

1 **ACGME Program Requirements for Graduate Medical Education**  
2 **in Colon and Rectal Surgery**

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

5  
6 *Effective: July 1, 2011*  
7

8 Introduction

9  
10 ~~Int.A. Duration and Scope of Training~~

11  
12 ~~Institutions offering residencies in colon and rectal surgery must provide the~~  
13 ~~necessary education to qualify the resident as a colon and rectal specialist in the~~  
14 ~~care of patients, in teaching, and in research. Surgeons admitted to each~~  
15 ~~residency are required to have completed a minimum of five years of an~~  
16 ~~accredited, graded program in general surgery. Thus, the residents should~~  
17 ~~already have developed a satisfactory level of clinical maturity, technical skills,~~  
18 ~~and surgical judgment which will enable them to begin a residency in colon and~~  
19 ~~rectal surgery for the purpose of specializing in this field of surgery. The period of~~  
20 ~~training must be one year and the program must comply with the institutional~~  
21 ~~requirements for residency training.~~  
22

23 Introduction

24  
25 A. Definition of Colon and Rectal Surgery

26  
27 Colon and rectal surgery is the specialty that focuses on the medical, surgical,  
28 endoscopic and perioperative management of disorders involving the colon,  
29 rectum and anus, and related problems of the abdomen, pelvis and perineum.  
30

31 B. Duration of Education

32  
33 The educational program in colon and rectal surgery must be 12 months in  
34 length.  
35

36 **I Institutions**

37  
38 **I.A. Sponsoring Institution**

39  
40 **One sponsoring institution must assume ultimate responsibility for the**  
41 **program, as described in the Institutional Requirements, and this**  
42 **responsibility extends to resident assignments at all participating sites.**  
43

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

48 I.A.1. At least 10% of the program director's salary should be provided by the  
49 sponsoring institution.  
50  
51

52 I.A.2. The program director must not be required to generate clinical or other  
53 income to provide this administrative support.

54  
55 I.A.3. The program must have a program coordinator with at least 15% of their  
56 time dedicated to the program.

57  
58 **I.B. Participating Sites**

59  
60 **I.B.1. There must be a program letter of agreement (PLA) between the**  
61 **program and each participating site providing a required**  
62 **assignment. The PLA must be renewed at least every five years.**

63  
64 **The PLA should:**

65  
66 **I.B.1.a) identify the faculty who will assume both educational and**  
67 **supervisory responsibilities for residents;**

68  
69 **I.B.1.b) specify their responsibilities for teaching, supervision, and**  
70 **formal evaluation of residents, as specified later in this**  
71 **document;**

72  
73 **I.B.1.c) specify the duration and content of the educational**  
74 **experience; and,**

75  
76 **I.B.1.d) state the policies and procedures that will govern resident**  
77 **education during the assignment.**

78  
79 **I.B.2. The program director must submit any additions or deletions of**  
80 **participating sites routinely providing an educational experience,**  
81 **required for all residents, of one month full time equivalent (FTE) or**  
82 **more through the Accreditation Council for Graduate Medical**  
83 **Education (ACGME) Accreditation Data System (ADS).**

84  
85 ~~I.B.3. Assignments at participating sites must be of sufficient length to ensure a~~  
86 ~~quality educational experience and should provide sufficient opportunity~~  
87 ~~for continuity of care. Although the number of participating sites may vary~~  
88 ~~with the various specialties' needs, all participating sites must~~  
89 ~~demonstrate the ability to promote the program goals and educational~~  
90 ~~and peer activities. Exceptions must be justified and approved in advance~~  
91 ~~by the Review Committee.~~

92  
93 **II Program Personnel and Resources**

94  
95 **II.A. Program Director**

96  
97 **II.A.1. There must be a single program director with authority and**  
98 **accountability for the operation of the program. The sponsoring**  
99 **institution's GMCC must approve a change in program director.**  
100 **After approval, the program director must submit this change to the**  
101 **ACGME via the ADS.**

102

- 103 II.A.1.a) ~~The program director should be a member of the staff of the~~  
104 ~~sponsoring or participating site.~~
- 105
- 106 II.A.1.b) ~~There should be a minimum of two staff members, including the~~  
107 ~~program director.~~
- 108
- 109 **II.A.2. The program director should continue in his or her position for a**  
110 **length of time adequate to maintain continuity of leadership and**  
111 **program stability.**
- 112
- 113 **II.A.3. Qualifications of the program director must include:**
- 114
- 115 **II.A.3.a) requisite specialty expertise and documented educational**  
116 **and administrative experience acceptable to the Review**  
117 **Committee;**
- 118
- 119 **II.A.3.b) current certification in the specialty by the American Board of**  
120 **Colon and Rectal Surgery, or specialty qualifications that are**  
121 **acceptable to the Review Committee; and,**
- 122
- 123 **II.A.3.c) current medical licensure and appropriate medical staff**  
124 **appointment;**
- 125
- 126 **II.A.3.d) at least five years of clinical practice in colon and rectal surgery;**
- 127
- 128 **II.A.3.e) at least three years of prior experience as a faculty member in**  
129 **either General Surgery or Colon and Rectal Surgery; residency**  
130 **program; and**
- 131
- 132 **II.A.3.f) membership on the medical staff of either the sponsoring**  
133 **institution or a participating site.**
- 134
- 135 **II.A.4. The program director must administer and maintain an educational**  
136 **environment conducive to educating the residents in each of the**  
137 **ACGME competency areas. The program director must:**
- 138
- 139 **II.A.4.a) oversee and ensure the quality of didactic and clinical**  
140 **education in all sites that participate in the program;**
- 141
- 142 **II.A.4.b) approve a local director at each participating site who is**  
143 **accountable for resident education;**
- 144
- 145 **II.A.4.c) approve the selection of program faculty as appropriate;**
- 146
- 147 **II.A.4.d) evaluate program faculty and approve the continued**  
148 **participation of program faculty based on evaluation;**
- 149
- 150 **II.A.4.e) monitor resident supervision at all participating sites;**
- 151
- 152 **II.A.4.f) prepare and submit all information required and requested by**  
153 **the ACGME, including but not limited to the program**

- 154 information forms and annual program resident updates to  
155 the ADS, and ensure that the information submitted is  
156 accurate and complete;
- 157
- 158 **II.A.4.g)** provide each resident with documented semiannual  
159 evaluation of performance with feedback;
- 160
- 161 **II.A.4.h)** ensure compliance with grievance and due process  
162 procedures as set forth in the Institutional Requirements and  
163 implemented by the sponsoring institution;
- 164
- 165 **II.A.4.i)** provide verification of residency education for all residents,  
166 including those who leave the program prior to completion;
- 167
- 168 **II.A.4.j)** implement policies and procedures consistent with the  
169 institutional and program requirements for resident duty  
170 hours and the working environment, including moonlighting,  
171 and, to that end, must:
- 172
- 173 **II.A.4.j).(1)** distribute these policies and procedures to the  
174 residents and faculty;
- 175
- 176 **II.A.4.j).(2)** monitor resident duty hours, according to sponsoring  
177 institutional policies, with a frequency sufficient to  
178 ensure compliance with ACGME requirements;
- 179
- 180 **II.A.4.j).(3)** adjust schedules as necessary to mitigate excessive  
181 service demands and/or fatigue; and,
- 182
- 183 **II.A.4.j).(4)** if applicable, monitor the demands of at-home call and  
184 adjust schedules as necessary to mitigate excessive  
185 service demands and/or fatigue.
- 186
- 187 **II.A.4.k)** monitor the need for and ensure the provision of back up  
188 support systems when patient care responsibilities are  
189 unusually difficult or prolonged;
- 190
- 191 **II.A.4.l)** comply with the sponsoring institution's written policies and  
192 procedures, including those specified in the Institutional  
193 Requirements, for selection, evaluation and promotion of  
194 residents, disciplinary action, and supervision of residents;
- 195
- 196 **II.A.4.m)** be familiar with and comply with ACGME and Review  
197 Committee policies and procedures as outlined in the ACGME  
198 Manual of Policies and Procedures;
- 199
- 200 **II.A.4.n)** obtain review and approval of the sponsoring institution's  
201 GMEC/DIO before submitting to the ACGME information or  
202 requests for the following:  
203  
204

