

1 **ACGME Program Requirements for Graduate Medical Education**
2 **in Anesthesiology**

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

5
6 Effective: July 1, 2008
7

8 Introduction

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10 Int.A. Definition and Scope of the Specialty

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12 The Review Committee representing the medical specialty of anesthesiology
13 exists in order to foster and maintain the highest standards of training and
14 educational facilities in anesthesiology, which the Review Committee defines as
15 the practice of medicine dealing with but not limited to the following:
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17 Int.A.1. assessment of, consultation for, and preparation of patients for
18 anesthesia;

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20 Int.A.2. relief and prevention of pain during and following surgical, obstetric,
21 therapeutic, and diagnostic procedures;

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23 Int.A.3. monitoring and maintenance of normal physiology during the
24 perioperative period;

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26 Int.A.4. management of critically ill patients;

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28 Int.A.5. diagnosis and treatment of acute, chronic, and cancer-related pain;

29
30 Int.A.6. clinical management and teaching of cardiac and pulmonary
31 resuscitation;

32
33 Int.A.7. evaluation of respiratory function and application of respiratory therapy;

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35 Int.A.8. conducting of clinical and basic science research; and,

36
37 Int.A.9. supervision, teaching, and evaluation of performance of personnel, both
38 medical and paramedical, involved in perioperative care.
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40 Int.B. Duration and Scope of Education

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42 Int.B.1. Length of Program

43
44 A minimum of four years of graduate medical education is necessary to
45 train a physician in the field of anesthesiology. Three years of the training
46 must be in clinical anesthesia. The Review Committee for Anesthesiology
47 and the Accreditation Council for Graduate Medical Education (ACGME)
48 accredit programs only in those institutions that possess the educational
49 resources to provide three years of clinical anesthesia training. The
50 capability to provide the Clinical Base Year within the same institution is
51 desirable but not required for accreditation.

52		
53	Int.B.2.	Program Design
54		
55		The continuum of education in anesthesiology consists of four years of
56		training, the Clinical Base Year (CBY) and 36 months of clinical
57		anesthesia training (CA-1, CA-2, and CA-3 years).
58		
59	Int.B.2.a)	Clinical Base Year
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61	Int.B.2.a).(1)	One year of the resident's total training must be the Clinical
62		Base Year, which should provide the resident with 12
63		months of broad education in medical disciplines relevant
64		to the practice of anesthesiology. The Clinical Base Year
65		usually precedes training in clinical anesthesia. It is
66		strongly recommended that the Clinical Base Year be
67		completed before the resident begins the CA-2 year; the
68		Clinical Base Year, however, must be completed before
69		the resident begins the CA-3 year.
70		
71	Int.B.2.a).(2)	If an accredited anesthesiology program offers this year of
72		training, the Review Committee will verify that the content
73		and oversight for the year are acceptable. If the year is
74		judged to be in substantial compliance with the
75		requirements for the Clinical Base Year (as defined below),
76		the Review Committee will accredit the residency as a
77		four-year program. When the Clinical Base Year is
78		approved as part of the accredited anesthesiology
79		residency program, the program director must maintain
80		oversight for all rotations on the services that are used for
81		the Clinical Base Year and must approve the rotations for
82		individual residents.
83		
84	Int.B.2.a).(3)	When the resident obtains the CBY in another accredited
85		program (e.g., a Transitional Year program or a PGY-1
86		experience in another specialty), the anesthesiology
87		program director must receive from the CBY program
88		director the resident's written performance evaluation
89		quarterly during the CBY. Acceptance into the CA-1 year
90		depends on the resident demonstrating satisfactory
91		abilities on these written evaluations. This requirement
92		pertains to the resident who has been accepted into an
93		anesthesiology program before starting the CBY. For
94		information concerning residents who transfer from a
95		residency in another specialty or from another
96		anesthesiology residency, refer to Sec. III.C. Resident
97		Transfers.
98		
99	Int.B.2.a).(4)	At least six months of the Clinical Base Year rotations must
100		include experience in caring for inpatients in internal
101		medicine, pediatrics, surgery, or any of the surgical
102		specialties, obstetrics and gynecology, neurology, family

103 medicine, or any combination of these. In addition, there
104 should be rotations in critical care and emergency
105 medicine, with at least one month, but no more than two
106 months, devoted to each. Up to one month may be taken
107 in anesthesiology. Rotations should ensure continuity of
108 teaching and clinical experience. Each month of training
109 may be counted only once. For example, a rotation in a
110 pediatric intensive care unit may count as either a month in
111 pediatrics or a month in critical care medicine.

112
113 Int.B.2.a).(5) The development of clinical skills and mature clinical
114 judgment requires that residents be given responsibility,
115 under proper supervision and commensurate with their
116 ability, for decision-making and for direct patient care in all
117 settings. The resident's patient care responsibilities should
118 include the planning of care, and the writing of orders,
119 progress notes and relevant records, subject to review and
120 approval by senior residents and attending physicians.

121
122 Int.B.2.a).(6) The resident should develop the following fundamental
123 clinical skill competencies during the Clinical Base Year:

124
125 Int.B.2.a).(6).(a) obtain a comprehensive medical history;

126
127 Int.B.2.a).(6).(b) perform a comprehensive physical examination;

128
129 Int.B.2.a).(6).(c) assess a patient's medical conditions;

130
131 Int.B.2.a).(6).(d) make appropriate use of diagnostic studies and
132 tests;

133
134 Int.B.2.a).(6).(e) integrate information to develop a differential
135 diagnosis; and,

136
137 Int.B.2.a).(6).(f) implement a treatment plan.

138
139 Int.B.2.a).(7) Each clinical service on which the Clinical Base Year
140 resident rotates must provide written evaluation of the
141 resident's performance at the end of the rotation. The
142 Anesthesiology program director is responsible for
143 reviewing these written evaluations on a quarterly basis.

