

**ACGME Program Requirements for
Graduate Medical Education
in Pediatrics**

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Editorial Revision: Common Program Requirements Background and Intent below VI.A.2.b)
revised, substance use disorder language updated July 1, 2021

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52 solving, evidence-based decision making, a commitment to lifelong learning, and
53 an attitude of caring that is derived from humanistic and professional values.
54 Educational experiences emphasize the competencies and skills needed to
55 practice general pediatrics of high quality in the community. Education in the
56 fields of subspecialty pediatrics enables graduates to participate as team
57 members in the care of patients with chronic and complex disorders.
58

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

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61 The educational program in pediatrics must be 36 months in length. (Core)*
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63 **I. Oversight**

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65 **I.A. Sponsoring Institution**

66
67 *The Sponsoring Institution is the organization or entity that assumes the*
68 *ultimate financial and academic responsibility for a program of graduate*
69 *medical education, consistent with the ACGME Institutional Requirements.*
70

71 *When the Sponsoring Institution is not a rotation site for the program, the*
72 *most commonly utilized site of clinical activity for the program is the*
73 *primary clinical site.*
74

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.

75
76 **I.A.1. The program must be sponsored by one ACGME-accredited**
77 **Sponsoring Institution. (Core)**
78

79 **I.B. Participating Sites**

80
81 *A participating site is an organization providing educational experiences or*
82 *educational assignments/rotations for residents.*
83

84 **I.B.1. The program, with approval of its Sponsoring Institution, must**
85 **designate a primary clinical site. (Core)**
86

87 **I.B.2. There must be a program letter of agreement (PLA) between the**
88 **program and each participating site that governs the relationship**
89 **between the program and the participating site providing a required**
90 **assignment. (Core)**
91

92 **I.B.2.a) The PLA must:**
93

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

95

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

98

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

101

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

106

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

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

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

107

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

112

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

118

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

119

- 120 **I.D. Resources**
- 121
- 122 **I.D.1. The program, in partnership with its Sponsoring Institution, must**
- 123 **ensure the availability of adequate resources for resident education.**
- 124 **(Core)**
- 125
- 126 I.D.1.a) There must be inpatient and outpatient facilities available to the
- 127 residents to achieve all of the required educational outcomes. **(Core)**
- 128
- 129 I.D.1.b) There must be an emergency facility that specializes in the care of
- 130 pediatric patients and that receives pediatric patients who have
- 131 been transported via the Emergency Medical Services system.
- 132 **(Core)**
- 133
- 134 I.D.1.c) Residents must have access to teaching and patient care work
- 135 space, including meeting rooms, computers, and medical and
- 136 electronic resources to achieve all of the required educational
- 137 outcomes. **(Core)**
- 138
- 139 **I.D.2. The program, in partnership with its Sponsoring Institution, must**
- 140 **ensure healthy and safe learning and working environments that**
- 141 **promote resident well-being and provide for: **(Core)****
- 142
- 143 **I.D.2.a) access to food while on duty; **(Core)****
- 144
- 145 **I.D.2.b) safe, quiet, clean, and private sleep/rest facilities available**
- 146 **and accessible for residents with proximity appropriate for**
- 147 **safe patient care; **(Core)****
- 148

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.

- 149
- 150 I.D.2.c) clean and private facilities for lactation that have refrigeration
- 151 capabilities, with proximity appropriate for safe patient care;
- 152 **(Core)**
- 153

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

154

- 155 I.D.2.d) security and safety measures appropriate to the participating
 156 site; and, ^(Core)
 157
- 158 I.D.2.e) accommodations for residents with disabilities consistent
 159 with the Sponsoring Institution's policy. ^(Core)
 160
- 161 I.D.3. Residents must have ready access to specialty-specific and other
 162 appropriate reference material in print or electronic format. This
 163 must include access to electronic medical literature databases with
 164 full text capabilities. ^(Core)
 165
- 166 I.D.4. The program's educational and clinical resources must be adequate
 167 to support the number of residents appointed to the program. ^(Core)
 168
- 169 I.D.4.a) The program must provide a volume, variety, and complexity in
 170 diagnoses and age, of pediatric patients necessary for residents to
 171 achieve all of the required educational outcomes. ^(Core)
 172
- 173 I.E. The presence of other learners and other care providers, including, but not
 174 limited to, residents from other programs, subspecialty fellows, and
 175 advanced practice providers, must enrich the appointed residents'
 176 education. ^(Core)
 177
- 178 I.E.1. The program must report circumstances when the presence of other
 179 learners has interfered with the residents' education to the DIO and
 180 Graduate Medical Education Committee (GMEC). ^(Core)
 181

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

- 182
- 183 II. Personnel
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- 185 II.A. Program Director
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- 187 II.A.1. There must be one faculty member appointed as program director
 188 with authority and accountability for the overall program, including
 189 compliance with all applicable program requirements. ^(Core)
 190
- 191 II.A.1.a) The Sponsoring Institution's GMEC must approve a change in
 192 program director. ^(Core)
 193
- 194 II.A.1.b) Final approval of the program director resides with the
 195 Review Committee. ^(Core)
 196

Background and Intent: While the ACGME recognizes the value of input from numerous individuals in the management of a residency, a single individual must be

designated as program director and made responsible for the program. This individual will have dedicated time for the leadership of the residency, and it is this individual's responsibility to communicate with the residents, faculty members, DIO, GMEC, and the ACGME. The program director's nomination is reviewed and approved by the GMEC. Final approval of program directors resides with the Review Committee.

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

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

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II.A.2. At a minimum, the program director must be provided with the salary support required to devote 50 percent FTE of non-clinical time to the administration of the program. ^(Core)

II.A.2.a) Additional support for the program director and the associate program director(s) must be provided based on program size as follows: ^(Core)

Number of Approved Resident Positions	Minimum Aggregate Program Director/Associate Program Director FTE
12-30	0.75
31-60	1.0
61-90	1.25
91-120	1.5
>120	1.75

211

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

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

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

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

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

Background and Intent: Leading a program requires knowledge and skills that are established during residency and subsequently further developed. The time period

from completion of residency until assuming the role of program director allows the individual to cultivate leadership abilities while becoming professionally established. The three-year period is intended for the individual's professional maturation.

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

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

- 219
220 **II.A.3.b)** must include current certification in the specialty for which
221 they are the program director by the American Board of
222 Pediatrics (ABP) or by the American Osteopathic Board of
223 Pediatrics (AOBP), or specialty qualifications that are
224 acceptable to the Review Committee; ^(Core)
225
226 **II.A.3.b).(1)** The program director ~~should~~ must meet the requirements
227 for either Maintenance of Certification in pediatrics or a
228 subspecialty of pediatrics through the ABP or Osteopathic
229 Continuous Certification through the AOBP. ^(Core)
230
231 **II.A.3.c)** must include current medical licensure and appropriate
232 medical staff appointment; and, ^(Core)
233
234 **II.A.3.d)** must include ongoing clinical activity. ^(Core)
235

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.

- 236
237 **II.A.4. Program Director Responsibilities**
238
239 The program director must have responsibility, authority, and
240 accountability for: administration and operations; teaching and
241 scholarly activity; resident recruitment and selection, evaluation,
242 and promotion of residents, and disciplinary action; supervision of
243 residents; and resident education in the context of patient care. ^(Core)
244
245 **II.A.4.a)** The program director must:
246
247 **II.A.4.a).(1)** be a role model of professionalism; ^(Core)
248

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.

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

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

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

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

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

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

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

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

Background and Intent: The program director has the responsibility to ensure that all who educate residents effectively role model the Core Competencies. Working with a resident is a privilege that is earned through effective teaching and professional role

modeling. This privilege may be removed by the program director when the standards of the clinical learning environment are not met.

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

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- II.A.4.a).(8) submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; ^(Core)
 - II.A.4.a).(9) provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s); ^(Core)
 - II.A.4.a).(10) provide a learning and working environment in which residents have the opportunity to raise concerns and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; ^(Core)
 - II.A.4.a).(11) ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process; ^(Core)
 - II.A.4.a).(12) ensure the program's compliance with the Sponsoring Institution's policies and procedures for due process when action is taken to suspend or dismiss, not to promote, or not to renew the appointment of a resident; ^(Core)

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

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- II.A.4.a).(13) ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; ^(Core)
 - II.A.4.a).(13).(a) Residents must not be required to sign a non-competition guarantee or restrictive covenant. ^(Core)
 - II.A.4.a).(14) document verification of program completion for all graduating residents within 30 days; ^(Core)
 - II.A.4.a).(15) provide verification of an individual resident's completion upon the resident's request, within 30 days; and, ^(Core)

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

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

II.B. Faculty

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

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

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

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

II.B.1.a) General Pediatricians

II.B.1.a).(1) There must be faculty members with expertise in general pediatrics who have ongoing responsibility for the care of general pediatric patients. ^(Core)

- 360 II.B.1.a).(2) These faculty members must participate actively in formal
 361 teaching sessions, and serve as attending physicians. ^(Core)
 362
- 363 II.B.1.a).(2).(a) This must occur on inpatients, outpatients, and
 364 term newborns. ^(Detail)
 365
- 366 II.B.1.b) Subspecialty Faculty
 367
 368 Faculty members with subspecialty board certification must
 369 function on an ongoing basis as integral parts of the clinical and
 370 instructional components of the program in both inpatient and
 371 outpatient settings. ^(Core)
 372
- 373 II.B.1.b).(1) This should include a faculty member in each of the
 374 following subspecialty areas of pediatrics: ^(Core)
 375
- 376 II.B.1.b).(1).(a) adolescent medicine; ^(Core)
 377
- 378 II.B.1.b).(1).(b) developmental-behavioral pediatrics; ^(Core)
 379
- 380 II.B.1.b).(1).(c) neonatal-perinatal medicine; ^(Core)
 381
- 382 II.B.1.b).(1).(d) pediatric critical care; ^(Core)
 383
- 384 II.B.1.b).(1).(e) pediatric emergency medicine; and, ^(Core)
 385
- 386 II.B.1.b).(1).(f) subspecialists from at least five other distinct
 387 pediatric medical disciplines. ^(Core)
 388
- 389 II.B.1.c) Other Faculty
 390
 391 At the primary clinical site, there must be at least one physician
 392 available for clinical consultation and teaching of residents who is
 393 Board-certified in each of the following areas: ^(Detail)
 394
- 395 II.B.1.c).(1) diagnostic radiology; ^(Detail)
 396
- 397 II.B.1.c).(2) pathology; and, ^(Detail)
 398
- 399 II.B.1.c).(3) surgery. ^(Detail)
 400
- 401 **II.B.2. Faculty members must:**
 402
- 403 **II.B.2.a) be role models of professionalism;** ^(Core)
 404
- 405 **II.B.2.b) demonstrate commitment to the delivery of safe, quality,**
 406 **cost-effective, patient-centered care;** ^(Core)
 407

<p>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</p>

strive for improvement in care and cost, embracing a commitment to the patient and the community they serve.

