ACGME Program Requirements for Graduate Medical Education in Anesthesiology including FAQs

Revision Information

Frequently asked questions (FAQs) incorporated into the Requirements July 1, 2026; effective July 1, 2026

ACGME-approved interim revision February 9, 2026; effective immediately. Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirements 1.3.a., 2.2.a., 2.8.c., 4.2.a., 4.2.e., 5.5.f., 5.5.h., 6.24., and 6.24.a. has been suspended. See explanatory text under 1.2. for modifications to this and related specialty-specific requirements.

ACGME-approved interim revision September 29, 2025; effective July 1, 2026

Definitions

For more information, see the ACGME Glossary of Terms.

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).

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ACGME Program Requirements for Graduate Medical Education

in Anesthesiology

Common Program Requirements (Residency) are in BOLD

Where applicable, italicized text is used to provide definitions or describe the underlying philosophy of the requirements in that section. These statements are not program requirements and are therefore not citable.

Introduction

Definition of Graduate Medical Education

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, cultural sensitivity, professionalism, and scholarship.

Graduate medical education transforms medical students into physician scholars who care for the patient, patient's family, and a heterogeneous 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, judgment, and empathy required for autonomous practice. Graduate medical education develops physicians who focus on excellence in delivery of safe, accessible, affordable, high-quality care for all, to improve the health of the populations they serve.

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.

Definition of Specialty

Anesthesiology is the practice of medicine dealing with the peri-operative management of patients. This includes the peri-operative/peri-procedural management of patients during surgical and other therapeutic and diagnostic procedures. This management encompasses the pre-operative preparation of the patient and their peri-operative maintenance of normal physiology, as well as the post-operative relief and prevention of pain. An anesthesiologist is skilled in the

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management and diagnosis of critically-ill patients, including those experiencing cardiac arrest, and in the diagnosis and management of acute, chronic, and cancer-related pain. These goals are achieved through a thorough understanding of physiology and pharmacology, and the ability to conduct, interpret, and apply the results of medical research. Finally, the anesthesiologist is skilled in the leadership of health services delivery, prudent fiscal resource stewardship, and quality improvement, as well as the supervision, education, and evaluation of the performance of personnel, both medical and paramedical, involved in peri-operative and peri-procedural care.

Section 1: Oversight

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.**

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

Participating Sites

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

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

1.2.a. The Sponsoring Institution must also sponsor or be affiliated with ACGME-accredited residencies in at least the specialties of general surgery and internal medicine. (Core)

> Specialty-Specific Background and Intent: Pending the outcome of the major revision of the Common Program Requirements, the presence of a clinical serv-

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ice in each specialty referenced will be considered an acceptable alternative to an ACGME-accredited program. It is important to note that before the new Common Program Requirements are finalized, this modification will be subject to public comment when the proposed Common Program Requirement major revision is posted on the ACGME website, tentatively scheduled to occur before the end of 2026.

1.3. 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)
[See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix]

1.3.a. The PLA must be renewed at least every 10 years. (Core)

[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 1.3.a has been suspended]

1.3.b. The PLA must be approved by the designated institutional official (DIO). (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.

Suggested elements to be considered in PLAs will be found in the 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**

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

1.5. 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)

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1.6. 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)

1.6.a. The majority of rotations for the anesthesiology program must occur at the primary clinical site. (Core)

1.6.a.1. Participating sites must provide rotations that the Sponsoring Institution is unable to provide. (Core)

1.6.a.1.a. Residents should not be required to rotate among multiple participating sites. (Detail)

[See FAQ in Appendix]

1.6.a.1.b. Assignments to a participating site should not exceed six months. (Detail)

1.7. Resources

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

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

1.8. 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:

1.8.a. access to food while on duty; (Core)

1.8.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.

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1.8.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 6.13.c.1.

1.8.d. security and safety measures appropriate to the participating site; and, (Core)

1.8.e. accommodations for residents with disabilities consistent with the Sponsoring Institution's policy. (Core)

1.9. 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)

1.10. Other Learners and Health Care Personnel

The presence of other learners and other health care personnel, including, but not limited to residents from other programs, subspecialty fellows, and advanced practice providers, must not negatively impact the appointed residents' education. (Core)

> **Background and Intent:** The clinical learning environment has become increasingly complex and often includes care providers, students, and postgraduate 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.

Section 2: Personnel

2.1. Program Director

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)

2.2. The Sponsoring Institution's GMEC must approve a change in program director and must verify the program director's licensure and clinical appointment. (Core)

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2.2.a. Final approval of the program director resides with the Review Committee. **(Core)**

[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 2.2.a has been suspended. It is noted that appointment of a program director who does not meet the Common Program Requirements and specialty specific requirements related to minimum qualifications of the program director may result in citation(s) for non-compliance with those requirements]

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.

2.3. 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.

2.4. 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)

[See FAQ in Appendix]

2.4.a. At a minimum, the program director must be provided with the dedicated time and support specified below for administration of the program. Additional support for program leadership must be provided as specified below. This additional support may be for the program director only or divided among the program director and one or more associate (or assistant) program directors. (Core)

Number of Approved Resident Positions	Minimum Support Required (FTE) for the Program Director	Minimum Additional Support Required (FTE) for Program Leadership	Total Minimum Program Leadership Support
1-20	0.2	0.2	0.4
21-30	0.4	0.2	0.6
31-40	0.4	0.3	0.7
41-50	0.4	0.4	0.8
51-60	0.4	0.5	0.9

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Number of Approved Resident Positions	Minimum Support Required (FTE) for the Program Director	Minimum Additional Support Required (FTE) for Program Leadership	Total Minimum Program Leadership Support
61-70	0.4	0.6	1.0
71-80	0.4	0.7	1.1
Over 80	0.4	0.8	1.2

Specialty-Specific Background and Intent: In determining the required minimum support for program leadership, the Review Committee considered the following goals: 1) sufficient total administrative time for leadership; 2) sufficient clinical exposure to the program director and associate program directors in the operating room; and 3) succession planning and faculty development. The Review Committee recommends the program director be clinically active for a minimum of 40 percent FTE.

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 2.6. – 2.6.l. 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.

In addition, it is important to remember that the dedicated time and support requirement for ACGME activities is a *minimum*, recognizing that, depending on the unique needs of the program, additional support may be warranted. The need to ensure adequate resources, including adequate support and dedicated time for the program director, is also addressed in

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Institutional Requirement 2.2.a. The amount of support and dedicated time needed for individual programs will vary based on a number of factors and may exceed the minimum specified in the applicable specialty/subspecialty-specific Program Requirements. It is expected that the Sponsoring Institution, in partnership with its accredited programs, will ensure support for program directors to fulfill their program responsibilities effectively.

[See FAQ in Appendix]

2.5. Qualifications of the Program Director

The program director must possess 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 a variety of 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.

2.5.a. The program director must possess current certification in the specialty for which they are the program director by the American Board of Anesthesiology **or by the American Osteopathic Board of** Anesthesiology**, or specialty qualifications that are acceptable to the Review Committee. (Core)**

2.5.b. The program director must demonstrate ongoing clinical activity. (Core)

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

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2.5.c. The program director must demonstrate ongoing academic achievements in anesthesiology, including publications, the development of educational programs, or the conduct of research. (Core)

2.6. 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)

2.6.a. The program director must 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.**

2.6.b. The program director must 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 eliminating health disparities.**

2.6.c. The program director must 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 account-**

able. The leadership team may include physician and non-physician personnel with varying levels of education, training, and experience.

2.6.d. **The program director must have the authority to approve or remove physicians and non-physicians as faculty members at all participating sites, including the designation of core faculty members, and must develop and oversee a process to evaluate candidates prior to approval. (Core)**

Background and Intent: The provision of optimal and safe patient care requires a team approach. The education of residents by non-physician educators may enable the resident to better manage patient care and provides valuable advancement of the residents' knowledge. Furthermore, other individuals contribute to the education of residents 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.

2.6.e. **The program director must 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.

2.6.f. **The program director must submit accurate and complete information required and requested by the DIO, GMEC, and ACGME. (Core)**

Background and Intent: This includes providing information in the form and format requested by the ACGME and obtaining requisite sign-off by the DIO.

2.6.g. **The program director must provide a learning and working environment in which residents have the opportunity to raise concerns, report mistreatment, and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation. (Core)**

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2.6.h. **The program director must ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process, including when action is taken to suspend or dismiss, or not to promote or 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.**

2.6.i. **The program director must ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination.** (Core)

2.6.j. **The program director must document verification of education for all residents within 30 days of completion of or departure from the program.** (Core)

2.6.k. **The program director must provide verification of an individual resident's education upon the resident's request, within 30 days.** (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.**

2.6.l. **The program director must provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s).** (Core)

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 and model exemplary behavior. 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, communi-

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ty, 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.

2.7. There must be a sufficient number of faculty members with competence to instruct and supervise all residents. (Core)

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

[See FAQ in Appendix] [See FAQ in Appendix]

2.7.b. Didactic and clinical teaching should be provided by faculty members with documented interests and expertise in the subspecialty involved. (Detail)

2.7.c. The number of faculty members must be sufficient to provide each resident with adequate supervision, which shall not vary substantially with the time of day or the day of the week. (Core)

2.7.d. Designated faculty members must be readily and consistently available for consultation and teaching. (Core)

2.8. Faculty Responsibilities
Faculty members must be role models of professionalism. (Core)

2.8.a. Faculty members must demonstrate commitment to the delivery of safe, high-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.