144
145 Int.B.2.b) Clinical Anesthesia Training: CA-1 through CA-3 Years

146
147 Int.B.2.b).(1) These three years consist of training in basic and
148 advanced anesthesia. They must encompass all aspects of
149 perioperative care to include evaluation and management
150 during the preoperative, intraoperative, and postoperative
151 periods. The clinical training must progressively challenge
152 the resident's cognitive and technical skills, and must
153 provide experience in direct and progressively responsible

154 patient management. As the resident advances through
155 training, she or he should have the opportunity to learn to
156 plan and to administer anesthesia care for patients with
157 more severe and complicated diseases, as well as patients
158 who undergo more complex surgical procedures. The
159 training must culminate in sufficiently independent
160 responsibility for clinical decision-making and patient care
161 so that the graduating resident exhibits sound clinical
162 judgment in a wide variety of clinical situations and can
163 function as a leader of perioperative care teams.

164
165 Int.B.2.b).(2) The program should provide initial rotations in surgical
166 anesthesia, critical care medicine, and pain medicine.
167 Experience in these rotations must emphasize the
168 fundamental aspects of anesthesia, preoperative
169 evaluation and immediate postoperative care of surgical
170 patients, and assessment and treatment of critically ill
171 patients and those with acute and chronic pain. Residents
172 should receive training in the complex technology and
173 equipment associated with these practices. There must be
174 documented evidence of direct faculty involvement with
175 tutorials, lectures, and clinical supervision.

176
177 Int.B.2.b).(3) Clinical experience in surgical anesthesia, pain medicine,
178 and critical care medicine should be distributed throughout
179 the curriculum in order to provide progressive responsibility
180 to trainees in the later stages of the curriculum.

181
182 Int.B.2.b).(4) During the 36 months of clinical anesthesia training, there
183 must be a minimum of two identifiable one month rotations
184 in each of obstetric anesthesia, pediatric anesthesia,
185 neuroanesthesia, and cardiothoracic anesthesia. If the
186 program director judges that a resident has gained
187 satisfactory skills and experience in clinical anesthesia in
188 any of these subspecialties before completion of the
189 second required month, the resident may pursue other
190 experiences that augment learning of perioperative care in
191 the subspecialty during the time remaining in the second
192 month. For example, a resident who has gained sufficient
193 experience in cardiac anesthesia (see IV.A.5.a) Patient
194 Care) before completion of the second month of a cardiac
195 anesthesia rotation may benefit from other perioperative
196 experiences such as caring for patients in a cardiac
197 angiographic suite or learning the basics of performance
198 and interpretation of transthoracic or transesophageal
199 echocardiograms.

200
201 Int.B.2.b).(5) Additional subspecialty rotations are encouraged, but the
202 cumulative time in any one subspecialty may not exceed
203 six months during the CA-1 through CA-3 years. Curricula
204 specific to all subspecialty rotations must be on file in the

205		department. Advanced subspecialty rotations, including
206		those in critical care medicine and pain medicine, must
207		reflect increased responsibility and learning opportunities.
208		These assignments must not compromise the learning
209		opportunities for residents participating in their initial
210		subspecialty rotations.
211		
212	Int.B.2.b).(6)	Experiences in perioperative care must include rotations in
213		critical care medicine, acute perioperative and chronic pain
214		management, preoperative evaluation, and postanesthesia
215		care. These experiences must consist of at least four
216		months of distinct progressive rotations in critical care
217		medicine; at least three months in pain medicine that may
218		include one month in an acute perioperative pain
219		management rotation, one month in a rotation for the
220		assessment and treatment of inpatients and outpatients
221		with chronic pain problems, and one month of regional
222		analgesia experience in pain medicine; one month in a
223		preoperative evaluation clinic; and 0.5 month in a
224		postanesthesia care unit. The Review Committee will allow
225		two months of critical care medicine and one month of pain
226		medicine experiences to occur during the Clinical Base
227		Year. The Review Committee anticipates that rotations in
228		preoperative evaluation clinics, acute perioperative pain
229		management, and postoperative care units may occur in
230		divided rotations. However, the rotation unit may not be
231		less than one week. Successive experiences must reflect
232		increased responsibility and learning opportunities.
233		
234	Int.B.2.b).(7)	During the 36 months of training residents may select
235		additional focused educational experiences in advanced
236		clinical anesthesiology subspecialties and/or related
237		activities, remaining CBY required rotations, or research.
238		For example, residents seeking broad exposure in critical
239		care-related specialties may choose to take one or more
240		rotations in echocardiography, nutrition, infectious
241		diseases, or nephrology. Some may wish to gain
242		experiences in pain medicine-related specialties such as
243		physical medicine & rehabilitation, neurology, or
244		psychiatry. Others may wish to choose advanced clinical
245		anesthesiology subspecialty rotations or unique
246		anesthesia-related experiences.
247		
248	Int.B.2.b).(8)	The program director must determine the sequencing of
249		the rotations.
250		
251	Int.B.2.b).(9)	All residents must hold current certification as providers for
252		advanced cardiac life support (ACLS).
253		
254	Int.C.	Program Objectives
255		

256 Int.C.1. An accredited program in anesthesiology must provide education,
257 training, and experience in an atmosphere of mutual respect between
258 instructor and residents so that residents will be stimulated and prepared
259 to apply acquired knowledge and talents independently. The program
260 must provide an environment that promotes the acquisition of the
261 knowledge, skills, clinical judgment, and attitudes essential to the practice
262 of anesthesiology.
263

264 Int.C.2. In addition to clinical skills, the program should emphasize interpersonal
265 skills, effective communication, and professionalism. The residency
266 program must work toward ensuring that its residents, by the time they
267 graduate, assume responsibility and act responsibly and with integrity;
268 demonstrate a commitment to excellence and ethical principles of clinical
269 care, including confidentiality of patient information, informed consent,
270 and business practices; demonstrate respect and regard for the needs of
271 patients and society that supersede self-interest; and work effectively as
272 members of a health-care team or other professional group. Further,
273 residents are expected to create and sustain a therapeutic relationship
274 with patients, engage in active listening, provide information using
275 appropriate language, ask clear questions, provide an opportunity for
276 comments and questions, and demonstrate sensitivity and
277 responsiveness to cultural differences, including awareness of their own
278 and their patients' cultural perspectives.
279

280 Int.C.3. These objectives can be achieved only when the program leadership,
281 faculty, supporting staff, and administration demonstrate a commitment to
282 the educational program and provide appropriate resources and facilities.
283 Service commitments must not compromise the achievement of
284 educational goals and objectives.
285