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409 **II.B.2.c)** demonstrate a strong interest in the education of residents;
410 (Core)
411
412 **II.B.2.d)** devote sufficient time to the educational program to fulfill
413 their supervisory and teaching responsibilities; (Core)
414
415 **II.B.2.e)** administer and maintain an educational environment
416 conducive to educating residents; (Core)
417
418 **II.B.2.f)** regularly participate in organized clinical discussions,
419 rounds, journal clubs, and conferences; and, (Core)
420
421 **II.B.2.g)** pursue faculty development designed to enhance their skills
422 at least annually; (Core)
423

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.

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425 **II.B.2.g).(1)** as educators; (Core)
426
427 **II.B.2.g).(2)** in quality improvement and patient safety; (Core)
428
429 **II.B.2.g).(3)** in fostering their own and their residents' well-being;
430 and, (Core)
431
432 **II.B.2.g).(4)** in patient care based on their practice-based learning
433 and improvement efforts. (Core)
434

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.

- 435
436 **II.B.3. Faculty Qualifications**
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438 **II.B.3.a)** Faculty members must have appropriate qualifications in
439 their field and hold appropriate institutional appointments.
440 (Core)
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442 **II.B.3.b)** Physician faculty members must:

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II.B.3.b).(1)

have current certification in the specialty by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics, or possess qualifications judged acceptable to the Review Committee. ^(Core)

Specialty-Specific Background and Intent: The onus of documenting alternate qualifications is the responsibility of the program director. For a faculty member who has not achieved pediatrics certification from the ABP or AOBP, the Review Committee will consider the following criteria in determining whether alternate qualifications are acceptable:

- completion of a pediatrics residency program
- leadership and/or participation on committees in national pediatric organizations
- scholarship within the field of pediatrics, specifically, evidence of ongoing scholarship documented by contributions to the peer-reviewed literature in pediatrics, and pediatrics presentations at national meetings
- experience in providing clinical activity in pediatrics

The Review Committee expects faculty members who are recent graduates of ACGME-accredited or AOA-approved pediatrics programs to take and pass the next available ABP or AOBP pediatrics certifying examination. If a faculty member is unable to take the next administration of the certifying examination, an explanation must be provided.

Years of practice are not an equivalent to specialty board certification, and the Review Committee does not accept the phrase "board eligible."

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II.B.3.c)

Any non-physician faculty members who participate in residency program education must be approved by the program director. ^(Core)

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

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II.B.4.

Core Faculty

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

Background and Intent: Core faculty members are critical to the success of resident education. They support the program leadership in developing, implementing, and

assessing curriculum and in assessing residents' progress toward achievement of competence in the specialty. Core faculty members should be selected for their broad knowledge of and involvement in the program, permitting them to effectively evaluate the program, including completion of the annual ACGME Faculty Survey.

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 465 **II.B.4.a) Core faculty members must be designated by the program**
 466 **director.** ^(Core)
 467
 468 **II.B.4.b) Core faculty members must complete the annual ACGME**
 469 **Faculty Survey.** ^(Core)
 470
 471 **II.B.4.c) In addition to the program director, there must be at least one**
 472 **ABP- or ABOP-certified core faculty member for every five**
 473 **residents in the program.** ^(Core)
 474

475 **II.C. Program Coordinator**

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 477 **II.C.1. There must be a program coordinator.** ^(Core)
 478
 479 **II.C.2. At a minimum, the program coordinator must be supported at 50**
 480 **percent FTE for the administration of the program.** ^(Core)
 481
 482 **II.C.2.a) Additional support must be provided based on program size as**
 483 **follows:** ^(Core)
 484

Number of Approved Resident Positions	Minimum FTE Coordinator(s) Required
12-30	1.0
31-60	1.5
61-90	2.0
91-120	3.0
121 or more	3.5

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

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

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

The program coordinator is a member of the leadership team and is critical to the success of the program. As such, the program coordinator must possess skills in leadership and personnel management. Program coordinators are expected to develop unique knowledge of the ACGME and Program Requirements, policies, and

procedures. Program coordinators assist the program director in accreditation efforts, educational programming, and support of residents.

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

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II.D. Other Program Personnel

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

II.D.1. The sponsoring institution and the program must support additional program leadership to include a liaison(s) to assist the program director in effective administration of the program. ^(Core)

II.D.1.a) The program leadership must not be required to generate clinical or other income for this support. ^(Core)

II.D.1.b) The minimum amount of full-time equivalent (FTE) support provided must be based on the size of the program as follows:
^(Detail)

II.D.1.b).(1) For programs with 12-30 residents, there must be a minimum of 1.0 FTE liaison. ^(Detail)

II.D.1.b).(2) For programs with 31-90 residents, there must be a minimum of 2.0 FTE liaisons. ^(Detail)

II.D.1.b).(3) For programs with more than 90 residents, there must be a minimum of 3.0 FTE liaisons. ^(Detail)

Specialty-Specific Background and Intent: A senior resident, chief resident, or junior faculty member may serve as the liaison. More than one individual may be designated to serve as liaison. As long as a designated liaison is available to residents and program leadership at all times, a single designated liaison or any combination of part-time senior resident, chief resident, or junior faculty member would be acceptable.

513

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.

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III. Resident Appointments

III.A. Eligibility Requirements

- 518
519 **III.A.1.** **An applicant must meet one of the following qualifications to be**
520 **eligible for appointment to an ACGME-accredited program:** ^(Core)
521
522 **III.A.1.a)** **graduation from a medical school in the United States or**
523 **Canada, accredited by the Liaison Committee on Medical**
524 **Education (LCME) or graduation from a college of**
525 **osteopathic medicine in the United States, accredited by the**
526 **American Osteopathic Association Commission on**
527 **Osteopathic College Accreditation (AOACOCA); or,** ^(Core)
528
529 **III.A.1.b)** **graduation from a medical school outside of the United**
530 **States or Canada, and meeting one of the following additional**
531 **qualifications:** ^(Core)
532
533 **III.A.1.b).(1)** **holding a currently valid certificate from the**
534 **Educational Commission for Foreign Medical**
535 **Graduates (ECFMG) prior to appointment; or,** ^(Core)
536
537 **III.A.1.b).(2)** **holding a full and unrestricted license to practice**
538 **medicine in the United States licensing jurisdiction in**
539 **which the ACGME-accredited program is located.** ^(Core)
540
541 **III.A.2.** **All prerequisite post-graduate clinical education required for initial**
542 **entry or transfer into ACGME-accredited residency programs must**
543 **be completed in ACGME-accredited residency programs, AOA-**
544 **approved residency programs, Royal College of Physicians and**
545 **Surgeons of Canada (RCPSC)-accredited or College of Family**
546 **Physicians of Canada (CFPC)-accredited residency programs**
547 **located in Canada, or in residency programs with ACGME**
548 **International (ACGME-I) Advanced Specialty Accreditation.** ^(Core)
549
550 **III.A.2.a)** **Residency programs must receive verification of each**
551 **resident's level of competency in the required clinical field**
552 **using ACGME, CanMEDS, or ACGME-I Milestones evaluations**
553 **from the prior training program upon matriculation.** ^(Core)
554

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.

- 555
556 **III.A.3.** **A physician who has completed a residency program that was not**
557 **accredited by ACGME, AOA, RCPSC, CFPC, or ACGME-I (with**
558 **Advanced Specialty Accreditation) may enter an ACGME-accredited**
559 **residency program in the same specialty at the PGY-1 level and, at**
560 **the discretion of the program director of the ACGME-accredited**
561 **program and with approval by the GMEC, may be advanced to the**
562 **PGY-2 level based on ACGME Milestones evaluations at the ACGME-**

563 accredited program. This provision applies only to entry into
564 residency in those specialties for which an initial clinical year is not
565 required for entry. ^(Core)

566
567 **III.B. The program director must not appoint more residents than approved by**
568 **the Review Committee.** ^(Core)
569

570 **III.B.1. All complement increases must be approved by the Review**
571 **Committee.** ^(Core)
572

573 **III.B.2. The program should offer a minimum total of four positions at each level**
574 **of education.** ^(Detail)
575

576 **III.C. Resident Transfers**

577
578 **The program must obtain verification of previous educational experiences**
579 **and a summative competency-based performance evaluation prior to**
580 **acceptance of a transferring resident, and Milestones evaluations upon**
581 **matriculation.** ^(Core)
582

583 **IV. Educational Program**

584
585 ***The ACGME accreditation system is designed to encourage excellence and***
586 ***innovation in graduate medical education regardless of the organizational***
587 ***affiliation, size, or location of the program.***
588

589 ***The educational program must support the development of knowledgeable, skillful***
590 ***physicians who provide compassionate care.***
591

592 ***In addition, the program is expected to define its specific program aims consistent***
593 ***with the overall mission of its Sponsoring Institution, the needs of the community***
594 ***it serves and that its graduates will serve, and the distinctive capabilities of***
595 ***physicians it intends to graduate. While programs must demonstrate substantial***
596 ***compliance with the Common and specialty-specific Program Requirements, it is***
597 ***recognized that within this framework, programs may place different emphasis on***
598 ***research, leadership, public health, etc. It is expected that the program aims will***
599 ***reflect the nuanced program-specific goals for it and its graduates; for example, it***
600 ***is expected that a program aiming to prepare physician-scientists will have a***
601 ***different curriculum from one focusing on community health.***
602

603 **IV.A. The curriculum must contain the following educational components:** ^(Core)
604

605 **IV.A.1. a set of program aims consistent with the Sponsoring Institution's**
606 **mission, the needs of the community it serves, and the desired**
607 **distinctive capabilities of its graduates;** ^(Core)
608

609 **IV.A.1.a) The program's aims must be made available to program**
610 **applicants, residents, and faculty members.** ^(Core)
611

612 **IV.A.2. competency-based goals and objectives for each educational**
613 **experience designed to promote progress on a trajectory to**

614 autonomous practice. These must be distributed, reviewed, and
615 available to residents and faculty members; ^(Core)
616

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

617
618 **IV.A.3.** delineation of resident responsibilities for patient care, progressive
619 responsibility for patient management, and graded supervision; ^(Core)
620

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.