2.8.b. Faculty members must demonstrate a strong interest in the education of residents, including devoting sufficient time to the educational program to fulfill their supervisory and teaching responsibilities. (Core)

2.8.c. Faculty members must administer and maintain an educational environment conducive to educating residents. (Core)

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[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 2.8.c. has been suspended]

2.8.d. **Faculty members must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.** (Core)

2.8.e. **Faculty members must 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.**

2.8.e.1. **as educators and evaluators;** (Detail)

2.8.e.2. **in quality improvement, eliminating health care disparities, and patient safety;** (Detail)

2.8.e.3. **in fostering their own and their residents' well-being; and,** (Detail)

2.8.e.4. **in patient care based on their practice-based learning and improvement efforts.** (Detail)

> **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.**

2.9. **Faculty Qualifications**

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

2.10. **Physician Faculty Members**

Physician faculty members must have current certification in the specialty by the American Board of Anesthesiology **or the American Osteopathic Board of** Anesthesiology**, or possess qualifications judged acceptable to the Review Committee.** (Core)

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2.10.a. Any other specialty or subspecialty physician faculty members must have current certification in their specialty or subspecialty by the appropriate American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board, or possess qualifications judged acceptable to the Review Committee. (Core)

Background and Intent: The ACGME expects that physician faculty members (especially core and other required faculty members) have current certification in the specialty or subspecialty by the relevant ABMS member board and/or AOA certifying board. However, in certain instances when a physician faculty member was never eligible for initial certification in the US by one of these entities, programs will be considered in compliance if all the following qualifications are met. The physician faculty member:

1. **completed residency or fellowship in the relevant specialty or subspecialty;**
2. **held board certification (if available) in the country where they trained or practiced, if outside the US;**
3. **holds full and unrestricted licensure to practice medicine in the state where the program is located;**
4. **has three years of experience in practice (after residency/fellowship) in the US, in the specialty or subspecialty for which they will serve as a physician faculty member;**
5. **meets standards of professionalism;**
6. **has demonstrated clinical qualifications and satisfactory patient outcomes; and,**
7. **fulfills at least one of the following: a) demonstrated participation in additional clinical or research training in the specialty or subspecialty; b) demonstrated scholarship in the specialty or subspecialty; c) demonstrated leadership during or after residency/fellowship.**

2.11. 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 autonomous 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

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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.

2.11.a. Core faculty members must complete the annual ACGME Faculty Survey. (Core)

2.11.b. There must be at least six core physician faculty members, not including the program director. (Core)

2.12. Program Coordinator

There must be a program coordinator. (Core)

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

[See FAQ in Appendix]

2.12.b. At a minimum, the program coordinator must be provided with the dedicated time and support specified below for administration of the program: (Core)

Number of Approved Resident Positions	Minimum Support Required (FTE)
9-10	0.7
11-15	0.8
16-20	0.9
21-25	1.0
26-30	1.1
31-35	1.2
36-40	1.3
41-45	1.4
46-50	1.5
51-55	1.6
56-60	1.7
61-65	1.8
66-70	1.9
71-75	2.0
76-80	2.1
81-85	2.2
86-90	2.3
91-95	2.4

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Number of Approved Resident Positions	Minimum Support Required (FTE)
96-100	2.5
101-105	2.6
106-110	2.7
111-115	2.8
116-120	2.9
Over 120	3.0

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.

The minimum required dedicated time and support specified in 2.12.b. includes activities directly related to administration of the accredited program. It is understood that coordinators often have additional responsibilities, beyond those directly related to program administration, including, but not limited to, departmental administrative responsibilities, medical school clerkships, planning lectures that are not solely intended for the accredited program, and mandatory reporting for entities other than the ACGME. Assignment of these other responsibilities will necessitate consideration of allocation of additional support so as not to preclude the coordinator from devoting the time specified above solely to administrative activities that support the accredited program.

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In addition, it is important to remember that the dedicated time and support requirement for ACGME activities is a minimum, recognizing that, depending on the unique needs of the program, additional support may be warranted. The need to ensure adequate resources, including adequate support and dedicated time for the program coordinator, is also addressed in Institutional Requirement 2.2.d. The amount of support and dedicated time needed for individual programs will vary based on a number of factors and may exceed the minimum specified in the applicable specialty/subspecialty-specific Program Requirements. It is expected that the Sponsoring Institution, in partnership with its accredited programs, will ensure support for program coordinators to fulfill their program responsibilities effectively.

[See FAQ in Appendix]

2.13. 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.

Section 3: Resident Appointments

3.1. Residents must not be required to sign a non-competition guarantee or restrictive covenant. (Core)

3.2. Eligibility Requirements

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

3.2.a. graduation from a medical school in the United States, 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)

3.2.b. graduation from a medical school outside of the United States, and meeting one of the following additional qualifications: (Core)

- **holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core)**

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

3.3. 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)

3.3.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.

3.3.a.1. Residents entering a 36-month anesthesiology program that does not include education in fundamental clinical skills of medicine must have successfully completed 12 months of education in fundamental clinical skills of medicine in a program that satisfies the requirements in 3.3. (Core)

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

3.3.a.1.b. When residents complete education in fundamental clinical skills of medicine in another accredited program, the anesthesiology program director must ensure they receive their written performance evaluations. (Core)

3.4. Resident Complement

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

Background and Intent: Programs are required to request approval of all complement changes, whether temporary or permanent, by the Review Committee through ADS. Permanent increases require prior approval from

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the Review Committee and temporary increases may also require approval. Specialty-specific instructions for requesting a complement increase are found in the "Documents and Resources" page of the applicable specialty section of the ACGME website.

[See FAQ in Appendix]

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

3.5. 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. (Core)

[See FAQ in Appendix]

3.6. Prior to accepting a transfer resident, the program must obtain from the resident, and retain written confirmation that the resident understands the impact of the transfer on their eligibility for their intended specialty board's initial certification. (Core)

Section 4: 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.

It is recognized that 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.

4.1. Length of Program

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

4.2. Educational Components

The curriculum must contain the following educational components:

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4.2.a. **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, which must be made available to program applicants, residents, and faculty members; (Core)**

[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 4.2.a. has been suspended]

4.2.b. **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 evaluations. Milestones are considered formative and should be used to identify learning needs. Milestones data may lead to focused or general curricular revision in any given program or to individualized learning plans for any specific resident.**

4.2.c. **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.**

4.2.d. **a broad range of structured didactic activities; and, (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.**

4.2.e. **formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)**

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[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 4.2.e. has been suspended]

ACGME Competencies

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.

The program must integrate all ACGME Competencies into the curriculum.

4.3. ACGME Competencies – Professionalism
Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)

Residents must demonstrate competence in:

4.3.a. compassion, integrity, and respect for others; (Core)

4.3.b. responsiveness to patient needs that supersedes self-interest; (Core)

4.3.c. cultural awareness; (Core)

4.3.d. respect for patient privacy and autonomy; (Core)

4.3.e. accountability to patients, society, and the profession; (Core)

4.3.f. respect and responsiveness to heterogeneous patient populations, including but not limited to gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation; (Core)

4.3.g. ability to recognize and develop a plan for one's own personal and professional well-being; and, (Core)

4.3.h. appropriately disclosing and addressing conflict or duality of 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 practitioner. 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.**

4.4. ACGME Competencies – Patient Care and Procedural Skills (Part A)
Residents must be able to provide patient care that is patient- and family-centered, compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. (Core)

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Background and Intent: Quality patient care is safe, effective, timely, efficient, patient-centered, fair, and designed to improve population health, while reducing per capita costs. 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.

4.4.a. Residents must demonstrate competence in fundamental clinical skills of medicine, including:

4.4.a.1. obtaining a comprehensive medical history; (Core)

4.4.a.2. performing a comprehensive physical examination; (Core)

4.4.a.3. assessing a patient's medical conditions; (Core)

4.4.a.4. making appropriate use of diagnostic studies and tests; (Core)

4.4.a.5. integrating information to develop a differential diagnosis; and, (Core)

4.4.a.6. implementing a treatment plan. (Core)

4.4.b. Residents must demonstrate competence in anesthetic management, including care for:

4.4.b.1. patients younger than 12 years of age undergoing surgery or other procedures requiring anesthetics; (Core)

4.4.b.1.a. This experience must involve care for 100 patients younger than 12 years of age. (Core)

4.4.b.1.b. Within this patient group, 20 children must be younger than three years of age, including five younger than three months of age. (Core)

4.4.b.2. patients who are evaluated for management of acute, chronic, or cancer-related pain disorders; (Core)

4.4.b.2.a. This experience must involve care for 20 patients presenting for initial evaluation of pain. (Core)

4.4.b.2.b. Residents must be familiar with the breadth of pain management, including clinical experience with interventional pain procedures. (Core)

4.4.b.3. patients scheduled for evaluation prior to elective surgical procedures; (Core)

4.4.b.4. patients immediately after anesthesia, including direct care of patients in the post-anesthesia-care unit, and responsibilities for management of pain, hemodynamic changes, and emergencies related to the post-anesthesia care unit; and, (Core)

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4.4.b.5. critically-ill patients. (Core)

4.4.c. Residents must achieve competence in the delivery of anesthetic care to:

4.4.c.1. patients undergoing vaginal delivery; (Core)

4.4.c.1.a. This experience must involve care for 40 patients. (Core)

4.4.c.2. patients undergoing cesarean sections; (Core)

4.4.c.2.a. This experience must involve care for 20 patients. (Core)

4.4.c.3. patients undergoing cardiac surgery; (Core)

4.4.c.3.a. This experience must involve care for 20 patients. (Core)

4.4.c.3.b. The care provided to 10 of these patients must involve the use of cardiopulmonary bypass. (Core)

4.4.c.4. patients undergoing open or endovascular procedures on major vessels, including carotid surgery, intrathoracic vascular surgery, intra-abdominal vascular surgery, or peripheral vascular surgery; (Core)

4.4.c.4.a. This experience must involve care for 20 patients, not including surgery for vascular access or repair of vascular access. (Core)

4.4.c.5. patients undergoing non-cardiac intrathoracic surgery, including pulmonary surgery and surgery of the great vessels, esophagus, and the mediastinum and its structures; (Core)

4.4.c.5.a. This experience must involve care for 20 patients. (Core)

4.4.c.6. patients undergoing intracerebral procedures, including those undergoing intracerebral endovascular procedures; (Core)

4.4.c.6.a. This experience must involve care for 20 patients, the majority of which must involve an open cranium. (Core)

4.4.c.7. patients for whom epidural anesthetics are used as part of the anesthetic technique or epidural catheters are placed for peri-operative analgesia; (Core)

4.4.c.7.a. This experience must involve care for 40 patients. (Core)

4.4.c.8. patients undergoing procedures for complex, immediate life-threatening pathology; (Core)

