

**ACGME Program Requirements for
Graduate Medical Education
in Vascular Surgery (Integrated)**

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1
2 **Proposed ACGME Program Requirements for Graduate Medical Education**
3 **in Vascular Surgery (Integrated)**
4

5 **Common Program Requirements (Residency) are in BOLD**
6

7 Where applicable, text in italics describes the underlying philosophy of the requirements in that
8 section. These philosophic statements are not program requirements and are therefore not
9 citable.
10

The "Specialty-Specific Background and Intent" text in the boxes below provide detail regarding the intention behind specific requirements, as well as guidance on how to implement the requirements in a way that supports excellence in residency education. Programs will note that the Vascular Surgery Subspecialty FAQs companion document has been integrated into this document and, where appropriate, guidance is given on additional Review Committee resource information.

11
12 **Introduction**
13

14 **Int.A.** *Graduate medical education is the crucial step of professional*
15 *development between medical school and autonomous clinical practice. It*
16 *is in this vital phase of the continuum of medical education that residents*
17 *learn to provide optimal patient care under the supervision of faculty*
18 *members who not only instruct, but serve as role models of excellence,*
19 *compassion, professionalism, and scholarship.*
20

21 *Graduate medical education transforms medical students into physician*
22 *scholars who care for the patient, family, and a diverse community; create*
23 *and integrate new knowledge into practice; and educate future generations*
24 *of physicians to serve the public. Practice patterns established during*
25 *graduate medical education persist many years later.*
26

27 *Graduate medical education has as a core tenet the graded authority and*
28 *responsibility for patient care. The care of patients is undertaken with*
29 *appropriate faculty supervision and conditional independence, allowing*
30 *residents to attain the knowledge, skills, attitudes, and empathy required*
31 *for autonomous practice. Graduate medical education develops physicians*
32 *who focus on excellence in delivery of safe, equitable, affordable, quality*
33 *care; and the health of the populations they serve. Graduate medical*
34 *education values the strength that a diverse group of physicians brings to*
35 *medical care.*
36

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

45 *of patients, residents, fellows, faculty members, students, and all members*
46 *of the health care team.*

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

49
50 Vascular surgery is the surgical specialty involving diseases of the arterial,
51 venous, and lymphatic circulatory systems, exclusive of those circulatory vessels
52 intrinsic to the heart and intracranial vessels. Specialists in this discipline
53 demonstrate the knowledge, skills, and understanding of the medical science
54 relative to the vascular system, as well as mature technical skills and surgical
55 judgment.

56
57 **Int.C. Length of Educational Program**

58
59 The educational program in vascular surgery for integrated programs must be 60
60 months in length. ^(Core)

61
62 **I. Oversight**

63
64 **I.A. Sponsoring Institution**

65
66 *The Sponsoring Institution is the organization or entity that assumes the*
67 *ultimate financial and academic responsibility for a program of graduate*
68 *medical education, consistent with the ACGME Institutional Requirements.*

69
70 *When the Sponsoring Institution is not a rotation site for the program, the*
71 *most commonly utilized site of clinical activity for the program is the*
72 *primary clinical site.*

73
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.

74
75 **I.A.1. The program must be sponsored by one ACGME-accredited**
76 **Sponsoring Institution. ^{(Core)*}**

77
78 **I.B. Participating Sites**

79
80 *A participating site is an organization providing educational experiences or*
81 *educational assignments/rotations for residents.*

82
83 **I.B.1. The program, with approval of its Sponsoring Institution, must**
84 **designate a primary clinical site. ^(Core)**

85

- 86 **I.B.2.** There must be a program letter of agreement (PLA) between the
87 program and each participating site that governs the relationship
88 between the program and the participating site providing a required
89 assignment. ^(Core)
90
- 91 **I.B.2.a)** The PLA must:
- 92
- 93 **I.B.2.a).(1)** be renewed at least every 10 years; and, ^(Core)
94
- 95 **I.B.2.a).(2)** be approved by the designated institutional official
96 (DIO). ^(Core)
97
- 98 **I.B.3.** The program must monitor the clinical learning and working
99 environment at all participating sites. ^(Core)
100
- 101 **I.B.3.a)** At each participating site there must be one faculty member,
102 designated by the program director as the site director, who
103 is accountable for resident education at that site, in
104 collaboration with the program director. ^(Core)
105

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**

- 106
- 107 **I.B.4.** The program director must submit any additions or deletions of
108 participating sites routinely providing an educational experience,
109 required for all residents, of one month full time equivalent (FTE) or
110 more through the ACGME's Accreditation Data System (ADS). ^(Core)
111
- 112 **I.B.5.** Participating sites should be geographically proximate to the primary
113 clinical site to allow all residents to attend joint conferences, basic science
114 lectures, and morbidity and mortality reviews on a regular and
115 documented basis. ^(Core)
116

117 I.B.5.a) Geographically remote participating sites must provide audiovisual
118 access to conferences and lectures at the central location or
119 document provision of an equivalent educational program of
120 lectures and conferences. ^(Core)
121

122 **I.C. The program, in partnership with its Sponsoring Institution, must engage in**
123 **practices that focus on mission-driven, ongoing, systematic recruitment**
124 **and retention of a diverse and inclusive workforce of residents, fellows (if**
125 **present), faculty members, senior administrative staff members, and other**
126 **relevant members of its academic community.** ^(Core)
127

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).

128
129 **I.D. Resources**

130
131 **I.D.1. The program, in partnership with its Sponsoring Institution, must**
132 **ensure the availability of adequate resources for resident education.**
133 ^(Core)

134
135 I.D.1.a) These resources must include:

136
137 I.D.1.a).(1) a common office space for residents that includes a
138 sufficient number of computers and adequate workspace
139 at the primary clinical site; ^(Core)
140

141 I.D.1.a).(2) software resources for production of presentations,
142 manuscripts, and portfolios; and, ^(Core)
143

144 I.D.1.a).(3) online radiographic and laboratory reporting systems at the
145 primary clinical site and all participating sites. ^(Core)
146

147 I.D.1.b) The facility used to provide residents with experience in
148 interpretation of non-invasive vascular laboratory testing must be
149 accredited by a recognized organization that would allow
150 residency graduates to fulfill the requirements of eligibility for
151 specialty board certification. ^(Core)
152

153 I.D.1.b).(1) The laboratory must be currently accredited in extracranial
154 cerebrovascular, peripheral arterial and peripheral venous
155 testing, and must provide substantial experience in
156 abdominal and visceral vascular imaging. ^(Detail)
157

158 **I.D.2. The program, in partnership with its Sponsoring Institution, must**
159 **ensure healthy and safe learning and working environments that**
160 **promote resident well-being and provide for:** ^(Core)
161

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

163

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

167

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.

168

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

172

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).

173

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

176

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

179

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

184

Specialty-Specific Background and Intent: The Review Committee interprets "ready access" to mean availability at all clinical sites utilized by the program.

185

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

188

189 I.D.4.a) An accredited vascular surgery program must be conducted in an
190 institution(s) that can document a sufficient breadth of patient care
191 that routinely cares for patients with a broad spectrum of vascular
192 diseases and conditions. (Core)

193

194 I.D.4.b) In addition, these institutions must include facilities and staff
195 members for a variety of other services that provide a critical role
196 in the care of patients with vascular conditions, including
197 cardiovascular services, critical care services, general surgery
198 services, nephrology services, neurology services, and radiology
199 services. ^(Core)
200

201 I.D.4.c) The institutional volume and variety of open and endovascular
202 operative experience must be adequate to ensure a sufficient
203 number and distribution of complex cases (as determined by the
204 Review Committee) for each resident in the program. ^(Core)
205

206 **I.E. The presence of other learners and other care providers, including, but not**
207 **limited to, residents from other programs, subspecialty fellows, and**
208 **advanced practice providers, must enrich the appointed residents'**
209 **education. ^(Core)**
210

211 **I.E.1. The program must report circumstances when the presence of other**
212 **learners has interfered with the residents' education to the DIO and**
213 **Graduate Medical Education Committee (GMEC). ^(Core)**
214

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.

215
216 **II. Personnel**
217

218 **II.A. Program Director**
219

220 **II.A.1. There must be one faculty member appointed as program director**
221 **with authority and accountability for the overall program, including**
222 **compliance with all applicable program requirements. ^(Core)**
223

224 **II.A.1.a) The Sponsoring Institution's GMEC must approve a change in**
225 **program director. ^(Core)**
226

227 **II.A.1.b) Final approval of the program director resides with the**
228 **Review Committee. ^(Core)**
229

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

230
231 **II.A.1.c) The program must demonstrate retention of the program**
232 **director for a length of time adequate to maintain continuity**
233 **of leadership and program stability. ^(Core)**

234
235
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237

II.A.1.c).(1) The term of appointment must be for the length of the program plus one year. ^(Detail)

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

II.A.2.a) The program director must be provided a minimum of 20 percent protected time for program administration. ^(Core)

II.A.2.b) Program directors who oversee both an integrated and an independent vascular surgery program must be provided a minimum of 10 percent additional protected time for administration of the integrated program. ^(Core)

II.A.2.c) Program directors who oversee both an independent and an integrated vascular surgery program which, combined, have 10 or more residents/fellows must appoint an associate program director. ^(Core)

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

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

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

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

256

Specialty-Specific Background and Intent: Programs are advised that the Common Program Requirements specify that protected time is specifically for the administration of the program and not for clinical activities. The program is further advised that the Program Requirements for the independent and integrated vascular surgery programs are two distinct sets of requirements. If a single program director has responsibility for both program formats, the applicable protected time is outlined in II.A.2. of both sets of Program Requirements.