286 I. Institutions

287 I.A. Sponsoring Institution

288 **One sponsoring institution must assume ultimate responsibility for the**
289 **program, as described in the Institutional Requirements, and this**
290 **responsibility extends to resident assignments at all participating sites.**
291

292 **The sponsoring institution and the program must ensure that the program**
293 **director has sufficient protected time and financial support for his or her**
294 **educational and administrative responsibilities to the program.**
295

296 I.A.1. The institution sponsoring an accredited program in anesthesiology must
297 also sponsor or be affiliated with ACGME-approved residencies in at least
298 the specialties of general surgery and internal medicine.
299

300 I.B. Participating Sites

301 I.B.1. **There must be a program letter of agreement (PLA) between the**
302 **program and each participating site providing a required**
303 **assignment. The PLA must be renewed at least every five years.**
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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.3. A participating site may be either *integrated* or *non-integrated* with the parent institution:
 - I.B.3.a) *An integrated site* must formally acknowledge the authority of the core program director over the educational program in that hospital, including the appointments of all faculty and all residents. Integrated sites should be in geographic proximity to the parent institution to allow all residents to attend joint conferences. If a site is not in geographic proximity and joint conferences cannot be held, an equivalent educational program in the integrated site must be fully established and documented. Rotations to integrated sites are not limited in duration. It is expected, however, that the majority of the program will be provided in the parent institution. Prior approval of the Review Committee must be obtained for participation of a site on an integrated basis, regardless of the duration of the rotation.
 - I.B.3.b) *A non-integrated site* is one that is related to the core program for the purpose of providing limited rotations that complement the experience available in the parent institution. Assignments at non-integrated sites must be made for educational purposes and not to fulfill service needs. Rotations to non-integrated sites may be no more than a maximum of 12 months during the three years of clinical anesthesia. Prior approval of the Review Committee must be obtained if the duration of a rotation at a site will exceed six months.

- 357 **II Program Personnel and Resources**
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- 359 **II.A. Program Director**
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- 361 **II.A.1. There must be a single program director with authority and**
362 **accountability for the operation of the program. The sponsoring**
363 **institution's GMEC must approve a change in program director.**
364 **After approval, the program director must submit this change to the**
365 **ACGME via the ADS.**
366
- 367 II.A.1.a) When the program director is not the department chair, the
368 department chair must be an anesthesiologist who also meets the
369 qualification criteria found below in II.A.3.a)-e).
370
- 371 II.A.1.b) Frequent changes in leadership or long periods of temporary
372 leadership may adversely affect an educational program and may
373 present serious cause for concern. The Review Committee may
374 initiate an inspection of the program in conjunction with this
375 change when it deems it necessary to ensure continuing quality.
376
- 377 **II.A.2. The program director should continue in his or her position for a**
378 **length of time adequate to maintain continuity of leadership and**
379 **program stability.**
380
- 381 **II.A.3. Qualifications of the program director must include:**
382
- 383 **II.A.3.a) requisite specialty expertise and documented educational**
384 **and administrative experience acceptable to the Review**
385 **Committee;**
386
- 387 **II.A.3.b) current certification in the specialty by the American Board of**
388 **Anesthesiology, or specialty qualifications that are acceptable**
389 **to the Review Committee; and,**
390
- 391 **II.A.3.c) current medical licensure and appropriate medical staff**
392 **appointment.**
393
- 394 II.A.3.d) licensure to practice medicine in the state where the institution
395 that sponsors the program is located. (Certain federal programs
396 are exempted.)
397
- 398 II.A.3.e) faculty experience, leadership, organizational and administrative
399 qualifications, and the ability to function effectively within an
400 institutional governance. The program director must have
401 significant academic achievements in anesthesiology, such as
402 publications, the development of educational programs, or the
403 conduct of research.
404
- 405 **II.A.4. The program director must administer and maintain an educational**
406 **environment conducive to educating the residents in each of the**
407 **ACGME competency areas. The program director must:**

- 408
409 **II.A.4.a)** oversee and ensure the quality of didactic and clinical
410 education in all sites that participate in the program;
411
- 412 **II.A.4.b)** approve a local director at each participating site who is
413 accountable for resident education;
414
- 415 **II.A.4.c)** approve the selection of program faculty as appropriate;
416
- 417 **II.A.4.d)** evaluate program faculty and approve the continued
418 participation of program faculty based on evaluation;
419
- 420 **II.A.4.e)** monitor resident supervision at all participating sites;
421
- 422 **II.A.4.f)** prepare and submit all information required and requested by
423 the ACGME, including but not limited to the program
424 information forms and annual program resident updates to
425 the ADS, and ensure that the information submitted is
426 accurate and complete;
427
- 428 **II.A.4.g)** provide each resident with documented semiannual
429 evaluation of performance with feedback;
430
- 431 **II.A.4.h)** ensure compliance with grievance and due process
432 procedures as set forth in the Institutional Requirements and
433 implemented by the sponsoring institution;
434
- 435 **II.A.4.i)** provide verification of residency education for all residents,
436 including those who leave the program prior to completion;
437
- 438 **II.A.4.j)** implement policies and procedures consistent with the
439 institutional and program requirements for resident duty
440 hours and the working environment, including moonlighting,
441 and, to that end, must:
442
- 443 **II.A.4.j).(1)** distribute these policies and procedures to the
444 residents and faculty;
445
- 446 **II.A.4.j).(2)** monitor resident duty hours, according to sponsoring
447 institutional policies, with a frequency sufficient to
448 ensure compliance with ACGME requirements;
449
- 450 **II.A.4.j).(3)** adjust schedules as necessary to mitigate excessive
451 service demands and/or fatigue; and,
452
- 453 **II.A.4.j).(4)** if applicable, monitor the demands of at-home call and
454 adjust schedules as necessary to mitigate excessive
455 service demands and/or fatigue.
456
- 457 **II.A.4.k)** monitor the need for and ensure the provision of back up
458 support systems when patient care responsibilities are

459 unusually difficult or prolonged;

