in BOLD

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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 of the Specialty

Urology is the specialty that evaluates and treats patients with disorders of the genitourinary tract, including the adrenal gland. Specialists in this discipline must demonstrate knowledge of the basic and clinical sciences related to the normal and diseased genitourinary system as well as attendant skills in medical and surgical therapy. Residency programs must educate physicians in the prevention and treatment of genitourinary disease, including the diagnosis, medical and surgical management, and reconstruction of the genitourinary tract.

Int.C. Duration and Scope of Education

Int.C.1. The prerequisite for admission to a urology residency program is a minimum of one year of an Accreditation Council for Graduate Medical Education (ACGME)-accredited surgery program. Based on educational objectives, two years of general surgery is an alternative format. During these one or two years, residents must spend a minimum of three months in general surgery as well as a minimum of three months in the core surgical rotations of critical care, vascular surgery, or trauma. Additional

clinical assignments, not including dedicated research time, must enhance the resident education and prepare residents for the practice of urology. The educational program for the general surgery period is developed by the program director of the respective surgery residency program with the input and approval of the respective urology program director.

Int.C.2. A minimum of 48 months of clinical urology education is required. Within the final 24 months of urology education, residents must serve at least 12 months as a chief resident. The clinical and academic experience as a chief resident should prepare the resident for an independent practice of urology. As such, this Chief Resident experience should include management of patients with complex urologic disease, advanced procedures, and, with appropriate supervision, a high level of responsibility and independence.

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.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.

I.B.1.a) The PLA should:

I.B.1.b) identify the faculty who will assume both educational and supervisory responsibilities for residents;

I.B.1.c) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;

I.B.1.d) specify the duration and content of the educational experience; and,

I.B.1.e) state the policies and procedures that will govern resident education during the assignment.

I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience,

required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).

- I.B.3. Assignments at participating sites must be of sufficient length to ensure a quality educational experience, and should provide sufficient opportunity for continuity of care. Although the number of participating sites may vary, all participating sites must demonstrate the ability to promote the program goals.
- I.B.3.a) The inclusion of more than four participating sites is an exception, and is not acceptable unless based on sound educational rationale and approved in advance by the Review Committee. Two or more residents should rotate to each participating site to maintain peer-interaction, unless special resources are offered.
- I.B.3.b) Assignments to distant sites must be justified on the basis of educational resources that are not available at the sponsoring institution.

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 GMCC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.**
- 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.2.a) The program director should continue in his or her position for a minimum of six years. An absence of three months or more must be reported to the Review Committee.
- 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 Urology, 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 clinical and scholarly expertise in Urology that should be apparent from the program director's curriculum vitae.
- 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:

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.2.** **The physician faculty must have current certification in the specialty by the American Board of Urology, or possess qualifications acceptable to the Review Committee.**
- II.B.2.a) To provide a diverse educational experience, several faculty members should have subspecialty education and concentrate their practice in one or more of the following urological domains: voiding dysfunction, female urology, reconstruction, oncology, calculus disease, pediatrics, sexual dysfunction and infertility. In addition, the faculty should have experience with the following urologic techniques: endo-urology, minimally-invasive intra-abdominal and pelvic surgical techniques (e.g., laparoscopy/robotics), major flank and pelvic surgery, urologic imaging, and microsurgery. Ideally, residents should have clinical interaction with faculty having expertise in geriatrics, infectious disease, renovascular disease, renal transplantation, trauma, interventional radiology, plastic surgery, and medical oncology.
- II.B.2.b) In addition to the program director, there must be at least two clinical urology faculty devoting sufficient time to supervise and teach the residents, and who are committed fully to the educational objectives of the residency program. A faculty-to-resident ratio of at least 1:2 in the total program is required. The program director may be counted as one of the faculty in determining the ratio. The program director must notify the Review Committee if the number of clinical urology faculty members drops below three, or if the ratio falls below 1:2 and remains below that level longer than one year.
- II.B.2.c) The program director is responsible for the appointment of a local site director who must:
 - II.B.2.c).(1) be a urologist in good standing at the participating site and have the majority of his or her practice at that site;
 - II.B.2.c).(2) be responsible for the education of the residents at the participating site;