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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.

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

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

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

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

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II.A.4. Program Director Responsibilities

The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation,

282 and promotion of residents, and disciplinary action; supervision of
283 residents; and resident education in the context of patient care. ^(Core)

284
285 **II.A.4.a) The program director must:**

286
287 **II.A.4.a).(1) be a role model of professionalism;** ^(Core)
288

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.

289
290 **II.A.4.a).(2) design and conduct the program in a fashion**
291 **consistent with the needs of the community, the**
292 **mission(s) of the Sponsoring Institution, and the**
293 **mission(s) of the program;** ^(Core)
294

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.

295
296 **II.A.4.a).(3) administer and maintain a learning environment**
297 **conducive to educating the residents in each of the**
298 **ACGME Competency domains;** ^(Core)
299

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.

300
301 **II.A.4.a).(4) develop and oversee a process to evaluate candidates**
302 **prior to approval as program faculty members for**
303 **participation in the residency program education and**
304 **at least annually thereafter, as outlined in V.B.;** ^(Core)
305

306 **II.A.4.a).(5) have the authority to approve program faculty**
307 **members for participation in the residency program**
308 **education at all sites;** ^(Core)
309

- 310 **II.A.4.a).(6)** have the authority to remove program faculty
311 members from participation in the residency program
312 education at all sites; ^(Core)
313
314 **II.A.4.a).(7)** have the authority to remove residents from
315 supervising interactions and/or learning environments
316 that do not meet the standards of the program; ^(Core)
317

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.

- 318
319 **II.A.4.a).(8)** submit accurate and complete information required
320 and requested by the DIO, GMEC, and ACGME; ^(Core)
321
322 **II.A.4.a).(9)** provide applicants who are offered an interview with
323 information related to the applicant's eligibility for the
324 relevant specialty board examination(s); ^(Core)
325
326 **II.A.4.a).(10)** provide a learning and working environment in which
327 residents have the opportunity to raise concerns and
328 provide feedback in a confidential manner as
329 appropriate, without fear of intimidation or retaliation;
330 ^(Core)
331
332 **II.A.4.a).(11)** ensure the program's compliance with the Sponsoring
333 Institution's policies and procedures related to
334 grievances and due process; ^(Core)
335
336 **II.A.4.a).(12)** ensure the program's compliance with the Sponsoring
337 Institution's policies and procedures for due process
338 when action is taken to suspend or dismiss, not to
339 promote, or not to renew the appointment of a
340 resident; ^(Core)
341

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.

- 342
343 **II.A.4.a).(13)** ensure the program's compliance with the Sponsoring
344 Institution's policies and procedures on employment
345 and non-discrimination; ^(Core)
346

- 347 **II.A.4.a).(13).(a)** Residents must not be required to sign a non-
 348 competition guarantee or restrictive covenant.
 349 (Core)
 350
 351 **II.A.4.a).(14)** document verification of program completion for all
 352 graduating residents within 30 days; (Core)
 353
 354 **II.A.4.a).(15)** provide verification of an individual resident’s
 355 completion upon the resident’s request, within 30
 356 days; and, (Core)
 357

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.

- 358
 359 **II.A.4.a).(16)** obtain review and approval of the Sponsoring
 360 Institution’s DIO before submitting information or
 361 requests to the ACGME, as required in the Institutional
 362 Requirements and outlined in the ACGME Program
 363 Director’s Guide to the Common Program
 364 Requirements. (Core)
 365

366 **II.B. Faculty**

367
 368 *Faculty members are a foundational element of graduate medical education*
 369 *– faculty members teach residents how to care for patients. Faculty*
 370 *members provide an important bridge allowing residents to grow and*
 371 *become practice-ready, ensuring that patients receive the highest quality of*
 372 *care. They are role models for future generations of physicians by*
 373 *demonstrating compassion, commitment to excellence in teaching and*
 374 *patient care, professionalism, and a dedication to lifelong learning. Faculty*
 375 *members experience the pride and joy of fostering the growth and*
 376 *development of future colleagues. The care they provide is enhanced by*
 377 *the opportunity to teach. By employing a scholarly approach to patient*
 378 *care, faculty members, through the graduate medical education system,*
 379 *improve the health of the individual and the population.*

380
 381 *Faculty members ensure that patients receive the level of care expected*
 382 *from a specialist in the field. They recognize and respond to the needs of*
 383 *the patients, residents, community, and institution. Faculty members*
 384 *provide appropriate levels of supervision to promote patient safety. Faculty*
 385 *members create an effective learning environment by acting in a*
 386 *professional manner and attending to the well-being of the residents and*
 387 *themselves.*
 388

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.

- 389
 390 **II.B.1.** **At each participating site, there must be a sufficient number of**
 391 **faculty members with competence to instruct and supervise all**
 392 **residents at that location.** ^(Core)
 393
 394 **II.B.1.a)** The members of the physician faculty must reflect sufficient
 395 diversity of interest and capability to represent the many facets of
 396 vascular surgery. ^(Detail)
 397
 398 **II.B.2.** **Faculty members must:**
 399
 400 **II.B.2.a)** **be role models of professionalism;** ^(Core)
 401
 402 **II.B.2.b)** **demonstrate commitment to the delivery of safe, quality,**
 403 **cost-effective, patient-centered care;** ^(Core)
 404

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

- 405
 406 **II.B.2.c)** **demonstrate a strong interest in the education of residents;**
 407 ^(Core)
 408
 409 **II.B.2.d)** **devote sufficient time to the educational program to fulfill**
 410 **their supervisory and teaching responsibilities;** ^(Core)
 411
 412 **II.B.2.e)** **administer and maintain an educational environment**
 413 **conducive to educating residents;** ^(Core)
 414
 415 **II.B.2.f)** **regularly participate in organized clinical discussions,**
 416 **rounds, journal clubs, and conferences; and,** ^(Core)
 417
 418 **II.B.2.g)** **pursue faculty development designed to enhance their skills**
 419 **at least annually;** ^(Core)
 420

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.

- 421
 422 **II.B.2.g).(1)** **as educators;** ^(Core)
 423
 424 **II.B.2.g).(2)** **in quality improvement and patient safety;** ^(Core)
 425
 426 **II.B.2.g).(3)** **in fostering their own and their residents' well-being;**
 427 **and,** ^(Core)

428
429 **II.B.2.g).(4)** in patient care based on their practice-based learning
430 and improvement efforts. ^(Core)
431

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.

432
433 **II.B.3. Faculty Qualifications**

434
435 **II.B.3.a) Faculty members must have appropriate qualifications in**
436 **their field and hold appropriate institutional appointments.**
437 ^(Core)

438
439 **II.B.3.b) Physician faculty members must:**

440
441 **II.B.3.b).(1) have current certification in the specialty by the**
442 **American Board of Surgery or the American**
443 **Osteopathic Board of Surgery, or possess**
444 **qualifications judged acceptable to the Review**
445 **Committee.** ^(Core)

446
447 **II.B.3.c) Any non-physician faculty members who participate in**
448 **residency program education must be approved by the**
449 **program director.** ^(Core)
450

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.

451
452 **II.B.4. Core Faculty**

453
454 **Core faculty members must have a significant role in the education**
455 **and supervision of residents and must devote a significant portion**
456 **of their entire effort to resident education and/or administration, and**
457 **must, as a component of their activities, teach, evaluate, and**
458 **provide formative feedback to residents.** ^(Core)
459

Background and Intent: Core faculty members are critical to the success of resident education. They support the program leadership in developing, implementing, and assessing curriculum, mentoring residents, and assessing residents’ progress toward achievement of competence in and the independent practice of the specialty. Core

faculty members should be selected for their broad knowledge of and involvement in the program, permitting them to effectively evaluate the program. Core faculty members may also be selected for their specific expertise and unique contribution to the program. Core faculty members are engaged in a broad range of activities, which may vary across programs and specialties. Core faculty members provide clinical teaching and supervision of residents, and also participate in non-clinical activities related to resident education and program administration. Examples of these non-clinical activities include, but are not limited to, interviewing and selecting resident applicants, providing didactic instruction, mentoring residents, simulation exercises, completing the annual ACGME Faculty Survey, and participating on the program's Clinical Competency Committee, Program Evaluation Committee, and other GME committees.

- 460
461 **II.B.4.a)** **Core faculty members must be designated by the program**
462 **director.** ^(Core)
463
464 **II.B.4.b)** **Core faculty members must complete the annual ACGME**
465 **Faculty Survey.** ^(Core)
466
467 **II.B.4.c)** In addition to the program director, there must be a minimum of
468 four board-certified vascular surgeons and one board-certified
469 general surgeon designated as core faculty members. ^(Core)
470
471 **II.B.4.d)** For programs with 10 or more approved residency positions, there
472 must be, in addition to the program director, a minimum of one
473 core faculty member for each approved position. ^(Core)
474
475 **II.B.4.d).(1)** The majority of those core faculty members must be board-
476 certified vascular surgeons. ^(Core)
477
478 **II.B.4.d).(2)** There must be a minimum of one board-certified general
479 surgeon designated as a core faculty member. ^(Core)
480

481 **II.C. Program Coordinator**

- 482
483 **II.C.1.** **There must be a program coordinator.** ^(Core)
484
485 **II.C.2.** **The program coordinator must be provided with dedicated time and**
486 **support adequate for administration of the program based upon its**
487 **size and configuration.** ^(Core)
488

- 489 **II.C.2.a)** Additional support must be provided based on program size as
490 follows: ^(Core)
491

Number of Approved Resident Positions	Minimum FTE Required
1-9	0.5
10 or more	1.0

492

493 II.C.2.b) A program with 20 or more residents must provide the program
494 coordinator with additional administrative support. ^(Core)
495

Specialty-Specific Background and Intent: Support for a single coordinator who has responsibility for both an integrated vascular surgery program and an independent vascular surgery program is addressed in II.C.2. of the Program Requirements for each of those program formats and is cumulative.

