ACGME Program Requirements for

Graduate Medical Education

In Anesthesiology

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Currently in Effect Program Requirements incorporated into the 2019 Common Program Requirements

Contents

ACGME Program Requirements for Graduate Medical Education in Anesthesiology

Common Program Requirements (Residency) are in BOLD

Where applicable, text in italics describes the underlying philosophy of the requirements in that section. These philosophic statements are not program requirements and are therefore not citable.

Introduction

Int.A. ***Graduate medical education is the crucial step of professional development between medical school and autonomous clinical practice. It is in this vital phase of the continuum of medical education that residents learn to provide optimal patient care under the supervision of faculty members who not only instruct, but serve as role models of excellence, compassion, professionalism, and scholarship.***

Graduate medical education transforms medical students into physician scholars who care for the patient, family, and a diverse community; create and integrate new knowledge into practice; and educate future generations of physicians to serve the public. Practice patterns established during graduate medical education persist many years later.

Graduate medical education has as a core tenet the graded authority and responsibility for patient care. The care of patients is undertaken with appropriate faculty supervision and conditional independence, allowing residents to attain the knowledge, skills, attitudes, and empathy required for autonomous practice. Graduate medical education develops physicians who focus on excellence in delivery of safe, equitable, affordable, quality care; and the health of the populations they serve. Graduate medical education values the strength that a diverse group of physicians brings to medical care.

Graduate medical education occurs in clinical settings that establish the foundation for practice-based and lifelong learning. The professional development of the physician, begun in medical school, continues through faculty modeling of the effacement of self-interest in a humanistic environment that emphasizes joy in curiosity, problem-solving, academic rigor, and discovery. This transformation is often physically, emotionally, and intellectually demanding and occurs in a variety of clinical learning environments committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.

Int.B. **Definition of Specialty**

The Review Committee representing the medical specialty of anesthesiology exists in order to foster and maintain the highest standards of education and educational facilities in anesthesiology, which the Review Committee defines as the practice of medicine dealing with the peri-operative management of patients.

This includes the peri-operative/peri-procedural management of patients during surgical and other therapeutic and diagnostic procedures. This management encompasses the pre-operative preparation of the patient and their peri-operative maintenance of normal physiology, as well as the post-operative relief and prevention of pain. An anesthesiologist is skilled in the management and diagnosis of critically-ill patients, including those experiencing cardiac arrest, and in the diagnosis and management of acute, chronic, and cancer-related pain. These goals are achieved through a thorough understanding of physiology and pharmacology, and the ability to conduct, interpret, and apply the results of medical research. Finally, the anesthesiologist is skilled in the leadership of health services delivery, prudent fiscal resource stewardship, and quality improvement, as well as the supervision, education, and evaluation of the performance of personnel, both medical and paramedical, involved in peri-operative and peri-procedural care.

Int.C. Length of Educational Program

The educational programs in anesthesiology are configured in 36-month and 48-month formats. The latter includes 12 months of education in fundamental clinical skills of medicine, and both include 36 months of education in clinical anesthesia (CA-1, CA-2, and CA-3 years). (Core)*

I. Oversight

I.A. Sponsoring Institution

The Sponsoring Institution is the organization or entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education, consistent with the ACGME Institutional Requirements.

When the Sponsoring Institution is not a rotation site for the program, the most commonly utilized site of clinical activity for the program is the primary clinical site.

Background and Intent: Participating sites will reflect the health care needs of the community and the educational needs of the residents. A wide variety of organizations may provide a robust educational experience and, thus, Sponsoring Institutions and participating sites may encompass inpatient and outpatient settings including, but not limited to a university, a medical school, a teaching hospital, a nursing home, a school of public health, a health department, a public health agency, an organized health care delivery system, a medical examiner's office, an educational consortium, a teaching health center, a physician group practice, federally qualified health center, or an educational foundation.

I.A.1. The program must be sponsored by one ACGME-accredited Sponsoring Institution. (Core)

I.B. Participating Sites

A participating site is an organization providing educational experiences or educational assignments/rotations for residents.

I.B.1. **The program, with approval of its Sponsoring Institution, must designate a primary clinical site.** (Core)

I.B.1.a) The sponsoring institution must also sponsor or be affiliated with ACGME-accredited residencies in at least the specialties of general surgery and internal medicine. (Core) [Moved from I.A.1]

I.B.2. **There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment.** (Core)

I.B.2.a) **The PLA must:**

I.B.2.a).(1) **be renewed at least every 10 years; and,** (Core)

I.B.2.a).(2) **be approved by the designated institutional official (DIO).** (Core)

I.B.3. **The program must monitor the clinical learning and working environment at all participating sites.** (Core)

I.B.3.a) **At each participating site there must be one faculty member, designated by the program director as the site director, who is accountable for resident education at that site, in collaboration with the program director.** (Core)

Background and Intent: While all residency programs must be sponsored by a single ACGME-accredited Sponsoring Institution, many programs will utilize other clinical settings to provide required or elective training experiences. At times it is appropriate to utilize community sites that are not owned by or affiliated with the Sponsoring Institution. Some of these sites may be remote for geographic, transportation, or communication issues. When utilizing such sites the program must ensure the quality of the educational experience. The requirements under I.B.3. are intended to ensure that this will be the case.

Suggested elements to be considered in PLAs will be found in the ACGME Program Director's Guide to the Common Program Requirements. These include:

- **Identifying the faculty members who will assume educational and supervisory responsibility for residents**
- **Specifying the responsibilities for teaching, supervision, and formal evaluation of residents**
- **Specifying the duration and content of the educational experience**
- **Stating the policies and procedures that will govern resident education during the assignment**

I.B.4. **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 ACGME's Accreditation Data System (ADS). (Core)

I.B.5. The majority of rotations for the anesthesiology program must occur at the sponsoring institution. (Core) [Moved from I.B.3]

I.B.5.a) Participating sites must provide rotations that the sponsoring institution is unable to provide. (Core) [Moved from I.B.3.a)]

~~I.B.5.a).(1) These sites must be identified in ADS with the educational justification and be supported through Case Log data. (Core)~~ [Moved from I.B.3.a).(1)]

I.B.5.a).(2) Residents should not be required to rotate among multiple participating sites. (Detail)† [Moved from I.B.3.a).(2)]

I.B.5.a).(3) Assignments to a participating site should not exceed six months. (Detail) [Moved from I.B.3.a).(3)]

~~I.B.5.a).(3).(a) Assignments of greater than six months to a participating site must be approved in advance by the Review Committee. (Core)~~ [Moved from I.B.3.a).(3).(a)]

I.C. The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative staff members, and other relevant members of its academic community. (Core)

Background and Intent: It is expected that the Sponsoring Institution has, and programs implement, policies and procedures related to recruitment and retention of minorities underrepresented in medicine and medical leadership in accordance with the Sponsoring Institution's mission and aims. The program's annual evaluation must include an assessment of the program's efforts to recruit and retain a diverse workforce, as noted in V.C.1.c).(5).(c).

I.D. Resources

I.D.1. The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education. (Core)

I.D.1.a) There must be adequate space and equipment for the educational program, including meeting rooms, classrooms with visual and other educational aids, study areas for residents, office space for faculty members and residents, diagnostic and therapeutic facilities, laboratory facilities, computer support, and appropriate on-call facilities for male and female residents and faculty members. (Core) [Moved from II.D.1]

I.D.2. **The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for: (Core)**

I.D.2.a) **access to food while on duty; (Core)**

I.D.2.b) **safe, quiet, clean, and private sleep/rest facilities available and accessible for residents with proximity appropriate for safe patient care; (Core)**

Background and Intent: Care of patients within a hospital or health system occurs continually through the day and night. Such care requires that residents function at their peak abilities, which requires the work environment to provide them with the ability to meet their basic needs within proximity of their clinical responsibilities. Access to food and rest are examples of these basic needs, which must be met while residents are working. Residents should have access to refrigeration where food may be stored. Food should be available when residents are required to be in the hospital overnight. Rest facilities are necessary, even when overnight call is not required, to accommodate the fatigued resident.

I.D.2.c) **clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)**

Background and Intent: Sites must provide private and clean locations where residents may lactate and store the milk within a refrigerator. These locations should be in close proximity to clinical responsibilities. It would be helpful to have additional support within these locations that may assist the resident with the continued care of patients, such as a computer and a phone. While space is important, the time required for lactation is also critical for the well-being of the resident and the resident's family, as outlined in VI.C.1.d).(1).

I.D.2.d) **security and safety measures appropriate to the participating site; and, (Core)**

I.D.2.e) **accommodations for residents with disabilities consistent with the Sponsoring Institution's policy. (Core)**

I.D.3. **Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core)**

I.D.4. **The program's educational and clinical resources must be adequate to support the number of residents appointed to the program. (Core)**

I.E. **The presence of other learners and other care providers, including, but not limited to, residents from other programs, subspecialty fellows, and advanced practice providers, must enrich the appointed residents' education. (Core)**

I.E.1. **The program must report circumstances when the presence of other learners has interfered with the residents' education to the DIO and Graduate Medical Education Committee (GMEC).** (Core)

Background and Intent: The clinical learning environment has become increasingly complex and often includes care providers, students, and post-graduate residents and fellows from multiple disciplines. The presence of these practitioners and their learners enriches the learning environment. Programs have a responsibility to monitor the learning environment to ensure that residents' education is not compromised by the presence of other providers and learners.

II. Personnel

II.A. Program Director

II.A.1. **There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements.** (Core)

II.A.1.a) **The Sponsoring Institution's GMEC must approve a change in program director.** (Core)

II.A.1.b) **Final approval of the program director resides with the Review Committee.** (Core)

Background and Intent: While the ACGME recognizes the value of input from numerous individuals in the management of a residency, a single individual must be designated as program director and made responsible for the program. This individual will have dedicated time for the leadership of the residency, and it is this individual's responsibility to communicate with the residents, faculty members, DIO, GMEC, and the ACGME. The program director's nomination is reviewed and approved by the GMEC. Final approval of program directors resides with the Review Committee.

II.A.1.c) **The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability.** (Core)

Background and Intent: The success of residency programs is generally enhanced by continuity in the program director position. The professional activities required of a program director are unique and complex and take time to master. All programs are encouraged to undertake succession planning to facilitate program stability when there is necessary turnover in the program director position.

II.A.2. **At a minimum, the program director must be provided with the salary support required to devote 20 percent FTE (at least eight hours per week) of non-clinical time to the administration of the program.** (Core)

II.A.2.a) ~~receive protected time to lead the program, including time for administrative duties, curriculum and faculty development, Milestone validation, and education research, as well as didactic and other resident education activities such as simulation.~~ ~~(Core)~~ [Moved from II.A.4.p)]

~~II.A.2.a).(1)~~ ~~Programs with one-20 residents must provide a minimum of 20 percent protected time for the program director.~~ ~~(Core)~~ ~~[Moved from II.A.4.p).(1)]~~

II.A.2.b) Programs with more than 20 residents must provide a minimum of 40 percent protected time for the program director. (Core) [Moved from II.A.4.p).(2)]

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

II.A.3.a) must include specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee; (Core)

Background and Intent: Leading a program requires knowledge and skills that are established during residency and subsequently further developed. The time period from completion of residency until assuming the role of program director allows the individual to cultivate leadership abilities while becoming professionally established. The three-year period is intended for the individual's professional maturation.

The broad allowance for educational and/or administrative experience recognizes that strong leaders arise through diverse pathways. These areas of expertise are important when identifying and appointing a program director. The choice of a program director should be informed by the mission of the program and the needs of the community.

In certain circumstances, the program and Sponsoring Institution may propose and the Review Committee may accept a candidate for program director who fulfills these goals but does not meet the three-year minimum.

II.A.3.b) must include current certification in the specialty for which they are the program director by the American Board of Anesthesiology **or by the American Osteopathic Board of** Anesthesiology**, or specialty qualifications that are acceptable to the Review Committee; (Core)**

II.A.3.c) must include current medical licensure and appropriate medical staff appointment; and, (Core)

II.A.3.d) must include ongoing clinical activity. (Core)

Background and Intent: A program director is a role model for faculty members and residents. The program director must participate in clinical activity consistent with the specialty. This activity will allow the program director to role model the Core Competencies for the faculty members and residents.