- 205 II.A.4.n).(1) all applications for ACGME accreditation of new  
 206 programs;  
 207
- 208 II.A.4.n).(2) changes in resident complement;  
 209
- 210 II.A.4.n).(3) major changes in program structure or length of  
 211 training;  
 212
- 213 II.A.4.n).(4) progress reports requested by the Review Committee;  
 214
- 215 II.A.4.n).(5) responses to all proposed adverse actions;  
 216
- 217 II.A.4.n).(6) requests for increases or any change to resident duty  
 218 hours;  
 219
- 220 II.A.4.n).(7) voluntary withdrawals of ACGME-accredited  
 221 programs;  
 222
- 223 II.A.4.n).(8) requests for appeal of an adverse action;  
 224
- 225 II.A.4.n).(9) appeal presentations to a Board of Appeal or the  
 226 ACGME; and,  
 227
- 228 II.A.4.n).(10) proposals to ACGME for approval of innovative  
 229 educational approaches.  
 230
- 231 II.A.4.o) obtain DIO review and co-signature on all program  
 232 information forms, as well as any correspondence or  
 233 document submitted to the ACGME that addresses:  
 234
- 235 II.A.4.o).(1) program citations, and/or  
 236
- 237 II.A.4.o).(2) request for changes in the program that would have  
 238 significant impact, including financial, on the program  
 239 or institution.  
 240
- 241 II.A.4.p) clearly define the lines of authority between the program  
 242 residents, other learners, the program faculty, other faculty and  
 243 the administration. This policy must be distributed to the residents,  
 244 all learners and faculty, and must ensure that the policy is  
 245 followed;  
 246
- 247 II.A.4.q) ensure that a current, well-organized, written plan for rotation of  
 248 residents among the various services and participating institutions  
 249 involved is maintained, is available to the residents and faculty,  
 250 and is reviewed and updated at least annually;  
 251
- 252 II.A.4.r) monitor resident stress, including mental or emotional conditions  
 253 inhibiting performance or learning, and drug- or alcohol-related  
 254 dysfunction; and  
 255

- 256 II.A.4.r).(1) Both the program director and faculty should be sensitive  
 257 to the need for timely provision of confidential counseling  
 258 and psychological support services to residents;  
 259
- 260 II.A.4.r).(2) Situations that demand excessive services or that  
 261 consistently produce undesirable stress on residents must  
 262 be evaluated and modified.  
 263
- 264 II.A.4.s) dedicate at least 10% of his or her time to directing the program,  
 265 in addition to teaching.  
 266
- 267 **II.B. Faculty**  
 268
- 269 **II.B.1. At each participating site, there must be a sufficient number of**  
 270 **faculty with documented qualifications to instruct and supervise all**  
 271 **residents at that location.**  
 272
- 273 **The faculty must:**  
 274
- 275 **II.B.1.a) devote sufficient time to the educational program to fulfill**  
 276 **their supervisory and teaching responsibilities; and to**  
 277 **demonstrate a strong interest in the education of residents,**  
 278 **and**  
 279
- 280 **II.B.1.b) administer and maintain an educational environment**  
 281 **conducive to educating residents in each of the ACGME**  
 282 **competency areas.**  
 283
- 284 II.B.1.b).(1) The physician faculty must maintain professional standards  
 285 of clinical excellence and ethical behavior  
 286
- 287 **II.B.2. The physician faculty must have current certification in the specialty**  
 288 **by the American Board of Colon and Rectal Surgery, or possess**  
 289 **qualifications acceptable to the Review Committee.**  
 290
- 291 **II.B.3. The physician faculty must possess current medical licensure and**  
 292 **appropriate medical staff appointment.**  
 293
- 294 **II.B.4. The nonphysician faculty must have appropriate qualifications in**  
 295 **their field and hold appropriate institutional appointments.**  
 296
- 297 **II.B.5. The faculty must establish and maintain an environment of inquiry**  
 298 **and scholarship with an active research component.**  
 299
- 300 **II.B.5.a) The faculty must regularly participate in organized clinical**  
 301 **discussions, rounds, journal clubs, and conferences.**  
 302
- 303 **II.B.5.b) Some members of the faculty should also demonstrate**  
 304 **scholarship by one or more of the following:**  
 305
- 306 **II.B.5.b).(1) peer-reviewed funding;**

- 307  
308 **II.B.5.b).(2)** publication of original research or review articles in  
309 peer-reviewed journals, or chapters in textbooks;  
310  
311 **II.B.5.b).(3)** publication or presentation of case reports or clinical  
312 series at local, regional, or national professional and  
313 scientific society meetings; or,  
314  
315 **II.B.5.b).(4)** participation in national committees or educational  
316 organizations.  
317  
318 **II.B.5.c)** Faculty should encourage and support residents in scholarly  
319 activities.  
320  
321 **II.B.5.d)** At least one faculty member must be actively involved in regional  
322 or national specialty societies.  
323  
324 **II.B.5.e)** At least one faculty member must be regularly active in scholastic  
325 inquiry. Research performed by the resident must not substitute  
326 for active faculty involvement.  
327  
328 **II.B.6.** There must be a minimum of three full-time equivalent (FTE) American  
329 Board of Colon and Rectal Surgery (ABCRS)-certified faculty members  
330 active in the program, including the program director.  
331  
332 **II.C. Other Program Personnel**  
333  
334 **The institution and the program must jointly ensure the availability of all**  
335 **necessary professional, technical, and clerical personnel for the effective**  
336 **administration of the program.**  
337  
338 **II.D. Resources**  
339  
340 **The institution and the program must jointly ensure the availability of**  
341 **adequate resources for resident education, as defined in the specialty**  
342 **program requirements.**  
343  
344 **II.D.1.** ~~The program should supply the necessary volume and variety of colon~~  
345 ~~and rectal surgery to assure adequate training of residents. If there is~~  
346 ~~insufficient volume or variety in the primary sites, arrangements should be~~  
347 ~~made for an affiliation with a participating site to correct the inadequacy.~~  
348 The program must provide the necessary volume and variety of colon and  
349 rectal patients and surgery to ensure adequate training of residents.  
350  
351 **II.D.2.** ~~Adequate numbers of both diagnostic and therapeutic colonoscopies~~  
352 ~~must be available either at the colon and rectal training program or~~  
353 ~~through an appropriate institutional affiliation to satisfy this particular~~  
354 ~~need. Residents must be provided with adequate office workspace with~~  
355 computer hardware, software, support and Internet access, reference  
356 assistance, and statistical support.  
357

