Accreditation Council for Graduate Medical Education

ACGME
Common Program Requirements (Residency)

Common Program Requirements (Residency) Contents

Common Program Requirements (Residency)

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

Note: Review Committees may further specify only where indicated by "The Review Committee may/must further specify."

Introduction

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

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

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

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

~~Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.~~

~~The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the~~

52		domains of clinical competency requires the resident physician to assume
53		personal responsibility for the care of individual patients. For the resident, the
54		essential learning activity is interaction with patients under the guidance and
55		supervision of faculty members who give value, context, and meaning to those
56		interactions. As residents gain experience and demonstrate growth in their ability
57		to care for patients, they assume roles that permit them to exercise those skills
58		with greater independence. This concept--graded and progressive responsibility--
59		is one of the core tenets of American graduate medical education. Supervision in
60		the setting of graduate medical education has the goals of assuring the provision
61		of safe and effective care to the individual patient; assuring each resident's
62		development of the skills, knowledge, and attitudes required to enter the
63		unsupervised practice of medicine; and establishing a foundation for continued
64		professional growth.

65		
66	Int.B.	Definition of Specialty
67		
68		[The Review Committee must further specify]
69		
70	Int.C.	Length of Educational Program
71		
72		[The Review Committee must further specify]
73		
74	I.	Oversight Institutions
75		
76	I.A.	Sponsoring Institution
77		
78		*The Sponsoring Institution is the organization or entity that assumes the ultimate*
79		*financial and academic responsibility for a program of graduate medical*
80		*education, consistent with the ACGME Institutional Requirements.*
81		
82		*When the Sponsoring Institution is not a rotation site for the program, the most*
83		*commonly utilized site of clinical activity for the program is the primary clinical*
84		*site.*
85		

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.

86		
87	I.A.1.	The program must be sponsored by one ACGME-accredited Sponsoring
88		Institution. (Core)*
89		
90		One sponsoring institution must assume ultimate responsibility for the
91		program, as described in the Institutional Requirements, and this
92		responsibility extends to resident assignments at all participating sites.
93		(Core)*
94		

95		~~The sponsoring institution and the program must ensure that the program~~
96		~~director has sufficient protected time and financial support for his or her~~
97		~~educational and administrative responsibilities to the program.~~ ~~(Core)~~
98		
99	I.B.	Participating Sites
100		
101		*A participating site is an organization providing educational experiences or*
102		*educational assignments/rotations for residents.*
103		
104	I.B.1.	The program, with approval of its Sponsoring Institution, must designate a
105		primary clinical site. (Core)
106		
107		[The Review Committee may specify which other specialties/programs
108		must be present at the primary clinical site]
109		
110	I.B.2.	There must be a program letter of agreement (PLA) between the program
111		and each participating site that governs the relationship between the
112		program and the participating site providing a required assignment. (Core)
113		
114	I.B.2.a)	The PLA ~~should~~ must:
115		
116	I.B.2.a).(1)	be renewed at least every ~~five~~ 10 years; and, (Core)
117		
118	I.B.2.a).(2)	be approved by the designated institutional official (DIO).
119		(Core)
120		
121	~~I.B.2.a).(3)~~	~~identify the faculty who will assume both educational and~~
122		~~supervisory responsibilities for residents;~~ ~~(Detail)~~
123		
124	~~I.B.2.a).(4)~~	~~specify their responsibilities for teaching, supervision, and~~
125		~~formal evaluation of residents, as specified later in this~~
126		~~document;~~ ~~(Detail)~~
127		
128	~~I.B.2.a).(5)~~	~~specify the duration and content of the educational~~
129		~~experience; and,~~ ~~(Detail)~~
130		
131	~~I.B.2.a).(6)~~	~~state the policies and procedures that will govern resident~~
132		~~education during the assignment.~~ ~~(Detail)~~
133		
134	I.B.3.	The program must monitor the clinical learning and working environment
135		at all participating sites. (Core)
136		
137	I.B.3.a)	At each participating site there must be one faculty member,
138		designated by the program director as the site director, who is
139		accountable for resident education at that site, in collaboration
140		with the program director. (Core)
141		

> 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 |

142
143 I.B.4.   The program director must submit any additions or deletions of
144   participating sites routinely providing an educational experience, required
145   for all residents, of one month full time equivalent (FTE) or more through
146   the ACGME's Accreditation Data System (ADS). (Core)
147
148   [The Review Committee may further specify][As further specified by the
149   Review Committee]
150
151 I.C.   The program, in partnership with its Sponsoring Institution, must engage in
152   practices that focus on mission-driven, ongoing, systematic recruitment and
153   retention of a diverse and inclusive workforce of residents, fellows (if present),
154   faculty members, senior administrative staff members, and other relevant
155   members of its academic community. (Core)
156

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).

157
158 I.D.   Resources
159
160 I.D.1.   The institution and the program must jointly ensure The program, in
161   partnership with its Sponsoring Institution, must ensure the availability of
162   adequate resources for resident education, as defined in the specialty
163   program requirements. (Core) [Moved here from II.D.]
164
165   [The Review Committee must further specify] [As further specified by the
166   Review Committee]
167
168 I.D.2.   The program, in partnership with its Sponsoring Institution, must ensure
169   healthy and safe learning and working environments that promote
170   resident well-being and provide for: (Core)
171
172 I.D.2.a)   access to food while on duty; (Core)
173

174	I.D.2.b)	safe, quiet, clean, and private sleep/rest facilities available and
175		accessible for residents with proximity appropriate for safe patient
176		care; (Core)
177		

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.

178		
179	I.D.2.c)	clean and private facilities for lactation that have refrigeration
180		capabilities, with proximity appropriate for safe patient care; (Core)
181		

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).

182		
183	I.D.2.d)	security and safety measures appropriate to the participating site;
184		and, (Core)
185		
186	I.D.2.e)	accommodations for residents with disabilities consistent with the
187		Sponsoring Institution's policy. (Core)
188		
189	I.D.3.	~~Medical Information Access~~
190		
191		Residents must have ready access to specialty-specific and other
192		appropriate reference material in print or electronic format. This must
193		include access to electronic medical literature databases with full text
194		search ~~capabilities should be available~~. (~~Core~~Detail) [Moved here from II.E.]
195		
196	I.D.4.	The program's educational and clinical resources must be adequate to
197		support the number of residents appointed to the program. (Core) [Moved
198		here from III.B.]
199		
200		[The Review Committee may further specify] ~~[As further specified by the~~
201		~~Review Committee]~~
202		
203	I.E.	~~Appointment of Fellows and Other Learners~~
204		
205		The presence of other learners and other care providers, (including, but not
206		limited to, residents from other ~~specialties~~ programs, subspecialty fellows, and
207		advanced practice providers ~~,PhD students, and nurse practitioners)~~, in the
208		~~program~~ must ~~not interfere with~~ enrich the appointed residents' education. (Core)
209		[Moved here from III.D.]

210		
211	I.E.1.	The program ~~director~~ must report <u>circumstances when</u> the presence of
212		other learners <u>has interfered with the residents' education</u> to the DIO and
213		Graduate Medical Education Committee (GMEC) ~~in accordance with~~
214		~~Sponsoring Institution guidelines.~~ ^(Core~~Detail~~) [Moved here from III.D.1.]
215		
216		~~[As further specified by the Review Committee]~~
217		

> <u>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.</u>

218		
219	II.	~~Program~~ Personnel ~~and Resources~~
220		
221	II.A.	Program Director
222		
223	II.A.1.	There must be <u>one faculty member appointed as</u> ~~a single~~ program
224		director with authority and accountability for ~~the operation of~~ the <u>overall</u>
225		program, <u>including compliance with all applicable program requirements.</u>
226		^(Core)
227		
228	II.A.1.a)	The Sponsoring Institution's GMEC must approve a change in
229		program director. ^(Core)
230		
231	~~II.A.1.a).(1)~~	~~The program director must submit this change to the~~
232		~~ACGME via the ADS.~~ ^{~~(Core)~~}
233		
234		~~[As further specified by the Review Committee]~~
235		
236	II.A.1.b)	<u>Final approval of the program director resides with the Review</u>
237		<u>Committee.</u> ^(Core)
238		

> <u>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.</u>

239		
240	II.A.1.c)	<u>The program must demonstrate retention of</u> the program director
241		~~should continue in his or her position~~ for a length of time adequate
242		to maintain continuity of leadership and program stability. ^(Core~~Detail~~)
243		
244		<u>[The Review Committee may further specify]</u>
245		

> 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.

246

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

250

251   [The Review Committee may further specify]

252

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

255

256 II.A.3.   Qualifications of the program director ~~must include~~:

257

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

261

> 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.

262

263 II.A.3.b)   must include current certification in the specialty for which they are
264   the program director by the American Board of _____ or by the
265   American Osteopathic Board of _____, or specialty qualifications
266   that are acceptable to the Review Committee; ~~and,~~ (Core)

267

268   [The Review Committee may further specify acceptable specialty
269   qualifications or that only ABMS and AOA certification will be
270   considered acceptable]

271

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

274

275   ~~[As further specified by the Review Committee]~~

276

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

278

> 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.

279
280   [The Review Committee may further specify additional program director
281   qualifications] ~~[As further specified by the Review Committee]~~
282
283 II.A.4.   Program Director Responsibilities
284
285   The program director must have responsibility, authority, and
286   accountability for: administration and operations; teaching and scholarly
287   activity; resident recruitment and selection, evaluation, and promotion of
288   residents, and disciplinary action; supervision of residents; and resident
289   education in the context of patient care. [(Core)]
290
291 II.A.4.a)   The program director must:
292
293 II.A.4.a).(1)   be a role model of professionalism; [(Core)]
294

> 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.

295
296 II.A.4.a).(2)   design and conduct the program in a fashion consistent
297   with the needs of the community, the mission(s) of the
298   Sponsoring Institution, and the mission(s) of the program;
299   [(Core)]
300

> 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.

301
302 II.A.4.a).(3)   administer and maintain a learning ~~an educational~~
303   environment conducive to educating the residents in each
304   of the ACGME Competency domains ~~areas~~; [(Core)]
305

> 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.