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

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

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

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

497
498 **II.D. Other Program Personnel**

499
500 The program, in partnership with its Sponsoring Institution, must jointly
501 ensure the availability of necessary personnel for the effective
502 administration of the program. ^(Core)
503

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.

504
505 **III. Resident Appointments**

506
507 **III.A. Eligibility Requirements**

508
509 **III.A.1. An applicant must meet one of the following qualifications to be**
510 **eligible for appointment to an ACGME-accredited program: ^(Core)**

- 511
512 **III.A.1.a)** graduation from a medical school in the United States or
513 Canada, accredited by the Liaison Committee on Medical
514 Education (LCME) or graduation from a college of
515 osteopathic medicine in the United States, accredited by the
516 American Osteopathic Association Commission on
517 Osteopathic College Accreditation (AOACOCA); or, ^(Core)
518
- 519 **III.A.1.b)** graduation from a medical school outside of the United
520 States or Canada, and meeting one of the following additional
521 qualifications: ^(Core)
522
- 523 **III.A.1.b).(1)** holding a currently valid certificate from the
524 Educational Commission for Foreign Medical
525 Graduates (ECFMG) prior to appointment; or, ^(Core)
526
- 527 **III.A.1.b).(2)** holding a full and unrestricted license to practice
528 medicine in the United States licensing jurisdiction in
529 which the ACGME-accredited program is located. ^(Core)
530
- 531 **III.A.2.** All prerequisite post-graduate clinical education required for initial
532 entry or transfer into ACGME-accredited residency programs must
533 be completed in ACGME-accredited residency programs, AOA-
534 approved residency programs, Royal College of Physicians and
535 Surgeons of Canada (RCPSC)-accredited or College of Family
536 Physicians of Canada (CFPC)-accredited residency programs
537 located in Canada, or in residency programs with ACGME
538 International (ACGME-I) Advanced Specialty Accreditation. ^(Core)
539
- 540 **III.A.2.a)** Residency programs must receive verification of each
541 resident's level of competency in the required clinical field
542 using ACGME, CanMEDS, or ACGME-I Milestones evaluations
543 from the prior training program upon matriculation. ^(Core)
544
- 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.**
- 545
- 546 **III.A.3.** A physician who has completed a residency program that was not
547 accredited by ACGME, AOA, RCPSC, CFPC, or ACGME-I (with
548 Advanced Specialty Accreditation) may enter an ACGME-accredited
549 residency program in the same specialty at the PGY-1 level and, at
550 the discretion of the program director of the ACGME-accredited
551 program and with approval by the GMC, may be advanced to the
552 PGY-2 level based on ACGME Milestones evaluations at the ACGME-
553 accredited program. This provision applies only to entry into
554 residency in those specialties for which an initial clinical year is not
555 required for entry. ^(Core)

- 556
557 **III.B. The program director must not appoint more residents than approved by**
558 **the Review Committee. (Core)**
559
- 560 **III.B.1. All complement increases must be approved by the Review**
561 **Committee. (Core)**
562
- 563 **III.C. Resident Transfers**
- 564
565 **The program must obtain verification of previous educational experiences**
566 **and a summative competency-based performance evaluation prior to**
567 **acceptance of a transferring resident, and Milestones evaluations upon**
568 **matriculation. (Core)**
569
- 570 **III.C.1. Resident transfers into an integrated vascular surgery program must be**
571 **approved in advance by the Review Committee. (Core)**
572
- 573 **III.C.2. To be eligible for transfer at the PGY-2 level, residents must have**
574 **satisfactorily completed a minimum of one year in an ACGME-accredited**
575 **program in surgery, integrated vascular surgery, or integrated thoracic**
576 **surgery. (Core)**
577
- 578 **III.C.3. To be eligible for transfer at the PGY-3 level, residents must have**
579 **satisfactorily completed a minimum of two years in an ACGME-accredited**
580 **integrated vascular surgery program, or a combination of a minimum of**
581 **one year in an ACGME-accredited program in surgery or integrated**
582 **thoracic surgery and a minimum of one year in an ACGME-accredited**
583 **integrated vascular surgery program. (Core)**
584
- 585 **III.C.4. To be eligible for transfer at the PGY-4 level, residents must have**
586 **satisfactorily completed a minimum of three years in an ACGME-**
587 **accredited integrated vascular surgery program, or a combination of a**
588 **minimum of one year in an ACGME-accredited program in surgery or**
589 **integrated thoracic surgery and a minimum of two years in an ACGME-**
590 **accredited Integrated Vascular Surgery program. (Core)**
591
- 592 **IV. Educational Program**
593
- 594 ***The ACGME accreditation system is designed to encourage excellence and***
595 ***innovation in graduate medical education regardless of the organizational***
596 ***affiliation, size, or location of the program.***
597
- 598 ***The educational program must support the development of knowledgeable, skillful***
599 ***physicians who provide compassionate care.***
600
- 601 ***In addition, the program is expected to define its specific program aims consistent***
602 ***with the overall mission of its Sponsoring Institution, the needs of the community***
603 ***it serves and that its graduates will serve, and the distinctive capabilities of***
604 ***physicians it intends to graduate. While programs must demonstrate substantial***
605 ***compliance with the Common and specialty-specific Program Requirements, it is***
606 ***recognized that within this framework, programs may place different emphasis on***

607 *research, leadership, public health, etc. It is expected that the program aims will*
608 *reflect the nuanced program-specific goals for it and its graduates; for example, it*
609 *is expected that a program aiming to prepare physician-scientists will have a*
610 *different curriculum from one focusing on community health.*

611
612 **IV.A. The curriculum must contain the following educational components:** ^(Core)

613
614 **IV.A.1. a set of program aims consistent with the Sponsoring Institution's**
615 **mission, the needs of the community it serves, and the desired**
616 **distinctive capabilities of its graduates;** ^(Core)

617
618 **IV.A.1.a) The program's aims must be made available to program**
619 **applicants, residents, and faculty members.** ^(Core)

620
621 **IV.A.2. competency-based goals and objectives for each educational**
622 **experience designed to promote progress on a trajectory to**
623 **autonomous practice. These must be distributed, reviewed, and**
624 **available to residents and faculty members;** ^(Core)
625

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.

626
627 **IV.A.3. delineation of resident responsibilities for patient care, progressive**
628 **responsibility for patient management, and graded supervision;** ^(Core)
629

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.

630
631 **IV.A.4. a broad range of structured didactic activities;** ^(Core)

632
633 **IV.A.4.a) Residents must be provided with protected time to participate**
634 **in core didactic activities.** ^(Core)
635

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.

- 636
637 **IV.A.5.** advancement of residents' knowledge of ethical principles
638 foundational to medical professionalism; and, ^(Core)
639
640 **IV.A.6.** advancement in the residents' knowledge of the basic principles of
641 scientific inquiry, including how research is designed, conducted,
642 evaluated, explained to patients, and applied to patient care. ^(Core)
643
644 **IV.B.** **ACGME Competencies**
645

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.

- 646
647 **IV.B.1.** The program must integrate the following ACGME Competencies
648 into the curriculum: ^(Core)
649
650 **IV.B.1.a)** **Professionalism**
651
652 Residents must demonstrate a commitment to
653 professionalism and an adherence to ethical principles. ^(Core)
654
655 **IV.B.1.a).(1)** Residents must demonstrate competence in:
656
657 **IV.B.1.a).(1).(a)** compassion, integrity, and respect for others;
658 ^(Core)
659
660 **IV.B.1.a).(1).(b)** responsiveness to patient needs that
661 supersedes self-interest; ^(Core)
662

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.

- 663
664 **IV.B.1.a).(1).(c)** respect for patient privacy and autonomy; ^(Core)
665
666 **IV.B.1.a).(1).(d)** accountability to patients, society, and the
667 profession; ^(Core)
668
669 **IV.B.1.a).(1).(e)** respect and responsiveness to diverse patient
670 populations, including but not limited to
671 diversity in gender, age, culture, race, religion,
672 disabilities, national origin, socioeconomic
673 status, and sexual orientation; ^(Core)
674

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

678
679 IV.B.1.a).(1).(g) appropriately disclosing and addressing
680 conflict or duality of interest. (Core)

681
682 IV.B.1.b) Patient Care and Procedural Skills
683

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.