II.A.3.e) ~~faculty experience, leadership, organizational, and administrative qualifications; and,~~ (Core) [Moved from II.A.3.d)]

II.A.3.f) must demonstrated ongoing academic achievements in anesthesiology, including publications, the development of educational programs, or the conduct of research. (Core) [Moved from II.A.3.e)]

II.A.4. Program Director Responsibilities

The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care. (Core)

II.A.4.a) The program director must:

II.A.4.a).(1) be a role model of professionalism; (Core)

Background and Intent: The program director, as the leader of the program, must serve as a role model to residents in addition to fulfilling the technical aspects of the role. As residents are expected to demonstrate compassion, integrity, and respect for others, they must be able to look to the program director as an exemplar. It is of utmost importance, therefore, that the program director model outstanding professionalism, high quality patient care, educational excellence, and a scholarly approach to work. The program director creates an environment where respectful discussion is welcome, with the goal of continued improvement of the educational experience.

II.A.4.a).(2) design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program; (Core)

Background and Intent: The mission of institutions participating in graduate medical education is to improve the health of the public. Each community has health needs that vary based upon location and demographics. Programs must understand the social determinants of health of the populations they serve and incorporate them in the design and implementation of the program curriculum, with the ultimate goal of addressing these needs and health disparities.

II.A.4.a).(3) administer and maintain a learning environment conducive to educating the residents in each of the ACGME Competency domains; (Core)

Background and Intent: The program director may establish a leadership team to assist in the accomplishment of program goals. Residency programs can be highly complex. In a complex organization, the leader typically has the ability to delegate authority to others, yet remains accountable. The leadership team may include

physician and non-physician personnel with varying levels of education, training, and experience.

II.A.4.a).(4) **develop and oversee a process to evaluate candidates prior to approval as program faculty members for participation in the residency program education and at least annually thereafter, as outlined in V.B.;** (Core)

II.A.4.a).(5) **have the authority to approve program faculty members for participation in the residency program education at all sites;** (Core)

II.A.4.a).(6) **have the authority to remove program faculty members from participation in the residency program education at all sites;** (Core)

II.A.4.a).(7) **have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program;** (Core)

Background and Intent: The program director has the responsibility to ensure that all who educate residents effectively role model the Core Competencies. Working with a resident is a privilege that is earned through effective teaching and professional role modeling. This privilege may be removed by the program director when the standards of the clinical learning environment are not met.

There may be faculty in a department who are not part of the educational program, and the program director controls who is teaching the residents.

II.A.4.a).(8) **submit accurate and complete information required and requested by the DIO, GMEC, and ACGME;** (Core)

II.A.4.a).(9) **provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s);** (Core)

II.A.4.a).(10) **provide a learning and working environment in which residents have the opportunity to raise concerns and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation;** (Core)

II.A.4.a).(11) **ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process;** (Core)

II.A.4.a).(12) **ensure the program's compliance with the Sponsoring Institution's policies and procedures for due process when action is taken to suspend or dismiss, not to promote, or not to renew the appointment of a resident;** (Core)

Background and Intent: A program does not operate independently of its Sponsoring Institution. It is expected that the program director will be aware of the Sponsoring Institution's policies and procedures, and will ensure they are followed by the program's leadership, faculty members, support personnel, and residents.

II.A.4.a).(13) **ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; (Core)**

II.A.4.a).(13).(a) **Residents must not be required to sign a non-competition guarantee or restrictive covenant. (Core)**

II.A.4.a).(14) **document verification of program completion for all graduating residents within 30 days; (Core)**

II.A.4.a).(15) **provide verification of an individual resident's completion upon the resident's request, within 30 days; and, (Core)**

Background and Intent: Primary verification of graduate medical education is important to credentialing of physicians for further training and practice. Such verification must be accurate and timely. Sponsoring Institution and program policies for record retention are important to facilitate timely documentation of residents who have previously completed the program. Residents who leave the program prior to completion also require timely documentation of their summative evaluation.

II.A.4.a).(16) **obtain review and approval of the Sponsoring Institution's DIO before submitting information or requests to the ACGME, as required in the Institutional Requirements and outlined in the ACGME Program Director's Guide to the Common Program Requirements. (Core)**

II.B. Faculty

Faculty members are a foundational element of graduate medical education – faculty members teach residents how to care for patients. Faculty members provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.

Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves.

Background and Intent: "Faculty" refers to the entire teaching force responsible for educating residents. The term "faculty," including "core faculty," does not imply or require an academic appointment or salary support.

II.B.1. **At each participating site, there must be a sufficient number of faculty members with competence to instruct and supervise all residents at that location.** (Core)

II.B.1.a) The members of the faculty must have varying interests, capabilities, and backgrounds, and include individuals who have specialized expertise in the subspecialties of anesthesiology, including critical care, obstetric anesthesia, pediatric anesthesia, neuroanesthesia, cardiothoracic anesthesia, and pain medicine, and also in research. (Core) [Moved from II.B.6)]

II.B.1.b) Didactic and clinical teaching should be provided by faculty members with documented interests and expertise in the subspecialty involved. (Detail) [Moved from II.B.6.a)]

II.B.1.c) The number of faculty members must be sufficient to provide each resident with adequate supervision, which shall not vary substantially with the time of day or the day of the week. (Core) [Moved from II.B.7]

II.B.1.d) Designated faculty members must be readily and consistently available for consultation and teaching. (Core) [Moved from II.B.8]

II.B.2. **Faculty members must:**

II.B.2.a) **be role models of professionalism;** (Core)

II.B.2.b) **demonstrate commitment to the delivery of safe, quality, cost-effective, patient-centered care;** (Core)

Background and Intent: Patients have the right to expect quality, cost-effective care with patient safety at its core. The foundation for meeting this expectation is formed during residency and fellowship. Faculty members model these goals and continually strive for improvement in care and cost, embracing a commitment to the patient and the community they serve.

II.B.2.c) **demonstrate a strong interest in the education of residents;** (Core)

II.B.2.d) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; (Core)

II.B.2.e) administer and maintain an educational environment conducive to educating residents; (Core)

II.B.2.f) regularly participate in organized clinical discussions, rounds, journal clubs, and conferences; and, (Core)

II.B.2.g) pursue faculty development designed to enhance their skills at least annually: (Core)

Background and Intent: Faculty development is intended to describe structured programming developed for the purpose of enhancing transference of knowledge, skill, and behavior from the educator to the learner. Faculty development may occur in a variety of configurations (lecture, workshop, etc.) using internal and/or external resources. Programming is typically needs-based (individual or group) and may be specific to the institution or the program. Faculty development programming is to be reported for the residency program faculty in the aggregate.

II.B.2.g).(1) as educators; (Core)

II.B.2.g).(2) in quality improvement and patient safety; (Core)

II.B.2.g).(3) in fostering their own and their residents' well-being; and, (Core)

II.B.2.g).(4) in patient care based on their practice-based learning and improvement efforts. (Core)

Background and Intent: Practice-based learning serves as the foundation for the practice of medicine. Through a systematic analysis of one's practice and review of the literature, one is able to make adjustments that improve patient outcomes and care. Thoughtful consideration to practice-based analysis improves quality of care, as well as patient safety. This allows faculty members to serve as role models for residents in practice-based learning.

II.B.3. Faculty Qualifications

II.B.3.a) Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)

II.B.3.b) Physician faculty members must:

II.B.3.b).(1) have current certification in the specialty by the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology, or possess qualifications judged acceptable to the Review Committee. (Core)

II.B.3.c) **Any non-physician faculty members who participate in residency program education must be approved by the program director.** (Core)

Background and Intent: The provision of optimal and safe patient care requires a team approach. The education of residents by non-physician educators enables the resident to better manage patient care and provides valuable advancement of the residents' knowledge. Furthermore, other individuals contribute to the education of the resident in the basic science of the specialty or in research methodology. If the program director determines that the contribution of a non-physician individual is significant to the education of the residents, the program director may designate the individual as a program faculty member or a program core faculty member.

II.B.4. **Core Faculty**

Core faculty members must have a significant role in the education and supervision of residents and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents. (Core)

Background and Intent: Core faculty members are critical to the success of resident education. They support the program leadership in developing, implementing, and assessing curriculum and in assessing residents' progress toward achievement of competence in the specialty. Core faculty members should be selected for their broad knowledge of and involvement in the program, permitting them to effectively evaluate the program, including completion of the annual ACGME Faculty Survey.

II.B.4.a) **Core faculty members must be designated by the program director.** (Core)

II.B.4.b) **Core faculty members must complete the annual ACGME Faculty Survey.** (Core)

[The Review Committee must specify the minimum number of core faculty and/or the core faculty-resident ratio]

[The Review Committee's specification will be included in the upcoming focused revision to the Anesthesiology Program Requirements]

II.C. **Program Coordinator**

II.C.1. **There must be a program coordinator.** (Core)

II.C.2. **At a minimum, the program coordinator must be supported at 50 percent FTE (at least 20 hours per week) for administrative time.** (Core)

Background and Intent: Each program requires a lead administrative person, frequently referred to as a program coordinator, administrator, or as titled by the institution. This person will frequently manage the day-to-day operations of the

program and serve as an important liaison with learners, faculty and other staff members, and the ACGME. Individuals serving in this role are recognized as program coordinators by the ACGME.

The program coordinator is a member of the leadership team and is critical to the success of the program. As such, the program coordinator must possess skills in leadership and personnel management. Program coordinators are expected to develop unique knowledge of the ACGME and Program Requirements, policies, and procedures. Program coordinators assist the program director in accreditation efforts, educational programming, and support of residents.

Programs, in partnership with their Sponsoring Institutions, should encourage the professional development of their program coordinators and avail them of opportunities for both professional and personal growth. Programs with fewer residents may not require a full-time coordinator; one coordinator may support more than one program.

II.D. Other Program Personnel

The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective administration of the program. (Core)

Background and Intent: Multiple personnel may be required to effectively administer a program. These may include staff members with clerical skills, project managers, education experts, and staff members to maintain electronic communication for the program. These personnel may support more than one program in more than one discipline.

III. Resident Appointments

III.A. Eligibility Requirements

III.A.1. An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program: (Core)

III.A.1.a) graduation from a medical school in the United States or Canada, accredited by the Liaison Committee on Medical Education (LCME) or graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA); or, (Core)

III.A.1.b) graduation from a medical school outside of the United States or Canada, and meeting one of the following additional qualifications: (Core)

III.A.1.b).(1) holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core)

III.A.1.b).(2) **holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located.** (Core)

III.A.2. **All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, AOA-approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada, or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation.** (Core)

III.A.2.a) **Residency programs must receive verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation.** (Core)

III.A.2.a).(1) Residents entering a 36-month anesthesiology program that does not include education in fundamental clinical skills of medicine must have successfully completed 12 months of education in fundamental clinical skills of medicine in a program that satisfies the requirements in III.A.2. ~~is ACGME-accredited or RCPSC-accredited located in Canada.~~ (Core) [Moved from III.A.1.a).(1)]

III.A.2.a).(1).(a) If such residents have also been accepted into an anesthesiology program, then in order to be accepted into the CA-1 year, they must demonstrate satisfactory abilities on quarterly written performance evaluations prior to starting their education in fundamental clinical skills of medicine. (Core) [Moved from III.A.1.a).(1).(a)]

III.A.2.a).(1).(b) When a resident completes education in fundamental clinical skills of medicine in another accredited program, the anesthesiology program director must ensure that he/she receives the resident's quarterly written performance evaluations. (Core) [Moved from II.A.4.q).(2)]

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Background and Intent: Programs with ACGME-I Foundational Accreditation or from institutions with ACGME-I accreditation do not qualify unless the program has also achieved ACGME-I Advanced Specialty Accreditation. To ensure entrants into ACGME-accredited programs from ACGME-I programs have attained the prerequisite milestones for this training, they must be from programs that have ACGME-I Advanced Specialty Accreditation.