306

307	II.A.4.a).(4)	develop and oversee a process to evaluate candidates
308		prior to approval as program faculty members for
309		participation in the residency program education and at
310		least annually thereafter, as outlined in V.B.; (Core)
311		
312	II.A.4.a).(5)	have the authority to approve program faculty members for
313		participation in the residency program education at all
314		sites; approve the selection of program faculty as
315		appropriate; (Core)
316		
317	II.A.4.a).(6)	have the authority to remove program faculty members
318		from participation in the residency program education at all
319		sites; approve the continued participation of program
320		faculty based on evaluation; (Core)
321		
322	II.A.4.a).(7)	have the authority to remove residents from supervising
323		interactions and/or learning environments that do not meet
324		the standards of the program; (Core)
325		

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.

326		
327	II.A.4.a).(8)	prepare and submit accurate and complete all information
328		required and requested by the DIO, GMEC, and ACGME;
329		(Core)
330		
331	II.A.4.a).(8).(a)	This includes but is not limited to the program
332		application forms and annual program updates to
333		the ADS, and ensure that the information submitted
334		is accurate and complete. (Core)
335		
336	II.A.4.a).(9)	provide applicants who are offered an interview with
337		information related to the applicant's eligibility for the
338		relevant specialty board examination(s); (Core)
339		
340	II.A.4.a).(10)	provide a learning and working environment in which
341		residents have the opportunity to raise concerns and
342		provide feedback in a confidential manner as appropriate,
343		without fear of intimidation or retaliation; (Core)
344		
345	II.A.4.a).(11)	ensure the program's compliance with the Sponsoring
346		Institution's policies and procedures related to grievances,
347		and due process procedures as set forth in the Institutional
348		Requirements and implemented by the sponsoring

349		~~institution;~~ (Core~~Detail~~)
350		
351	II.A.4.a).(12)	ensure the program's compliance with the Sponsoring
352		Institution's policies and procedures for due process when
353		action is taken to suspend or dismiss, not to promote, or
354		not to renew the appointment of a resident; (Core)
355		

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.

356		
357	II.A.4.a).(13)	ensure the program's compliance with the Sponsoring
358		Institution's policies and procedures on employment and
359		non-discrimination; (Core)
360		
361	II.A.4.a).(13).(a)	Residents must not be required to sign a non-
362		competition guarantee or restrictive covenant. (Core)
363		
364	II.A.4.a).(14)	document verification of program completion for all
365		graduating residents within 30 days; (Core)
366		
367	II.A.4.a).(15)	provide verification of an individual resident's completion
368		upon the resident's request, within 30 days ~~residency~~
369		~~education for all residents, including those who leave the~~
370		~~program prior to completion~~; and, (Core~~Detail~~)
371		

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.

372		
373	II.A.4.a).(16)	obtain review and approval of the Sponsoring Institution's
374		~~GMEC/~~DIO before submitting information or requests to
375		the ACGME, as required in the Institutional Requirements
376		and outlined in the ACGME Program Director's Guide to
377		the Common Program Requirements~~, including~~. (Core)
378		
379	~~II.A.4.a).(16).(a)~~	~~all applications for ACGME accreditation of new~~
380		~~programs;~~ (Detail)
381		
382	~~II.A.4.a).(16).(b)~~	~~changes in resident complement;~~ (Detail)
383		
384	~~II.A.4.a).(16).(c)~~	~~major changes in program structure or length of~~
385		~~training;~~ (Detail)
386		
387	~~II.A.4.a).(16).(d)~~	~~progress reports requested by the Review~~
388		~~Committee;~~ (Detail)
389		

390	II.A.4.a).(16).(e)	requests for increases or any change to resident
391		duty hours; (Detail)
392		
393	II.A.4.a).(16).(f)	voluntary withdrawals of ACGME-accredited
394		programs; (Detail)
395		
396	II.A.4.a).(16).(g)	requests for appeal of an adverse action; and, (Detail)
397		
398	II.A.4.a).(16).(h)	appeal presentations to a Board of Appeal or the
399		ACGME. (Detail)
400		
401	II.A.4.a).(17)	oversee and ensure the quality of didactic and clinical
402		education in all sites that participate in the program; (Core)
403		
404	II.A.4.a).(18)	approve a local director at each participating site who is
405		accountable for resident education; (Core)
406		
407	II.A.4.a).(19)	evaluate program faculty; (Core)
408		
409	II.A.4.a).(20)	monitor resident supervision at all participating sites; (Core)
410		
411	II.A.4.a).(21)	implement policies and procedures consistent with the
412		institutional and program requirements for resident duty
413		hours and the working environment, including
414		moonlighting, (Core)
415		
416		and, to that end, must:
417		
418	II.A.4.a).(21).(a)	distribute these policies and procedures to the
419		residents and faculty; (Detail)
420		
421	II.A.4.a).(21).(b)	monitor resident duty hours, according to
422		sponsoring institutional policies, with a frequency
423		sufficient to ensure compliance with ACGME
424		requirements; (Core)
425		
426	II.A.4.a).(21).(c)	adjust schedules as necessary to mitigate
427		excessive service demands and/or fatigue; and,
428		(Detail)
429		
430	II.A.4.a).(21).(d)	if applicable, monitor the demands of at-home call
431		and adjust schedules as necessary to mitigate
432		excessive service demands and/or fatigue. (Detail)
433		
434	II.A.4.a).(22)	monitor the need for and ensure the provision of back up
435		support systems when patient care responsibilities are
436		unusually difficult or prolonged; (Detail)
437		
438	II.A.4.a).(23)	comply with the sponsoring institution's written policies and
439		procedures, including those specified in the Institutional
440		Requirements, for selection, evaluation and promotion of

| 441 | | | residents, disciplinary action, and supervision of residents; (Detail) |
| 442 | | | |

443			
444	II.A.4.a).(24)		be familiar with and comply with ACGME and Review
445			Committee policies and procedures as outlined in the
446			ACGME Manual of Policies and Procedures; (Detail)

447			
448	II.A.4.a).(25)		obtain DIO review and co-signature on all program
449			application forms, as well as any correspondence or
450			document submitted to the ACGME that addresses: (Detail)

| 451 | | | |
| 452 | II.A.4.a).(25).(a) | | program citations, and/or, (Detail) |

453			
454	II.A.4.a).(25).(b)		request for changes in the program that would have
455			significant impact, including financial, on the
456			program or institution. (Detail)

457

458   [As further specified by the Review Committee]

459

460   II.B.   Faculty

461

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

473

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

480

> 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.

481

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

485

486   [The Review Committee may further specify]

487

488   II.B.2.   ~~The~~ Faculty members must:

489		
490	II.B.2.a)	be role models of professionalism; (Core)
491		
492	II.B.2.b)	demonstrate commitment to the delivery of safe, quality, cost-
493		effective, patient-centered care; (Core)
494		

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.

495		
496	II.B.2.c)	demonstrate a strong interest in the education of residents; (Core)
497		
498	II.B.2.d)	devote sufficient time to the educational program to fulfill their
499		supervisory and teaching responsibilities; and to demonstrate a
500		strong interest in the education of residents; and, (Core)
501		
502	II.B.2.e)	administer and maintain an educational environment conducive to
503		educating residents in each of the ACGME competency areas.;
504		(Core)
505		
506	II.B.2.f)	The faculty must regularly participate in organized clinical
507		discussions, rounds, journal clubs, and conferences; and, (CoreDetail)
508		
509	II.B.2.g)	pursue faculty development designed to enhance their skills at
510		least annually: (Core)
511		

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.

512		
513	II.B.2.g).(1)	as educators; (Core)
514		
515	II.B.2.g).(2)	in quality improvement and patient safety; (Core)
516		
517	II.B.2.g).(3)	in fostering their own and their residents' well-being; and,
518		(Core)
519		
520	II.B.2.g).(4)	in patient care based on their practice-based learning and
521		improvement efforts. (Core)
522		

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. |

523
524   [The Review Committee may further specify additional faculty
525   responsibilities]
526
527   II.B.3.   Faculty Qualifications
528
529   II.B.3.a)   ~~The Non-physician f~~Faculty members must have appropriate
530   qualifications in their field and hold appropriate institutional
531   appointments. (Core)
532
533   [The Review Committee may further specify]
534
535   II.B.3.b)   ~~The~~ Physician faculty members must:
536
537   II.B.3.b).(1)   have current certification in the specialty by the American
538   Board of _____ or the American Osteopathic Board of
539   _____, or possess qualifications judged acceptable to the
540   Review Committee. (Core)
541
542   ~~II.B.3.b).(2)   The physician faculty must possess current medical~~
543   ~~licensure and appropriate medical staff appointment.~~ (Core)
544
545   [The Review Committee may further specify additional
546   qualifications] ~~[As further specified by the Review Committee]~~
547
548   II.B.3.c)   Any non-physician faculty members who participate in residency
549   program education must be approved by the program director.
550   (Core)
551
552   [The Review Committee may further specify]
553

| 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. |

554
555   II.B.4.   Core Faculty
556
557   Core faculty members must have a significant role in the education and
558   supervision of residents and must devote a significant portion of their
559   entire effort to resident education and/or administration, and must, as a
560   component of their activities, teach, evaluate, and provide formative
561   feedback to residents. (Core)
562

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

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

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

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

II.B.5.　　　~~The faculty must establish and maintain an environment of inquiry and scholarship with an active research component. (Core)~~

II.B.5.a)　　　　　~~Some members of the faculty should also demonstrate scholarship by one or more of the following:~~

II.B.5.a).(1)　　　　　~~peer-reviewed funding; (Detail)~~

II.B.5.a).(2)　　　　　~~publication of original research or review articles in peer-reviewed journals, or chapters in textbooks; (Detail)~~

II.B.5.a).(3)　　　　　~~publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or, (Detail)~~

II.B.5.a).(4)　　　　　~~participation in national committees or educational organizations. (Detail)~~

II.B.6.　　　~~Faculty should encourage and support residents in scholarly activities. (Core)~~

　　　　　~~[As further specified by the Review Committee]~~

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

II.C.　　　Program Coordinator

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

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

[The Review Committee may further specify]

Background and Intent: Each program requires a lead administrative person, frequently referred to as a program coordinator, administrator, or as titled by the institution. This person will frequently manage the day-to-day operations of the program and serve as an important liaison with learners, faculty and other staff members, and the ACGME. Individuals serving in this role are recognized as program coordinators by the ACGME.

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

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

608
609   II.D.   Other Program Personnel
610
611   The ~~institution and the~~ program, in partnership with its Sponsoring Institution,
612   must jointly ensure the availability of ~~all~~ necessary ~~professional, technical, and~~
613   ~~clerical~~ personnel for the effective administration of the program. (Core)
614
615   [The Review Committee may further specify] ~~[As further specified by the Review~~
616   ~~Committee]~~
617

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.

