ACGME Common Program Requirements (Residency)

Background and Intent boxes have been removed from the requirements and will be replaced by a Guidance Statement.

Link to Rationale and Impact Statement

Revision Information

Proposed major revision; posted for review and comment September 8, 2026
Proposed effective date July 1, 2028

Definitions

For more information, see the ACGME Glossary of Terms.

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

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

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

Osteopathic Recognition

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

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ACGME Common Program Requirements (Residency)

Common Program Requirements (Residency) are in BOLD

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

Note: Review Committees may further specify only where indicated by "The Review Committee may/must further specify."

Introduction

Definition of Graduate Medical Education

Graduate medical education is the crucial step of professional development between medical school and autonomous clinical practice. It is in this vital phase of the continuum of medical education that resident~~s~~ physicians receive the training required to become independent practicing physicians who provide high-quality care in their specialty. Graduate medical education has, as a core tenet, graded authority and responsibility for patient care, under the supervision of appropriately qualified faculty members ~~learn to provide optimal patient care under the supervision of faculty members who not only instruct, but serve as role models of excellence, compassion, cultural sensitivity, professionalism, and scholarship.~~

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

~~Graduate medical education has as a core tenet the graded authority and responsibility for patient care. The care of patients is undertaken with appropriate faculty supervision and conditional independence, allowing residents to attain the knowledge, skills, attitudes, judgment, and empathy required for autonomous practice. Graduate medical education develops physicians who focus on excellence in delivery of safe, accessible, affordable, high-quality care for all, to improve the health of the populations they serve.~~

~~Graduate medical education occurs in clinical settings that establish the foundation for practice-based and lifelong learning. The professional development of the physician, begun in medical school, continues through faculty modeling of the effacement of self-interest in a humanistic environment that emphasizes joy in curiosity, problem-solving, academic rigor, and discovery. This transformation is often physically, emotionally, and intellectually demanding and occurs in a variety of~~

~~*clinical learning environments committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.*~~

Definition of Specialty
[The Review Committee must ~~further~~ specify]

Section 1: Oversight

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

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

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

[Link to Guidance Statement]

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

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

[The Review Committee may specify which other specialties/~~programs~~ must be present at the primary clinical site]

[Link to Guidance Statement]

~~**1.3.** **There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment.** **(Core)**~~

Note: This requirement has been modified and moved to 1.6.a.

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

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

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

Note: This requirement has been modified and moved to 2.1.

~~**1.5. At each participating site there must be one faculty member, designated by the program director as the site director, who is accountable for resident education at that site, in collaboration with the program director.** (Core)~~

Note: This requirement has been modified and moved to 1.6.b.

Participating Sites

1.6. ~~**The program director must submit any additions or deletions of**~~ **For all participating sites that routinely provide~~ing~~ ~~an~~ required educational experience~~, required for residents,~~ of one month full time equivalent (FTE) or more, the program must:** ~~**through the ACGME's Accreditation Data System (ADS).**~~ (Core)

~~**[The Review Committee may further specify]**~~

Note: Upon approval and implementation of the Common Program Requirements, existing specialty-specific requirements in this section will be deleted.

1.6.a. **have an approved program letter of agreement (PLA) between the program and each participating site;**

Note: This requirement has been modified and moved from 1.3.

1.6.b. **have a site director, designated by the program director, who is a faculty member accountable for resident education at that site, in collaboration with the program director;**

Note: This requirement has been modified and moved from 1.5.

1.6.c. **submit a request for a change in participating sites to the Sponsoring Institution's Graduate Medical Education Committee (GMEC) for review and approval, including educational rationale, and, when applicable, information regarding distance and travel time and support for housing needs; and,**

1.6.d. **enter participating site changes into the ACGME's Accreditation Data System (ADS) after GMEC review and approval.**

1.7. **Specialty-Specific Required Resources**

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

[The Review Committee must ~~further~~ specify required resources]

1.8. **The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for:**

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

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

[Link to Guidance Statement]

1.8.c. **safe options for residents who may be too fatigued to safely return home;**

Note: This requirement has been modified and moved from 6.25.

[Link to Guidance Statement]

1.8.d. **time free from clinical and educational duties during work hours to address lactation needs, and clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; ~~(Core)~~**

[Link to Guidance Statement]

1.8.e. **security and workplace safety measures appropriate to the participating site; ~~and,~~ ~~(Core)~~**

Note: This requirement incorporates 6.19.a.

1.8.f. **accommodations for residents with disabilities consistent with the Sponsoring Institution's policy~~.~~; and, ~~(Core)~~**

1.8.g. **a program-specific policy addressing the needs of pregnant residents, which includes duty and schedule modifications and management of unique occupational exposures, as warranted.**

1.9. **Residents must have ready access to specialty-specific and other appropriate decision support materials and evidence-based guidelines~~reference material in print or electronic format~~. This must include access to electronic medical literature databases with full text capabilities. ~~(Core)~~**

1.10. Ancillary support services must be sufficient to prevent routine reliance on residents to fulfill non-physician obligations.

Note: This requirement has been modified and moved from 6.16.a.

1.11. ~~Other Learners and Health Care Personnel~~

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

1.12. The presence of other health care personnel, such as advanced practice providers, must not adversely impact the education of the program's residents.

~~[The Review Committee may further specify]~~

Note: Upon approval and implementation of the Common Program Requirements, existing specialty-specific requirements in this section will be deleted.

Section 2: Personnel

Program Director

2.1. ~~Program Director~~

There must be one faculty member ~~appointed~~ designated as program director, ~~with~~ who must have responsibility, authority, and accountability for the ~~overall~~ program, including: ~~compliance with all applicable program requirements.~~ ~~(Core)~~

- administration and operations;
- teaching and scholarly activity;
- resident recruitment and selection;
- assessment and promotion of residents, disciplinary action, and supervision of residents;
- resident education in the context of patient care;

Note: The above bullets have been moved from 2.15.

- compliance with accreditation requirements and Sponsoring Institution policies;

Note: The above bullet has been modified and moved from 2.15.h.

i.

