ACGME Program Requirements for Graduate Medical Education in Internal Medicine

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Contents

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Common Program Requirements (Residency) are in BOLD

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

Introduction

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

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

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

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

Int.B. **Definition of Specialty**

Internists are specialists who care for adult patients through comprehensive, clinical problem solving. They integrate the history, physical examination, and all available data to deliver, direct, and coordinate care across varied clinical

settings, both in person and remotely through telemedicine. Internists are diagnosticians who manage the care of patients who present with undifferentiated, complex illnesses, and comorbidities; promote health and health equity in communities; collaborate with colleagues; and lead, mentor, and serve multidisciplinary teams. Internists integrate care across organ systems and disease processes throughout the adult lifespan. They are expert communicators, creative and adaptable to the changing needs of patients and the health care environment. They advocate for their patients within the health care system to achieve the patient's and family's care goals. Internists embrace lifelong learning and the privilege and responsibility of educating patients, populations, and other health professionals. The discipline is characterized by a compassionate, cognitive, scholarly, relationship-oriented approach to comprehensive patient care.

The successful, fulfilled internist maintains this core function and these core values. Internists find meaning and purpose in caring for individual patients with increased efficiency through well-functioning teams, and are equipped and trained to manage change effectively and lead those teams. They understand and manage the business of medicine to optimize cost-conscious care for their patients. They apply data management science to population and patient applications and help solve the clinical problems of their patients and their community. Internists communicate fluently and are able to educate and clearly explain complex data and concepts to all audiences, especially patients. They collaborate with patients to implement health care ethics in all aspects of their care. Internists display emotional intelligence in their relationships with colleagues, team members, and patients, maximizing both their own and their teams' well-being. They are dedicated professionals who have the knowledge, skills, and attitudes to effectively use all available resources, and bring intellectual curiosity and human warmth to their patients and community.

Specialty-Specific Background and Intent: The Review Committee developed this definition to clearly articulate the core functions and values of internal medicine and describe what is needed to move the specialty forward through program requirements. They express what the Review Committee aspires to see in the graduates of internal medicine residency programs, faculty members, and the broader internal medicine community.

Int.C. Length of Educational Program

An accredited residency program in internal medicine must provide 36 months of supervised graduate medical education. (Core)

Specialty-Specific Background and Intent: While internal medicine residency must be completed within a 36-month supervised educational framework (barring remediation and extended leaves), the requirements were written to be flexible and allow program directors the opportunity to create more individualized educational experiences for residents who have achieved, or are on a trajectory to achieve, competence in the foundational areas of internal medicine. This was a guiding principle for the revision process. The requirements for the foundational areas of internal medicine and individualized educational experiences are located in Section IV.C.: Curriculum Organization and Resident Experiences.

I. Oversight

I.A. Sponsoring Institution

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

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

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

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

I.B. Participating Sites

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

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

I.B.1.a) The program, in partnership with its Sponsoring Institution, must ensure that there is a reporting relationship between the internal medicine subspecialty programs and the residency program director. (Core)

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

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

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

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

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

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

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

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

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

I.B.4. **The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the ACGME's Accreditation Data System (ADS).** (Core)

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

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

I.D. **Resources**

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

I.D.1.a) The program, in partnership with its Sponsoring institution, must:

I.D.1.a).(1) provide the broad range of facilities and clinical support services necessary to provide comprehensive and timely care of adult patients; (Core)

I.D.1.a).(2) ensure that the program has adequate space available, including meeting rooms, classrooms, examination rooms, computers, visual and other educational aids, and office space; (Core)

I.D.1.a).(3) ensure that appropriate in-person or remote/virtual consultations, including those done using telecommunication technology, are available in settings in which residents work; (Core)

I.D.1.a).(4) provide access to an electronic health record; and, (Core)

Specialty-Specific Background and Intent: An electronic health record (EHR) can include electronic notes, orders, and lab reporting. Such a system also facilitates data reporting regarding the care provided to a patient or a panel of patients. It may also include systems for enhancing the quality and safety of patient care. An EHR does not have to be present at all participating sites and does not have to include every element of patient care information. However, a system that simply reports laboratory or imaging results does not meet the definition of an EHR.

I.D.1.a).(5) provide residents with access to training using simulation to support resident education and patient safety. (Core)

Specialty-Specific Background and Intent: The Review Committee does not expect each program to own a simulator or to have a simulation center. “Simulation” is used broadly to mean learning about patient care in settings that do not include actual patients. This could include objective structured clinical examinations (OSCEs), standardized patients, patient simulators, or electronic simulation of resuscitation, procedures, and other clinical scenarios.

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

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

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

Background and Intent: Care of patients within a hospital or health system occurs continually through the day and night. Such care requires that residents function at their peak abilities, which requires the work environment to provide them with the ability to meet their basic needs within proximity of their clinical responsibilities. Access to food and rest are examples of these basic needs, which must be met while residents are working. Residents should have access to refrigeration where food may

be stored. Food should be available when residents are required to be in the hospital overnight. Rest facilities are necessary, even when overnight call is not required, to accommodate the fatigued resident.

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

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

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

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

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

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

I.D.4.a) The program must provide residents with a patient population representative of both the broad spectrum of clinical disorders and medical conditions managed by internists, and of the community being served. (Core)

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

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

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

II. Personnel

II.A. Program Director

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

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

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

Background and Intent: While the ACGME recognizes the value of input from numerous individuals in the management of a residency, a single individual must be designated as program director and have overall responsibility for the program. The program director's nomination is reviewed and approved by the GMEC. Final approval of the program director resides with the applicable ACGME Review Committee.