618
619   III.   Resident Appointments
620
621   III.A.   Eligibility ~~Criteria~~ Requirements
622
623   III.A.1.   ~~The program director must comply with the criteria for resident eligibility~~
624   ~~as specified in the Institutional Requirements.~~ (Core) An applicant must
625   meet one of the following qualifications to be eligible for appointment to
626   an ACGME-accredited program: (Core)
627
628   III.A.1.a)   graduation from a medical school in the United States or Canada,
629   accredited by the Liaison Committee on Medical Education
630   (LCME) or graduation from a college of osteopathic medicine in
631   the United States, accredited by the American Osteopathic
632   Association Commission on Osteopathic College Accreditation
633   (AOACOCA); or, (Core)
634

635	III.A.1.b)	graduation from a medical school outside of the United States or Canada, and meeting one of the following additional qualifications: ^(Core)
636		
637		
638		

| 635 | III.A.1.b) | graduation from a medical school outside of the United States or Canada, and meeting one of the following additional qualifications: (Core) |

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

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

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

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

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

     [The Review Committee may further specify prerequisite postgraduate clinical education]

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

III.A.3.   A physician who has completed a residency program that was not accredited by ACGME, AOA, RCPSC, CFPC, or ACGME-I (with Advanced Specialty Accreditation) may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director of the ACGME-accredited program and with approval by the GMEC, may be advanced to the PGY-2 level based on ACGME Milestones evaluations assessments at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry. (Core)

III.A.4.   Resident Eligibility Exception

     The Review Committee for _____ will allow the following exception to the resident eligibility requirements: (Core)

681		
682		[Note: A Review Committee may permit the eligibility exception if the
683		specialty requires completion of a prerequisite residency program prior to
684		admission. If this language is not applicable, this section will not appear in
685		the specialty-specific requirements.]
686		
687	III.A.4.a)	An ACGME-accredited residency program may accept an
688		exceptionally qualified international graduate applicant who does
689		not satisfy the eligibility requirements listed in III.A.1.-III.A.3., but
690		who does meet all of the following additional qualifications and
691		conditions: (Core)
692		
693	III.A.4.a).(1)	evaluation by the program director and residency selection
694		committee of the applicant's suitability to enter the
695		program, based on prior training and review of the
696		summative evaluations of this training; and, (Core)
697		
698	III.A.4.a).(2)	review and approval of the applicant's exceptional
699		qualifications by the GMEC; and, (Core)
700		
701	III.A.4.a).(3)	verification of Educational Commission for Foreign Medical
702		Graduates (ECFMG) certification. (Core)
703		
704	III.A.4.b)	Applicants accepted through this exception must have an
705		evaluation of their performance by the Clinical Competency
706		Committee within 12 weeks of matriculation. (Core)
707		
708	III.A.4.c)	A Review Committee may grant the exception to the eligibility
709		requirements specified in Section III.A.2.b) for residency programs
710		that require completion of a prerequisite residency program prior
711		to admission. (Core)
712		
713	III.A.4.d)	Review Committees will grant no other exceptions to these
714		eligibility requirements for residency education. (Core)
715		
716	III.A.5.	Eligibility Requirements – Fellowship Programs [Section moved to
717		Common Program Requirements (Fellowship)]
718		
719		All required clinical education for entry into ACGME-accredited fellowship
720		programs must be completed in an ACGME-accredited residency
721		program, or in an RCPSC-accredited or CFPC- accredited residency
722		program located in Canada. (Core)
723		
724	III.A.5.a)	Fellowship programs must receive verification of each entering
725		fellow's level of competency in the required field using ACGME or
726		CanMEDS Milestones assessments from the core residency
727		program. (Core)
728		
729	III.A.5.b)	Fellow Eligibility Exception
730		
731		A Review Committee may grant the following exception to the

732		fellowship eligibility requirements:
733		
734		An ACGME-accredited fellowship program may accept an
735		exceptionally qualified applicant**, who does not satisfy the
736		eligibility requirements listed in Sections III.A.2. and III.A.2.a), but
737		who does meet all of the following additional qualifications and
738		conditions: (Core)
739		
740	III.A.5.c)	Assessment by the program director and fellowship selection
741		committee of the applicant's suitability to enter the program, based
742		on prior training and review of the summative evaluations of
743		training in the core specialty; and (Core)
744		
745	III.A.5.c).(1)	Review and approval of the applicant's exceptional
746		qualifications by the GMEC or a subcommittee of the
747		GMEC; and (Core)
748		
749	III.A.5.c).(2)	Satisfactory completion of the United States Medical
750		Licensing Examination (USMLE) Steps 1, 2, and, if the
751		applicant is eligible, 3, and; (Core)
752		
753	III.A.5.c).(3)	For an international graduate, verification of Educational
754		Commission for Foreign Medical Graduates (ECFMG)
755		certification; and, (Core)
756		
757	III.A.5.c).(4)	Applicants accepted by this exception must complete
758		fellowship Milestones evaluation (for the purposes of
759		establishment of baseline performance by the Clinical
760		Competency Committee), conducted by the receiving
761		fellowship program within six weeks of matriculation. This
762		evaluation may be waived for an applicant who has
763		completed an ACGME International-accredited residency
764		based on the applicant's Milestones evaluation conducted
765		at the conclusion of the residency program. (Core)
766		
767	III.A.5.c).(4).(a)	If the trainee does not meet the expected level of
768		Milestones competency following entry into the
769		fellowship program, the trainee must undergo a
770		period of remediation, overseen by the Clinical
771		Competency Committee and monitored by the
772		GMEC or a subcommittee of the GMEC. This
773		period of remediation must not count toward time in
774		fellowship training. (Core)
775		
776		** An exceptionally qualified applicant has (1) completed a non-
777		ACGME-accredited residency program in the core specialty, and
778		(2) demonstrated clinical excellence, in comparison to peers,
779		throughout training. Additional evidence of exceptional
780		qualifications is required, which may include one of the following:
781		(a) participation in additional clinical or research training in the
782		specialty or subspecialty; (b) demonstrated scholarship in the

783		specialty or subspecialty; (c) demonstrated leadership during or
784		after residency training; (d) completion of an ACGME-
785		International-accredited residency program.

787 [Each Review Committee will decide no later than December 31, 2013 whether the exception
788 specified above will be permitted. If the Review Committee will not allow this exception, the
789 program requirements will include the following statement]:

791	III.A.5.d)	The Review Committee for _____ does not allow exceptions to the
792		Eligibility Requirements for Fellowship Programs in Section III.A.2.
793		(Core)

| 795 | III.B. | Number of Residents |

797 The program director must ~~may~~ not appoint more residents than approved by the
798 Review Committee, ~~unless otherwise stated in the specialty-specific~~
799 ~~requirements.~~ (Core)

| 801 | III.B.1. | All complement increases must be approved by the Review Committee. |
| 802 | | (Core) |

804 [The Review Committee may further specify minimum complement numbers] ~~[As~~
805 ~~further specified by the Review Committee]~~

| 807 | III.C. | Resident Transfers |

809 ~~Before accepting a resident who is transferring from another program,~~ The
810 program ~~director~~ must obtain ~~written or electronic~~ verification of previous
811 educational experiences and a summative competency-based performance
812 evaluation prior to acceptance of a transferring resident, and Milestones
813 evaluations upon matriculation. (~~Core~~Detail)

815 [The Review Committee may further specify]

817	III.C.1.	A program director must provide timely verification of residency education
818		and summative performance evaluations for residents who may leave the
819		program prior to completion. (Detail)

| 821 | IV. | Educational Program |

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

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

830 *In addition, the program is expected to define its specific program aims consistent with*
831 *the overall mission of its Sponsoring Institution, the needs of the community it serves*
832 *and that its graduates will serve, and the distinctive capabilities of physicians it intends to*
833 *graduate. While programs must demonstrate substantial compliance with the Common*

834   *and specialty-specific Program Requirements, it is recognized that within this framework,*
835   *programs may place different emphasis on research, leadership, public health, etc. It is*
836   *expected that the program aims will reflect the nuanced program-specific goals for it and*
837   *its graduates; for example, it is expected that a program aiming to prepare physician-*
838   *scientists will have a different curriculum from one focusing on community health.*
839
840   IV.A.   The curriculum must contain the following educational components: (Core)
841
842   IV.A.1.   a set of program aims consistent with the Sponsoring Institution's
843   mission, the needs of the community it serves, and the desired distinctive
844   capabilities of its graduates; (Core)
845
846   IV.A.1.a)   The program's aims must be made ~~Overall educational goals for~~
847   ~~the program, which the program must make~~ available to program
848   applicants, residents, and faculty members. (Core)
849
850   IV.A.2.   competency-based goals and objectives for each ~~assignment at each~~
851   educational ~~level~~ experience designed to promote progress on a
852   trajectory to autonomous practice., ~~which the program must distribute~~
853   These must be distributed, reviewed, and available to residents and
854   faculty members ~~at least annually, in either written or electronic form~~; (Core)
855

> 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.

856
857   IV.A.3.   delineation of resident responsibilities for patient care, progressive
858   responsibility for patient management, and graded supervision; ~~of~~
859   ~~residents over the continuum of the program; and,~~ (Core)
860

> 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.

861
862   IV.A.4.   a broad range of structured didactic activities ~~regularly scheduled didactic~~
863   ~~sessions~~; (Core)
864
865   IV.A.4.a)   Residents must be provided with protected time to participate in
866   core didactic activities. (Core)
867

> 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.

868

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

871

872 IV.A.6. advancement in ~~The curriculum must advance~~ the residents' knowledge
873 of the basic principles of ~~research~~ scientific inquiry, including how
874 research is designed, conducted, evaluated, explained to patients, and
875 applied to patient care. (Core) [Moved here from IV.B.1.]

876

877 IV.B. ACGME Competencies

878

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.

879

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

882

883 IV.B.1.a) Professionalism

884

885 Residents must demonstrate a commitment to ~~carrying out~~
886 ~~professional responsibilities~~ professionalism and an adherence to
887 ethical principles. (~~Outcome~~Core)

888

889 IV.B.1.a).(1) Residents must ~~are expected to~~ demonstrate competence
890 in:

891

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

894

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

897

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.

