



**Accreditation Council for  
Graduate Medical Education**

# **ACGME Common Program Requirements (Residency)**

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2 **Common Program Requirements (Residency)**  
3

4 Where applicable, text in italics describes the underlying philosophy of the requirements  
5 in that section. These philosophic statements are not program requirements and are  
6 therefore not citable.  
7

8 **Note:** Review Committees may further specify only where indicated by “The Review  
9 Committee may/must further specify.”

10  
11 **Introduction**

12  
13 **Int.A.** *Graduate medical education is the crucial step of professional  
14 development between medical school and autonomous clinical practice. It  
15 is in this vital phase of the continuum of medical education that residents  
16 learn to provide optimal patient care under the supervision of faculty  
17 members who not only instruct, but serve as role models of excellence,  
18 compassion, professionalism, and scholarship.*

19  
20 *Graduate medical education transforms medical students into physician  
21 scholars who care for the patient, family, and a diverse community; create  
22 and integrate new knowledge into practice; and educate future generations  
23 of physicians to serve the public. Practice patterns established during  
24 graduate medical education persist many years later.*

25  
26 *Graduate medical education has as a core tenet the graded authority and  
27 responsibility for patient care. The care of patients is undertaken with  
28 appropriate faculty supervision and conditional independence, allowing  
29 residents to attain the knowledge, skills, attitudes, and empathy required  
30 for autonomous practice. Graduate medical education develops physicians  
31 who focus on excellence in delivery of safe, equitable, affordable, quality  
32 care; and the health of the populations they serve. Graduate medical  
33 education values the strength that a diverse group of physicians brings to  
34 medical care.*

35  
36 *Graduate medical education occurs in clinical settings that establish the  
37 foundation for practice-based and lifelong learning. The professional  
38 development of the physician, begun in medical school, continues through  
39 faculty modeling of the effacement of self-interest in a humanistic  
40 environment that emphasizes joy in curiosity, problem-solving, academic  
41 rigor, and discovery. This transformation is often physically, emotionally,  
42 and intellectually demanding and occurs in a variety of clinical learning  
43 environments committed to graduate medical education and the well-being  
44 of patients, residents, fellows, faculty members, students, and all members  
45 of the health care team.*

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47 **Int.B.** **Definition of Specialty**

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49 [The Review Committee must further specify]

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51 **Int.C.** **Length of Educational Program**

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[The Review Committee must further specify]

**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.

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**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)**

[The Review Committee may specify which other specialties/programs must be present at the primary clinical site]

**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)**

- 94 **I.B.3.** The program must monitor the clinical learning and working  
95 environment at all participating sites. <sup>(Core)</sup>  
96  
97 **I.B.3.a)** At each participating site there must be one faculty member,  
98 designated by the program director as the site director, who  
99 is accountable for resident education at that site, in  
100 collaboration with the program director. <sup>(Core)</sup>  
101

**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

- 102  
103 **I.B.4.** The program director must submit any additions or deletions of  
104 participating sites routinely providing an educational experience,  
105 required for all residents, of one month full time equivalent (FTE) or  
106 more through the ACGME's Accreditation Data System (ADS). <sup>(Core)</sup>  
107  
108 [The Review Committee may further specify]  
109  
110 **I.C.** The program, in partnership with its Sponsoring Institution, must engage in  
111 practices that focus on mission-driven, ongoing, systematic recruitment  
112 and retention of a diverse and inclusive workforce of residents, fellows (if  
113 present), faculty members, senior administrative staff members, and other  
114 relevant members of its academic community. <sup>(Core)</sup>  
115

**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).

- 116  
117 **I.D.** Resources  
118

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

122  
123 [The Review Committee must further specify]  
124

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

128  
129 **I.D.2.a)** access to food while on duty; (Core)

130  
131 **I.D.2.b)** safe, quiet, clean, and private sleep/rest facilities available  
132 and accessible for residents with proximity appropriate for  
133 safe patient care; (Core)

134

**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.**

135

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

139

**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).**

140

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

143

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

146

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

151

152 **I.D.4.** The program’s educational and clinical resources must be adequate  
153 to support the number of residents appointed to the program. <sup>(Core)</sup>

154  
155 [The Review Committee may further specify]

156  
157 **I.E.** The presence of other learners and other care providers, including, but not  
158 limited to, residents from other programs, subspecialty fellows, and  
159 advanced practice providers, must enrich the appointed residents’  
160 education. <sup>(Core)</sup>

161  
162 **I.E.1.** The program must report circumstances when the presence of other  
163 learners has interfered with the residents’ education to the DIO and  
164 Graduate Medical Education Committee (GMEC). <sup>(Core)</sup>  
165

**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.

166  
167 **II. Personnel**

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169 **II.A. Program Director**

170  
171 **II.A.1.** There must be one faculty member appointed as program director  
172 with authority and accountability for the overall program, including  
173 compliance with all applicable program requirements. <sup>(Core)</sup>

174  
175 **II.A.1.a)** The Sponsoring Institution’s GMEC must approve a change in  
176 program director. <sup>(Core)</sup>

177  
178 **II.A.1.b)** Final approval of the program director resides with the  
179 Review Committee. <sup>(Core)</sup>  
180

**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.

181  
182 **II.A.1.c)** The program must demonstrate retention of the program  
183 director for a length of time adequate to maintain continuity  
184 of leadership and program stability. <sup>(Core)</sup>

185  
186 [The Review Committee may further specify]

187

**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.**

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**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. <sup>(Core)</sup>**

**[The Review Committee may further specify. If the Review Committee specifies support greater than 20 percent, II.A.2. and the accompanying Background and Intent will be modified to reflect the level of support specified by the Review Committee]**

**[The Review Committee may further specify regarding support for associate program director(s)]**

**Background and Intent: Twenty percent FTE is defined as one day per week.**

**“Administrative time” is defined as non-clinical time spent meeting the responsibilities of the program director as detailed in requirements II.A.4.-II.A.4.a).(16).**

**The requirement does not address the source of funding required to provide the specified salary support.**

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**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; <sup>(Core)</sup>**

**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.**

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**II.A.3.b) must include current certification in the specialty for which they are the program director by the American Board of \_\_\_\_\_**

212 or by the American Osteopathic Board of \_\_\_\_\_, or specialty  
213 qualifications that are acceptable to the Review Committee;  
214 (Core)

215  
216 [The Review Committee may further specify acceptable  
217 specialty qualifications or that only ABMS and AOA  
218 certification will be considered acceptable]

219  
220 **II.A.3.c)** must include current medical licensure and appropriate  
221 medical staff appointment; and, (Core)

222  
223 **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.**

225  
226 [The Review Committee may further specify additional program  
227 director qualifications]

228  
229 **II.A.4.** Program Director Responsibilities

230  
231 The program director must have responsibility, authority, and  
232 accountability for: administration and operations; teaching and  
233 scholarly activity; resident recruitment and selection, evaluation,  
234 and promotion of residents, and disciplinary action; supervision of  
235 residents; and resident education in the context of patient care. (Core)

236  
237 **II.A.4.a)** The program director must:

238  
239 **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.**

241  
242 **II.A.4.a).(2)** design and conduct the program in a fashion  
243 consistent with the needs of the community, the  
244 mission(s) of the Sponsoring Institution, and the  
245 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.