684
685 IV.B.1.b).(1) Residents must be able to provide patient care that is
686 compassionate, appropriate, and effective for the
687 treatment of health problems and the promotion of
688 health. (Core)

689
690 IV.B.1.b).(1).(a) Residents must demonstrate manual dexterity
691 appropriate for their educational levels. (Core)

692
693 IV.B.1.b).(1).(b) Residents must develop and execute patient care
694 plans appropriate for their educational levels. (Core)

695
696 IV.B.1.b).(2) Residents must be able to perform all medical,
697 diagnostic, and surgical procedures considered
698 essential for the area of practice. (Core)

699
700 IV.B.1.b).(2).(a) Residents must develop competence in performing
701 operative procedures in the following list of defined
702 categories:

703
704 IV.B.1.b).(2).(a).(i) open abdominal; (Core)

705
706 IV.B.1.b).(2).(a).(i).(a) aortic; (Core)

707
708 IV.B.1.b).(2).(a).(ii) open cerebrovascular; (Core)

709
710 IV.B.1.b).(2).(a).(iii) open peripheral; (Core)

711
712 IV.B.1.b).(2).(a).(iv) complex; (Core)

713		
714	IV.B.1.b).(2).(a).(v)	endovascular aneurysm repair; <small>(Core)</small>
715		
716	IV.B.1.b).(2).(a).(vi)	endovascular diagnostic; <small>(Core)</small>
717		
718	IV.B.1.b).(2).(a).(vii)	endovascular therapeutic; and, <small>(Core)</small>
719		
720	IV.B.1.b).(2).(a).(viii)	peripheral. <small>(Core)</small>
721		
722	IV.B.1.b).(2).(a).(ix)	<u>endovascular, including:</u> <small>(Core)</small>
723		
724	IV.B.1.b).(2).(a).(ix).(a)	<u>aortoiliac;</u> <small>(Core)</small>
725		
726	IV.B.1.b).(2).(a).(ix).(b)	<u>peripheral; and,</u> <small>(Core)</small>
727		
728	IV.B.1.b).(2).(a).(ix).(c)	<u>thoracic.</u> <small>(Core)</small>
729		
730	IV.B.1.b).(2).(a).(x)	<u>venous;</u> <small>(Core)</small>
731		
732	IV.B.1.b).(2).(a).(xi)	<u>open dialysis access; and,</u> <small>(Core)</small>
733		
734	IV.B.1.b).(2).(a).(xii)	<u>other major.</u> <small>(Core)</small>
735		
736	IV.B.1.b).(2).(a).(xii).(a)	<u>amputation.</u> <small>(Core)</small>
737		
738	IV.B.1.b).(2).(b)	Residents must develop competence in patient management, including determining an appropriate diagnosis and operative plan, providing pre-operative care, and directing post-operative care.
739		<small>(Core)</small>
740		
741		
742		
743		
744	IV.B.1.b).(2).(c)	Residents must develop competence in assessing the vascular portion of angiography, computed tomography (CT) scanning, magnetic resonance imaging (MRI), and magnetic resonance angiogram (MRA) images. <small>(Core)</small>
745		
746		
747		
748		
749		
750	IV.B.1.b).(2).(d)	Residents must demonstrate the ability to accurately interpret non-invasive vascular laboratory studies. <small>(Core)</small>
751		
752		
753		
754	IV.B.1.b).(2).(d).(i)	This experience must include the range and number of non-invasive studies that would allow graduates to fulfill the requirements of eligibility for specialty board certification.
755		<small>(Core)</small>
756		
757		
758		
759		
760	IV.B.1.c)	Medical Knowledge
761		
762		Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-
763		

- 764 **behavioral sciences, as well as the application of this**
 765 **knowledge to patient care.** (Core)
 766
 767 IV.B.1.c).(1) Residents must demonstrate knowledge of anatomy,
 768 biology, embryology, microbiology, physiology, and
 769 pathology as they relate to the pathophysiology, diagnosis,
 770 and treatment of vascular lesions. (Core)
 771
 772 IV.B.1.c).(2) Residents must demonstrate knowledge of the methods
 773 and techniques of angiography, CT scanning, MRI, MRA,
 774 and other vascular imaging modalities. (Core)
 775
 776 IV.B.1.c).(3) Residents must demonstrate knowledge of the roles of
 777 different specialists and other health care professionals in
 778 overall patient management. (Core)
 779

780 **IV.B.1.d)**

Practice-based Learning and Improvement

781
 782 **Residents must demonstrate the ability to investigate and**
 783 **evaluate their care of patients, to appraise and assimilate**
 784 **scientific evidence, and to continuously improve patient care**
 785 **based on constant self-evaluation and lifelong learning.** (Core)
 786

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.

- 787
 788 IV.B.1.d).(1) **Residents must demonstrate competence in:**
 789
 790 IV.B.1.d).(1).(a) **identifying strengths, deficiencies, and limits in**
 791 **one’s knowledge and expertise;** (Core)
 792
 793 IV.B.1.d).(1).(b) **setting learning and improvement goals;** (Core)
 794
 795 IV.B.1.d).(1).(c) **identifying and performing appropriate learning**
 796 **activities;** (Core)
 797
 798 IV.B.1.d).(1).(d) **systematically analyzing practice using quality**
 799 **improvement methods, and implementing**
 800 **changes with the goal of practice improvement;**
 801 (Core)
 802
 803 IV.B.1.d).(1).(e) **incorporating feedback and formative**
 804 **evaluation into daily practice;** (Core)
 805

806	IV.B.1.d).(1).(f)	locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems; and, ^(Core)
807		
808		
809		
810	IV.B.1.d).(1).(g)	using information technology to optimize learning. ^(Core)
811		
812		
813	IV.B.1.e)	Interpersonal and Communication Skills
814		
815		Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. ^(Core)
816		
817		
818		
819		
820	IV.B.1.e).(1)	Residents must demonstrate competence in:
821		
822	IV.B.1.e).(1).(a)	communicating effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; ^(Core)
823		
824		
825		
826		
827	IV.B.1.e).(1).(b)	communicating effectively with physicians, other health professionals, and health-related agencies; ^(Core)
828		
829		
830		
831	IV.B.1.e).(1).(c)	working effectively as a member or leader of a health care team or other professional group; ^(Core)
832		
833		
834		
835	IV.B.1.e).(1).(d)	educating patients, families, students, residents, and other health professionals; ^(Core)
836		
837		
838	IV.B.1.e).(1).(e)	acting in a consultative role to other physicians and health professionals; and, ^(Core)
839		
840		
841	IV.B.1.e).(1).(f)	maintaining comprehensive, timely, and legible medical records, if applicable. ^(Core)
842		
843		
844	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)
845		
846		
847		
848		

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

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

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

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. ^(Core)

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

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

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

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

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

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

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

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

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

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

889 **IV.B.1.f).(2)** Residents must learn to advocate for patients within
890 the health care system to achieve the patient's and
891 family's care goals, including, when appropriate, end-
892 of-life goals. ^(Core)
893

894 **IV.C. Curriculum Organization and Resident Experiences**
895

896 **IV.C.1. The curriculum must be structured to optimize resident educational**
897 **experiences, the length of these experiences, and supervisory**
898 **continuity.** ^(Core)
899

900 IV.C.1.a) Residents' clinical rotations must be a minimum of four weeks in
901 duration. ^(Core)
902

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.

903
904 **IV.C.2. The program must provide instruction and experience in pain**
905 **management if applicable for the specialty, including recognition of**
906 **the signs of addiction.** ^(Core)
907

908 IV.C.3. The following conferences must exist:
909

910 IV.C.3.a) a review, held at least biweekly, of all current complications and
911 deaths, including radiological and pathological correlation of
912 surgical specimens and autopsies when relevant; ^(Detail)
913

914 IV.C.3.b) a course or a structured series of conferences to ensure coverage
915 of the basic and clinical sciences fundamental to vascular surgery,
916 as well as the technological advances that relate to vascular
917 surgery and the care of patients with vascular diseases; ^(Detail)
918

919 IV.C.3.c) regular organized clinical teaching; and, ^(Detail)
920

921 IV.C.3.d) a regular review of recent literature in a journal club format. ^(Detail)
922

923 IV.C.4. Residents must actively participate in the planning and presentation of
924 required conferences. ^(Core)
925

926 IV.C.4.a) Each resident must attend at least 75 percent of all required
927 conferences. ^(Detail)
928

929 IV.C.4.b) At least 50 percent of the core faculty, in aggregate, must attend
930 program conferences. ^(Detail)
931

932 IV.C.5. The curriculum for each resident must include:
933

934	IV.C.5.a)	18 months of core surgical education experience, which may include: general surgery, cardiac surgery, thoracic surgery, congenital cardiac surgery, cardiothoracic surgery, critical care, urology, gynecology, neurological surgery, plastic surgery, burn surgery, trauma, surgical critical care, pediatric surgery, abdominal and alimentary tract surgery, basic and advanced laparoscopic skills, head and neck and endocrine surgery, surgical oncology, and transplantation; ^(Core)
935		
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943	IV.C.5.a).(1)	This experience must include: documented educational experiences in core surgical education, including pre- and post-operative evaluation and care; critical care and trauma management; and basic technical experience in skin and soft tissue, abdomen and alimentary track, airway management, laparoscopic surgery, and thoracic surgery. ^(Core)
944		
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951	IV.C.5.b)	30 months of documented educational experiences concentrated in vascular surgery; and, ^(Core)
952		
953		
954	IV.C.5.c)	12 months of documented educational experiences that may be a combination of: ^(Core)
955		
956		
957	IV.C.5.c).(1)	a maximum of six months of vascular surgery-related rotations (e.g., “vascular medicine” cardiology, interventional radiology); ^(Core)
958		
959		
960		
961	IV.C.5.c).(2)	a maximum of six months in additional core surgery rotations; ^(Core)
962		
963		
964	IV.C.5.c).(3)	a maximum of 12 months of vascular surgery rotations; and, ^(Core)
965		
966		
967	IV.C.5.c).(4)	a maximum of six months of dedicated research experience. ^(Core)
968		
969		
970	IV.C.6.	The final two years of residency education (i.e., PGY-4 and PGY-5) must occur in the same program. ^(Core)
971		
972		
973	IV.C.7.	Residents must perform a minimum of 500 operations, to include 250 major vascular reconstructive procedures. ^(Core)
974		
975		
976	IV.C.7.a)	Operative experience in excess of 1500 total cases must be justified by the program director. ^(Core)
977		
978		
979	IV.C.8.	The curriculum for each resident must include a final year with chief resident responsibility on the vascular surgery service at the primary clinical site or at a participating site. ^(Core)
980		
981		
982		
983	IV.C.8.a)	A vascular surgery fellow and a chief resident in an integrated vascular surgery program may function together on the same
984		