III.A.3. **A physician who has completed a residency program that was not accredited by ACGME, AOA, RCPSC, CFPC, or ACGME-I (with Advanced Specialty Accreditation) may enter an ACGME-accredited**

residency program in the same specialty at the PGY-1 level and, at the discretion of the program director of the ACGME-accredited program and with approval by the GMEC, may be advanced to the PGY-2 level based on ACGME Milestones evaluations at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry. (Core)

III.B. **The program director must not appoint more residents than approved by the Review Committee.** (Core)

III.B.1. **All complement increases must be approved by the Review Committee.** (Core)

III.B.2. There must be a minimum of nine residents with, on average, three appointed in each of the CA-1, CA-2, and CA-3 years. (Core) [Moved from III.B.2]

III.B.3. ~~Any proposed increase in the number of residents must receive prior approval from the Review Committee.~~ (Core) [Moved from III.B.3]

III.C. **Resident Transfers**

The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring resident, and Milestones evaluations upon matriculation. (Core)

IV. Educational Program

The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.

The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.

In addition, the program is expected to define its specific program aims consistent with the overall mission of its Sponsoring Institution, the needs of the community it serves and that its graduates will serve, and the distinctive capabilities of physicians it intends to graduate. While programs must demonstrate substantial compliance with the Common and specialty-specific Program Requirements, it is recognized that within this framework, programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-specific goals for it and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from one focusing on community health.

IV.A. **The curriculum must contain the following educational components:** (Core)

IV.A.1. **a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates; (Core)**

IV.A.1.a) **The program's aims must be made available to program applicants, residents, and faculty members. (Core)**

IV.A.2. **competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice. These must be distributed, reviewed, and available to residents and faculty members; (Core)**

Background and Intent: The trajectory to autonomous practice is documented by Milestones evaluation. The Milestones detail the progress of a resident in attaining skill in each competency domain. They are developed by each specialty group and allow evaluation based on observable behaviors. Milestones are considered formative and should be used to identify learning needs. This may lead to focused or general curricular revision in any given program or to individualized learning plans for any specific resident.

IV.A.3. **delineation of resident responsibilities for patient care, progressive responsibility for patient management, and graded supervision; (Core)**

Background and Intent: These responsibilities may generally be described by PGY level and specifically by Milestones progress as determined by the Clinical Competency Committee. This approach encourages the transition to competency-based education. An advanced learner may be granted more responsibility independent of PGY level and a learner needing more time to accomplish a certain task may do so in a focused rather than global manner.

IV.A.4. **a broad range of structured didactic activities; (Core)**

IV.A.4.a) **Residents must be provided with protected time to participate in core didactic activities. (Core)**

Background and Intent: It is intended that residents will participate in structured didactic activities. It is recognized that there may be circumstances in which this is not possible. Programs should define core didactic activities for which time is protected and the circumstances in which residents may be excused from these didactic activities. Didactic activities may include, but are not limited to, lectures, conferences, courses, labs, asynchronous learning, simulations, drills, case discussions, grand rounds, didactic teaching, and education in critical appraisal of medical evidence.

IV.A.5. **advancement of residents' knowledge of ethical principles foundational to medical professionalism; and, (Core)**

IV.A.6. **advancement in the residents' knowledge of the basic principles of scientific inquiry, including how research is designed, conducted, evaluated, explained to patients, and applied to patient care. (Core)**

IV.B. ACGME Competencies

Background and Intent: The Competencies provide a conceptual framework describing the required domains for a trusted physician to enter autonomous practice. These Competencies are core to the practice of all physicians, although the specifics are further defined by each specialty. The developmental trajectories in each of the Competencies are articulated through the Milestones for each specialty.

IV.B.1. The program must integrate the following ACGME Competencies into the curriculum: (Core)

IV.B.1.a) Professionalism

Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)

IV.B.1.a).(1) Residents must demonstrate competence in:

IV.B.1.a).(1).(a) compassion, integrity, and respect for others; (Core)

IV.B.1.a).(1).(b) responsiveness to patient needs that supersedes self-interest; (Core)

Background and Intent: This includes the recognition that under certain circumstances, the interests of the patient may be best served by transitioning care to another provider. Examples include fatigue, conflict or duality of interest, not connecting well with a patient, or when another physician would be better for the situation based on skill set or knowledge base.

IV.B.1.a).(1).(c) respect for patient privacy and autonomy; (Core)

IV.B.1.a).(1).(d) accountability to patients, society, and the profession; (Core)

IV.B.1.a).(1).(e) respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation; (Core)

IV.B.1.a).(1).(f) ability to recognize and develop a plan for one's own personal and professional well-being; and, (Core)

IV.B.1.a).(1).(g) appropriately disclosing and addressing conflict or duality of interest. (Core)

IV.B.1.b) Patient Care and Procedural Skills

Background and Intent: Quality patient care is safe, effective, timely, efficient, patient-centered, equitable, and designed to improve population health, while reducing per capita costs. (See the Institute of Medicine [IOM]'s *Crossing the Quality Chasm: A New Health System for the 21st Century*, 2001 and Berwick D, Nolan T, Whittington J. *The Triple Aim: care, cost, and quality. Health Affairs.* 2008; 27(3):759-769.). In addition, there should be a focus on improving the clinician's well-being as a means to improve patient care and reduce burnout among residents, fellows, and practicing physicians.

These organizing principles inform the Common Program Requirements across all Competency domains. Specific content is determined by the Review Committees with input from the appropriate professional societies, certifying boards, and the community.

IV.B.1.b).(1) **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.** **(Core)**

IV.B.1.b).(1).(a) Residents must demonstrate competence in fundamental clinical skills of medicine, including: [Moved from IV.A.5.a).(1).(a)]

IV.B.1.b).(1).(a).(i) obtaining a comprehensive medical history; ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(1).(a).(i)]

IV.B.1.b).(1).(a).(ii) performing a comprehensive physical examination; ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(1).(a).(ii)]

IV.B.1.b).(1).(a).(iii) assessing a patient's medical conditions; ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(1).(a).(iii)]

IV.B.1.b).(1).(a).(iv) making appropriate use of diagnostic studies and tests; ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(1).(a).(iv)]

IV.B.1.b).(1).(a).(v) integrating information to develop a differential diagnosis; and, ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(1).(a).(v)]

IV.B.1.b).(1).(a).(vi) implementing a treatment plan. ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(1).(a).(vi)]

IV.B.1.b).(1).(b) Residents must demonstrate competence in anesthetic management, including care for: [Moved from IV.A.5.a).(1).(b)]

IV.B.1.b).(1).(b).(i) patients younger than 12 years of age undergoing surgery or other procedures

requiring anesthetics; ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(1).(b).(i)]

IV.B.1.b).(1).(b).(i).(a) This experience must involve care for 100 patients younger than 12 years of age. (Core) [Moved from IV.A.5.a).(1).(b).(i).(a)]

IV.B.1.b).(1).(b).(i).(b) Within this patient group, 20 children must be younger than three years of age, including five younger than three months of age. (Core) [Moved from IV.A.5.a).(1).(b).(i).(b)]

IV.B.1.b).(1).(b).(ii) patients who are evaluated for management of acute, chronic, or cancer-related pain disorders; ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(1).(b).(ii)]

IV.B.1.b).(1).(b).(ii).(a) This experience must involve care for 20 patients presenting for initial evaluation of pain. (Core) [Moved from IV.A.5.A).(1).(b).(ii).(a)]

IV.B.1.b).(1).(b).(ii).(b) Residents must be familiar with the breadth of pain management, including clinical experience with interventional pain procedures. ~~(Outcome)~~(Core) [Moved from IV.A.5.A).(1).(b).(ii).(b)]

IV.B.1.b).(1).(b).(iii) patients scheduled for evaluation prior to elective surgical procedures; ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(1).(b).(iii)]

IV.B.1.b).(1).(b).(iv) patients immediately after anesthesia, including direct care of patients in the post-anesthesia-care unit, and responsibilities for management of pain, hemodynamic changes, and emergencies related to the post-anesthesia care unit; and, ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(1).(b).(iv)

IV.B.1.b).(1).(b).(v) critically-ill patients. ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(1).(b).(v)]

IV.B.1.b).(1).(c) Residents must achieve competence in the delivery of anesthetic care to: [Moved from IV.A.5.a).(2)]

IV.B.1.b).(1).(c).(i) patients undergoing vaginal delivery; ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(2).(a)]

IV.B.1.b).(1).(c).(i).(a) This experience must involve care for 40 patients. (Core) [Moved from IV.A.5.a).(2).(a).(i)]

IV.B.1.b).(1).(c).(ii) patients undergoing cesarean sections; ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(2).(b)]

IV.B.1.b).(1).(c).(ii).(a) This experience must involve care for 20 patients. (Core) [Moved from IV.A.5.a).(2).(b).(i)]

IV.B.1.b).(1).(c).(iii) patients undergoing cardiac surgery; ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(2).(c)]

IV.B.1.b).(1).(c).(iii).(a) This experience must involve care for 20 patients. (Core) [Moved from IV.A.5.a).(2).(c).(i)]

IV.B.1.b).(1).(c).(iii).(b) The care provided to 10 of these patients must involve the use of cardiopulmonary bypass. (Core) [Moved from IV.A.5.a).(2).(c).(i).(a)]

IV.B.1.b).(1).(c).(iv) patients undergoing open or endovascular procedures on major vessels, including carotid surgery, intrathoracic vascular surgery, intra-abdominal vascular surgery, or peripheral vascular surgery; ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(2).(d)]

IV.B.1.b).(1).(c).(iv).(a) This experience must involve care for 20 patients, not including surgery for vascular access or repair of vascular access. (Core) [Moved from IV.A.5.a).(2).(d).(i)]

IV.B.1.b).(1).(c).(v) patients undergoing non-cardiac intrathoracic surgery, including pulmonary surgery and surgery of the great vessels, esophagus, and the mediastinum and its structures; ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(2).(e)]

IV.B.1.b).(1).(c).(v).(a) This experience must involve care for 20 patients. (Core) [Moved from IV.A.5.a).(2).(e).(i)]

IV.B.1.b).(1).(c).(vi) patients undergoing intracerebral procedures, including those undergoing

intracerebral endovascular procedures; ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(2).(f)]

IV.B.1.b).(1).(c).(vi).(a) This experience must involve care for 20 patients, the majority of which must involve an open cranium. (Core) [Moved from IV.A.5.a).(2).(f).(i)]

IV.B.1.b).(1).(c).(vii) patients for whom epidural anesthetics are used as part of the anesthetic technique or epidural catheters are placed for peri-operative analgesia; ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(2).(g)]

IV.B.1.b).(1).(c).(vii).(a) This experience must involve care for 40 patients. (Core) [Moved from IV.A.5.a).(2).(g).(i)]

IV.B.1.b).(1).(c).(viii) patients undergoing procedures for complex, immediate life-threatening pathology; ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(2).(h)]

IV.B.1.b).(1).(c).(viii).(a) This experience must involve care for 20 patients. (Core) [Moved from IV.A.5.a).(2).(h).(i)]

IV.B.1.b).(1).(c).(ix) patients undergoing surgical procedures, including cesarean sections, with spinal anesthetics; ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(2).(i)]

IV.B.1.b).(1).(c).(ix).(a) This experience must involve care for 40 patients. (Core) [Moved from IV.A.5.a).(2).(i).(i)]

IV.B.1.b).(1).(c).(x) patients undergoing surgical procedures in whom peripheral nerve blocks are used as part of the anesthetic technique or peri-operative analgesic management; ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(2).(j)]

IV.B.1.b).(1).(c).(x).(a) This experience must involve care for 40 patients. (Core) [Moved from IV.A.5.a).(2).(j).(i)]

IV.B.1.b).(1).(c).(xi) patients with acute post-operative pain, including those with patient-controlled intravenous techniques, neuraxial blockade, and other pain-control modalities; ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(2).(k)]