- monitoring the clinical learning and working environment at each participating site;

Note: The above bullet has been modified and moved from 1.4.

- providing documentation of resident education within 30 days of completion of or departure from the program, or at the request of the resident; and,

Note: The above bullet has been modified and moved from 2.15.j.-k.

- collaboration with the designated institutional official (DIO) and GMEC for effective administration of and resource allocation for the program.

[The Review Committee may permit a co-program director when necessary to ensure resident eligibility for all board certification options.]

2.2. The program director must design and conduct the program in a fashion consistent with the needs of the community and the mission(s) of both the Sponsoring Institution and the program.

Note: This requirement has been modified and moved from 2.15.b.

2.3. The program director must administer and maintain a learning environment conducive to educating residents in each of the ACGME Competency domains.

Note: This requirement has been modified and moved from 2.15.c.

2.4. The program director must have the authority to approve or remove physicians and non-physicians as program faculty members at all participating sites, including the designation of core faculty members.

Note: This requirement has been modified and moved from 2.15.d.

2.5. The program director must have the authority to reassign residents as needed when supervising faculty members and/or learning environments do not meet the standards of the program.

Note: This requirement has been modified and moved from 2.15.e.

2.6. The program director must submit accurate and complete information required as requested by the DIO, GMEC, and ACGME.

Note: This requirement has been modified and moved from 2.15.f.

2.7. The program director must provide applicants who are offered an interview, and residents upon matriculation into the program, with information related to eligibility and options for specialty board examination(s) for the appropriate American Board of Medical Specialties (ABMS) member board(s) and/or American Osteopathic Association (AOA) certifying board(s).

~~[This requirement may be omitted at the discretion of the Review Committee]~~

Note: This requirement and bracketed language have been modified and moved from 2.15.l.

Upon approval and implementation of the Common Program Requirements, this requirement cannot be omitted by Review Committees.

2.7.a. The program director must also provide information related to eligibility for other specialty board examinations upon request of a resident.

[Link to Guidance Statement]

2.8. Any request for a change in program director must be submitted to the Sponsoring Institution's GMEC for review and approval.~~The Sponsoring Institution's GMEC must approve a change in program director and must verify the program director's licensure and clinical appointment.~~ ~~(Core)~~

~~**2.8.a.** Final approval of the program director resides with the Review Committee. (Core)~~

~~[For specialties that require Review Committee approval of the program director, the Review Committee may further specify. This requirement will be deleted for those specialties that do not require Review Committee approval of the program director]~~

Note: Upon approval and implementation of the Common Program Requirements, existing specialty-specific requirements in this section will be deleted.

~~**2.9.** The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability. (Core)~~

~~[The Review Committee may further specify]~~

Note: Upon approval and implementation of the Common Program Requirements, existing specialty-specific requirements in this section will be deleted.

~~2.10. 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)~~

~~[The Review Committee must further specify minimum dedicated time for program administration, and will determine whether program leadership refers to the program director or both the program director and associate/assistant program director(s)]~~

Note: This requirement and bracketed language have been modified and moved to 2.14.

Qualifications of the Program Director

2.11. ~~Qualifications of the Program Director~~
The program director must possess specialty expertise and ~~at least three years of~~ documented educational and/or administrative experience supporting the acquisition of the knowledge and skills required to be an effective program leader., ~~or qualifications acceptable to the Review Committee.~~ (Core)

2.11.a. If the program director has less than three years of educational and/or administrative experience, a mentoring plan specifying the assigned mentor, frequency of meetings, and duration of the mentorship period must be developed, documented, and overseen by the GMEC or DIO.

[Link to Guidance Statement]

2.12. The program director must possess current certification in the specialty for which they are the program director by the American Board of _____or by the American Osteopathic Board of _____., ~~or specialty qualifications that are acceptable to the Review Committee.~~ (Core) If an individual is not eligible for certification by either entity, GMEC approval must be obtained following the process described in the Guidance Statement.

[The Review Committee may specify that ABMS/AOA certification in a related subspecialty is acceptable]

~~[The Review Committee may further specify acceptable specialty qualifications or that only ABMS and AOA certification will be considered acceptable]~~

Note: Upon approval and implementation of the Common Program Requirements, existing specialty-specific requirements in this section will be deleted.

[Link to Guidance Statement]

2.13. The program director must demonstrate ongoing clinical activity. ~~(Core)~~

~~[The Review Committee may further specify additional program director qualifications]~~

Note: Upon approval and implementation of the Common Program Requirements, existing specialty-specific requirements in this section will be deleted.

2.14. The program director and, as applicable, the program's leadership team, must be provided with support adequate for administration of the program. Decisions regarding allocation of this support must be based upon program size, complexity, and configuration/format(s), and fluctuating program and Sponsoring Institution needs.

[The Review Committee must further specify minimum dedicated time for program administration, and may specify regarding what portion of the program leadership FTE must be allocated solely to the program director, and what portion may be distributed among the assistant/associate program director(s) and/or program director and assistant/associate program director(s)]

Note: This requirement and bracketed language have been modified and moved from 2.10.

[Link to Guidance Statement]

~~**2.15. Program Director Responsibilities**~~

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

Note: This requirement has been moved to bullets under 2.1.

~~**2.15.a.** The program director must be a role model of professionalism. (Core)~~

Note: This requirement has been modified and moved to 6.17.a.

~~2.15.b. The program director must design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program. (Core)~~

Note: This requirement has been modified and moved to 2.2.

~~2.15.c. The program director must administer and maintain a learning environment conducive to educating the residents in each of the ACGME Competency domains. (Core)~~

Note: This requirement has been modified and moved to 2.3.

~~2.15.d. The program director must have the authority to approve or remove physicians and non-physicians as faculty members at all participating sites, including the designation of core faculty members, and must develop and oversee a process to evaluate candidates prior to approval. (Core)~~

Note: This requirement has been modified and moved to 2.4.

~~2.15.e. The program director must have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program. (Core)~~

Note: This requirement has been modified and moved to 2.5.

~~2.15.f. The program director must submit accurate and complete information required and requested by the DIO, GMEC, and ACGME. (Core)~~

Note: This requirement has been modified and moved to 2.6.