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

**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.

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- 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.; <sup>(Core)</sup>

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

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

- 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; <sup>(Core)</sup>

**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.

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

- 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); <sup>(Core)</sup>

- 278 **II.A.4.a).(10)** provide a learning and working environment in which  
 279 residents have the opportunity to raise concerns and  
 280 provide feedback in a confidential manner as  
 281 appropriate, without fear of intimidation or retaliation;  
 282 (Core)  
 283
- 284 **II.A.4.a).(11)** ensure the program’s compliance with the Sponsoring  
 285 Institution’s policies and procedures related to  
 286 grievances and due process; (Core)  
 287
- 288 **II.A.4.a).(12)** ensure the program’s compliance with the Sponsoring  
 289 Institution’s policies and procedures for due process  
 290 when action is taken to suspend or dismiss, not to  
 291 promote, or not to renew the appointment of a  
 292 resident; (Core)  
 293

**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.**

- 294
- 295 **II.A.4.a).(13)** ensure the program’s compliance with the Sponsoring  
 296 Institution’s policies and procedures on employment  
 297 and non-discrimination; (Core)  
 298
- 299 **II.A.4.a).(13).(a)** Residents must not be required to sign a non-  
 300 competition guarantee or restrictive covenant.  
 301 (Core)  
 302
- 303 **II.A.4.a).(14)** document verification of program completion for all  
 304 graduating residents within 30 days; (Core)  
 305
- 306 **II.A.4.a).(15)** provide verification of an individual resident’s  
 307 completion upon the resident’s request, within 30  
 308 days; and, (Core)  
 309

**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.**

- 310
- 311 **II.A.4.a).(16)** obtain review and approval of the Sponsoring  
 312 Institution’s DIO before submitting information or  
 313 requests to the ACGME, as required in the Institutional  
 314 Requirements and outlined in the ACGME Program  
 315 Director’s Guide to the Common Program  
 316 Requirements. (Core)  
 317
- 318 **II.B. Faculty**

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

331  
332  
333 *Faculty members ensure that patients receive the level of care expected*  
334 *from a specialist in the field. They recognize and respond to the needs of*  
335 *the patients, residents, community, and institution. Faculty members*  
336 *provide appropriate levels of supervision to promote patient safety. Faculty*  
337 *members create an effective learning environment by acting in a*  
338 *professional manner and attending to the well-being of the residents and*  
339 *themselves.*

340

**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.**

341

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

345

[The Review Committee may further specify]

346

347  
348 **II.B.2.** Faculty members must:

349

350 **II.B.2.a)** be role models of professionalism; <sup>(Core)</sup>

351

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

354

**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.**

355

356 **II.B.2.c)** demonstrate a strong interest in the education of residents;  
357 <sup>(Core)</sup>

358

359 **II.B.2.d)** devote sufficient time to the educational program to fulfill  
360 their supervisory and teaching responsibilities; <sup>(Core)</sup>

361

- 362 **II.B.2.e)** administer and maintain an educational environment  
 363 conducive to educating residents; <sup>(Core)</sup>  
 364  
 365 **II.B.2.f)** regularly participate in organized clinical discussions,  
 366 rounds, journal clubs, and conferences; and, <sup>(Core)</sup>  
 367  
 368 **II.B.2.g)** pursue faculty development designed to enhance their skills  
 369 at least annually: <sup>(Core)</sup>  
 370

**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.

- 371  
 372 **II.B.2.g).(1)** as educators; <sup>(Core)</sup>  
 373  
 374 **II.B.2.g).(2)** in quality improvement and patient safety; <sup>(Core)</sup>  
 375  
 376 **II.B.2.g).(3)** in fostering their own and their residents' well-being;  
 377 and, <sup>(Core)</sup>  
 378  
 379 **II.B.2.g).(4)** in patient care based on their practice-based learning  
 380 and improvement efforts. <sup>(Core)</sup>  
 381

**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.

382  
 383 [The Review Committee may further specify additional faculty  
 384 responsibilities]  
 385

386 **II.B.3. Faculty Qualifications**

- 387  
 388 **II.B.3.a)** Faculty members must have appropriate qualifications in  
 389 their field and hold appropriate institutional appointments.  
 390 <sup>(Core)</sup>

391 [The Review Committee may further specify]

392  
 393  
 394 **II.B.3.b) Physician faculty members must:**

- 395  
 396 **II.B.3.b).(1)** have current certification in the specialty by the  
 397 American Board of \_\_\_\_\_ or the American Osteopathic  
 398 Board of \_\_\_\_\_, or possess qualifications judged  
 399 acceptable to the Review Committee. <sup>(Core)</sup>

400  
401 [The Review Committee may further specify additional  
402 qualifications]

403  
404 **II.B.3.c)** Any non-physician faculty members who participate in  
405 residency program education must be approved by the  
406 program director. <sup>(Core)</sup>

407  
408 [The Review Committee may further specify]

409

**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.

410  
411 **II.B.4.** Core Faculty

412  
413 Core faculty members must have a significant role in the education  
414 and supervision of residents and must devote a significant portion  
415 of their entire effort to resident education and/or administration, and  
416 must, as a component of their activities, teach, evaluate, and  
417 provide formative feedback to residents. <sup>(Core)</sup>

418

**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.

419  
420 **II.B.4.a)** Core faculty members must be designated by the program  
421 director. <sup>(Core)</sup>

422  
423 **II.B.4.b)** Core faculty members must complete the annual ACGME  
424 Faculty Survey. <sup>(Core)</sup>

425  
426 [The Review Committee must specify the minimum number of core  
427 faculty and/or the core faculty-resident ratio]

428  
429 [The Review Committee may further specify requirements regarding  
430 support for core faculty members]

431  
432 [The Review Committee may specify requirements specific to  
433 associate program director(s)]

434  
435 **II.C.** Program Coordinator

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437 II.C.1. There must be a program coordinator. <sup>(Core)</sup>

438  
439 II.C.2. At a minimum, the program coordinator must be supported at 50  
440 percent FTE ~~(at least 20 hours per week)~~ for ~~administrative time~~ the  
441 administration of the program. <sup>(Core)</sup>

442  
443 [The Review Committee may further specify. If the Review  
444 Committee specifies support greater than 50 percent, II.C.2. and the  
445 accompanying Background and Intent will be modified to reflect the  
446 level of support specified by the Review Committee]  
447

**Background and Intent: Fifty percent FTE is defined as two-and-a-half (2.5) days per week.**

**The requirement does not address the source of funding required to provide the specified salary support.**

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.

448  
449 II.D. Other Program Personnel

450  
451 The program, in partnership with its Sponsoring Institution, must jointly  
452 ensure the availability of necessary personnel for the effective  
453 administration of the program. <sup>(Core)</sup>

454  
455 [The Review Committee may further specify]  
456

**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.**

457  
458 III. Resident Appointments

- 459  
460 **III.A. Eligibility Requirements**  
461  
462 **III.A.1. An applicant must meet one of the following qualifications to be**  
463 **eligible for appointment to an ACGME-accredited program:** <sup>(Core)</sup>  
464  
465 **III.A.1.a) graduation from a medical school in the United States or**  
466 **Canada, accredited by the Liaison Committee on Medical**  
467 **Education (LCME) or graduation from a college of**  
468 **osteopathic medicine in the United States, accredited by the**  
469 **American Osteopathic Association Commission on**  
470 **Osteopathic College Accreditation (AOACOCA); or,** <sup>(Core)</sup>  
471  
472 **III.A.1.b) graduation from a medical school outside of the United**  
473 **States or Canada, and meeting one of the following additional**  
474 **qualifications:** <sup>(Core)</sup>  
475  
476 **III.A.1.b).(1) holding a currently valid certificate from the**  
477 **Educational Commission for Foreign Medical**  
478 **Graduates (ECFMG) prior to appointment; or,** <sup>(Core)</sup>  
479  
480 **III.A.1.b).(2) holding a full and unrestricted license to practice**  
481 **medicine in the United States licensing jurisdiction in**  
482 **which the ACGME-accredited program is located.** <sup>(Core)</sup>  
483  
484 **III.A.2. All prerequisite post-graduate clinical education required for initial**  
485 **entry or transfer into ACGME-accredited residency programs must**  
486 **be completed in ACGME-accredited residency programs, AOA-**  
487 **approved residency programs, Royal College of Physicians and**  
488 **Surgeons of Canada (RCPSC)-accredited or College of Family**  
489 **Physicians of Canada (CFPC)-accredited residency programs**  
490 **located in Canada, or in residency programs with ACGME**  
491 **International (ACGME-I) Advanced Specialty Accreditation.** <sup>(Core)</sup>  
492  
493 **III.A.2.a) Residency programs must receive verification of each**  
494 **resident's level of competency in the required clinical field**  
495 **using ACGME, CanMEDS, or ACGME-I Milestones evaluations**  
496 **from the prior training program upon matriculation.** <sup>(Core)</sup>  
497  
498 **[The Review Committee may further specify prerequisite**  
499 **postgraduate clinical education]**  
500
- 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.**
- 501  
502 **III.A.3. A physician who has completed a residency program that was not**  
503 **accredited by ACGME, AOA, RCPSC, CFPC, or ACGME-I (with**