898

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

901

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

904

905 IV.B.1.a).(1).(e) respect ~~sensitivity~~ and responsiveness to diverse

906		patient populations, including but not limited to
907		diversity in gender, age, culture, race, religion,
908		disabilities, national origin, socioeconomic status,
909		and sexual orientation; (OutcomeCore)
910		
911	IV.B.1.a).(1).(f)	ability to recognize and develop a plan for one's
912		own personal and professional well-being; and,
913		(Core)
914		
915	IV.B.1.a).(1).(g)	appropriately disclosing and addressing conflict or
916		duality of interest. (Core)
917		
918		[As further specified by the Review Committee]
919		
920	IV.B.1.b)	Patient Care and Procedural Skills
921		

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.

922		
923	IV.B.1.b).(1)	Residents must be able to provide patient care that is
924		compassionate, appropriate, and effective for the treatment
925		of health problems and the promotion of health. Residents:
926		(OutcomeCore)
927		
928		[The Review Committee must further specify] [As further
929		specified by the Review Committee]
930		
931	IV.B.1.b).(2)	Residents must be able to competently perform all
932		medical, diagnostic, and surgical procedures considered
933		essential for the area of practice. Residents: (OutcomeCore)
934		
935		[The Review Committee may further specify] [As further
936		specified by the Review Committee]
937		
938	IV.B.1.c)	Medical Knowledge
939		
940		Residents must demonstrate knowledge of established and
941		evolving biomedical, clinical, epidemiological and social-
942		behavioral sciences, as well as the application of this knowledge
943		to patient care. Residents: (OutcomeCore)
944		
945		[The Review Committee must further specify] [As further specified

946		by the Review Committee]
947		
948	IV.B.1.d)	Practice-based Learning and Improvement

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

> Background and Intent: Practice-based learning and improvement is one of the defining characteristics of being a physician. It is the ability to investigate and evaluate the care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning.
>
> The intention of this Competency is to help a physician develop the habits of mind required to continuously pursue quality improvement, well past the completion of residency.

IV.B.1.d).(1) Residents must demonstrate competence in ~~are expected to develop skills and habits to be able to meet the following goals~~:

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

IV.B.1.d).(1).(b) setting ~~set~~ learning and improvement goals; (~~Outcome~~Core)

IV.B.1.d).(1).(c) identifying ~~identify~~ and performing ~~perform~~ appropriate learning activities; (~~Outcome~~Core)

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

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

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

IV.B.1.d).(1).(g) using ~~use~~ information technology to optimize learning. (~~Outcome~~Core)

~~IV.B.1.d).(1).(h)~~ ~~participate in the education of patients, families, students, residents and other health professionals. (Outcome)~~

[The Review Committee may further specify by adding to the list of

990 991		sub-competencies] [As further specified by the Review Committee]
992		
993	IV.B.1.e)	Interpersonal and Communication Skills
994		
995 996 997 998		Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (OutcomeCore)
999		
1000 1001	IV.B.1.e).(1)	Residents must demonstrate competence in are expected to:
1002		
1003 1004 1005 1006	IV.B.1.e).(1).(a)	communicating communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; (OutcomeCore)
1007		
1008 1009 1010	IV.B.1.e).(1).(b)	communicating communicate effectively with physicians, other health professionals, and health-related agencies; (OutcomeCore)
1011		
1012 1013 1014	IV.B.1.e).(1).(c)	working work effectively as a member or leader of a health care team or other professional group; (OutcomeCore)
1015		
1016 1017	IV.B.1.e).(1).(d)	educating patients, families, students, residents, and other health professionals; (Core)
1018		
1019 1020	IV.B.1.e).(1).(e)	acting act in a consultative role to other physicians and health professionals; and, (OutcomeCore)
1021		
1022 1023	IV.B.1.e).(1).(f)	maintaining maintain comprehensive, timely, and legible medical records, if applicable. (OutcomeCore)
1024		
1025 1026 1027	IV.B.1.e).(2)	Residents must learn to communicate with patients and families to partner with them to assess their care goals, including, when appropriate, end-of-life goals. (Core)
1028		
1029 1030 1031		[The Review Committee may further specify by adding to the list of sub-competencies] [As further specified by the Review Committee]
1032		

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.	
1033		
1034	IV.B.1.f)	Systems-based Practice
1035		
1036		Residents must demonstrate an awareness of and
1037		responsiveness to the larger context and system of health care,
1038		including the social determinants of health, as well as the ability to
1039		call effectively on other resources ~~in the system~~ to provide optimal
1040		health care. (~~Outcome~~Core)
1041		
1042	IV.B.1.f).(1)	Residents must demonstrate competence in ~~are expected~~
1043		~~to~~:
1044		
1045	IV.B.1.f).(1).(a)	working ~~work~~ effectively in various health care
1046		delivery settings and systems relevant to their
1047		clinical specialty; (~~Outcome~~Core)
1048		

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.

1049		
1050	IV.B.1.f).(1).(b)	coordinating ~~coordinate~~ patient care across ~~within~~
1051		the health care ~~systems~~ continuum and beyond as
1052		relevant to their clinical specialty; (~~Outcome~~Core)
1053		

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.

1054		
1055	IV.B.1.f).(1).(c)	advocating ~~advocate~~ for quality patient care and
1056		optimal patient care systems; (~~Outcome~~Core)
1057		
1058	IV.B.1.f).(1).(d)	working ~~work~~ in interprofessional teams to enhance
1059		patient safety and improve patient care quality;
1060		(~~Outcome~~Core)
1061		
1062	IV.B.1.f).(1).(e)	participating ~~participate~~ in identifying system errors
1063		and implementing potential systems solutions;
1064		(~~Outcome~~Core)
1065		
1066	IV.B.1.f).(1).(f)	incorporating ~~incorporate~~ considerations of value,
1067		cost awareness, delivery and payment, and risk-
1068		benefit analysis in patient and/or population-based
1069		care as appropriate; and, (~~Outcome~~Core)
1070		
1071	IV.B.1.f).(1).(g)	understanding health care finances and its impact
1072		on individual patients' health decisions. (Core)
1073		

1074	IV.B.1.f).(2)	Residents must learn to advocate for patients within the
1075		health care system to achieve the patient's and family's
1076		care goals, including, when appropriate, end-of-life goals.
1077		(Core)

1078

1079   [The Review Committee may further specify by adding to the list of
1080   sub-competencies] [As further specified by the Review
1081   Committee]

1082

1083   IV.C.   Curriculum Organization and Resident Experiences

1084

1085   IV.C.1.   The curriculum must be structured to optimize resident educational
1086   experiences, the length of these experiences, and supervisory continuity.
1087   (Core)

1088

1089   [The Review Committee must further specify]

1090

> 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.

1091

1092   IV.C.2.   The program must provide instruction and experience in pain
1093   management if applicable for the specialty, including recognition of the
1094   signs of addiction. (Core)

1095

1096   [The Review Committee may further specify]

1097

1098   [The Review Committee may specify required didactic and clinical experiences]

1099

1100   IV.D.   Scholarship

1101

1102   *Medicine is both an art and a science. The physician is a humanistic scientist*
1103   *who cares for patients. This requires the ability to think critically, evaluate the*
1104   *literature, appropriately assimilate new knowledge, and practice lifelong learning.*
1105   *The program and faculty must create an environment that fosters the acquisition*
1106   *of such skills through resident participation in scholarly activities. Scholarly*
1107   *activities may include discovery, integration, application, and teaching.*

1108

1109   *The ACGME recognizes the diversity of residencies and anticipates that*
1110   *programs prepare physicians for a variety of roles, including clinicians, scientists,*
1111   *and educators. It is expected that the program's scholarship will reflect its*
1112   *mission(s) and aims, and the needs of the community it serves. For example,*
1113   *some programs may concentrate their scholarly activity on quality improvement,*
1114   *population health, and/or teaching, while other programs might choose to utilize*
1115   *more classic forms of biomedical research as the focus for scholarship.*

1116

1117   IV.D.1.   Program Responsibilities

1118

1119	IV.D.1.a)	The program must demonstrate evidence of scholarly activities
1120		consistent with its mission(s) and aims. (Core)
1121		
1122	IV.D.1.b)	The ~~sponsoring institution and~~ program, in partnership with its
1123		Sponsoring Institution, must ~~should~~ allocate adequate ~~educational~~
1124		resources to facilitate resident and faculty involvement in scholarly
1125		activities. (~~Core~~Detail)
1126		
1127		[The Review Committee may further specify] [~~As further specified~~
1128		~~by the Review Committee~~]
1129		
1130	IV.D.1.c)	The program must advance residents' knowledge and practice of
1131		the scholarly approach to evidence-based patient care. (Core)
1132		

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.

1133		
1134	IV.D.2.	Faculty Scholarly Activity
1135		
1136	IV.D.2.a)	Among their scholarly activity, programs must demonstrate
1137		accomplishments in at least three of the following domains: (Core)
1138		

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

1149		• Innovations in education
1150		
1151	IV.D.2.b)	The program must demonstrate dissemination of scholarly activity
1152		within and external to the program by the following methods:
1153		
1154		[Review Committee will choose to require either IV.D.2.b).(1) or
1155		both IV.D.2.b).(1) and IV.D.2.b).(2)]
1156		

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.

1157		
1158	IV.D.2.b).(1)	faculty participation in grand rounds, posters, workshops,
1159		quality improvement presentations, podium presentations,
1160		grant leadership, non-peer-reviewed print/electronic
1161		resources, articles or publications, book chapters,
1162		textbooks, webinars, service on professional committees,
1163		or serving as a journal reviewer, journal editorial board
1164		member, or editor; (Outcome)‡
1165		
1166	IV.D.2.b).(2)	peer-reviewed publication. (Outcome)
1167		
1168	IV.D.3.	Residents' Scholarly Activity
1169		
1170	IV.D.3.a)	Residents must should participate in scholarship scholarly activity.
1171		(Core)
1172		
1173		[The Review Committee may further specify] [As further specified
1174		by the Review Committee]
1175		
1176	V. Evaluation	
1177		
1178	V.A.	Resident Evaluation
1179		
1180	V.A.1.	Feedback and Evaluation Formative Evaluation
1181		

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.

1182

1183 V.A.1.a) Faculty members must directly observe, evaluate, and frequently
1184 provide feedback on resident performance during each rotation or
1185 similar educational assignment. ~~The faculty must evaluate~~
1186 ~~resident performance in a timely manner during each rotation or~~
1187 ~~similar educational assignment, and document this evaluation at~~
1188 ~~completion of the assignment.~~ (Core)
1189

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.