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461 **II.A.4.l)** comply with the sponsoring institution’s written policies and
462 procedures, including those specified in the Institutional
463 Requirements, for selection, evaluation and promotion of
464 residents, disciplinary action, and supervision of residents;

465

466 **II.A.4.m)** be familiar with and comply with ACGME and Review
467 Committee policies and procedures as outlined in the ACGME
468 Manual of Policies and Procedures;

469

470 **II.A.4.n)** obtain review and approval of the sponsoring institution’s
471 GMEC/DIO before submitting to the ACGME information or
472 requests for the following:

473

474 **II.A.4.n).(1)** all applications for ACGME accreditation of new
475 programs;

476

477 **II.A.4.n).(2)** changes in resident complement;

478

479 **II.A.4.n).(3)** major changes in program structure or length of
480 training;

481

482 **II.A.4.n).(4)** progress reports requested by the Review Committee;

483

484 **II.A.4.n).(5)** responses to all proposed adverse actions;

485

486 **II.A.4.n).(6)** requests for increases or any change to resident duty
487 hours;

488

489 **II.A.4.n).(7)** voluntary withdrawals of ACGME-accredited
490 programs;

491

492 **II.A.4.n).(8)** requests for appeal of an adverse action;

493

494 **II.A.4.n).(9)** appeal presentations to a Board of Appeal or the
495 ACGME; and,

496

497 **II.A.4.n).(10)** proposals to ACGME for approval of innovative
498 educational approaches.

499

500 **II.A.4.o)** obtain DIO review and co-signature on all program
501 information forms, as well as any correspondence or
502 document submitted to the ACGME that addresses:

503

504 **II.A.4.o).(1)** program citations, and/or

505

506 **II.A.4.o).(2)** request for changes in the program that would have
507 significant impact, including financial, on the program
508 or institution.

509

- 510 II.A.4.p) confirm that all residents completing the program have met the
511 requirements of the 48-month continuum, i.e., the Clinical Base
512 Year and the 36-month anesthesiology residency;
513
- 514 II.A.4.q) regularly review the residents' clinical experience logs and verify
515 their accuracy and completeness when they are transmitted to the
516 Review Committee;
517
- 518 II.A.4.r) ensure that the residency program has a written policy and an
519 educational program regarding substance abuse as it relates to
520 physician well-being that specifically address the needs of
521 anesthesiology;
522
- 523 II.A.4.s) require residents to maintain an electronic record of their clinical
524 experience. The program director or faculty must review the
525 record on a regular basis. It must be submitted annually to the
526 Review Committee office in accordance with the format and the
527 due date specified by the Review Committee. The logs must be
528 reviewed for accuracy and completeness before they are
529 submitted to the Review Committee; and,
530
- 531 II.A.4.t) have the means for monitoring the appropriate distribution of
532 cases among the residents.
533

534 **II.B. Faculty**

535

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

539

540 **The faculty must:**

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

546

547 **II.B.1.b) administer and maintain an educational environment**
548 **conducive to educating residents in each of the ACGME**
549 **competency areas.**

550

551 **II.B.2. The physician faculty must have current certification in the specialty**
552 **by the American Board of Anesthesiology, or possess qualifications**
553 **acceptable to the Review Committee.**

554

555 **II.B.2.a)** The number of faculty must be sufficient to provide each resident
556 with adequate supervision, which shall not vary substantially with
557 the time of day or the day of the week. In the clinical anesthesia
558 setting, faculty members should not direct anesthesia at more
559 than two anesthetizing locations simultaneously.
560

- 561 II.B.2.b) Faculty who are not ABA-certified should be in the process of
562 obtaining certification.
563
- 564 **II.B.3. The physician faculty must possess current medical licensure and
565 appropriate medical staff appointment.**
566
- 567 **II.B.4. The nonphysician faculty must have appropriate qualifications in
568 their field and hold appropriate institutional appointments.**
569
- 570 **II.B.5. The faculty must establish and maintain an environment of inquiry
571 and scholarship with an active research component.**
572
- 573 **II.B.5.a) The faculty must regularly participate in organized clinical
574 discussions, rounds, journal clubs, and conferences.**
575
- 576 **II.B.5.b) Some members of the faculty should also demonstrate
577 scholarship by one or more of the following:**
578
- 579 **II.B.5.b).(1) peer-reviewed funding;**
580
- 581 **II.B.5.b).(2) publication of original research or review articles in
582 peer-reviewed journals, or chapters in textbooks;**
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- 584 **II.B.5.b).(3) publication or presentation of case reports or clinical
585 series at local, regional, or national professional and
586 scientific society meetings; or,**
587
- 588 **II.B.5.b).(4) participation in national committees or educational
589 organizations.**
590
- 591 **II.B.5.b).(5) All above scholarship components must be present in the
592 program.**
593
- 594 **II.B.5.c) Faculty should encourage and support residents in scholarly
595 activities.**
596
- 597 **II.B.6. The faculty should have varying interests, capabilities, and backgrounds,
598 and must include individuals who have specialized expertise in the
599 subspecialties of anesthesiology, which includes but is not limited to
600 critical care, obstetric anesthesia, pediatric anesthesia, neuroanesthesia,
601 cardiothoracic anesthesia, and pain medicine. Didactic and clinical
602 teaching must be provided by faculty with documented interests and
603 expertise in the subspecialty involved. Fellowship training, several years
604 of practice (primarily within a subspecialty), and membership and active
605 participation in national organizations related to the subspecialty may
606 signify expertise.**
607
- 608 **II.B.7. Teaching by residents of medical students and junior residents represents
609 a valid learning experience. The use of a resident as an instructor of
610 junior residents, however, must not substitute for experienced faculty.**
611