985		service but must not have primary responsibility for the same
986		patients. ^(Core)
987		
988	IV.C.8.b)	A senior resident in an integrated vascular surgery program and a
989		chief resident in a general surgery residency program may
990		function together on the same service but must not have primary
991		responsibility for the same patients. ^(Core)
992		
993	IV.C.9.	Resident experiences must include:
994		
995	IV.C.9.a)	primary responsibility for continuity of patient care, including
996		ambulatory care, inpatient care, referral and consultation, and
997		utilization of community resources; ^(Core)
998		
999	IV.C.9.b)	progressive senior surgical responsibilities in the total care of
1000		vascular surgery patients, including pre-operative evaluation,
1001		therapeutic decision-making, operative experience, and post-
1002		operative management; ^(Core)
1003		
1004	IV.C.9.c)	participation in providing consultation with faculty member
1005		supervision. ^(Core)
1006		
1007	IV.C.9.c).(1)	Residents should have clearly defined educational
1008		responsibilities for other residents, medical students, and
1009		professional personnel. ^(Detail)
1010		
1011	IV.C.9.c).(1).(a)	Teaching by vascular surgery residents should
1012		include correlation of basic biomedical knowledge
1013		with the clinical aspects of vascular surgery. ^(Detail)
1014		
1015	IV.C.9.d)	experience in the application, assessment, and limitations of non-
1016		invasive vascular diagnostic techniques; and, ^(Core)
1017		
1018	IV.C.9.d).(1)	The program must provide didactic and clinical training in
1019		non-invasive vascular diagnostic testing and interpretation.
1020		^(Detail)
1021		
1022	IV.C.9.d).(2)	Such education must not be achieved solely through
1023		attendance at off-site review or test preparation courses.
1024		^(Detail)
1025		
1026	IV.C.9.e)	experience with outpatient activities. ^(Detail)
1027		
1028	IV.C.9.e).(1)	Residents must devote an average of at least one half-day
1029		per week to outpatient activities. ^(Core)
1030		
1031	IV.C.10.	When justified by experience, senior residents should serve as teaching
1032		assistants to more junior residents in vascular or general surgery. ^(Detail)
1033		
1034	IV.D.	Scholarship
1035		

1036 *Medicine is both an art and a science. The physician is a humanistic*
1037 *scientist who cares for patients. This requires the ability to think critically,*
1038 *evaluate the literature, appropriately assimilate new knowledge, and*
1039 *practice lifelong learning. The program and faculty must create an*
1040 *environment that fosters the acquisition of such skills through resident*
1041 *participation in scholarly activities. Scholarly activities may include*
1042 *discovery, integration, application, and teaching.*

1043
1044 *The ACGME recognizes the diversity of residencies and anticipates that*
1045 *programs prepare physicians for a variety of roles, including clinicians,*
1046 *scientists, and educators. It is expected that the program's scholarship will*
1047 *reflect its mission(s) and aims, and the needs of the community it serves.*
1048 *For example, some programs may concentrate their scholarly activity on*
1049 *quality improvement, population health, and/or teaching, while other*
1050 *programs might choose to utilize more classic forms of biomedical*
1051 *research as the focus for scholarship.*

1052
1053 **IV.D.1. Program Responsibilities**

1054
1055 **IV.D.1.a) The program must demonstrate evidence of scholarly**
1056 **activities consistent with its mission(s) and aims. ^(Core)**

1057
1058 **IV.D.1.b) The program, in partnership with its Sponsoring Institution,**
1059 **must allocate adequate resources to facilitate resident and**
1060 **faculty involvement in scholarly activities. ^(Core)**

1061
1062 **IV.D.1.c) The program must advance residents' knowledge and**
1063 **practice of the scholarly approach to evidence-based patient**
1064 **care. ^(Core)**

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

Elements of a scholarly approach to patient care include:

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

The scholarly approach to patient care begins with curiosity, is grounded in the principles of evidence-based medicine, expands the knowledge base through

dissemination, and develops the habits of lifelong learning by encouraging residents to be scholarly teachers.

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IV.D.2. Faculty Scholarly Activity

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

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

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

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

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

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

IV.D.3. Resident Scholarly Activity

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

- 1105
 1106 IV.D.3.a).(1) Residents must have instruction in critical thinking, design
 1107 of experiments, and evaluation of data. ^(Detail)
 1108
 1109 IV.D.3.a).(2) Residents should participate in clinical and/or laboratory
 1110 research. ^(Detail)
 1111

1112 **V. Evaluation**

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 1114 **V.A. Resident Evaluation**

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 1116 **V.A.1. Feedback and Evaluation**
 1117

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.

- 1118
 1119 **V.A.1.a) Faculty members must directly observe, evaluate, and**
 1120 **frequently provide feedback on resident performance during**
 1121 **each rotation or similar educational assignment. ^(Core)**
 1122

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.

- 1123
- 1124 **V.A.1.b)** **Evaluation must be documented at the completion of the**
- 1125 **assignment.** ^(Core)
- 1126
- 1127 **V.A.1.b).(1)** **For block rotations of greater than three months in**
- 1128 **duration, evaluation must be documented at least**
- 1129 **every three months.** ^(Core)
- 1130
- 1131 **V.A.1.b).(2)** **Longitudinal experiences, such as continuity clinic in**
- 1132 **the context of other clinical responsibilities, must be**
- 1133 **evaluated at least every three months and at**
- 1134 **completion.** ^(Core)
- 1135
- 1136 **V.A.1.c)** **The program must provide an objective performance**
- 1137 **evaluation based on the Competencies and the specialty-**
- 1138 **specific Milestones, and must:** ^(Core)
- 1139
- 1140 **V.A.1.c).(1)** **use multiple evaluators (e.g., faculty members, peers,**
- 1141 **patients, self, and other professional staff members);**
- 1142 **and,** ^(Core)
- 1143
- 1144 **V.A.1.c).(2)** **provide that information to the Clinical Competency**
- 1145 **Committee for its synthesis of progressive resident**
- 1146 **performance and improvement toward unsupervised**
- 1147 **practice.** ^(Core)
- 1148
- 1149 **V.A.1.d)** **The program director or their designee, with input from the**
- 1150 **Clinical Competency Committee, must:**
- 1151
- 1152 **V.A.1.d).(1)** **meet with and review with each resident their**
- 1153 **documented semi-annual evaluation of performance,**
- 1154 **including progress along the specialty-specific**
- 1155 **Milestones;** ^(Core)
- 1156
- 1157 **V.A.1.d).(1).(a)** **The semi-annual assessment must include a**
- 1158 **review of each resident's operative experience to**
- 1159 **ensure breadth and balance of experience in the**
- 1160 **surgical care of vascular diseases.** ^(Core)
- 1161
- 1162 **V.A.1.d).(1).(a).(i)** **The program director must ensure that the**
- 1163 **operative experience of individual residents**
- 1164 **in the same program is comparable.** ^(Detail)
- 1165
- 1166 **V.A.1.d).(2)** **assist residents in developing individualized learning**
- 1167 **plans to capitalize on their strengths and identify areas**
- 1168 **for growth; and,** ^(Core)
- 1169
- 1170 **V.A.1.d).(3)** **develop plans for residents failing to progress,**
- 1171 **following institutional policies and procedures.** ^(Core)

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

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

- 1173
1174 **V.A.1.e)** At least annually, there must be a summative evaluation of
1175 each resident that includes their readiness to progress to the
1176 next year of the program, if applicable. ^(Core)
1177
- 1178 **V.A.1.f)** The evaluations of a resident's performance must be
1179 accessible for review by the resident. ^(Core)
1180
- 1181 **V.A.2.** Final Evaluation
- 1182
- 1183 **V.A.2.a)** The program director must provide a final evaluation for each
1184 resident upon completion of the program. ^(Core)
1185
- 1186 **V.A.2.a).(1)** The specialty-specific Milestones, and when applicable
1187 the specialty-specific Case Logs, must be used as
1188 tools to ensure residents are able to engage in
1189 autonomous practice upon completion of the program.
1190 ^(Core)
1191
- 1192 **V.A.2.a).(2)** The final evaluation must:
- 1193
- 1194 **V.A.2.a).(2).(a)** become part of the resident's permanent record
1195 maintained by the institution, and must be
1196 accessible for review by the resident in
1197 accordance with institutional policy; ^(Core)
1198
- 1199 **V.A.2.a).(2).(b)** verify that the resident has demonstrated the
1200 knowledge, skills, and behaviors necessary to
1201 enter autonomous practice; ^(Core)
1202
- 1203 **V.A.2.a).(2).(c)** consider recommendations from the Clinical
1204 Competency Committee; and, ^(Core)
1205

- 1206 **V.A.2.a).(2).(d)** be shared with the resident upon completion of
 1207 the program. ^(Core)
 1208
 1209 **V.A.3.** **A Clinical Competency Committee must be appointed by the**
 1210 **program director.** ^(Core)
 1211
 1212 **V.A.3.a)** **At a minimum, the Clinical Competency Committee must**
 1213 **include three members of the program faculty, at least one of**
 1214 **whom is a core faculty member.** ^(Core)
 1215
 1216 **V.A.3.a).(1)** **Additional members must be faculty members from**
 1217 **the same program or other programs, or other health**
 1218 **professionals who have extensive contact and**
 1219 **experience with the program’s residents.** ^(Core)
 1220

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.