621
622 **IV.A.4.** a broad range of structured didactic activities; ^(Core)
623

624 **IV.A.4.a)** Residents must be provided with protected time to participate
625 in core didactic activities. ^(Core)
626

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.

627
628 **IV.A.5.** advancement of residents' knowledge of ethical principles
629 foundational to medical professionalism; and, ^(Core)
630

631 **IV.A.6.** advancement in the residents' knowledge of the basic principles of
632 scientific inquiry, including how research is designed, conducted,
633 evaluated, explained to patients, and applied to patient care. ^(Core)
634

635 **IV.B.** ACGME Competencies
636

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

637

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

640

641 **IV.B.1.a) Professionalism**

642

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

645

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

647

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

650

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

653

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

654

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

656

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

659

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

665

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

669

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

672

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

674

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

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

675		
676	IV.B.1.b).(1)	Residents must be able to provide patient care that is
677		compassionate, appropriate, and effective for the
678		treatment of health problems and the promotion of
679		health. (Core)
680		
681	IV.B.1.b).(1).(a)	Residents must demonstrate the ability to:
682		
683	IV.B.1.b).(1).(a).(i)	gather essential and accurate information
684		about the patient; (Core)
685		
686	IV.B.1.b).(1).(a).(ii)	organize and prioritize responsibilities to
687		provide patient care that is safe, effective,
688		and efficient; (Core)
689		
690	IV.B.1.b).(1).(a).(iii)	provide transfer of care that ensures
691		seamless transitions; (Core)
692		
693	IV.B.1.b).(1).(a).(iv)	interview patients and families about the
694		particulars of the medical condition for
695		which they seek care, with specific attention
696		to behavioral, psychosocial, environmental,
697		and family unit correlates of disease; (Core)
698		
699	IV.B.1.b).(1).(a).(v)	perform complete and accurate physical
700		examinations; (Core)
701		
702	IV.B.1.b).(1).(a).(vi)	make informed diagnostic and therapeutic
703		decisions that result in optimal clinical
704		judgment; (Core)
705		
706	IV.B.1.b).(1).(a).(vii)	develop and carry-out management plans;
707		(Core)
708		
709	IV.B.1.b).(1).(a).(viii)	counsel patients and families; (Core)
710		
711	IV.B.1.b).(1).(a).(ix)	provide effective health maintenance and
712		anticipatory guidance; (Core)
713		
714	IV.B.1.b).(1).(a).(x)	provide appropriate role modeling; and, (Core)
715		
716	IV.B.1.b).(1).(a).(xi)	provide appropriate supervision. (Core)
717		
718	IV.B.1.b).(1).(b)	<u>To promote healthy emotional development and</u>
719		<u>resilience in children, adolescents, and their</u>
720		<u>families, residents must demonstrate the ability to:</u>
721		

722	IV.B.1.b).(1).(b).(i)	<u>provide behavioral and mental health care across all clinical settings that is sensitive to the developmental stage of the patient and the cultural context of the patient and family;</u>
723		<u>and,</u> ^(Core)
724		
725		
726		
727		
728	IV.B.1.b).(1).(b).(ii)	<u>identify, manage, co-manage, and appropriately refer patients with common behavioral and mental health issues to specialists and resources when indicated.</u>
729		^(Core)
730		
731		
732		
733		
734	IV.B.1.b).(2)	Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. ^(Core)
735		
736		
737		
738	IV.B.1.b).(2).(a)	Residents must be able to competently perform procedures used by a pediatrician in general practice, including being able to describe the steps in the procedure, indications, contraindications, complications, pain management, post-procedure care, and interpretation of applicable results. Residents must demonstrate procedural competence by performing the following: ^(Core)
739		
740		
741		
742		
743		
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745		
746		
747	IV.B.1.b).(2).(a).(i)	bag-mask ventilation; ^(Core)
748		
749	IV.B.1.b).(2).(a).(ii)	bladder catheterization; ^(Core)
750		
751	IV.B.1.b).(2).(a).(iii)	giving immunizations; ^(Core)
752		
753	IV.B.1.b).(2).(a).(iv)	incision and drainage of abscess; ^(Core)
754		
755	IV.B.1.b).(2).(a).(v)	lumbar puncture; ^(Core)
756		
757	IV.B.1.b).(2).(a).(vi)	neonatal endotracheal intubation; ^(Core)
758		
759	IV.B.1.b).(2).(a).(vii)	peripheral intravenous catheter placement; ^(Core)
760		
761		
762	IV.B.1.b).(2).(a).(viii)	reduction of simple dislocation; ^(Core)
763		
764	IV.B.1.b).(2).(a).(ix)	simple laceration repair; ^(Core)
765		
766	IV.B.1.b).(2).(a).(x)	simple removal of foreign body; ^(Core)
767		
768	IV.B.1.b).(2).(a).(xi)	temporary splinting of fracture; ^(Core)
769		
770	IV.B.1.b).(2).(a).(xii)	umbilical catheter placement; and, ^(Core)
771		
772	IV.B.1.b).(2).(a).(xiii)	venipuncture. ^(Core)

773
774 IV.B.1.b).(2).(b) Residents must complete training and maintain
775 certification in Pediatric Advanced Life Support,
776 including simulated placement of an intraosseous
777 line, and Neonatal Resuscitation. ^(Core)
778

779 **IV.B.1.c) Medical Knowledge**

780
781 **Residents must demonstrate knowledge of established and**
782 **evolving biomedical, clinical, epidemiological and social-**
783 **behavioral sciences, as well as the application of this**
784 **knowledge to patient care.** ^(Core)
785

786 IV.B.1.c).(1) Residents must demonstrate sufficient knowledge of the
787 basic and clinically supportive sciences appropriate to
788 pediatrics; ^(Core)
789

790 IV.B.1.c).(2) Residents must be competent in the understanding of the
791 indications, contraindications, and complications for the
792 following: ^(Core)
793

794 IV.B.1.c).(2).(a) arterial line placement; ^(Core)
795

796 IV.B.1.c).(2).(b) arterial puncture; ^(Core)
797

798 IV.B.1.c).(2).(c) chest tube placement; ^(Core)
799

800 IV.B.1.c).(2).(d) circumcision; ^(Core)
801

802 IV.B.1.c).(2).(e) endotracheal intubation of non-neonates; and, ^(Core)
803

804 IV.B.1.c).(2).(f) thoracentesis. ^(Core)
805

806 IV.B.1.c).(3) Residents should receive real and/or simulated training
807 when these procedures are important for a resident's post-
808 residency position. ^(Detail)
809

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

811
812 **Residents must demonstrate the ability to investigate and**
813 **evaluate their care of patients, to appraise and assimilate**
814 **scientific evidence, and to continuously improve patient care**
815 **based on constant self-evaluation and lifelong learning.** ^(Core)
816

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

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

- 817
818 **IV.B.1.d).(1)** **Residents must demonstrate competence in:**
819
- 820 **IV.B.1.d).(1).(a)** **identifying strengths, deficiencies, and limits in**
821 **one’s knowledge and expertise;** ^(Core)
822
- 823 **IV.B.1.d).(1).(b)** **setting learning and improvement goals;** ^(Core)
824
- 825 **IV.B.1.d).(1).(c)** **identifying and performing appropriate learning**
826 **activities;** ^(Core)
827
- 828 **IV.B.1.d).(1).(d)** **systematically analyzing practice using quality**
829 **improvement methods, and implementing**
830 **changes with the goal of practice improvement;**
831 ^(Core)
832
- 833 **IV.B.1.d).(1).(e)** **incorporating feedback and formative**
834 **evaluation into daily practice;** ^(Core)
835
- 836 **IV.B.1.d).(1).(f)** **locating, appraising, and assimilating evidence**
837 **from scientific studies related to their patients’**
838 **health problems;** ^(Core)
839
- 840 **IV.B.1.d).(1).(g)** **using information technology to optimize**
841 **learning;** ^(Core)
842
- 843 **IV.B.1.d).(1).(h)** **being an effective teacher;** ^(Core)
844
- 845 **IV.B.1.d).(1).(i)** **participating in the education of students, residents,**
846 **and other health professionals; and,** ^(Core)
847
- 848 **IV.B.1.d).(1).(j)** **taking primary responsibility for lifelong learning to**
849 **improve knowledge, skills, and practice**
850 **performance through familiarity with general and**
851 **experience-specific goals and objectives and**
852 **attendance at conferences.** ^(Core)
853
- 854 **IV.B.1.e)** **Interpersonal and Communication Skills**
855
- 856 **Residents must demonstrate interpersonal and**
857 **communication skills that result in the effective exchange of**
858 **information and collaboration with patients, their families,**
859 **and health professionals.** ^(Core)
860
- 861 **IV.B.1.e).(1)** **Residents must demonstrate competence in:**
862
- 863 **IV.B.1.e).(1).(a)** **communicating effectively with patients,**
864 **families, and the public, as appropriate, across**