4.4.c.8.a. This experience must involve care for 20 patients. (Core)

4.4.c.9. patients undergoing surgical procedures, including cesarean sections, with spinal anesthetics; (Core)

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4.4.c.9.a. This experience must involve care for 40 patients. (Core)

4.4.c.10. patients undergoing surgical procedures in whom peripheral nerve blocks are used as part of the anesthetic technique or peri-operative analgesic management; (Core)

4.4.c.10.a. This experience must involve care for 40 patients. (Core)

4.4.c.11. patients with acute post-operative pain, including those with patient-controlled intravenous techniques, neuraxial blockade, and other pain-control modalities; (Core)

4.4.c.12. patients whose peri-operative care requires specialized techniques, including: (Core)

4.4.c.12.a. a broad spectrum of airway management techniques, to include laryngeal masks, fiberoptic intubation, and lung isolation techniques, such as double lumen endotracheal tube placement and endobronchial blockers; (Core)

4.4.c.12.b. central vein and pulmonary artery catheter placement, and the use of transesophageal echocardiography and evoked potentials; and, (Core)

4.4.c.12.c. use of electroencephalography (EEG) or processed EEG monitoring as part of the procedure, or adequate didactic instruction to ensure familiarity with EEG use and interpretation. (Core)

4.4.c.13. patients undergoing a variety of diagnostic or therapeutic procedures outside the surgical suite. (Core)

This must include competency in:

4.4.c.13.a. using surface ultrasound and transesophageal and transthoracic echocardiography to guide the performance of invasive procedures and to evaluate organ function and pathology as related to anesthesia, critical care, and resuscitation; (Core)

4.4.c.13.b. understanding the principles of ultrasound, including the physics of ultrasound transmission, ultrasound transducer construction, and transducer selection for specific applications, to include being able to obtain images with an understanding of limitations and artifacts; (Core)

4.4.c.13.c. obtaining standard views of the heart and inferior vena cava with transthoracic echocardiography allowing the evaluation of myocardial function, estimation of central venous pressure, and gross pericardial/cardiac pathology (e.g., large pericardial effusion); (Core)

4.4.c.13.d. obtaining standard views of the heart with transesophageal echocardiography allowing the evaluation of myocardial function and gross pericardial/cardiac pathology (e.g., large pericardial effusion); (Core)

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4.4.c.13.e. using transthoracic ultrasound for the detection of pneumothorax and pleural effusion; (Core)

4.4.c.13.f. using surface ultrasound to guide vascular access (both central and peripheral) and to guide regional anesthesia procedures; and, (Core)

4.4.c.13.g. describing techniques, views, and findings in standard language. (Core)

4.5. ACGME Competencies – Patient Care and Procedural Skills (Part B)
Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)

4.6. ACGME Competencies – Medical Knowledge
Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, including scientific inquiry, as well as the application of this knowledge to patient care. (Core)

4.6.a. Residents must demonstrate appropriate medical knowledge in the topics related to the anesthetic care of patients, including:

4.6.a.1. practice management to address issues such as: (Core)

4.6.a.1.a. operating room management; (Core)

4.6.a.1.b. evaluation of types of practice; (Core)

4.6.a.1.c. contract negotiations; (Core)

4.6.a.1.d. billing arrangements; (Core)

4.6.a.1.e. professional liability; (Core)

4.6.a.1.f. health care finance, legislative, and regulatory issues; and, (Core)

4.6.a.1.g. fiscal stewardship of health services delivery. (Core)

4.6.a.2. management skills, to include basic knowledge of organizational culture, decision making, change management, conflict resolution, and negotiation and advocacy; (Core)

4.6.a.3. care of the patient in the continuum of the peri-operative period, to include collaboration with medical and surgical colleagues to:

4.6.a.3.a. optimize preoperative patient condition; and, (Core)

4.6.a.3.b. optimize recovery; (Core)

4.6.a.4. management of the specific needs of patients undergoing diagnostic or therapeutic procedures outside of the surgical suite. (Core)

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4.7. ACGME Competencies – 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)

4.7.a. Residents must demonstrate competence in identifying strengths, deficiencies, and limits in one's knowledge and expertise. (Core)

4.7.b. Residents must demonstrate competence in setting learning and improvement goals. (Core)

4.7.c. Residents must demonstrate competence in identifying and performing appropriate learning activities. (Core)

4.7.d. Residents must demonstrate competence in systematically analyzing practice using quality improvement methods, including activities aimed at reducing health care disparities, and implementing changes with the goal of practice improvement. (Core)

4.7.e. Residents must demonstrate competence in incorporating feedback and formative evaluation into daily practice. (Core)

4.7.f. Residents must demonstrate competence in locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems. (Core)

4.8. ACGME Competencies – 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)

4.8.a. Residents must demonstrate competence in communicating effectively with patients and patients' families, as appropriate, across a broad range of socioeconomic circumstances, cultural backgrounds, and language capabilities, learning to engage interpretive services as required to provide appropriate care to each patient. (Core)

4.8.b. Residents must demonstrate competence in communicating effectively with physicians, other health professionals, and health-related agencies. (Core)

4.8.c. Residents must demonstrate competence in working effectively as a member or leader of a health care team or other professional group. (Core)

4.8.d. Residents must demonstrate competence in educating patients, patients' families, students, other residents, and other health professionals. (Core)

4.8.e. Residents must demonstrate competence in acting in a consultative role to other physicians and health professionals. (Core)

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4.8.f. **Residents must demonstrate competence in maintaining comprehensive, timely, and legible health care records, if applicable.** **(Core)**

4.8.g. **Residents must learn to communicate with patients and patients' families to partner with them to assess their care goals, including, when appropriate, end-of-life goals.** **(Core)**

4.8.h. Residents must demonstrate competence in maintaining a comprehensive anesthesia record for each patient, including evidence of pre- and post-operative anesthesia assessment, the drugs administered, the monitoring employed, the techniques used, the physiologic variations observed, the therapy provided, and the fluids administered. (Core)

4.8.i. Residents must demonstrate competence in creating and sustaining a therapeutic relationship with patients, engaging in active listening, providing information using appropriate language, asking clear questions, and providing an opportunity for comments and questions. (Core)

4.9. ACGME Competencies – 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)**

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.

4.9.a. **Residents must demonstrate competence in working effectively in various health care delivery settings and systems relevant to their clinical specialty.** **(Core)**

4.9.b. **Residents must demonstrate competence in 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.

4.9.c. **Residents must demonstrate competence in advocating for quality patient care and optimal patient care systems.** **(Core)**

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4.9.d. Residents must demonstrate competence in participating in identifying system errors and implementing potential systems solutions. (Core)

4.9.e. Residents must demonstrate competence in incorporating considerations of value, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate. (Core)

4.9.f. Residents must demonstrate competence in understanding health care finances and its impact on individual patients' health decisions. (Core)

4.9.g. Residents must demonstrate competence in using tools and techniques that promote patient safety and disclosure of patient safety events (real or simulated). (Detail)

4.9.h. Residents must learn to advocate for patients within the health care system to achieve the patient's and patient's family's care goals, including, when appropriate, end-of-life goals. (Core)

Curriculum Organization and Resident Experiences

4.10. Curriculum Structure

The curriculum must be structured to optimize resident educational experiences, the length of the experiences, and the supervisory continuity. These educational experiences include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events. (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.

4.10.a. Assignment of rotations must be of sufficient length to provide a quality educational experience, defined by continuity of patient care, ongoing supervision, longitudinal relationships with faculty members, and meaningful assessment and feedback, or as otherwise specified in the specialty-specific Program Requirements. (Core)

4.10.b. Clinical experiences should be structured to facilitate learning in a manner that allows residents to function as part of an effective interprofessional team that works together longitudinally with shared goals of patient safety and quality improvement. (Core)

4.11. Didactic and Clinical Experiences

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

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4.11.a. The program must have a written policy and an educational program regarding substance use disorders as related to physician well-being that specifically addresses the needs of anesthesiology. (Core)

4.11.b. Twelve months of the resident's educational program must provide broad education in fundamental clinical skills of medicine relevant to the practice of anesthesiology. (Core)

4.11.b.1. Fundamental clinical skills of medicine education completed as part of an anesthesiology residency need not be contiguous, but must be completed before starting the final year of the program. (Core)

4.11.b.2. At least six months of fundamental clinical skills of medicine education must include experience in caring for inpatients in family medicine, internal medicine, neurology, obstetrics and gynecology, pediatrics, surgery or any of the surgical specialties, or any combination of these. (Core)
[See FAQ in Appendix] [See FAQ in Appendix]

4.11.b.3. The program director must maintain oversight of resident education in fundamental clinical skills of medicine. (Core)

4.11.c. During the first 12 months of the program, there must be at least one month, but not more than two month(s) each of critical care and emergency medicine. (Core)
[See FAQ in Appendix]

4.11.d. Thirty-six months of education must be in peri-operative medicine. (Core)
[See FAQ in Appendix]

4.11.d.1. This must include experience with a wide spectrum of disease processes and surgical procedures available within the CA-1 through CA-3 years to provide each resident with broad exposure to different types of anesthetic management. (Core)

4.11.d.2. The program must ensure that the rotations for residents beginning the peri-operative medicine component of the residency be in surgical anesthesia, critical care medicine, and pain medicine. (Core)

4.11.d.3. Residents must receive training in the complex technology and equipment associated with the practice of anesthesiology. (Core)

4.11.d.4. Clinical experience in surgical anesthesia, pain medicine, and critical care medicine must be distributed throughout the curriculum in order to provide progressive responsibility in the later stages of the program. (Core)

4.11.e. Residents must have a rotation of at least two weeks in pre-operative medicine. (Core)

[See FAQ in Appendix]

4.11.f. Residents must have a rotation of at least two weeks in post-anesthesia care. (Core)

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4.11.f.1. Resident clinical responsibilities in the post-operative care unit must be limited to the care of post-operative patients, with the exception of providing emergency response capability for cardiac arrests and rapid response situations within the facility. (Core)

4.11.g. Resident education must include a minimum of four one-month rotations in critical care medicine. (Core)

4.11.g.1. No more than two months of this experience should occur prior to the CA-1 year. (Core)