IV.B.1.b).(1).(c).(xii)	patients whose peri-operative care requires specialized techniques, including: ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(2).(l)]
IV.B.1.b).(1).(c).(xiii)	a broad spectrum of airway management techniques, to include laryngeal masks, fiberoptic intubation, and lung isolation techniques, such as double lumen endotracheal tube placement and endobronchial blockers; ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(2).(l).(i)]
IV.B.1.b).(1).(c).(xiv)	central vein and pulmonary artery catheter placement, and the use of transesophageal echocardiography and evoked potentials; and, ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(2).(l).(ii)]
IV.B.1.b).(1).(c).(xv)	use of electroencephalography (EEG) or processed EEG monitoring as part of the procedure, or adequate didactic instruction to ensure familiarity with EEG use and interpretation. ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(2).(l).(iii)]
IV.B.1.b).(1).(c).(xvi)	patients undergoing a variety of diagnostic or therapeutic procedures outside the surgical suite. ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(2).(m)]
IV.B.1.b).(1).(c).(xvi).(a)	This must include competency in: [Moved from IV.A.5.a).(2).(m)]using surface ultrasound and transesophageal and transthoracic echocardiography to guide the performance of invasive procedures and to evaluate organ function and pathology as related to anesthesia, critical care, and resuscitation; ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(2).(m).(i)]
IV.B.1.b).(1).(c).(xvii)	understanding the principles of ultrasound, including the physics of ultrasound transmission, ultrasound transducer construction, and transducer selection for specific applications, to include being able to obtain images with an understanding of limitations and artifacts; ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(2).(m).(ii)]

IV.B.1.b).(1).(c).(xviii) obtaining standard views of the heart and inferior vena cava with transthoracic echocardiography allowing the evaluation of myocardial function, estimation of central venous pressure, and gross pericardial/cardiac pathology (e.g., large pericardial effusion); ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(2).(m).(iii)]

IV.B.1.b).(1).(c).(xix) obtaining standard views of the heart with transesophageal echocardiography allowing the evaluation of mycardial function and gross pericardial/cardiac pathology (e.g., large pericardial effusion); ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(2).(m).(iv)]

IV.B.1.b).(1).(c).(xx) using transthoracic ultrasound for the detection of pneumothorax and pleural effusion; ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(2).(m).(v)]

IV.B.1.b).(1).(c).(xxi) using surface ultrasound to guide vascular access (both central and peripheral) and to guide regional anesthesia procedures; and, ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(2).(m).(vi)]

IV.B.1.b).(1).(c).(xxii) describing techniques, views, and findings in standard language. ~~(Outcome)~~(Core) [Moved from IV.A.5.a).(2).(m).(vii)]

IV.B.1.b).(2) **Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)**

IV.B.1.c) **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. (Core)

IV.B.1.c).(1) Residents must demonstrate appropriate medical knowledge in the topics related to the anesthetic care of patients, including: [Moved from IV.A.5.b).(1)]

IV.B.1.c).(1).(a) practice management to address issues such as: ~~(Outcome)~~(Core) [Moved from IV.A.5.b).(1).(a)]

IV.B.1.c).(1).(a).(i) operating room management; ~~(Outcome)~~(Core) [Moved from IV.A.5.b).(1).(a).(i)]

IV.B.1.c).(1).(a).(ii) evaluation of types of practice; ~~(Outcome)~~(Core) [Moved from IV.A.5.b).(1).(a).(ii)]

IV.B.1.c).(1).(a).(iii) contract negotiations; ~~(Outcome)~~(Core) [Moved from IV.A.5.b).(1).(a).(iii)]

IV.B.1.c).(1).(a).(iv) billing arrangements; ~~(Outcome)~~(Core) [Moved from IV.A.5.b).(1).(a).(iv)]

IV.B.1.c).(1).(a).(v) professional liability; ~~(Outcome)~~(Core) [Moved from IV.A.5.b).(1).(a).(v)]

IV.B.1.c).(1).(a).(vi) health care finance, legislative, and regulatory issues; and, ~~(Outcome)~~(Core) [Moved from IV.A.5.b).(1).(a).(vi)]

IV.B.1.c).(1).(a).(vii) fiscal stewardship of health services delivery. ~~(Outcome)~~(Core) [Moved from IV.A.5.b).(1).(a).(vii)]

IV.B.1.c).(1).(b) management skills, to include basic knowledge of organizational culture, decision making, change management, conflict resolution, and negotiation and advocacy; ~~(Outcome)~~(Core) [Moved from IV.A.5.b).(1).(b)]

IV.B.1.c).(1).(c) care of the patient in the continuum of the peri-operative period, to include collaboration with medical and surgical colleagues to: [Moved from IV.A.5.b).(1).(c)]

IV.B.1.c).(1).(c).(i) optimize preoperative patient condition; and, ~~(Outcome)~~(Core) [Moved from IV.A.5.b).(1).(c).(i)]

IV.B.1.c).(1).(c).(ii) optimize recovery; ~~(Outcome)~~(Core) [Moved from IV.A.5.b).(1).(c).(ii)]

IV.B.1.c).(1).(d) management of the specific needs of patients undergoing diagnostic or therapeutic procedures outside of the surgical suite. ~~(Outcome)~~(Core) [Moved from IV.A.5.b).(1).(d)]

IV.B.1.d) Practice-based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning. (Core)

Background and Intent: Practice-based learning and improvement is one of the defining characteristics of being a physician. It is the ability to investigate and evaluate the care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning.

The intention of this Competency is to help a physician develop the habits of mind required to continuously pursue quality improvement, well past the completion of residency.

IV.B.1.d).(1) **Residents must demonstrate competence in:**

IV.B.1.d).(1).(a) **identifying strengths, deficiencies, and limits in one's knowledge and expertise; (Core)**

IV.B.1.d).(1).(b) **setting learning and improvement goals; (Core)**

IV.B.1.d).(1).(c) **identifying and performing appropriate learning activities; (Core)**

IV.B.1.d).(1).(d) **systematically analyzing practice using quality improvement methods, and implementing changes with the goal of practice improvement; (Core)**

IV.B.1.d).(1).(e) **incorporating feedback and formative evaluation into daily practice; (Core)**

IV.B.1.d).(1).(f) **locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems; and, (Core)**

IV.B.1.d).(1).(g) **using information technology to optimize learning. (Core)**

IV.B.1.e) **Interpersonal and Communication Skills**

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Core)

IV.B.1.e).(1) **Residents must demonstrate competence in:**

IV.B.1.e).(1).(a) **communicating effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; (Core)**

IV.B.1.e).(1).(b) **communicating effectively with physicians, other health professionals, and health-related agencies; (Core)**

IV.B.1.e).(1).(c) **working effectively as a member or leader of a health care team or other professional group; (Core)**

IV.B.1.e).(1).(d) **educating patients, families, students, residents, and other health professionals; (Core)**

IV.B.1.e).(1).(e) **acting in a consultative role to other physicians and health professionals; and, (Core)**

IV.B.1.e).(1).(f) **maintaining comprehensive, timely, and legible medical records, if applicable. (Core)**

IV.B.1.e).(1).(g) maintain<u>ing</u> a comprehensive anesthesia record for each patient, including evidence of pre- and post-operative anesthesia assessment, the drugs administered, the monitoring employed, the techniques used, the physiologic variations observed, the therapy provided, and the fluids administered; and, ~~(Outcome)~~<u>(Core)</u> [Moved from IV.A.5.d).(6)]

IV.B.1.e).(1).(h) <u>creating</u> ~~create~~ and sustain<u>ing</u> a therapeutic relationship with patients, <u>engaging</u> ~~engage~~ in active listening, <u>providing</u> ~~provide~~ information using appropriate language, ask<u>ing</u> clear questions, <u>and providing</u> ~~provide~~ an opportunity for comments and questions. ~~(Outcome)~~<u>(Core)</u> [Moved from IV.A.5.d).(7)]

IV.B.1.e).(2) **Residents must learn to communicate with patients and families to partner with them to assess their care goals, including, when appropriate, end-of-life goals. (Core)**

Background and Intent: When there are no more medications or interventions that can achieve a patient's goals or provide meaningful improvements in quality or length of life, a discussion about the patient's goals, values, and choices surrounding the end of life is one of the most important conversations that can occur. Residents must learn to participate effectively and compassionately in these meaningful human interactions, for the sake of their patients and themselves.

Programs may teach this skill through direct clinical experience, simulation, or other means of active learning.

IV.B.1.f) **Systems-based Practice**

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)

IV.B.1.f).(1) **Residents must demonstrate competence in:**

IV.B.1.f).(1).(a) **working effectively in various health care delivery settings and systems relevant to their clinical specialty;** (Core)

Background and Intent: Medical practice occurs in the context of an increasingly complex clinical care environment where optimal patient care requires attention to compliance with external and internal administrative and regulatory requirements.

IV.B.1.f).(1).(b) **coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty;** (Core)

Background and Intent: Every patient deserves to be treated as a whole person. Therefore it is recognized that any one component of the health care system does not meet the totality of the patient's needs. An appropriate transition plan requires coordination and forethought by an interdisciplinary team. The patient benefits from proper care and the system benefits from proper use of resources.

IV.B.1.f).(1).(c) **advocating for quality patient care and optimal patient care systems;** (Core)

IV.B.1.f).(1).(d) **working in interprofessional teams to enhance patient safety and improve patient care quality;** (Core)

IV.B.1.f).(1).(e) **participating in identifying system errors and implementing potential systems solutions;** (Core)

IV.B.1.f).(1).(f) **incorporating considerations of value, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate; and,** (Core)

IV.B.1.f).(1).(g) **understanding health care finances and its impact on individual patients' health decisions.** (Core)

IV.B.1.f).(2) **Residents must learn to advocate for patients within the health care system to achieve the patient's and family's care goals, including, when appropriate, end-of-life goals.** (Core)

IV.C. Curriculum Organization and Resident Experiences

IV.C.1. **The curriculum must be structured to optimize resident educational experiences, the length of these experiences, and supervisory continuity.** (Core)

[The Review Committee must further specify]

[The Review Committee's specification will be included in the upcoming focused revision to the Anesthesiology Program Requirements]

Background and Intent: In some specialties, frequent rotational transitions, inadequate continuity of faculty member supervision, and dispersed patient locations within the hospital have adversely affected optimal resident education and effective team-based care. The need for patient care continuity varies from specialty to specialty and by clinical situation, and may be addressed by the individual Review Committee.

IV.C.2. **The program must provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of addiction.** (Core)

IV.C.2.a) ~~ensure that the~~ The program must have ~~has~~ a written policy and an educational program regarding substance abuse as it relates to physician well-being that specifically addresses the needs of anesthesiology; (Core) [Moved from II.A.4.s)]

IV.C.3. 12 months of the resident's educational program must provide broad education in fundamental clinical skills of medicine relevant to the practice of anesthesiology. (Core) [Moved from IV.A.6.a)]

IV.C.3.a) Fundamental clinical skills of medicine education completed as part of an anesthesiology residency need not be contiguous, but must be completed before starting the final year of the program. (Core) [Moved from IV.A.6.a).(1)]

IV.C.3.b) At least six months of fundamental clinical skills of medicine education must include experience in caring for inpatients in family medicine, internal medicine, neurology, obstetrics and gynecology, pediatrics, surgery or any of the surgical specialties, or any combination of these. (Core) [Moved from IV.A.6.a).(2)]

IV.C.3.c) The program director must maintain oversight of resident education in fundamental clinical skills of medicine; (Core) [Moved from II.A.4.q)]

IV.C.4. During the first 12 months of the program, there must be at least one month, but not more than two month(s) each of critical care and emergency medicine. (Core) [Moved from IV.A.6.b)]

IV.C.5. Thirty-six months of education must be in peri-operative medicine. (Core) [Moved from IV.A.6.c)]

IV.C.5.a) This must include experience with a wide spectrum of disease processes and surgical procedures available within the CA-1 through CA-3 years to provide each resident with broad exposure to different types of anesthetic management. (Core) [Moved from IV.A.6.c).(1)]

IV.C.5.b) The program must ensure that the rotations for residents beginning the peri-operative medicine component of the residency be in surgical anesthesia, critical care medicine, and pain medicine. (Core) [Moved from IV.A.6.c).(2)]

IV.C.5.c) Residents must receive training in the complex technology and equipment associated with the practice of anesthesiology. (Core) [Moved from IV.A.6.c).(3)]

IV.C.5.d) Clinical experience in surgical anesthesia, pain medicine, and critical care medicine must be distributed throughout the curriculum in order to provide progressive responsibility in the later stages of the program. (Core) [Moved from IV.A.6.c).(4)]

IV.C.6. Residents must have a rotation of at least two weeks in pre-operative medicine. (Core) [Moved from IV.A.6.d)]

IV.C.7. Residents must have a rotation of at least two weeks in post-anesthesia care. (Core) [Moved from IV.A.6.e)]