1190

1191 V.A.1.b) Evaluation must be documented at the completion of the
1192 assignment. (Core)
1193

1194 V.A.1.b).(1) For block rotations of greater than three months in
1195 duration, evaluation must be documented at least every
1196 three months. (Core)
1197

1198 V.A.1.b).(2) Longitudinal experiences, such as continuity clinic in the
1199 context of other clinical responsibilities, must be evaluated
1200 at least every three months and at completion. (Core)
1201

1202 V.A.1.c) The program must provide an objective ~~assessments~~ performance
1203 evaluation based on the Competencies and ~~of competence in~~
1204 ~~patient care and procedural skills, medical knowledge, practice-~~
1205 ~~based learning and improvement, interpersonal and~~
1206 ~~communication skills, professionalism, and systems-based~~
1207 ~~practice based on~~ the specialty-specific Milestones, and must:

| 1208 | | (Core) |
| 1209 | | |

1210   V.A.1.c).(1)   use multiple evaluators (e.g., faculty <u>members</u>, peers,
1211   patients, self, and other professional staff <u>members</u>); <u>and,</u>
1212   (<u>Core</u>~~Detail~~)
1213

1214   V.A.1.c).(2)   <u>provide that information to the Clinical Competency</u>
1215   <u>Committee for its synthesis of progressive resident</u>
1216   <u>performance and improvement toward unsupervised</u>
1217   <u>practice.</u> (Core)
1218

1219   ~~V.A.1.c).(3)~~   ~~document progressive resident performance improvement~~
1220   ~~appropriate to educational level; and,~~ (Core)
1221

1222   ~~V.A.1.c).(4)~~   ~~provide each resident with documented semiannual~~
1223   ~~evaluation of performance with feedback.~~ (Core)
1224

1225   V.A.1.d)   <u>The program director or their designee, with input from the Clinical</u>
1226   <u>Competency Committee, must:</u>
1227

1228   V.A.1.d).(1)   <u>meet with and review with each resident their documented</u>
1229   <u>semi-annual evaluation of performance, including progress</u>
1230   <u>along the specialty-specific Milestones;</u> (Core)
1231

1232   V.A.1.d).(2)   <u>assist residents in developing individualized learning plans</u>
1233   <u>to capitalize on their strengths and identify areas for</u>
1234   <u>growth; and,</u> (Core)
1235

1236   V.A.1.d).(3)   <u>develop plans for residents failing to progress, following</u>
1237   <u>institutional policies and procedures.</u> (Core)
1238

> <u>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.</u>
>
> <u>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.</u>

1239

1240   V.A.1.e)   <u>At least annually, there must be a summative evaluation of each</u>
1241   <u>resident that includes their readiness to progress to the next year</u>
1242   <u>of the program, if applicable.</u> (Core)
1243

1244	V.A.1.f)	The evaluations of a resident's performance must be accessible
1245		for review by the resident, in accordance with institutional policy.
1246		(CoreDetail)

1247

1248   [The Review Committee may further specify under any requirement in
1249   V.A.1.-V.A.1.f)]

1250

1251 V.A.2.   Final Summative Evaluation

1252

1253 V.A.2.a)   The program director must provide a final summative evaluation
1254   for each resident upon completion of the program. (Core)

1255

1256 V.A.2.a).(1)   The specialty-specific Milestones, and when applicable the
1257   specialty-specific Case Logs, must be used as one of the
1258   tools to ensure residents are able to engage in
1259   autonomous practice core professional activities without
1260   supervision upon completion of the program. (Core)

1261

1262 V.A.2.a).(2)   The final this evaluation must:

1263

1264 V.A.2.a).(2).(a)   become part of the resident's permanent record
1265   maintained by the institution, and must be
1266   accessible for review by the resident in accordance
1267   with institutional policy; (CoreDetail)

1268

1269 V.A.2.a).(2).(b)   verify that the resident has demonstrated sufficient
1270   competence the knowledge, skills, and behaviors
1271   necessary to enter autonomous practice without
1272   direct supervision; (CoreDetail)

1273

1274 V.A.2.a).(2).(c)   consider recommendations from the Clinical
1275   Competency Committee; and, (Core)

1276

1277 V.A.2.a).(2).(d)   be shared with the resident upon completion of the
1278   program. (Core)

1279

1280 V.A.2.a).(2).(e)   document the resident's performance during the
1281   final period of education. (Detail)

1282

1283 V.A.3.   A Clinical Competency Committee must be appointed by the program
1284   director. The program director must appoint the Clinical Competency
1285   Committee. (Core)

1286

1287 V.A.3.a)   At a minimum, the Clinical Competency Committee must include
1288   be composed of three members of the program faculty, at least
1289   one of whom is a core faculty member. (Core)

1290

1291 V.A.3.a).(1)   The program director may appoint additional members of
1292   the Clinical Competency Committee. These Additional
1293   members must be faculty members from the same
1294   program or other programs, or other health professionals

1295		who have extensive contact and experience with the
1296		program's residents ~~in patient care and other health care~~
1297		~~settings.~~ (Core)
1298		

> 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.

1299		
1300	~~V.A.3.a).(2)~~	~~Chief residents who have completed core residency~~
1301		~~programs in their specialty and are eligible for specialty~~
1302		~~board certification may be members of the Clinical~~
1303		~~Competency Committee.~~ (Core)
1304		
1305	V.A.3.b)	~~There must be a written description of the responsibilities of the~~
1306		~~Clinical Competency Committee.~~ (Core) The Clinical Competency
1307		Committee ~~should~~ must:
1308		
1309	V.A.3.b).(1)	review all resident evaluations at least semi-annually; (Core)
1310		
1311	V.A.3.b).(2)	determine each resident's progress on achievement of the
1312		specialty-specific Milestones ~~prepare and ensure the~~
1313		~~reporting of Milestones evaluations of each resident semi-~~
1314		~~annually to ACGME~~; and, (Core)
1315		
1316	V.A.3.b).(3)	meet prior to the residents' semi-annual evaluations and
1317		advise the program director regarding each resident's
1318		progress~~, including promotion, remediation, and dismissal~~.
1319		(Core~~Detail~~)
1320		
1321	V.B.	Faculty Evaluation
1322		
1323	V.B.1.	~~At least annually, t~~The program must have a process to evaluate each
1324		faculty member's performance as it relates to the educational program at
1325		least annually. (Core)
1326		

> Background and Intent: The program director is responsible for the education program and for whom delivers it. While the term "faculty" may be applied to physicians within a given institution for other reasons, it is applied to residency program faculty members only through approval by a program director. The development of the faculty improves the education, clinical, and research aspects of a program. Faculty members have a strong commitment to

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

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

V.B.1.b)   This evaluation must include ~~at least annual~~ written, anonymous, and confidential evaluations by the residents. (Core~~Detail~~)

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

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

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

V.C.   Program Evaluation and Improvement

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

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

V.C.1.b)   Program Evaluation Committee ~~must have a written description of its~~ responsibilities must include:

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

1359		program oversight; (Core)
1360		
1361	V.C.1.b).(2)	review of the program's self-determined goals and
1362		progress toward meeting them; (Core)
1363		
1364	V.C.1.b).(3)	guiding ongoing program improvement, including
1365		development of new goals, based upon outcomes; and,
1366		(Core)
1367		
1368	V.C.1.b).(4)	review of the current operating environment to identify
1369		strengths, challenges, opportunities, and threats as related
1370		to the program's mission and aims. (Core)
1371		
1372	~~V.C.1.b).(5)~~	~~should participate actively in:~~
1373		
1374	~~V.C.1.b).(5).(a)~~	~~planning, developing, implementing, and evaluating~~
1375		~~educational activities of the program;~~ ~~(Detail)~~
1376		
1377	~~V.C.1.b).(5).(b)~~	~~reviewing and making recommendations for~~
1378		~~revision of competency-based curriculum goals and~~
1379		~~objectives; and,~~ ~~(Detail)~~
1380		
1381	~~V.C.1.b).(5).(c)~~	~~addressing areas of non-compliance with ACGME~~
1382		~~standards; and,~~ ~~(Detail)~~
1383		
1384	~~V.C.1.b).(5).(d)~~	~~reviewing the program annually using evaluations~~
1385		~~of faculty, residents, and others, as specified below.~~
1386		~~(Detail)~~
1387		
1388	~~V.C.1.b).(6)~~	~~The program, through the PEC, must document formal,~~
1389		~~systematic evaluation of the curriculum at least annually,~~
1390		~~and is responsible for rendering a written, annual program~~
1391		~~evaluation.~~ ~~(Core)~~
1392		

> 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.

1393		
1394	V.C.1.c)	The Program Evaluation Committee should consider the following
1395		elements in its assessment of the program~~The program must~~
1396		~~monitor and track each of the following areas~~:
1397		
1398	V.C.1.c).(1)	curriculum; (Core)
1399		
1400	V.C.1.c).(2)	outcomes from prior Annual Program Evaluation(s); (Core)
1401		
1402	V.C.1.c).(3)	ACGME letters of notification, including citations, Areas for
1403		Improvement, and comments; (Core)

1404		
1405	V.C.1.c).(4)	quality and safety of patient care; (Core)
1406		
1407	V.C.1.c).(5)	aggregate resident and faculty:
1408		
1409	V.C.1.c).(5).(a)	well-being; (Core)
1410		
1411	V.C.1.c).(5).(b)	recruitment and retention; (Core)
1412		
1413	V.C.1.c).(5).(c)	workforce diversity; (Core)
1414		
1415	V.C.1.c).(5).(d)	engagement in quality improvement and patient
1416		safety; (Core)
1417		
1418	V.C.1.c).(5).(e)	scholarly activity; (Core)
1419		
1420	V.C.1.c).(5).(f)	ACGME Resident and Faculty Surveys; and, (Core)
1421		
1422	V.C.1.c).(5).(g)	written evaluations of the program. (Core)
1423		
1424	V.C.1.c).(6)	aggregate resident:
1425		
1426	V.C.1.c).(6).(a)	achievement of the Milestones; (Core)
1427		
1428	V.C.1.c).(6).(b)	in-training examinations (where applicable); (Core)
1429		
1430	V.C.1.c).(6).(c)	board pass and certification rates~~graduate~~
1431		~~performance, including performance of program~~
1432		~~graduates on the certification examination~~; and,
1433		(Core)
1434		
1435	V.C.1.c).(6).(d)	graduate ~~resident~~ performance. (Core)
1436		
1437	V.C.1.c).(7)	aggregate faculty:
1438		
1439	V.C.1.c).(7).(a)	evaluation; and, (Core)
1440		
1441	V.C.1.c).(7).(b)	professional ~~faculty~~ development. (Core)
1442		
1443	~~V.C.1.c).(8)~~	~~program quality; and, (Core)~~
1444		
1445	~~V.C.1.c).(8).(a)~~	~~Residents and faculty must have the opportunity to~~
1446		~~evaluate the program confidentially and in writing at~~
1447		~~least annually, and (Detail)~~
1448		
1449	~~V.C.1.c).(8).(b)~~	~~The program must use the results of residents' and~~
1450		~~faculty members' assessments of the program~~
1451		~~together with other program evaluation results to~~
1452		~~improve the program. (Detail)~~
1453		
1454	~~V.C.1.c).(9)~~	~~progress on the previous year's action plan(s). (Core)~~