- 358 II.D.3. Residents must be provided with rapid, reliable systems for  
359 communicating with supervising faculty.  
360
- 361 **II.E. Medical Information Access**  
362  
363 **Residents must have ready access to specialty-specific and other**  
364 **appropriate reference material in print or electronic format. Electronic**  
365 **medical literature databases with search capabilities should be available.**  
366
- 367 II.E.1. Residents must have easy and rapid access to electronic medical  
368 reference resources and the major on-line, full-text journals relevant to  
369 the specialty for education and patient care at all participating sites.  
370
- 371 **III Resident Appointments**  
372
- 373 **III.A. Eligibility Criteria**  
374  
375 **The program director must comply with the criteria for resident eligibility**  
376 **as specified in the Institutional Requirements.**  
377
- 378 III.A.1. Prior to appointment in the program, residents should have demonstrated  
379 a satisfactory level of clinical maturity, technical skills, and surgical  
380 judgment which will enable them to begin a residency in colon and rectal  
381 surgery for the purpose of specializing in this field of surgery.  
382
- 383 III.A.2. Prior to appointment in the program, residents must:  
384
- 385 III.A.2.a) have completed a residency program of not less than five years of  
386 progressive education in the U.S. or Canada that is accredited by  
387 the Accreditation Council for Graduate Medical Education or the  
388 Royal College of Physicians and Surgeons of Canada; and  
389
- 390 III.A.2.b) be certified by the American Board of Surgery; or, have completed  
391 the educational requirements to sit for the American Board of  
392 Surgery (ABS) qualifying examinations (or its equivalent).  
393
- 394 **III.B. Number of Residents**  
395  
396 **The program director may not appoint more residents than approved by the**  
397 **Review Committee, unless otherwise stated in the specialty-specific**  
398 **requirements. The program's educational resources must be adequate to**  
399 **support the number of residents appointed to the program.**  
400
- 401 **III.C. Resident Transfers**  
402
- 403 **III.C.1. Before accepting a resident who is transferring from another**  
404 **program, the program director must obtain written or electronic**  
405 **verification of previous educational experiences and a summative**  
406 **competency-based performance evaluation of the transferring**  
407 **resident.**  
408

- 409 **III.C.2.** **A program director must provide timely verification of residency**  
410 **education and summative performance evaluations for residents**  
411 **who leave the program prior to completion.**  
412
- 413 **III.D.** **Appointment of Fellows and Other Learners**  
414  
415 **The presence of other learners (including, but not limited to, residents from**  
416 **other specialties, subspecialty fellows, PhD students, and nurse**  
417 **practitioners) in the program must not interfere with the appointed**  
418 **residents' education. The program director must report the presence of**  
419 **other learners to the DIO and GMEC in accordance with sponsoring**  
420 **institution guidelines.**  
421
- 422 **IV** **Educational Program**  
423
- 424 **IV.A.** **The curriculum must contain the following educational components:**  
425
- 426 **IV.A.1.** **Overall educational goals for the program, which the program must**  
427 **distribute to residents and faculty annually;**  
428
- 429 IV.A.1.a) A comprehensive educational curriculum covering all defined  
430 components of Colon and Rectal Surgery must be used by the  
431 program as a guide for resident education.  
432
- 433 IV.A.1.b) Each program must provide a minimum standard breadth and  
434 depth of education, including clinical exposure, operative  
435 experience and didactic teaching, so that graduates are experts in  
436 all major aspects of colon and rectal surgery.  
437
- 438 IV.A.1.c) The educational process must lead to the acquisition of an  
439 appropriate fund of knowledge and technical skills, the ability to  
440 integrate the acquired knowledge into clinical settings, and the  
441 development of sound surgical judgment and skills.  
442
- 443 **IV.A.2.** **Competency-based goals and objectives for each assignment at**  
444 **each educational level, which the program must distribute to**  
445 **residents and faculty annually, in either written or electronic form.**  
446 **These should be reviewed by the resident at the start of each**  
447 **rotation;**  
448
- 449 IV.A.2.a) The resident and faculty must jointly review the goals and  
450 objectives at the beginning of each rotation.  
451
- 452 IV.A.2.b) The rotation goals and objectives must be reviewed again at the  
453 end of the rotation to assess the degree to which they were  
454 attained as part of the evaluation of the resident, the teaching  
455 faculty, the rotation and the program.  
456
- 457 **IV.A.3.** **Regularly scheduled didactic sessions;**  
458  
459

- 460 IV.A.3.a) There must be a structured, program-long series of didactic  
461 sessions with the faculty that follows the written curriculum on at  
462 least a weekly basis.  
463
- 464 IV.A.3.b) Regular colon and rectal conferences must be coordinated among  
465 program sites to allow attendance by a majority of faculty and  
466 residents.  
467
- 468 IV.A.3.b).(1) A conference attendance record for both residents and  
469 faculty must be maintained.  
470
- 471 IV.A.3.b).(2) Residents must attend a minimum of 70% of all  
472 conferences, excluding excused time away for meetings,  
473 vacation and illness.  
474
- 475 IV.A.3.b).(3) Full-time faculty must attend a minimum of 50% of all full  
476 program conferences including morbidity and mortality  
477 conferences, journal clubs, and relevant team rounds.  
478
- 479 IV.A.3.c) Regular conferences must include:  
480
- 481 IV.A.3.c).(1) Morbidity and mortality conferences at least monthly where  
482 all complications occurring on the colon and rectal  
483 service(s) are presented for peer-review and follow-up.  
484
- 485 IV.A.3.c).(1).(a) Cases must be presented by the colon and rectal  
486 surgery resident(s). The involved faculty must be  
487 present and other colon and rectal surgery faculty  
488 should participate.  
489
- 490 IV.A.3.c).(2) A journal club conference where important articles from the  
491 current and past literature are presented by the resident(s)  
492 and any other learners on the service and are discussed  
493 for content as well as study design.  
494
- 495 IV.A.3.d) Related pathology and radiology studies should be presented  
496 during these conferences.  
497
- 498 IV.A.3.e) Formal clinical teaching rounds with the responsible faculty must  
499 be conducted on each rotation on at least a weekly basis.  
500
- 501 **IV.A.4. Delineation of resident responsibilities for patient care, progressive**  
502 **responsibility for patient management, and supervision of residents**  
503 **over the continuum of the program; and,**  
504
- 505 **IV.A.5. ACGME Competencies**  
506
- 507 **The program must integrate the following ACGME competencies**  
508 **into the curriculum:**  
509  
510