~~2.15.g. The program director must provide a learning and working environment in which residents have the opportunity to raise concerns, report mistreatment, and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation. (Core)~~

Note: This requirement has been modified and moved to 6.17.c.

~~2.15.h. The program director must ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process, including when action is taken to suspend or dismiss, or not to promote or renew the appointment of a resident. (Core)~~

Note: This requirement has been modified and moved to bullet under 2.1.

~~**2.15.i. The program director must ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination. (Core)**~~

Note: This requirement has been modified and moved to bullet under 2.1.

~~**2.15.j. The program director must document verification of education for all residents within 30 days of completion of or departure from the program. (Core)**~~

Note: This requirement has been modified and moved to bullet under 2.1.

~~**2.15.k. The program director must provide verification of an individual resident's education upon the resident's request, within 30 days. (Core)**~~

Note: This requirement has been modified and moved to bullet under 2.1.

~~**2.15.l. The program director must provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s). (Core)**~~

~~**[This requirement may be omitted at the discretion of the Review Committee]**~~

Note: This requirement has been modified and moved to 2.7.

Faculty

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

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

[Link to Guidance Statement]

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

[The Review Committee may further specify]

Faculty Responsibilities

~~**2.17. Faculty Responsibilities**~~

~~**Faculty members must be role models of professionalism.** (Core)~~

Note: This requirement has been modified and moved to 6.17.a.

~~**2.17.a. Faculty members must demonstrate commitment to the delivery of safe, high-quality, cost-effective, patient-centered care.** (Core)~~

Note: This requirement has been modified and moved to 4.13.

2.18. **Faculty members must demonstrate a strong interest in the education of residents, including devoting sufficient time and effort to the educational program to fulfill their supervisory, ~~and~~ teaching, and resident assessment responsibilities.** ~~(Core)~~

~~**2.19. Faculty members must administer and maintain an educational environment conducive to educating residents.** (Core)~~

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

[Link to Guidance Statement]

2.21. **Faculty members must pursue faculty development designed to enhance their skills at least annually.:** ~~(Core)~~

[Link to Guidance Statement]

~~2.21.a. as educators and evaluators; (Detail)~~

~~2.21.b. in quality improvement, eliminating health care disparities, and patient safety; (Detail)~~

~~2.21.c. in fostering their own and their residents' well-being; and, (Detail)~~

~~2.21.d. in patient care based on their practice-based learning and improvement efforts. (Detail)~~

2.22. Programs must ensure that there are opportunities for faculty development in Competency-Based Medical Education (CBME).

[The Review Committee may further specify additional faculty responsibilities. Specialty-specific program requirements requiring supervising faculty members to be within the same specialty should include flexibility that permits some portion of the resident's clinical experience to be supervised by qualified faculty members in other specialties.]

Faculty Qualifications

2.23. ~~Faculty Qualifications~~

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

[The Review Committee may further specify qualifications for non-physician faculty members]

Physician Faculty Members

2.24. ~~Physician Faculty Members~~

Physician faculty members must have current certification in the specialty by the American Board of __or the American Osteopathic Board of _____. If an individual is not eligible for certification by either entity, GMEC approval must be obtained following the process described in the Guidance Statement.~~, or possess qualifications judged acceptable to the Review Committee.~~ (Core)~~

[The Review Committee may specify that ABMS/AOA certification in a related subspecialty is acceptable]

[The Review Committee may further specify:

(1) additional faculty qualifications unrelated to 2.2410.;~~-~~and/or,

(2) requirements regarding non-physician faculty members.]

[Link to Guidance Statement]

2.24.a. Any other specialty or subspecialty physician faculty members must have current certification in their specialty or subspecialty by the appropriate ABMS member board or AOA certifying board. If an individual is not eligible for certification by either entity, GMEC approval must be obtained following the process described in the Guidance Statement. ~~, or possess qualifications judged acceptable to the Review Committee.~~ ~~(Core)~~

[The Review Committee may further specify regarding the need for other specialty or subspecialty physician faculty members, and unrelated to 2.24~~10~~.]

[Link to Guidance Statement]

Core Faculty

2.25. ~~Core Faculty~~

The program director must designate ~~C~~core faculty members based on their ~~must have a significant role in the~~ educational responsibilities and contributions to the program, including supervision, assessment, formative feedback, and education of residents. ~~and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents.~~ ~~(Core)~~

[The Review Committee must specify either a minimum number of core faculty members, or a ratio of core faculty to residents that does not require more than one faculty member for every five residents]

Note: This bracketed language has been modified and moved from 2.25.a.

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

~~**[The Review Committee must specify the minimum number of core faculty and/or the core faculty-resident ratio]**~~

Note: This bracketed language has been modified and moved to 2.25.

[The Review Committee may further specify ~~either~~ one of the following:

1. **requirements regarding dedicated time and support for core faculty members' non-clinical responsibilities related to resident education and/or administration of the program; or,**

2. requirements regarding the role and responsibilities of core faculty members, including both clinical and non-clinical activities, and the corresponding time commitment required to meet those responsibilities.]

[The Review Committee may specify requirements specific to associate program director(s), unrelated to 2.2410.]

[Link to Guidance Statement]

Graduate Medical Education Administrative Professional

2.26. ~~Program Coordinator~~
There must be ~~a program coordinator~~at least one graduate medical education (GME) administrative professional. ~~(Core)~~

[Link to Guidance Statement]

2.26.a. The ~~program coordinator~~ GME administrative professional must be provided with dedicated time and support adequate for administration of the program. Decisions regarding allocation of this support must be based upon ~~its~~ program size, complexity, and configuration/format(s), and fluctuating program and Sponsoring Institution needs. ~~(Core)~~

[The Review Committee must further specify minimum dedicated time for the ~~program coordinator~~ GME administrative professional]

[Link to Guidance Statement]

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

[The Review Committee may ~~further~~ specify additional required program personnel]

Section 3: Resident Appointments

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

Note: This requirement is addressed in Institutional Requirement 4.13. Non-competition.