865		a broad range of socioeconomic and cultural backgrounds; ^(Core)
866		
867		
868	IV.B.1.e).(1).(b)	communicating effectively with physicians, other health professionals, and health-related agencies; ^(Core)
869		
870		
871		
872	IV.B.1.e).(1).(c)	working effectively as a member or leader of a health care team or other professional group; ^(Core)
873		
874		
875		
876	IV.B.1.e).(1).(d)	educating patients, families, students, residents, and other health professionals; ^(Core)
877		
878		
879	IV.B.1.e).(1).(e)	acting in a consultative role to other physicians and health professionals; ^(Core)
880		
881		
882	IV.B.1.e).(1).(f)	maintaining comprehensive, timely, and legible medical records, if applicable; and, ^(Core)
883		
884		
885	IV.B.1.e).(1).(g)	demonstrating the insight and understanding into emotion and human response to emotion that allows one to appropriately develop and manage human interactions. ^(Core)
886		
887		
888		
889		
890	IV.B.1.e).(2)	Residents must learn to communicate with patients and families to partner with them to assess their care goals, including, when appropriate, end-of-life goals. ^(Core)
891		
892		
893		
894		

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

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

895		
896	IV.B.1.f)	Systems-based Practice
897		
898		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)
899		
900		
901		
902		
903		
904	IV.B.1.f).(1)	Residents must demonstrate competence in:
905		

906 **IV.B.1.f).(1).(a)** working effectively in various health care
907 delivery settings and systems relevant to their
908 clinical specialty; ^(Core)
909

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.

910
911 **IV.B.1.f).(1).(b)** coordinating patient care across the health care
912 continuum and beyond as relevant to their
913 clinical specialty; ^(Core)
914

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.

915
916 **IV.B.1.f).(1).(c)** advocating for quality patient care and optimal
917 patient care systems; ^(Core)
918

919 **IV.B.1.f).(1).(d)** working in interprofessional teams to enhance
920 patient safety and improve patient care quality;
921 ^(Core)
922

923 **IV.B.1.f).(1).(e)** participating in identifying system errors and
924 implementing potential systems solutions; ^(Core)
925

926 **IV.B.1.f).(1).(f)** incorporating considerations of value, cost
927 awareness, delivery and payment, and risk-
928 benefit analysis in patient and/or population-
929 based care as appropriate; ^(Core)
930

931 **IV.B.1.f).(1).(g)** understanding health care finances and its
932 impact on individual patients' health decisions;
933 and, ^(Core)
934

935 **IV.B.1.f).(1).(h)** advocating for the promotion of health and the
936 prevention of disease and injury in populations.
937 ^(Core)
938

939 **IV.B.1.f).(2)** Residents must learn to advocate for patients within
940 the health care system to achieve the patient's and
941 family's care goals, including, when appropriate, end-
942 of-life goals. ^(Core)
943

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

945
946 **IV.C.1.** The curriculum must be structured to optimize resident educational
947 experiences, the length of these experiences, and supervisory
948 continuity. ^(Core)

949
950 IV.C.1.a) Assignment of rotations must be structured to minimize the
951 frequency of rotational transitions, and rotations must be of
952 sufficient length to provide a quality educational experience,
953 defined by continuity of patient care, ongoing supervision,
954 longitudinal relationships with faculty members, and meaningful
955 assessment and feedback. (Core)
956

957 IV.C.1.b) Clinical experiences should be structured to facilitate learning in a
958 manner that allows residents to function as part of an effective
959 interprofessional team that works together longitudinally with
960 shared goals of patient safety and quality improvement. (Core)
961

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.

962
963 **IV.C.2. The program must provide instruction and experience in pain**
964 **management if applicable for the specialty, including recognition of**
965 **the signs of addiction.** (Core)
966

967 IV.C.3. The program must be structured to provide at least 30 months of required
968 residency education at the primary clinical site and other participating
969 sites. (Core)
970

971 IV.C.4. The program must have planned educational experiences. (Core)
972

973 IV.C.4.a) This should include both independent study and group learning
974 exercises necessary to ensure each resident acquires the
975 knowledge, skills, and attitudes needed for the practice of
976 pediatrics. (Detail)
977

978 IV.C.4.b) The program must establish requirements for resident and faculty
979 member participation. (Detail)
980

981 IV.C.4.b).(1) Participation by residents must be monitored. (Detail)
982

983 IV.C.4.b).(2) Faculty members must provide oversight and participate as
984 appropriate. (Detail)
985

986 IV.C.4.c) Residents must have experience in a supervisory role, under
987 faculty guidance. (Core)
988

989 IV.C.4.c).(1) This should occur for a minimum of five educational units
990 during the last 24 months of education. (Detail)
991

992 IV.C.5. The curriculum should be organized in educational units. (Core)
993

994	IV.C.5.a)	An educational unit should be a block (four weeks or one month)
995		or a longitudinal experience. ^(Core)
996		
997	IV.C.5.a).(1)	An outpatient educational unit should be a minimum of 32
998		half-day sessions. ^(Detail)
999		
1000	IV.C.5.a).(2)	An inpatient educational unit should be a minimum of 200
1001		hours. ^(Detail)
1002		
1003	IV.C.5.b)	The curriculum for each required educational unit must be
1004		developed by a member of the core faculty who will ensure
1005		orientation, supervision, teaching, and timely feedback and
1006		evaluation. ^(Detail)
1007		
1008	IV.C.6.	The overall structure of the program must include: ^(Core)
1009		
1010	IV.C.6.a)	a minimum of six educational units of an individualized curriculum;
1011		^(Core)
1012		
1013	IV.C.6.a).(1)	The individualized curriculum must be determined by the
1014		learning needs and career plans of each resident and must
1015		be developed through the guidance of a faculty mentor.
1016		^(Core)
1017		
1018	IV.C.6.b)	a minimum of 10 educational units of inpatient care experiences,
1019		including: ^(Core)
1020		
1021	IV.C.6.b).(1)	inpatient pediatrics; ^(Core)
1022		
1023	IV.C.6.b).(1).(a)	There must be five educational units. ^(Detail)
1024		
1025	IV.C.6.b).(1).(b)	No more than one of the five required educational
1026		units should be devoted to the care of patients in a
1027		single subspecialty. ^(Detail)
1028		
1029	IV.C.6.b).(2)	neonatal intensive care; ^(Core)
1030		
1031	IV.C.6.b).(2).(a)	There must be two educational units. ^(Detail)
1032		
1033	IV.C.6.b).(3)	pediatric critical care; and, ^(Core)
1034		
1035	IV.C.6.b).(3).(a)	There must be two educational units. ^(Detail)
1036		
1037	IV.C.6.b).(4)	term newborn care. ^(Core)
1038		
1039	IV.C.6.b).(4).(a)	There must be one educational unit. ^(Detail)
1040		
1041	IV.C.6.c)	a minimum of nine educational units of additional subspecialty
1042		experiences, including: ^(Core)
1043		
1044	IV.C.6.c).(1)	adolescent medicine; ^(Core)

1045		
1046	IV.C.6.c).(1).(a)	There must be one educational unit. (Detail)
1047		
1048	IV.C.6.c).(2)	developmental-behavioral pediatrics; (Core)
1049		
1050	IV.C.6.c).(2).(a)	There must be one educational unit. (Detail)
1051		
1052	IV.C.6.c).(3)	four educational units of four key subspecialties from the following subspecialties: (Core)
1053		
1054		
1055	IV.C.6.c).(3).(a)	child abuse; (Core)
1056		
1057	IV.C.6.c).(3).(b)	medical genetics; (Core)
1058		
1059	IV.C.6.c).(3).(c)	<u>mental and behavioral health;</u> (Core)
1060		
1061	IV.C.6.c).(3).(d)	pediatric allergy and immunology; (Core)
1062		
1063	IV.C.6.c).(3).(e)	pediatric cardiology; (Core)
1064		
1065	IV.C.6.c).(3).(f)	pediatric dermatology; (Core)
1066		
1067	IV.C.6.c).(3).(g)	pediatric endocrinology; (Core)
1068		
1069	IV.C.6.c).(3).(h)	pediatric gastroenterology; (Core)
1070		
1071	IV.C.6.c).(3).(i)	pediatric hematology-oncology; (Core)
1072		
1073	IV.C.6.c).(3).(j)	pediatric infectious diseases; (Core)
1074		
1075	IV.C.6.c).(3).(k)	pediatric nephrology; (Core)
1076		
1077	IV.C.6.c).(3).(l)	pediatric neurology; (Core)
1078		
1079	IV.C.6.c).(3).(m)	pediatric pulmonology; or, (Core)
1080		
1081	IV.C.6.c).(3).(n)	pediatric rheumatology. (Core)
1082		
1083	IV.C.6.c).(4)	three additional educational units consisting of single subspecialties or combinations of subspecialties. (Core)
1084		
1085		
1086	IV.C.6.c).(4).(a)	These should consist of experiences from either the list above or from the following: (Detail)
1087		
1088		
1089	IV.C.6.c).(4).(a).(i)	child and adolescent psychiatry; (Detail)
1090		
1091	IV.C.6.c).(4).(a).(ii)	hospice and palliative medicine; (Detail)
1092		
1093	IV.C.6.c).(4).(a).(iii)	neurodevelopmental disabilities; (Detail)
1094		

1095	IV.C.6.c).(4).(a).(iv)	pediatric anesthesiology; ^(Detail)
1096		
1097	IV.C.6.c).(4).(a).(v)	pediatric dentistry; ^(Detail)
1098		
1099	IV.C.6.c).(4).(a).(vi)	pediatric ophthalmology; ^(Detail)
1100		
1101	IV.C.6.c).(4).(a).(vii)	pediatric orthopaedic surgery; ^(Detail)
1102		
1103	IV.C.6.c).(4).(a).(viii)	pediatric otolaryngology; ^(Detail)
1104		
1105	IV.C.6.c).(4).(a).(ix)	pediatric rehabilitation medicine; ^(Detail)
1106		
1107	IV.C.6.c).(4).(a).(x)	pediatric radiology; ^(Detail)
1108		
1109	IV.C.6.c).(4).(a).(xi)	pediatric surgery; ^(Detail)
1110		
1111	IV.C.6.c).(4).(a).(xii)	sleep medicine; or, ^(Detail)
1112		
1113	IV.C.6.c).(4).(a).(xiii)	sports medicine. ^(Detail)
1114		

Specialty-Specific Background and Intent: The design of subspecialty experiences needs to blend inpatient and outpatient experiences that reflect the spectrum of practice in the specialty and emphasize the skills required for practice by a general pediatrician.