504 Advanced Specialty Accreditation) may enter an ACGME-accredited  
505 residency program in the same specialty at the PGY-1 level and, at  
506 the discretion of the program director of the ACGME-accredited  
507 program and with approval by the GMEC, may be advanced to the  
508 PGY-2 level based on ACGME Milestones evaluations at the ACGME-  
509 accredited program. This provision applies only to entry into  
510 residency in those specialties for which an initial clinical year is not  
511 required for entry. <sup>(Core)</sup>

512  
513 **III.A.4. Resident Eligibility Exception**

514  
515 The Review Committee for \_\_\_\_\_ will allow the following exception  
516 to the resident eligibility requirements: <sup>(Core)</sup>

517  
518 [Note: A Review Committee may permit the eligibility exception if the  
519 specialty requires completion of a prerequisite residency program  
520 prior to admission. If the specialty-specific Program Requirements  
521 define multiple program formats, the Review Committee may permit  
522 the exception only for the format(s) that require completion of a  
523 prerequisite residency program prior to admission. If this language  
524 is not applicable, this section will not appear in the specialty-  
525 specific requirements.]

526  
527 **III.A.4.a) An ACGME-accredited residency program may accept an**  
528 **exceptionally qualified international graduate applicant who**  
529 **does not satisfy the eligibility requirements listed in III.A.1.-**  
530 **III.A.3., but who does meet all of the following additional**  
531 **qualifications and conditions: <sup>(Core)</sup>**

532  
533 **III.A.4.a).(1) evaluation by the program director and residency**  
534 **selection committee of the applicant's suitability to**  
535 **enter the program, based on prior training and review**  
536 **of the summative evaluations of this training; and, <sup>(Core)</sup>**

537  
538 **III.A.4.a).(2) review and approval of the applicant's exceptional**  
539 **qualifications by the GMEC; and, <sup>(Core)</sup>**

540  
541 **III.A.4.a).(3) verification of Educational Commission for Foreign**  
542 **Medical Graduates (ECFMG) certification. <sup>(Core)</sup>**

543  
544 **III.A.4.b) Applicants accepted through this exception must have an**  
545 **evaluation of their performance by the Clinical Competency**  
546 **Committee within 12 weeks of matriculation. <sup>(Core)</sup>**

547  
548 **III.B. The program director must not appoint more residents than approved by**  
549 **the Review Committee. <sup>(Core)</sup>**

550  
551 **III.B.1. All complement increases must be approved by the Review**  
552 **Committee. <sup>(Core)</sup>**

553

554 [The Review Committee may further specify minimum complement  
555 numbers]

556  
557 **III.C. Resident Transfers**

558  
559 The program must obtain verification of previous educational experiences  
560 and a summative competency-based performance evaluation prior to  
561 acceptance of a transferring resident, and Milestones evaluations upon  
562 matriculation. <sup>(Core)</sup>

563  
564 [The Review Committee may further specify]

565  
566 **IV. Educational Program**

567  
568 *The ACGME accreditation system is designed to encourage excellence and*  
569 *innovation in graduate medical education regardless of the organizational*  
570 *affiliation, size, or location of the program.*

571  
572 *The educational program must support the development of knowledgeable, skillful*  
573 *physicians who provide compassionate care.*

574  
575 *In addition, the program is expected to define its specific program aims consistent*  
576 *with the overall mission of its Sponsoring Institution, the needs of the community*  
577 *it serves and that its graduates will serve, and the distinctive capabilities of*  
578 *physicians it intends to graduate. While programs must demonstrate substantial*  
579 *compliance with the Common and specialty-specific Program Requirements, it is*  
580 *recognized that within this framework, programs may place different emphasis on*  
581 *research, leadership, public health, etc. It is expected that the program aims will*  
582 *reflect the nuanced program-specific goals for it and its graduates; for example, it*  
583 *is expected that a program aiming to prepare physician-scientists will have a*  
584 *different curriculum from one focusing on community health.*

585  
586 **IV.A. The curriculum must contain the following educational components:** <sup>(Core)</sup>

587  
588 **IV.A.1. a set of program aims consistent with the Sponsoring Institution’s**  
589 **mission, the needs of the community it serves, and the desired**  
590 **distinctive capabilities of its graduates;** <sup>(Core)</sup>

591  
592 **IV.A.1.a) The program’s aims must be made available to program**  
593 **applicants, residents, and faculty members.** <sup>(Core)</sup>

594  
595 **IV.A.2. competency-based goals and objectives for each educational**  
596 **experience designed to promote progress on a trajectory to**  
597 **autonomous practice. These must be distributed, reviewed, and**  
598 **available to residents and faculty members;** <sup>(Core)</sup>

599

**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.

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- IV.A.3. delineation of resident responsibilities for patient care, progressive responsibility for patient management, and graded supervision; <sup>(Core)</sup>

**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.

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- IV.A.4. a broad range of structured didactic activities; <sup>(Core)</sup>
- IV.A.4.a) Residents must be provided with protected time to participate in core didactic activities. <sup>(Core)</sup>

**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.

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- IV.A.5. advancement of residents' knowledge of ethical principles foundational to medical professionalism; and, <sup>(Core)</sup>
- 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. <sup>(Core)</sup>
- 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.

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- IV.B.1. The program must integrate the following ACGME Competencies into the curriculum: <sup>(Core)</sup>
- IV.B.1.a) Professionalism
- Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. <sup>(Core)</sup>

- 629 IV.B.1.a).(1) Residents must demonstrate competence in:
- 630
- 631 IV.B.1.a).(1).(a) compassion, integrity, and respect for others;  
(Core)
- 632
- 633
- 634 IV.B.1.a).(1).(b) responsiveness to patient needs that  
635 supersedes self-interest; (Core)  
636

**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.

- 637
- 638 IV.B.1.a).(1).(c) respect for patient privacy and autonomy; (Core)
- 639
- 640 IV.B.1.a).(1).(d) accountability to patients, society, and the  
641 profession; (Core)  
642
- 643 IV.B.1.a).(1).(e) respect and responsiveness to diverse patient  
644 populations, including but not limited to  
645 diversity in gender, age, culture, race, religion,  
646 disabilities, national origin, socioeconomic  
647 status, and sexual orientation; (Core)  
648
- 649 IV.B.1.a).(1).(f) ability to recognize and develop a plan for one's  
650 own personal and professional well-being; and,  
651 (Core)  
652
- 653 IV.B.1.a).(1).(g) appropriately disclosing and addressing  
654 conflict or duality of interest. (Core)  
655
- 656 IV.B.1.b) Patient Care and Procedural Skills  
657

**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.

- 658
- 659 IV.B.1.b).(1) Residents must be able to provide patient care that is  
660 compassionate, appropriate, and effective for the

661 treatment of health problems and the promotion of  
662 health. <sup>(Core)</sup>

663  
664 [The Review Committee must further specify]

665  
666 **IV.B.1.b).(2)** Residents must be able to perform all medical,  
667 diagnostic, and surgical procedures considered  
668 essential for the area of practice. <sup>(Core)</sup>

669  
670 [The Review Committee may further specify]

671  
672 **IV.B.1.c)** Medical Knowledge

673 Residents must demonstrate knowledge of established and  
674 evolving biomedical, clinical, epidemiological and social-  
675 behavioral sciences, as well as the application of this  
676 knowledge to patient care. <sup>(Core)</sup>

677  
678 [The Review Committee must further specify]

680  
681 **IV.B.1.d)** Practice-based Learning and Improvement

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

687

**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.**

688  
689 **IV.B.1.d).(1)** Residents must demonstrate competence in:

690  
691 **IV.B.1.d).(1).(a)** identifying strengths, deficiencies, and limits in  
692 one's knowledge and expertise; <sup>(Core)</sup>