4.11.g.2. Each critical care medicine rotation must be at least one month in duration, with progressive patient care responsibility in advanced rotations. (Core)

4.11.g.3. Training must take place in units, providing care for both men and women, in which the majority of patients have multisystem disease. (Core)

4.11.g.4. Residents must actively participate in all patient care activities as fully integrated members of the critical care team. (Core)

4.11.g.5. During at least two of the required four months of critical care medicine, faculty anesthesiologists experienced in the practice and teaching of critical care must be actively involved in the care of the critically-ill patients seen by residents, and in the educational activities of the residents. (Core)

4.11.h. Resident education must include a minimum of two one-month rotations each in obstetric anesthesia, pediatric anesthesia, neuroanesthesia, and cardiothoracic anesthesia. (Core)

4.11.h.1. Additional subspecialty and research rotations are encouraged, but resident rotations in a single anesthesia subspecialty must not exceed six months. (Detail)

4.11.h.2. Advanced subspecialty rotations must not compromise the learning opportunities for residents participating in their initial subspecialty rotations. (Core)

4.11.i. Resident education must include a minimum of three months in pain medicine, including: (Core)

4.11.i.1. one month in an acute peri-operative pain management rotation; (Core)

4.11.i.2. one month in a rotation for the assessment and treatment of inpatients and outpatients with chronic pain; and, (Core)

4.11.i.3. one month of a regional analgesia experience rotation. (Core)

4.11.j. Residents must have at least two weeks of experience managing the anesthetic care of patients undergoing diagnostic or therapeutic procedures outside of the surgical suite. (Core)

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4.11.k. In the clinical anesthesia setting, faculty members must not direct anesthesia at more than two anesthetizing locations simultaneously when supervising residents. (Core)

[See FAQ in Appendix]

4.11.k.1. Clinical instruction of residents by non-physician personnel should be limited to not more than 10 percent of total instruction, and should use such personnel only when access to their specific expertise will enhance the educational experience of residents. (Detail)

4.11.l. All residents must obtain advanced cardiac life support (ACLS) certification at least once during the program. (Core)

4.11.m. Residents must participate in at least one simulated clinical experience each year. (Core)

[See FAQ in Appendix]

4.11.n. The program director must ensure regular review of the residents' clinical experience logs and verify their accuracy and completeness when they are transmitted to the Review Committee. (Core)

[See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix]

4.11.n.1. The program director must ensure that experience logs are submitted annually to the Review Committee in accordance with the format and the due date specified by the Committee. (Core)

4.11.o. The program director must determine sequencing of rotations. (Detail)

4.11.p. The program director must monitor the appropriate distribution of cases among the residents. (Core)

4.11.q. The program director must ensure that service commitments do not compromise the achievement of educational goals and objectives. (Core)

4.11.r. The curriculum must contain didactic instruction through a variety of learning opportunities occurring in conference, in the clinical setting or online that encompasses clinical anesthesiology and related areas of basic science. (Core)

4.11.s. Other topics from internal medicine that are important for the pre-operative preparation of the patient, from surgery as to the nature of the surgical procedure affecting anesthetic care, and from obstetrics that impacts anesthetic management of the patient, should be included. (Core)

[See FAQ in Appendix]

4.11.s.1. The material covered in the didactic program must demonstrate appropriate continuity and sequencing to ensure that residents are ultimately exposed to all subjects at regularly held learning exercises. (Core)

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4.11.s.1.a. There should be evidence of regular faculty member participation in didactic sessions. (Detail)

4.11.s.1.b. The program director and faculty members from other disciplines and other institutions should conduct these sessions. (Detail)

4.11.t. When 12 months of education in fundamental clinical skills of medicine is approved as part of the accredited program, the program director must maintain oversight for all rotations, and must approve the rotations for individual residents. (Core)

4.11.u. The program director must review written resident performance evaluations from each clinical service on which each resident rotates on a quarterly basis. (Core)

4.11.v. The education must culminate in sufficiently independent responsibility for clinical decision-making and patient care, so that the graduating resident exhibits sound clinical judgment in a wide variety of clinical situations and can function as a leader of peri-operative care teams. (Core)

4.11.w. As the resident advances through the program, goals and objectives must reflect the opportunity to learn to plan and administer anesthesia care for patients with more severe and complicated diseases, as well as for patients who undergo more complex surgical procedures. (Core)

4.11.x. International rotations should be limited to the final year of training and should be limited to three months or less. (Detail)

4.11.x.1. International rotations must be approved by the Review Committee through a written request submitted by the program director. (Detail)
[See FAQ in Appendix]

4.12. Pain Management

The program must provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of substance use disorder. (Core)

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 variety 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.

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4.13. Program Responsibilities

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

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

4.13.b. The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. (Core)

4.14. Faculty Scholarly Activity

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**

4.14.a. The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:

- **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)**
- **peer-reviewed publication. (Outcome)**

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

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differences in scholarship requirements between different specialties and between residencies and fellowships in the same specialty.

4.15. Resident Scholarly Activity

Residents must participate in scholarship. (Core)

4.15.a. Each resident must complete, under faculty member supervision, an academic assignment. (Core)

[See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix]

4.15.a.1. Academic assignments should include grand rounds presentations; preparation and publication of review articles, book chapters, manuals for teaching or clinical practice; or development, performance, or participation in one or more clinical or laboratory investigations. (Detail)

4.15.a.1.a. The outcome of resident investigations should be suitable for presentation at local, regional, or national scientific meetings, and/or result in peer-reviewed abstracts or manuscripts. (Detail)

Section 5: Evaluation

5.1. Resident Evaluation: Feedback and Evaluation

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

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**

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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.

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.

5.1.a. Evaluation must be documented at the completion of the assignment. (Core)
[See FAQ in Appendix]

5.1.a.1. For block rotations of greater than three months in duration, evaluation must be documented at least every three months. (Core)

5.1.a.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)

5.1.b. The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones. (Core)

5.1.b.1. The program must use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members). (Core)

5.1.b.2. The program must provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. (Core)

5.1.c. The program director or their designee, with input from the Clinical Competency Committee, must meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones. (Core)

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5.1.d. **The program director or their designee, with input from the Clinical Competency Committee, must assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth.** (Core)

5.1.e. **The program director or their designee, with input from the Clinical Competency Committee, must 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.

5.1.f. **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)

5.1.g. **The evaluations of a resident's performance must be accessible for review by the resident.** (Core)

5.2. **Resident Evaluation: Final Evaluation**

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

5.2.a. **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)

5.2.b. **The final evaluation must 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)

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5.2.c. **The final evaluation must verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice. (Core)**

5.2.d. **The final evaluation must be shared with the resident upon completion of the program. (Core)**

5.3. **Clinical Competency Committee**

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

[See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix]

5.3.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)**

[See FAQ in Appendix] [See FAQ in Appendix]

5.3.b. **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.

5.3.c. **The Clinical Competency Committee must review all resident evaluations at least semi-annually. (Core)**

5.3.d. **The Clinical Competency Committee must determine each resident's progress on achievement of the specialty-specific Milestones. (Core)**

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5.3.e. **The Clinical Competency Committee must meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress.** (Core)

5.4. Faculty Evaluation

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 educational program and all educators. 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 varied 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.

5.4.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)

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

5.4.c. **Faculty members must receive feedback on their evaluations at least annually.** (Core)

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

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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.

5.5. Program Evaluation and Improvement

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)

5.5.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)

5.5.b. Program Evaluation Committee responsibilities must include review of the program's self-determined goals and progress toward meeting them. (Core)

5.5.c. Program Evaluation Committee responsibilities must include guiding ongoing program improvement, including development of new goals, based upon outcomes. (Core)

5.5.d. Program Evaluation Committee responsibilities must include 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: To achieve its mission and educate 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. The Program Evaluation Committee advises the program director through program oversight.

5.5.e. The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate resident and faculty written evaluations of the program, and other relevant data in its assessment of the program . (Core)

Background and Intent: Other data to be considered for assessment include:

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- **Curriculum**
- **ACGME letters of notification, including citations, Areas for Improvement, and comments**
- **Quality and safety of patient care**
- **Aggregate resident and faculty well-being; recruitment and retention; engagement in quality improvement and patient safety; and scholarly activity**
- **ACGME Resident and Faculty Survey results**
- **Aggregate resident Milestones evaluations, and achievement on in-training examinations (where applicable), board pass and certification rates, and graduate performance.**
- **Aggregate faculty evaluation and professional development**

5.5.f. **The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)**

[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 5.5.f. has been suspended]

5.5.g. **The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the residents and the members of the teaching faculty, and be submitted to the DIO. (Core)**

5.5.h. **The program must complete a Self-Study and submit it to the DIO. (Core)**

[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 5.5.h. has been suspended]

Board Certification

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.

5.6. **Board Certification**

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)

5.6.a. **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**

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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)

5.6.b. **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)**

5.6.c. **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)**

5.6.d. **For each of the exams referenced in 5.6.a.-c., 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 5.6.d. is designed to address this.

5.6.e. **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.

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Section 6: The Learning and Working Environment

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***
- ***Appreciation for the privilege of caring for patients***
- ***Commitment to the well-being of the students, residents, faculty members, and all members of the health care team***

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.

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

Patient Safety Events

Reporting, investigation, and follow-up of safety 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.

6.2. Residents, fellows, faculty members, and other clinical staff members must know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report such events. (Core)

6.2.a. Residents, fellows, faculty members, and other clinical staff members must be provided with summary information of their institution's patient safety reports. (Core)

6.3. Residents must participate as team members in real and/or simulated interprofessional clinical patient safety and quality improvement activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)

Quality Metrics

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

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6.4. Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)

[See FAQ in Appendix]

Supervision and Accountability

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.

6.5. Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. This information must be available to residents, faculty members, other members of the health care team, and patients. (Core)

Background and Intent: Each patient will 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.

6.6. 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)

Background and Intent: Appropriate supervision is essential for patient safety and high-quality teaching. Supervision is also contextual. There is tremendous variability of resident-patient interactions, training locations, and resident skills and abilities, even at the same level of the educational program. The degree of supervision for a resident is expected to evolve progressively as the resident gains more experience, even with the same patient condition or procedure. The level of supervision for each resident is commensurate with that resident's level of independence in practice; this level of supervision may be enhanced based on factors such as patient safety, complexity, acuity, urgency, risk of serious safety events, or other pertinent variables.