- 612 **II.C. Other Program Personnel**
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614 **The institution and the program must jointly ensure the availability of all**
615 **necessary professional, technical, and clerical personnel for the effective**
616 **administration of the program.**
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- 618 **II.D. Resources**
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620 **The institution and the program must jointly ensure the availability of**
621 **adequate resources for resident education, as defined in the specialty**
622 **program requirements.**
623
- 624 **II.D.1. Space and Equipment**
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626 There must be adequate space and equipment for the educational
627 program, including meeting rooms, classrooms with visual and other
628 educational aids, study areas for residents, office space for teaching staff,
629 diagnostic and therapeutic facilities, laboratory facilities, and computer
630 support. The institution must provide appropriate on-call facilities for male
631 and female residents and faculty.
632
- 633 **II.E. Medical Information Access**
634
635 **Residents must have ready access to specialty-specific and other**
636 **appropriate reference material in print or electronic format. Electronic**
637 **medical literature databases with search capabilities should be available.**
638
- 639 **III Resident Appointments**
640
- 641 **III.A. Eligibility Criteria**
642
643 **The program director must comply with the criteria for resident eligibility**
644 **as specified in the Institutional Requirements.**
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- 646 **III.B. Number of Residents**
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648 **The program director may not appoint more residents than approved by the**
649 **Review Committee, unless otherwise stated in the specialty-specific**
650 **requirements. The program’s educational resources must be adequate to**
651 **support the number of residents appointed to the program.**
652
- 653 **III.B.1. General issues considered by the Review Committee include the**
654 **adequacy of resources for resident education such as volume and variety**
655 **of patients and related clinical material available for education, faculty-**
656 **resident ratio, institutional funding and support of education, the quality of**
657 **faculty teaching, and scholarship. Specific criteria evaluated when**
658 **establishing numbers of residents for programs include:**
659
- 660 **III.B.1.a) ABA certification rate of program graduates during the most recent**
661 **applicable five-year period;**
662

- 663 III.B.1.b) Current accreditation status and duration of review cycle;
664
665 III.B.1.c) Most recent accreditation citations, especially any relating to
666 adequacy of clinical experience and/or faculty coverage; and,
667
668 III.B.1.d) Clinical volumes demonstrating that there will be sufficient
669 experience for all residents.
670
671 III.B.2. Appointment of a minimum of nine residents with, on average, three
672 appointed in each of the CA-1, CA-2 and CA-3 years is required. Any
673 proposed increase in the number of residents must receive prior approval
674 by the Review Committee.
675
676 **III.C. Resident Transfers**
677
678 **III.C.1. Before accepting a resident who is transferring from another**
679 **program, the program director must obtain written or electronic**
680 **verification of previous educational experiences and a summative**
681 **competency-based performance evaluation of the transferring**
682 **resident.**
683
684 **III.C.2. A program director must provide timely verification of residency**
685 **education and summative performance evaluations for residents**
686 **who leave the program prior to completion.**
687
688 **III.D. Appointment of Fellows and Other Learners**
689
690 **The presence of other learners (including, but not limited to, residents from**
691 **other specialties, subspecialty fellows, PhD students, and nurse**
692 **practitioners) in the program must not interfere with the appointed**
693 **residents' education. The program director must report the presence of**
694 **other learners to the DIO and GMEC in accordance with sponsoring**
695 **institution guidelines.**
696
697 III.D.1. The integration of nonphysician personnel into a department with an
698 accredited program in anesthesiology will not influence the accreditation
699 of such a program unless it becomes evident that such personnel
700 interfere with the training of resident physicians. Interference may result
701 from dilution of faculty effort, dilution of the available teaching experience,
702 or downgrading of didactic material. Clinical instruction of residents by
703 nonphysician personnel is inappropriate, as is excessive supervision of
704 such personnel by resident staff. Additional necessary professional,
705 technical, and clerical personnel must be provided to support the
706 program.
707
708 **IV Educational Program**
709
710 **IV.A. The curriculum must contain the following educational components:**
711
712 **IV.A.1. Overall educational goals for the program, which the program must**
713 **distribute to residents and faculty annually;**

714		
715	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;
716		
717		
718		
719		
720		
721	IV.A.3.	Regularly scheduled didactic sessions;
722		
723	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,
724		
725		
726		
727	IV.A.5.	ACGME Competencies
728		
729		The program must integrate the following ACGME competencies into the curriculum:
730		
731		
732	IV.A.5.a)	Patient Care
733		
734		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:
735		
736		
737		
738	IV.A.5.a).(1)	must have a wide spectrum of disease processes and surgical procedures available within the program to provide each resident with a broad exposure to different types of anesthetic management within the anesthesiology residency program. The following list represents the minimum clinical experience that should be obtained by each resident in the program. Care should be provided for:
739		
740		
741		
742		
743		
744		
745		
746	IV.A.5.a).(1).(a)	40 patients undergoing vaginal delivery. There must be evidence of direct resident involvement in cases involving high-risk obstetrics;
747		
748		
749		
750	IV.A.5.a).(1).(b)	20 patients undergoing cesarean sections;
751		
752	IV.A.5.a).(1).(c)	100 patients less than 12 years of age undergoing surgery or other procedures requiring anesthetics. Within this patient group, 20 children must be less than three years of age, including five less than three months of age;
753		
754		
755		
756		
757		
758	IV.A.5.a).(1).(d)	20 patients undergoing cardiac surgery. The majority of these cardiac procedures must involve the use of cardiopulmonary bypass;
759		
760		
761		
762	IV.A.5.a).(1).(e)	20 patients undergoing open or endovascular procedures on major vessels, including carotid surgery, intrathoracic vascular surgery, intra-
763		
764		