693  
694 **IV.B.1.d).(1).(b)** setting learning and improvement goals; <sup>(Core)</sup>

695  
696 **IV.B.1.d).(1).(c)** identifying and performing appropriate learning  
697 activities; <sup>(Core)</sup>

698  
699 **IV.B.1.d).(1).(d)** systematically analyzing practice using quality  
700 improvement methods, and implementing  
701 changes with the goal of practice improvement;  
702 <sup>(Core)</sup>

703		
704	<b>IV.B.1.d).(1).(e)</b>	<b>incorporating feedback and formative evaluation into daily practice;</b> <sup>(Core)</sup>
705		
706		
707	<b>IV.B.1.d).(1).(f)</b>	<b>locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems; and,</b> <sup>(Core)</sup>
708		
709		
710		
711	<b>IV.B.1.d).(1).(g)</b>	<b>using information technology to optimize learning.</b> <sup>(Core)</sup>
712		
713		
714		<b>[The Review Committee may further specify by adding to the list of sub-competencies]</b>
715		
716		
717	<b>IV.B.1.e)</b>	<b>Interpersonal and Communication Skills</b>
718		
719		<b>Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.</b> <sup>(Core)</sup>
720		
721		
722		
723		
724	<b>IV.B.1.e).(1)</b>	<b>Residents must demonstrate competence in:</b>
725		
726	<b>IV.B.1.e).(1).(a)</b>	<b>communicating effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;</b> <sup>(Core)</sup>
727		
728		
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730		
731	<b>IV.B.1.e).(1).(b)</b>	<b>communicating effectively with physicians, other health professionals, and health-related agencies;</b> <sup>(Core)</sup>
732		
733		
734		
735	<b>IV.B.1.e).(1).(c)</b>	<b>working effectively as a member or leader of a health care team or other professional group;</b> <sup>(Core)</sup>
736		
737		
738		
739	<b>IV.B.1.e).(1).(d)</b>	<b>educating patients, families, students, residents, and other health professionals;</b> <sup>(Core)</sup>
740		
741		
742	<b>IV.B.1.e).(1).(e)</b>	<b>acting in a consultative role to other physicians and health professionals; and,</b> <sup>(Core)</sup>
743		
744		
745	<b>IV.B.1.e).(1).(f)</b>	<b>maintaining comprehensive, timely, and legible medical records, if applicable.</b> <sup>(Core)</sup>
746		
747		
748	<b>IV.B.1.e).(2)</b>	<b>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.</b> <sup>(Core)</sup>
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[The Review Committee may further specify by adding to the list of sub-competencies]

**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.**

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**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.

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**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.

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**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)**

- 786  
787 **IV.B.1.f).(1).(f)** incorporating considerations of value, cost  
788 awareness, delivery and payment, and risk-  
789 benefit analysis in patient and/or population-  
790 based care as appropriate; and, <sup>(Core)</sup>  
791
- 792 **IV.B.1.f).(1).(g)** understanding health care finances and its  
793 impact on individual patients' health decisions.  
794 <sup>(Core)</sup>  
795
- 796 **IV.B.1.f).(2)** Residents must learn to advocate for patients within  
797 the health care system to achieve the patient's and  
798 family's care goals, including, when appropriate, end-  
799 of-life goals. <sup>(Core)</sup>  
800

[The Review Committee may further specify by adding to the list of sub-competencies]

804 **IV.C. Curriculum Organization and Resident Experiences**

- 806 **IV.C.1.** The curriculum must be structured to optimize resident educational  
807 experiences, the length of these experiences, and supervisory  
808 continuity. <sup>(Core)</sup>  
809

[The Review Committee must further specify]

**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.

- 812
- 813 **IV.C.2.** The program must provide instruction and experience in pain  
814 management if applicable for the specialty, including recognition of  
815 the signs of addiction. <sup>(Core)</sup>  
816

[The Review Committee may further specify]

[The Review Committee may specify required didactic and clinical experiences]

822 **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.*

831  
832 *The ACGME recognizes the diversity of residencies and anticipates that*  
833 *programs prepare physicians for a variety of roles, including clinicians,*  
834 *scientists, and educators. It is expected that the program’s scholarship will*  
835 *reflect its mission(s) and aims, and the needs of the community it serves.*  
836 *For example, some programs may concentrate their scholarly activity on*  
837 *quality improvement, population health, and/or teaching, while other*  
838 *programs might choose to utilize more classic forms of biomedical*  
839 *research as the focus for scholarship.*

840  
841 **IV.D.1. Program Responsibilities**

842  
843 **IV.D.1.a) The program must demonstrate evidence of scholarly**  
844 **activities consistent with its mission(s) and aims. (Core)**

845  
846 **IV.D.1.b) The program, in partnership with its Sponsoring Institution,**  
847 **must allocate adequate resources to facilitate resident and**  
848 **faculty involvement in scholarly activities. (Core)**

849  
850 **[The Review Committee may further specify]**

851  
852 **IV.D.1.c) The program must advance residents’ knowledge and**  
853 **practice of the scholarly approach to evidence-based patient**  
854 **care. (Core)**

855

**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.

856  
857 **IV.D.2. Faculty Scholarly Activity**  
858

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

- 862
- 863 • **Research in basic science, education, translational**
- 864 **science, patient care, or population health**
- 865 • **Peer-reviewed grants**
- 866 • **Quality improvement and/or patient safety initiatives**
- 867 • **Systematic reviews, meta-analyses, review articles,**
- 868 **chapters in medical textbooks, or case reports**
- 869 • **Creation of curricula, evaluation tools, didactic**
- 870 **educational activities, or electronic educational**
- 871 **materials**
- 872 • **Contribution to professional committees, educational**
- 873 **organizations, or editorial boards**
- 874 • **Innovations in education**
- 875

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

879

880 **[Review Committee will choose to require either IV.D.2.b).(1)**  
881 **or both IV.D.2.b).(1) and IV.D.2.b).(2)]**  
882

**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.**

883

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

892

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

894

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

896

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

898

899 **[The Review Committee may further specify]**

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**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.

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**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.

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

916	<b>V.A.1.b).(1)</b>	<b>For block rotations of greater than three months in duration, evaluation must be documented at least every three months. (Core)</b>
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920	<b>V.A.1.b).(2)</b>	<b>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)</b>
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925	<b>V.A.1.c)</b>	<b>The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones, and must: (Core)</b>
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929	<b>V.A.1.c).(1)</b>	<b>use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, (Core)</b>
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933	<b>V.A.1.c).(2)</b>	<b>provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. (Core)</b>
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938	<b>V.A.1.d)</b>	<b>The program director or their designee, with input from the Clinical Competency Committee, must:</b>
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941	<b>V.A.1.d).(1)</b>	<b>meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones; (Core)</b>
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946	<b>V.A.1.d).(2)</b>	<b>assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and, (Core)</b>
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950	<b>V.A.1.d).(3)</b>	<b>develop plans for residents failing to progress, following institutional policies and procedures. (Core)</b>
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**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.