IV.C.7.a) Resident clinical responsibilities in the post-operative care unit must be limited to the care of post-operative patients, with the exception of providing emergency response capability for cardiac arrests and rapid response situations within the facility. (Core) [Moved from IV.A.6.e).(1)]

IV.C.8. Resident education must include a minimum of four months of critical care medicine, (Core) [Moved from IV.A.6.f)]

IV.C.8.a) No more than two months of this experience should occur prior to the CA-1 year. (Core) [Moved from IV.A.6.f).(1)]

IV.C.8.b) Each critical care medicine rotation must be at least one month in duration, with progressive patient care responsibility in advanced rotations. (Core) [Moved from IV.A.6.f).(2)]

IV.C.8.c) Training must take place in units, providing care for both men and women, in which the majority of patients have multisystem disease. (Core) [Moved from IV.A.6.f).(3)]

IV.C.8.d) Residents must actively participate in all patient care activities as fully integrated members of the critical care team. (Core) [Moved from IV.A.6.f).(4)]

IV.C.8.e) During at least two of the required four months of critical care medicine, faculty anesthesiologists experienced in the practice and teaching of critical care must be actively involved in the care of the critically-ill patients seen by residents, and in the educational activities of the residents. (Core) [Moved from IV.A.6.f).(5)]

IV.C.9. Resident education must include a minimum of two one-month rotations each in obstetric anesthesia, pediatric anesthesia, neuroanesthesia, and cardiothoracic anesthesia. (Core) [Moved from IV.A.6.g)]

IV.C.9.a) Additional subspecialty and research rotations are encouraged, but resident rotations in a single anesthesia subspecialty must not exceed six months. (Detail) [Moved from IV.A.6.g).(1)]

IV.C.9.b) Advanced subspecialty rotations must not compromise the learning opportunities for residents participating in their initial subspecialty rotations. (Core) [Moved from IV.A.6.g).(2)]

IV.C.10. Resident education must include a minimum of three months in pain medicine, including: (Core) [Moved from IV.A.6.h)]

IV.C.10.a) one month in an acute peri-operative pain management rotation; (Core) [Moved from IV.A.6.h).(1)]

IV.C.10.b) one month in a rotation for the assessment and treatment of inpatients and outpatients with chronic pain; and, (Core) [Moved from IV.A.6.h).(2)]

IV.C.10.c) one month of a regional analgesia experience rotation. (Core) [Moved from IV.A.6.h).(3)]

IV.C.11. Residents must have at least two weeks of experience managing the anesthetic care of patients undergoing diagnostic or therapeutic procedures outside of the surgical suite. (Core) [Moved from IV.A.6.i)]

IV.C.12. In the clinical anesthesia setting, faculty members must not direct anesthesia at more than two anesthetizing locations simultaneously when supervising residents. (Core) [Moved from IV.A.6.j)]

IV.C.12.a) Clinical instruction of residents by non-physician personnel should be limited to not more than 10 percent of total instruction, and should use such personnel only when access to their specific expertise will enhance the educational experience of residents. (Detail) [Moved from IV.A.6.j).(1)]

IV.C.13. All residents must obtain advanced cardiac life support (ACLS) certification at least once during the program. (Core) [Moved from IV.A.6.k)]

IV.C.14. Residents must participate in at least one simulated clinical experience each year. (Core) [Moved from IV.A.6.l)]

IV.C.15. The program director must ensure regular review of the residents' clinical experience logs and verify their accuracy and completeness when they are transmitted to the Review Committee. (Core) [Moved from II.A.4.r)]

IV.C.15.a) The program director must ensure that experience logs are submitted annually to the Review Committee in accordance with the format and the due date specified by the Committee. (Core) [Moved from II.A.4.r).(1)]

IV.C.16. The program director must determine sequencing of rotations; (Detail) [Moved from II.A.4.t)]

IV.C.17. The program director must monitor the appropriate distribution of cases among the residents; and, (Core) [Moved from II.A.4.u)]

IV.C.18. The program director must ensure that service commitments do not compromise the achievement of educational goals and objectives. (Core) [Moved from II.A.4.v)]

IV.C.19. The curriculum must contain didactic instruction through a variety of learning opportunities occurring in conference, in the clinical setting or online that encompasses clinical anesthesiology and related areas of basic science. (Core) [Moved from IV.A.3.a)]

IV.C.20. Other topics from internal medicine that are important for the pre-operative preparation of the patient, from surgery as to the nature of the surgical procedure affecting anesthetic care, and from obstetrics that impacts anesthetic management of the patient, should be included. (Core) [Moved from IV.A.3.b)]

IV.C.20.a) The material covered in the didactic program must demonstrate appropriate continuity and sequencing to ensure that residents are ultimately exposed to all subjects at regularly held learning exercises. (Core) [Moved from IV.A.3.b).(1)]

IV.C.20.a).(1) There should be evidence of regular faculty member participation in didactic sessions. (Detail) [Moved from IV.A.3.b).(2)]

IV.C.20.a).(2) The program director and faculty members from other disciplines and other institutions should conduct these sessions. (Detail) [Moved from IV.A.3.b).(3)]

IV.C.21. When 12 months of education in fundamental clinical skills of medicine is approved as part of the accredited program, the program director must maintain oversight for all rotations, and must approve the rotations for individual residents. (Core) [Moved from II.A.4.q).(1)]

IV.C.22. The program director must review written resident performance evaluations from each clinical service on which each resident rotates on a quarterly basis. (Core) [Moved from II.A.4.q).(1).(a)]

IV.C.23. The education must culminate in sufficiently independent responsibility for clinical decision-making and patient care, so that the graduating resident exhibits sound clinical judgment in a wide variety of clinical situations and can function as a leader of peri-operative care teams. (Core) [Moved from IV.A.1.a)]

IV.C.24. As the resident advances through the program, goals and objectives must reflect the opportunity to learn to plan and administer anesthesia care for patients with more severe and complicated diseases, as well as for patients who undergo more complex surgical procedures. (Core) [Moved from IV.A.2.a)]

IV.C.25. International rotations should be limited to the final year of training and should be limited to three months or less. (Detail) [Moved from I.B.3.a).(4)]

IV.C.25.a) International rotations must be approved by the Review Committee through a written request submitted by the program director. (Detail) [Moved from I.B.3.a).(4).(a)]

IV.C.25.b) ~~There should be a signed agreement between the program and the international site or organization which addresses educational resources; responsibilities for expenses for the rotation, including travel and living expenses; and the plan for monitoring ACGME duty hour requirements.~~ ~~(Detail)~~ [Moved from I.B.3.a).(4).(b)]

IV.C.25.c) ~~The program director should reapply for approval of the international rotation if there is a change in educational resources; responsibilities for expenses for the rotation, including travel and living expenses; or the plan for monitoring ACGME duty hour requirements.~~ ~~(Detail)~~ [Moved from I.B.3.a).(4).(c)]

IV.D. Scholarship

Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through resident participation in scholarly activities. Scholarly activities may include discovery, integration, application, and teaching.

The ACGME recognizes the diversity of residencies and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.

IV.D.1. Program Responsibilities

IV.D.1.a) The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)

IV.D.1.b) The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities. (Core)

IV.D.1.c) The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. (Core)

Background and Intent: The scholarly approach can be defined as a synthesis of teaching, learning, and research with the aim of encouraging curiosity and critical thinking based on an understanding of physiology, pathophysiology, differential diagnosis, treatments, treatment alternatives, efficiency of care, and patient safety. While some faculty members are responsible for fulfilling the traditional elements of scholarship through research, integration, and teaching, all faculty members are responsible for advancing residents' scholarly approach to patient care.

Elements of a scholarly approach to patient care include:

- **Asking meaningful questions to stimulate residents to utilize learning resources to create a differential diagnosis, a diagnostic algorithm, and treatment plan**
- **Challenging the evidence that the residents use to reach their medical decisions so that they understand the benefits and limits of the medical literature**
- **When appropriate, dissemination of scholarly learning in a peer-reviewed manner (publication or presentation)**
- **Improving resident learning by encouraging them to teach using a scholarly approach**

The scholarly approach to patient care begins with curiosity, is grounded in the principles of evidence-based medicine, expands the knowledge base through dissemination, and develops the habits of lifelong learning by encouraging residents to be scholarly teachers.

IV.D.2. Faculty Scholarly Activity

IV.D.2.a) Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core)

- **Research in basic science, education, translational science, patient care, or population health**
- **Peer-reviewed grants**
- **Quality improvement and/or patient safety initiatives**
- **Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports**
- **Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials**
- **Contribution to professional committees, educational organizations, or editorial boards**
- **Innovations in education**

IV.D.2.b) **The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:**

Background and Intent: For the purposes of education, metrics of scholarly activity represent one of the surrogates for the program's effectiveness in the creation of an environment of inquiry that advances the residents' scholarly approach to patient care. The Review Committee will evaluate the dissemination of scholarship for the program as a whole, not for individual faculty members, for a five-year interval, for both core and non-core faculty members, with the goal of assessing the effectiveness of the creation of such an environment. The ACGME recognizes that there may be differences in scholarship requirements between different specialties and between residencies and fellowships in the same specialty.

IV.D.2.b).(1) **faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; (Outcome)‡**

IV.D.2.b).(2) **peer-reviewed publication. (Outcome)**

IV.D.3. **Resident Scholarly Activity**

IV.D.3.a) **Residents must participate in scholarship. (Core)**

IV.D.3.b) Each resident must complete, under faculty member supervision, an academic assignment. (Core) [Moved from IV.B.4]

IV.D.3.b).(1) Academic assignments should include grand rounds presentations; preparation and publication of review articles, book chapters, manuals for teaching or clinical practice; or development, performance, or participation in

one or more clinical or laboratory investigations. (Detail) [Moved from IV.B.4.a)]

IV.D.3.b).(1).(a) The outcome of resident investigations should be suitable for presentation at local, regional, or national scientific meetings, and/or result in peer-reviewed abstracts or manuscripts. (Detail) [Moved from IV.B.4.a).(1)]

V. Evaluation

V.A. Resident Evaluation

V.A.1. Feedback and Evaluation

Background and Intent: Feedback is ongoing information provided regarding aspects of one's performance, knowledge, or understanding. The faculty empower residents to provide much of that feedback themselves in a spirit of continuous learning and self-reflection. Feedback from faculty members in the context of routine clinical care should be frequent, and need not always be formally documented.

Formative and summative evaluation have distinct definitions. Formative evaluation is *monitoring resident learning* and providing ongoing feedback that can be used by residents to improve their learning in the context of provision of patient care or other educational opportunities. More specifically, formative evaluations help:

- **residents identify their strengths and weaknesses and target areas that need work**
- **program directors and faculty members recognize where residents are struggling and address problems immediately**

Summative evaluation is *evaluating a resident's learning* by comparing the residents against the goals and objectives of the rotation and program, respectively. Summative evaluation is utilized to make decisions about promotion to the next level of training, or program completion.

End-of-rotation and end-of-year evaluations have both summative and formative components. Information from a summative evaluation can be used formatively when residents or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the residency program.

Feedback, formative evaluation, and summative evaluation compare intentions with accomplishments, enabling the transformation of a neophyte physician to one with growing expertise.

V.A.1.a) **Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)**

Background and Intent: Faculty members should provide feedback frequently throughout the course of each rotation. Residents require feedback from faculty

members to reinforce well-performed duties and tasks, as well as to correct deficiencies. This feedback will allow for the development of the learner as they strive to achieve the Milestones. More frequent feedback is strongly encouraged for residents who have deficiencies that may result in a poor final rotation evaluation.

V.A.1.b) **Evaluation must be documented at the completion of the assignment.** (Core)

V.A.1.b).(1) **For block rotations of greater than three months in duration, evaluation must be documented at least every three months.** (Core)

V.A.1.b).(2) **Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion.** (Core)

V.A.1.c) **The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones, and must:** (Core)

V.A.1.c).(1) **use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and,** (Core)

V.A.1.c).(2) **provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice.** (Core)

V.A.1.d) **The program director or their designee, with input from the Clinical Competency Committee, must:**

V.A.1.d).(1) **meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones;** (Core)

V.A.1.d).(2) **assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and,** (Core)

V.A.1.d).(3) **develop plans for residents failing to progress, following institutional policies and procedures.** (Core)

Background and Intent: Learning is an active process that requires effort from the teacher and the learner. Faculty members evaluate a resident's performance at least at the end of each rotation. The program director or their designee will review those evaluations, including their progress on the Milestones, at a minimum of every six months. Residents should be encouraged to reflect upon the evaluation, using the information to reinforce well-performed tasks or knowledge or to modify deficiencies

in knowledge or practice. Working together with the faculty members, residents should develop an individualized learning plan.