765		abdominal vascular surgery, or peripheral vascular
766		surgery. Excluded from this category is surgery for
767		vascular access or repair of vascular access;
768		
769	IV.A.5.a).(1).(f)	20 patients undergoing non-cardiac intrathoracic
770		surgery, including pulmonary surgery and surgery
771		of the great vessels, esophagus, and the
772		mediastinum and its structures;
773		
774	IV.A.5.a).(1).(g)	20 patients undergoing intracerebral procedures.
775		These patients include those undergoing
776		intracerebral endovascular procedures. However,
777		the majority of these twenty procedures must
778		involve an open cranium;
779		
780	IV.A.5.a).(1).(h)	40 patients undergoing surgical procedures,
781		including cesarean sections, in whom epidural
782		anesthetics are used as part of the anesthetic
783		technique or epidural catheters are placed for
784		perioperative analgesia. Use of a combined
785		spinal/epidural technique may be counted as both a
786		spinal and an epidural procedure;
787		
788	IV.A.5.a).(1).(i)	20 patients undergoing procedures for complex,
789		life-threatening injuries. Examples of these injuries
790		include trauma associated with car crashes, falls
791		from high places, penetrating wounds, industrial
792		and farm accidents, and assaults. Burns covering
793		more than 20% of body surface area also are
794		included in this category;
795		
796	IV.A.5.a).(1).(j)	40 patients undergoing surgical procedures,
797		including cesarean sections, with spinal
798		anesthetics. Use of a combined spinal/epidural
799		technique may be counted as both a spinal and an
800		epidural procedure;
801		
802	IV.A.5.a).(1).(k)	40 patients undergoing surgical procedures in
803		whom peripheral nerve blocks are used as part of
804		the anesthetic technique or perioperative analgesic
805		management;
806		
807	IV.A.5.a).(1).(l)	20 new patients who are evaluated for
808		management of acute, chronic, or cancer-related
809		pain disorders. Residents should have familiarity
810		with the breadth of pain management including
811		clinical experience with interventional pain
812		procedures;
813		
814	IV.A.5.a).(1).(m)	Patients with acute postoperative pain. There must
815		be documented involvement in the management of

816		acute postoperative pain, including familiarity with
817		patient-controlled intravenous techniques, neuraxial
818		blockade, and other pain-control modalities;
819		
820	IV.A.5.a).(1).(n)	Patients scheduled for evaluation prior to elective
821		surgical procedures. There must be documented
822		involvement for at least four weeks in preoperative
823		medicine;
824		
825	IV.A.5.a).(1).(o)	Patients who require specialized techniques for
826		their perioperative care. There must be significant
827		experience with a broad spectrum of airway
828		management techniques (e.g., performance of
829		fiberoptic intubation and lung isolation techniques
830		such as double lumen endotracheal tube placement
831		and endobronchial blockers). Residents also should
832		have significant experience with central vein and
833		pulmonary artery catheter placement and the use of
834		transesophageal echocardiography and evoked
835		potentials. The resident must either personally
836		participate in cases in which EEG or processed
837		EEG monitoring is actively used as part of the
838		procedure or have adequate didactic instruction to
839		ensure familiarity with EEG use and interpretation.
840		Bispectral index use and other similar interpolated
841		modalities are not sufficient to satisfy this
842		requirement;
843		
844	IV.A.5.a).(1).(p)	Patients immediately after anesthesia. There must
845		be a postanesthesia care experience of 0.5 month
846		involving direct care of patients in the
847		postanesthesia-care unit and responsibilities for
848		management of pain, hemodynamic changes, and
849		emergencies related to the postanesthesia-care
850		unit. The Review Committee expects resident
851		clinical responsibilities in the postoperative care
852		unit to be limited to the care of postoperative
853		patients, with the exception of providing emergency
854		response capability for cardiac arrests and rapid
855		response situations within the facility. Designated
856		faculty must be readily and consistently available
857		for consultation and teaching.
858		
859	IV.A.5.a).(1).(q)	Critically ill patients. There must be a minimum of
860		four months of critical care medicine distributed
861		throughout the curriculum in order to provide
862		progressive responsibility to trainees in the later
863		stages of the curriculum. No more than two months
864		of critical care medicine will be credited for training
865		that occurs before the CA-1 year. Each critical care
866		medicine rotation should be at least one month in

867 duration, with progressive patient care
868 responsibility in advanced rotations. Overall, this
869 training must take place in units providing care for
870 both men and women in which the majority of
871 patients have multisystem disease. The
872 postanesthesia-care unit experience does not
873 satisfy this requirement. Anesthesia residents must
874 actively participate in all patient care activities and
875 as a fully integrated member of the critical care
876 team. During at least two of the required four
877 months of critical care medicine, faculty
878 anesthesiologists experienced in the practice and
879 teaching of critical care must be actively involved in
880 the care of the critically ill patients and the
881 educational activities of the residents.

883 IV.A.5.a).(1).(r) Patients undergoing diagnostic or therapeutic
884 procedures outside of the surgical suites. There
885 must be appropriate didactic instruction and
886 sufficient clinical experience in managing the
887 specific needs of patients undergoing these
888 procedures.

890 IV.A.5.a).(2) must maintain a comprehensive anesthesia record for
891 each patient as an ongoing reflection of the drugs
892 administered, the monitoring employed, the techniques
893 used, the physiologic variations observed, the therapy
894 provided as required, and the fluids administered. The
895 patient's medical record should contain evidence of
896 preoperative and postoperative anesthesia assessment.

898 **IV.A.5.b) Medical Knowledge**

899
900 **Residents must demonstrate knowledge of established and**
901 **evolving biomedical, clinical, epidemiological and social-**
902 **behavioral sciences, as well as the application of this**
903 **knowledge to patient care. Residents:**

904
905 IV.A.5.b).(1) should have didactic instruction that encompasses clinical
906 anesthesiology and related areas of basic science, as well
907 as pertinent topics from other medical and surgical
908 disciplines. Didactic presentations related to the specific
909 issues noted in section IV.A.5.b) (Medical Knowledge) are
910 required. Practice management should be included in the
911 curriculum, and should address issues such as operating
912 room management, types of practice, job acquisition,
913 financial planning, contract negotiations, billing
914 arrangements, professional liability, and legislative and
915 regulatory issues. The material covered in the didactic
916 program should demonstrate appropriate continuity and
917 sequencing to ensure that residents are ultimately exposed

918 to all subjects at regularly held teaching conferences. The
919 number and types of such conferences may vary among
920 programs, but there must be evidence of regular faculty
921 participation. The program director should also seek to
922 enrich the program by providing lectures and contact with
923 faculty from other disciplines and other institutions;
924

925 IV.A.5.b).(2) must have appropriate didactic instruction and sufficient
926 clinical experience in managing problems of the geriatric
927 population; and,
928

929 IV.A.5.b).(3) must have appropriate didactic instruction and sufficient
930 clinical experience in managing the specific needs of the
931 ambulatory surgical patient.
932

933 **IV.A.5.c) Practice-based Learning and Improvement**

934
935 **Residents must demonstrate the ability to investigate and**
936 **evaluate their care of patients, to appraise and assimilate**
937 **scientific evidence, and to continuously improve patient care**
938 **based on constant self-evaluation and life-long learning.**
939 **Residents are expected to develop skills and habits to be able**
940 **to meet the following goals:**