- 953  
954 **V.A.1.e)** At least annually, there must be a summative evaluation of  
955 each resident that includes their readiness to progress to the  
956 next year of the program, if applicable. <sup>(Core)</sup>  
957
- 958 **V.A.1.f)** The evaluations of a resident's performance must be  
959 accessible for review by the resident. <sup>(Core)</sup>  
960  
961 [The Review Committee may further specify under any requirement  
962 in V.A.1.-V.A.1.f)]  
963
- 964 **V.A.2.** Final Evaluation  
965
- 966 **V.A.2.a)** The program director must provide a final evaluation for each  
967 resident upon completion of the program. <sup>(Core)</sup>  
968
- 969 **V.A.2.a).(1)** The specialty-specific Milestones, and when applicable  
970 the specialty-specific Case Logs, must be used as  
971 tools to ensure residents are able to engage in  
972 autonomous practice upon completion of the program.  
973 <sup>(Core)</sup>  
974
- 975 **V.A.2.a).(2)** The final evaluation must:  
976
- 977 **V.A.2.a).(2).(a)** become part of the resident's permanent record  
978 maintained by the institution, and must be  
979 accessible for review by the resident in  
980 accordance with institutional policy; <sup>(Core)</sup>  
981
- 982 **V.A.2.a).(2).(b)** verify that the resident has demonstrated the  
983 knowledge, skills, and behaviors necessary to  
984 enter autonomous practice; <sup>(Core)</sup>  
985
- 986 **V.A.2.a).(2).(c)** consider recommendations from the Clinical  
987 Competency Committee; and, <sup>(Core)</sup>  
988
- 989 **V.A.2.a).(2).(d)** be shared with the resident upon completion of  
990 the program. <sup>(Core)</sup>  
991
- 992 **V.A.3.** A Clinical Competency Committee must be appointed by the  
993 program director. <sup>(Core)</sup>  
994
- 995 **V.A.3.a)** At a minimum, the Clinical Competency Committee must  
996 include three members of the program faculty, at least one of  
997 whom is a core faculty member. <sup>(Core)</sup>  
998
- 999 **V.A.3.a).(1)** Additional members must be faculty members from  
1000 the same program or other programs, or other health

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professionals who have extensive contact and experience with the program's residents. <sup>(Core)</sup>

**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.

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

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

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

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

**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.** <sup>(Core)</sup>

**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.

- 1023  
1024 V.B.1.a) This evaluation must include a review of the faculty member's  
1025 clinical teaching abilities, engagement with the educational  
1026 program, participation in faculty development related to their  
1027 skills as an educator, clinical performance, professionalism,  
1028 and scholarly activities. (Core)  
1029  
1030 V.B.1.b) This evaluation must include written, anonymous, and  
1031 confidential evaluations by the residents. (Core)  
1032  
1033 V.B.2. Faculty members must receive feedback on their evaluations at least  
1034 annually. (Core)  
1035  
1036 V.B.3. Results of the faculty educational evaluations should be  
1037 incorporated into program-wide faculty development plans. (Core)  
1038

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.

- 1039  
1040 V.C. Program Evaluation and Improvement  
1041  
1042 V.C.1. The program director must appoint the Program Evaluation  
1043 Committee to conduct and document the Annual Program  
1044 Evaluation as part of the program's continuous improvement  
1045 process. (Core)  
1046  
1047 V.C.1.a) The Program Evaluation Committee must be composed of at  
1048 least two program faculty members, at least one of whom is a  
1049 core faculty member, and at least one resident. (Core)  
1050  
1051 V.C.1.b) Program Evaluation Committee responsibilities must include:  
1052  
1053 V.C.1.b).(1) acting as an advisor to the program director, through  
1054 program oversight; (Core)  
1055  
1056 V.C.1.b).(2) review of the program's self-determined goals and  
1057 progress toward meeting them; (Core)  
1058  
1059 V.C.1.b).(3) guiding ongoing program improvement, including  
1060 development of new goals, based upon outcomes;  
1061 and, (Core)  
1062

1063 **V.C.1.b).(4)** review of the current operating environment to identify  
1064 strengths, challenges, opportunities, and threats as  
1065 related to the program's mission and aims. <sup>(Core)</sup>  
1066

**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.**

1067  
1068 **V.C.1.c)** The Program Evaluation Committee should consider the  
1069 following elements in its assessment of the program:  
1070  
1071 **V.C.1.c).(1)** curriculum; <sup>(Core)</sup>  
1072  
1073 **V.C.1.c).(2)** outcomes from prior Annual Program Evaluation(s);  
1074 <sup>(Core)</sup>  
1075  
1076 **V.C.1.c).(3)** ACGME letters of notification, including citations,  
1077 Areas for Improvement, and comments; <sup>(Core)</sup>  
1078  
1079 **V.C.1.c).(4)** quality and safety of patient care; <sup>(Core)</sup>  
1080  
1081 **V.C.1.c).(5)** aggregate resident and faculty:  
1082  
1083 **V.C.1.c).(5).(a)** well-being; <sup>(Core)</sup>  
1084  
1085 **V.C.1.c).(5).(b)** recruitment and retention; <sup>(Core)</sup>  
1086  
1087 **V.C.1.c).(5).(c)** workforce diversity; <sup>(Core)</sup>  
1088  
1089 **V.C.1.c).(5).(d)** engagement in quality improvement and patient  
1090 safety; <sup>(Core)</sup>  
1091  
1092 **V.C.1.c).(5).(e)** scholarly activity; <sup>(Core)</sup>  
1093  
1094 **V.C.1.c).(5).(f)** ACGME Resident and Faculty Surveys; and,  
1095 <sup>(Core)</sup>  
1096  
1097 **V.C.1.c).(5).(g)** written evaluations of the program. <sup>(Core)</sup>  
1098  
1099 **V.C.1.c).(6)** aggregate resident:  
1100  
1101 **V.C.1.c).(6).(a)** achievement of the Milestones; <sup>(Core)</sup>  
1102  
1103 **V.C.1.c).(6).(b)** in-training examinations (where applicable);  
1104 <sup>(Core)</sup>  
1105  
1106 **V.C.1.c).(6).(c)** board pass and certification rates; and, <sup>(Core)</sup>  
1107

- 1108 V.C.1.c).(6).(d) graduate performance. (Core)  
 1109  
 1110 V.C.1.c).(7) aggregate faculty:  
 1111  
 1112 V.C.1.c).(7).(a) evaluation; and, (Core)  
 1113  
 1114 V.C.1.c).(7).(b) professional development. (Core)  
 1115  
 1116 V.C.1.d) The Program Evaluation Committee must evaluate the  
 1117 program's mission and aims, strengths, areas for  
 1118 improvement, and threats. (Core)  
 1119  
 1120 V.C.1.e) The annual review, including the action plan, must:  
 1121  
 1122 V.C.1.e).(1) be distributed to and discussed with the members of  
 1123 the teaching faculty and the residents; and, (Core)  
 1124  
 1125 V.C.1.e).(2) be submitted to the DIO. (Core)  
 1126  
 1127 V.C.2. The program must complete a Self-Study prior to its 10-Year  
 1128 Accreditation Site Visit. (Core)  
 1129  
 1130 V.C.2.a) A summary of the Self-Study must be submitted to the DIO.  
 1131 (Core)  
 1132

**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.**

- 1133  
 1134 V.C.3. *One goal of ACGME-accredited education is to educate physicians*  
 1135 *who seek and achieve board certification. One measure of the*  
 1136 *effectiveness of the educational program is the ultimate pass rate.*  
 1137  
 1138 *The program director should encourage all eligible program*  
 1139 *graduates to take the certifying examination offered by the*  
 1140 *applicable American Board of Medical Specialties (ABMS) member*  
 1141 *board or American Osteopathic Association (AOA) certifying board.*  
 1142  
 1143 V.C.3.a) For specialties in which the ABMS member board and/or AOA  
 1144 certifying board offer(s) an annual written exam, in the  
 1145 preceding three years, the program's aggregate pass rate of  
 1146 those taking the examination for the first time must be higher

- 1147 than the bottom fifth percentile of programs in that specialty.  
 1148 (Outcome)
- 1149
- 1150 **V.C.3.b)** For specialties in which the ABMS member board and/or AOA  
 1151 certifying board offer(s) a biennial written exam, in the  
 1152 preceding six years, the program’s aggregate pass rate of  
 1153 those taking the examination for the first time must be higher  
 1154 than the bottom fifth percentile of programs in that specialty.  
 1155 (Outcome)
- 1156
- 1157 **V.C.3.c)** For specialties in which the ABMS member board and/or AOA  
 1158 certifying board offer(s) an annual oral exam, in the preceding  
 1159 three years, the program’s aggregate pass rate of those  
 1160 taking the examination for the first time must be higher than  
 1161 the bottom fifth percentile of programs in that specialty.  
 1162 (Outcome)
- 1163
- 1164 **V.C.3.d)** For specialties in which the ABMS member board and/or AOA  
 1165 certifying board offer(s) a biennial oral exam, in the preceding  
 1166 six years, the program’s aggregate pass rate of those taking  
 1167 the examination for the first time must be higher than the  
 1168 bottom fifth percentile of programs in that specialty. (Outcome)
- 1169
- 1170 **V.C.3.e)** For each of the exams referenced in V.C.3.a)-d), any program  
 1171 whose graduates over the time period specified in the  
 1172 requirement have achieved an 80 percent pass rate will have  
 1173 met this requirement, no matter the percentile rank of the  
 1174 program for pass rate in that specialty. (Outcome)
- 1175

**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.**

- 1176
- 1177 **V.C.3.f)** Programs must report, in ADS, board certification status  
 1178 annually for the cohort of board-eligible residents that  
 1179 graduated seven years earlier. (Core)
- 1180

**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.

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## 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.