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

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

II.A.2. The program director and, as applicable, the program's leadership team, must be provided with support adequate for administration of the program based upon its size and configuration. (Core)

II.A.2.a) At a minimum, the program director must be provided with the dedicated time and support specified below for administration of the program:

Number of Approved Resident Positions	Minimum Support Required (FTE)
<7	.2
7-10	.4
>10	.5

~~At a minimum, the program director must be provided with the salary support required to devote 50 percent FTE of non-clinical time to the administration of the program.~~ (Core)

II.A.2.b) Programs with more than 15 residents must appoint an associate program director(s). The associate program directors(s) must be provided with support equal to a dedicated minimum time for administration of the program as follows:

Number of Approved Resident Positions	Minimum Support Required (FTE)
<15	0
16-20	.1
21-25	.2
26-30	.3
31-35	.4
36-40	.5
41-45	.6
46-50	.7
51-55	.8
56-60	.9
61-65	1.0
66-70	1.1
71-75	1.2
76-80	1.3
81-85	1.4
86-90	1.5
91-95	1.6
96-100	1.7
101-105	1.8
106-110	1.9
111-115	2.0
116-120	2.1
121-125	2.2
126-130	2.3
131-135	2.4
136-140	2.5
141-145	2.6
146-150	2.7
151-155	2.8
156-160	2.9
161-165	3.0
166-170	3.1
171-175	3.2
176-180	3.3
181-185	3.4
186-190	3.5
191-195	3.6
196-200	3.7
201-205	3.8
206-210	3.9

211-215	4.0
216-220	4.1
221-225	4.2
226-230	4.3

~~Additional salary support must be provided for an associate program director(s) to devote non-clinical time to the administration of the program as follows:~~ (Core)

~~Number of Approved Resident Positions~~	~~Minimum Number of ABIM- or AOBIM-certified Associate Program Directors~~	~~Minimum Aggregate FTE Salary Support for Associate Program Director Duties~~
~~24-40~~	~~1~~	~~0.5~~
~~41-79~~	~~2~~	~~1.0~~
~~80-119~~	~~3~~	~~1.5~~
~~120-159~~	~~4~~	~~2.0~~
~~>159~~	~~5~~	~~2.5~~

Background and Intent: To achieve successful graduate medical education, individuals serving as education and administrative leaders of residency programs, as well as those significantly engaged in the education, supervision, evaluation, and mentoring of residents, must have sufficient dedicated professional time to perform the vital activities required to sustain an accredited program.

The ultimate outcome of graduate medical education is excellence in resident education and patient care.

The program director and, as applicable, the program leadership team, devote a portion of their professional effort to the oversight and management of the residency program, as defined in II.A.4.-II.A.4.a).(16). Both provision of support for the time required for the leadership effort and flexibility regarding how this support is provided are important. Programs, in partnership with their Sponsoring Institutions, may provide support for this time in a variety of ways. Examples of support may include, but are not limited to, salary support, supplemental compensation, educational value units, or relief of time from other professional duties.

Program directors and, as applicable, members of the program leadership team, who are new to the role may need to devote additional time to program oversight and management initially as they learn and become proficient in administering the program. It is suggested that during this initial period the support described above be increased as needed.

~~Specialty-Specific Background and Intent: The Review Committee believes that salary support can be shared among multiple associate program directors, as delegated, and at the discretion of, the program director. Associate program directors are expected to assist the program director in performance of administrative activities required to maintain the educational program. The percentage of FTE support is based on a 40-hour work week. As was discussed in the Background and Intent related to salary support, a 50 percent FTE is~~

~~defined as two-and-one-half-days per week of salary support, which can be shared or split among multiple associate program directors. Programs can also redistribute the FTE back to the program director. For instance, a program with 28 residents can split the 50 percent FTE so that one associate program director receives 25 percent and the program director receives 75 percent FTE (50 percent along with the remaining 25 percent from the associate program director FTE).~~

For instance, a program with an approved complement of 36 residents is required to have 50% FTE support for the program director and 50 percent FTE support for the associate program director(s). The Review Committee decided not to specify how the support should be distributed among associate program directors to allow programs, in partnership with their sponsoring institution, to allocate the support as they see fit. Further, the program could redistribute the FTE back to the program director; for example, in this instance, the associate program director(s) could receive 25 percent FTE support and the program director could receive 75 percent FTE support (50 percent plus the remaining 25 percent from the associate program director FTE support).

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

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

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

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

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

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

II.A.3.b).(1) The Review Committee only accepts current certification in internal medicine from the ABIM or AOBIM. (Core)

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

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

II.A.3.e) must have experience working as part of an interdisciplinary, inter-professional team to create an educational environment that promotes high-quality care, patient safety, and resident well-being. (Core)

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

II.A.4. Program Director Responsibilities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

II.B. Faculty

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

the opportunity to teach. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.

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

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

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

II.B.1.a) Faculty members with credentials appropriate to the care setting must supervise all clinical experiences. (Core)

II.B.1.a).(1) There must be physicians with certification in internal medicine by the ABIM or AOBIM to teach and supervise internal medicine residents while they are on internal medicine inpatient and outpatient rotations. (Core)

Specialty-Specific Background and Intent: The Review Committee believes the best role models for internal medicine residents are internal medicine physicians with certification in internal medicine from the ABIM or AOBIM. Providing such faculty members ensures specialty-specific educators with significant experience managing and providing comprehensive patient care to complex patients. However, the Review Committee recognizes there are circumstances and clinical settings in which a non-internist who has been approved by the program director would be an appropriate supervisor. Examples include but are not limited to the following:

- On inpatient medicine ward rotations, it is appropriate for a family medicine physician with the American Board of Family Medicine's Designation of Focused Practice in Hospital Medicine to teach and supervise internal medicine residents.
- On inpatient medicine rotations in the critical care setting, it would be appropriate for a non-internist who has been approved by the program director and the medical intensive care unit director to teach and supervise internal medicine residents. For example, it would be appropriate for emergency medicine physicians with certification in internal medicine-critical care medicine to supervise internal medicine residents on critical care medicine rotations. It is also appropriate for physicians with certification in critical care from other disciplines to teach and supervise in limited circumstances, such as evening or weekend cross-coverage.
- On outpatient medicine rotations/experiences, it is appropriate for a non-internist with documented expertise (e.g., a family medicine physician with extensive outpatient/ambulatory experience or procedural proficiency) to teach and supervise

internal medicine residents provided the non-internist is approved by the site director and the program director.

II.B.1.a).(2) Physicians certified by the ABIM or the AOBIM in the relevant subspecialty must be available to teach and supervise internal medicine residents while they are on internal medicine subspecialty rotations. (Core)

II.B.1.a).(3) Physicians certified by an ABMS or AOA board in the relevant subspecialty should be available to teach and supervise internal medicine residents while they are on multidisciplinary subspecialty rotations. (Core)

Specialty-Specific Background and Intent: For example, it would be appropriate for a faculty member certified in geriatric medicine by the ABIM, AOBIM, American Board of Family Medicine, or American Osteopathic Board of Family Medicine to teach and supervise internal medicine residents on geriatric medicine rotations.