- II.B.2.c).(3) be responsible for the supervision of all educational and clinical activities of the program at that site.
- 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.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. There must be adequate space and equipment for the educational program, including meeting rooms and classrooms with audiovisual and other educational aids; office space for staff; diagnostic, therapeutic, and research facilities; and outpatient facilities, clinic, and office space accessible to residents for preoperative evaluation and postoperative follow-up.**

II.D.2. Clinical facilities must contain state-of-the-art equipment to perform diagnostic and therapeutic procedures. Equipment to perform the following procedures must be available: flexible cystoscopy, ureteroscopy, percutaneous endoscopy, percutaneous renal access, extracorporeal shock wave lithotripsy, ultrasonography and biopsy, fluoroscopy, laparoscopy, laser therapy. Urodynamic evaluation equipment should be present. Video imaging should be available to allow adequate supervision and education during endoscopic procedures.

II.D.3. A sufficient number and variety of inpatient and ambulatory adult and pediatric patients with urologic disease must be available for resident education.

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. Any change in the number of residents, whether permanent or temporary, must receive prior approval of the Review Committee. Requests for changes in the resident complement of a program must be based on a strong educational rationale. A vacancy in a resident complement, if filled, must be at the same level in which the vacancy occurs, unless otherwise approved by the Review Committee.

III.C. Resident Transfers

III.C.1. **Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident.**

III.C.2. **A program director must provide timely verification of residency education and summative performance evaluations for residents**

who leave the program prior to completion.

III.D. Appointment of Fellows and Other Learners

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

- III.D.1. A log that details the operative experience of all fellows as well as an impact statement must be submitted with the urology resident operative logs at the time of the site visit. If a program's resident rotates to a participating site that offers a urologic fellowship program, an impact statement and operative log of the fellow(s) from the participating site must be available at the time of the program review.

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; and,

IV.A.5. ACGME Competencies

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

IV.A.5.a) Patient Care

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

- IV.A.5.a).(1) must be provided with experience in direct patient care with increasing levels of responsibility in patient management as they advance through the program;

- IV.A.5.a).(2) should have responsibility under supervision for the total care of the patient, including initial evaluation, establishment of diagnosis, selection of appropriate therapy, and management of complications;
- IV.A.5.a).(3) must participate in the continuity of patient care through preoperative and postoperative clinics and inpatient contact. When residents participate in preoperative and postoperative care in a clinic or private office setting, the program director must ensure that the resident functions with an appropriate degree of responsibility under supervision;
- IV.A.5.a).(4) should be given responsibility based upon the individual resident's knowledge, problem-solving ability, manual skills, experience, and the severity and complexity of each patient's status.

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) must have didactic instruction that includes the following core domains:
- IV.A.5.b).(1).(a) voiding dysfunction
 - IV.A.5.b).(1).(b) female urology
 - IV.A.5.b).(1).(c) reconstruction
 - IV.A.5.b).(1).(d) oncology
 - IV.A.5.b).(1).(e) calculus disease
 - IV.A.5.b).(1).(f) pediatrics
 - IV.A.5.b).(1).(g) reproductive and sexual dysfunction
- IV.A.5.b).(2) must receive instruction in the following core techniques:
- IV.A.5.b).(2).(a) endo-urology
 - IV.A.5.b).(2).(b) minimally-invasive intra-abdominal and pelvic surgical techniques (e.g., laparoscopy/robotics)
 - IV.A.5.b).(2).(c) major flank and pelvic surgery

IV.A.5.b).(2).(d)	perineal and genital surgery
IV.A.5.b).(2).(e)	urologic imaging including fluoroscopy, interventional radiology, and ultrasound
IV.A.5.b).(2).(f)	microsurgery
IV.A.5.b).(3)	must receive instruction in:
IV.A.5.b).(3).(a)	bioethics
IV.A.5.b).(3).(b)	radiation safety
IV.A.5.b).(3).(c)	biostatistics
IV.A.5.b).(3).(d)	epidemiology
IV.A.5.b).(3).(e)	geriatrics
IV.A.5.b).(3).(f)	infectious disease
IV.A.5.b).(3).(g)	renovascular disease
IV.A.5.b).(3).(h)	renal transplantation
IV.A.5.b).(3).(i)	trauma
IV.A.5.b).(3).(j)	plastic surgery
IV.A.5.b).(3).(k)	medical oncology