Educational units allow for experiences that are block or longitudinal. Subspecialties on the "second list" (IV.C.6.c).(4).(a).(i)-(xiii)) do not have to occur in full educational units. They can be shorter and combined with other specialties to add up to the three educational units.

1115		
1116	IV.C.6.d)	a minimum of five educational units of ambulatory experiences,
1117		including: ^(Core)
1118		
1119	IV.C.6.d).(1)	ambulatory experiences to include elements of community
1120		pediatrics and child advocacy; and ^(Core)
1121		
1122	IV.C.6.d).(1).(a)	There must be two educational units. ^(Detail)
1123		
1124	IV.C.6.d).(2)	pediatric emergency medicine and acute illness. ^(Core)
1125		
1126	IV.C.6.d).(2).(a)	There must be three educational units of pediatric
1127		emergency medicine, at least two of which must be
1128		in the emergency department. ^(Detail)
1129		
1130	IV.C.6.d).(2).(b)	Residents must have first-contact evaluation of
1131		pediatric patients in the emergency department.
1132		^(Detail)
1133		
1134	IV.C.6.e)	a minimum of 36 half-day sessions per year of a longitudinal
1135		outpatient experience. ^(Core)
1136		
1137	IV.C.6.e).(1)	The sessions must not be scheduled in fewer than 26
1138		weeks per year. ^(Core)

- 1139
 1140 IV.C.6.e).(2) There must be an adequate volume of patients to ensure
 1141 exposure to the spectrum of normal development at all age
 1142 levels, as well as the longitudinal management of children
 1143 with special health care needs and chronic conditions. (Core)
 1144
 1145 IV.C.6.e).(3) There must be a longitudinal working experience between
 1146 each resident and a single or core group of faculty
 1147 members with expertise in primary care pediatrics and the
 1148 principles of the medical home. (Core)
 1149
 1150 IV.C.6.e).(4) PGY-1 and PGY-2 residents must have a longitudinal
 1151 general pediatric outpatient experience in a setting that
 1152 provides a medical home for the spectrum of pediatric
 1153 patients. (Core)
 1154
 1155 IV.C.6.e).(5) PGY-3 residents should continue this experience at the
 1156 same clinical site or, if appropriate for an individual
 1157 resident's career goals, sessions in the final year may take
 1158 place in a longitudinal subspecialty clinic or alternate
 1159 primary care site. (Detail)
 1160
 1161 IV.C.6.e).(6) The medical home model of care must focus on wellness
 1162 and prevention, coordination of care, longitudinal
 1163 management of children with special health care needs
 1164 and chronic conditions, and provide a patient- and family-
 1165 centered approach to care. (Detail)
 1166
 1167 IV.C.6.e).(7) Consistent with the concept of the medical home, residents
 1168 must care for a panel of patients that identify the resident
 1169 as their primary care provider. (Detail)
 1170

1171 **IV.D. Scholarship**

1172
 1173 ***Medicine is both an art and a science. The physician is a humanistic***
 1174 ***scientist who cares for patients. This requires the ability to think critically,***
 1175 ***evaluate the literature, appropriately assimilate new knowledge, and***
 1176 ***practice lifelong learning. The program and faculty must create an***
 1177 ***environment that fosters the acquisition of such skills through resident***
 1178 ***participation in scholarly activities. Scholarly activities may include***
 1179 ***discovery, integration, application, and teaching.***

1180
 1181 ***The ACGME recognizes the diversity of residencies and anticipates that***
 1182 ***programs prepare physicians for a variety of roles, including clinicians,***
 1183 ***scientists, and educators. It is expected that the program's scholarship will***
 1184 ***reflect its mission(s) and aims, and the needs of the community it serves.***
 1185 ***For example, some programs may concentrate their scholarly activity on***
 1186 ***quality improvement, population health, and/or teaching, while other***
 1187 ***programs might choose to utilize more classic forms of biomedical***
 1188 ***research as the focus for scholarship.***
 1189

1190	IV.D.1.	Program Responsibilities
1191		
1192	IV.D.1.a)	The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. ^(Core)
1193		
1194		
1195	IV.D.1.b)	The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities. ^(Core)
1196		
1197		
1198		
1199	IV.D.1.c)	The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. ^(Core)
1200		
1201		
1202		

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

Elements of a scholarly approach to patient care include:

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

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

1203		
1204	IV.D.2.	Faculty Scholarly Activity
1205		
1206	IV.D.2.a)	Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: ^(Core)
1207		
1208		
1209		
1210		<ul style="list-style-type: none"> • 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
1211		
1212		
1213		
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1215		

- 1216 • Creation of curricula, evaluation tools, didactic
- 1217 educational activities, or electronic educational
- 1218 materials
- 1219 • Contribution to professional committees, educational
- 1220 organizations, or editorial boards
- 1221 • Innovations in education

1222
 1223 **IV.D.2.b)** The program must demonstrate dissemination of scholarly
 1224 activity within and external to the program by the following
 1225 methods:
 1226

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

1227
 1228 **IV.D.2.b).(1)** faculty participation in grand rounds, posters,
 1229 workshops, quality improvement presentations,
 1230 podium presentations, grant leadership, non-peer-
 1231 reviewed print/electronic resources, articles or
 1232 publications, book chapters, textbooks, webinars,
 1233 service on professional committees, or serving as a
 1234 journal reviewer, journal editorial board member, or
 1235 editor; ^{(Outcome)‡}

1236
 1237 **IV.D.2.b).(2)** peer-reviewed publication. ^(Outcome)

1238
 1239 **IV.D.3. Resident Scholarly Activity**

1240
 1241 **IV.D.3.a)** Residents must participate in scholarship. ^(Core)

1242
 1243 **V. Evaluation**

1244
 1245 **V.A. Resident Evaluation**

1246
 1247 **V.A.1. Feedback and Evaluation**

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

Formative and summative evaluation have distinct definitions. Formative evaluation is *monitoring resident learning* and providing ongoing feedback that can be used by

residents to improve their learning in the context of provision of patient care or other educational opportunities. More specifically, formative evaluations help:

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

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

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

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

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

Background and Intent: Faculty members should provide feedback frequently throughout the course of each rotation. Residents require feedback from faculty members to reinforce well-performed duties and tasks, as well as to correct deficiencies. This feedback will allow for the development of the learner as they strive to achieve the Milestones. More frequent feedback is strongly encouraged for residents who have deficiencies that may result in a poor final rotation evaluation.

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

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

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

- V.A.1.b).(3)** Residents must be evaluated utilizing a structured approach by faculty members or other appropriate supervisors using multiple assessment methods, in different settings, for: ^(Core)

- V.A.1.b).(3).(a)** performing histories and physical examinations;

1273		(Detail)
1274		
1275	V.A.1.b).(3).(b)	providing effective counseling of patients and families on the broad range of issues addressed by general pediatricians; (Detail)
1276		
1277		
1278		
1279	V.A.1.b).(3).(c)	demonstrating the ability to make diagnostic and therapeutic decisions based on best evidence and to develop and carry out management plans; and, (Detail)
1280		
1281		
1282		
1283		
1284	V.A.1.b).(3).(d)	providing longitudinal care for healthy and chronically-ill children of all ages. (Detail)
1285		
1286		
1287	V.A.1.c)	The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones, and must: (Core)
1288		
1289		
1290		
1291	V.A.1.c).(1)	use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, (Core)
1292		
1293		
1294		
1295	V.A.1.c).(2)	provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. (Core)
1296		
1297		
1298		
1299		
1300	V.A.1.d)	The program director or their designee, with input from the Clinical Competency Committee, must:
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1302		
1303	V.A.1.d).(1)	meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones; (Core)
1304		
1305		
1306		
1307		
1308	V.A.1.d).(2)	assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and, (Core)
1309		
1310		
1311		
1312	V.A.1.d).(2).(a)	administer an In-Training Examination annually; and, (Core)
1313		
1314		
1315	V.A.1.d).(2).(b)	create and document an individualized learning plan at least annually. (Core)
1316		
1317		
1318	V.A.1.d).(2).(b).(i)	The program must provide a system to assist residents in this process, including: (Detail)
1319		
1320		
1321		
1322	V.A.1.d).(2).(b).(i).(a)	faculty mentorship to help residents create learning goals; and, (Detail)
1323		

1324
 1325 V.A.1.d).(2).(b).(i).(b) systems for tracking and monitoring
 1326 progress toward completing the
 1327 individualized learning plan. ^(Detail)
 1328
 1329 V.A.1.d).(3) develop plans for residents failing to progress,
 1330 following institutional policies and procedures. ^(Core)
 1331

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.