- 1221
 1222 **V.A.3.b)** **The Clinical Competency Committee must:**
 1223
 1224 **V.A.3.b).(1)** **review all resident evaluations at least semi-annually;**
 1225 ^(Core)
 1226
 1227 **V.A.3.b).(2)** **determine each resident’s progress on achievement of**
 1228 **the specialty-specific Milestones; and,** ^(Core)
 1229
 1230 **V.A.3.b).(3)** **meet prior to the residents’ semi-annual evaluations**
 1231 **and advise the program director regarding each**
 1232 **resident’s progress.** ^(Core)
 1233
 1234 **V.B.** **Faculty Evaluation**
 1235
 1236 **V.B.1.** **The program must have a process to evaluate each faculty**
 1237 **member’s performance as it relates to the educational program at**
 1238 **least annually.** ^(Core)
 1239

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.

- 1240
1241 **V.B.1.a)** This evaluation must include a review of the faculty member's
1242 clinical teaching abilities, engagement with the educational
1243 program, participation in faculty development related to their
1244 skills as an educator, clinical performance, professionalism,
1245 and scholarly activities. (Core)
1246
1247 **V.B.1.b)** This evaluation must include written, anonymous, and
1248 confidential evaluations by the residents. (Core)
1249
1250 **V.B.2.** Faculty members must receive feedback on their evaluations at least
1251 annually. (Core)
1252
1253 **V.B.3.** Results of the faculty educational evaluations should be
1254 incorporated into program-wide faculty development plans. (Core)
1255

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.

- 1256
1257 **V.C. Program Evaluation and Improvement**
1258
1259 **V.C.1.** The program director must appoint the Program Evaluation
1260 Committee to conduct and document the Annual Program
1261 Evaluation as part of the program's continuous improvement
1262 process. (Core)
1263
1264 **V.C.1.a)** The Program Evaluation Committee must be composed of at
1265 least two program faculty members, at least one of whom is a
1266 core faculty member, and at least one resident. (Core)
1267

- 1268 **V.C.1.b) Program Evaluation Committee responsibilities must include:**
 1269
 1270 **V.C.1.b).(1) acting as an advisor to the program director, through**
 1271 **program oversight;** ^(Core)
 1272
 1273 **V.C.1.b).(2) review of the program’s self-determined goals and**
 1274 **progress toward meeting them;** ^(Core)
 1275
 1276 **V.C.1.b).(3) guiding ongoing program improvement, including**
 1277 **development of new goals, based upon outcomes;**
 1278 **and,** ^(Core)
 1279
 1280 **V.C.1.b).(4) review of the current operating environment to identify**
 1281 **strengths, challenges, opportunities, and threats as**
 1282 **related to the program’s mission and aims.** ^(Core)
 1283

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.

- 1284
 1285 **V.C.1.c) The Program Evaluation Committee should consider the**
 1286 **following elements in its assessment of the program:**
 1287
 1288 **V.C.1.c).(1) curriculum;** ^(Core)
 1289
 1290 **V.C.1.c).(2) outcomes from prior Annual Program Evaluation(s);**
 1291 ^(Core)
 1292
 1293 **V.C.1.c).(3) ACGME letters of notification, including citations,**
 1294 **Areas for Improvement, and comments;** ^(Core)
 1295
 1296 **V.C.1.c).(4) quality and safety of patient care;** ^(Core)
 1297
 1298 **V.C.1.c).(5) aggregate resident and faculty:**
 1299
 1300 **V.C.1.c).(5).(a) well-being;** ^(Core)
 1301
 1302 **V.C.1.c).(5).(b) recruitment and retention;** ^(Core)
 1303
 1304 **V.C.1.c).(5).(c) workforce diversity;** ^(Core)
 1305
 1306 **V.C.1.c).(5).(d) engagement in quality improvement and patient**
 1307 **safety;** ^(Core)
 1308
 1309 **V.C.1.c).(5).(e) scholarly activity;** ^(Core)
 1310
 1311 **V.C.1.c).(5).(f) ACGME Resident and Faculty Surveys; and,**
 1312 ^(Core)

- 1313
- 1314 **V.C.1.c).(5).(g)** written evaluations of the program. ^(Core)
- 1315
- 1316 **V.C.1.c).(6)** aggregate resident:
- 1317
- 1318 **V.C.1.c).(6).(a)** achievement of the Milestones; ^(Core)
- 1319
- 1320 **V.C.1.c).(6).(b)** in-training examinations (where applicable);
- 1321 ^(Core)
- 1322
- 1323 **V.C.1.c).(6).(c)** board pass and certification rates; and, ^(Core)
- 1324
- 1325 **V.C.1.c).(6).(d)** graduate performance. ^(Core)
- 1326
- 1327 **V.C.1.c).(7)** aggregate faculty:
- 1328
- 1329 **V.C.1.c).(7).(a)** evaluation; and, ^(Core)
- 1330
- 1331 **V.C.1.c).(7).(b)** professional development. ^(Core)
- 1332
- 1333 **V.C.1.d)** The Program Evaluation Committee must evaluate the
- 1334 program's mission and aims, strengths, areas for
- 1335 improvement, and threats. ^(Core)
- 1336
- 1337 **V.C.1.e)** The annual review, including the action plan, must:
- 1338
- 1339 **V.C.1.e).(1)** be distributed to and discussed with the members of
- 1340 the teaching faculty and the residents; and, ^(Core)
- 1341
- 1342 **V.C.1.e).(2)** be submitted to the DIO. ^(Core)
- 1343
- 1344 **V.C.2.** The program must complete a Self-Study prior to its 10-Year
- 1345 Accreditation Site Visit. ^(Core)
- 1346
- 1347 **V.C.2.a)** A summary of the Self-Study must be submitted to the DIO.
- 1348 ^(Core)
- 1349

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.

1350

- 1351 **V.C.3.** *One goal of ACGME-accredited education is to educate physicians*
 1352 *who seek and achieve board certification. One measure of the*
 1353 *effectiveness of the educational program is the ultimate pass rate.*
 1354
 1355 *The program director should encourage all eligible program*
 1356 *graduates to take the certifying examination offered by the*
 1357 *applicable American Board of Medical Specialties (ABMS) member*
 1358 *board or American Osteopathic Association (AOA) certifying board.*
 1359
- 1360 **V.C.3.a)** For specialties in which the ABMS member board and/or AOA
 1361 certifying board offer(s) an annual written exam, in the
 1362 preceding three years, the program’s aggregate pass rate of
 1363 those taking the examination for the first time must be higher
 1364 than the bottom fifth percentile of programs in that specialty.
 1365 (Outcome)
 1366
- 1367 **V.C.3.b)** For specialties in which the ABMS member board and/or AOA
 1368 certifying board offer(s) a biennial written exam, in the
 1369 preceding six years, the program’s aggregate pass rate of
 1370 those taking the examination for the first time must be higher
 1371 than the bottom fifth percentile of programs in that specialty.
 1372 (Outcome)
 1373
- 1374 **V.C.3.c)** For specialties in which the ABMS member board and/or AOA
 1375 certifying board offer(s) an annual oral exam, in the preceding
 1376 three years, the program’s aggregate pass rate of those
 1377 taking the examination for the first time must be higher than
 1378 the bottom fifth percentile of programs in that specialty.
 1379 (Outcome)
 1380
- 1381 **V.C.3.d)** For specialties in which the ABMS member board and/or AOA
 1382 certifying board offer(s) a biennial oral exam, in the preceding
 1383 six years, the program’s aggregate pass rate of those taking
 1384 the examination for the first time must be higher than the
 1385 bottom fifth percentile of programs in that specialty. (Outcome)
 1386
- 1387 **V.C.3.e)** For each of the exams referenced in V.C.3.a)-d), any program
 1388 whose graduates over the time period specified in the
 1389 requirement have achieved an 80 percent pass rate will have
 1390 met this requirement, no matter the percentile rank of the
 1391 program for pass rate in that specialty. (Outcome)
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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

A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and

attitudes of its personnel toward safety in order to identify areas for improvement.

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

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

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

The program must have a structure that promotes safe, interprofessional, team-based care. (Core)

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

Education on Patient Safety

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

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

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

Patient Safety Events

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

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

Residents, fellows, faculty members, and other clinical staff members must:

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

know their responsibilities in reporting patient safety events at the clinical site;
(Core)

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

know how to report patient safety events, including near misses, at the clinical site; and, (Core)

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

be provided with summary information of their institution's patient safety reports. (Core)

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

Residents must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause

1502		analyses or other activities that include
1503		analysis, as well as formulation and
1504		implementation of actions. ^(Core)
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1506	VI.A.1.a).(4)	Resident Education and Experience in Disclosure of
1507		Adverse Events
1508		
1509		<i>Patient-centered care requires patients, and when</i>
1510		<i>appropriate families, to be apprised of clinical</i>
1511		<i>situations that affect them, including adverse events.</i>
1512		<i>This is an important skill for faculty physicians to</i>
1513		<i>model, and for residents to develop and apply.</i>
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1515	VI.A.1.a).(4).(a)	All residents must receive training in how to
1516		disclose adverse events to patients and
1517		families. ^(Core)
1518		
1519	VI.A.1.a).(4).(b)	Residents should have the opportunity to
1520		participate in the disclosure of patient safety
1521		events, real or simulated. ^{(Detail)†}
1522		
1523	VI.A.1.b)	Quality Improvement
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1525	VI.A.1.b).(1)	Education in Quality Improvement
1526		
1527		<i>A cohesive model of health care includes quality-</i>
1528		<i>related goals, tools, and techniques that are necessary</i>
1529		<i>in order for health care professionals to achieve</i>
1530		<i>quality improvement goals.</i>
1531		
1532	VI.A.1.b).(1).(a)	Residents must receive training and experience
1533		in quality improvement processes, including an
1534		understanding of health care disparities. ^(Core)
1535		
1536	VI.A.1.b).(2)	Quality Metrics
1537		
1538		<i>Access to data is essential to prioritizing activities for</i>
1539		<i>care improvement and evaluating success of</i>
1540		<i>improvement efforts.</i>
1541		
1542	VI.A.1.b).(2).(a)	Residents and faculty members must receive
1543		data on quality metrics and benchmarks related
1544		to their patient populations. ^(Core)
1545		
1546	VI.A.1.b).(3)	Engagement in Quality Improvement Activities
1547		
1548		<i>Experiential learning is essential to developing the</i>
1549		<i>ability to identify and institute sustainable systems-</i>
1550		<i>based changes to improve patient care.</i>
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1552	VI.A.1.b).(3).(a)	Residents must have the opportunity to participate in interprofessional quality improvement activities. ^(Core)
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1556	VI.A.1.b).(3).(a).(i)	This should include activities aimed at reducing health care disparities. ^(Detail)
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1559	VI.A.2.	Supervision and Accountability
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1561	VI.A.2.a)	<i>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.</i>
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1570		<i>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.</i>
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1576	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)
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1583	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)
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1587	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)
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1592	VI.A.2.b)	<i>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.</i>
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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.