Residents who are experiencing difficulties with achieving progress along the Milestones may require intervention to address specific deficiencies. Such intervention, documented in an individual remediation plan developed by the program director or a faculty mentor and the resident, will take a variety of forms based on the specific learning needs of the resident. However, the ACGME recognizes that there are situations which require more significant intervention that may alter the time course of resident progression. To ensure due process, it is essential that the program director follow institutional policies and procedures.

V.A.1.e) **At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable.** (Core)

V.A.1.f) **The evaluations of a resident's performance must be accessible for review by the resident.** (Core)

V.A.2. **Final Evaluation**

V.A.2.a) **The program director must provide a final evaluation for each resident upon completion of the program.** (Core)

V.A.2.a).(1) **The specialty-specific Milestones, and when applicable the specialty-specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program.** (Core)

V.A.2.a).(2) **The final evaluation must:**

V.A.2.a).(2).(a) **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;** (Core)

V.A.2.a).(2).(b) **verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice;** (Core)

V.A.2.a).(2).(c) **consider recommendations from the Clinical Competency Committee; and,** (Core)

V.A.2.a).(2).(d) **be shared with the resident upon completion of the program.** (Core)

V.A.3. **A Clinical Competency Committee must be appointed by the program director.** (Core)

V.A.3.a) **At a minimum, the Clinical Competency Committee must include three members of the program faculty, at least one of whom is a core faculty member.** (Core)

V.A.3.a).(1) **Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents.** (Core)

Background and Intent: The requirements regarding the Clinical Competency Committee do not preclude or limit a program director's participation on the Clinical Competency Committee. The intent is to leave flexibility for each program to decide the best structure for its own circumstances, but a program should consider: its program director's other roles as resident advocate, advisor, and confidante; the impact of the program director's presence on the other Clinical Competency Committee members' discussions and decisions; the size of the program faculty; and other program-relevant factors. The program director has final responsibility for resident evaluation and promotion decisions.

Program faculty may include more than the physician faculty members, such as other physicians and non-physicians who teach and evaluate the program's residents. There may be additional members of the Clinical Competency Committee. Chief residents who have completed core residency programs in their specialty may be members of the Clinical Competency Committee.

V.A.3.b) **The Clinical Competency Committee must:**

V.A.3.b).(1) **review all resident evaluations at least semi-annually;** (Core)

V.A.3.b).(2) **determine each resident's progress on achievement of the specialty-specific Milestones; and,** (Core)

V.A.3.b).(3) **meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress.** (Core)

V.B. Faculty Evaluation

V.B.1. **The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually.** (Core)

Background and Intent: The program director is responsible for the education program and for whom delivers it. While the term "faculty" may be applied to physicians within a given institution for other reasons, it is applied to residency program faculty members only through approval by a program director. The development of the faculty improves the education, clinical, and research aspects of a program. Faculty members have a strong commitment to the resident and desire to provide optimal education and work opportunities. Faculty members must be provided feedback on their contribution to the mission of the program. All faculty members who interact with residents desire

feedback on their education, clinical care, and research. If a faculty member does not interact with residents, feedback is not required. With regard to the diverse operating environments and configurations, the residency program director may need to work with others to determine the effectiveness of the program's faculty performance with regard to their role in the educational program. All teaching faculty members should have their educational efforts evaluated by the residents in a confidential and anonymous manner. Other aspects for the feedback may include research or clinical productivity, review of patient outcomes, or peer review of scholarly activity. The process should reflect the local environment and identify the necessary information. The feedback from the various sources should be summarized and provided to the faculty on an annual basis by a member of the leadership team of the program.

V.B.1.a) **This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities.** (Core)

V.B.1.b) **This evaluation must include written, anonymous, and confidential evaluations by the residents.** (Core)

V.B.2. **Faculty members must receive feedback on their evaluations at least annually.** (Core)

V.B.3. **Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans.** (Core)

Background and Intent: The quality of the faculty's teaching and clinical care is a determinant of the quality of the program and the quality of the residents' future clinical care. Therefore, the program has the responsibility to evaluate and improve the program faculty members' teaching, scholarship, professionalism, and quality care. This section mandates annual review of the program's faculty members for this purpose, and can be used as input into the Annual Program Evaluation.

V.C. Program Evaluation and Improvement

V.C.1. **The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process.** (Core)

V.C.1.a) **The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident.** (Core)

V.C.1.b) **Program Evaluation Committee responsibilities must include:**

V.C.1.b).(1) **acting as an advisor to the program director, through program oversight;** (Core)

V.C.1.b).(2) review of the program's self-determined goals and progress toward meeting them; (Core)

V.C.1.b).(3) guiding ongoing program improvement, including development of new goals, based upon outcomes; and, (Core)

V.C.1.b).(4) review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core)

Background and Intent: In order to achieve its mission and train quality physicians, a program must evaluate its performance and plan for improvement in the Annual Program Evaluation. Performance of residents and faculty members is a reflection of program quality, and can use metrics that reflect the goals that a program has set for itself. The Program Evaluation Committee utilizes outcome parameters and other data to assess the program's progress toward achievement of its goals and aims.

V.C.1.c) The Program Evaluation Committee should consider the following elements in its assessment of the program:

V.C.1.c).(1) curriculum; (Core)

V.C.1.c).(2) outcomes from prior Annual Program Evaluation(s); (Core)

V.C.1.c).(3) ACGME letters of notification, including citations, Areas for Improvement, and comments; (Core)

V.C.1.c).(4) quality and safety of patient care; (Core)

V.C.1.c).(5) aggregate resident and faculty:

V.C.1.c).(5).(a) well-being; (Core)

V.C.1.c).(5).(b) recruitment and retention; (Core)

V.C.1.c).(5).(c) workforce diversity; (Core)

V.C.1.c).(5).(d) engagement in quality improvement and patient safety; (Core)

V.C.1.c).(5).(e) scholarly activity; (Core)

V.C.1.c).(5).(f) ACGME Resident and Faculty Surveys; and, (Core)

V.C.1.c).(5).(g) written evaluations of the program. (Core)

V.C.1.c).(6) aggregate resident:

V.C.1.c).(6).(a) achievement of the Milestones; (Core)

V.C.1.c).(6).(b) in-training examinations (where applicable); (Core)

V.C.1.c).(6).(c) board pass and certification rates; and, (Core)

V.C.1.c).(6).(d) graduate performance. (Core)

V.C.1.c).(7) aggregate faculty:

V.C.1.c).(7).(a) evaluation; and, (Core)

V.C.1.c).(7).(b) professional development. (Core)

V.C.1.d) The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)

V.C.1.e) The annual review, including the action plan, must:

V.C.1.e).(1) be distributed to and discussed with the members of the teaching faculty and the residents; and, (Core)

V.C.1.e).(2) be submitted to the DIO. (Core)

V.C.2. The program must complete a Self-Study prior to its 10-Year Accreditation Site Visit. (Core)

V.C.2.a) A summary of the Self-Study must be submitted to the DIO. (Core)

Background and Intent: Outcomes of the documented Annual Program Evaluation can be integrated into the 10-year Self-Study process. The Self-Study is an objective, comprehensive evaluation of the residency program, with the aim of improving it. Underlying the Self-Study is this longitudinal evaluation of the program and its learning environment, facilitated through sequential Annual Program Evaluations that focus on the required components, with an emphasis on program strengths and self-identified areas for improvement. Details regarding the timing and expectations for the Self-Study and the 10-Year Accreditation Site Visit are provided in the *ACGME Manual of Policies and Procedures*. Additionally, a description of the Self-Study process, as well as information on how to prepare for the 10-Year Accreditation Site Visit, is available on the ACGME website.

V.C.3. ***One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.***

The program director should encourage all eligible program graduates to take the certifying examination offered by the

applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.

V.C.3.a) **For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.** **(Outcome)**

V.C.3.b) **For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.** **(Outcome)**

V.C.3.c) **For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.** **(Outcome)**

V.C.3.d) **For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.** **(Outcome)**

V.C.3.e) **For each of the exams referenced in V.C.3.a)-d), any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty.** **(Outcome)**

Background and Intent: Setting a single standard for pass rate that works across specialties is not supportable based on the heterogeneity of the psychometrics of different examinations. By using a percentile rank, the performance of the lower five percent (fifth percentile) of programs can be identified and set on a path to curricular and test preparation reform.

There are specialties where there is a very high board pass rate that could leave successful programs in the bottom five percent (fifth percentile) despite admirable performance. These high-performing programs should not be cited, and V.C.3.e) is designed to address this.

V.C.3.f) **Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years earlier.** **(Core)**

Background and Intent: It is essential that residency programs demonstrate knowledge and skill transfer to their residents. One measure of that is the qualifying or initial certification exam pass rate. Another important parameter of the success of the program is the ultimate board certification rate of its graduates. Graduates are eligible for up to seven years from residency graduation for initial certification. The ACGME will calculate a rolling three-year average of the ultimate board certification rate at seven years post-graduation, and the Review Committees will monitor it.

The Review Committees will track the rolling seven-year certification rate as an indicator of program quality. Programs are encouraged to monitor their graduates' performance on board certification examinations.

In the future, the ACGME may establish parameters related to ultimate board certification rates.

V.C.3.g) ~~Upon completion of the program, all residents should enter the process of certification and take the required examinations at the earliest possible date. At least 70 percent of a program's graduates who are eligible for ABA board certification, averaged over five years, should pass on the first attempt.~~ ~~(Outcome)~~ [Moved from V.C.2.c).(1)]

V.C.3.h) ~~At least 70 percent of a program's graduates who take the AOBA certification exam, averaged over five years, should pass on the first attempt.~~ ~~(Outcome)~~ [Moved from V.C.2.c).(2)]

VI. The Learning and Working Environment

Residency education must occur in the context of a learning and working environment that emphasizes the following principles:

- ***Excellence in the safety and quality of care rendered to patients by residents today***
- ***Excellence in the safety and quality of care rendered to patients by today's residents in their future practice***
- ***Excellence in professionalism through faculty modeling of:***
  - ***the effacement of self-interest in a humanistic environment that supports the professional development of physicians***
  - ***the joy of curiosity, problem-solving, intellectual rigor, and discovery***
- ***Commitment to the well-being of the students, residents, faculty members, and all members of the health care team***

Background and Intent: The revised requirements are intended to provide greater flexibility within an established framework, allowing programs and residents more discretion to structure clinical education in a way that best supports the above

principles of professional development. With this increased flexibility comes the responsibility for programs and residents to adhere to the 80-hour maximum weekly limit (unless a rotation-specific exception is granted by a Review Committee), and to utilize flexibility in a manner that optimizes patient safety, resident education, and resident well-being. The requirements are intended to support the development of a sense of professionalism by encouraging residents to make decisions based on patient needs and their own well-being, without fear of jeopardizing their program's accreditation status. In addition, the proposed requirements eliminate the burdensome documentation requirement for residents to justify clinical and educational work hour variations.

Clinical and educational work hours represent only one part of the larger issue of conditions of the learning and working environment, and Section VI has now been expanded to include greater attention to patient safety and resident and faculty member well-being. The requirements are intended to support programs and residents as they strive for excellence, while also ensuring ethical, humanistic training. Ensuring that flexibility is used in an appropriate manner is a shared responsibility of the program and residents. With this flexibility comes a responsibility for residents and faculty members to recognize the need to hand off care of a patient to another provider when a resident is too fatigued to provide safe, high quality care and for programs to ensure that residents remain within the 80-hour maximum weekly limit.

VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability

VI.A.1. Patient Safety and Quality Improvement

All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Graduate medical education must prepare residents to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by residents who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.

Residents must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating residents will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

It is necessary for residents and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.

VI.A.1.a) Patient Safety

VI.A.1.a).(1) Culture of Safety

A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.