II.B.1.a).(4) Physicians certified by an ABMS or AOA board in the relevant specialty should be available to teach and supervise internal medicine residents while they are having non-internal medicine experiences. (Core)

Specialty-Specific Background and Intent: For example, it would be appropriate for a faculty member certified in neurology by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry to teach and supervise internal medicine residents on neurology rotations.

II.B.2. Faculty members must:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

II.B.2.h) There must be a subspecialty education coordinator (SEC) in each of the subspecialties of internal medicine and in the multidisciplinary subspecialty of geriatric medicine. (Core)

Specialty-Specific Background and Intent: An SEC is necessary in each of the following subspecialties of internal medicine: cardiovascular disease; critical care medicine; endocrinology, diabetes, and metabolism; gastroenterology; hematology; infectious disease; nephrology; medical oncology; pulmonary disease; and rheumatology.

II.B.2.h).(1) Each SEC must be accountable to the program director for coordination of all educational experiences in the subspecialty area. (Core)

II.B.2.h).(2) Each SEC must be certified in the relevant subspecialty by the ABIM or the AOBIM, except that the geriatric medicine SEC must be certified in the subspecialty by the relevant ABMS member board or AOA certifying board. (Core)

Specialty-Specific Background and Intent: SECs are responsible for developing the educational content and curriculum for the subspecialty area. An associate program director or core faculty member can also function as an SEC with adequate additional administrative resources. Double-boarded SECs can act as education coordinators for two specialties (e.g., hematology-medical oncology and pulmonary disease-critical care medicine). The SEC for geriatric medicine can be certified by the ABIM, the AOBIM, the American Board of Family Medicine, or the American Osteopathic Board of Family Medicine. The Review Committee encourages programs that cannot identify an SEC for a particular subspecialty area to consider the option of sharing one with a program that does have one. The SEC can be remotely located and associated with multiple residency programs.

II.B.2.i) There must be faculty members with expertise in the analysis and interpretation of practice data, data management science and clinical decision support systems, and managing emerging health issues. (Core)

Specialty-Specific Background and Intent: Advances in technology are likely to significantly impact and redefine patient care, and this requirement is intended to ensure that residents are provided with access to faculty members with knowledge, skills, or experience in the analysis and interpretation of practice data, and who are able to analyze and evaluate the validity of decisions from advanced data management and clinical decision support systems. Faculty members with expertise in this area can be physicians or non-physicians, core or non-core faculty members. Institutions may already have such experts assisting programs in meeting the Common Program Requirement to systematically analyze practice data to improve patient care [IV.B.1.d).(1).(d)]. The Review Committee encourages programs that cannot identify an existing internal candidate with expertise in this area to consider the option of sharing one with a program that does. The faculty member can be remotely located and associated with multiple residency programs.

II.B.2.j) Faculty members must have experience working in interdisciplinary, interprofessional team-based health care delivery models. (Core)

Specialty-Specific Background and Intent: The Review Committee believes that interdisciplinary, interprofessional, team-based care is the foundation of care delivery. Individuals working within such teams are essential to resident education.

II.B.3. Faculty Qualifications

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

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

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

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

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

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

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

Background and Intent: Core faculty members are critical to the success of resident education. They support the program leadership in developing, implementing, and assessing curriculum, mentoring residents, and assessing residents' progress toward achievement of competence in and the independent practice of 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. Core faculty members may also be selected for their specific expertise and unique contribution to the program. Core faculty members are engaged in a broad range of activities, which may vary across programs and specialties. Core faculty members provide clinical teaching and supervision of residents, and also participate in non-clinical activities related to resident education and program administration. Examples of these non-clinical activities include, but are not limited to, interviewing and selecting resident applicants, providing didactic instruction, mentoring residents, simulation exercises, completing the annual ACGME Faculty Survey, and participating on the program's Clinical Competency Committee, Program Evaluation Committee, and other GME committees.

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)

II.B.4.c) In addition to the program director and associate program director(s), programs must have the minimum number of ABIM- or AOBIM-certified core faculty members based on the number of approved resident positions, as follows. (Core)

II.B.4.d At a minimum, the required core faculty members, in aggregate and excluding program leadership, must be provided with support equal to an average dedicated minimum of .1 FTE for educational and administrative responsibilities that do not involve direct patient care. (Core)

Number of Approved Resident Positions	Minimum number of ABIM- or AOBIM-certified Core Faculty Members
<30	3
30-39	4
40-49	5
50-59	6
60-69	7
70-79	8
80-89	9
90-99	10
100-109	11
110-119	12
120-129	13
130-139	14
140-149	15
150-159	16
160-169	17
170-179	18
180-189	19
190-199	20
200-209	21

Specialty-Specific Background and Intent: For instance, a program with an approved complement of 36 residents is required to have a minimum of four ABIM- or AOBIM-certified core faculty members, each with 10 percent FTE support. The duties of the program director, associate program director(s), and internal medicine core faculty members are separate and distinct. As such, the minimum required internal medicine core faculty members are in addition to the program director and the associate program director(s). One individual cannot "count" as both an associate program director and internal medicine core faculty member.

Educational responsibilities for the minimum required internal medicine core faculty members: The requirement related to support for core internal medicine faculty members is intended to ensure these faculty members have sufficient protected time to meet the following educational responsibilities:

- Membership on the Clinical Competency Committee
- Participation in the annual program review as Chair or member of the Program Evaluation Committee
- Implementation and analysis of the outcome of action plans developed by the Program Evaluation Committee
- Significant participation in recruitment and selection, including efforts related to the program's commitment to diversity

- Advising, mentoring, and coaching residents (co-creating, implementing, and monitoring individualized learning plans)
- Designing and overseeing remediation plans
- Supporting/overseeing residents in the development/assessment of quality improvement/patient safety projects
- Supporting/overseeing residents in the conduct of their scholarly work, including the dissemination of such work through presentations, posters/abstracts, and peer-reviewed publications
- Significant participation in educational activities (didactics, lab, or simulation)
- Overseeing faculty development for the program's faculty members
- Designing and implementing simulation and/or standardized patients for teaching and assessment
- Developing, implementing, and assessing one or more of the major components of the curriculum, such as patient safety, quality, health disparities, or core didactics
- Designing and implementing the program's assessment strategies, making certain there are robust methods used to assess each competency, and ensuring they provide meaningful information by which the Clinical Competency Committee can judge resident performance on the Milestones
- Leading the program's efforts related to resident and faculty member well-being

Each core faculty member does not need to participate in every listed educational responsibility.