Eligibility Requirements

3.2. ~~**Eligibility Requirements**~~
The program must have written policies and procedures for resident recruitment, selection, eligibility, and appointment, consistent with the ACGME Institutional and Common Program Requirements, that ensures any qualified applicant is considered eligible for appointment to the program.

3.3. **Prior to matriculation in an ACGME-accredited program, ~~An applicant~~ a resident must meet one of the following qualifications ~~to be eligible for appointment to an ACGME-accredited program~~: ~~(Core)~~**

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

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

- **holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, ~~(Core)~~**
- **holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. ~~(Core)~~**

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

[Link to Guidance Statement]

3.4.a. **Residency programs must receive a summative, competency-based performance assessment for ~~verification of~~ each resident~~'s level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program~~ upon matriculation. ~~(Core)~~**

[The Review Committee may further specify prerequisite postgraduate

clinical education]

Note: This requirement has been modified and moved from 3.6.

3.4.b. **Prior to accepting a transfer resident, the program must provide the transferring resident with a written description of the impact of the transfer on their eligibility for their intended specialty board's initial certification.**

Note: This requirement has been modified and moved from 3.7.

[Link to Guidance Statement]

3.4.c. **Resident Eligibility Exception**
The Review Committee for _____will allow the following exception to the resident eligibility requirements: ~~(Core)~~

[Note: A Review Committee may permit the eligibility exception if the specialty requires completion of a prerequisite residency program prior to admission. If the specialty-specific Program Requirements define multiple program formats, the Review Committee may permit the exception only for the format(s) that require completion of a prerequisite residency program prior to admission. If this language is not applicable, this section will not appear in the specialty-specific Program Requirements.]

3.4.c.1. **An ACGME-accredited residency program may accept an exceptionally qualified international graduate applicant who does not satisfy the eligibility requirements listed in 3.2~~3~~.-3.3~~4~~., but who does meet all of the following additional qualifications and conditions: ~~(Core)~~**

3.4.c.1.a. **~~evaluation~~ assessment by the program director and residency selection committee of the applicant's suitability to enter the program, based on prior training and review of the summative ~~evaluations~~ assessments of this training; and, ~~(Core)~~**

3.4.c.1.b. **review and approval of the applicant's exceptional qualifications by the GMEC; and, ~~(Core)~~**

3.4.c.1.c. **verification of ECFMG certification. ~~(Core)~~**

3.4.c.2. **Applicants accepted through this exception must have an ~~evaluation~~ assessment of their performance by the Clinical Competency Committee within 12 weeks of matriculation. ~~(Core)~~**

Resident Complement

3.5. **~~Resident Complement~~**

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

[The Review Committee may further specify regarding designation of preliminary and categorical resident positions~~minimum complement numbers~~]

[Link to Guidance Statement]

~~**3.6. Resident Transfers**~~

~~**The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring resident.** (Core)~~

Note: This requirement has been modified and moved to 3.4.a.

~~**3.7. Prior to accepting a transfer resident, the program must obtain from the resident, and retain written confirmation that the resident understands the impact of the transfer on their eligibility for their intended specialty board's initial certification.** (Core)~~

Note: This requirement has been modified and moved to 3.4.b.

Section 4: Educational Program

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

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

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

[Link to Guidance Statement]

4.1. Length of Program

[The Review Committee must ~~further~~ specify]

Educational Components

~~**4.2. Educational Components**~~

The curriculum must contain the following educational components:

~~4.2.a.~~ ~~a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates, which must be made available to program applicants, residents, and faculty members;~~ ~~(Core)~~

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

[Link to Guidance Statement]

~~4.2.c.~~ ~~delineation of resident responsibilities for patient care, progressive responsibility for patient management, and graded supervision;~~ ~~(Core)~~

4.2.d. a broad range of structured ~~didactic~~ educational activities, including but not limited to didactic and clinical experiences.~~; and,~~ ~~(Core)~~

[Link to Guidance Statement]

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

ACGME Competencies

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

[Link to Guidance Statement]

The program must integrate all ACGME Competencies into the curriculum.

ACGME Competencies – Professionalism

4.3. ~~ACGME Competencies – Professionalism~~

~~Residents must demonstrate a commitment to~~ The program must provide instruction and assessment of residents' professionalism and adherence to ethical principles, including in the use of technology (e.g., artificial intelligence). ~~(Core)~~

[Link to Guidance Statement]

~~Residents must demonstrate competence in:~~

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

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

~~4.3.c. cultural awareness; (Core)~~

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

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

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

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

~~4.3.h. appropriately disclosing and addressing conflict or duality of interest. (Core)~~

ACGME Competencies – Patient Care and Procedural Skills

4.4. ~~ACGME Competencies – Patient Care and Procedural Skills (Part A) Residents must be able to provide patient~~ The program must provide instruction in and assessment of residents' ability to provide care that is patient~~- and family-~~centered, compassionate, equitable, appropriate, and effective for the treatment of health problems and the promotion of health. ~~(Core)~~

~~[The Review Committee must further specify]~~

Note: Upon approval and implementation of the Common Program Requirements, existing specialty-specific requirements in this section will be removed.

4.5. ~~ACGME Competencies – Patient Care and Procedural Skills (Part B) Residents must be able~~The program must provide instruction in and assessment of residents' technical skills needed to perform all medical, diagnostic, therapeutic, and surgical procedures considered essential for the area of practice. ~~(Core)~~

~~[The Review Committee may further specify]~~

Note: Upon approval and implementation of the Common Program

Requirements, existing specialty-specific requirements in this section will be removed.

ACGME Competencies – Medical Knowledge

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

~~[The Review Committee must further specify]~~

Note: Upon approval and implementation of the Common Program Requirements, existing specialty-specific requirements in this section will be removed.

ACGME Competencies – Practice-Based Learning and Improvement

4.7. ~~ACGME Competencies – Practice-Based Learning and Improvement~~
~~Residents must demonstrate the~~The program must provide instruction in and assessment of residents' ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on ~~constant self-evaluation~~ informed self-assessment and lifelong learning. ~~(Core)~~

[Link to Guidance Statement]

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

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

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

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

~~**4.7.e.** Residents must demonstrate competence in incorporating feedback~~

~~and formative evaluation into daily practice.~~ ~~(Core)~~

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

~~[The Review Committee may further specify by adding to the list of sub-competencies]~~

Note: Upon approval and implementation of the Common Program Requirements, existing specialty-specific requirements in this section will be removed.