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 1604 **VI.A.2.b).(1)** **The program must demonstrate that the appropriate**
 1605 **level of supervision in place for all residents is based**
 1606 **on each resident’s level of training and ability, as well**
 1607 **as patient complexity and acuity. Supervision may be**
 1608 **exercised through a variety of methods, as appropriate**
 1609 **to the situation.** ^(Core)
 1610
 1611 **VI.A.2.b).(2)** **The program must define when physical presence of a**
 1612 **supervising physician is required.** ^(Core)
 1613
 1614 **VI.A.2.c)** **Levels of Supervision**
 1615
 1616 **To promote appropriate resident supervision while providing**
 1617 **for graded authority and responsibility, the program must use**
 1618 **the following classification of supervision:** ^(Core)
 1619
 1620 **VI.A.2.c).(1)** **Direct Supervision:**
 1621
 1622 **VI.A.2.c).(1).(a)** **the supervising physician is physically present**
 1623 **with the resident during the key portions of the**
 1624 **patient interaction.** ^(Core)
 1625
 1626 **VI.A.2.c).(1).(a).(i)** **PGY-1 residents must initially be**
 1627 **supervised directly, only as described in**
 1628 **VI.A.2.c).(1).(a).** ^(Core)
 1629
 1630 **VI.A.2.c).(1).(a).(i).(a)** **The program must define those**
 1631 **physician tasks for which PGY-1**
 1632 **residents may be supervised**
 1633 **indirectly, with direct supervision**
 1634 **available, and must define “direct**
 1635 **supervision” in the context of the**
 1636 **program.** ^(Core)
 1637
 1638 **VI.A.2.c).(1).(a).(i).(b)** **The program must define those**
 1639 **physician tasks for which PGY-1**
 1640 **residents must be supervised**
 1641 **directly until they have demonstrated**
 1642 **competence as defined by the**
 1643 **program director, and must maintain**

1644		records of such demonstrations of
1645		competence. ^(Core)
1646		
1647	VI.A.2.c).(2)	Indirect Supervision: the supervising physician is not
1648		providing physical or concurrent visual or audio
1649		supervision but is immediately available to the
1650		resident for guidance and is available to provide
1651		appropriate direct supervision. ^(Core)
1652		
1653	VI.A.2.c).(3)	Oversight – the supervising physician is available to
1654		provide review of procedures/encounters with
1655		feedback provided after care is delivered. ^(Core)
1656		
1657	VI.A.2.d)	The privilege of progressive authority and responsibility,
1658		conditional independence, and a supervisory role in patient
1659		care delegated to each resident must be assigned by the
1660		program director and faculty members. ^(Core)
1661		
1662	VI.A.2.d).(1)	The program director must evaluate each resident’s
1663		abilities based on specific criteria, guided by the
1664		Milestones. ^(Core)
1665		
1666	VI.A.2.d).(2)	Faculty members functioning as supervising
1667		physicians must delegate portions of care to residents
1668		based on the needs of the patient and the skills of
1669		each resident. ^(Core)
1670		
1671	VI.A.2.d).(3)	Senior residents or fellows should serve in a
1672		supervisory role to junior residents in recognition of
1673		their progress toward independence, based on the
1674		needs of each patient and the skills of the individual
1675		resident or fellow. ^(Detail)
1676		
1677	VI.A.2.e)	Programs must set guidelines for circumstances and events
1678		in which residents must communicate with the supervising
1679		faculty member(s). ^(Core)
1680		
1681	VI.A.2.e).(1)	Each resident must know the limits of their scope of
1682		authority, and the circumstances under which the
1683		resident is permitted to act with conditional
1684		independence. ^(Outcome)
1685		

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

1686		
1687	VI.A.2.f)	Faculty supervision assignments must be of sufficient
1688		duration to assess the knowledge and skills of each resident
1689		and to delegate to the resident the appropriate level of patient
1690		care authority and responsibility. ^(Core)
1691		

- 1692 **VI.B. Professionalism**
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 1694 **VI.B.1. Programs, in partnership with their Sponsoring Institutions, must**
 1695 **educate residents and faculty members concerning the professional**
 1696 **responsibilities of physicians, including their obligation to be**
 1697 **appropriately rested and fit to provide the care required by their**
 1698 **patients. ^(Core)**
 1699
 1700 **VI.B.2. The learning objectives of the program must:**
 1701
 1702 **VI.B.2.a) be accomplished through an appropriate blend of supervised**
 1703 **patient care responsibilities, clinical teaching, and didactic**
 1704 **educational events; ^(Core)**
 1705
 1706 **VI.B.2.b) be accomplished without excessive reliance on residents to**
 1707 **fulfill non-physician obligations; and, ^(Core)**
 1708

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.

- 1709
 1710 **VI.B.2.c) ensure manageable patient care responsibilities. ^(Core)**
 1711

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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 1713 **VI.B.3. The program director, in partnership with the Sponsoring Institution,**
 1714 **must provide a culture of professionalism that supports patient**
 1715 **safety and personal responsibility. ^(Core)**
 1716
 1717 **VI.B.4. Residents and faculty members must demonstrate an understanding**
 1718 **of their personal role in the:**
 1719
 1720 **VI.B.4.a) provision of patient- and family-centered care; ^(Outcome)**
 1721
 1722 **VI.B.4.b) safety and welfare of patients entrusted to their care,**
 1723 **including the ability to report unsafe conditions and adverse**
 1724 **events; ^(Outcome)**

1725

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

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

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

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

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

1737

1738

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

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

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

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

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

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

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VI.C. Well-Being

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Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require

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

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

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

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

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- VI.C.1. The responsibility of the program, in partnership with the Sponsoring Institution, to address well-being must include:**
- VI.C.1.a) efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; ^(Core)**
- VI.C.1.b) attention to scheduling, work intensity, and work compression that impacts resident well-being; ^(Core)**
- VI.C.1.c) evaluating workplace safety data and addressing the safety of residents and faculty members; ^(Core)**

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

1801
1802 VI.C.1.d) policies and programs that encourage optimal resident and
1803 faculty member well-being; and, ^(Core)
1804

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.

1805
1806 VI.C.1.d).(1) Residents must be given the opportunity to attend
1807 medical, mental health, and dental care appointments,
1808 including those scheduled during their working hours.
1809 ^(Core)
1810

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.

1811
1812 VI.C.1.e) attention to resident and faculty member burnout,
1813 depression, and substance use disorders. The program, in
1814 partnership with its Sponsoring Institution, must educate
1815 faculty members and residents in identification of the
1816 symptoms of burnout, depression, and substance use
1817 disorders, including means to assist those who experience
1818 these conditions. Residents and faculty members must also
1819 be educated to recognize those symptoms in themselves and
1820 how to seek appropriate care. The program, in partnership
1821 with its Sponsoring Institution, must: ^(Core)
1822

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>).

1823
1824 VI.C.1.e).(1) encourage residents and faculty members to alert the
1825 program director or other designated personnel or
1826 programs when they are concerned that another
1827 resident, fellow, or faculty member may be displaying
1828 signs of burnout, depression, a substance use
1829 disorder, suicidal ideation, or potential for violence;
1830 ^(Core)
1831

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.

- 1832
1833 VI.C.1.e).(2) provide access to appropriate tools for self-screening;
1834 and, (Core)
1835
1836 VI.C.1.e).(3) provide access to confidential, affordable mental
1837 health assessment, counseling, and treatment,
1838 including access to urgent and emergent care 24
1839 hours a day, seven days a week. (Core)
1840

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.

- 1841
1842 VI.C.2. There are circumstances in which residents may be unable to attend
1843 work, including but not limited to fatigue, illness, family
1844 emergencies, and parental leave. Each program must allow an
1845 appropriate length of absence for residents unable to perform their
1846 patient care responsibilities. (Core)
1847
1848 VI.C.2.a) The program must have policies and procedures in place to
1849 ensure coverage of patient care. (Core)
1850
1851 VI.C.2.b) These policies must be implemented without fear of negative
1852 consequences for the resident who is or was unable to
1853 provide the clinical work. (Core)
1854

Background and Intent: Residents may need to extend their length of training depending on length of absence and specialty board eligibility requirements.