II.B.5. Associate Program Directors

Associate program directors assist the program director in the administrative and clinical oversight of the educational program.

II.B.5.a) Associate program directors must:

II.B.5.a).(1) have current certification from the ABIM or AOBIM in either internal medicine or a subspecialty of internal medicine; (Core)

II.B.5.a).(2) report directly to the program director; (Core)

II.B.5.a).(3) participate in academic societies and in educational programs designed to enhance their educational and administrative skills; and, (Core)

II.B.5.a).(4) take an active role in curriculum development, resident teaching and evaluation, continuous program improvement, and faculty development. (Core)

II.C. Program Coordinator

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

II.C.2. The program coordinator must be provided with dedicated time and support adequate for administration of the program based upon its size and configuration. (Core)

II.C.2.a) At a minimum, the program coordinator must be provided with the dedicated time and support specified below for administration of the program. Additional administrative support must be provided based on the program size as follows: (Core)

Number of Approved Resident Positions	Minimum FTE Required for Coordinator Support	Additional Aggregate FTE Required for Administration of the Program
<7	.5	0
7-10	.5	.2
10-15	.5	.3
16-20	.5	.4
21-25	.5	.5
26-30	.5	.6
31-35	.5	.7
36-40	.5	.8
41-45	.5	.9
46-50	.5	1.0
51-55	.5	1.1
56-60	.5	1.2
61-65	.5	1.3
66-70	.5	1.4
71-75	.5	1.5
76-80	.5	1.6
81-85	.5	1.7
86-90	.5	1.8
91-95	.5	1.9
96-100	.5	2.0
101-105	.5	2.1
106-110	.5	2.2
111-115	.5	2.3
116-120	.5	2.4
121-125	.5	2.5
126-130	.5	2.6
131-135	.5	2.7
136-140	.5	2.8
141-145	.5	2.9
146-150	.5	3.0
151-155	.5	3.1
156-160	.5	3.2
161-165	.5	3.3
166-170	.5	3.4
171-175	.5	3.5
176-180	.5	3.6
181-185	.5	3.7
186-190	.5	3.8

191-195	.5	3.9
196-200	.5	4.0
201-205	.5	4.1
206-210	.5	4.2
211-215	.5	4.3
216-220	.5	4.4
221-225	.5	4.5
226-230	.5	4.6

~~At a minimum, the program coordinator must be supported at 50 percent FTE for the administration of the program.~~ ~~(Core)~~

Background and Intent: The requirement does not address the source of funding required to provide the specified salary support.

Each program requires a lead administrative person, frequently referred to as a program coordinator, administrator, or as otherwise titled by the institution. This person will frequently manage the day-to-day operations of the program and serve as an important liaison and facilitator between the 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 key 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 appropriate to the complexity of the program. Program coordinators are expected to develop in-depth knowledge of the ACGME and Program Requirements, including policies and procedures. Program coordinators assist the program director in meeting accreditation requirements, 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.

Specialty-Specific Background and Intent: For instance, a program with an approved complement of 36 residents is required to have 130 percent FTE for coordinator support. The Review Committee decided not to specify how the support should be distributed to allow programs, in partnership with their Sponsoring Institution, to allocate the support as they see fit.

II.D. Other Program Personnel

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

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

III. Resident Appointments

III.A. Eligibility Requirements

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

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

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

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

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

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

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

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

milestones for this training, they must be from programs that have ACGME-I Advanced Specialty Accreditation.

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

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

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

III.B.1.a) There must be a sufficient number of residents to allow peer-to-peer interaction and learning. (Core)

III.B.1.a).(1) The program should offer a minimum of nine positions. (Detail)

Specialty-Specific Background and Intent: The Review Committee believes that peer-to-peer interactions and learning are extremely important components of residency education and has set the minimum number of residents to nine. While three residents per educational year is suggested, it is not required as long as there is relative balance per level. To ensure that resident education is not compromised by having too few residents, the number of residents in a program will be monitored at each review, particularly for those programs with significant decreases in complement. However, this requirement is categorized as a “detail” as there may be programs that have specific circumstances that allow them to function with a smaller resident complement. This categorization allows the establishment of residency education programs in rural and medically underserved areas and populations when the Review Committee determines that the program has sufficient resources to ensure substantial compliance with accreditation requirements.

III.C. **Resident Transfers**

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

IV. Educational Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IV.B. ACGME Competencies

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

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

IV.B.1.a) Professionalism

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

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

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

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

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

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

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

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

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

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

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

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

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

IV.B.1.b).(1) **Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. (Core)**

IV.B.1.b).(1).(a) Residents must demonstrate the ability to manage the care of patients:

IV.B.1.a).(1).(a).(i) using clinical skills of interviewing and physical examination; (Core)

IV.B.1.a).(1).(a).(ii) in a variety of roles within a health system with progressive responsibility, including serving as the direct provider, a member, or leader of an interprofessional team of providers; as a consultant to other physicians; and as a teacher to the patient, the patient's family, and other health care workers; (Core)

IV.B.1.a).(1).(a).(iii) including the prevention, counseling, detection, diagnosis, and treatment of adult diseases; (Core)

IV.B.1.a).(1).(a).(iv) in a variety of health care settings, including the inpatient ward, critical care units, and various ambulatory settings; (Core)

Specialty-Specific Background and Intent: Emerging models of care and needs of populations served by programs will result in residents having educational experiences in novel or non-traditional settings. Examples of non-traditional educational settings include rotations on mobile buses that travel to areas of increased need, and "pop-up" health clinics within community centers.