511	<b>IV.A.5.a)</b>	<b>Patient Care</b>
512		
513		<b>Residents must be able to provide patient care that is</b>
514		<b>compassionate, appropriate, and effective for the treatment of</b>
515		<b>health problems and the promotion of health. Residents:</b>
516		
517	IV.A.5.a).(1)	<del>will have training in both diagnostic and therapeutic</del>
518		<del>colonoscopy. The objective is to develop the</del>
519		<del>necessary competence in the use of this procedure to</del>
520		<del>qualify as an expert in the field; <u>must demonstrate</u></del>
521		<del><u>proficiency in the evaluation and management of patients</u></del>
522		<del><u>with all of the essential colon and rectal surgical disorders.</u></del>
523		
524	IV.A.5.a).(1).(a)	<u>Proficiency in evaluation and management must</u>
525		<u>include:</u>
526		
527	IV.A.5.a).(1).(a).(i)	<u>preoperative diagnosis, indications,</u>
528		<u>alternatives, risks and preparation;</u>
529		
530	IV.A.5.a).(1).(a).(ii)	<u>assessment of patient risk, nutritional</u>
531		<u>status, co-morbidities, and need for</u>
532		<u>preoperative treatment and perioperative</u>
533		<u>prophylaxis;</u>
534		
535	IV.A.5.a).(1).(a).(iii)	<u>appropriate non-operative management;</u>
536		
537	IV.A.5.a).(1).(a).(iv)	<u>operative management including all</u>
538		<u>technical aspects, intraoperative decision-</u>
539		<u>making, avoidance and management of</u>
540		<u>intraoperative complications, and</u>
541		<u>management of unexpected findings; and</u>
542		
543	IV.A.5.a).(1).(a).(v)	<u>postoperative management including</u>
544		<u>recognition and treatment of complications;</u>
545		<u>and, appropriate follow-up and additional</u>
546		<u>treatment.</u>
547		
548	IV.A.5.a).(1).(b)	<u>The essential colon and rectal surgery disorders</u>
549		<u>must include:</u>
550		
551	IV.A.5.a).(1).(b).(i)	<u>Abdominal and pelvic disorders, including</u>
552		
553	IV.A.5.a).(1).(b).(i).(a)	<u>carcinoma of the colon, rectum and</u>
554		<u>anus;</u>
555		
556	IV.A.5.a).(1).(b).(i).(b)	<u>diverticular disease;</u>
557		
558	IV.A.5.a).(1).(b).(i).(c)	<u>Inflammatory bowel disease</u>
559		<u>including Crohn's disease and</u>
560		<u>ulcerative colitis;</u>

561		
562	IV.A.5.a).(1).(b).(i).(d)	<u>Inherited colorectal disorders including familial polyposis, hereditary cancer syndromes; other inherited polyposis syndromes and related genetic disorders;</u>
563		
564		
565		
566		
567		
568	IV.A.5.a).(1).(b).(i).(e)	<u>other neoplastic processes including GIST tumors, lymphoma, carcinoid, desmoids, small bowel and mesenteric tumors;</u>
569		
570		
571		
572		
573	IV.A.5.a).(1).(b).(i).(f)	<u>lower gastrointestinal hemorrhage;</u>
574		
575	IV.A.5.a).(1).(b).(i).(g)	<u>gastrointestinal obstruction including those due to adhesions, malignancy, volvulus, hernias and pseudo obstruction;</u>
576		
577		
578		
579		
580	IV.A.5.a).(1).(b).(i).(h)	<u>colorectal infectious diseases including sexually transmitted diseases (STDs) and other colidities such as clostridium difficile and HIV related infection; and</u>
581		
582		
583		
584		
585		
586	IV.A.5.a).(1).(b).(i).(i)	<u>radiation enteritis and the effects of ionizing radiation.</u>
587		
588		
589	IV.A.5.a).(1).(b).(ii)	<u>Anorectal and perineal disorders, including</u>
590		
591	IV.A.5.a).(1).(b).(ii).(a)	<u>anal fissure;</u>
592		
593	IV.A.5.a).(1).(b).(ii).(b)	<u>fistulas, anorectal and rectovaginal;</u>
594		
595	IV.A.5.a).(1).(b).(ii).(c)	<u>hemorrhoids;</u>
596		
597	IV.A.5.a).(1).(b).(ii).(d)	<u>pruritus ani;</u>
598		
599	IV.A.5.a).(1).(b).(ii).(e)	<u>anorectal stenosis;</u>
600		
601	IV.A.5.a).(1).(b).(ii).(f)	<u>presacral/retrorectal lesions including cysts;</u>
602		
603		
604	IV.A.5.a).(1).(b).(ii).(g)	<u>meningocele, chordoma, and teratoma;</u>
605		
606		
607	IV.A.5.a).(1).(b).(ii).(h)	<u>pilonidal disease;</u>
608		
609	IV.A.5.a).(1).(b).(ii).(i)	<u>hidradenitis; and</u>
610		
611	IV.A.5.a).(1).(b).(ii).(j)	<u>necrotizing fasciitis.</u>

612		
613	IV.A.5.a).(1).(b).(iii)	<u>Pelvic floor disorders, including</u>
614		
615	IV.A.5.a).(1).(b).(iii).(a)	<u>rectal and pelvic prolapse, solitary</u>
616		<u>rectal ulcer syndrome, rectocele;</u>
617		
618	IV.A.5.a).(1).(b).(iii).(b)	<u>constipation including clinical and</u>
619		<u>physiological evaluation, dysmotility,</u>
620		<u>animus and other forms of pelvic</u>
621		<u>outlet obstruction; and</u>
622		
623	IV.A.5.a).(1).(b).(iii).(c)	<u>fecal incontinence.</u>
624		
625	IV.A.5.a).(2)	<u>will develop skills in patient evaluation, examination, office</u>
626		<u>treatment, and surgical aftercare. Where feasible, such</u>
627		<u>training should include work in the faculty member's office,</u>
628		<u>as well as in the out-patient clinic of the hospital; and, <u>must</u></u>
629		<u>demonstrate a high level of skill and dexterity in the</u>
630		<u>performance of all essential colon and rectal surgical</u>
631		<u>procedures. The essential procedures include:</u>
632		
633	IV.A.5.a).(2).(a)	<u>Abdominal procedures, including:</u>
634		
635	IV.A.5.a).(2).(a).(i)	<u>segmental colectomy including ileocolic</u>
636		<u>resection and colon resection;</u>
637		
638	IV.A.5.a).(2).(a).(ii)	<u>low anterior resection with colorectal and</u>
639		<u>coloanal anastomosis;</u>
640		
641	IV.A.5.a).(2).(a).(iii)	<u>abdominoperineal resection and total</u>
642		<u>proctocolectomy;</u>
643		
644	IV.A.5.a).(2).(a).(iv)	<u>small bowel resection;</u>
645		
646	IV.A.5.a).(2).(a).(v)	<u>stricturoplasty;</u>
647		
648	IV.A.5.a).(2).(a).(vi)	<u>ileal pouch-anal anastomosis;</u>
649		
650	IV.A.5.a).(2).(a).(vii)	<u>procedures for rectal prolapse;</u>
651		
652	IV.A.5.a).(2).(a).(viii)	<u>creation of stomas and surgical</u>
653		<u>management of stoma complications; and</u>
654		
655	IV.A.5.a).(2).(a).(ix)	<u>laparoscopic abdominal and gastrointestinal</u>
656		<u>surgery, including colon and rectal</u>
657		<u>resections, ostomy construction and</u>
658		<u>prolapse repair.</u>
659		
660	IV.A.5.a).(2).(b)	<u>Anorectal and perineal procedures, including:</u>
661		
662		