[See FAQ in Appendix]

Levels of Supervision

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

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6.7. Direct Supervision

The supervising physician is physically present with the resident during the key portions of the patient interaction.

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.

[See FAQ in Appendix]

6.7.a. PGY-1 residents must initially be supervised directly, only as described in the above definition. (Core)

[See FAQ in Appendix]

6.7.b. The use of telecommunication technology for direct supervision must not be used with invasive procedures, including the conduct of anesthesia. (Core)

6.7.c. The supervising physician and the resident must interact with each other, and the patient, to solicit the key elements of the clinic visit and agree upon a management plan. (Core)

6.7.d. The use of telecommunication technology for direct supervision must be limited to history-taking and patient examination, assessment, and counseling. (Core)

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.

Oversight

The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

6.8. The program must define when physical presence of a supervising physician is required. (Core)

[See FAQ in Appendix]

6.9. 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)

6.9.a. The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones. (Core)

6.9.b. 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)

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6.9.c. **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)

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

6.10.a. **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.

6.11. **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)

6.12. **Professionalism**

Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional and ethical responsibilities of physicians, including but not limited to their obligation to be appropriately rested and fit to provide the care required by their patients. (Core)

Background and Intent: This requirement emphasizes the professional responsibility of residents and faculty members to arrive for work adequately rested and ready to care for patients. It is also the responsibility of residents, faculty members, 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. This includes recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team, and 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 practitioner.

6.12.a. **The learning objectives of the program must be accomplished without excessive reliance on residents to fulfill non-physician obligations.** (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

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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.

6.12.b. **The learning objectives of the program must 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.

6.12.c. **The learning objectives of the program must include efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, providing administrative support, promoting progressive independence and flexibility, and enhancing professional relationships.** (Core)

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

Background and Intent: The accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data are the responsibility of the program leadership, residents, and faculty.

[See FAQ in Appendix]

6.12.e. **Residents and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events.** (Core)
[See FAQ in Appendix]

6.12.f. **Programs, in partnership with their Sponsoring Institutions, must provide a professional, respectful, and civil environment that is psychologically safe and that is free from discrimination, sexual and other forms of harassment,**

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mistreatment, abuse, or coercion of students, residents, faculty, and staff. (Core)

Background and Intent: Psychological safety is defined as an environment of trust and respect that allows individuals to feel able to ask for help, admit mistakes, raise concerns, suggest ideas, and challenge ways of working and the ideas of others on the team, including the ideas of those in authority, without fear of humiliation, and the knowledge that mistakes will be handled justly and fairly.

The ACGME is unable to adjudicate disputes between individuals, including residents, faculty members, and staff members. However, information that suggests a pattern of behavior that violates the requirement above will trigger a careful review and, if deemed appropriate, action by the Review Committee and/or ACGME, in accordance with ACGME Policies and Procedures.

6.12.g. 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)

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. 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.

6.13. The responsibility of the program, in partnership with the Sponsoring Institution, must include:

6.13.a. attention to scheduling, work intensity, and work compression that impacts resident well-being; (Core)

6.13.b. evaluating workplace safety data and addressing the safety of residents and faculty members; (Core)

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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 safety events.

6.13.c. **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. 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.

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

6.13.d. **education of residents and faculty members in:**

6.13.d.1. **identification of the symptoms of burnout, depression, and substance use disorders, suicidal ideation, or potential for violence, including means to assist those who experience these conditions; (Core)**
[See FAQ in Appendix]

6.13.d.2. **recognition of these symptoms in themselves and how to seek appropriate care; and, (Core)**

6.13.d.3. **access to appropriate tools for self-screening. (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).

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 may be concerned that

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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/well-being programs within the institution. In cases of physician impairment, the program director or designated personnel should follow the policies of their institution for reporting.

6.13.e. providing 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.

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

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

6.14.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

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requirements. Teammates should assist colleagues in need and fairly reintegrate them upon return.

6.15. Fatigue Mitigation

Programs must educate all residents and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes. (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.

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.

6.16. 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)

6.17. Clinical Responsibilities

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

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

6.18. Teamwork

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Residents must care for patients in an environment that maximizes communication and promotes safe, interprofessional, team-based care in the specialty and larger health system. (Core)

Background and Intent: Effective programs will have a structure that promotes safe, interprofessional, team-based care. Optimal patient safety occurs in the setting of a coordinated interprofessional learning and working environment.

6.19. Transitions of Care

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

[See FAQ in Appendix]

6.19.a. Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety. (Core)

6.19.b. Programs must ensure that residents are competent in communicating with team members in the hand-off process. (Outcome)

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: 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 terms are used 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.

6.20. 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, including 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

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or participate in an educational activity, these additional hours must be accounted for in the allocated 80 hours when averaged over four weeks.

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 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.

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.

[See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix]

6.21. Mandatory Time Free of Clinical Work and Education

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

Background and Intent: 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

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occurs within the context of the 80-hour and the one-day-off-in-seven requirements. 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.

6.21.a. 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.

[See FAQ in Appendix]

6.21.b. 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."

[See FAQ in Appendix]

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6.22. Maximum Clinical Work and Education Period Length

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

6.22.a. 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. Additional patient care responsibilities must not be assigned to a resident during this time. (Core)

Background and Intent: The additional time referenced in 6.22.a. 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.

[See FAQ in Appendix]

6.23. Clinical and Educational Work Hour Exceptions

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: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events. (Detail)

6.23.a. These additional hours of care or education must 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.

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

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

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[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 6.24. has been suspended]

6.25. Moonlighting

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)

[See FAQ in Appendix]

6.25.a. 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)

6.25.b. PGY-1 residents are not permitted to moonlight. (Core)

[See FAQ in Appendix]

6.26. In-House Night Float

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

[See FAQ in Appendix]

6.27. 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)

6.28. At-Home Call

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)

[See FAQ in Appendix] [See FAQ in Appendix]

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

Background and Intent: As noted in 6.20., clinical work done from home when a resident is taking at-home call must count toward the 80-hour maximum weekly limit. This 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

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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.

[See FAQ in Appendix]

7. Frequently Asked Questions: Anesthesiology

FAQs related to Anesthesiology Program Requirements

Last updated July 2026

Review Committee for Anesthesiology

Section 1: Oversight

Questions concerning *"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)"* (1.3)

Q: What is the purpose of program letters of agreement (PLAs)?

A: PLAs provide details on faculty members, supervision, evaluation, educational content, length of assignment, and policies and procedures for each required assignment that occurs outside of an accredited program's Sponsoring Institution. These documents are intended to protect the program's residents/fellows by ensuring an appropriate educational experience under adequate supervision.

Questions concerning *"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)"* (1.3)

Q: Under what circumstances are PLAs required?

A: There must be PLAs between an accredited program and all participating sites to which residents/fellows rotate for required education or assignments. PLAs are not required for participating sites under the same governance as the program's Sponsoring Institution. PLAs are not required for elective rotations for individual residents and fellows, but programs and Sponsoring Institutions may determine if there are local expectations for a PLA or similar agreement.

Questions concerning *"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)"* (1.3)

Q: Are PLAs necessary for "courses," such as the Armed Forces Institute of Pathology course or the Bellevue Hospital Toxicology Course?

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A: These types of courses are not examples of participating sites, and therefore do not require PLAs.

Questions concerning *"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)"* (1.3)

Q: Who should sign the PLAs?
A: It is the responsibility of the designated institutional official (DIO), in collaboration with the Graduate Medical Education Committee (GMEC) of the Sponsoring Institution, to establish and administer the local policies and procedures regarding PLAs and determine the individuals authorized to sign the PLAs.

Questions concerning *"Residents should not be required to rotate among multiple participating sites. (Detail)"* (1.6.a.1.a)

Q: Why should residents not be required to rotate among multiple participating sites?
A: The intent of this requirement is to ensure residents are not required to travel unnecessarily to hospitals or other clinical sites for education or training that could reasonably be provided locally by the Sponsoring Institution's affiliated sites. The Review Committee understands that some programs, such as those sponsored by institutions in rural areas based on a consortium model, will by necessity have residents rotate across three to four sites to achieve the required rotations. The focus of the requirement is to protect the residents from being used to meet the service needs of multiple hospitals/clinical operations.

Section 2: Personnel

Questions concerning *"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)"* (2.4) , *"At a minimum, the program director must be provided with the dedicated time and support specified below for administration of the program. Additional support for program leadership must be provided as specified below. This additional support may be for the program director only or divided among the program director and one or more associate (or assistant) program directors. (Core)"* (2.4.a) , *"The program coordinator must be provided with dedicated time and support adequate for administration of the program based upon its size and configuration. (Core)"* (2.12.a) , *"At a minimum, the program coordinator must be provided with the dedicated time and support specified below for administration of the program: (Core)"* (2.12.b)

Q: Are there circumstances in which a Sponsoring Institution, in partnership with its programs, is required to provide support and dedicated time that exceeds the minimum specified in the requirements?
A: The dedicated time and support requirements for ACGME activities specified in 2.4. and 2.4.a. for program leadership, 2.12.a. and 2.12.b. for program coordinators, and section 2.11. for those specialties that specify a minimum level of support for core faculty members, are minimum requirements, recognizing that, depending on the unique needs of the program, additional support may be warranted. The need to ensure adequate resources, including adequate support and dedicated time for the program director, is also addressed in Institutional Requirements 2.2.-2.2.d. The amount of support and dedicated time needed for individual programs will vary based on a number of factors and may exceed the mini-

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mum specified in the applicable specialty-/subspecialty-specific Program Requirements. It is expected that the Sponsoring Institution, in partnership with its accredited programs, will ensure support for program directors, core faculty members, and program coordinators to fulfill their program responsibilities effectively. If the Institutional Review Committee determines that support and dedicated time for one or more programs within a Sponsoring Institution is inadequate, it may issue a citation even if the minimum specified in the applicable specialty-/subspecialty-specific Program Requirements has been met.