1455		
1456	V.C.1.d)	The Program Evaluation Committee must evaluate the program's
1457		mission and aims, strengths, areas for improvement, and threats.
1458		(Core)
1459		
1460	V.C.1.e)	The annual review, including the action plan, must:
1461		
1462	V.C.1.e).(1)	be distributed to and discussed with the members of the
1463		teaching faculty and the residents; and, (Core)
1464		
1465	V.C.1.e).(2)	be submitted to the DIO. (Core)
1466		
1467	V.C.1.f)	~~The PEC must prepare a written plan of action to document~~
1468		~~initiatives to improve performance in one or more of the areas~~
1469		~~listed in section V.C.2., as well as delineate how they will be~~
1470		~~measured and monitored.~~ (Core)
1471		
1472	~~V.C.1.f).(1)~~	~~The action plan should be reviewed and approved by the~~
1473		~~teaching faculty and documented in meeting minutes.~~ (Detail)
1474		
1475	V.C.2.	The program must complete a Self-Study prior to its 10-Year
1476		Accreditation Site Visit. (Core)
1477		
1478	V.C.2.a)	A summary of the Self-Study must be submitted to the DIO. (Core)
1479		

> 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.

1480		
1481	V.C.3.	*One goal of ACGME-accredited education is to educate physicians who*
1482		*seek and achieve board certification. One measure of the effectiveness of*
1483		*the educational program is the ultimate pass rate.*
1484		
1485		*The program director should encourage all eligible program graduates to*
1486		*take the certifying examination offered by the applicable American Board*
1487		*of Medical Specialties (ABMS) member board or American Osteopathic*
1488		*Association (AOA) certifying board.*
1489		
1490	V.C.3.a)	For specialties in which the ABMS member board and/or AOA
1491		certifying board offer(s) an annual written exam, in the preceding
1492		three years, the program's aggregate pass rate of those taking the
1493		examination for the first time must be higher than the bottom fifth
1494		percentile of programs in that specialty. (Outcome)
1495		

1496	V.C.3.b)	For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)
1497		
1498		
1499		
1500		
1501		
1502	V.C.3.c)	For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)
1503		
1504		
1505		
1506		
1507		
1508	V.C.3.d)	For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)
1509		
1510		
1511		
1512		
1513		
1514	V.C.3.e)	For each of the exams referenced in V.C.3.a)-d), any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty. (Outcome)
1515		
1516		
1517		
1518		
1519		

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.

1520		
1521	V.C.3.f)	Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years earlier. (Core)
1522		
1523		
1524		

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.

1525
1526   VI.   The Learning and Working Environment
1527
1528   *Residency education must occur in the context of a learning and working environment*
1529   *that emphasizes the following principles:*
1530
1531   • *Excellence in the safety and quality of care rendered to patients by residents today*
1532
1533   • *Excellence in the safety and quality of care rendered to patients by today's residents*
1534   *in their future practice*
1535
1536   • *Excellence in professionalism through faculty modeling of:*
1537
1538   ○ *the effacement of self-interest in a humanistic environment that supports the*
1539   *professional development of physicians*
1540
1541   ○ *the joy of curiosity, problem-solving, intellectual rigor, and discovery*
1542
1543   • *Commitment to the well-being of the students, residents, faculty members, and all*
1544   *members of the health care team*
1545

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.

1546
1547   VI.A.   Patient Safety, Quality Improvement, Supervision, and Accountability
1548
1549   VI.A.1.   Patient Safety and Quality Improvement
1550
1551   *All physicians share responsibility for promoting patient safety and*
1552   *enhancing quality of patient care. Graduate medical education must*

1553		*prepare residents to provide the highest level of clinical care with*
1554		*continuous focus on the safety, individual needs, and humanity of their*
1555		*patients. It is the right of each patient to be cared for by residents who are*
1556		*appropriately supervised; possess the requisite knowledge, skills, and*
1557		*abilities; understand the limits of their knowledge and experience; and*
1558		*seek assistance as required to provide optimal patient care.*
1559		
1560		*Residents must demonstrate the ability to analyze the care they provide,*
1561		*understand their roles within health care teams, and play an active role in*
1562		*system improvement processes. Graduating residents will apply these*
1563		*skills to critique their future unsupervised practice and effect quality*
1564		*improvement measures.*
1565		
1566		*It is necessary for residents and faculty members to consistently work in a*
1567		*well-coordinated manner with other health care professionals to achieve*
1568		*organizational patient safety goals.*
1569		
1570	VI.A.1.a)	Patient Safety
1571		
1572	VI.A.1.a).(1)	Culture of Safety
1573		
1574		*A culture of safety requires continuous identification of*
1575		*vulnerabilities and a willingness to transparently deal with*
1576		*them. An effective organization has formal mechanisms to*
1577		*assess the knowledge, skills, and attitudes of its personnel*
1578		*toward safety in order to identify areas for improvement.*
1579		
1580	VI.A.1.a).(1).(a)	The program, its faculty, residents, and fellows
1581		must actively participate in patient safety systems
1582		and contribute to a culture of safety. (Core)
1583		
1584	VI.A.1.a).(1).(b)	The program must have a structure that promotes
1585		safe, interprofessional, team-based care. (Core)
1586		
1587	VI.A.1.a).(2)	Education on Patient Safety
1588		
1589		Programs must provide formal educational activities that
1590		promote patient safety-related goals, tools, and
1591		techniques. (Core)
1592		

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

1593		
1594		[The Review Committee may further specify]
1595		
1596	VI.A.1.a).(3)	Patient Safety Events
1597		
1598		*Reporting, investigation, and follow-up of adverse events,*
1599		*near misses, and unsafe conditions are pivotal*
1600		*mechanisms for improving patient safety, and are essential*

1601			*for the success of any patient safety program. Feedback*
1602			*and experiential learning are essential to developing true*
1603			*competence in the ability to identify causes and institute*
1604			*sustainable systems-based changes to ameliorate patient*
1605			*safety vulnerabilities.*
1606			
1607	VI.A.1.a).(3).(a)		Residents, fellows, faculty members, and other
1608			clinical staff members must:
1609			
1610	VI.A.1.a).(3).(a).(i)		know their responsibilities in reporting
1611			patient safety events at the clinical site; (Core)
1612			
1613	VI.A.1.a).(3).(a).(ii)		know how to report patient safety events,
1614			including near misses, at the clinical site;
1615			and, (Core)
1616			
1617	VI.A.1.a).(3).(a).(iii)		be provided with summary information of
1618			their institution's patient safety reports. (Core)
1619			
1620	VI.A.1.a).(3).(b)		Residents must participate as team members in
1621			real and/or simulated interprofessional clinical
1622			patient safety activities, such as root cause
1623			analyses or other activities that include analysis, as
1624			well as formulation and implementation of actions.
1625			(Core)
1626			
1627	VI.A.1.a).(4)		Resident Education and Experience in Disclosure of
1628			Adverse Events
1629			
1630			*Patient-centered care requires patients, and when*
1631			*appropriate families, to be apprised of clinical situations*
1632			*that affect them, including adverse events. This is an*
1633			*important skill for faculty physicians to model, and for*
1634			*residents to develop and apply.*
1635			
1636	VI.A.1.a).(4).(a)		All residents must receive training in how to
1637			disclose adverse events to patients and families.
1638			(Core)
1639			
1640	VI.A.1.a).(4).(b)		Residents should have the opportunity to
1641			participate in the disclosure of patient safety
1642			events, real or simulated. (Detail)†
1643			
1644	VI.A.1.b)	Quality Improvement	
1645			
1646	VI.A.1.b).(1)		Education in Quality Improvement
1647			
1648			*A cohesive model of health care includes quality-related*
1649			*goals, tools, and techniques that are necessary in order for*
1650			*health care professionals to achieve quality improvement*
1651			*goals.*

1652		
1653	VI.A.1.b).(1).(a)	Residents must receive training and experience in
1654		quality improvement processes, including an
1655		understanding of health care disparities. (Core)
1656		
1657	VI.A.1.b).(2)	Quality Metrics
1658		

1659 *Access to data is essential to prioritizing activities for care*
1660 *improvement and evaluating success of improvement*
1661 *efforts.*
1662

1663 VI.A.1.b).(2).(a)   Residents and faculty members must receive data
1664   on quality metrics and benchmarks related to their
1665   patient populations. (Core)
1666

1667 VI.A.1.b).(3)   Engagement in Quality Improvement Activities
1668

1669 *Experiential learning is essential to developing the ability to*
1670 *identify and institute sustainable systems-based changes*
1671 *to improve patient care.*
1672

1673 VI.A.1.b).(3).(a)   Residents must have the opportunity to participate
1674   in interprofessional quality improvement activities.
1675   (Core)
1676

1677 VI.A.1.b).(3).(a).(i)   This should include activities aimed at
1678   reducing health care disparities. (Detail)
1679

1680   [The Review Committee may further specify under any
1681   requirement in VI.A.1.b) – VI.A.1.b).(3).(a).(i)]
1682

1683 VI.A.2.   Supervision and Accountability
1684

1685   [Review Committee further specification for section VI.A.2. is under
1686   review. No changes will be made to specialty-specific Program
1687   Requirements under this section until recommendations are finalized.]
1688

1689 VI.A.2.a)   *Although the attending physician is ultimately responsible for the*
1690   *care of the patient, every physician shares in the responsibility*
1691   *and accountability for their efforts in the provision of care.*
1692   *Effective programs, in partnership with their Sponsoring*
1693   *Institutions, define, widely communicate, and monitor a structured*
1694   *chain of responsibility and accountability as it relates to the*
1695   *supervision of all patient care.*
1696