941
942 **IV.A.5.c).(1) identify strengths, deficiencies, and limits in one's**
943 **knowledge and expertise;**

944
945 **IV.A.5.c).(2) set learning and improvement goals;**

946
947 **IV.A.5.c).(3) identify and perform appropriate learning activities;**

948
949 **IV.A.5.c).(4) systematically analyze practice using quality**
950 **improvement methods, and implement changes with**
951 **the goal of practice improvement;**

952
953 **IV.A.5.c).(5) incorporate formative evaluation feedback into daily**
954 **practice;**

955
956 **IV.A.5.c).(6) locate, appraise, and assimilate evidence from**
957 **scientific studies related to their patients' health**
958 **problems;**

959
960 **IV.A.5.c).(7) use information technology to optimize learning; and,**

961
962 **IV.A.5.c).(8) participate in the education of patients, families,**
963 **students, residents and other health professionals.**

964
965 **IV.A.5.d) Interpersonal and Communication Skills**

966
967 **Residents must demonstrate interpersonal and**
968 **communication skills that result in the effective exchange of**

969		information and collaboration with patients, their families, and health professionals. Residents are expected to:
970		
971		
972	IV.A.5.d).(1)	communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
973		
974		
975		
976	IV.A.5.d).(2)	communicate effectively with physicians, other health professionals, and health related agencies;
977		
978		
979	IV.A.5.d).(3)	work effectively as a member or leader of a health care team or other professional group;
980		
981		
982	IV.A.5.d).(4)	act in a consultative role to other physicians and health professionals; and,
983		
984		
985	IV.A.5.d).(5)	maintain comprehensive, timely, and legible medical records, if applicable.
986		
987		
988	IV.A.5.e)	Professionalism
989		
990		Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:
991		
992		
993		
994	IV.A.5.e).(1)	compassion, integrity, and respect for others;
995		
996	IV.A.5.e).(2)	responsiveness to patient needs that supersedes self-interest;
997		
998		
999	IV.A.5.e).(3)	respect for patient privacy and autonomy;
1000		
1001	IV.A.5.e).(4)	accountability to patients, society and the profession; and,
1002		
1003		
1004	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.
1005		
1006		
1007		
1008		
1009	IV.A.5.f)	Systems-based Practice
1010		
1011		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:
1012		
1013		
1014		
1015		
1016		
1017	IV.A.5.f).(1)	work effectively in various health care delivery settings and systems relevant to their clinical specialty;
1018		
1019		

1020		
1021	IV.A.5.f).(2)	coordinate patient care within the health care system relevant to their clinical specialty;
1022		
1023		
1024	IV.A.5.f).(3)	incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
1025		
1026		
1027		
1028	IV.A.5.f).(4)	advocate for quality patient care and optimal patient care systems;
1029		
1030		
1031	IV.A.5.f).(5)	work in interprofessional teams to enhance patient safety and improve patient care quality; and,
1032		
1033		
1034	IV.A.5.f).(6)	participate in identifying system errors and implementing potential systems solutions.
1035		
1036		
1037	IV.A.6.	<u>Residents must participate in at least one simulated clinical experience each year.</u>
1038		
1039		
1040	IV.B.	Residents' Scholarly Activities
1041		
1042	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.
1043		
1044		
1045		
1046	IV.B.2.	Residents should participate in scholarly activity.
1047		
1048	IV.B.3.	The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.
1049		
1050		
1051		
1052	IV.B.4.	Each resident must complete an academic assignment. This assignment usually occurs during the final 24 months of training, but it may, at the program director's discretion, occur earlier. Academic projects may include grand rounds presentations, preparation and publication of review articles, book chapters, manuals for teaching or clinical practice, or similar academic activities. Alternatively, a resident may elect to develop and perform or participate in one or more clinical or laboratory investigations. The Review Committee expects that the outcomes of resident investigations will be suitable for presentation at local, regional, or national scientific meetings and that many will result in peer-reviewed abstracts or manuscripts. A faculty supervisor must be in charge of each project and investigation.
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1063		
1064		
1065	V	Evaluation
1066		
1067	V.A.	Resident Evaluation
1068		
1069	V.A.1.	Formative Evaluation
1070		

1071	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.
1072		
1073		
1074		
1075		
1076	V.A.1.b)	The program must:
1077		
1078	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;
1079		
1080		
1081		
1082		
1083		
1084	V.A.1.b).(2)	use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);
1085		
1086		
1087	V.A.1.b).(3)	document progressive resident performance improvement appropriate to educational level; and,
1088		
1089		
1090	V.A.1.b).(4)	provide each resident with documented semiannual evaluation of performance with feedback.
1091		
1092		
1093	V.A.1.c)	The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.
1094		
1095		
1096		
1097	V.A.2.	Summative Evaluation
1098		
1099		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:
1100		
1101		
1102		
1103		
1104		
1105	V.A.2.a)	document the resident's performance during the final period of education, and
1106		
1107		
1108	V.A.2.b)	verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.
1109		
1110		
1111	V.B.	Faculty Evaluation
1112		
1113	V.B.1.	At least annually, the program must evaluate faculty performance as it relates to the educational program.
1114		
1115		
1116	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.
1117		
1118		
1119		
1120	V.B.3.	This evaluation must include at least annual written confidential evaluations by the residents.
1121		

1122		
1123	V.C.	Program Evaluation and Improvement
1124		
1125	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:
1126		
1127		
1128		
1129	V.C.1.a)	resident performance;
1130		
1131	V.C.1.b)	faculty development;
1132		
1133	V.C.1.c)	graduate performance, including performance of program graduates on the certification examination; and,
1134		
1135		
1136	V.C.1.d)	program quality. Specifically:
1137		
1138	V.C.1.d).(1)	Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and
1139		
1140		
1141		
1142	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.
1143		
1144		
1145		
1146	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.
1147		
1148		
1149		
1150		
1151		
1152	V.C.3.	As part of the overall evaluation of the program, the Review Committee will take into consideration the information provided by the ABA regarding resident performance on the certifying examinations over the most recent five-year period. The Review Committee will also take into account noticeable improvements or declines during the period considered. Program graduates should take the certifying examination, and at least 70% of the program graduates should become certified.
1153		
1154		
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1158		
1159		
1160	VI	Resident Duty Hours in the Learning and Working Environment
1161		
1162	VI.A.	Principles
1163		
1164	VI.A.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.
1165		
1166		
1167		
1168	VI.A.2.	The learning objectives of the program must not be compromised by excessive reliance on residents to fulfill service obligations.
1169		
1170		
1171	VI.A.3.	Didactic and clinical education must have priority in the allotment of residents' time and energy.
1172		

