ACGME Common Program Requirements Major Revision
Second Stakeholder Survey

Thank you for participating in the second survey for the ACGME's Common Program Requirements major revision. For ease of readability and navigation, we recommend viewing this survey on a laptop, desktop, or tablet.

We want to gather as broad a range of feedback as possible, and all responses will go to the Common Program Requirements Major Revision Task Force to help inform their work. This survey focuses specifically on the resident learning experience and consists of eight topic sections:

- Work Hours
- Dedicated Time
- Well-Being
- Quality and Safety
- Faculty Member-to-Resident Ratio
- Categorization
- Nutrition
- Artificial Intelligence (AI)

The first question identifying your current role is required. All other questions are optional, and you may skip any item you like. Please note that once you complete or skip a question, you will not be able to go back to previous questions.

If you are submitting feedback gathered from your organization as a whole, please select "Responding on behalf of an organization" in the first question and list the organization's name.

Feel free to use text fields to enter citations to any research you feel supports your feedback and/or could inform the revision process. For your reference, we have linked the current Common Program Requirements (Residency) here.

Demographics

A. What best describes your current role? (Select one)
   - Resident
   - Fellow
   - Chief Executive (CEO, CMO, COO, etc.)
   - Department Chair
   - Designated Institutional Official (DIO)/Associate Designated Institutional Official
   - Division Chief
   - Faculty Member, Core
   - Faculty Member, Non-Core
   - Institutional Coordinator/Administrator

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- Medical Student
- Member of the Public
- Quality/Patient Safety Officer
- Recent Graduate (completed most recent Graduate Medical Education in the past five years)
- Program Coordinator/Administrator
- Program Director/Associate Program Director (Residency)
- Program Director/Associate Program Director (Fellowship)
- Responding on behalf of an organization (please specify the organization): [text box – 200-character limit]
- Other (please specify): [text box – 100-character limit]

B. What best describes your current institution type or work infrastructure? (Select one)
   - Academic Medical Center/Medical School
   - Children's Hospital
   - Community Health Center (FQHC/THC)
   - Community Hospital
   - Consortium
   - General/Teaching Hospital
   - Government Public Health Agency
   - Military Treatment Facility
   - Nursing Home/Rehabilitation Facility
   - Other Ambulatory Care Facility
   - Other Specialty Hospital
   - Pathology Lab/Medical Examiner's Office
   - Rural Health Clinic
   - VA Healthcare System Facility
   - Other (please specify): [text box – 100-character limit]
C. What best describes your current work setting? (Select one)
   - Rural
   - Rural Track Program (more than 50% rural with some urban)
   - Suburban
   - Urban
   - Urban in a medically underserved community
   - Other (please specify): [text box – 100-character limit]
D. How many ACGME-accredited programs does your Sponsoring Institution oversee? (Select one)
   - 0
   - 1
   - 2-5
   - 6-25
   - 26-50
   - 51-75

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- 76-100
- >100
- Not Applicable

E. How many residents/fellows are currently in your ACGME-accredited program? (Select one)
    - 0-5
    - 6-10
    - 11-20
    - 21-30
    - 31-50
    - 51-100
    - >100
    - Not Applicable
F. Select your specialty(ies)/subspecialty(ies), including any specialty/subspecialty that falls under your administrative purview. (Select all that apply.)
    - Allergy and Immunology
    - Anesthesiology
    - Anesthesiology Subspecialty
    - Colon and Rectal Surgery
    - Dermatology
    - Dermatology Subspecialty
    - Emergency Medicine
    - Emergency Medicine Subspecialty
    - Family Medicine
    - Internal Medicine
    - Internal Medicine Subspecialty
    - Medical Genetics and Genomics
    - Medical Genetics and Genomics Subspecialty
    - Neurological Surgery
    - Neurology
    - Child Neurology
    - Neurology Subspecialty
    - Nuclear Medicine
    - Obstetrics and Gynecology
    - Obstetrics and Gynecology Subspecialty
    - Ophthalmology
    - Ophthalmology Subspecialty
    - Orthopaedic Surgery
    - Orthopaedic Surgery Subspecialty
    - Osteopathic Neuromusculoskeletal Medicine
    - Otolaryngology – Head and Neck Surgery
    - Otolaryngology – Head and Neck Surgery Subspecialty
    - Pathology

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- Pathology Subspecialty
- Pediatrics
- Pediatrics Subspecialty
- Physical Medicine and Rehabilitation
- Physical Medicine and Rehabilitation Subspecialty
- Plastic Surgery
- Preventive Medicine
- Preventive Medicine Subspecialty
- Psychiatry
- Psychiatry Subspecialty
- Radiation Oncology
- Radiology
- Radiology Subspecialty
- Surgery
- Surgery Subspecialty
- Thoracic Surgery
- Thoracic Surgery Subspecialty
- Transitional Year
- Urology
- Urology Subspecialty
- Vascular Surgery
- Vascular Surgery Subspecialty
- Not applicable