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**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**

1250 Programs must provide formal educational activities  
1251 that promote patient safety-related goals, tools, and  
1252 techniques. <sup>(Core)</sup>  
1253

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

1254  
1255 [The Review Committee may further specify]  
1256

1257 **VI.A.1.a).(3) Patient Safety Events**

1258 *Reporting, investigation, and follow-up of adverse*  
1259 *events, near misses, and unsafe conditions are pivotal*  
1260 *mechanisms for improving patient safety, and are*  
1261 *essential for the success of any patient safety*  
1262 *program. Feedback and experiential learning are*  
1263 *essential to developing true competence in the ability*  
1264 *to identify causes and institute sustainable systems-*  
1265 *based changes to ameliorate patient safety*  
1266 *vulnerabilities.*

1269 **VI.A.1.a).(3).(a) Residents, fellows, faculty members, and other**  
1270 **clinical staff members must:**

1271  
1272 **VI.A.1.a).(3).(a).(i) know their responsibilities in reporting**  
1273 **patient safety events at the clinical site;**  
1274 <sup>(Core)</sup>

1275  
1276 **VI.A.1.a).(3).(a).(ii) know how to report patient safety**  
1277 **events, including near misses, at the**  
1278 **clinical site; and,** <sup>(Core)</sup>

1279  
1280 **VI.A.1.a).(3).(a).(iii) be provided with summary information**  
1281 **of their institution's patient safety**  
1282 **reports.** <sup>(Core)</sup>

1283  
1284 **VI.A.1.a).(3).(b) Residents must participate as team members in**  
1285 **real and/or simulated interprofessional clinical**  
1286 **patient safety activities, such as root cause**  
1287 **analyses or other activities that include**  
1288 **analysis, as well as formulation and**  
1289 **implementation of actions.** <sup>(Core)</sup>

1290  
1291 **VI.A.1.a).(4) Resident Education and Experience in Disclosure of**  
1292 **Adverse Events**

1293  
1294 *Patient-centered care requires patients, and when*  
1295 *appropriate families, to be apprised of clinical*  
1296 *situations that affect them, including adverse events.*  
1297 *This is an important skill for faculty physicians to*  
1298 *model, and for residents to develop and apply.*

1299		
1300	<b>VI.A.1.a).(4).(a)</b>	<b>All residents must receive training in how to disclose adverse events to patients and families.</b> <sup>(Core)</sup>
1301		
1302		
1303		
1304	<b>VI.A.1.a).(4).(b)</b>	<b>Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated.</b> <sup>(Detail)†</sup>
1305		
1306		
1307		
1308	<b>VI.A.1.b)</b>	<b>Quality Improvement</b>
1309		
1310	<b>VI.A.1.b).(1)</b>	<b>Education in Quality Improvement</b>
1311		
1312		<i><b>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.</b></i>
1313		
1314		
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1316		
1317	<b>VI.A.1.b).(1).(a)</b>	<b>Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities.</b> <sup>(Core)</sup>
1318		
1319		
1320		
1321	<b>VI.A.1.b).(2)</b>	<b>Quality Metrics</b>
1322		
1323		<i><b>Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.</b></i>
1324		
1325		
1326		
1327	<b>VI.A.1.b).(2).(a)</b>	<b>Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations.</b> <sup>(Core)</sup>
1328		
1329		
1330		
1331	<b>VI.A.1.b).(3)</b>	<b>Engagement in Quality Improvement Activities</b>
1332		
1333		<i><b>Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.</b></i>
1334		
1335		
1336		
1337	<b>VI.A.1.b).(3).(a)</b>	<b>Residents must have the opportunity to participate in interprofessional quality improvement activities.</b> <sup>(Core)</sup>
1338		
1339		
1340		
1341	<b>VI.A.1.b).(3).(a).(i)</b>	<b>This should include activities aimed at reducing health care disparities.</b> <sup>(Detail)</sup>
1342		
1343		
1344		<b>[The Review Committee may further specify under any requirement in VI.A.1.b)-VI.A.1.b).(3).(a).(i)]</b>
1345		
1346		
1347	<b>VI.A.2.</b>	<b>Supervision and Accountability</b>
1348		

1349 VI.A.2.a) *Although the attending physician is ultimately responsible for*  
1350 *the care of the patient, every physician shares in the*  
1351 *responsibility and accountability for their efforts in the*  
1352 *provision of care. Effective programs, in partnership with*  
1353 *their Sponsoring Institutions, define, widely communicate,*  
1354 *and monitor a structured chain of responsibility and*  
1355 *accountability as it relates to the supervision of all patient*  
1356 *care.*

1357  
1358 *Supervision in the setting of graduate medical education*  
1359 *provides safe and effective care to patients; ensures each*  
1360 *resident's development of the skills, knowledge, and attitudes*  
1361 *required to enter the unsupervised practice of medicine; and*  
1362 *establishes a foundation for continued professional growth.*  
1363

1364 VI.A.2.a).(1) Each patient must have an identifiable and  
1365 appropriately-credentialed and privileged attending  
1366 physician (or licensed independent practitioner as  
1367 specified by the applicable Review Committee) who is  
1368 responsible and accountable for the patient's care.  
1369 (Core)

1370  
1371 VI.A.2.a).(1).(a) This information must be available to residents,  
1372 faculty members, other members of the health  
1373 care team, and patients. (Core)

1374  
1375 VI.A.2.a).(1).(b) Residents and faculty members must inform  
1376 each patient of their respective roles in that  
1377 patient's care when providing direct patient  
1378 care. (Core)

1379  
1380 VI.A.2.b) *Supervision may be exercised through a variety of methods.*  
1381 *For many aspects of patient care, the supervising physician*  
1382 *may be a more advanced resident or fellow. Other portions of*  
1383 *care provided by the resident can be adequately supervised*  
1384 *by the appropriate immediate availability of the supervising*  
1385 *faculty member, fellow, or senior resident physician, either on*  
1386 *site or by means of telecommunication technology telephonic*  
1387 *and/or electronic modalities. Some activities require the*  
1388 *physical presence of the supervising faculty member. In*  
1389 *some circumstances, supervision may include post-hoc*  
1390 *review of resident-delivered care with feedback.*  
1391

**Background and Intent: There are circumstances where direct supervision without physical presence does not fulfill the requirements of the specific Review Committee. Review Committees will further specify what is meant by direct supervision without physical presence in specialties where allowed. "Physically present" is defined as follows: The teaching physician is located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service.**