663	IV.A.5.a).(2).(b).(i)	<u>hemorrhoidectomy including operative and office treatment;</u>
664		
665		
666	IV.A.5.a).(2).(b).(ii)	<u>fistulotomies including primary and staged advancement flap repairs of complex anorectal and rectovaginal fistulas;</u>
667		
668		
669		
670	IV.A.5.a).(2).(b).(iii)	<u>transanal excision of rectal neoplasms;</u>
671		
672	IV.A.5.a).(2).(b).(iv)	<u>perineal repairs of rectal prolapse;</u>
673		
674	IV.A.5.a).(2).(b).(v)	<u>internal sphincterotomy;</u>
675		
676	IV.A.5.a).(2).(b).(vi)	<u>anoplasty;</u>
677		
678	IV.A.5.a).(2).(b).(vii)	<u>treatment of pilonidal disease; and</u>
679		
680	IV.A.5.a).(2).(b).(viii)	<u>treatment of hidradenitis.</u>
681		
682	IV.A.5.a).(2).(c)	<u>Endoscopic procedures, including:</u>
683		
684	IV.A.5.a).(2).(c).(i)	<u>colonoscopy, including diagnostic and therapeutic;</u>
685		
686		
687	IV.A.5.a).(2).(c).(ii)	<u>sigmoidoscopy including rigid and flexible; and</u>
688		
689		
690	IV.A.5.a).(2).(c).(iii)	<u>anoscopy.</u>
691		
692	IV.A.5.a).(2).(d)	<u>Administration of conscious sedation and local analgesia.</u>
693		
694		
695	IV.A.5.a).(2).(e)	<u>Pelvic floor procedures including interpretation of clinical and laboratory study results, including anorectal ultrasound/pelvic MRI, anorectal manometry, defecography, and transit time studies.</u>
696		
697		
698		
699		
700	IV.A.5.a).(3)	<u>must have ample opportunity and responsibility for the care of patients with anorectal and colonic diseases. must demonstrate substantial familiarity with additional colon and rectal surgery-related procedures, including:</u>
701		
702		
703		
704		
705	IV.A.5.a).(3).(a)	<u>abdominal procedures including continent ileostomy and pelvic exenteration;</u>
706		
707		
708	IV.A.5.a).(3).(b)	<u>anastomotic techniques including both sewn and stapled methods of colonic and anal anastomoses;</u>
709		
710		
711	IV.A.5.a).(3).(c)	<u>alternate pelvic pouch techniques including colonic J-pouch and colooplasty;</u>
712		
713		

714	IV.A.5.a).(3).(d)	<u>anorectal procedures including alternative methods of fistula repair such as fibrin glue and/or plug placement;</u>
715		
716		
717		
718	IV.A.5.a).(3).(e)	<u>other procedures for fecal incontinence including alternative methods of sphincter repair, augmentation and implantable devices;</u>
719		
720		
721		
722	IV.A.5.a).(3).(f)	<u>procedures for pelvic prolapse in addition to rectal prolapse including rectocele and enterocele repairs;</u>
723		
724		
725	IV.A.5.a).(3).(g)	<u>transanal endoscopic microsurgery;</u>
726		
727	IV.A.5.a).(3).(h)	<u>pelvic floor and gastrointestinal physiological assessment and procedures, their uses, and indications, including performance and interpretation of anorectal manometry, electromyography and pudendal nerve testing, defecography/dynamic MRI, transit time assessment, and pelvic floor exercise, rehabilitation and directed biofeedback;</u>
728		
729		
730		
731		
732		
733		
734		
735		
736	IV.A.5.a).(3).(i)	<u>flaps and grafts for perineal reconstruction;</u>
737		
738	IV.A.5.a).(3).(j)	<u>management of colorectal trauma and foreign bodies; and</u>
739		
740		
741	IV.A.5.a).(3).(k)	<u>the indications for and interpretation of CT colonography.</u>
742		
743		

**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:**

744		
745		
746		
747		
748		
749		
750		
751	IV.A.5.b).(1)	<u>will obtain sufficient knowledge of those aspects of anesthesiology, radiology, and pathology that relate to colon and rectal surgery to develop overall competence as a specialist. Such training is best accomplished in cooperation with the departments of anesthesiology, radiology, and pathology. <u>must demonstrate expertise in their knowledge of the anatomy, embryology and physiology of the colon, rectum, anus and related structures;</u></u>
752		
753		
754		
755		
756		
757		
758		
759		
760		
761	IV.A.5.b).(2)	<u>must demonstrate competence in their knowledge of the essential colorectal disorders;</u>
762		
763		
764		

- 765 IV.A.5.b).(3) must demonstrate substantial familiarity with additional  
766 colon and rectal surgery-related issues, including:  
767  
768 IV.A.5.b).(3).(a) related medical conditions;  
769  
770 IV.A.5.b).(3).(b) congenital disorders including imperforate anus,  
771 Hirschsprung's disease, urogenital and sacral  
772 dysgenesis including spina bifida, and congenital  
773 pelvic and sacral neoplasms;  
774  
775 IV.A.5.b).(3).(c) other pelvic disorders including urinary  
776 incontinence, cystocele, vaginal and uterine  
777 prolapse and enterocele;  
778  
779 IV.A.5.b).(3).(d) other pediatric and congenital disorders including  
780 prolapse, encopresis, childhood fissure, Meckel's  
781 diverticulum, juvenile polyposis and malrotation;  
782  
783 IV.A.5.b).(3).(e) gynecological disorders including endometriosis,  
784 considerations in managing the pregnant patient  
785 with colorectal disorders, and related intraoperative  
786 findings such as ovarian lesions, fibroids and  
787 endometrial implants, gynecological prolapse;  
788  
789 IV.A.5.b).(3).(f) urological disorders including urinary incontinence,  
790 fistulas to the urinary tract, involvement of the  
791 ureters, bladder and urethra in CRD, identifying and  
792 avoiding intraoperative injury to the ureters;  
793  
794 IV.A.5.b).(3).(g) vascular and mesenteric disorders affecting the  
795 colon and rectum;  
796  
797 IV.A.5.b).(3).(h) radiological and other imaging modalities including  
798 plain x-rays, contrast studies, computed  
799 tomography (CT), positron emission tomography  
800 (PET), magnetic resonance imaging (MRI), nuclear  
801 medicine scans, angiography, defecography,  
802 abdominal ultrasound, evaluation for deep vein  
803 thrombosis and pulmonary embolism, fistulograms  
804 and sinograms;  
805  
806 IV.A.5.b).(3).(i) the pathology of colon and rectal disorders; and  
807  
808 IV.A.5.b).(3).(j) genetics and molecular biology as they apply to  
809 colorectal disorders.