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

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VI.D. Fatigue Mitigation

VI.D.1. Programs must:

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

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

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

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

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

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

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

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

VI.E.1. Clinical Responsibilities

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

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

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1889	VI.E.1.a)	The workload associated with optimal clinical care of surgical patients is a continuum from the moment of admission to the point of discharge. ^(Core)
1890		
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1892		
1893	VI.E.1.b)	During the residency education process, surgical teams should be made up of attending surgeons, fellows and residents at various PG levels (when appropriate), medical students (when appropriate), and other health care providers. ^(Core)
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1898	VI.E.1.c)	The work of the caregiver team should be assigned to team members based on each member's level of education, experience, and competence. ^(Core)
1899		
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1902	VI.E.1.d)	As residents progress through levels of increasing competence and responsibility, it is expected that work assignments will keep pace with their advancement. ^(Core)
1903		
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1906	VI.E.2.	Teamwork
1907		
1908		Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty and larger health system. ^(Core)
1909		
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1913	VI.E.2.a)	Effective surgical practices must entail the involvement of members with a mix of complementary skills and attributes (physicians, nurses, and other staff). Success requires both an unwavering mutual respect for those skills and contributions, and a shared commitment to the process of patient care. ^(Core)
1914		
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1919	VI.E.2.b)	Residents must collaborate with other surgical residents, with faculty, and other physicians outside of their specialty, and non-traditional health care providers, to best formulate treatment plans for an increasingly diverse patient population. ^(Core)
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1924	VI.E.2.c)	Residents must assume personal responsibility to complete all tasks to which they are assigned (or which they voluntarily assume) in a timely fashion. These tasks must be completed in the hours assigned, or, if that is not possible, residents must learn and utilize the established methods for handing off remaining tasks to another member of the resident team so that patient care is not compromised. ^(Core)
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1932 VI.E.2.d) Lines of authority should be defined by programs, and all
1933 residents must have a working knowledge of these expected
1934 reporting relationships to maximize quality care and patient safety.
1935 (Core)

1936
1937 **VI.E.3. Transitions of Care**

1938
1939 **VI.E.3.a) Programs must design clinical assignments to optimize**
1940 **transitions in patient care, including their safety, frequency,**
1941 **and structure. (Core)**

1942
1943 **VI.E.3.b) Programs, in partnership with their Sponsoring Institutions,**
1944 **must ensure and monitor effective, structured hand-over**
1945 **processes to facilitate both continuity of care and patient**
1946 **safety. (Core)**

1947
1948 **VI.E.3.c) Programs must ensure that residents are competent in**
1949 **communicating with team members in the hand-over process.**
1950 **(Outcome)**

1951
1952 **VI.E.3.d) Programs and clinical sites must maintain and communicate**
1953 **schedules of attending physicians and residents currently**
1954 **responsible for care. (Core)**

1955
1956 **VI.E.3.e) Each program must ensure continuity of patient care,**
1957 **consistent with the program's policies and procedures**
1958 **referenced in VI.C.2-VI.C.2.b), in the event that a resident may**
1959 **be unable to perform their patient care responsibilities due to**
1960 **excessive fatigue or illness, or family emergency. (Core)**

1961
1962 **VI.F. Clinical Experience and Education**

1963
1964 *Programs, in partnership with their Sponsoring Institutions, must design*
1965 *an effective program structure that is configured to provide residents with*
1966 *educational and clinical experience opportunities, as well as reasonable*
1967 *opportunities for rest and personal activities.*

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

1969
1970 **VI.F.1. Maximum Hours of Clinical and Educational Work per Week**

1971
1972 **Clinical and educational work hours must be limited to no more than**
1973 **80 hours per week, averaged over a four-week period, inclusive of all**
1974 **in-house clinical and educational activities, clinical work done from**
1975 **home, and all moonlighting. (Core)**

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

Scheduling

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

Oversight

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

Work from Home

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

During the public comment period many individuals raised questions and concerns related to this change. Some questioned whether minute by minute tracking would be required; in other words, if a resident spends three minutes on a phone call and then a few hours later spends two minutes on another call, will the resident need to report that

time. Others raised concerns related to the ability of programs and institutions to verify the accuracy of the information reported by residents. The new requirements are not an attempt to micromanage this process. Residents are to track the time they spend on clinical work from home and to report that time to the program. Decisions regarding whether to report infrequent phone calls of very short duration will be left to the individual resident. Programs will need to factor in time residents are spending on clinical work at home when schedules are developed to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks. There is no requirement that programs assume responsibility for documenting this time. Rather, the program's responsibility is ensuring that residents report their time from home and that schedules are structured to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks.

PGY-1 and PGY-2 Residents

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

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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.

1995

1996 VI.F.2.c) Residents must have at least 14 hours free of clinical work
1997 and education after 24 hours of in-house call. (Core)
1998

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.

1999 VI.F.2.d) Residents must be scheduled for a minimum of one day in
2000 seven free of clinical work and required education (when
2001 averaged over four weeks). At-home call cannot be assigned
2002 on these free days. (Core)
2003
2004

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."

2005 VI.F.3. Maximum Clinical Work and Education Period Length
2006
2007

2008 VI.F.3.a) Clinical and educational work periods for residents must not
2009 exceed 24 hours of continuous scheduled clinical
2010 assignments. (Core)
2011

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)

2037 VI.F.4.b) These additional hours of care or education will be counted
2038 toward the 80-hour weekly limit. ^(Detail)
2039

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.

2040
2041 VI.F.4.c) A Review Committee may grant rotation-specific exceptions
2042 for up to 10 percent or a maximum of 88 clinical and
2043 educational work hours to individual programs based on a
2044 sound educational rationale.

2045
2046 The Review Committee for Surgery will not accept requests for
2047 exceptions to the 80-hour limit to the residents' work week.
2048

2049 VI.F.4.c).(1) In preparing a request for an exception, the program
2050 director must follow the clinical and educational work
2051 hour exception policy from the *ACGME Manual of*
2052 *Policies and Procedures.* ^(Core)
2053

2054 VI.F.4.c).(2) Prior to submitting the request to the Review
2055 Committee, the program director must obtain approval
2056 from the Sponsoring Institution's GMEC and DIO. ^(Core)
2057

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

2058
2059 VI.F.5. Moonlighting

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2061 VI.F.5.a) Moonlighting must not interfere with the ability of the resident
2062 to achieve the goals and objectives of the educational
2063 program, and must not interfere with the resident's fitness for
2064 work nor compromise patient safety. ^(Core)
2065

2066 VI.F.5.b) Time spent by residents in internal and external moonlighting
2067 (as defined in the ACGME Glossary of Terms) must be
2068 counted toward the 80-hour maximum weekly limit. ^(Core)

2069
2070 **VI.F.5.c) PGY-1 residents are not permitted to moonlight. (Core)**
2071

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>).

2072
2073 **VI.F.6. In-House Night Float**
2074
2075 **Night float must occur within the context of the 80-hour and one-**
2076 **day-off-in-seven requirements. (Core)**
2077

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.

2078
2079 **VI.F.6.a) Night float rotations must not exceed two months in succession, or**
2080 **three months in succession for rotations with night shifts**
2081 **alternating with day shifts. (Detail)**
2082

2083 **VI.F.6.b) There can be no more than four months of night float per year.**
2084 **(Detail)**
2085

2086 **VI.F.6.c) There must be at least two months between each night float**
2087 **rotation. (Detail)**
2088

2089 **VI.F.6.d) The total amount of night float for any resident over a five-year**
2090 **residency must be no more than 15 months (Detail)**
2091

2092 **VI.F.6.d).(1) Any rotation that requires residents to work nights in**
2093 **succession, is considered a night float rotation, and the**
2094 **total time on nights is counted toward the maximum**
2095 **allowable time for each resident over the five-year**
2096 **residency. (Core)**
2097

2098 **VI.F.7. Maximum In-House On-Call Frequency**
2099
2100 **Residents must be scheduled for in-house call no more frequently**
2101 **than every third night (when averaged over a four-week period). (Core)**
2102

2103 **VI.F.8. At-Home Call**
2104

2105 **VI.F.8.a) Time spent on patient care activities by residents on at-home**
2106 **call must count toward the 80-hour maximum weekly limit.**
2107 **The frequency of at-home call is not subject to the every-**
2108 **third-night limitation, but must satisfy the requirement for one**
2109 **day in seven free of clinical work and education, when**
2110 **averaged over four weeks. (Core)**
2111

- 2112 VI.F.8.a).(1) At-home call must not be so frequent or taxing as to
 2113 preclude rest or reasonable personal time for each
 2114 resident. ^(Core)
 2115
 2116 VI.F.8.b) Residents are permitted to return to the hospital while on at-
 2117 home call to provide direct care for new or established
 2118 patients. These hours of inpatient patient care must be
 2119 included in the 80-hour maximum weekly limit. ^(Detail)
 2120

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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 2124 ***Core Requirements:** Statements that define structure, resource, or process elements
 2125 essential to every graduate medical educational program.
 2126
 2127 †**Detail Requirements:** Statements that describe a specific structure, resource, or process, for
 2128 achieving compliance with a Core Requirement. Programs and sponsoring institutions in
 2129 substantial compliance with the Outcome Requirements may utilize alternative or innovative
 2130 approaches to meet Core Requirements.
 2131
 2132 ‡**Outcome Requirements:** Statements that specify expected measurable or observable
 2133 attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their
 2134 graduate medical education.
 2135
 2136 **Osteopathic Recognition**
 2137 For programs with or applying for Osteopathic Recognition, the Osteopathic Recognition
 2138 Requirements also apply (www.acgme.org/OsteopathicRecognition).