VI.A.1.a).(1).(a) **The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety.** **(Core)**

VI.A.1.a).(1).(b) **The program must have a structure that promotes safe, interprofessional, team-based care.** **(Core)**

VI.A.1.a).(2) **Education on Patient Safety**

Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques. **(Core)**

Background and Intent: Optimal patient safety occurs in the setting of a coordinated interprofessional learning and working environment.

VI.A.1.a).(3) **Patient Safety Events**

Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.

VI.A.1.a).(3).(a) **Residents, fellows, faculty members, and other clinical staff members must:**

VI.A.1.a).(3).(a).(i) **know their responsibilities in reporting patient safety events at the clinical site;** **(Core)**

VI.A.1.a).(3).(a).(ii) **know how to report patient safety events, including near misses, at the clinical site; and,** **(Core)**

VI.A.1.a).(3).(a).(iii) **be provided with summary information of their institution's patient safety reports.** **(Core)**

VI.A.1.a).(3).(b) Residents must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)

VI.A.1.a).(4) Resident Education and Experience in Disclosure of Adverse Events

Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for residents to develop and apply.

VI.A.1.a).(4).(a) All residents must receive training in how to disclose adverse events to patients and families. (Core)

VI.A.1.a).(4).(b) Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated. (Detail)

VI.A.1.b) Quality Improvement

VI.A.1.b).(1) Education in Quality Improvement

A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.

VI.A.1.b).(1).(a) Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities. (Core)

VI.A.1.b).(2) Quality Metrics

Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.

VI.A.1.b).(2).(a) Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)

VI.A.1.b).(3) Engagement in Quality Improvement Activities

Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.

VI.A.1.b).(3).(a) **Residents must have the opportunity to participate in interprofessional quality improvement activities. (Core)**

VI.A.1.b).(3).(a).(i) **This should include activities aimed at reducing health care disparities. (Detail)**

VI.A.2. Supervision and Accountability

VI.A.2.a) ***Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.***

Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

VI.A.2.a).(1) **Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care. (Core)**

VI.A.2.a).(1).(a) **This information must be available to residents, faculty members, other members of the health care team, and patients. (Core)**

VI.A.2.a).(1).(b) **Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. (Core)**

VI.A.2.b) ***Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member, fellow, or senior resident physician, either on site or by means of telephonic and/or electronic modalities. Some***

activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.

VI.A.2.b).(1) **The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation.** (Core)

VI.A.2.c) **Levels of Supervision**

To promote oversight of resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision: (Core)

VI.A.2.c).(1) **Direct Supervision – the supervising physician is physically present with the resident and patient.** (Core)

VI.A.2.c).(2) **Indirect Supervision:**

VI.A.2.c).(2).(a) **with Direct Supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.** (Core)

VI.A.2.c).(2).(b) **with Direct Supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.** (Core)

VI.A.2.c).(3) **Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.** (Core)

VI.A.2.d) **The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.** (Core)

VI.A.2.d).(1) **The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones.** (Core)

VI.A.2.d).(2) **Faculty members functioning as supervising physicians must delegate portions of care to residents**

based on the needs of the patient and the skills of each resident. (Core)

VI.A.2.d).(3) **Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.** (Detail)

VI.A.2.e) **Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s).** (Core)

VI.A.2.e).(1) **Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence.** (Outcome)

Background and Intent: The ACGME Glossary of Terms defines conditional independence as: Graded, progressive responsibility for patient care with defined oversight.

VI.A.2.e).(1).(a) **Initially, PGY-1 residents must be supervised either directly, or indirectly with direct supervision immediately available. [Each Review Committee may describe the conditions and the achieved competencies under which PGY-1 residents progress to be supervised indirectly with direct supervision available.]** (Core)

VI.A.2.f) **Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility.** (Core)

VI.B. Professionalism

VI.B.1. **Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients.** (Core)

VI.B.2. **The learning objectives of the program must:**

VI.B.2.a) **be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events;** (Core)

VI.B.2.b) **be accomplished without excessive reliance on residents to fulfill non-physician obligations; and,** (Core)

Background and Intent: Routine reliance on residents to fulfill non-physician obligations increases work compression for residents and does not provide an optimal educational experience. Non-physician obligations are those duties which in most institutions are performed by nursing and allied health professionals, transport services, or clerical staff. Examples of such obligations include transport of patients from the wards or units for procedures elsewhere in the hospital; routine blood drawing for laboratory tests; routine monitoring of patients when off the ward; and clerical duties, such as scheduling. While it is understood that residents may be expected to do any of these things on occasion when the need arises, these activities should not be performed by residents routinely and must be kept to a minimum to optimize resident education.

VI.B.2.c) **ensure manageable patient care responsibilities.** (Core)

Background and Intent: The Common Program Requirements do not define "manageable patient care responsibilities" as this is variable by specialty and PGY level. Review Committees will provide further detail regarding patient care responsibilities in the applicable specialty-specific Program Requirements and accompanying FAQs. However, all programs, regardless of specialty, should carefully assess how the assignment of patient care responsibilities can affect work compression, especially at the PGY-1 level.

VI.B.3. **The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility.** (Core)

VI.B.4. **Residents and faculty members must demonstrate an understanding of their personal role in the:**

VI.B.4.a) **provision of patient- and family-centered care;** (Outcome)

VI.B.4.b) **safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events;** (Outcome)

Background and Intent: This requirement emphasizes that responsibility for reporting unsafe conditions and adverse events is shared by all members of the team and is not solely the responsibility of the resident.

VI.B.4.c) **assurance of their fitness for work, including:** (Outcome)

Background and Intent: This requirement emphasizes the professional responsibility of faculty members and residents to arrive for work adequately rested and ready to care for patients. It is also the responsibility of faculty members, residents, and other members of the care team to be observant, to intervene, and/or to escalate their concern about resident and faculty member fitness for work, depending on the situation, and in accordance with institutional policies.

VI.B.4.c).(1) **management of their time before, during, and after clinical assignments; and,** (Outcome)

VI.B.4.c).(2) recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team. (Outcome)

VI.B.4.d) commitment to lifelong learning; (Outcome)

VI.B.4.e) monitoring of their patient care performance improvement indicators; and, (Outcome)

VI.B.4.f) accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data. (Outcome)

VI.B.5. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider. (Outcome)

VI.B.6. Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff. (Core)

VI.B.7. Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)

VI.C. Well-Being

Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of residency training.

Residents and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. For example, a culture which encourages covering for colleagues after an illness without the expectation of reciprocity reflects the ideal of professionalism. A positive culture in a clinical learning environment models constructive behaviors, and prepares residents with the skills and attitudes needed to thrive throughout their careers.

Background and Intent: The ACGME is committed to addressing physician well-being for individuals and as it relates to the learning and working environment. The creation of a learning and working environment with a culture of respect and accountability for physician well-being is crucial to physicians' ability to deliver the safest, best possible care to patients. The ACGME is leveraging its resources in four key areas to support the ongoing focus on physician well-being: education, influence, research, and collaboration. Information regarding the ACGME's ongoing efforts in this area is available on the ACGME website.

As these efforts evolve, information will be shared with programs seeking to develop and/or strengthen their own well-being initiatives. In addition, there are many activities that programs can utilize now to assess and support physician well-being. These include culture of safety surveys, ensuring the availability of counseling services, and attention to the safety of the entire health care team.

VI.C.1. **The responsibility of the program, in partnership with the Sponsoring Institution, to address well-being must include:**

VI.C.1.a) **efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; (Core)**

VI.C.1.b) **attention to scheduling, work intensity, and work compression that impacts resident well-being; (Core)**

VI.C.1.c) **evaluating workplace safety data and addressing the safety of residents and faculty members; (Core)**

Background and Intent: This requirement emphasizes the responsibility shared by the Sponsoring Institution and its programs to gather information and utilize systems that monitor and enhance resident and faculty member safety, including physical safety. Issues to be addressed include, but are not limited to, monitoring of workplace injuries, physical or emotional violence, vehicle collisions, and emotional well-being after adverse events.

VI.C.1.d) **policies and programs that encourage optimal resident and faculty member well-being; and, (Core)**

Background and Intent: Well-being includes having time away from work to engage with family and friends, as well as to attend to personal needs and to one's own health, including adequate rest, healthy diet, and regular exercise.

VI.C.1.d).(1) **Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core)**

Background and Intent: The intent of this requirement is to ensure that residents have the opportunity to access medical and dental care, including mental health care, at times that are appropriate to their individual circumstances. Residents must be provided with time away from the program as needed to access care, including appointments scheduled during their working hours.

VI.C.1.e) **attention to resident and faculty member burnout, depression, and substance abuse. The program, in partnership with its Sponsoring Institution, must educate faculty members and residents in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must: (Core)**

Background and Intent: Programs and Sponsoring Institutions are encouraged to review materials in order to create systems for identification of burnout, depression, and substance abuse. Materials and more information are available on the Physician Well-being section of the ACGME website (http://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being).

VI.C.1.e).(1) **encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence; (Core)**

Background and Intent: Individuals experiencing burnout, depression, substance abuse, and/or suicidal ideation are often reluctant to reach out for help due to the stigma associated with these conditions, and are concerned that seeking help may have a negative impact on their career. Recognizing that physicians are at increased risk in these areas, it is essential that residents and faculty members are able to report their concerns when another resident or faculty member displays signs of any of these conditions, so that the program director or other designated personnel, such as the department chair, may assess the situation and intervene as necessary to facilitate access to appropriate care. Residents and faculty members must know which personnel, in addition to the program director, have been designated with this responsibility; those personnel and the program director should be familiar with the institution's impaired physician policy and any employee health, employee assistance, and/or wellness programs within the institution. In cases of physician impairment, the program director or designated personnel should follow the policies of their institution for reporting.

VI.C.1.e).(2) **provide access to appropriate tools for self-screening; and, (Core)**

VI.C.1.e).(3) provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)

Background and Intent: The intent of this requirement is to ensure that residents have immediate access at all times to a mental health professional (psychiatrist, psychologist, Licensed Clinical Social Worker, Primary Mental Health Nurse Practitioner, or Licensed Professional Counselor) for urgent or emergent mental health issues. In-person, telemedicine, or telephonic means may be utilized to satisfy this requirement. Care in the Emergency Department may be necessary in some cases, but not as the primary or sole means to meet the requirement.

The reference to affordable counseling is intended to require that financial cost not be a barrier to obtaining care.

VI.C.2. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and parental leave. Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities. (Core)

VI.C.2.a) The program must have policies and procedures in place to ensure coverage of patient care. (Core)

VI.C.2.b) These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work. (Core)

Background and Intent: Residents may need to extend their length of training depending on length of absence and specialty board eligibility requirements. Teammates should assist colleagues in need and equitably reintegrate them upon return.

VI.D. Fatigue Mitigation

VI.D.1. Programs must:

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

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

VI.D.1.c) encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. (Detail)

Background and Intent: Providing medical care to patients is physically and mentally demanding. Night shifts, even for those who have had enough rest, cause fatigue.

Experiencing fatigue in a supervised environment during training prepares residents for managing fatigue in practice. It is expected that programs adopt fatigue mitigation processes and ensure that there are no negative consequences and/or stigma for using fatigue mitigation strategies.

This requirement emphasizes the importance of adequate rest before and after clinical responsibilities. Strategies that may be used include, but are not limited to, strategic napping; the judicious use of caffeine; availability of other caregivers; time management to maximize sleep off-duty; learning to recognize the signs of fatigue, and self-monitoring performance and/or asking others to monitor performance; remaining active to promote alertness; maintaining a healthy diet; using relaxation techniques to fall asleep; maintaining a consistent sleep routine; exercising regularly; increasing sleep time before and after call; and ensuring sufficient sleep recovery periods.

VI.D.2. **Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2–VI.C.2.b), in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue.** (Core)

VI.D.3. **The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home.** (Core)

VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care

VI.E.1. Clinical Responsibilities

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

Background and Intent: The changing clinical care environment of medicine has meant that work compression due to high complexity has increased stress on residents. Faculty members and program directors need to make sure residents function in an environment that has safe patient care and a sense of resident well-being. Some Review Committees have addressed this by setting limits on patient admissions, and it is an essential responsibility of the program director to monitor resident workload. Workload should be distributed among the resident team and interdisciplinary teams to minimize work compression.