G. How many years have you been in your current role? (Select one)
    - 2 years or less
    - 3-5 years
    - 6-10 years
    - More than 10 years
H. How many years have you been in graduate medical education (GME) leadership? (Select one) [Branching: Chief Executive, Department Chair, Designated Institutional Official, Division Chief, Program Director/Associate Program Director]
    - 2 years or less
    - 3-5 years
    - 6-10 years
    - More than 10 years

Work Hours

The Common Program Requirements currently set limits on clinical and educational work hours for residents. The specialty-specific Program Requirements may further reduce, but not increase, these limits. The ACGME recognizes the need to balance the value and burden of these requirements and, to that end, is gathering input on how best to achieve that balance.

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1. For each requirement, indicate if it should be retained as is, be modified, or deleted. If you select “Modify” or “Delete,” feel free to offer your suggestions for modifying or to explain your recommendation for deleting.

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

   6.21. Residents should have eight hours off between scheduled clinical work and education periods.

   6.21.a. Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.

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

   6.22. Maximum Clinical Work and Education Period Length: Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.

   6.22.a. Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time.

   6.23. Clinical and Educational Work Hour Exceptions: In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient’s family; or to attend unique educational events.

   6.23.a. These additional hours of care or education must be counted toward the 80-hour weekly limit.

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

   6.25. Moonlighting: Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident’s fitness for work nor compromise patient safety.

   6.25.a. Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit.

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

6.26. In-House Night Float: Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. [The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

6.27. Maximum In-House On-Call Frequency: Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).

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

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

2. Please indicate your level of agreement with the following statements:
   [Likert scale: (1) Strongly disagree, (2) Disagree, (3) Neutral, (4) Agree, (5) Strongly agree]
   - Work hours limits should be progressive, with higher limits based on resident level within the program or resident competence.
   - The ACGME should create a standard definition of a “day off” (e.g., 24 hours away from the clinical setting)

3. How much flexibility should the specialty Review Committees have in further limiting work hour requirements? [Likert scale: (1) No flexibility, (2) A little flexibility, (3) Moderate flexibility, (4) A lot of flexibility, (5) Complete flexibility]

4. Please provide any additional comments on the current work hours requirements. [text field. Character limit 500]

Dedicated Time

The Common Program Requirements currently address dedicated time for non-clinical responsibilities devoted to oversight, administration, and management of the program for program leaders and program coordinators. The specialty-specific Program Requirements include the corresponding required minimum non-clinical FTE requirements. While the Common Program Requirements do not include dedicated time for core faculty members, there is an opportunity for the Review Committees to establish a minimum non-clinical FTE for core faculty members’ non-clinical responsibilities related to resident education and/or administration of the program.

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The Common Program Requirements Major Revision Task Force is also seeking input on the current ACGME FTE minimum for program leadership and program coordinators in securing adequate resources for effective program administration.

[Medical Students, Members of the Public, Residents, Fellows, and Recent Graduates will not receive the questions in the Dedicated Time section.]

5. Indicate to what extent the current ACGME minimum non-clinical FTE for **program leadership** (program director, associate program director) is sufficient.

   [Likert scale: (1) Never sufficient; (2) Rarely sufficient; (3) Sometimes sufficient; (4) Sufficient; (5) More than sufficient, (6) Not applicable]

6. Should the ACGME define minimum non-clinical FTE for **program leadership** (program director, associate program director)? [Yes/No]

   - [If yes] Select from one of the following statements:
     - The minimum non-clinical FTE for program leadership should be consistent across all specialties.
     - The minimum non-clinical FTE for program leadership should be variable by specialty as determined by the Review Committees based on number of residents.

   - [If no] Select the reasons why the ACGME should not define minimum non-clinical FTE for **program leadership** (program director, associate program director) (select all that apply):
     - Institutions are better equipped to determine the amount of time required in their context.
     - It is too expensive for our institution and limits program expansion/program continuation.
     - It led to our institution only agreeing to pay for the minimum required FTE regardless of a program's unique needs.
     - Other (please specify): [text field]

7. Indicate to what extent the current ACGME minimum non-clinical FTE for **program coordinators** is sufficient.

   [Likert scale: (1) Never sufficient; (2) Rarely sufficient; (3) Sometimes sufficient; (4) Sufficient; (5) More than sufficient, (6) Not applicable]

8. Should the ACGME define minimum non-clinical FTE for **program coordinators**? [Yes/No]
   - [If yes] Select from one of the following statements:

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        - The minimum dedicated time for program coordinators should be consistent across all specialties.
        - The minimum dedicated time for program coordinators should be variable by specialty as determined by the Review Committees based on number of residents.