IV.B.1.a).(1).(a).(v) for whom they have limited or no physical contact, through the use of telemedicine; (Core)

IV.B.1.a).(1).(a).(vi) in the subspecialties of internal medicine; (Core)

IV.B.1.a).(1).(a).(vii) using population-based data; (Core)

Specialty-Specific Background and Intent: Understanding population health within the context of prevention is an important competency for the physician practicing medicine in the future. Residents need experience using, understanding, and analyzing population health data so that they can develop health care plans to improve health outcomes for their patients. For instance, residents may be provided experience in analyzing and interpreting data from health registries, and understanding the local impact of infectious and non-infectious epidemics (e.g., obesity or opioid) and pandemics, and the important role social determinants of health have when developing and applying health care and preventive care decisions.

IV.B.1.a).(1).(a).(viii) using critical thinking and evidence-based tools. (Core)

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

IV.B.1.b).(2).(a) Residents must demonstrate the ability to:

IV.B.1.b).(2).(a).(i) use and/or perform point-of-care laboratory, diagnostic, and/or imaging studies relevant to the care of the patient; (Core)

Specialty-Specific Background and Intent: The Review Committee intentionally did not identify specific laboratory, diagnostic, and/or imaging studies that residents must perform because it believes that scientific advances will be constant and ongoing, and whatever is codified in the requirements quickly becomes outdated. Additionally, the decision to not specifically denote

studies in the requirements aligns with the Committee's overall position that residents should perform and develop expertise with those procedures appropriate to their future practice needs, as noted in the requirement below. However, the Committee acknowledges that offering point-of-care ultrasonography to residents who believe this will be relevant for their future career practice may be one way to meet the above-mentioned requirement.

IV.B.1.b).(2).(a).(ii) perform diagnostic and therapeutic procedures relevant to their specific career paths; and, (Core)

IV.B.1.b).(2).(a).(iii) treat their patients' conditions with practices that are patient-centered, safe, scientifically based, effective, timely, and cost-effective. (Core)

IV.B.1.c) Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. (Core)

IV.B.1.c).(1) Residents must demonstrate a level of expertise in the knowledge of the broad spectrum of clinical disorders seen by an internist, including: (Core)

IV.B.1.c).(1).(a) the core content of general internal medicine, which includes the internal medicine subspecialties, the multidisciplinary subspecialties of geriatric medicine, hospice and palliative medicine and addiction medicine, and neurology. (Core)

IV.B.1.c).(2) Residents must demonstrate sufficient knowledge in the following areas:

IV.B.1.c).(2).(a) evaluation of patients with an undiagnosed and undifferentiated presentation; (Core)

IV.B.1.c).(2).(b) pharmacotherapeutic and non-pharmacotherapeutic treatment of the broad spectrum of medical conditions and clinical disorders managed by internists; (Core)

IV.B.1.c).(2).(c) provision of preventive care; (Core)

IV.B.1.c).(2).(d) interpretation of clinical tests and images; (Core)

IV.B.1.c).(2).(e) recognition and initial management of urgent medical problems; and, (Core)

IV.B.1.c).(2).(f) application of technology appropriate for the clinical context, including evolving techniques. (Core)

Specialty-Specific Background and Intent: Advances in technology will likely continue to make substantive changes in patient diagnosis and management. This requirement ensures that residents will be able to gain experience and become familiar with emerging technologies, such as intensive care units managed remotely or the use of personalized or precision medicine.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as

the ability to call effectively on other resources to provide optimal health care. (Core)

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

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

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

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

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

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

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

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

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

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

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

IV.C. Curriculum Organization and Resident Experiences

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

IV.C.1.a) Rotations must be of sufficient length to provide longitudinal relationships with faculty members to allow for meaningful assessment and feedback. (Core)

IV.C.1.b) Rotations must be structured to allow residents to function as part of effective interprofessional teams that work together towards the shared goals of patient safety and quality improvement. (Core)

IV.C.1.c) Rotations must be structured to minimize conflicting inpatient and outpatient responsibilities. (Core)

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.

Specialty-Specific Background and Intent: The Review Committee encourages programs to think of ways to balance the inherent conflicts between inpatient and outpatient responsibilities, including using an effective hand-off process. For example, programs may want to consider schedules that allow members of the interprofessional health care team to provide coverage for the inpatient service when residents are in continuity clinics. Alternatively, programs may consider creating schedules that either provide more continuity clinic experiences or an exclusive continuity clinic experience when residents are not on inpatient rotations to allow them to have less or no clinic during inpatient rotations.

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

IV.C.3. The educational program for all residents must include: (Core)

IV.C.3.a) at least 30 months of clinical experiences; (Core)

IV.C.3.b) a longitudinal team-based continuity experience for the duration of the program; (Core)

IV.C.3.c) foundational experience in internal medicine, including:

IV.C.3.c).(1) at least 10 months of clinical experiences in the outpatient setting; (Core)

Specialty-Specific Background and Intent: Clinical experiences in the following settings may be used to fulfill this requirement: general internal medicine continuity clinics; internal medicine subspecialty clinics (e.g., HIV clinic); non-medicine clinics (e.g., dermatology or

physical medicine and rehabilitation clinic); walk-in clinics; neighborhood health clinics; home care visit programs; urgent care clinics; and ambulatory block rotations.

Time devoted to the longitudinal continuity experience can count towards the minimum required 10 months of foundational experiences in the outpatient setting. For the purposes of this calculation, a month is equivalent to four weeks, 20 days, or 40 half-days. For example, 40 half-day continuity clinic sessions would equal one month of outpatient experience.

IV.C.3.c).(2) at least 10 months of clinical experiences in the inpatient and critical care settings; (Core)

IV.C.3.c).(2).(a) Critical care experiences must be a minimum of two months and a maximum of six months and must not occur solely in the PGY-1. (Core)

IV.C.3.c).(3) clinical experiences in each of the internal medicine subspecialties; and, (Core)

Specialty-Specific Background and Intent: Clinical experiences in the each of the subspecialties can be used to fulfill either the minimum required number of months in the inpatient or outpatient setting, depending on the setting the experience is provided. For instance, a month rotation on a hematology-oncology service would count towards meeting the inpatient minimums whereas a month in an oncology clinic would count towards outpatient.