ACGME Competencies – Interpersonal and Communication Skills

4.8. ~~ACGME Competencies – Interpersonal and Communication Skills~~ ~~Residents must demonstrate interpersonal and communication skills that result in the~~ The program must provide instruction in and assessment of residents' ability to effectively exchange ~~of~~ information and collaborate~~ion~~ with ~~patients, their families, and health professionals~~ different individuals and teams, including patient hand-offs. ~~(Core)~~

Note: This requirement has been modified and moved from 6.28.b.

[Link to Guidance Statement]

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

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

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

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

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

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

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

~~[The Review Committee may further specify by adding to the list of sub-competencies]~~

Note: Upon approval and implementation of the Common Program Requirements, existing specialty-specific requirements in this section will be removed.

ACGME Competencies – Systems-Based Practice

4.9. ~~ACGME Competencies – Systems-Based Practice~~

The program ~~Residents~~ must provide instruction in and assessment of residents' understanding of health system resources in the context of ~~demonstrate an awareness of and responsiveness to the larger context and system of health care, including~~ the social determinants of health, ~~as well as~~ and their ability to call effectively ~~collaborate with other providers and use~~ on those resources to provide optimal health care, including the use of existing and emerging technologies (e.g., artificial intelligence). ~~(Core)~~

[Link to Guidance Statement]

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

~~4.9.b. Residents must demonstrate competence in coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty. (Core)~~

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

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

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

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

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

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

~~[The Review Committee may further specify by adding to the list of sub-competencies]~~

Note: Upon approval and implementation of the Common Program Requirements, existing specialty-specific requirements in this section will be removed.

Curriculum Organization and Resident Experiences

4.10. ~~Curriculum Structure~~
~~The curriculum must be structured to optimize resident educational experiences, the length of the experiences, and the supervisory continuity. These educational experiences include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events. (Core)~~
Assignment of rotations must be structured to minimize the frequency of rotational transitions, and rotations must be of sufficient length to provide a quality educational experience, defined by continuity of patient care, ongoing supervision, longitudinal relationships with faculty members, and meaningful assessment and feedback.

Note: This requirement has been modified and moved from 6.28. and 6.28.a.

[The Review Committee ~~must~~ may further specify]

[Link to Guidance Statement]

4.11. **The program must provide an environment that ensures appropriate patient care responsibilities, with attention to scheduling, work intensity, and work compression, considering resident competence and patient complexity.**

Note: This requirement has been modified and moved from 6.16.b. and 6.18.a.

[Link to Guidance Statement]

4.12. **The clinical responsibilities for each resident must be based on patient safety, assessments of resident ability, severity and complexity of patient illness/condition, and available support services.**

[Optimal clinical workload may be specified by the Review Committee]

Note: This requirement has been modified and moved from 6.26.

[Link to Guidance Statement]

4.13. **Clinical experiences must emphasize high-quality, cost-effective, patient-centered care appropriate for the specialty.**

Note: This requirement has been modified and moved from 2.17.a.

Planned Educational Activities

4.14. ~~**Didactic and Clinical Experiences**~~

Residents must be provided with protected time from clinical responsibilities to participate in ~~core didactic~~ planned educational activities. ~~(Core)~~

[The Review Committee may specify required didactic and clinical experiences]

[Link to Guidance Statement]

~~**4.15. Pain Management**~~

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

[The Review Committee may ~~further~~ specify regarding pain management and substance use disorder above in 4.14.]

Inquiry and Scholarship

[Link to Guidance Statement]

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

~~*integration, application, and teaching.*~~

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

~~**4.16. Program Responsibilities**~~

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

Note: This requirement has been incorporated into 4.18.

~~**4.16.a.** The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities.~~ (Core)

~~**[The Review Committee may further specify]**~~

Note: This requirement has been incorporated into 4.18.

Upon approval and implementation of the Common Program Requirements, existing specialty-specific requirements in this section will be deleted.

~~**4.16.b.** The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care.~~ (Core)

Note: This requirement has been modified and moved to 4.17.a.

Environment of Inquiry

4.17. **The program must establish and maintain an environment of inquiry in which the program director and faculty foster resident acquisition of relevant skills, including the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice principles of lifelong learning.**

[Link to Guidance Statement]

4.17.a. **To maintain this environment of inquiry, the faculty and residents must participate in the following activities:**

- **Scheduled educational events designed to develop competence in analysis and interpretation of medical literature;**

- **Clinical teaching by the faculty that regularly references reliable, relevant information which supports patient care and a critical appraisal of medical evidence; and,**
- **Regular presentations by faculty members and residents to discuss the application of current evidence as applicable to the specialty and patient care.**

Scholarly Activity

4.18. ~~**Faculty Scholarly Activity**~~

~~**Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains:** (Core)~~ **The program, in partnership with its Sponsoring Institution, must allocate adequate resources for, and must demonstrate evidence of, resident and faculty involvement in scholarly activities.**

Program scholarly activity must include:

Note: This requirement combines 4.16. and 4.16.a.

[Link to Guidance Statement]

4.18.a. **Completion of at least one of the activities listed below by each core and other required faculty member at least once every three years:**

- **Creation and delivery of curricula, including didactic presentations**

Note: This requirement has been modified and moved from a bullet below.

- **Creation of assessment or program evaluation tools**

Note: This requirement has been modified and moved from a bullet below.

- **Delivery of local, regional, or national presentations**
- **Service on institutional, regional, or national professional committees, educational organizations, or editorial boards**

Note: This requirement has been modified and moved from a bullet below.