1332
 1333 V.A.1.e) At least annually, there must be a summative evaluation of
 1334 each resident that includes their readiness to progress to the
 1335 next year of the program, if applicable. ^(Core)
 1336
 1337 V.A.1.f) The evaluations of a resident's performance must be
 1338 accessible for review by the resident. ^(Core)
 1339
 1340 V.A.2. Final Evaluation
 1341
 1342 V.A.2.a) The program director must provide a final evaluation for each
 1343 resident upon completion of the program. ^(Core)
 1344
 1345 V.A.2.a).(1) The specialty-specific Milestones, and when applicable
 1346 the specialty-specific Case Logs, must be used as
 1347 tools to ensure residents are able to engage in
 1348 autonomous practice upon completion of the program.
 1349 ^(Core)
 1350
 1351 V.A.2.a).(2) The final evaluation must:
 1352
 1353 V.A.2.a).(2).(a) become part of the resident's permanent record
 1354 maintained by the institution, and must be
 1355 accessible for review by the resident in
 1356 accordance with institutional policy; ^(Core)
 1357

- 1358 **V.A.2.a).(2).(b)** verify that the resident has demonstrated the
 1359 knowledge, skills, and behaviors necessary to
 1360 enter autonomous practice; ^(Core)
 1361
 1362 **V.A.2.a).(2).(c)** consider recommendations from the Clinical
 1363 Competency Committee; and, ^(Core)
 1364
 1365 **V.A.2.a).(2).(d)** be shared with the resident upon completion of
 1366 the program. ^(Core)
 1367
 1368 **V.A.3.** **A Clinical Competency Committee must be appointed by the**
 1369 **program director.** ^(Core)
 1370
 1371 **V.A.3.a)** **At a minimum, the Clinical Competency Committee must**
 1372 **include three members of the program faculty, at least one of**
 1373 **whom is a core faculty member.** ^(Core)
 1374
 1375 **V.A.3.a).(1)** **Additional members must be faculty members from**
 1376 **the same program or other programs, or other health**
 1377 **professionals who have extensive contact and**
 1378 **experience with the program’s residents.** ^(Core)
 1379

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.

- 1380
 1381 **V.A.3.b)** **The Clinical Competency Committee must:**
 1382
 1383 **V.A.3.b).(1)** **review all resident evaluations at least semi-annually;**
 1384 ^(Core)
 1385
 1386 **V.A.3.b).(2)** **determine each resident’s progress on achievement of**
 1387 **the specialty-specific Milestones; and,** ^(Core)
 1388
 1389 **V.A.3.b).(3)** **meet prior to the residents’ semi-annual evaluations**
 1390 **and advise the program director regarding each**
 1391 **resident’s progress.** ^(Core)
 1392
 1393 **V.B. Faculty Evaluation**

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

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

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- V.B.1.a) This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities. ^(Core)**
- V.B.1.b) This evaluation must include written, anonymous, and confidential evaluations by the residents. ^(Core)**
- V.B.2. Faculty members must receive feedback on their evaluations at least annually. ^(Core)**
- V.B.3. Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. ^(Core)**

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

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- V.C. Program Evaluation and Improvement**
- V.C.1. The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program**

- 1420 **Evaluation as part of the program's continuous improvement**
 1421 **process.** ^(Core)
 1422
 1423 **V.C.1.a)** **The Program Evaluation Committee must be composed of at**
 1424 **least two program faculty members, at least one of whom is a**
 1425 **core faculty member, and at least one resident.** ^(Core)
 1426
 1427 **V.C.1.b)** **Program Evaluation Committee responsibilities must include:**
 1428
 1429 **V.C.1.b).(1)** **acting as an advisor to the program director, through**
 1430 **program oversight;** ^(Core)
 1431
 1432 **V.C.1.b).(2)** **review of the program's self-determined goals and**
 1433 **progress toward meeting them;** ^(Core)
 1434
 1435 **V.C.1.b).(3)** **guiding ongoing program improvement, including**
 1436 **development of new goals, based upon outcomes;**
 1437 **and,** ^(Core)
 1438
 1439 **V.C.1.b).(4)** **review of the current operating environment to identify**
 1440 **strengths, challenges, opportunities, and threats as**
 1441 **related to the program's mission and aims.** ^(Core)
 1442

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

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 1444 **V.C.1.c)** **The Program Evaluation Committee should consider the**
 1445 **following elements in its assessment of the program:**
 1446
 1447 **V.C.1.c).(1)** **curriculum;** ^(Core)
 1448
 1449 **V.C.1.c).(2)** **outcomes from prior Annual Program Evaluation(s);**
 1450 ^(Core)
 1451
 1452 **V.C.1.c).(3)** **ACGME letters of notification, including citations,**
 1453 **Areas for Improvement, and comments;** ^(Core)
 1454
 1455 **V.C.1.c).(4)** **quality and safety of patient care;** ^(Core)
 1456
 1457 **V.C.1.c).(5)** **aggregate resident and faculty:**
 1458
 1459 **V.C.1.c).(5).(a)** **well-being;** ^(Core)
 1460
 1461 **V.C.1.c).(5).(b)** **recruitment and retention;** ^(Core)
 1462
 1463 **V.C.1.c).(5).(c)** **workforce diversity;** ^(Core)
 1464

1465	V.C.1.c).(5).(d)	engagement in quality improvement and patient safety; ^(Core)
1466		
1467		
1468	V.C.1.c).(5).(e)	scholarly activity; ^(Core)
1469		
1470	V.C.1.c).(5).(f)	ACGME Resident and Faculty Surveys; and,
1471		^(Core)
1472		
1473	V.C.1.c).(5).(g)	written evaluations of the program. ^(Core)
1474		
1475	V.C.1.c).(6)	aggregate resident:
1476		
1477	V.C.1.c).(6).(a)	achievement of the Milestones; ^(Core)
1478		
1479	V.C.1.c).(6).(b)	in-training examinations (where applicable);
1480		^(Core)
1481		
1482	V.C.1.c).(6).(c)	board pass and certification rates; and, ^(Core)
1483		
1484	V.C.1.c).(6).(d)	graduate performance. ^(Core)
1485		
1486	V.C.1.c).(7)	aggregate faculty:
1487		
1488	V.C.1.c).(7).(a)	evaluation; and, ^(Core)
1489		
1490	V.C.1.c).(7).(b)	professional development. ^(Core)
1491		
1492	V.C.1.d)	The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. ^(Core)
1493		
1494		
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1496	V.C.1.e)	The annual review, including the action plan, must:
1497		
1498	V.C.1.e).(1)	be distributed to and discussed with the members of the teaching faculty and the residents; and, ^(Core)
1499		
1500		
1501	V.C.1.e).(2)	be submitted to the DIO. ^(Core)
1502		
1503	V.C.2.	The program must complete a Self-Study prior to its 10-Year Accreditation Site Visit. ^(Core)
1504		
1505		
1506	V.C.2.a)	A summary of the Self-Study must be submitted to the DIO.
1507		^(Core)
1508		

Background and Intent: Outcomes of the documented Annual Program Evaluation can be integrated into the 10-year Self-Study process. The Self-Study is an objective, comprehensive evaluation of the residency program, with the aim of improving it. Underlying the Self-Study is this longitudinal evaluation of the program and its learning environment, facilitated through sequential Annual Program Evaluations that focus on the required components, with an emphasis on program strengths and self-identified areas for improvement. Details regarding the timing and expectations for the

Self-Study and the 10-Year Accreditation Site Visit are provided in the *ACGME Manual of Policies and Procedures*. Additionally, a description of the [Self-Study process](#), as well as information on how to prepare for the [10-Year Accreditation Site Visit](#), is available on the ACGME website.

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

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

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

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

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

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

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

Background and Intent: Setting a single standard for pass rate that works across specialties is not supportable based on the heterogeneity of the psychometrics of different examinations. By using a percentile rank, the performance of the lower five

percent (fifth percentile) of programs can be identified and set on a path to curricular and test preparation reform.

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

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

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

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

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

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VI. The Learning and Working Environment

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

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

Background and Intent: The revised requirements are intended to provide greater flexibility within an established framework, allowing programs and residents more

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

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

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

VI.A.1. Patient Safety and Quality Improvement

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

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

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

VI.A.1.a) Patient Safety

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

1608 ***A culture of safety requires continuous identification***
1609 ***of vulnerabilities and a willingness to transparently***
1610 ***deal with them. An effective organization has formal***
1611 ***mechanisms to assess the knowledge, skills, and***
1612 ***attitudes of its personnel toward safety in order to***
1613 ***identify areas for improvement.***
1614

1615 **VI.A.1.a).(1).(a)** **The program, its faculty, residents, and fellows**
1616 **must actively participate in patient safety**
1617 **systems and contribute to a culture of safety.**
1618 **(Core)**

1619 **VI.A.1.a).(1).(b)** **The program must have a structure that**
1620 **promotes safe, interprofessional, team-based**
1621 **care. (Core)**
1622

1623 **VI.A.1.a).(2)** **Education on Patient Safety**

1624 **Programs must provide formal educational activities**
1625 **that promote patient safety-related goals, tools, and**
1626 **techniques. (Core)**
1627

1628 **Background and Intent: Optimal patient safety occurs in the setting of a coordinated**
1629 **interprofessional learning and working environment.**

1630 **VI.A.1.a).(3)** **Patient Safety Events**

1631 ***Reporting, investigation, and follow-up of adverse***
1632 ***events, near misses, and unsafe conditions are pivotal***
1633 ***mechanisms for improving patient safety, and are***
1634 ***essential for the success of any patient safety***
1635 ***program. Feedback and experiential learning are***
1636 ***essential to developing true competence in the ability***
1637 ***to identify causes and institute sustainable systems-***
1638 ***based changes to ameliorate patient safety***
1639 ***vulnerabilities.***
1640

1641 **VI.A.1.a).(3).(a)** **Residents, fellows, faculty members, and other**
1642 **clinical staff members must:**

1643 **VI.A.1.a).(3).(a).(i)** **know their responsibilities in reporting**
1644 **patient safety events at the clinical site;**
1645 **(Core)**

1646 **VI.A.1.a).(3).(a).(ii)** **know how to report patient safety**
1647 **events, including near misses, at the**
1648 **clinical site; and, (Core)**

1649 **VI.A.1.a).(3).(a).(iii)** **be provided with summary information**
1650 **of their institution's patient safety**
1651 **reports. (Core)**
1652

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1658	VI.A.1.a).(3).(b)	Residents must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. ^(Core)
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1665	VI.A.1.a).(4)	Resident Education and Experience in Disclosure of Adverse Events
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1668		<i>Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for residents to develop and apply.</i>
1669		
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1674	VI.A.1.a).(4).(a)	All residents must receive training in how to disclose adverse events to patients and families. ^(Core)
1675		
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1678	VI.A.1.a).(4).(b)	Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated. ^(Detail)
1679		
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1682	VI.A.1.b)	Quality Improvement
1683		
1684	VI.A.1.b).(1)	Education in Quality Improvement
1685		
1686		<i>A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.</i>
1687		
1688		
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1691	VI.A.1.b).(1).(a)	Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities. ^(Core)
1692		
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1695	VI.A.1.b).(2)	Quality Metrics
1696		
1697		<i>Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.</i>
1698		
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1701	VI.A.1.b).(2).(a)	Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. ^(Core)
1702		
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1705	VI.A.1.b).(3)	Engagement in Quality Improvement Activities
1706		

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

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VI.A.1.b).(3).(a)

Residents must have the opportunity to participate in interprofessional quality improvement activities. ^(Core)

VI.A.1.b).(3).(a).(i)

This should include activities aimed at reducing health care disparities. ^(Detail)

VI.A.2.