IV.C.3.c).(4) clinical experiences in geriatric medicine, hospice and palliative medicine, addiction medicine, emergency medicine, and neurology. (Core)

IV.C.3.d) at least six months of individualized educational experiences to participate in opportunities relevant to their future practice or to further skill/competency development in the foundational areas. (Core)

Specialty-Specific Background and Intent: The Review Committee views these four components of internal medicine residency (at least 30 months of clinical experience, longitudinal continuity experience, foundational internal medicine experience, and at least six months of individualized experience) as distinct but overlapping. For example, the longitudinal continuity experience could be obtained through discrete blocks or interspersed among other clinical experiences. Time in an outpatient clinic may be part of the continuity experience or may be part of a subspecialty experience, or both, and it would count towards the minimum for both foundational outpatient experience and the 30 months of clinical experience. Additional time in that clinic may be part of a resident's individualized learning experiences, which would also count towards the 30-month minimum. The six months of individualized learning experiences may be all clinical experiences that would count towards the 30-month minimum, or they may include non-clinical experiences.

The requirements acknowledge that in addition to providing residents with broad foundational educational experiences in ambulatory and hospital-based internal medicine, programs must ensure residents have educational experiences that take into account their future plans and

the different paces and trajectories at and on which residents will learn and demonstrate competence in the foundational areas.

Individualized educational experiences will be determined by the program director and take into account demonstrated competence in the foundational areas noted above, resources, program aims, and the residents' future practice plans. Although six months can be devoted to individualized experiences, some residents may require more time to achieve competence in the foundational educational areas, which may result in less time for individualized educational experiences. Some residents may need to devote the entirety of residency to achieve competence in the foundational areas. The converse may be possible. Programs may have the opportunity to allocate more than six months of individualized educational opportunities for residents who have achieved or are on target to achieve competence in the foundational areas. These opportunities may include more ambulatory/outpatient experiences for residents interested in practicing in an outpatient setting after residency, more inpatient experiences for those interested in hospitalist medicine careers, or more experiences in a subspecialty for those interested in subspecializing. Individualized educational experiences may be integrated throughout the 36 months of the educational program and do not need to be consecutive.

The Review Committee is interested in programs pursuing innovations in internal medicine education and training. Additional information on the development of the Program Requirements and the Review Committee's interest in exploring innovative proposals that will guide future versions of the Program Requirements can be found on the Internal Medicine section of the ACGME website.

IV.C.4. While on inpatient rotations:

IV.C.4.a) residents' responsibilities must be limited to patients for whom the teaching team has diagnostic and therapeutic responsibility; (Core)

IV.C.4.b) programs must monitor and limit the number of resident-attending relationships to ensure that communication and education is not compromised; (Core)

IV.C.4.c) non-physician faculty members must not supervise internal medicine residents on inpatient rotations; (Core)

Specialty-Specific Background and Intent: While it is important for residents to acquire experience in leading and participating in interprofessional, interdisciplinary health care teams, the overall supervision of all clinical care provided by residents is the responsibility of the members of the physician faculty. A physician faculty member may delegate an appropriately qualified non-physician to assist a resident in discrete activities, such as performing procedures.

IV.C.4.d) residents from other specialties must not supervise internal medicine residents on any internal medicine inpatient rotation; (Core)

IV.C.4.e) the resident team and each attending physician must have the responsibility to make management rounds on their patients and

communicate effectively with each other at a frequency appropriate to the changing care needs of the patients; (Core)

IV.C.4.f) residents must write all orders for patients under their care, with appropriate supervision by the attending physician; (Core)

IV.C.4.f).(1) In those circumstances when another attending physician or consultant writes an order on a resident's patient, the attending or consultant must communicate the action to the resident in a timely manner. (Core)

IV.C.4.g) PGY-1 residents must not be assigned more than five new patients per admitting day; (Core)

IV.C.4.g).(1) an additional two patients may be assigned if they are in-house transfers from the medical services. (Core)

IV.C.4.h) PGY-1 residents must not be assigned more than eight new patients in a 48-hour period; (Core)

IV.C.4.i) PGY-1 residents must not be responsible for the ongoing care of more than 10 patients; (Core)

IV.C.4.j) when supervising more than one PGY-1 resident, the PGY-2 or PGY-3 supervising resident must not be responsible for the supervision or admission of more than 10 new patients and four transfer patients per admitting day or more than 16 new patients in a 48-hour period; (Core)

IV.C.4.k) when supervising one PGY-1 resident, the PGY-2 or PGY-3 supervising resident must not be responsible for the ongoing care of more than 14 patients; and, (Core)

IV.C.4.l) when supervising more than one PGY-1 resident, the PGY-2 or PGY-3 supervising resident must not be responsible for the ongoing care of more than 20 patients. (Core)

Specialty-Specific Background and Intent: The Review Committee cannot prescriptively and explicitly assign patient census limits for every possible educational scenario or circumstance given the variability in these settings and the complexity and acuity of the patients. Instead, the committee asks program and institutional leadership teams to proactively and regularly monitor the census, complexity, and acuity of patients assigned to resident-comprised health care teams, and the structure and composition of the team, particularly the knowledge, skills, and abilities of the team members, to determine the appropriate patient team size for the situation. Although the Review Committee limits the number of new patients PGY-2 and PGY-3 residents can be assigned per admitting day (Program Requirements IV.C.4. j)-l)), programs can exercise flexibility and deviate from these limits for PGY-3 residents who have significant experience in the inpatient setting and are interested in hospitalist medicine careers in the future. The leadership team will need to carefully review institutional patient safety outcome data when determining patient census team limits in such scenarios. The census limits noted above apply to all inpatient experiences during the 36 months of supervised graduate medical

education regardless of whether an inpatient rotation is part of the foundational educational experiences in internal medicine or part of the individualized experiences.

IV.C.5. While on outpatient rotations:

IV.C.5.a) residents must have clinical experiences in chronic disease management, preventive health, patient counseling, and common acute ambulatory problems; and, (Core)

IV.C.5.b) residents must have a longitudinal, team-based, continuity experience for the duration of the educational program through which they develop a long-term therapeutic relationship with a panel of patients. (Core)

Specialty-Specific Background and Intent: The Review Committee believes that residents can only achieve a long-term therapeutic relationship with a panel of patients if the continuity clinic experience takes place for the entirety of the educational program. This will allow patients to understand that the resident is "their" primary care doctor, and residents to see the continuity clinic patients as "their" patients. While new patients will be added to the panel (and others will leave) throughout the course of the program, the Review Committee suggests that residents will remain in the same clinic throughout the 36 months to maintain continuity of care for their patient panel.