IV.A.5.c)

Practice-based Learning and Improvement

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

IV.A.5.c).(1)	identify strengths, deficiencies, and limits in one's knowledge and expertise;
IV.A.5.c).(2)	set learning and improvement goals;
IV.A.5.c).(3)	identify and perform appropriate learning activities;
IV.A.5.c).(4)	systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;

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

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

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

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

IV.A.5.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.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.

V. Evaluation

V.A. Resident Evaluation

V.A.1. Formative Evaluation

V.A.1.a) The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.

V.A.1.b) The program must:

V.A.1.b).(1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;

V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);

V.A.1.b).(3) document progressive resident performance improvement appropriate to educational level; and,

V.A.1.b).(4) provide each resident with documented semiannual evaluation of performance with feedback.

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.C. Program Evaluation and Improvement

V.C.1. The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:

V.C.1.a) resident performance;

V.C.1.b) faculty development;

V.C.1.c) graduate performance, including performance of program graduates on the certification examination; and,

V.C.1.d) program quality. Specifically:

V.C.1.d).(1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and

V.C.1.d).(2) The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.

V.C.2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.

VI. Resident Duty Hours in the Learning and Working Environment

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

VI.A.1. Programs and sponsoring institutions must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.

VI.A.2. The program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational

environment.

VI.A.3. The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.

VI.A.4. The learning objectives of the program must:

VI.A.4.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,

VI.A.4.b) not be compromised by excessive reliance on residents to fulfill non-physician service obligations.

VI.A.5. The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following:

VI.A.5.a) assurance of the safety and welfare of patients entrusted to their care;

VI.A.5.b) provision of patient- and family-centered care;

VI.A.5.c) assurance of their fitness for duty;

VI.A.5.d) management of their time before, during, and after clinical assignments;

VI.A.5.e) recognition of impairment, including illness and fatigue, in themselves and in their peers;

VI.A.5.f) attention to lifelong learning;

VI.A.5.g) the monitoring of their patient care performance improvement indicators; and,

VI.A.5.h) honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.

VI.A.6. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.

VI.B. Transitions of Care

VI.B.1. Programs must design clinical assignments to minimize the number

of transitions in patient care.

- VI.B.2. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.
- VI.B.3. Programs must ensure that residents are competent in communicating with team members in the hand-over process.
- VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.

VI.C. Alertness Management/Fatigue Mitigation

- VI.C.1. The program must:
 - VI.C.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;
 - VI.C.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; and,
 - VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.
- VI.C.2. Each program must have a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties.
- VI.C.3. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home.

VI.D. Supervision of Residents

- VI.D.1. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.
 - 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.F.1. Each resident must have the opportunity to interact with other providers such as nurses, other specialists, social workers, and mid-level providers.

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

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.

URO-1 and URO-2 residents are considered to be at the intermediate level.

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

URO-3 and URO-4 residents are considered to be in the final years of education.

VI.G.5.c).(1) This preparation must occur within the context of the

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

VI.G.5.c).(1).(a)

Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.

VI.G.5.c).(1).(b)

The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.

VI.G.6.

Maximum Frequency of In-House Night Float

Residents must not be scheduled for more than six consecutive nights of night float.

VI.G.6.a)

Residents cannot be assigned more than eight weeks of night float per year.

VI.G.6.b)

Night float rotations must not exceed 16 weeks total during URO-1 and URO-2.

VI.G.7.

Maximum In-House On-Call Frequency

PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

VI.G.8.

At-Home Call

VI.G.8.a)

Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.

VI.G.8.a).(1)

At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

VI.G.8.b)

Residents are permitted to return to the hospital while on at-

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

VII. Innovative Projects

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

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