Supervision and Accountability

VI.A.2.a)

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

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

VI.A.2.a).(1)

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

Specialty-Specific Background and Intent: Physician assistants, nurse practitioners, psychologists, physical and occupational therapists, speech and language pathologists, dietitians/nutritionists, counselors, and audiologists are just some of the providers who see their own patients and may serve as teachers and/or supervisors for residents as appropriate in ambulatory (i.e., school-based health centers, child development clinics) and inpatient (i.e., neonatal intensive care unit (NICU)) settings. Some states may have regulatory rules that won't allow licensed independent practitioners to supervise residents.

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VI.A.2.a).(1).(a)

This information must be available to residents, faculty members, other members of the health care team, and patients. ^(Core)

VI.A.2.a).(1).(b)

Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. ^(Core)

1751
 1752 **VI.A.2.b)** *Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the appropriate availability of the supervising faculty member, fellow, or senior resident physician, either on site or by means of telecommunication technology. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.*
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Background and Intent: Appropriate supervision is essential for patient safety and high-quality teaching. Supervision is also contextual. There is tremendous diversity of resident patient interactions, education and training locations, and resident skills and abilities even at the same level of the educational program. The degree of supervision is expected to evolve progressively as a resident gains more experience, even with the same patient condition or procedure. All residents have a level of supervision commensurate with their level of autonomy in practice; this level of supervision may be enhanced based on factors such as patient safety, complexity, acuity, urgency, risk of serious adverse events, or other pertinent variables.

1763
 1764 **VI.A.2.b).(1)** **The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident’s level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation.** ^(Core)
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1771 **VI.A.2.b).(2)** **The program must define when physical presence of a supervising physician is required.** ^(Core)
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1774 **VI.A.2.c)** **Levels of Supervision**
 1775
 1776 **To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:** ^(Core)
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1780 **VI.A.2.c).(1)** **Direct Supervision:**

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 1782 **VI.A.2.c).(1).(a)** **the supervising physician is physically present with the resident during the key portions of the patient interaction.** ^(Core)
 1783
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 1786 **VI.A.2.c).(1).(a).(i)** **PGY-1 residents must initially be supervised directly, only as described in VI.A.2.c).(1).(a).** ^(Core)
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 1790 **VI.A.2.c).(1).(a).(i).(a)** **PGY-1 residents must always be supervised either directly or**
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indirectly with direct supervision
immediately available. ^(Detail)

Specialty-Specific Background and Intent: PGY-1 residents may not take “parent concern calls” from home, but may make/take “parent concern calls” during their clinical and educational work hours in the hospital or from another clinical site where supervision is either direct or indirect with direct supervision immediately available.

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- VI.A.2.c).(2)** **Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.** ^(Core)
- VI.A.2.c).(3)** **Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.** ^(Core)
- VI.A.2.d)** **The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.** ^(Core)
- VI.A.2.d).(1)** **The program director must evaluate each resident’s abilities based on specific criteria, guided by the Milestones.** ^(Core)
- VI.A.2.d).(2)** **Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident.** ^(Core)
- VI.A.2.d).(3)** **Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.** ^(Detail)
- VI.A.2.e)** **Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s).** ^(Core)
- VI.A.2.e).(1)** **Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence.** ^(Outcome)

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

1835
1836 **VI.A.2.f)** Faculty supervision assignments must be of sufficient
1837 duration to assess the knowledge and skills of each resident
1838 and to delegate to the resident the appropriate level of patient
1839 care authority and responsibility. ^(Core)
1840

1841 **VI.B. Professionalism**

1842
1843 **VI.B.1.** Programs, in partnership with their Sponsoring Institutions, must
1844 educate residents and faculty members concerning the professional
1845 responsibilities of physicians, including their obligation to be
1846 appropriately rested and fit to provide the care required by their
1847 patients. ^(Core)
1848

1849 **VI.B.2.** The learning objectives of the program must:

1850
1851 **VI.B.2.a)** be accomplished through an appropriate blend of supervised
1852 patient care responsibilities, clinical teaching, and didactic
1853 educational events; ^(Core)
1854

1855 **VI.B.2.b)** be accomplished without excessive reliance on residents to
1856 fulfill non-physician obligations; and, ^(Core)
1857

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

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1859 **VI.B.2.c)** ensure manageable patient care responsibilities. ^(Core)
1860

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

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1862 **VI.B.3.** The program director, in partnership with the Sponsoring Institution,
1863 must provide a culture of professionalism that supports patient
1864 safety and personal responsibility. ^(Core)
1865

1866 **VI.B.4.** Residents and faculty members must demonstrate an understanding
1867 of their personal role in the:

- 1868
1869 **VI.B.4.a)** provision of patient- and family-centered care; (Outcome)
1870
1871 **VI.B.4.b)** safety and welfare of patients entrusted to their care,
1872 including the ability to report unsafe conditions and adverse
1873 events; (Outcome)
1874

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

- 1875
1876 **VI.B.4.c)** assurance of their fitness for work, including: (Outcome)
1877

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

- 1878
1879 **VI.B.4.c).(1)** management of their time before, during, and after
1880 clinical assignments; and, (Outcome)
1881
1882 **VI.B.4.c).(2)** recognition of impairment, including from illness,
1883 fatigue, and substance use, in themselves, their peers,
1884 and other members of the health care team. (Outcome)
1885
1886 **VI.B.4.d)** commitment to lifelong learning; (Outcome)
1887
1888 **VI.B.4.e)** monitoring of their patient care performance improvement
1889 indicators; and, (Outcome)
1890
1891 **VI.B.4.f)** accurate reporting of clinical and educational work hours,
1892 patient outcomes, and clinical experience data. (Outcome)
1893

- 1894 **VI.B.5.** All residents and faculty members must demonstrate
1895 responsiveness to patient needs that supersedes self-interest. This
1896 includes the recognition that under certain circumstances, the best
1897 interests of the patient may be served by transitioning that patient's
1898 care to another qualified and rested provider. (Outcome)
1899

- 1900 **VI.B.6.** Programs, in partnership with their Sponsoring Institutions, must
1901 provide a professional, equitable, respectful, and civil environment
1902 that is free from discrimination, sexual and other forms of
1903 harassment, mistreatment, abuse, or coercion of students,
1904 residents, faculty, and staff. (Core)
1905

- 1906 **VI.B.7.** Programs, in partnership with their Sponsoring Institutions, should
1907 have a process for education of residents and faculty regarding

1908 unprofessional behavior and a confidential process for reporting,
1909 investigating, and addressing such concerns. ^(Core)

1910
1911 **VI.C. Well-Being**

1912
1913 *Psychological, emotional, and physical well-being are critical in the*
1914 *development of the competent, caring, and resilient physician and require*
1915 *proactive attention to life inside and outside of medicine. Well-being*
1916 *requires that physicians retain the joy in medicine while managing their*
1917 *own real-life stresses. Self-care and responsibility to support other*
1918 *members of the health care team are important components of*
1919 *professionalism; they are also skills that must be modeled, learned, and*
1920 *nurtured in the context of other aspects of residency training.*

1921
1922 *Residents and faculty members are at risk for burnout and depression.*
1923 *Programs, in partnership with their Sponsoring Institutions, have the same*
1924 *responsibility to address well-being as other aspects of resident*
1925 *competence. Physicians and all members of the health care team share*
1926 *responsibility for the well-being of each other. For example, a culture which*
1927 *encourages covering for colleagues after an illness without the expectation*
1928 *of reciprocity reflects the ideal of professionalism. A positive culture in a*
1929 *clinical learning environment models constructive behaviors, and prepares*
1930 *residents with the skills and attitudes needed to thrive throughout their*
1931 *careers.*

1932

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

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

1933
1934 **VI.C.1. The responsibility of the program, in partnership with the**
1935 **Sponsoring Institution, to address well-being must include:**

1936
1937 **VI.C.1.a) efforts to enhance the meaning that each resident finds in the**
1938 **experience of being a physician, including protecting time**
1939 **with patients, minimizing non-physician obligations,**
1940 **providing administrative support, promoting progressive**
1941 **autonomy and flexibility, and enhancing professional**
1942 **relationships;** ^(Core)

1943

- 1944 VI.C.1.b) attention to scheduling, work intensity, and work
 1945 compression that impacts resident well-being; (Core)
 1946
 1947 VI.C.1.c) evaluating workplace safety data and addressing the safety of
 1948 residents and faculty members; (Core)
 1949

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

- 1950
 1951 VI.C.1.d) policies and programs that encourage optimal resident and
 1952 faculty member well-being; and, (Core)
 1953

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.