1697   *Supervision in the setting of graduate medical education provides*
1698   *safe and effective care to patients; ensures each resident's*
1699   *development of the skills, knowledge, and attitudes required to*
1700   *enter the unsupervised practice of medicine; and establishes a*
1701   *foundation for continued professional growth.*
1702

1703	VI.A.2.a).(1)	Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care. (Core)

1703 VI.A.2.a).(1) Each patient must have an identifiable and appropriately-
1704 credentialed and privileged attending physician (or
1705 licensed independent practitioner as specified by the
1706 applicable Review Committee) who is responsible and
1707 accountable for the patient's care. (Core)
1708
1709 VI.A.2.a).(1).(a) This information must be available to residents,
1710 faculty members, other members of the health care
1711 team, and patients. (Core)
1712
1713 VI.A.2.a).(1).(b) Residents and faculty members must inform each
1714 patient of their respective roles in that patient's care
1715 when providing direct patient care. (Core)
1716
1717 VI.A.2.b) *Supervision may be exercised through a variety of methods. For*
1718 *many aspects of patient care, the supervising physician may be a*
1719 *more advanced resident or fellow. Other portions of care provided*
1720 *by the resident can be adequately supervised by the immediate*
1721 *availability of the supervising faculty member, fellow, or senior*
1722 *resident physician, either on site or by means of telephonic and/or*
1723 *electronic modalities. Some activities require the physical*
1724 *presence of the supervising faculty member. In some*
1725 *circumstances, supervision may include post-hoc review of*
1726 *resident-delivered care with feedback.*
1727
1728 VI.A.2.b).(1) The program must demonstrate that the appropriate level
1729 of supervision in place for all residents is based on each
1730 resident's level of training and ability, as well as patient
1731 complexity and acuity. Supervision may be exercised
1732 through a variety of methods, as appropriate to the
1733 situation. (Core)
1734
1735 [The Review Committee may specify which activities
1736 require different levels of supervision.]
1737
1738 VI.A.2.c) Levels of Supervision
1739
1740 To promote oversight of resident supervision while providing for
1741 graded authority and responsibility, the program must use the
1742 following classification of supervision: (Core)
1743
1744 VI.A.2.c).(1) Direct Supervision – the supervising physician is physically
1745 present with the resident and patient. (Core)
1746
1747 VI.A.2.c).(2) Indirect Supervision:
1748
1749 VI.A.2.c).(2).(a) with Direct Supervision immediately available – the
1750 supervising physician is physically within the
1751 hospital or other site of patient care, and is
1752 immediately available to provide Direct Supervision.
1753 (Core)

1754		
1755	VI.A.2.c).(2).(b)	with Direct Supervision available – the supervising
1756		physician is not physically present within the
1757		hospital or other site of patient care, but is
1758		immediately available by means of telephonic
1759		and/or electronic modalities, and is available to
1760		provide Direct Supervision. (Core)
1761		
1762	VI.A.2.c).(3)	Oversight – the supervising physician is available to
1763		provide review of procedures/encounters with feedback
1764		provided after care is delivered. (Core)
1765		
1766	VI.A.2.d)	The privilege of progressive authority and responsibility,
1767		conditional independence, and a supervisory role in patient care
1768		delegated to each resident must be assigned by the program
1769		director and faculty members. (Core)
1770		
1771	VI.A.2.d).(1)	The program director must evaluate each resident's
1772		abilities based on specific criteria, guided by the
1773		Milestones. (Core)
1774		
1775	VI.A.2.d).(2)	Faculty members functioning as supervising physicians
1776		must delegate portions of care to residents based on the
1777		needs of the patient and the skills of each resident. (Core)
1778		
1779	VI.A.2.d).(3)	Senior residents or fellows should serve in a supervisory
1780		role to junior residents in recognition of their progress
1781		toward independence, based on the needs of each patient
1782		and the skills of the individual resident or fellow. (Detail)
1783		
1784	VI.A.2.e)	Programs must set guidelines for circumstances and events in
1785		which residents must communicate with the supervising faculty
1786		member(s). (Core)
1787		
1788	VI.A.2.e).(1)	Each resident must know the limits of their scope of
1789		authority, and the circumstances under which the resident
1790		is permitted to act with conditional independence. (Outcome)
1791		

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

1792		
1793	VI.A.2.e).(1).(a)	Initially, PGY-1 residents must be supervised either
1794		directly, or indirectly with direct supervision
1795		immediately available. [Each Review Committee
1796		may describe the conditions and the achieved
1797		competencies under which PGY-1 residents
1798		progress to be supervised indirectly with direct
1799		supervision available.] (Core)
1800		
1801	VI.A.2.f)	Faculty supervision assignments must be of sufficient duration to
1802		assess the knowledge and skills of each resident and to delegate

1803			to the resident the appropriate level of patient care authority and
1804			responsibility. (Core)
1805			
1806	VI.B.		Professionalism
1807			
1808	VI.B.1.		Programs, in partnership with their Sponsoring Institutions, must educate
1809			residents and faculty members concerning the professional
1810			responsibilities of physicians, including their obligation to be appropriately
1811			rested and fit to provide the care required by their patients. (Core)
1812			
1813	VI.B.2.		The learning objectives of the program must:
1814			
1815	VI.B.2.a)		be accomplished through an appropriate blend of supervised
1816			patient care responsibilities, clinical teaching, and didactic
1817			educational events; (Core)
1818			
1819	VI.B.2.b)		be accomplished without excessive reliance on residents to fulfill
1820			non-physician obligations; and, (Core)
1821			

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.

1822			
1823	VI.B.2.c)		ensure manageable patient care responsibilities. (Core)
1824			
1825			[The Review Committee may further specify]
1826			

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.

1827			
1828	VI.B.3.		The program director, in partnership with the Sponsoring Institution, must
1829			provide a culture of professionalism that supports patient safety and
1830			personal responsibility. (Core)
1831			
1832	VI.B.4.		Residents and faculty members must demonstrate an understanding of
1833			their personal role in the:
1834			
1835	VI.B.4.a)		provision of patient- and family-centered care; (Outcome)
1836			

1837	VI.B.4.b)	safety and welfare of patients entrusted to their care, including the
1838		ability to report unsafe conditions and adverse events; (Outcome)
1839		

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.

1840		
1841	VI.B.4.c)	assurance of their fitness for work, including: (Outcome)
1842		

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.

1843		
1844	VI.B.4.c).(1)	management of their time before, during, and after clinical
1845		assignments; and, (Outcome)
1846		
1847	VI.B.4.c).(2)	recognition of impairment, including from illness, fatigue,
1848		and substance use, in themselves, their peers, and other
1849		members of the health care team. (Outcome)
1850		
1851	VI.B.4.d)	commitment to lifelong learning; (Outcome)
1852		
1853	VI.B.4.e)	monitoring of their patient care performance improvement
1854		indicators; and, (Outcome)
1855		
1856	VI.B.4.f)	accurate reporting of clinical and educational work hours, patient
1857		outcomes, and clinical experience data. (Outcome)
1858		
1859	VI.B.5.	All residents and faculty members must demonstrate responsiveness to
1860		patient needs that supersedes self-interest. This includes the recognition
1861		that under certain circumstances, the best interests of the patient may be
1862		served by transitioning that patient's care to another qualified and rested
1863		provider. (Outcome)
1864		
1865	VI.B.6.	Programs, in partnership with their Sponsoring Institutions, must provide
1866		a professional, equitable, respectful, and civil environment that is free
1867		from discrimination, sexual and other forms of harassment, mistreatment,
1868		abuse, or coercion of students, residents, faculty, and staff. (Core)
1869		
1870	VI.B.7.	Programs, in partnership with their Sponsoring Institutions, should have a
1871		process for education of residents and faculty regarding unprofessional
1872		behavior and a confidential process for reporting, investigating, and
1873		addressing such concerns. (Core)
1874		
1875	VI.C.	Well-Being
1876		
1877		*Psychological, emotional, and physical well-being are critical in the development*
1878		*of the competent, caring, and resilient physician and require proactive attention*

1879   *to life inside and outside of medicine. Well-being requires that physicians retain*
1880   *the joy in medicine while managing their own real-life stresses. Self-care and*
1881   *responsibility to support other members of the health care team ~~is an~~ are*
1882   *important component~~s~~ of professionalism; ~~it is~~ they are also ~~a~~ skill~~s~~ that must be*
1883   *modeled, learned, and nurtured in the context of other aspects of residency*
1884   *training.*
1885
1886   *~~In the current health care environment, r~~Residents and faculty members are at*
1887   *~~increased~~ risk for burnout and depression. Programs, in partnership with their*
1888   *Sponsoring Institutions, have the same responsibility to address well-being as*
1889   *~~they do to evaluate~~ other aspects of resident competence. Physicians and all*
1890   *members of the health care team share responsibility for the well-being of each*
1891   *other. For example, a culture which encourages covering for colleagues after an*
1892   *illness without the expectation of reciprocity reflects the ideal of professionalism.*
1893   *A positive culture in a clinical learning environment models constructive*
1894   *behaviors, and prepares residents with the skills and attitudes needed to thrive*
1895   *throughout their careers.*
1896

> 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.

1897
1898   VI.C.1.   ~~This~~ The responsibility of the program, in partnership with the Sponsoring
1899   Institution, to address well-being must include:
1900
1901   VI.C.1.a)   efforts to enhance the meaning that each resident finds in the
1902   experience of being a physician, including protecting time with
1903   patients, minimizing non-physician obligations, providing
1904   administrative support, promoting progressive autonomy and
1905   flexibility, and enhancing professional relationships; (Core)
1906
1907   VI.C.1.b)   attention to scheduling, work intensity, and work compression that
1908   impacts resident well-being; (Core)
1909
1910   VI.C.1.c)   evaluating workplace safety data and addressing the safety of
1911   residents and faculty members; (Core)
1912

> 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.

1913
1914　VI.C.1.d)　　　　　　　　policies and programs that encourage optimal resident and faculty
1915　　　　　　　　　　　　　member well-being; and, (Core)
1916

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.

1917
1918　VI.C.1.d).(1)　　　　　　　Residents must be given the opportunity to attend medical,
1919　　　　　　　　　　　　　mental health, and dental care appointments, including
1920　　　　　　　　　　　　　those scheduled during their working hours. (Core)
1921

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.