- **Conducting ~~R~~research in basic science, education, translational science, patient care, or population health**
- ~~**Peer-reviewed**~~ **Authoring submitted grants in education/training, scientific research, or service ~~grants~~**
- **Leading a ~~Q~~quality improvement and/or patient safety initiatives~~**

- Authoring a submitted original research article, ~~S~~systematic review~~s~~, meta-analysi~~e~~s, review article~~s~~, chapter~~s~~ in a medical textbook, or case report~~s~~
- Meaningful participation in advocacy for improvements such as local, regional, national, and/or global health care or public health policy
- ~~Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials~~

Note: This requirement has been modified and moved to bullets above.

- ~~Contribution to professional committees, educational organizations, or editorial boards~~

Note: This requirement has been modified and moved to bullets above.

- ~~Innovations in education~~

[Link to Guidance Statement]

4.18.b. Completion of at least one of the activities listed below by each resident prior to graduation from the program:

- Creation and delivery of curricula, including didactic presentations
- Creation of assessment or program evaluation tools
- Delivery of local, regional, or national presentations
- Service on institutional, regional, or national professional committees, educational organizations, or editorial boards
- Conducting research in basic science, education, translational science, patient care, or population health
- Authoring submitted grants in education/training, scientific research, or service
- Leading a quality improvement and/or patient safety initiative
- Authoring a submitted original research article, systematic review, meta-analysis, review article, chapter in a medical textbook, or case report
- Meaningful participation in advocacy for improvements such as local, regional, national, and/or global health care or public health policy

[Link to Guidance Statement]

~~4.18.c. The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:~~

- ~~faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications,~~

~~book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; (Outcome)~~

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

~~[Review Committee will choose to require either the first bullet or both bullets under 4.18.c.]~~

~~4.19. Resident Scholarly Activity~~

~~Residents must participate in scholarship. (Core)~~

~~[The Review Committee may further specify]~~

Note: This requirement has been modified and moved to 4.18.b.

Upon approval and implementation of the Common Program Requirements, existing specialty-specific requirements in this section will be deleted.

Section 5: Program Evaluation and Resident Assessment

Resident Assessment

5.1. ~~Resident Evaluation: Feedback and Evaluation~~

A Clinical Competency Committee (CCC) must be appointed by the program director to review all resident assessments at least semi-annually and advise the program director regarding each resident's progress on specialty-specific Milestones.

Note: This requirement combines 5.12. and 5.12.c-e.

5.1.a. **At a minimum, the CCC must include three members of the program faculty who have extensive contact and experience with the program's residents.**

Note: This requirement has been modified and combines 5.12.a. and 5.12.b.

[Link to Guidance Statement]

5.2. **The program must have a comprehensive system of objective assessment that is reviewed and updated annually; that is competency-based and specialty-specific (including specialty-specific Case Logs, when applicable); that involves multiple assessors (e.g., faculty members, peers, patients, self, and other professional staff members); and which informs CCC actions. This program of**

assessment must include a plan for structured growth toward autonomous practice.

Note: This requirement combines 5.3.b.-5.3.b.2.

[Link to Guidance Statement]

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

[Link to Guidance Statement]

~~**5.3.a.** **Evaluation must be documented at the completion of the assignment. (Core)**~~

Note: This requirement has been modified and moved to 5.4.

~~**5.3.a.1.** **For block rotations of greater than three months in duration, evaluation must be documented at least every three months. (Core)**~~

Note: This requirement has been modified and moved to 5.5.

~~**5.3.a.2.** **Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion. (Core)**~~

Note: This requirement has been modified and moved to 5.5.

~~**5.3.b.** **The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones. (Core)**~~

Note: This requirement has been modified and moved to 5.2.

~~**5.3.b.1.** **The program must use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members). (Core)**~~

Note: This requirement has been modified and moved to 5.2.

~~**5.3.b.2.** **The program must provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. (Core)**~~

Note: This requirement has been modified and moved to 5.2.

5.4. **Faculty members must perform, and provide to the resident in a timely fashion, a written assessment of resident performance after completion of each educational assignment.**

Note: This requirement has been modified and moved from 5.3.a.

5.5. **For ~~block rotations~~ experiences greater than three months in duration, assessment ~~evaluation~~ must be documented and provided to the resident at least every three months.**

Note: This requirement has been modified and moved from 5.3.a.1.-2.

5.6. **The program director or their designee, with input from the CCC, must meet ~~with~~ and review with each resident their documented semi-annual ~~evaluation~~ assessment of performance, including progress along the specialty-specific Milestones and Case Logs, as applicable. ~~(Core)~~**

[Link to Guidance Statement]

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

5.8. **The program director or their designee, with input from the CCC, must develop plans for residents failing to progress, following institutional policies and procedures. ~~(Core)~~**

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

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

~~[The Review Committee may further specify under any requirement in 5.1.a. – 5.5.]~~

Note: Upon approval and implementation of the Common Program Requirements, existing specialty-specific requirements in this section will be deleted.

Final Resident Assessment

5.11. **~~Resident Evaluation: Final Evaluation~~**

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

5.11.a. ~~**The specialty-specific Milestones, and when applicable the specialty-specific Case Logs, must be used as tools to ensure**~~ **The final assessment must verify that the resident~~s~~ ~~are able to engage in~~ has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice~~ ~~upon completion of the program~~. ~~(Core)~~**

Note: This requirement has been modified and moved from 5.11.c.

5.11.b. **The final ~~evaluation~~ assessment must become part of the resident's permanent record ~~maintained by the institution, and must be accessible for review by the resident~~ in accordance with institutional policy, and must be shared with the resident upon completion of the program. ~~(Core)~~**

Note: This requirement has been modified and moved from 5.11.d.

~~**5.11.c.**~~ ~~**The final evaluation must verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice. (Core)**~~

Note: This requirement has been modified and moved to 5.11.a.

~~**5.11.d.**~~ ~~**The final evaluation must be shared with the resident upon completion of the program. (Core)**~~

Note: This requirement has been modified and moved to 5.11.b.

~~**5.12. Clinical Competency Committee**~~

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

Note: This requirement has been incorporated into 5.1.

~~**5.12.a.**~~ ~~**At a minimum, the Clinical Competency Committee must include three members of the program faculty, at least one of whom is a core faculty member. (Core)**~~

Note: This requirement has been modified and moved to 5.1.a.