Note that Review Committees may choose to specify minimum time and support for the program director only, or may specify minimum time and support that may be divided among the program director and one or more associate or assistant program directors. Questions regarding the requirements for a specific specialty should be directed to the Review Committee Executive Director.

Questions concerning *"The members of the faculty must have varying interests, capabilities, and backgrounds, and include individuals who have specialized expertise in the subspecialties of anesthesiology, including critical care, obstetric anesthesia, pediatric anesthesia, neuroanesthesia, cardiothoracic anesthesia, and pain medicine, and also in research. (Core)"* (2.7.a)

Q: Who can participate as a critical care medicine (CCM) faculty member for the program?
A: Only faculty members experienced in the practice and teaching of critical care can be considered CCM faculty members for the program. Although the Review Committee recognizes that CCM is a multidisciplinary specialty, it requires that at least one member of the CCM faculty be an anesthesiologist who should function in a meaningful way in residents' intensive care unit (ICU) rotations.

Questions concerning *"The members of the faculty must have varying interests, capabilities, and backgrounds, and include individuals who have specialized expertise in the subspecialties of anesthesiology, including critical care, obstetric anesthesia, pediatric anesthesia, neuroanesthesia, cardiothoracic anesthesia, and pain medicine, and also in research. (Core)"* (2.7.a)

Q: What are the qualifications for the cardiothoracic anesthesiology faculty member(s)?
A: Cardiothoracic anesthesiology faculty members can demonstrate their expertise and qualifications in cardiothoracic anesthesiology through certification in advanced peri-operative transesophageal echocardiography (TEE) certification through the National Board of Echocardiography.

Section 3: Resident Appointments

Questions concerning *"Resident Complement"* (3.4)

Q: What criteria are used to determine the resident complement for a program?
A: The Review Committee determines a program's resident complement based on several factors, including case volume, adequate number of faculty members committed to resident education, and faculty members' scholarly activity. If a program has a solid educational rationale for increasing its resident complement, see "Requests for Changes in Resident Complement" on the Documents and Resources page of the Anesthesiology section of the ACGME website.

Questions concerning *"Resident Transfers"* (3.5)

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Q: How should a transferring resident's anesthesia experience obtained prior to transferring into the program be reported?

A: Any experience gained by a resident in one ACGME-accredited anesthesiology program before transferring to another ACGME- accredited program should be included in that resident's Case Logs. For instance, if a resident was accepted in the Clinical Anesthesia (CA)-2 year, the data submitted must include the CA-1 year of experience gained elsewhere. To transfer the data, the program director or coordinator must use the "Resident Transfer Request" link (under the "Resident" heading) on the "Program Setup" tab in the Case Log System in ADS.

Note: This does not apply to residents who transfer into anesthesiology from other specialties.

Section 4: Educational Program

Questions concerning *"At least six months of fundamental clinical skills of medicine education must include experience in caring for inpatients in family medicine, internal medicine, neurology, obstetrics and gynecology, pediatrics, surgery or any of the surgical specialties, or any combination of these. (Core)"* (4.11.b.2)

Q: Can ICU rotations substitute for inpatient experience during the fundamental clinical skills portion of the educational program?

A: Yes, an ICU rotation can serve as inpatient experience as part of the residents' fundamental clinical skills education. However, if a program uses ICU experiences to fulfill fundamental clinical skills inpatient requirements, the program director must design a curriculum (goals and objectives, teaching methods, and outcome measurement tools) that demonstrates how the experience allows the residents to develop the fundamental clinical skill competencies as outlined in Program Requirement 4.4.a. An ICU experience cannot be used to fulfill requirements for both inpatient care and critical care medicine.

Questions concerning *"At least six months of fundamental clinical skills of medicine education must include experience in caring for inpatients in family medicine, internal medicine, neurology, obstetrics and gynecology, pediatrics, surgery or any of the surgical specialties, or any combination of these. (Core)"* (4.11.b.2)

Q: How do inpatient care and critical care educational requirements differ during the fundamental clinical skills education?

A: Inpatient care involves basic routine medical care of individuals with common health problems and chronic illness. It encompasses both initial evaluation of a patient and continuity of care during the course of therapy, including initial diagnosis and treatment, management of acute and chronic conditions, preventive health services, and appropriate referral for a higher level of care when required. Inpatient care rotations should be designed to allow residents to develop fundamental clinical skills, as outlined in Program Requirement 4.4.a.

Critical care is the specialized care of patients who have life threatening conditions. These conditions require comprehensive care and constant monitoring in an ICU or equivalent. If a rotation involves the care of patients requiring short-term overnight post-anesthesia units, intermediate/step-down or transitional care units, or emergency departments, and does not

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include ongoing clinical assessment and management of critical illness, then it does not fulfill the critical care requirement.

Questions concerning *"During the first 12 months of the program, there must be at least one month, but not more than two month(s) each of critical care and emergency medicine. (Core)"* (4.11.c)

Q: How should emergency medicine experiences be addressed for residents who transfer to a three-year program at the CA-1 level?

A: As stated in the Program Requirements, there must be at least one month but not more than two months of emergency medicine included in the integrated 12-month fundamental clinical skills education. If a resident transfers into the program from another medical specialty, the anesthesiology program director must document that the transfer resident met, or had an equivalent experience to meet, the emergency medicine requirement. If such experience was not provided in a previous program, the resident must complete this requirement before the start of the CA-3 year.

Questions concerning *"Thirty-six months of education must be in peri-operative medicine. (Core)"* (4.11.d)

Q: How should regional anesthesia and acute/post-operative pain service rotations be designed to be in compliance with the requirements for experience in peri-operative care?

A: The intent of this requirement is to ensure that all residents have at least one month of exposure to concentrated experience in providing regional anesthesia/analgesia, one month of concentrated experience in caring for patients with acute pain as part of a structured inpatient service, and one month of concentrated experience caring for patients with chronic pain in the inpatient and/or outpatient settings. While the exact format of these rotations will vary among institutions, the regional anesthesia experience may be carried out in the context of an operating room rotation where many (but not necessarily all) of the patients cared for by the resident will be receiving regional anesthetic techniques for post-operative pain management. In contrast, the acute post-operative and chronic pain rotations should be discrete experiences occurring outside of the operating room setting where the resident is an integral part of the organized team(s) providing these services.

Questions concerning *"Residents must have a rotation of at least two weeks in pre-operative medicine. (Core)"* (4.11.e)

Q: What pre-operative experience is acceptable to the Review Committee?

A: The requirement for pre-operative evaluation is intended to ensure that all anesthesiology residents receive formal education in the evaluation of patients prior to surgery. During the pre-operative experience, residents must gain knowledge about appropriate pre-operative testing and evaluation that will be required to determine if a patient is ready for anesthesia and surgery, and how to optimize anesthetic care. The experience should provide residents with an understanding of the most effective systems for patient assessment, staffing of a pre-operative assessment program, and alternative methods for gathering and evaluating the pre-operative data. Residents should also learn how to analyze pre-operative data and make evidence-based decisions about anesthetic management. The exact structure of the pre-operative experience will vary from institution to institution and faculty members should

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evaluate the experience based on the program's educational outcome data, including the Milestones.

Questions concerning *"In the clinical anesthesia setting, faculty members must not direct anesthesia at more than two anesthetizing locations simultaneously when supervising residents. (Core)"* (4.11.k)

Q: Does the Review Committee allow exceptions to the requirement that faculty members not direct anesthesia at more than two anesthetizing locations simultaneously when supervising residents?

A: The Review Committee expects programs to adhere to the 1:2 supervision rule at all times, as this requirement is essential to both patient safety and the quality of resident education. As noted in the requirement, faculty members may not supervise more than two concurrent anesthetizing locations, except in rare, unanticipated circumstances. Examples may include sudden patient deterioration or a faculty member unexpectedly becoming unavailable due to illness. Such occurrences are understood to be uncommon and must not be incorporated into routine scheduling.

The Committee does not consider predictable or recurrent situations, such as routine trauma or emergency service coverage that regularly results in exceeding the 1:2 ratio, to fall under this exception. Frequent or systemic violations reflect non-compliance and signal inadequate program or institutional resources. Programs are expected to plan faculty coverage to meet anticipated clinical demands, document any rare exceptions when they occur, and work with institutional leadership to address structural challenges. In summary, the Committee views isolated exceptions as part of clinical reality, while recurring patterns indicate non-compliance with the supervision standard.

Questions concerning *"Residents must participate in at least one simulated clinical experience each year. (Core)"* (4.11.m)

Q: How can programs ensure residents receive adequate experience in simulation?

A: The Committee expects that residents will participate in at least one yearly simulated intra-operative clinical experience that serves to improve and assess medical knowledge, interpersonal and communication skills, professionalism, systems-based practice, or practice-based learning and improvement. The Committee does not require that any program use a simulator or have a simulation center, but programs are encouraged to incorporate surgeons and nurses into the simulation experience. The Committee believes that a formal debriefing mechanism is an important component of each simulation session in order to ensure that the participants receive meaningful competency-based outcomes assessment.

Questions concerning *"The program director must ensure regular review of the residents' clinical experience logs and verify their accuracy and completeness when they are transmitted to the Review Committee. (Core)"* (4.11.n)

Q: If residents had some anesthesia experience during their fundamental clinical skills education, should this be logged in the Case Log System?

A: Yes, fundamental clinical skills procedures can and should be logged. For Case Log System reporting purposes, fundamental clinical skills experience should be entered as "Year in Program: 1," as illustrated below:

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Case Log System "Resident Year"	Three-Year Program	Four-Year Program
1	CA1	FCSE
2	CA2	CA1
3	CA3	CA2
4	N/A	CA3

Questions concerning *"The program director must ensure regular review of the residents' clinical experience logs and verify their accuracy and completeness when they are transmitted to the Review Committee. (Core)"* (4.11.n)

Q: Can some procedures be counted more than once?

A: When two major anesthetic techniques are used during one procedure, both may be counted in the Case Log System. For example, if an epidural is inserted and the patient also receives a general anesthetic, the case can be "counted" as a general anesthesia case *and* as an epidural insertion. If the epidural is used during surgery, it should be considered an epidural anesthetic; if it is inserted only for post-operative pain control, it should be considered an epidural for pain management. Regional anesthetics, when accompanied by sedation and monitored anesthesia care (MAC), can be counted as regional anesthetics and MAC cases.