810 **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**

816 based on constant self-evaluation and life-long learning.  
817 Residents are expected to develop skills and habits to be able  
818 to meet the following goals:

- 819  
820 **IV.A.5.c).(1)** identify strengths, deficiencies, and limits in one's  
821 knowledge and expertise;  
822  
823 **IV.A.5.c).(2)** set learning and improvement goals;  
824  
825 **IV.A.5.c).(3)** identify and perform appropriate learning activities;  
826  
827 **IV.A.5.c).(4)** systematically analyze practice using quality  
828 improvement methods, and implement changes with  
829 the goal of practice improvement;  
830  
831 **IV.A.5.c).(5)** incorporate formative evaluation feedback into daily  
832 practice;  
833  
834 **IV.A.5.c).(6)** locate, appraise, and assimilate evidence from  
835 scientific studies related to their patients' health  
836 problems;  
837  
838 **IV.A.5.c).(7)** use information technology to optimize learning; and,  
839  
840 **IV.A.5.c).(8)** participate in the education of patients, families,  
841 students, residents and other health professionals.  
842  
843 **IV.A.5.c).(9)** ~~teach to contribute to the educational process. Teaching~~  
844 ~~should be a regular part of the training program. The~~  
845 ~~resident should assist when possible in the instruction of~~  
846 ~~general surgical residents, and medical students, as well~~  
847 ~~as nurses, and other allied health professionals. It is~~  
848 ~~important to include instruction in the care of intestinal~~  
849 ~~stomas, especially in institutions that do not have~~  
850 ~~enterostomal therapists. teach as a regular part of the~~  
851 ~~education program.~~  
852  
853 **IV.A.5.c).(10)** evaluate and analyze patient care outcomes; and,  
854  
855 **IV.A.5.c).(11)** utilize an evidence-based approach to patient care.

856  
857 **IV.A.5.d) Interpersonal and Communication Skills**

858  
859 Residents must demonstrate interpersonal and  
860 communication skills that result in the effective exchange of  
861 information and collaboration with patients, their families,  
862 and health professionals. Residents are expected to:

- 863  
864 **IV.A.5.d).(1)** communicate effectively with patients, families, and  
865 the public, as appropriate, across a broad range of  
866 socioeconomic and cultural backgrounds;

- 867  
 868 **IV.A.5.d).(2)** **communicate effectively with physicians, other health**  
 869 **professionals, and health related agencies;**  
 870  
 871 **IV.A.5.d).(3)** **work effectively as a member or leader of a health care**  
 872 **team or other professional group;**  
 873  
 874 **IV.A.5.d).(4)** **act in a consultative role to other physicians and**  
 875 **health professionals; and,**  
 876  
 877 **IV.A.5.d).(5)** **maintain comprehensive, timely, and legible medical**  
 878 **records, if applicable.**

879  
 880 **IV.A.5.e)** **Professionalism**

881  
 882 **Residents must demonstrate a commitment to carrying out**  
 883 **professional responsibilities and an adherence to ethical**  
 884 **principles. Residents are expected to demonstrate:**

- 885  
 886 **IV.A.5.e).(1)** **compassion, integrity, and respect for others;**  
 887  
 888 **IV.A.5.e).(2)** **responsiveness to patient needs that supersedes self-**  
 889 **interest;**  
 890  
 891 **IV.A.5.e).(3)** **respect for patient privacy and autonomy;**  
 892  
 893 **IV.A.5.e).(4)** **accountability to patients, society and the profession;**  
 894 **and,**  
 895  
 896 **IV.A.5.e).(5)** **sensitivity and responsiveness to a diverse patient**  
 897 **population, including but not limited to diversity in**  
 898 **gender, age, culture, race, religion, disabilities, and**  
 899 **sexual orientation.**  
 900  
 901 **IV.A.5.e).(6)** **a high standard of ethical behavior;**  
 902  
 903 **IV.A.5.e).(7)** **a commitment to continuity of care; and,**  
 904  
 905 **IV.A.5.e).(8)** **a commitment to attaining the highest degree of**  
 906 **professional competency as a specialist in the field.**

907  
 908 **IV.A.5.f)** **Systems-based Practice**

909  
 910 **Residents must demonstrate an awareness of and**  
 911 **responsiveness to the larger context and system of health**  
 912 **care, as well as the ability to call effectively on other**  
 913 **resources in the system to provide optimal health care.**  
 914 **Residents are expected to:**

- 915  
 916 **IV.A.5.f).(1)** **work effectively in various health care delivery**  
 917 **settings and systems relevant to their clinical**

- 918 specialty;
- 919
- 920 **IV.A.5.f).(2) coordinate patient care within the health care system**  
 921 **relevant to their clinical specialty;**
- 922
- 923 **IV.A.5.f).(3) incorporate considerations of cost awareness and**  
 924 **risk-benefit analysis in patient and/or population-**  
 925 **based care as appropriate;**
- 926
- 927 **IV.A.5.f).(4) advocate for quality patient care and optimal patient**  
 928 **care systems;**
- 929
- 930 **IV.A.5.f).(5) work in interprofessional teams to enhance patient**  
 931 **safety and improve patient care quality; and,**
- 932
- 933 **IV.A.5.f).(6) participate in identifying system errors and**  
 934 **implementing potential systems solutions.**

935

936 IV.A.6. Curriculum Organization and Resident Experiences

937

938 IV.A.6.a) The program must be organized so that residents participate in  
 939 patient evaluation and care in each of the following settings:

940

941 IV.A.6.a).(1) ambulatory clinic/office;

942

943 IV.A.6.a).(2) inpatient care/hospital;

944

945 IV.A.6.a).(3) operating theater, including in-patient and ambulatory;

946

947 IV.A.6.a).(4) emergency department;

948

949 IV.A.6.a).(5) endoscopy suite/center; and

950

951 IV.A.6.a).(6) physiology laboratory.

952

953 IV.A.6.b) Residents must be exposed to basic and complex patients with  
 954 the following conditions:

955

956 IV.A.6.b).(1) colon, rectal and anal cancer;

957

958 IV.A.6.b).(2) relevant genetic disorders including familial adenomatous  
 959 polyposis (FAP) and hereditary non-polyposis colorectal  
 960 cancer (HNPCC);

961

962 IV.A.6.b).(3) inflammatory bowel disease including ulcerative colitis;  
 963 diverticular disease; the broad spectrum of anorectal  
 964 disease; and

965

966 IV.A.6.b).(4) colorectal physiological disorders including fecal  
 967 incontinence, constipation, rectal and pelvic prolapse and  
 968 intestinal dysmotility.