1392

1393	VI.A.2.b).(1)	The program must demonstrate that the appropriate
1394		level of supervision in place for all residents is based
1395		on each resident's level of training and ability, as well
1396		as patient complexity and acuity. Supervision may be
1397		exercised through a variety of methods, as appropriate
1398		to the situation. <sup>(Core)</sup>
1399		
1400		[The Review Committee may specify which
1401		activities require different levels of
1402		supervision.]
1403		
1404	VI.A.2.b).(2)	<u>The program must define when physical presence of a</u>
1405		<u>supervising physician is required.</u> <sup>(Core)</sup>
1406		
1407	VI.A.2.c)	Levels of Supervision
1408		
1409		To promote <u>appropriate oversight</u> of resident supervision
1410		while providing for graded authority and responsibility, the
1411		program must use the following classification of supervision:
1412		<sup>(Core)</sup>
1413		
1414	VI.A.2.c).(1)	Direct Supervision:
1415		
1416	VI.A.2.c).(1).(a)	the supervising physician is physically present
1417		with the resident <u>and during the key portions of</u>
1418		<u>the patient interaction;</u> <sup>(Core)</sup> <u>or,</u>
1419		
1420		<u>[The Review Committee may further</u>
1421		<u>specify]</u>
1422		
1423	VI.A.2.c).(1).(a).(i)	<del>Initially,</del> PGY-1 residents must <u>initially</u> be
1424		<del>supervised either directly, or indirectly</del>
1425		<del>with direct supervision immediately</del>
1426		<del>available only as described in</del>
1427		<u>VI.A.2.c).(1).(a).</u> <sup>(Core)</sup> <i>[Moved from</i>
1428		<i>VI.A.2.e).(1).(a)]</i>
1429		
1430		<del>[The Each</del> Review Committee may
1431		describe the conditions <del>and the achieved</del>
1432		<del>competencies</del> under which PGY-1
1433		residents progress to be supervised
1434		indirectly <del>with direct supervision</del>
1435		<del>available]</del> <i>[Moved from VI.A.2.e).(1).(a)]</i>
1436		
1437	VI.A.2.c).(1).(b)	<u>the supervising physician and/or patient is not</u>
1438		<u>physically present with the resident and the</u>
1439		<u>supervising physician is concurrently</u>
1440		<u>monitoring the patient care through appropriate</u>
1441		<u>telecommunication technology.</u> <sup>(Core)</sup>
1442		

1443 [The Review Committee must further specify if  
1444 VI.A.2.c).(1).(b) is permitted]

1445  
1446 [The Review Committee will choose to require  
1447 either VI.A.2.c).(1).(a), or both VI.A.2.c).(1).(a)  
1448 and VI.A.2.c).(1).(b)]  
1449

1450 **VI.A.2.c).(2)** **Indirect Supervision: the supervising physician is not**  
1451 **providing physical or concurrent visual or audio**  
1452 **supervision but is immediately available to the**  
1453 **resident for guidance and is available to provide**  
1454 **appropriate direct supervision.** <sup>(Core)</sup>  
1455

1456 ~~**VI.A.2.c).(2).(a)** **with Direct Supervision immediately available—**~~  
1457 ~~**the supervising physician is physically within**~~  
1458 ~~**the hospital or other site of patient care, and is**~~  
1459 ~~**immediately available to provide Direct**~~  
1460 ~~**Supervision.**~~ <sup>(Core)</sup>  
1461

1462 ~~**VI.A.2.c).(2).(b)** **with Direct Supervision available— the**~~  
1463 ~~**supervising physician is not physically present**~~  
1464 ~~**within the hospital or other site of patient care,**~~  
1465 ~~**but is immediately available by means of**~~  
1466 ~~**telephonic and/or electronic modalities, and is**~~  
1467 ~~**available to provide Direct Supervision.**~~ <sup>(Core)</sup>  
1468

1469 **VI.A.2.c).(3)** **Oversight – the supervising physician is available to**  
1470 **provide review of procedures/encounters with**  
1471 **feedback provided after care is delivered.** <sup>(Core)</sup>  
1472

1473 **VI.A.2.d)** **The privilege of progressive authority and responsibility,**  
1474 **conditional independence, and a supervisory role in patient**  
1475 **care delegated to each resident must be assigned by the**  
1476 **program director and faculty members.** <sup>(Core)</sup>  
1477

1478 **VI.A.2.d).(1)** **The program director must evaluate each resident’s**  
1479 **abilities based on specific criteria, guided by the**  
1480 **Milestones.** <sup>(Core)</sup>  
1481

1482 **VI.A.2.d).(2)** **Faculty members functioning as supervising**  
1483 **physicians must delegate portions of care to residents**  
1484 **based on the needs of the patient and the skills of**  
1485 **each resident.** <sup>(Core)</sup>  
1486

1487 **VI.A.2.d).(3)** **Senior residents or fellows should serve in a**  
1488 **supervisory role to junior residents in recognition of**  
1489 **their progress toward independence, based on the**  
1490 **needs of each patient and the skills of the individual**  
1491 **resident or fellow.** <sup>(Detail)</sup>  
1492

1493 VI.A.2.e) Programs must set guidelines for circumstances and events  
1494 in which residents must communicate with the supervising  
1495 faculty member(s). <sup>(Core)</sup>  
1496

1497 VI.A.2.e).(1) Each resident must know the limits of their scope of  
1498 authority, and the circumstances under which the  
1499 resident is permitted to act with conditional  
1500 independence. <sup>(Outcome)</sup>  
1501

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

1502  
1503 ~~VI.A.2.e).(1).(a) Initially, PGY-1 residents must be supervised~~  
1504 ~~either directly, or indirectly with direct~~  
1505 ~~supervision immediately available. [Each~~  
1506 ~~Review Committee may describe the conditions~~  
1507 ~~and the achieved competencies under which~~  
1508 ~~PGY-1 residents progress to be supervised~~  
1509 ~~indirectly with direct supervision available.] <sup>(Core)</sup>~~  
1510 ~~[Moved above to VI.A.2.c).(1).(a).(i) and~~  
1511 ~~modified]~~

1512  
1513 VI.A.2.f) Faculty supervision assignments must be of sufficient  
1514 duration to assess the knowledge and skills of each resident  
1515 and to delegate to the resident the appropriate level of patient  
1516 care authority and responsibility. <sup>(Core)</sup>  
1517

1518 VI.B. Professionalism

1519  
1520 VI.B.1. Programs, in partnership with their Sponsoring Institutions, must  
1521 educate residents and faculty members concerning the professional  
1522 responsibilities of physicians, including their obligation to be  
1523 appropriately rested and fit to provide the care required by their  
1524 patients. <sup>(Core)</sup>  
1525

1526 VI.B.2. The learning objectives of the program must:

1527  
1528 VI.B.2.a) be accomplished through an appropriate blend of supervised  
1529 patient care responsibilities, clinical teaching, and didactic  
1530 educational events; <sup>(Core)</sup>  
1531

1532 VI.B.2.b) be accomplished without excessive reliance on residents to  
1533 fulfill non-physician obligations; and, <sup>(Core)</sup>  
1534

**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.

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

[The Review Committee may further specify]

**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.**

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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.**

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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.**

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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)

- 1564  
1565 VI.B.4.d) commitment to lifelong learning; (Outcome)  
1566  
1567 VI.B.4.e) monitoring of their patient care performance improvement  
1568 indicators; and, (Outcome)  
1569  
1570 VI.B.4.f) accurate reporting of clinical and educational work hours,  
1571 patient outcomes, and clinical experience data. (Outcome)  
1572  
1573 VI.B.5. All residents and faculty members must demonstrate  
1574 responsiveness to patient needs that supersedes self-interest. This  
1575 includes the recognition that under certain circumstances, the best  
1576 interests of the patient may be served by transitioning that patient's  
1577 care to another qualified and rested provider. (Outcome)  
1578  
1579 VI.B.6. Programs, in partnership with their Sponsoring Institutions, must  
1580 provide a professional, equitable, respectful, and civil environment  
1581 that is free from discrimination, sexual and other forms of  
1582 harassment, mistreatment, abuse, or coercion of students,  
1583 residents, faculty, and staff. (Core)  
1584  
1585 VI.B.7. Programs, in partnership with their Sponsoring Institutions, should  
1586 have a process for education of residents and faculty regarding  
1587 unprofessional behavior and a confidential process for reporting,  
1588 investigating, and addressing such concerns. (Core)  
1589  
1590 VI.C. Well-Being  
1591  
1592 *Psychological, emotional, and physical well-being are critical in the*  
1593 *development of the competent, caring, and resilient physician and require*  
1594 *proactive attention to life inside and outside of medicine. Well-being*  
1595 *requires that physicians retain the joy in medicine while managing their*  
1596 *own real-life stresses. Self-care and responsibility to support other*  
1597 *members of the health care team are important components of*  
1598 *professionalism; they are also skills that must be modeled, learned, and*  
1599 *nurtured in the context of other aspects of residency training.*  
1600  
1601 *Residents and faculty members are at risk for burnout and depression.*  
1602 *Programs, in partnership with their Sponsoring Institutions, have the same*  
1603 *responsibility to address well-being as other aspects of resident*  
1604 *competence. Physicians and all members of the health care team share*  
1605 *responsibility for the well-being of each other. For example, a culture which*  
1606 *encourages covering for colleagues after an illness without the expectation*  
1607 *of reciprocity reflects the ideal of professionalism. A positive culture in a*  
1608 *clinical learning environment models constructive behaviors, and prepares*  
1609 *residents with the skills and attitudes needed to thrive throughout their*  
1610 *careers.*  
1611

**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.

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**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.**

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**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.**

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**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.