1922
1923　VI.C.1.e)　　　　　　　　attention to resident and faculty member burnout, depression, and
1924　　　　　　　　　　　　　substance abuse. The program, in partnership with its Sponsoring
1925　　　　　　　　　　　　　Institution, must educate faculty members and residents in
1926　　　　　　　　　　　　　identification of the symptoms of burnout, depression, and
1927　　　　　　　　　　　　　substance abuse, including means to assist those who experience
1928　　　　　　　　　　　　　these conditions. Residents and faculty members must also be
1929　　　　　　　　　　　　　educated to recognize those symptoms in themselves and how to
1930　　　　　　　　　　　　　seek appropriate care. The program, in partnership with its
1931　　　　　　　　　　　　　Sponsoring Institution, must: (Core)
1932

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).

1933
1934　VI.C.1.e).(1)　　　　　　　encourage residents and faculty members to alert the
1935　　　　　　　　　　　　　program director or other designated personnel or
1936　　　　　　　　　　　　　programs when they are concerned that another resident,
1937　　　　　　　　　　　　　fellow, or faculty member may be displaying signs of
1938　　　　　　　　　　　　　burnout, depression, substance abuse, suicidal ideation, or
1939　　　　　　　　　　　　　potential for violence; (Core)
1940

Background and Intent: Individuals experiencing burnout, depression, substance abuse, and/or suicidal ideation are often reluctant to reach out for help due to the stigma associated with these conditions, and are concerned that seeking help may have a negative impact on their career. Recognizing that physicians are at increased risk in these areas, it is essential that residents and faculty members are able to report their concerns when another resident or faculty member displays signs of any of these conditions, so that the program director or other designated personnel, such as the department chair, may assess the situation and intervene as necessary to facilitate access to appropriate care. Residents and faculty members must

know which personnel, in addition to the program director, have been designated with this responsibility; those personnel and the program director should be familiar with the institution's impaired physician policy and any employee health, employee assistance, and/or wellness programs within the institution. In cases of physician impairment, the program director or designated personnel should follow the policies of their institution for reporting.

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

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

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

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

VI.C.2. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, ~~and~~ family emergencies, and parental leave. Each program must allow an appropriate length of absence for residents ~~have policies and procedures in place that ensure coverage of patient care in the event that a resident may be~~ unable to perform their patient care responsibilities. (Core)

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

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

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

VI.D. Fatigue Mitigation

VI.D.1. Programs must:

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

1973	VI.D.1.b)	educate all faculty members and residents in alertness
1974		management and fatigue mitigation processes; and, (Core)
1975		
1976	VI.D.1.c)	encourage residents to use fatigue mitigation processes to
1977		manage the potential negative effects of fatigue on patient care
1978		and learning. (Detail)
1979		

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.

1980		
1981	VI.D.2.	Each program must ensure continuity of patient care, consistent with the
1982		program's policies and procedures referenced in VI.C.2–VI.C.2.b), in the
1983		event that a resident may be unable to perform their patient care
1984		responsibilities due to excessive fatigue. (Core)
1985		
1986	VI.D.3.	The program, in partnership with its Sponsoring Institution, must ensure
1987		adequate sleep facilities and safe transportation options for residents who
1988		may be too fatigued to safely return home. (Core)
1989		
1990	VI.E.	Clinical Responsibilities, Teamwork, and Transitions of Care
1991		
1992	VI.E.1.	Clinical Responsibilities
1993		
1994		The clinical responsibilities for each resident must be based on PGY
1995		level, patient safety, resident ability, severity and complexity of patient
1996		illness/condition, and available support services. (Core)
1997		
1998		[Optimal clinical workload may be further specified by each Review
1999		Committee]
2000		

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.

2001		
2002	VI.E.2.	Teamwork
2003		
2004		Residents must care for patients in an environment that maximizes
2005		communication. This must include the opportunity to work as a member of
2006		effective interprofessional teams that are appropriate to the delivery of
2007		care in the specialty and larger health system. (Core)
2008		
2009		[The Review Committee may further specify]
2010		
2011	VI.E.3.	Transitions of Care
2012		
2013	VI.E.3.a)	Programs must design clinical assignments to optimize transitions
2014		in patient care, including their safety, frequency, and structure.
2015		(Core)
2016		
2017	VI.E.3.b)	Programs, in partnership with their Sponsoring Institutions, must
2018		ensure and monitor effective, structured hand-over processes to
2019		facilitate both continuity of care and patient safety. (Core)
2020		
2021	VI.E.3.c)	Programs must ensure that residents are competent in
2022		communicating with team members in the hand-over process.
2023		(Outcome)
2024		
2025	VI.E.3.d)	Programs and clinical sites must maintain and communicate
2026		schedules of attending physicians and residents currently
2027		responsible for care. (Core)
2028		
2029	VI.E.3.e)	Each program must ensure continuity of patient care, consistent
2030		with the program's policies and procedures referenced in VI.C.2-
2031		VI.C.2.b), in the event that a resident may be unable to perform
2032		their patient care responsibilities due to excessive fatigue or
2033		illness, or family emergency. (Core)
2034		
2035	VI.F.	Clinical Experience and Education
2036		
2037		*Programs, in partnership with their Sponsoring Institutions, must design an*
2038		*effective program structure that is configured to provide residents with*
2039		*educational and clinical experience opportunities, as well as reasonable*
2040		*opportunities for rest and personal activities.*
2041		

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.

2042		
2043	VI.F.1.	Maximum Hours of Clinical and Educational Work per Week
2044		
2045		Clinical and educational work hours must be limited to no more than 80

2046	hours per week, averaged over a four-week period, inclusive of all in-
2047	house clinical and educational activities, clinical work done from home,
2048	and all moonlighting. (Core)
2049	

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.

2050
2051 VI.F.2. Mandatory Time Free of Clinical Work and Education
2052
2053 VI.F.2.a) The program must design an effective program structure that is
2054 configured to provide residents with educational opportunities, as
2055 well as reasonable opportunities for rest and personal well-being.
2056 (Core)
2057
2058 VI.F.2.b) Residents should have eight hours off between scheduled clinical
2059 work and education periods. (Detail)
2060
2061 VI.F.2.b).(1) There may be circumstances when residents choose to
2062 stay to care for their patients or return to the hospital with
2063 fewer than eight hours free of clinical experience and
2064 education. This must occur within the context of the 80-
2065 hour and the one-day-off-in-seven requirements. (Detail)
2066

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.

2067
2068 VI.F.2.c) Residents must have least 14 hours free of clinical work and
2069 education after 24 hours of in-house call. (Core)
2070

> 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.

2071
2072 VI.F.2.d) Residents must be scheduled for a minimum of one day in seven
2073 free of clinical work and required education (when averaged over
2074 four weeks). At-home call cannot be assigned on these free days.
2075 (Core)
2076

> 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."

2077
2078 VI.F.3. Maximum Clinical Work and Education Period Length
2079
2080 VI.F.3.a) Clinical and educational work periods for residents must not
2081 exceed 24 hours of continuous scheduled clinical assignments.
2082 (Core)
2083

> 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.

2084
2085 VI.F.3.a).(1)   Up to four hours of additional time may be used for
2086   activities related to patient safety, such as providing
2087   effective transitions of care, and/or resident education. (Core)
2088
2089 VI.F.3.a).(1).(a)   Additional patient care responsibilities must not be
2090   assigned to a resident during this time. (Core)
2091

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.

2092
2093 VI.F.4.   Clinical and Educational Work Hour Exceptions
2094
2095 VI.F.4.a)   In rare circumstances, after handing off all other responsibilities, a
2096   resident, on their own initiative, may elect to remain or return to
2097   the clinical site in the following circumstances:
2098
2099 VI.F.4.a).(1)   to continue to provide care to a single severely ill or
2100   unstable patient; (Detail)
2101
2102 VI.F.4.a).(2)   humanistic attention to the needs of a patient or family; or,
2103   (Detail)
2104
2105 VI.F.4.a).(3)   to attend unique educational events. (Detail)
2106
2107 VI.F.4.b)   These additional hours of care or education will be counted toward
2108   the 80-hour weekly limit. (Detail)
2109

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

		ensure that the decision to remain is initiated by the resident and that residents are not coerced. This additional time must be counted toward the 80-hour maximum weekly limit.

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

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

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

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

VI.F.5.   Moonlighting

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

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

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

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

VI.F.6.   In-House Night Float

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

           [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

| 2147 | | Review Committee.] |
| 2148 | | |

2149

2150   VI.F.7.   Maximum In-House On-Call Frequency

2151

2152   Residents must be scheduled for in-house call no more frequently than
2153   every third night (when averaged over a four-week period). [Core]

2154

2155   VI.F.8.   At-Home Call

2156

2157   VI.F.8.a)   Time spent on patient care activities by residents on at-home call
2158   must count toward the 80-hour maximum weekly limit. The
2159   frequency of at-home call is not subject to the every-third-night
2160   limitation, but must satisfy the requirement for one day in seven
2161   free of clinical work and education, when averaged over four
2162   weeks. [Core]

2163

2164   VI.F.8.a).(1)   At-home call must not be so frequent or taxing as to
2165   preclude rest or reasonable personal time for each
2166   resident. [Core]

2167

2168   VI.F.8.b)   Residents are permitted to return to the hospital while on at-home
2169   call to provide direct care for new or established patients. These
2170   hours of inpatient patient care must be included in the 80-hour
2171   maximum weekly limit. [Detail]

2172

2173   [The Review Committee may further specify under any requirement in VI.F. – VI.F.8.b)]

2174

> 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.

2175

2176   ***

2177   ***Core Requirements:** Statements that define structure, resource, or process elements
2178   essential to every graduate medical educational program.

2179

2180   [†]**Detail Requirements:** Statements that describe a specific structure, resource, or process, for
2181   achieving compliance with a Core Requirement. Programs and sponsoring institutions in
2182   substantial compliance with the Outcome Requirements may utilize alternative or innovative

2183   approaches to meet Core Requirements.
2184
2185   ‡**Outcome Requirements:** Statements that specify expected measurable or observable
2186   attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their
2187   graduate medical education.
2188
2189   **Osteopathic Recognition**
2190   For programs seeking Osteopathic Recognition for the entire program, or for a track within the
2191   program, the Osteopathic Recognition Requirements are also applicable.
2192   (http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/Osteopathic_Recogniton_Re
2193   quirements.pdf)
2194