969		
970	IV.A.6.c)	<u>Residents must have a broad operative experience, including:</u>
971		
972	IV.A.6.c).(1)	<u>abdominal/pelvic, both open and laparoscopic;</u>
973		
974	IV.A.6.c).(2)	<u>anorectal; and</u>
975		
976	IV.A.6.c).(3)	<u>Endoscopic, including rigid proctoscopy, flexible</u>
977		<u>sigmoidoscopy and colonoscopy.</u>
978		
979	IV.A.6.d)	<u>Residents must have exposure to testing methods including:</u>
980		
981	IV.A.6.d).(1)	<u>anorectal manometry;</u>
982		
983	IV.A.6.d).(2)	<u>electromyography and pudendal nerve testing;</u>
984		
985	IV.A.6.d).(3)	<u>defecography/dynamic MRI,</u>
986		
987	IV.A.6.d).(4)	<u>transit time assessment; and</u>
988		
989	IV.A.6.d).(5)	<u>pelvic floor exercise, rehabilitation and directed</u>
990		<u>biofeedback.</u>
991		
992	IV.A.6.e)	<u>Residents must have formal instruction and clinical experiences in</u>
993		<u>all essential disorders and procedures.</u>
994		
995	IV.A.6.f)	<u>Residents must participate in the evaluation and treatment of</u>
996		<u>patients with the following diagnoses:</u>
997		
998	IV.A.6.f).(1)	<u>at least 110 patients with anorectal and physiologic</u>
999		<u>disorders including hemorrhoids, fistulas, abscesses,</u>
1000		<u>fissures, constipation, incontinence and pelvic floor</u>
1001		<u>problems; and</u>
1002		
1003	IV.A.6.f).(2)	<u>at least 215 patients with abdominal disorders including</u>
1004		<u>neoplasia of the colon, rectum and anus, inflammatory</u>
1005		<u>bowel disease, diverticular disease and rectal prolapse.</u>
1006		
1007	IV.A.6.g)	<u>Residents must document the following minimum overall case</u>
1008		<u>numbers:</u>
1009		
1010	IV.A.6.g).(1)	<u>120 abdominal operations including:</u>
1011		
1012	IV.A.6.g).(1).(a)	<u>30 laparoscopic resections; and</u>
1013		
1014	IV.A.6.g).(1).(b)	<u>30 pelvic dissections;</u>
1015		
1016	IV.A.6.g).(2)	<u>60 anorectal operations;</u>
1017		
1018	IV.A.6.g).(3)	<u>185 procedures evaluating the gastrointestinal tract and</u>
1019		<u>pelvic floor including sigmoidoscopy/proctoscopy.</u>

- 1020 anoscopy, rectal and anal ultrasound, pelvic floor  
 1021 evaluation and colonoscopies (at least 140 total  
 1022 procedures including 30 interventional procedures); and  
 1023  
 1024 IV.A.6.g).(4) endoscopic procedures should not account for more than  
 1025 50% of cases.  
 1026  
 1027 IV.A.6.h) A colon and rectal surgery resident and a chief resident in general  
 1028 surgery or a fellow (whether the fellow is in an ACGME-accredited  
 1029 position or not) must not have primary responsibility for the same  
 1030 patient except that a colon and rectal surgery resident and a  
 1031 critical care fellow may co-manage the non-operative care of the  
 1032 same patient.  
 1033  
 1034 **IV.B. Residents' Scholarly Activities**  
 1035  
 1036 **IV.B.1. The curriculum must advance residents' knowledge of the basic**  
 1037 **principles of research, including how research is conducted,**  
 1038 **evaluated, explained to patients, and applied to patient care.**  
 1039  
 1040 **IV.B.2. Residents should participate in scholarly activity.**  
 1041  
 1042 IV.B.2.a) Each resident should participate in at least two of the following  
 1043 activities:  
 1044  
 1045 IV.B.2.a).(1) ongoing research studies with the faculty;  
 1046  
 1047 IV.B.2.a).(2) a resident-initiated research project with faculty  
 1048 supervision;  
 1049  
 1050 IV.B.2.a).(3) scientific presentations at local, regional, national or  
 1051 international meetings;  
 1052  
 1053 IV.B.2.a).(4) articles in peer reviewed publications; or,  
 1054  
 1055 IV.B.2.a).(5) writing book chapters or current standards papers.  
 1056  
 1057 **IV.B.3. The sponsoring institution and program should allocate adequate**  
 1058 **educational resources to facilitate resident involvement in scholarly**  
 1059 **activities.**  
 1060  
 1061 IV.B.4. Resident's scholarly activity must be communicated to the program  
 1062 director, who must document each of these activities for each resident  
 1063 annually.  
 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**  
1072 **manner during each rotation or similar educational**  
1073 **assignment, and document this evaluation at completion of**  
1074 **the assignment.**  
1075
- 1076 V.A.1.a).(1) The program director must formally discuss the resident's  
1077 performance, including the six competencies, clinical  
1078 experience, and duty hours in a face to face meeting on a  
1079 quarterly basis.  
1080
- 1081 V.A.1.a).(1).(a) This evaluation must be documented, signed by the  
1082 program director and the resident, and maintained  
1083 for review by the faculty, resident, institution and  
1084 site visitor.  
1085
- 1086 V.A.1.a).(2) The ACGME Case Log System must be used to assess  
1087 resident experience with both diagnoses and procedures.  
1088
- 1089 V.A.1.a).(2).(a) The resident must enter the cases regularly and  
1090 accurately.  
1091
- 1092 V.A.1.a).(2).(b) The program director must review the Case Log  
1093 results at least quarterly to assess the resident's  
1094 progress and to ensure completion of the goals and  
1095 objectives of each rotation.  
1096
- 1097 V.A.1.a).(2).(c) The program director must review case distribution  
1098 regularly. If a deficit is identified, specific plans  
1099 must be made to remedy the problem.  
1100
- 1101 V.A.1.a).(2).(c).(i) These plans must be documented and  
1102 shared with the resident and faculty.  
1103
- 1104 V.A.1.a).(2).(c).(ii) Review of these plans must be performed at  
1105 the next quarterly evaluation to assess  
1106 results.  
1107
- 1108 V.A.1.a).(2).(d) The program director must ensure minimum case  
1109 numbers for each resident and assess resident  
1110 technical competence.  
1111
- 1112 V.A.1.a).(2).(e) The program director must ensure the residents  
1113 complete the Case Log in a timely fashion, and that  
1114 the resident completes Case Log in its entirety prior  
1115 to completing the program.  
1116
- 1117 **V.A.1.b)** **The program must:**  
1118
- 1119 **V.A.1.b).(1)** **provide objective assessments of competence in**  
1120 **patient care, medical knowledge, practice-based**  
1121 **learning and improvement, interpersonal and**

- 1122 communication skills, professionalism, and systems-  
1123 based practice;
- 1124
- 1125 V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients,  
1126 self, and other professional staff);
- 1127
- 1128 V.A.1.b).(3) document progressive resident performance  
1129 improvement appropriate to educational level; and,
- 1130
- 1131 V.A.1.b).(4) provide each resident with documented semiannual  
1132 evaluation of performance with feedback.
- 1133
- 1134 V.A.1.c) The evaluations of resident performance must be accessible  
1135 for review by the resident, in accordance with institutional  
1136 policy.
- 1137
- 1138 V.A.1.d) The Colon and Rectal Surgery In-Training Examination  
1139 (CARSITE) or a similar, specialty-specific examination should be  
1140 used as one method of resident evaluation.
- 1141
- 1142 V.A.1.d).(1) The results should be reviewed in a debriefing session with  
1143 each resident in which faculty provide feedback regarding  
1144 identified gaps in knowledge and help the resident develop  
1145 strategies to resolve these deficiencies.
- 1146
- 1147 V.A.1.e) The American Board of Surgery In-service Training Examination  
1148 (ABSITE) must not be used for specialty-specific evaluation of  
1149 resident knowledge in Colon and Rectal Surgery.
- 1150
- 1151 V.A.2. **Summative Evaluation**
- 1152
- 1153 The program director must provide a summative evaluation for each  
1154 resident upon completion of the program. This evaluation must  
1155 become part of the resident's permanent record maintained by the  
1156 institution, and must be accessible for review by the resident in  
1157 accordance with institutional policy. This evaluation must:
- 1158
- 1159 V.A.2.a) document the resident's performance during the final period  
1160 of education, and
- 1161
- 1162 V.A.2.b) verify that the resident has demonstrated sufficient  
1163 competence to enter practice without direct supervision.
- 1164
- 1165 V.B. **Faculty Evaluation**
- 1166
- 1167 V.B.1. **At least annually, the program must evaluate faculty performance as**  
1168 **it relates to the educational program.**
- 1169
- 1170 V.B.2. **These evaluations should include a review of the faculty's clinical**  
1171 **teaching abilities, commitment to the educational program, clinical**  
1172 **knowledge, professionalism, and scholarly activities.**