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**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: <sup>(Core)</sup>

**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>).**

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**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; <sup>(Core)</sup>

**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.**

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**VI.C.1.e).(2)**

provide access to appropriate tools for self-screening; and, <sup>(Core)</sup>

**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. <sup>(Core)</sup>

1667

**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.

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- 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. <sup>(Core)</sup>
- VI.C.2.a)** The program must have policies and procedures in place to ensure coverage of patient care. <sup>(Core)</sup>
- 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. <sup>(Core)</sup>

**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.

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- 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; <sup>(Core)</sup>
  - VI.D.1.b)** educate all faculty members and residents in alertness management and fatigue mitigation processes; and, <sup>(Core)</sup>
  - VI.D.1.c)** encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. <sup>(Detail)</sup>

**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.

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- 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. <sup>(Core)</sup>
  - 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. <sup>(Core)</sup>
  - 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. <sup>(Core)</sup>
    - [Optimal clinical workload may be further specified by each Review Committee]

**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.

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- 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. <sup>(Core)</sup>
    - [The Review Committee may further specify]
  - VI.E.3. Transitions of Care

- 1730 VI.E.3.a) Programs must design clinical assignments to optimize  
 1731 transitions in patient care, including their safety, frequency,  
 1732 and structure. <sup>(Core)</sup>  
 1733
- 1734 VI.E.3.b) Programs, in partnership with their Sponsoring Institutions,  
 1735 must ensure and monitor effective, structured hand-over  
 1736 processes to facilitate both continuity of care and patient  
 1737 safety. <sup>(Core)</sup>  
 1738
- 1739 VI.E.3.c) Programs must ensure that residents are competent in  
 1740 communicating with team members in the hand-over process.  
 1741 <sup>(Outcome)</sup>  
 1742
- 1743 VI.E.3.d) Programs and clinical sites must maintain and communicate  
 1744 schedules of attending physicians and residents currently  
 1745 responsible for care. <sup>(Core)</sup>  
 1746
- 1747 VI.E.3.e) Each program must ensure continuity of patient care,  
 1748 consistent with the program’s policies and procedures  
 1749 referenced in VI.C.2-VI.C.2.b), in the event that a resident may  
 1750 be unable to perform their patient care responsibilities due to  
 1751 excessive fatigue or illness, or family emergency. <sup>(Core)</sup>  
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- 1753 VI.F. Clinical Experience and Education  
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 1755 *Programs, in partnership with their Sponsoring Institutions, must design*  
 1756 *an effective program structure that is configured to provide residents with*  
 1757 *educational and clinical experience opportunities, as well as reasonable*  
 1758 *opportunities for rest and personal activities.*  
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**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.

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 1761 VI.F.1. Maximum Hours of Clinical and Educational Work per Week  
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 1763 Clinical and educational work hours must be limited to no more than  
 1764 80 hours per week, averaged over a four-week period, inclusive of all  
 1765 in-house clinical and educational activities, clinical work done from  
 1766 home, and all moonlighting. <sup>(Core)</sup>  
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**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.

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**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. <sup>(Core)</sup>**

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

**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. <sup>(Detail)</sup>**

**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.**

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

**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.**

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1791 VI.F.2.d) Residents must be scheduled for a minimum of one day in  
1792 seven free of clinical work and required education (when  
1793 averaged over four weeks). At-home call cannot be assigned  
1794 on these free days. <sup>(Core)</sup>  
1795

**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."

1796 VI.F.3. Maximum Clinical Work and Education Period Length

1797 VI.F.3.a) Clinical and educational work periods for residents must not  
1798 exceed 24 hours of continuous scheduled clinical  
1799 assignments. <sup>(Core)</sup>  
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**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.

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1804 **VI.F.3.a).(1)** Up to four hours of additional time may be used for  
1805 activities related to patient safety, such as providing  
1806 effective transitions of care, and/or resident education.  
1807 (Core)  
1808  
1809 **VI.F.3.a).(1).(a)** Additional patient care responsibilities must not  
1810 be assigned to a resident during this time. (Core)  
1811

**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.

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1813 **VI.F.4.** Clinical and Educational Work Hour Exceptions  
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1815 **VI.F.4.a)** In rare circumstances, after handing off all other  
1816 responsibilities, a resident, on their own initiative, may elect  
1817 to remain or return to the clinical site in the following  
1818 circumstances:  
1819  
1820 **VI.F.4.a).(1)** to continue to provide care to a single severely ill or  
1821 unstable patient; (Detail)  
1822  
1823 **VI.F.4.a).(2)** humanistic attention to the needs of a patient or  
1824 family; or, (Detail)  
1825  
1826 **VI.F.4.a).(3)** to attend unique educational events. (Detail)  
1827  
1828 **VI.F.4.b)** These additional hours of care or education will be counted  
1829 toward the 80-hour weekly limit. (Detail)  
1830

**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.

- 1831  
1832 VI.F.4.c) A Review Committee may grant rotation-specific exceptions  
1833 for up to 10 percent or a maximum of 88 clinical and  
1834 educational work hours to individual programs based on a  
1835 sound educational rationale.  
1836  
1837 VI.F.4.c).(1) In preparing a request for an exception, the program  
1838 director must follow the clinical and educational work  
1839 hour exception policy from the *ACGME Manual of*  
1840 *Policies and Procedures.* (Core)  
1841  
1842 VI.F.4.c).(2) Prior to submitting the request to the Review  
1843 Committee, the program director must obtain approval  
1844 from the Sponsoring Institution's GMEC and DIO. (Core)  
1845

**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.

- 1846  
1847 VI.F.5. Moonlighting  
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1849 VI.F.5.a) Moonlighting must not interfere with the ability of the resident  
1850 to achieve the goals and objectives of the educational  
1851 program, and must not interfere with the resident's fitness for  
1852 work nor compromise patient safety. (Core)  
1853  
1854 VI.F.5.b) Time spent by residents in internal and external moonlighting  
1855 (as defined in the ACGME Glossary of Terms) must be  
1856 counted toward the 80-hour maximum weekly limit. (Core)  
1857  
1858 VI.F.5.c) PGY-1 residents are not permitted to moonlight. (Core)  
1859

**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>).

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1861 VI.F.6. In-House Night Float  
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1863 Night float must occur within the context of the 80-hour and one-  
1864 day-off-in-seven requirements. (Core)

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[The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

**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.**

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**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). <sup>(Core)</sup>

**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. <sup>(Core)</sup>**

**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. <sup>(Core)</sup>**

**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. <sup>(Detail)</sup>**

[The Review Committee may further specify under any requirement in VI.F.-VI.F.8.b)]

**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.

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1902 †**Detail Requirements:** Statements that describe a specific structure, resource, or process, for  
1903 achieving compliance with a Core Requirement. Programs and sponsoring institutions in  
1904 substantial compliance with the Outcome Requirements may utilize alternative or innovative  
1905 approaches to meet Core Requirements.  
1906

1907 ‡**Outcome Requirements:** Statements that specify expected measurable or observable  
1908 attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their  
1909 graduate medical education.  
1910

1911 **Osteopathic Recognition**

1912 For programs with or applying for Osteopathic Recognition, the Osteopathic Recognition  
1913 Requirements also apply ([www.acgme.org/OsteopathicRecognition](http://www.acgme.org/OsteopathicRecognition)).