    - [If no] Select all the reasons why the ACGME should not define minimum non-clinical FTE for **program coordinators** (select all that apply):
        - Institutions are better equipped to determine the amount of time required in their context.
        - It is too expensive for our institution and limits program expansion/program continuation.
        - It led to our institution only agreeing to pay for the minimum required FTE regardless of a program's unique needs.
        - Other (please specify): [text field]

9. Should the ACGME define minimum non-clinical FTE for **core faculty members**? [Yes/No]
    - [If yes] Select from one of the following statements:
        - The minimum non-clinical FTE for core faculty members should be consistent across all specialties.
        - The minimum non-clinical FTE for core faculty members should be variable by specialty as determined by the Review Committees based on number of residents.

    - [If no] Select the reasons why the ACGME should not define minimum non-clinical FTE for **core faculty members** (select all that apply):
        - Institutions are better equipped to determine the amount of time required in their context.
        - It is too expensive for our institution and limits program expansion/program continuation.
        - It led to our institution only agreeing to pay for the minimum required FTE regardless of a program's unique needs.
        - Other (please specify): [text field]

10. The total physician non-clinical FTE (program director, associate program director, core faculty members):
    - should be based on the professional role (program director, associate program director, core faculty member).
    - should be added together rather than listed by role and distributed according to local needs.

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11. Provide any additional comments regarding minimum dedicated time for program leadership, program coordinators, and core faculty members.

12. [Display question if respondent indicated above that the ACGME should define minimum time for program leadership **OR** program coordinator **OR** core faculty members]
    Have you asked your institution for additional dedicated time to meet your program's needs? [Y/N]
    - [If yes] Was your request approved? [Y/N]
    - [If request was approved] Based on which of the following was it approved? (Select all that apply)
        - Number of residents
        - Program maturity
        - Number of tracks
        - Number of participating sites
        - Accreditation status
        - Case Log reporting
        - Program director experience
        - Program coordinator experience
        - Grant funding
        - Other (please specify): [text field]

13. [This question will appear for DIOs only] Please select the statement that most accurately reflects how decisions regarding the allocation of dedicated time for program leadership/core faculty members/program coordinators are made in your institution.
    - We only provide the minimum specified in the Program Requirements.
    - We provide additional time beyond the minimum required.
        - [If additional time beyond the minimum is provided] What is this based on? (Select all that apply)
            - Number of residents
            - Program maturity
            - Number of tracks
            - Number of participating sites
            - Accreditation status
            - Case Log reporting
            - Program director experience
            - Program coordinator experience
            - Grant funding
            - Other (please specify): [text field]

14. Please provide any additional comments on the current dedicated time requirements for program needs. [text field. Character limit 500]

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Well-Being

Section 6 of the Common Program Requirements includes requirements that support resident and faculty member well-being. Consider these requirements with regard to their overall impact on well-being.

15. For each requirement, indicate if it should be retained as is, modified, or deleted. Feel free to offer any additional comments on the well-being requirements.

- 6.13.a. [The responsibility of the program, in partnership with the Sponsoring Institution, must include:] attention to scheduling, work intensity, and work compression that impacts resident well-being
- 6.13.b. [The responsibility of the program, in partnership with the Sponsoring Institution, must include:] evaluating workplace safety data and addressing the safety of residents and faculty members
- 6.13.c. [The responsibility of the program, in partnership with the Sponsoring Institution, must include:] policies and programs that encourage optimal resident and faculty member well-being
- 6.13.c.1. Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours.
- 6.13.d.1. [The responsibility of the program, in partnership with the Sponsoring Institution, must include education of residents and faculty members in:] identification of the symptoms of burnout, depression, and substance use disorders, suicidal ideation, or potential for violence, including means to assist those who experience these conditions
- 6.13.d.2. [The responsibility of the program, in partnership with the Sponsoring Institution, must include education of residents and faculty members in:] recognition of these symptoms in themselves and how to seek appropriate care
- 6.13.d.3. [The responsibility of the program, in partnership with the Sponsoring Institution, must include education of residents and faculty members in:] access to appropriate tools for self-screening
- 6.13.e. [The responsibility of the program, in partnership with the Sponsoring Institution, must include education of residents and faculty members in:] providing access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week
- 6.14. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and medical, parental, or caregiver leave. Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities.
- 6.15. Programs must educate all residents and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes.