Questions concerning *"The program director must ensure regular review of the residents' clinical experience logs and verify their accuracy and completeness when they are transmitted to the Review Committee. (Core)"* (4.11.n)

Q: Can two residents/fellows individually count the same case if they both participate in the patient's care?

A: If two individuals were involved in the majority of a major case (such as a liver transplant), including the most significant portions, both can receive credit for the case by entering it into the Case Log System. When one resident or fellow completes a case for another, only the individual involved in the most significant aspects of the case or the majority of the procedure should record credit for the case.

Questions concerning *"Other topics from internal medicine that are important for the pre-operative preparation of the patient, from surgery as to the nature of the surgical procedure affecting anesthetic care, and from obstetrics that impacts anesthetic management of the patient, should be included. (Core)"* (4.11.s)

Q: What specific topics should be covered during didactic sessions so that residents can meet the required knowledge outcomes?

A: Although not required, the ABA Content Outline is a good resource for determining specific content for didactic sessions in clinical anesthesiology topics and related areas of the basic sciences. Topics from other specialties relevant to the practice of anesthesiology should be covered as well. These include the pre-operative preparation of the patient (internal medicine), the nature of the surgical procedure affecting anesthetic care (surgery), and the impacts of anesthetic management on the patient (obstetrics).

Questions concerning *"International rotations must be approved by the Review Committee through a written request submitted by the program director. (Detail)"* (4.11.x.1)

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Q: What documents does the Review Committee need to review to approve international rotations?

A: One-time elective international rotations do not need to be reviewed or approved by the Review Committee. Any education or training away from an ACGME-accredited program (permanent or one-time) requires approval by the American Board of Anesthesiology's Credentials Committee.

Programs that wish to include a permanent international rotation must request approval from the Review Committee prior to initiating such a rotation. The process includes submission of a completed form, which can be found on the Documents and Resources page of the Anesthesiology section of the ACGME website.

Questions concerning *"Each resident must complete, under faculty member supervision, an academic assignment. (Core)"* (4.15.a)

Q: Should a resident in a research track be subtracted from the resident complement for the period of the research assignment?

A: No. A program does not have an "empty" slot if a resident spends up to six months in a research track. All residents, regardless of whether they are in research tracks or clinical rotations, should be counted in the program's total resident complement.

Note: The research track experience differs from an innovative program, requests for which are addressed separately by the Review Committee.

Questions concerning *"Each resident must complete, under faculty member supervision, an academic assignment. (Core)"* (4.15.a)

Q: How much time should be available for research within anesthesiology residencies?

A: There is no minimum time requirement that must be available for research. However, every resident must complete an academic assignment during the program.

Questions concerning *"Each resident must complete, under faculty member supervision, an academic assignment. (Core)"* (4.15.a)

Q: Can participation in lectures, journal clubs, or anesthesia committees meet the requirements for scholarly activity?

A: No. Although these activities are important and are considered an essential part of a program's academic endeavors, they cannot substitute for publication in scholarly journals and other academic pursuits, which are essential for the specialty to advance and for residents and fellows to gain exposure to how research is conducted.

Section 5: Evaluation

Questions concerning *"Evaluation must be documented at the completion of the assignment. (Core)"* (5.1.a)

Q: Can the Anesthesiology Milestones be used as rotational evaluations?

A: No. Milestones can be used to inform rotational evaluations, but should not be used verbatim and not in their entirety, as they are not applicable to all rotations.

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Questions concerning *"Clinical Competency Committee"* (5.3)

Q: Can the program director serve as chair of the Clinical Competency Committee (CCC)?
A: While the ACGME does not prohibit the program director from serving as the chair of the CCC, the American Board of Anesthesiology (ABA) disallows the program director from chairing the CCC. See the ABA Policy Book for more information, as this may adversely impact a graduating resident's ability to be certified through the ABA in the future.

Questions concerning *"Clinical Competency Committee"* (5.3)

Q: What is the role of the program director on the Clinical Competency Committee (CCC)?
A: The requirements regarding the CCC do not preclude or limit a program director's participation on the committee, however, programs should consult with Review Committee staff for any specialty or subspecialty-specific guidance. The intent is to leave flexibility for each program to decide the best structure for its own circumstances. Still, a program should consider: its program director's other roles as resident/fellow advocate, advisor, and confidante; the impact of the program director's presence on the other CCC members' discussions and decisions; the size of the program faculty; and other program-relevant factors. The program director has final responsibility for the program's evaluation and promotion decisions.

Questions concerning *"Clinical Competency Committee"* (5.3)

Q: What is the role of the program coordinator on the CCC?
A: Program coordinators play a critical role in their programs and may, through the program's resident/fellow evaluation system, provide valuable insight on resident/fellow performance in areas such as interpersonal and communication skills, teamwork, and professionalism. Further, the program coordinator may, at the program director's discretion, attend CCC meetings to support the activities of the CCC, such as collation of data on each resident/fellow, taking meeting minutes, recording decisions, and managing the submission of Milestones data to the ACGME. However, evaluation of resident/fellow competence related to the Milestones for patient care and medical knowledge is a vital responsibility of the CCC and these assessments should be made by individuals with background and experience in health care. Therefore, program coordinators, although they may administratively support the committee and take part in the 360 assessments of the residents/fellows, may not serve as voting members of the CCC.

Questions concerning *"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)"* (5.3.a)

Q: How can small programs have three program faculty members on the CCC?
A: The intent is to have enough members to broaden the input on each resident's/fellow's evaluation. Program faculty representation can include more than physician faculty members, such as other physicians and non-physicians who teach and evaluate the program's residents/fellows. For example, a fellowship may include faculty members from the affiliated residency program or from required rotations in other specialties.

Questions concerning *"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)"* (5.3.a)

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Q: What role can program residents, including chief residents who have not completed the program, play on the CCC?

A: Program residents and chief residents in accredited years of the program may provide input to the CCC Chair and/or the program director, outside the context of CCC meetings, through the evaluation system. However, to ensure that residents' peers are not involved in promotion and graduation decisions, and that they are not involved in recommendations for remediation or disciplinary actions, these residents may not serve as CCC members or attend CCC meetings.

Section 6: The Learning and Working Environment

Questions concerning *"Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)"* (6.4)

Q: With regards to the requirement relating to provision of data to residents/fellows and faculty members on quality metrics and benchmarks related to their patient populations, is the expectation that individual data regarding clinical performance must be provided?

A: Providing individual, specialty-specific data is desirable, but not required. The requirement seeks to ensure that quality metrics used by the Sponsoring Institution are shared with residents/fellows and faculty members. Examples of metrics include, but are not limited to, those provided by the Hospital Consumer Assessment of Healthcare Providers and Systems, Centers for Medicaid and Medicare Services, Press Gainey, and National Surgical Quality Improvement Program.

Questions concerning *"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)"* (6.6) , *"Direct Supervision"* (6.7) , *"The program must define when physical presence of a supervising physician is required. (Core)"* (6.8)

Q: How should the appropriate level of supervision be determined for each resident or fellow?

A: The assignment of progressive responsibility for patient care to residents and fellows is an essential component of graduate medical education and is necessary to prepare residents and fellows to be independent practitioners. While decisions regarding the appropriate level of supervision are made by the program director in consultation with the CCC, the Common Program Requirements provide a framework for the progression from direct supervision to oversight. The program director determines the level of supervision required for an individual resident or fellow both by assessing the abilities and competence of the resident/fellow and the needs of the individual patient. Therefore, the level of supervision required for a resident or fellow may vary based on the circumstances.

Questions concerning *"PGY-1 residents must initially be supervised directly, only as described in the above definition. (Core)"* (6.7.a)

Q: Can PGY-1 residents take at-home call, and if so, what are the work hour restrictions for this?

A: PGY-1 residents are not initially allowed to take at-home call because appropriate supervision (either direct supervision or indirect supervision with direct supervision immediately available) is not possible when a resident is on at-home call. However, a Review Commit-

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tee may specify the circumstances and achieved competencies required for residents to progress to be supervised indirectly with direct supervision available at some point after the beginning and before the end of the PGY-1. Program directors should review the specialty-specific Program Requirements for further clarification.

Questions concerning *"The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)"* (6.12.d) , *"Residents and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events. (Core)"* (6.12.e) , *"Moonlighting"* (6.25) , *"PGY-1 residents are not permitted to moonlight. (Core)"* (6.25.b)

Q: In addition to the 80-hour maximum weekly limit, do all other clinical and educational work hour rules apply to moonlighting (maximum clinical and educational work period length, minimum time off between shifts, etc.)?

A: The hours spent moonlighting are counted toward the total hours worked for the week. No other clinical and educational work hour requirements apply, but the following requirements do:

- 6.25 “Moonlighting must not interfere with the ability of the resident/fellow to achieve the goals and objectives of the educational program, and must not interfere with the resident’s/fellow’s fitness for work nor compromise patient safety.”
- 6.12.d.-6.12.e.“The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. Residents/Fellows and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events.”

Questions concerning *"identification of the symptoms of burnout, depression, and substance use disorders, suicidal ideation, or potential for violence, including means to assist those who experience these conditions; (Core)"* (6.13.d.1)

Q: Can residents/fellows be required to use vacation or sick time when attending appointments during scheduled working hours?

A: The requirements do not specify whether residents/fellows will be required to use vacation or sick time for medical, dental, and mental health appointments. Programs should comply with their institution’s policies regarding time off for such appointments.

The intent of this requirement is to ensure that residents and fellows are able to attend appointments as needed, and that their work schedule not prevent them from seeking care when they need it, including during scheduled call days.

Questions concerning *"Transitions of Care"* (6.19)

Q: What are the ACGME’s expectations regarding transitions of care, and how should programs and institutions monitor effective transitions of care and minimize the number of such transitions?