~~**5.12.b.**~~ ~~**Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents. (Core)**~~

Note: This requirement has been modified and moved to 5.1.a.

~~5.12.c. The Clinical Competency Committee must review all resident evaluations at least semi-annually. (Core)~~

Note: This requirement has been incorporated into 5.1.

~~5.12.d. The Clinical Competency Committee must determine each resident's progress on achievement of the specialty-specific Milestones. (Core)~~

Note: This requirement has been incorporated into 5.1.

~~5.12.e. The Clinical Competency Committee must meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress. (Core)~~

Note: This requirement has been modified and incorporated into 5.1.

Faculty Assessment

5.13. ~~Faculty Evaluation~~

The program must have a process to assess~~evaluate~~ each faculty member's performance as it relates to the educational program and provide feedback to the faculty member at least annually. ~~(Core)~~

Note: This requirement has been modified and moved from 5.13.c.

[Link to Guidance Statement]

~~5.13.a. This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities. (Core)~~

5.13.b. This assessment~~evaluation~~ must include written, anonymous, and confidential assessments~~evaluations~~ by the residents. ~~(Core)~~

~~5.13.c. Faculty members must receive feedback on their evaluations at least annually. (Core)~~

Note: This requirement has been modified and moved to 5.13.

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

[Link to Guidance Statement]

Program Evaluation and Improvement

5.14. ~~Program Evaluation and Improvement~~
The program director must appoint ~~the~~ a Program Evaluation Committee (PEC), ~~to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process.~~ (Core) ~~Program Evaluation Committee responsibilities must include~~ responsible for the review of ~~the current operating environment to identify~~ program strengths, challenges, opportunities, and threats, as related to the program's mission and aims. ~~(Core)~~

Note: This requirement has been combined with 5.14.d.

5.14.a. The ~~Program Evaluation Committee~~ PEC must include, at a minimum, ~~be composed of at least~~ two program faculty members~~, at least one of whom is a core faculty member,~~ and ~~at least~~ one resident. ~~(Core)~~

5.14.b. The PEC must complete an Annual Program Evaluation that defines annual program improvement goals, and considers: 1) program outcomes; 2) the results of the ACGME Resident and Faculty Surveys; and 3) written, anonymous, and confidential program evaluations by residents and faculty members. ~~Program Evaluation Committee responsibilities must include review of the program's self-determined goals and progress toward meeting them.~~ (Core)

Note: This requirement incorporates 5.14.c. and 5.14.e.

~~**5.14.c.** Program Evaluation Committee responsibilities must include guiding ongoing program improvement, including development of new goals, based upon outcomes. (Core)~~

Note: This requirement is incorporated into 5.14.b.

~~**5.14.d.** Program Evaluation Committee responsibilities must include review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core)~~

Note: This requirement has been modified and incorporated into 5.14.

~~**5.14.e.** The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate resident and faculty written evaluations of the program, and other relevant data in its assessment of the program. (Core)~~

Note: This requirement has been incorporated into 5.14.b.

~~5.14.f. The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)~~

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

[Link to Guidance Statement]

~~5.14.h. The program must complete a Self-Study and submit it to the DIO. (Core)~~

Board Certification

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

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

[If certification in the specialty is not offered by the ABMS and/or the AOA, 5.15~~6~~. – 5.16.e. will be omitted.]

5.15. ~~Board Certification~~

For ~~specialties in which the~~ ABMS member board and/or AOA certifying board ~~offer(s) an annual~~ written exam performance, ~~in the preceding three years,~~ for two out of the three most recent board exam administrations, the program's ~~aggregate~~ pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty or equal to or above 80 percent if the bottom fifth percentile is below that threshold. ~~(Outcome)~~

[For specialties with multi-part exams, the Review Committee may further specify which exam will be the basis for this requirement.]

[Link to Guidance Statement]

5.16. The ultimate board pass rate, which is the percentage of ABMS member board and/or AOA certifying board eligible program graduates who seek and obtain certification within seven years of completion of the program, must be at least 90 percent.

[Link to Guidance Statement]

~~5.16.a. For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)~~

~~5.16.b. For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)~~

~~5.16.c. For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)~~

~~5.16.d. For each of the exams referenced in 5.6.a.-c., any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty. (Outcome)~~

~~5.16.e. Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years earlier. (Core)~~

Section 6: The Learning and Working Environment

[Link to Guidance Statement]

~~The Learning and Working Environment~~

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

- ~~*Excellence in the safety and quality of care rendered to patients by residents today*~~
- ~~*Excellence in the safety and quality of care rendered to patients by today's residents in their future practice*~~
- ~~*Excellence in professionalism*~~
- ~~*Appreciation for the privilege of caring for patients*~~

- ~~*Commitment to the well-being of the students, residents, faculty members, and all members of the health care team*~~

~~**Culture of Safety**~~

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

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

Note: This requirement has been modified and incorporated into 6.3. and 6.5.

~~**Patient Safety Events**~~

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

Patient Safety and Quality

6.2. **Programs must provide residents with instruction on systems for ~~Residents, fellows, faculty members, and other clinical staff members must know their responsibilities in~~ reporting patient safety events and unsafe conditions at ~~the clinical~~ all sites in which they are providing clinical care, including how to report such events. ~~(Core)~~**

[Link to Guidance Statement]

6.3. **Residents~~, fellows, faculty members, and other clinical staff members~~ must be provided with exposure to systems-based metrics of quality, safety, patient experience and cost, and where appropriate, service- and department-related data relevant to the specialty.~~summary information of their institution's patient safety reports. (Core)~~**

Note: This requirement has been modified and incorporates 6.1. and 6.6.

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

[The Review Committee may further specify]

Note: This requirement has been moved from 6.27.

[Link to Guidance Statement]

6.5. **The program must provide opportunities for ~~R~~resident ~~must~~ participate~~ion~~ 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.~~ Programs must facilitate/support participation for residents engaging in these activities.** ~~(Core)~~

Note: This requirement has been modified and incorporates 6.1. and 6.6.