- 1173
- 1174 **V.B.3.** This evaluation must include at least annual written confidential
- 1175 evaluations by the residents.
- 1176
- 1177 **V.C.** Program Evaluation and Improvement
- 1178
- 1179 **V.C.1.** The program must document formal, systematic evaluation of the
- 1180 curriculum at least annually. The program must monitor and track
- 1181 each of the following areas:
- 1182
- 1183 **V.C.1.a)** resident performance;
- 1184
- 1185 **V.C.1.b)** faculty development;
- 1186
- 1187 **V.C.1.c)** graduate performance, including performance of program
- 1188 graduates on the certification examination; and,
- 1189
- 1190 **V.C.1.d)** program quality. Specifically:
- 1191
- 1192 **V.C.1.d).(1)** Residents and faculty must have the opportunity to
- 1193 evaluate the program confidentially and in writing at
- 1194 least annually, and
- 1195
- 1196 **V.C.1.d).(2)** The program must use the results of residents’
- 1197 assessments of the program together with other
- 1198 program evaluation results to improve the program.
- 1199
- 1200 **V.C.1.d).(3)** At least 80% of a program’s graduates from ACGME-
- 1201 approved positions from the most recent five-year time
- 1202 period must sit for both the qualifying and certifying
- 1203 examinations for colon and rectal surgery within three
- 1204 years of completion of the residency; and
- 1205
- 1206 **V.C.1.d).(4)** A program’s graduates must achieve a pass rate on both
- 1207 the qualifying and certifying examinations for colon and
- 1208 rectal surgery of at least 80% for first-time takers of the
- 1209 examination in the most recent five-year time period.
- 1210
- 1211 **V.C.2.** If deficiencies are found, the program should prepare a written plan
- 1212 of action to document initiatives to improve performance in the
- 1213 areas listed in section V.C.1. The action plan should be reviewed
- 1214 and approved by the teaching faculty and documented in meeting
- 1215 minutes.
- 1216
- 1217 **VI** Resident Duty Hours in the Learning and Working Environment
- 1218
- 1219 **VI.A.** Principles
- 1220
- 1221 **VI.A.1.** The program must be committed to and be responsible for
- 1222 promoting patient safety and resident well-being and to providing a
- 1223 supportive educational environment.

- 1224  
1225 **VI.A.2.** The learning objectives of the program must not be compromised by  
1226 excessive reliance on residents to fulfill service obligations.  
1227
- 1228 **VI.A.3.** Didactic and clinical education must have priority in the allotment of  
1229 residents' time and energy.  
1230
- 1231 **VI.A.4.** Duty hour assignments must recognize that faculty and residents  
1232 collectively have responsibility for the safety and welfare of patients.  
1233
- 1234 **VI.B.** **Supervision of Residents**  
1235  
1236 The program must ensure that qualified faculty provide appropriate  
1237 supervision of residents in patient care activities.  
1238
- 1239 **VI.C.** **Fatigue**  
1240  
1241 Faculty and residents must be educated to recognize the signs of fatigue  
1242 and sleep deprivation and must adopt and apply policies to prevent and  
1243 counteract its potential negative effects on patient care and learning.  
1244
- 1245 **VI.D.** **Duty Hours (the terms in this section are defined in the ACGME Glossary**  
1246 **and apply to all programs)**  
1247  
1248 Duty hours are defined as all clinical and academic activities related to the  
1249 program; i.e., patient care (both inpatient and outpatient), administrative  
1250 duties relative to patient care, the provision for transfer of patient care,  
1251 time spent in-house during call activities, and scheduled activities, such as  
1252 conferences. Duty hours do *not* include reading and preparation time spent  
1253 away from the duty site.  
1254
- 1255 **VI.D.1.** Duty hours must be limited to 80 hours per week, averaged over a  
1256 four-week period, inclusive of all in-house call activities.  
1257
- 1258 **VI.D.2.** Residents must be provided with one day in seven free from all  
1259 educational and clinical responsibilities, averaged over a four-week  
1260 period, inclusive of call.  
1261
- 1262 **VI.D.3.** Adequate time for rest and personal activities must be provided.  
1263 This should consist of a 10-hour time period provided between all  
1264 daily duty periods and after in-house call.  
1265
- 1266 **VI.E.** **On-call Activities**  
1267
- 1268 **VI.E.1.** In-house call must occur no more frequently than every third night,  
1269 averaged over a four-week period.  
1270
- 1271 **VI.E.2.** Continuous on-site duty, including in-house call, must not exceed 24  
1272 consecutive hours. Residents may remain on duty for up to six  
1273 additional hours to participate in didactic activities, transfer care of  
1274 patients, conduct outpatient clinics, and maintain continuity of

1275		medical and surgical care.
1276		
1277	<b>VI.E.3.</b>	<b>No new patients may be accepted after 24 hours of continuous duty.</b>
1278		
1279	VI.E.3.a)	A new patient is defined as any patient for whom the <del>resident has not previously provided care.</del> <u>service has not previously provided care.</u>
1280		
1281		
1282		
1283	<b>VI.E.4.</b>	<b>At-home call (or pager call)</b>
1284		
1285	VI.E.4.a)	The frequency of at-home call is not subject to the every-third-night, or 24+6 limitation. However at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident.
1286		
1287		
1288		
1289		
1290	VI.E.4.b)	Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.
1291		
1292		
1293		
1294	VI.E.4.c)	When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.
1295		
1296		
1297		
1298	<b>VI.F.</b>	<b>Moonlighting</b>
1299		
1300	VI.F.1.	Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
1301		
1302		
1303	VI.F.2.	Internal moonlighting must be considered part of the 80-hour weekly limit on duty hours.
1304		
1305		
1306	VI.F.3.	<u>Moonlighting is not permitted during a colon and rectal surgery residency.</u>
1307		
1308	<b>VI.G.</b>	<b>Duty Hours Exceptions</b>
1309		
1310		<b>A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.</b>
1311		
1312		
1313	VI.G.1.	In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.
1314		
1315		
1316		
1317	VI.G.2.	Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.
1318		
1319		
1320		
1321		

1322 **VII Experimentation and Innovation**

1323

1324 **Requests for experimentation or innovative projects that may deviate from the**  
1325 **institutional, common and/or specialty specific program requirements must be**  
1326 **approved in advance by the Review Committee. In preparing requests, the**  
1327 **program director must follow Procedures for Approving Proposals for**  
1328 **Experimentation or Innovative Projects located in the ACGME Manual on Policies**  
1329 **and Procedures. Once a Review Committee approves a project, the sponsoring**  
1330 **institution and program are jointly responsible for the quality of education offered**  
1331 **to residents for the duration of such a project.**

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