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A: Transitions of care are critical elements in patient safety and must be organized such that complete and accurate clinical information on all involved patients is transmitted between the outgoing and incoming individuals and/or teams responsible for the specific patient or group of patients. Sponsoring Institutions and programs are expected to have a documented process in place for ensuring the effectiveness of transitions. Scheduling of on-call assignments should be optimized to ensure a minimal number of transitions, and there should be documentation of the process involved in arriving at the final schedule. Specific schedules will depend upon various factors, including the size of the program, the acuity and quantity of the workload, and the level of resident/fellow education.

Questions concerning *"Maximum Hours of Clinical and Educational Work per Week"* (6.20)

Q: What are the ACGME's expectations regarding monitoring of clinical and educational work hours for all accredited programs?

A: The ACGME requires that Sponsoring Institutions and programs monitor residents'/fellows' clinical and educational work hours, including work done from home (as applicable), to ensure they comply with the requirements, but does not specify how monitoring and tracking of clinical and educational work hours should be accomplished. The ACGME does not mandate a specific monitoring approach since the ideal approach should be tailored to each program and its Sponsoring Institution.

Questions concerning *"Maximum Hours of Clinical and Educational Work per Week"* (6.20)

Q: Do the ACGME Common Program Requirements related to clinical and educational work hours apply to research activities?

A: The clinical and educational work hour requirements pertain to all required hours in the program (the only exceptions are reading and self-learning). When research is a formal part of the residency/fellowship and occurs during the accredited years of the program, research hours or any combination of research and patient care activities must comply with the weekly limit on hours and other pertinent clinical and educational work hour requirements.

When programs offer an additional research year that is not part of the accredited years, or when residents/fellows conduct research on their own time, making these hours identical to other personal pursuits, these hours do not count toward the limit on clinical and educational work hours. The combined hours spent on self-directed research and program-required activities should meet the test for a reasonably rested and alert resident/fellow when the resident/fellow participates in patient care.

Questions concerning *"Maximum Hours of Clinical and Educational Work per Week"* (6.20)

Q: What is included in the definition of clinical and educational work hours under the requirement limiting them to 80 hours per week?

A: Clinical and educational work hours are defined as all clinical and academic activities related to the residency/fellowship program. This includes inpatient and outpatient clinical care, in-house call, short call, night float and day float, transfer of patient care, and administrative activities related to patient care, such as completing medical records, ordering and reviewing lab tests, and signing orders. For call from home, time devoted to clinical work done from home and time spent in the hospital after being called in to provide patient care

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count toward the 80-hour weekly limit. Types of work from home that must be counted include using an electronic health record and taking calls. Reading done in preparation for the following day's cases, studying, and research done from home do not count toward the 80 hours.

Hours spent on activities that are required in the accreditation requirements, such as membership on a hospital committee, or that are accepted practice in residency/fellowship programs, such as residents'/fellows' participation in interviewing residency/fellowship candidates, must be included in the count of clinical and educational work hours.

Time residents and fellows devote to military commitments counts toward the 80-hour limit only if that time is spent providing patient care.

Questions concerning *"Maximum Hours of Clinical and Educational Work per Week"* (6.20)

Q: If some of a program's residents/fellows attend a conference that requires travel, how should the hours be counted for clinical and educational work hour compliance?

A: If attendance at the conference is required by the program, or if the resident/fellow is a representative for the program (e.g., presenting a paper or poster), the hours should be included as clinical and educational work hours. Travel time and non-conference hours while away do not meet the definition of "clinical and educational work hours" in the ACGME requirements.

Questions concerning *"Maximum Hours of Clinical and Educational Work per Week"* (6.20)

Q: Why do the requirements specify that clinical work done from home must count toward the 80-hour weekly maximum, averaged over four weeks?

A: The requirements acknowledge the changes in medicine, including electronic health records, and the increase in the amount of work residents and fellows choose to do from home. Resident/Fellow decisions to complete work at home should be made in consultation with the resident's/fellow's supervisor. In such circumstances, residents/fellows should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality. The requirement provides flexibility for residents/fellows to do this while ensuring that the time spent completing clinical work from home is accomplished within the 80-hour weekly maximum.

Questions concerning *"Maximum Hours of Clinical and Educational Work per Week"* (6.20)

Q: How should the averaging of the clinical and educational work hour requirements (e.g., 80-hour weekly limit, one day free of clinical and educational work every week, and call no more frequently than every third night) be handled? For example, what should be done if a resident/fellow takes a vacation week?

A: Averaging must occur by rotation. This is done over one of the following: a four-week period; a one-month period (28-31 days); or the period of the rotation if it is shorter than four weeks. When rotations are shorter than four weeks in length, averaging must be made over these shorter assignments. This avoids heavy and light assignments being combined to achieve compliance.

If a resident/fellow takes vacation or other leave, the ACGME requires that vacation or leave days be omitted from the numerator and the denominator for calculating clinical and

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educational work hours, call frequency, or days off. The requirements do not permit a "rolling" average, because this may mask compliance problems by averaging across high and low clinical and educational work hour rotations. The rotation with the greatest hours and frequency of call must comply with the common clinical and educational work hour requirements.

Questions concerning *"Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)"* (6.21.a)

Q: If a post-call resident/fellow remains on site for up to four additional hours as described in the requirements, does the required 14-hour time-off period begin at the end of the scheduled 24-hour period, or when the resident/fellow leaves the hospital?

A: The 14-hour time-off period begins when the resident/fellow completes all required clinical and educational work, regardless of when the resident/fellow was scheduled to leave.

Questions concerning *"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)"* (6.21.b)

Q: Since the requirements state that residents/fellows must be provided with one day in seven free from all responsibilities, with one day defined as one continuous 24-hour period, how should programs interpret this requirement if the "day off" occurs after a resident's/fellow's on-call day?

A: The requirements specify a 24-hour day off. This day should ideally be a calendar day (i.e., the resident/fellow wakes up at home and has a whole day available). It is not permissible to have the day off regularly or frequently scheduled on a resident's/fellow's post-call day, but in smaller programs this may occasionally be necessary. Note that in this case, a resident/fellow would need to leave the hospital post-call early enough to allow for 24 hours off from clinical and educational work. Because call from home does not require a rest period, the day after home call may be used as a day off.

Questions concerning *"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. Additional patient care responsibilities must not be assigned to a resident during this time. (Core)"* (6.22.a)

Q: What activities are permitted during the four hours allowed for activities related to patient safety and/or resident/fellow education?

A: Residents/fellows who have completed a 24-hour clinical and educational work period may spend up to an additional four hours on site to ensure an appropriate, effective, and safe transition of care (including rounds), to maintain continuity of patient care, and to participate in educational activities such as conferences. During this four-hour period, residents/fellows must not be permitted to participate in the care of new patients in any patient care setting; must not be assigned to outpatient clinics, including continuity clinics; and must not be assigned to participate in a new procedure, such as an elective scheduled surgery. Residents/fellows who have satisfactorily completed the transition of care may attend an educational conference that occurs during this four-hour period.

Questions concerning *"In-House Night Float"* (6.26)

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Q: Does the Review Committee limit the maximum number of consecutive weeks of night float?

A: No. However, during an accreditation review, the Committee will determine whether residents on night float are able to take advantage of educational sessions and other opportunities offered during regular daytime hours. If the Committee determines that residents derive little benefit from night float or are unable to participate in other educational sessions as a result of night call responsibilities, the program may be cited for inadequate educational experience on the respective rotation.

Questions concerning *"At-Home Call"* (6.28)

Q: Is it permissible for residents/fellows to take call from home for extended periods, such as a month?

A: No. The requirement for one day free every week prohibits being assigned home call for an entire month. Assignment of a partial month (more than six days but fewer than 28 days) is possible. However, keep in mind that call from home is appropriate if service intensity and frequency of being called is low. Program directors are expected to monitor the intensity and workload resulting from home call through periodic assessment of workload and intensity of in-house activities.

Questions concerning *"At-Home Call"* (6.28) , *"At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core)"* (6.28.a)

Q: Which requirements apply to time in the hospital after being called in from home call?

A: For call taken from home (home or pager call), the time a resident/fellow spends in the hospital after being called in counts toward the weekly clinical and educational work hour limit. The only other numeric clinical and educational work hour requirement that applies is the one day free of clinical and educational work every week that must be free of all patient care responsibilities, which includes at-home call. Program directors must monitor the intensity and workload resulting from at-home call through periodic assessment of the frequency of being called into the hospital, and the length and intensity of the in-house activities.

When residents/fellows assigned to at-home call return to the hospital to care for patients, a new time-off period is not initiated, and therefore the requirement for eight hours between shifts does not apply. The frequency and duration of clinical work done from home and time returning to the hospital must not preclude rest or reasonable personal time for residents/fellows.

Other

Q: What does the Review Committee require of a resident taking approved medical, parental, or caregiver leave(s) of absence?

[FAQ: Institutional Requirement: 4.8.]

A: The Review Committee allows for flexibility in approved leaves of absence at the program level, provided that all clinical experience requirements are met, including case and procedure logs, and that the Clinical Competency Committee considers the affected resident fully prepared for autonomous practice. The program director is encouraged to seek guidance

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from the ABA's Absence from Training policy or with the AOBA, to ensure there will be no adverse effects on the resident's board eligibility and ultimate board certification.

Q: Can the clinical and educational work hour requirements be relaxed over holidays or during other times when a hospital is short-staffed, during periods when some residents/fellows are ill or on leave, or when there is an unusually large patient census or demand for care?

A: The ACGME expects that clinical and educational work hours in any given four-week period comply with all applicable requirements. This includes months with holidays, during which institutions may have fewer staff members available. During the holiday period, scheduling for the rotation (generally four weeks or a month) must comply with the common and specialty-specific clinical and educational work hour requirements. Further, the schedule during the holidays themselves may not violate common clinical and educational work hour requirements (such as the requirement for adequate rest between clinical and educational work periods), or specialty-specific requirements.

Q: Where are the ACGME Resident/Fellow and Faculty Survey -Common Program Requirements Crosswalk documents located?

A: The crosswalk documents for the Resident/Fellow and Faculty Surveys can be found on the ACGME website here. These resources help programs, residents, fellows, and faculty understand and interpret their ACGME Resident/Fellow and Faculty Survey results by mapping ACGME survey questions to the corresponding Common Program Requirements.

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