The committee believes this requirement can be best met through assigning residents to a general internal medicine clinic. However, to allow for residents to pursue post-residency interests during residency, programs may assign residents to subspecialty or specialized continuity clinics (e.g., an HIV clinic) if these assignments achieve the desired outcome noted in the requirement: that residents develop a long-term therapeutic relationship with a panel of patients.

IV.C.5.b).(1) Residents must serve as the primary physician for a panel of patients, with responsibility for chronic disease management, management of acute health problems, and preventive health care for their patients. (Core)

IV.C.5.b).(2) Residents must participate in the coordination of care of patients across health care settings and between outpatient visits. (Core)

IV.C.5.b).(3) Residents must be supervised and taught by faculty members with whom they have developed a longitudinal relationship. (Core)

IV.C.5.b).(4) Faculty members must maintain a ratio of residents or other learners to faculty preceptors not to exceed four to one; (Detail)

IV.C.5.b).(4).(a) Faculty members must not have other patient care responsibilities while supervising more than two residents or other learners. (Detail)

IV.C.6. Required Didactic Experiences

IV.C.6.a) The educational program must include didactic instruction based upon the core knowledge content of internal medicine. (Core)

IV.C.6.a).(1) Residents must participate in diverse teaching conferences or didactic sessions, including those dedicated to quality improvement. (Core)

IV.C.6.a).(2) The program must ensure that residents have the opportunity to review all knowledge content from conferences they could not attend. (Core)

Specialty-Specific Background and Intent: Core knowledge content presented during conferences will need to be made available for residents who missed the conference due to clinical responsibilities. This can include repeating the conference, recording and making it available electronically, or making the content provided during the conference available electronically.

IV.C.6.a).(3) Residents' educational experience must include didactic sessions in which residents interact with other residents and faculty members. (Core)

IV.C.6.a).(3).(a) The frequency of these sessions must be sufficient for peer-to-peer and peer-to-faculty member interaction. (Core)

IV.C.6.a).(4) Residents must be provided a patient or case-based approach to clinical teaching:

IV.C.6.a).(4).(a) on all inpatient, outpatient, telemedicine, and consultative services; (Core)

IV.C.6.a).(4).(b) with a frequency and duration sufficient to ensure a meaningful and continuous teaching relationship between the assigned teaching faculty member and the resident; and, (Core)

IV.C.6.a).(4).(c) that includes interactions between resident and the teaching faculty member, bedside teaching, discussion of pathophysiology, and the application of current evidence in diagnostic and therapeutic decisions. (Core)

IV.D. Scholarship

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

participation in scholarly activities. Scholarly activities may include discovery, integration, application, and teaching.

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

IV.D.1. Program Responsibilities

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

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

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

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

Elements of a scholarly approach to patient care include:

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

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

IV.D.2. Faculty Scholarly Activity

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

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

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

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

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

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

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

IV.D.3.a).(1) A program's graduates must demonstrate dissemination of scholarship within or external to the program by any of the following methods: (Core)

IV.D.3.a).(1).(a) presenting in grand rounds, poster sessions, leading conference presentations (journal club,

morbidity and mortality, case conferences); workshops; quality improvement presentations; podium presentations; grant leadership; non-peer-reviewed print/electronic resources; articles or publications; book chapters; textbooks; webinars; service on professional committees; or serving as a journal reviewer, journal editorial board member, or editor. (Core)

V. Evaluation

V.A. Resident Evaluation

V.A.1. Feedback and Evaluation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

V.A.1.g) The program must assess residents' skills in data gathering and analysis, physical examination, clinical reasoning, patient management, and procedures in all clinical settings. (Core)

V.A.2. Final Evaluation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

V.B. Faculty Evaluation

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

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

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

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

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

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

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

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

V.C. Program Evaluation and Improvement

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.

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

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

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

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

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

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

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

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

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

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

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

VI. The Learning and Working Environment

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

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

Background and Intent: The revised requirements are intended to provide greater flexibility within an established framework, allowing programs and residents more discretion to structure clinical education in a way that best supports the above principles of professional development. With this increased flexibility comes the responsibility for programs and residents to adhere to the 80-hour maximum weekly limit (unless a rotation-specific exception is granted by a Review Committee), and to utilize flexibility in a manner that optimizes patient safety, resident education, and resident well-being. The requirements are intended to support the development of a sense of professionalism by encouraging residents to make decisions based on patient needs and their own well-being, without fear of jeopardizing their program's

accreditation status. In addition, the proposed requirements eliminate the burdensome documentation requirement for residents to justify clinical and educational work hour variations.

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

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

VI.A.1. Patient Safety and Quality Improvement

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

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

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

VI.A.1.a) Patient Safety

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

VI.A.1.b) **Quality Improvement**

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

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

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

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

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

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

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

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

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

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

VI.A.2. Supervision and Accountability

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

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

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

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

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

VI.A.2.b) ***Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the appropriate availability of the supervising faculty member, fellow, or senior resident physician, either on site or by means of telecommunication technology. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.***

Background and Intent: Appropriate supervision is essential for patient safety and high-quality teaching. Supervision is also contextual. There is tremendous diversity of resident patient interactions, education and training locations, and resident skills and abilities even at the same level of the educational program. The degree of supervision

is expected to evolve progressively as a resident gains more experience, even with the same patient condition or procedure. All residents have a level of supervision commensurate with their level of autonomy in practice; this level of supervision may be enhanced based on factors such as patient safety, complexity, acuity, urgency, risk of serious adverse events, or other pertinent variables.

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

VI.A.2.b).(2) **The program must define when physical presence of a supervising physician is required.** (Core)

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

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

VI.A.2.c).(1) **Direct Supervision:**

VI.A.2.c).(1).(a) **the supervising physician is physically present with the resident during the key portions of the patient interaction; or,** (Core)

VI.A.2.c).(1).(a).(i) **PGY-1 residents must initially be supervised directly, only as described in VI.A.2.c).(1).(a).** (Core)

VI.A.2.c).(1).(a).(i).(a) A supervising physician must be immediately available to be physically present for PGY-1 residents on inpatient rotations who have demonstrated the skills sufficient to progress to indirect supervision. (Core)

VI.A.2.c).(1).(b) **the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.** (Core)

VI.A.2.c).(2) **Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.** (Core)

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

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

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

VI.A.2.d).(2) Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. (Core)

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

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

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

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

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

VI.B. Professionalism

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

VI.C. Well-Being

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

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

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

The ACGME also created a repository for well-being materials, assessments, presentations, and more on the Well-Being Tools and Resources page in Learn at ACGME for programs seeking to develop or strengthen their own well-being initiatives. There are many activities that programs can implement now to assess and support physician well-being. These include the distribution and analysis of culture of safety surveys, ensuring the availability of counseling services, and paying attention to the safety of the entire health care team.