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Quality and Safety

The Common Program Requirements include requirements focused on quality improvement and patient safety. Consider how the following requirements might best support residents' education in these areas.

16. For each requirement, indicate if it should be retained as is, modified, or deleted. Feel free to offer any additional comments on the quality and safety requirements.

    - 4.2.e. [The curriculum must include the following educational components:] formal educational activities that promote patient safety-related goals, tools, and techniques.
    - 4.9.g. [Residents must demonstrate competence in:] using tools and techniques that promote patient safety and disclosure of patient safety events (real or simulated).
    - 6.1. The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety.
    - 6.2. Residents, fellows, faculty members, and other clinical staff members must know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report such events.
    - 6.2.a. Residents, fellows, faculty members, and other clinical staff members must be provided with summary information of their institution's patient safety reports.
    - 6.3. Residents must participate as team members in real and/or simulated interprofessional clinical patient safety and quality improvement activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions.
    - 6.4. Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations.

Additional Topics

The final section of this survey consists of questions on each of the following topics: Faculty Member-to-Resident Ratio; Requirements Categorization (Core, Detail, Outcome); Nutrition; and Artificial Intelligence (AI).

Faculty Member-Resident Ratio

[Medical Students and Members of the Public will not receive this question.]

17. Which of the following statements reflects your opinion about ACGME faculty/resident ratio requirements:
    - Faculty/resident ratio requirements should be in place and should be equal for both urban and rural programs.
    - Faculty/resident ratio requirements should be in place but should be lower for rural programs than for urban programs.

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- Faculty/resident ratio requirements should be removed for rural programs but retained for urban programs.
- Faculty/resident ratio requirements should be removed for both rural and urban programs.

18. Feel free to provide rationale, evidence, or reference material here: [text field]

Categorization

[Only Designated Institutional Officials (DIO)/Associate Designated Institutional Officials, Program Coordinators/Administrators, and Program Directors/Associate Program Directors will receive this question.]

19. Indicate your level of agreement with the following statement:

    The categorization of the Common Program Requirements as “Core,” “Detail,” or “Outcome” has created an overall benefit for my program.

    [Likert scale: (1) Strongly disagree, (2) Disagree, (3) Neutral, (4) Agree, (5) Strongly agree, (6) I don’t understand the categorizations]

Nutrition

[Only Residents, Fellows, Faculty Members, Recent Graduates, Program Coordinators/Administrators, and Program Directors/Associate Program Directors will receive the Nutrition questions.]

20. My program’s curriculum includes instruction related to: (Select all that apply).

21. Which of the following aspects of nutrition should be required for programs in your specialty: (Select all that apply).

[Options below apply to both questions above]

- Demonstrating knowledge of the functions of essential nutrients
- Demonstrating knowledge of principles of a healthy balanced diet, in accordance with nutritional guidelines
- Demonstrating knowledge of nutritional content of foods, including macro- and micronutrients
- Demonstrating knowledge of pathological states that can affect absorption of food and nutrients
- Demonstrating knowledge of public health nutrition, including social determinants of health related to food access
- Screening for food/nutrition insecurity in patients
- Identifying community-based nutrition resources to address nutrition insecurity

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- Assessing nutritional status via food history, anthropometric measurements, and appropriate laboratory tests
- Initiating a non-judgmental conversation with patients about food and lifestyle
- Working collaboratively with other health professionals to deliver multidisciplinary nutrition care
- Making appropriate referrals to a range of professionals to support healthy nutrition
- Providing evidence-based, culturally aware nutrition/food recommendations
- Utilizing evidence-based models of behavior change to assist patients in establishing or modifying health-promoting dietary patterns
- Identifying and treating nutrient deficiencies
- Differentiating between food allergies and food intolerance
- Identifying and referring patients with eating disorders and related conditions
- Describing indications, administration, and complications of clinically assisted nutrition and hydration
- Demonstrating knowledge of breastfeeding and complementary feeding practices

Artificial Intelligence (AI)

[Only Residents, Fellows, Faculty Members, Recent Graduates, Program Coordinators/Administrators, and Program Directors/Associate Program Directors will receive this question.]

1. Considering the expansion of AI and other emerging technologies, complete the table below.

	Does your program have training on this?	Does your program have a policy on this?	Should the ACGME have a requirement on this?
	Yes/No	Yes/No	Yes/No
1. Use of AI and other emerging technologies in education			
2. Use of AI and other emerging technologies for clinical reasoning			
3. Use of AI and other emerging technologies in summarizing evidence			
4. Use of AI and other emerging technologies in administrative support			
5. Ethical use of AI and other emerging technologies (e.g., risk of cheating, patient privacy)			

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6. Access to AI tools and other emerging technologies for all residents			

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