- 1173
1174 **VI.A.4. Duty hour assignments must recognize that faculty and residents**
1175 **collectively have responsibility for the safety and welfare of patients.**
1176
- 1177 **VI.B. Supervision of Residents**
1178
1179 **The program must ensure that qualified faculty provide appropriate**
1180 **supervision of residents in patient care activities.**
1181
- 1182 **VI.B.1. Supervision shall not vary substantially with the time of day or day of the**
1183 **week. In the clinical setting, faculty members should not direct anesthesia**
1184 **at more than two anesthetizing locations simultaneously.**
1185
- 1186 **VI.C. Fatigue**
1187
1188 **Faculty and residents must be educated to recognize the signs of fatigue**
1189 **and sleep deprivation and must adopt and apply policies to prevent and**
1190 **counteract its potential negative effects on patient care and learning.**
1191
- 1192 **VI.D. Duty Hours (the terms in this section are defined in the ACGME Glossary**
1193 **and apply to all programs)**
1194
1195 **Duty hours are defined as all clinical and academic activities related to the**
1196 **program; i.e., patient care (both inpatient and outpatient), administrative**
1197 **duties relative to patient care, the provision for transfer of patient care,**
1198 **time spent in-house during call activities, and scheduled activities, such as**
1199 **conferences. Duty hours do *not* include reading and preparation time spent**
1200 **away from the duty site.**
1201
- 1202 **VI.D.1. Duty hours must be limited to 80 hours per week, averaged over a**
1203 **four-week period, inclusive of all in-house call activities.**
1204
- 1205 **VI.D.2. Residents must be provided with one day in seven free from all**
1206 **educational and clinical responsibilities, averaged over a four-week**
1207 **period, inclusive of call.**
1208
- 1209 **VI.D.3. Adequate time for rest and personal activities must be provided.**
1210 **This should consist of a 10-hour time period provided between all**
1211 **daily duty periods and after in-house call.**
1212
- 1213 **VI.D.3.a) The Review Committee will not consider requests for a rest period**
1214 **of less than 10 hours.**
1215
- 1216 **VI.E. On-call Activities**
1217
- 1218 **VI.E.1. In-house call must occur no more frequently than every third night,**
1219 **averaged over a four-week period.**
1220
- 1221 **VI.E.2. Continuous on-site duty, including in-house call, must not exceed 24**
1222 **consecutive hours. Residents may remain on duty for up to six**
1223 **additional hours to participate in didactic activities, transfer care of**

1224		patients, conduct outpatient clinics, and maintain continuity of
1225		medical and surgical care.
1226		
1227	VI.E.2.a)	During the six additional hours, residents may not administer
1228		anesthesia for a new operative case or manage new admissions
1229		to the intensive care unit.
1230		
1231	VI.E.3.	No new patients may be accepted after 24 hours of continuous duty.
1232		
1233	VI.E.3.a)	A new patient is defined as any patient for whom the resident has
1234		not previously provided care.
1235		
1236	VI.E.4.	At-home call (or pager call)
1237		
1238	VI.E.4.a)	The frequency of at-home call is not subject to the every-
1239		third-night, or 24+6 limitation. However at-home call must not
1240		be so frequent as to preclude rest and reasonable personal
1241		time for each resident.
1242		
1243	VI.E.4.b)	Residents taking at-home call must be provided with one day
1244		in seven completely free from all educational and clinical
1245		responsibilities, averaged over a four-week period.
1246		
1247	VI.E.4.c)	When residents are called into the hospital from home, the
1248		hours residents spend in-house are counted toward the 80-
1249		hour limit.
1250		
1251	VI.E.5.	On-call activities present the resident with the challenges of providing
1252		care outside regular duty hours. Therefore, on-call activities, including
1253		those that occur throughout the night, and on weekends and holidays, are
1254		necessary components of the education of all residents.
1255		
1256	VI.F.	Moonlighting
1257		
1258	VI.F.1.	Moonlighting must not interfere with the ability of the resident to
1259		achieve the goals and objectives of the educational program.
1260		
1261	VI.F.2.	Internal moonlighting must be considered part of the 80-hour weekly
1262		limit on duty hours.
1263		
1264	VI.G.	Duty Hours Exceptions
1265		
1266		A Review Committee may grant exceptions for up to 10% or a maximum of
1267		88 hours to individual programs based on a sound educational rationale.
1268		
1269	VI.G.1.	In preparing a request for an exception the program director must
1270		follow the duty hour exception policy from the ACGME Manual on
1271		Policies and Procedures.
1272		
1273	VI.G.2.	Prior to submitting the request to the Review Committee, the
1274		program director must obtain approval of the institution's GMEC and

1275 **DIO.**
1276
1277 VI.G.3. The RRC for Anesthesiology will not consider requests for an exception to
1278 the limit to 80 hours per week, averaged monthly.
1279

1280 **VII Experimentation and Innovation**
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1282 **Requests for experimentation or innovative projects that may deviate from the**
1283 **institutional, common and/or specialty specific program requirements must be**
1284 **approved in advance by the Review Committee. In preparing requests, the**
1285 **program director must follow Procedures for Approving Proposals for**
1286 **Experimentation or Innovative Projects located in the ACGME Manual on Policies**
1287 **and Procedures. Once a Review Committee approves a project, the sponsoring**
1288 **institution and program are jointly responsible for the quality of education offered**
1289 **to residents for the duration of such a project.**
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1293 Editorial revisions made April 16, 2003
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1296 ACGME Approved: February 14, 2006 Effective: July 1, 2008
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