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

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

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

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

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

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

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

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

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

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

Background and Intent: Programs and Sponsoring Institutions are encouraged to review materials to create systems for identification of burnout, depression, and substance use disorders. Materials and more information are available in Learn at ACGME (https://dl.acgme.org/pages/well-being-tools-resources).

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

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

department chair, may assess the situation and intervene as necessary to facilitate access to appropriate care. Residents and faculty members must know which personnel, in addition to the program director, have been designated with this responsibility; those personnel and the program director should be familiar with the institution's impaired physician policy and any employee health, employee assistance, and/or wellness programs within the institution. In cases of physician impairment, the program director or designated personnel should follow the policies of their institution for reporting.

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

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

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

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

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

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

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

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

VI.D. Fatigue Mitigation

VI.D.1. **Programs must:**

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

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

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

Background and Intent: Providing medical care to patients is physically and mentally demanding. Night shifts, even for those who have had enough rest, cause fatigue. Experiencing fatigue in a supervised environment during training prepares residents for managing fatigue in practice. It is expected that programs adopt fatigue mitigation processes and ensure that there are no negative consequences and/or stigma for using fatigue mitigation strategies.

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

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

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

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

VI.E.1. Clinical Responsibilities

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

VI.E.1.a) Programs must ensure that residents' clinical responsibilities on inpatient rotations are consistent with the requirements in IV.C.4. (Core)

Background and Intent: The changing clinical care environment of medicine has meant that work compression due to high complexity has increased stress on residents. Faculty members and program directors need to make sure residents function in an

environment that has safe patient care and a sense of resident well-being. Some Review Committees have addressed this by setting limits on patient admissions, and it is an essential responsibility of the program director to monitor resident workload. Workload should be distributed among the resident team and interdisciplinary teams to minimize work compression.

VI.E.2. Teamwork

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

VI.E.2.a) The program must provide educational experiences that allow residents to interact with and learn from other health care professionals, including physicians in other specialties, advanced practice providers, nurses, social workers, physical therapists, case managers, language interpreters, and dieticians, in order to achieve effective, interdisciplinary, and interprofessional team-based care. (Core)

Specialty-Specific Background and Intent: Physician and non-physicians, core and non-core faculty members, are part of the different teams that form depending on the health care situation and on patients' health status and circumstances. The intent of the requirement is to ensure that residents will have access to the appropriate health care personnel as defined by the circumstances, and that interdisciplinary, interprofessional teams will be constituted as appropriate and as needed.

VI.E.3. Transitions of Care

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

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

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

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

VI.E.3.e) Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2-VI.C.2.b), in the event that a resident may

be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency. (Core)

VI.F. Clinical Experience and Education

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

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

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

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

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

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

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

of the 80-hour requirement are identified, programs will be subject to citation and at risk for an adverse accreditation action.

Work from Home

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

During the public comment period many individuals raised questions and concerns related to this change. Some questioned whether minute by minute tracking would be required; in other words, if a resident spends three minutes on a phone call and then a few hours later spends two minutes on another call, will the resident need to report that time. Others raised concerns related to the ability of programs and institutions to verify the accuracy of the information reported by residents. The new requirements are not an attempt to micromanage this process. Residents are to track the time they spend on clinical work from home and to report that time to the program. Decisions regarding whether to report infrequent phone calls of very short duration will be left to the individual resident. Programs will need to factor in time residents are spending on clinical work at home when schedules are developed to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks. There is no requirement that programs assume responsibility for documenting this time. Rather, the program's responsibility is ensuring that residents report their time from home and that schedules are structured to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks.

PGY-1 and PGY-2 Residents

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

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

VI.F.2.a) The program must design an effective program structure that is configured to provide residents with educational

opportunities, as well as reasonable opportunities for rest and personal well-being. (Core)

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

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

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

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

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

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

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

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

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

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

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

The Task Force examined the impact of the request to consider 16-consecutive-hour limits for all residents, and rejected the proposition. It found that model incompatible with the actual practice of medicine and surgery in many specialties, excessively limiting in configuration of clinical services in many disciplines, and potentially disruptive of the inculcation of responsibility and professional commitment to altruism and placing the needs of patients above those of the physician.

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

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

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

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

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

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

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

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

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

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

Background and Intent: This requirement is intended to provide residents with some control over their schedules by providing the flexibility to voluntarily remain beyond the scheduled responsibilities under the circumstances described above. It is important to note that a resident may remain to attend a conference, or return for a conference later in the day, only if the decision is made voluntarily. Residents must not be required to stay. Programs allowing residents to remain or return beyond the scheduled work and clinical education period must ensure that the decision to remain is initiated by the resident and that residents are not coerced. This additional time must be counted toward the 80-hour maximum weekly limit.

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

The Review Committee for Internal Medicine will not consider requests for exceptions to the 80-hour limit to the resident work week.

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)

VI.F.6.a) Residents must not be assigned more than two months of night float during any year of the educational program, or more than four months of night float during the course of the residency. (Core)

VI.F.6.b) Residents must not be assigned to more than one month of consecutive night float rotation. (Core)

Specialty-Specific Background and Intent: Night float rotations are designed to either eliminate in-house call or to assist other residents during the night. Residents assigned to night float are assigned on-site duty during evening/night shifts and are responsible for admitting or cross-covering patients until morning and will not have daytime assignments or ongoing primary responsibility for these patients. The Committee has limited the number a program can assign because it believes too many such rotations can negatively affect resident well-being and contribute to burnout and fatigue. Overnight shifts occurring during critical care rotations (in the medical intensive care unit or the critical care unit) do not count towards night float, but towards the maximum six months of required critical care time. Overnight emergency medicine assignments do not count towards night float.

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

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

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

VI.F.8. **At-Home Call**

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

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

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

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

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

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

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

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

Osteopathic Recognition

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