- 1954
 1955 VI.C.1.d).(1) Residents must be given the opportunity to attend
 1956 medical, mental health, and dental care appointments,
 1957 including those scheduled during their working hours.
 1958 (Core)
 1959

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

- 1960
 1961 VI.C.1.e) attention to resident and faculty member burnout,
 1962 depression, and substance use disorders. The program, in
 1963 partnership with its Sponsoring Institution, must educate
 1964 faculty members and residents in identification of the
 1965 symptoms of burnout, depression, and substance use
 1966 disorders, including means to assist those who experience
 1967 these conditions. Residents and faculty members must also
 1968 be educated to recognize those symptoms in themselves and
 1969 how to seek appropriate care. The program, in partnership
 1970 with its Sponsoring Institution, must: (Core)
 1971

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

- 1972
 1973 VI.C.1.e).(1) encourage residents and faculty members to alert the
 1974 program director or other designated personnel or

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1976
1977
1978
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1980

programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, a substance use disorder, suicidal ideation, or potential for violence;
(Core)

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

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- VI.C.1.e).(2)** provide access to appropriate tools for self-screening; and, (Core)
- VI.C.1.e).(3)** provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)

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

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

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

2000 VI.C.2.b) These policies must be implemented without fear of negative
2001 consequences for the resident who is or was unable to
2002 provide the clinical work. ^(Core)
2003

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

2004 VI.D. Fatigue Mitigation

2005 VI.D.1. Programs must:

2006 VI.D.1.a) educate all faculty members and residents to recognize the
2007 signs of fatigue and sleep deprivation; ^(Core)
2008

2009 VI.D.1.b) educate all faculty members and residents in alertness
2010 management and fatigue mitigation processes; and, ^(Core)
2011

2012 VI.D.1.c) encourage residents to use fatigue mitigation processes to
2013 manage the potential negative effects of fatigue on patient
2014 care and learning. ^(Detail)
2015
2016
2017
2018

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

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

2019 VI.D.2. Each program must ensure continuity of patient care, consistent
2020 with the program's policies and procedures referenced in VI.C.2–
2021 VI.C.2.b), in the event that a resident may be unable to perform their
2022 patient care responsibilities due to excessive fatigue. ^(Core)
2023
2024

2025 VI.D.3. The program, in partnership with its Sponsoring Institution, must
2026 ensure adequate sleep facilities and safe transportation options for
2027 residents who may be too fatigued to safely return home. ^(Core)
2028

2029 VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care
2030

- 2031 **VI.E.1. Clinical Responsibilities**
 2032
 2033 **The clinical responsibilities for each resident must be based on PGY**
 2034 **level, patient safety, resident ability, severity and complexity of**
 2035 **patient illness/condition, and available support services.** ^(Core)
 2036
 2037 VI.E.1.a) The program director must have the authority and responsibility to
 2038 set appropriate clinical responsibilities for each resident based on
 2039 the PGY-level, patient safety, resident education, severity and
 2040 complexity of patient illness/condition and available support
 2041 services. ^(Core)
 2042
 2043 VI.E.1.b) Residents must be responsible for an appropriate patient load.
 2044 Insufficient patient experiences do not meet educational needs; an
 2045 excessive patient load suggests an inappropriate reliance on
 2046 residents for service obligations, which may jeopardize the
 2047 educational experience. ^(Core)
 2048

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

- 2049
 2050 **VI.E.2. Teamwork**
 2051
 2052 **Residents must care for patients in an environment that maximizes**
 2053 **communication. This must include the opportunity to work as a**
 2054 **member of effective interprofessional teams that are appropriate to**
 2055 **the delivery of care in the specialty and larger health system.** ^(Core)
 2056

Specialty-Specific Background and Intent: Examples of professional personnel who may be part of the interprofessional teams include nurses, physician assistants, advanced practice providers, pharmacists, social workers, child-life specialists, physical and occupational therapists, speech and language pathologists, audiologists, respiratory therapists, psychologists, and nutritionists.

- 2057
 2058 **VI.E.3. Transitions of Care**
 2059
 2060 **VI.E.3.a) Programs must design clinical assignments to optimize**
 2061 **transitions in patient care, including their safety, frequency,**
 2062 **and structure.** ^(Core)
 2063
 2064 **VI.E.3.b) Programs, in partnership with their Sponsoring Institutions,**
 2065 **must ensure and monitor effective, structured hand-over**
 2066 **processes to facilitate both continuity of care and patient**
 2067 **safety.** ^(Core)

- 2068
2069 VI.E.3.c) Programs must ensure that residents are competent in
2070 communicating with team members in the hand-over process.
2071 (Outcome)
2072
- 2073 VI.E.3.d) Programs and clinical sites must maintain and communicate
2074 schedules of attending physicians and residents currently
2075 responsible for care. (Core)
2076
- 2077 VI.E.3.e) Each program must ensure continuity of patient care,
2078 consistent with the program’s policies and procedures
2079 referenced in VI.C.2-VI.C.2.b), in the event that a resident may
2080 be unable to perform their patient care responsibilities due to
2081 excessive fatigue or illness, or family emergency. (Core)
2082
- 2083 VI.F. Clinical Experience and Education
2084
- 2085 *Programs, in partnership with their Sponsoring Institutions, must design*
2086 *an effective program structure that is configured to provide residents with*
2087 *educational and clinical experience opportunities, as well as reasonable*
2088 *opportunities for rest and personal activities.*
2089

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

- 2090
2091 VI.F.1. Maximum Hours of Clinical and Educational Work per Week
2092
- 2093 Clinical and educational work hours must be limited to no more than
2094 80 hours per week, averaged over a four-week period, inclusive of all
2095 in-house clinical and educational activities, clinical work done from
2096 home, and all moonlighting. (Core)
2097

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

Scheduling

While the ACGME acknowledges that, on rare occasions, a resident may work in excess of 80 hours in a given week, all programs and residents utilizing this flexibility will be required to adhere to the 80-hour maximum weekly limit when averaged over a four-week period. Programs that regularly schedule residents to work 80 hours per week and still permit residents to remain beyond their scheduled work period are likely to exceed the 80-hour maximum, which would not be in substantial compliance with the requirement. These programs should adjust schedules so that residents are scheduled

to work fewer than 80 hours per week, which would allow residents to remain beyond their scheduled work period when needed without violating the 80-hour requirement. Programs may wish to consider using night float and/or making adjustments to the frequency of in-house call to ensure compliance with the 80-hour maximum weekly limit.

Oversight

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

Work from Home

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

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

PGY-1 and PGY-2 Residents

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

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

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

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

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

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

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

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

Background and Intent: The requirement provides flexibility for programs to distribute days off in a manner that meets program and resident needs. It is strongly recommended that residents' preference regarding how their days off are distributed be

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

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

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

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

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

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

After careful consideration of the information available, the testimony and position of all parties submitting information, and presentations to the Task Force, the Task Force removed the 16-hour-consecutive-time-on-task requirement for PGY-1 residents. It

remains crucial that programs ensure that PGY-1 residents are supervised in compliance with the applicable Program Requirements, and that resident well-being is prioritized as described in Section VI.C. of these requirements.

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

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

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

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

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

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

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

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

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

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

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VI.F.4.c) A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and

2164 educational work hours to individual programs based on a
2165 sound educational rationale.

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2167 The Review Committee for Pediatrics will not consider requests
2168 for exceptions to the 80 hour limit to residents' work week.

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2170 **VI.F.5. Moonlighting**

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2172 **VI.F.5.a) Moonlighting must not interfere with the ability of the resident**
2173 **to achieve the goals and objectives of the educational**
2174 **program, and must not interfere with the resident's fitness for**
2175 **work nor compromise patient safety.** (Core)

2176
2177 **VI.F.5.b) Time spent by residents in internal and external moonlighting**
2178 **(as defined in the ACGME Glossary of Terms) must be**
2179 **counted toward the 80-hour maximum weekly limit.** (Core)

2180
2181 **VI.F.5.c) PGY-1 residents are not permitted to moonlight.** (Core)

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

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2184 **VI.F.6. In-House Night Float**

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2186 **Night float must occur within the context of the 80-hour and one-**
2187 **day-off-in-seven requirements.** (Core)

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2189 **VI.F.6.a) Night experiences should be of educational value.** (Core)

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2191 **VI.F.6.a).(1) In order to accomplish this, night assignments should have**
2192 **formal goals, objectives, and a specific evaluation**
2193 **component.** (Detail)

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

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2196 **VI.F.7. Maximum In-House On-Call Frequency**

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2198 **Residents must be scheduled for in-house call no more frequently**
2199 **than every third night (when averaged over a four-week period).** (Core)

2200 **VI.F.8. At-Home Call**

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2202 **VI.F.8.a) Time spent on patient care activities by residents on at-home**
2203 **call must count toward the 80-hour maximum weekly limit.**
2204 **The frequency of at-home call is not subject to the every-**
2205 **third-night limitation, but must satisfy the requirement for one**
2206 **day in seven free of clinical work and education, when**
2207 **averaged over four weeks.** (Core)

2208

- 2209 VI.F.8.a).(1) At-home call must not be so frequent or taxing as to
 2210 preclude rest or reasonable personal time for each
 2211 resident. ^(Core)
 2212
- 2213 VI.F.8.b) Residents are permitted to return to the hospital while on at-
 2214 home call to provide direct care for new or established
 2215 patients. These hours of inpatient patient care must be
 2216 included in the 80-hour maximum weekly limit. ^(Detail)
 2217

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

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

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- 2221 ***Core Requirements:** Statements that define structure, resource, or process elements
 2222 essential to every graduate medical educational program.
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- 2224 **†Detail Requirements:** Statements that describe a specific structure, resource, or process, for
 2225 achieving compliance with a Core Requirement. Programs and sponsoring institutions in
 2226 substantial compliance with the Outcome Requirements may utilize alternative or innovative
 2227 approaches to meet Core Requirements.
 2228
- 2229 **‡Outcome Requirements:** Statements that specify expected measurable or observable
 2230 attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their
 2231 graduate medical education.
 2232
- 2233 **Osteopathic Recognition**
 2234 For programs with or applying for Osteopathic Recognition, the Osteopathic Recognition
 2235 Requirements also apply (www.acgme.org/OsteopathicRecognition).