VI.E.2. Teamwork

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

VI.E.3. Transitions of Care

VI.E.3.a) **Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure.** (Core)

VI.E.3.b) **Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.** (Core)

VI.E.3.c) **Programs must ensure that residents are competent in communicating with team members in the hand-over process.** (Outcome)

VI.E.3.d) **Programs and clinical sites must maintain and communicate schedules of attending physicians and residents currently responsible for care.** (Core)

VI.E.3.e) **Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2-VI.C.2.b), in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency.** (Core)

VI.F. Clinical Experience and Education

Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.

Background and Intent: In the new requirements, the terms "clinical experience and education," "clinical and educational work," and "clinical and educational work hours" replace the terms "duty hours," "duty periods," and "duty." These changes have been made in response to concerns that the previous use of the term "duty" in reference to number of hours worked may have led some to conclude that residents' duty to "clock out" on time superseded their duty to their patients.

VI.F.1. Maximum Hours of Clinical and Educational Work per Week

Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)

Background and Intent: Programs and residents have a shared responsibility to ensure that the 80-hour maximum weekly limit is not exceeded. While the requirement has been written with the intent of allowing residents to remain beyond their scheduled work periods to care for a patient or participate in an educational activity, these additional hours must be accounted for in the allocated 80 hours when averaged over four weeks.

Scheduling
While the ACGME acknowledges that, on rare occasions, a resident may work in excess of 80 hours in a given week, all programs and residents utilizing this flexibility will be required to adhere to the 80-hour maximum weekly limit when averaged over a four-week period. Programs that regularly schedule residents to work 80 hours per week and still permit residents to remain beyond their scheduled work period are likely to exceed the 80-hour maximum, which would not be in substantial compliance with the requirement. These programs should adjust schedules so that residents are scheduled to work fewer than 80 hours per week, which would allow residents to remain beyond their scheduled work period when needed without violating the 80-hour requirement. Programs may wish to consider using night float and/or making adjustments to the frequency of in-house call to ensure compliance with the 80-hour maximum weekly limit.

Oversight
With increased flexibility introduced into the Requirements, programs permitting this flexibility will need to account for the potential for residents to remain beyond their assigned work periods when developing schedules, to avoid exceeding the 80-hour maximum weekly limit, averaged over four weeks. The ACGME Review Committees will strictly monitor and enforce compliance with the 80-hour requirement. Where violations of the 80-hour requirement are identified, programs will be subject to citation and at risk for an adverse accreditation action.

Work from Home
While the requirement specifies that clinical work done from home must be counted toward the 80-hour maximum weekly limit, the expectation remains that scheduling be structured so that residents are able to complete most work on site during scheduled clinical work hours without requiring them to take work home. The new requirements acknowledge the changing landscape of medicine, including electronic health records, and the resulting increase in the amount of work residents choose to do from home. The requirement provides flexibility for residents to do this while ensuring that the time spent by residents completing clinical work from home is accomplished within the 80-hour weekly maximum. Types of work from home that must be counted include using an electronic health record and taking calls from home. Reading done in preparation for the following day's cases, studying, and research done from home do not count toward the 80 hours. Resident decisions to leave the hospital before their clinical work has been completed and to finish that work later from home should be made in consultation with the resident's supervisor. In such circumstances, residents should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality.

During the public comment period many individuals raised questions and concerns related to this change. Some questioned whether minute by minute tracking would be required; in other words, if a resident spends three minutes on a phone call and then a few hours later spends two minutes on another call, will the resident need to report that time. Others raised concerns related to the ability of programs and institutions to verify the accuracy of the information reported by residents. The new requirements are not an attempt to micromanage this process. Residents are to track the time they spend on clinical work from home and to report that time to the program. Decisions regarding whether to report infrequent phone calls of very short duration will be left to the individual resident. Programs will need to factor in time residents are spending on clinical work at home when schedules are developed to ensure that residents are not

working in excess of 80 hours per week, averaged over four weeks. There is no requirement that programs assume responsibility for documenting this time. Rather, the program's responsibility is ensuring that residents report their time from home and that schedules are structured to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks.

PGY-1 and PGY-2 Residents
PGY-1 and PGY-2 residents may not have the experience to make decisions about when it is appropriate to utilize flexibility or may feel pressured to use it when unnecessary. Programs are responsible for ensuring that residents are provided with manageable workloads that can be accomplished during scheduled work hours. This includes ensuring that a resident's assigned direct patient load is manageable, that residents have appropriate support from their clinical teams, and that residents are not overburdened with clerical work and/or other non-physician duties.

VI.F.2. Mandatory Time Free of Clinical Work and Education

VI.F.2.a) **The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being. (Core)**

VI.F.2.b) **Residents should have eight hours off between scheduled clinical work and education periods. (Detail)**

VI.F.2.b).(1) **There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements. (Detail)**

Background and Intent: While it is expected that resident schedules will be structured to ensure that residents are provided with a minimum of eight hours off between scheduled work periods, it is recognized that residents may choose to remain beyond their scheduled time, or return to the clinical site during this time-off period, to care for a patient. The requirement preserves the flexibility for residents to make those choices. It is also noted that the 80-hour weekly limit (averaged over four weeks) is a deterrent for scheduling fewer than eight hours off between clinical and education work periods, as it would be difficult for a program to design a schedule that provides fewer than eight hours off without violating the 80-hour rule.

VI.F.2.c) **Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)**

Background and Intent: Residents have a responsibility to return to work rested, and thus are expected to use this time away from work to get adequate rest. In support of this goal, residents are encouraged to prioritize sleep over other discretionary activities.

VI.F.2.d) **Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days.** (Core)

Background and Intent: The requirement provides flexibility for programs to distribute days off in a manner that meets program and resident needs. It is strongly recommended that residents' preference regarding how their days off are distributed be considered as schedules are developed. It is desirable that days off be distributed throughout the month, but some residents may prefer to group their days off to have a "golden weekend," meaning a consecutive Saturday and Sunday free from work. The requirement for one free day in seven should not be interpreted as precluding a golden weekend. Where feasible, schedules may be designed to provide residents with a weekend, or two consecutive days, free of work. The applicable Review Committee will evaluate the number of consecutive days of work and determine whether they meet educational objectives. Programs are encouraged to distribute days off in a fashion that optimizes resident well-being, and educational and personal goals. It is noted that a day off is defined in the ACGME Glossary of Terms as "one (1) continuous 24-hour period free from all administrative, clinical, and educational activities."

VI.F.3. **Maximum Clinical Work and Education Period Length**

VI.F.3.a) **Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.** (Core)

Background and Intent: The Task Force examined the question of "consecutive time on task." It examined the research supporting the current limit of 16 consecutive hours of time on task for PGY-1 residents; the range of often conflicting impacts of this requirement on patient safety, clinical care, and continuity of care by resident teams; and resident learning found in the literature. Finally, it heard a uniform request by the specialty societies, certifying boards, membership societies and organizations, and senior residents to repeal this requirement. It heard conflicting perspectives from resident unions, a medical student association, and a number of public advocacy groups, some arguing for continuation of the requirement, others arguing for extension of the requirement to all residents.

Of greatest concern to the Task Force were the observations of disruption of team care and patient care continuity brought about with residents beyond the PGY-1 level adhering to differing requirements. The graduate medical education community uniformly requested that the Task Force remove this requirement. The most frequently-cited reason for this request was the complete disruption of the team, separating the PGY-1 from supervisory faculty members and residents who were best able to judge the ability of the resident and customize the supervision of patient care for each PGY-1. Cited nearly as frequently was the separation of the PGY-1 from the team, delaying maturation of clinical skills, and threatening to create a "shift" mentality in disciplines where overnight availability to patients is essential in delivery of care.

The Task Force examined the impact of the request to consider 16-consecutive-hour limits for all residents, and rejected the proposition. It found that model incompatible

with the actual practice of medicine and surgery in many specialties, excessively limiting in configuration of clinical services in many disciplines, and potentially disruptive of the inculcation of responsibility and professional commitment to altruism and placing the needs of patients above those of the physician.

After careful consideration of the information available, the testimony and position of all parties submitting information, and presentations to the Task Force, the Task Force removed the 16-hour-consecutive-time-on-task requirement for PGY-1 residents. It remains crucial that programs ensure that PGY-1 residents are supervised in compliance with the applicable Program Requirements, and that resident well-being is prioritized as described in Section VI.C. of these requirements.

VI.F.3.a).(1) **Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education.** (Core)

VI.F.3.a).(1).(a) **Additional patient care responsibilities must not be assigned to a resident during this time.** (Core)

Background and Intent: The additional time referenced in VI.F.3.a).(1) should not be used for the care of new patients. It is essential that the resident continue to function as a member of the team in an environment where other members of the team can assess resident fatigue, and that supervision for post-call residents is provided. This 24 hours and up to an additional four hours must occur within the context of 80-hour weekly limit, averaged over four weeks.

VI.F.4. **Clinical and Educational Work Hour Exceptions**

VI.F.4.a) **In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:**

VI.F.4.a).(1) **to continue to provide care to a single severely ill or unstable patient;** (Detail)

VI.F.4.a).(2) **humanistic attention to the needs of a patient or family; or,** (Detail)

VI.F.4.a).(3) **to attend unique educational events.** (Detail)

VI.F.4.b) **These additional hours of care or education will be counted toward the 80-hour weekly limit.** (Detail)

Background and Intent: This requirement is intended to provide residents with some control over their schedules by providing the flexibility to voluntarily remain beyond the scheduled responsibilities under the circumstances described above. It is important to note that a resident may remain to attend a conference, or return for a conference later in the day, only if the decision is made voluntarily. Residents must not be required to

stay. Programs allowing residents to remain or return beyond the scheduled work and clinical education period must ensure that the decision to remain is initiated by the resident and that residents are not coerced. This additional time must be counted toward the 80-hour maximum weekly limit.

VI.F.4.c) **A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.**

The Review Committee for Anesthesiology will not consider requests for exceptions to the 80-hour limit to the residents' work week.

VI.F.4.c).(1) **In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the *ACGME Manual of Policies and Procedures*. (Core)**

VI.F.4.c).(2) **Prior to submitting the request to the Review Committee, the program director must obtain approval from the Sponsoring Institution's GMEC and DIO. (Core)**

Background and Intent: The provision for exceptions for up to 88 hours per week has been modified to specify that exceptions may be granted for specific rotations if the program can justify the increase based on criteria specified by the Review Committee. As in the past, Review Committees may opt not to permit exceptions. The underlying philosophy for this requirement is that while it is expected that all residents should be able to train within an 80-hour work week, it is recognized that some programs may include rotations with alternate structures based on the nature of the specialty. DIO/GMEC approval is required before the request will be considered by the Review Committee.

VI.F.5. Moonlighting

VI.F.5.a) **Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. (Core)**

VI.F.5.b) **Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core)**

VI.F.5.c) **PGY-1 residents are not permitted to moonlight. (Core)**

Background and Intent: For additional clarification of the expectations related to moonlighting, please refer to the Common Program Requirement FAQs (available at http://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements).

VI.F.6. In-House Night Float

Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. (Core)

Background and Intent: The requirement for no more than six consecutive nights of night float was removed to provide programs with increased flexibility in scheduling.

VI.F.7. Maximum In-House On-Call Frequency

Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core)

VI.F.8. At-Home Call

VI.F.8.a) Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. (Core)

VI.F.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core)

VI.F.8.b) Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit. (Detail)

Background and Intent: This requirement has been modified to specify that clinical work done from home when a resident is taking at-home call must count toward the 80-hour maximum weekly limit. This change acknowledges the often significant amount of time residents devote to clinical activities when taking at-home call, and ensures that taking at-home call does not result in residents routinely working more than 80 hours per week. At-home call activities that must be counted include responding to phone calls and other forms of communication, as well as documentation, such as entering notes in an electronic health record. Activities such as reading about the next day's case, studying, or research activities do not count toward the 80-hour weekly limit.

In their evaluation of residency/fellowship programs, Review Committees will look at the overall impact of at-home call on resident/fellow rest and personal time.

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***Core Requirements:** Statements that define structure, resource, or process elements essential to every graduate medical educational program.

†**Detail Requirements:** Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in

substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

‡**Outcome Requirements:** Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.

Osteopathic Recognition

For programs with or applying for Osteopathic Recognition, the Osteopathic Recognition Requirements also apply (www.acgme.org/OsteopathicRecognition).