[Link to Guidance Statement]

~~**Quality Metrics**~~

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

~~**6.6.** **Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations.** (Core)~~

Note: This requirement has been modified and incorporated into 6.3. and 6.5.

Supervision and Accountability

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

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

[Link to Guidance Statement]

~~**6.7.** **Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. This information must be available to residents, faculty members, other members of the health care team, and patients.** (Core)~~

Levels of Supervision

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

Note: This language has been moved from below 6.10.d.

6.8. **Direct Supervision**

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

[The Review Committee may further specify]

The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.

[The Review Committee may choose to eliminate this piece of the definition]

Note: This language has been modified and moved from 6.11.

[The Review Committee may describe the conditions under which PGY-1 residents progress to be supervised indirectly]

Note: This bracketed language has been moved from 6.11.a.

Indirect Supervision

The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.

Note: This definition has been moved from below 6.11.b.

Oversight

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

Note: This definition has been moved from below 6.11.b.

6.9. **The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.**

Note: This requirement has been moved from 6.13.

6.10. **The program must ~~demonstrate that~~ maintain and adhere to a program-specific policy that describes the appropriate level of supervision, consistent with the**

definitions above, for all patient care activities. ~~in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation.~~ The policy must define: ~~(Core)~~

6.10.a. the process by which a program assesses residents' readiness to act with conditional independence and serve in a supervisory role to junior residents;

Note: This requirement incorporates 6.13.a., 6.13.c., and 6.14.a.

6.10.b. the responsibility of supervising clinicians to delegate portions of care to residents based on patient need and resident skill;

Note: This requirement has been moved and modified from 6.13.b.

6.10.c. how and when residents must communicate with the supervising clinician regarding the complexity and acuity of the patient, including changes to patient status; and,

Note: This requirement has been moved and modified from 6.14.

6.10.d. the circumstances and procedures for which direct supervision is required.

Note: This requirement has been modified and moved from 6.12.

[Link to Guidance Statement]

[The Review Committee may specify:
1. **which activities require different levels of supervision; and/or,**
2. **the role and/or restrictions of non-physician supervision of residents]**

~~**Levels of Supervision**~~

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

~~**6.11. Direct Supervision**~~

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

~~**[The Review Committee may further specify]**~~

~~***The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient***~~

~~*care through appropriate telecommunication technology.*~~

~~**[The RC may choose to eliminate this piece of the definition]**~~

Note: This language has been modified and moved to 6.8.

~~**6.11.a.** PGY-1 residents must initially be supervised directly, only as described in the above definition. (Core)~~

~~**[The Review Committee may describe the conditions under which PGY-1 residents progress to be supervised indirectly]**~~

Note: This bracketed language has been moved to 6.8.

~~**6.11.b.** [The Review Committee may further specify]~~

~~**Indirect Supervision**~~
~~*The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.*~~

Note: This definition has been moved above 6.9.

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

Note: This definition has been moved above 6.9.

~~**6.12.** The program must define when physical presence of a supervising physician is required. (Core)~~

Note: This requirement has been modified and moved to 6.10.d.

~~**6.13.** The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. (Core)~~

Note: This requirement has been moved to 6.9.

~~**6.13.a.** The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones. (Core)~~

Note: This requirement has been modified and incorporated into 6.10.a.

~~6.13.b. Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. (Core)~~

Note: This requirement has been modified and moved to 6.10.b.

~~6.13.c. Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)~~

Note: This requirement has been modified and moved to 6.10.a.

~~6.14. Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). (Core)~~

Note: This requirement has been modified and moved to 6.10.c.

~~6.14.a. Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. (Outcome)~~

Note: This requirement has been modified and moved to 6.10.a.

~~6.15. Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. (Core)~~

Learning and Working Environment

~~6.16. Professionalism~~

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

~~6.16.a. The learning objectives of the program must be accomplished without excessive reliance on residents to fulfill non-physician obligations. (Core)~~

Note: This requirement has been modified and moved to 1.10.

~~6.16.b. The learning objectives of the program must ensure manageable patient care responsibilities. (Core)~~

~~[The Review Committee may further specify]~~

Note: This requirement has been modified and moved to 4.11.

~~6.16.c. The learning objectives of the program must include efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, providing administrative support, promoting progressive independence and flexibility, and enhancing professional relationships. (Core)~~

~~6.16.d. The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)~~

Note: This requirement has been modified and moved to 6.17.

~~6.16.e. Residents and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events. (Core)~~

6.17. ~~Programs, in partnership with their Sponsoring Institutions,~~ The program must ~~provide~~ maintain a professional, respectful, and civil culture and environment that ~~is~~ supports patient safety and psychologically~~ly~~ safety, as shown through the following: ~~and that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff. (Core)~~

Note: A portion of this requirement has been modified and moved to 6.17.d.

6.17.a. the program director, faculty members, and residents consistently demonstrate professionalism and adherence to ethical principles;

Note: This requirement has been modified and moved from 2.15.a. and 2.17.

6.17.b. ~~Programs, in partnership with their Sponsoring Institutions, must provide a professional, respectful, and civil environment that is psychologically safe and that is free from~~ unprofessional and unethical conduct, discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty

members, and staff are not tolerated and are promptly addressed by the program when they occur;

Note: This requirement has been modified and moved from 6.17.

6.17.c. ~~The program director must provide a learning and working environment in which~~ residents have the opportunity to raise concerns, report mistreatment, and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; and,

Note: This requirement has been modified and moved from 2.15.g.

6.17.d. the ~~P~~programs~~,~~ in partnership with ~~their~~ its Sponsoring Institutions~~,~~ ~~should have a process for education of residents and faculty regarding unprofessional behavior and~~ has a confidential process for reporting, investigating, and addressing such concerns. ~~(Core)~~

Well-Being

[Link to Guidance Statement]

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

~~*Residents and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. A positive culture in a clinical learning environment models constructive behaviors, and prepares residents with the skills and attitudes needed to thrive throughout their careers.*~~

~~6.18. The responsibility of the program, in partnership with the Sponsoring Institution, must include:~~

~~6.18.a. attention to scheduling, work intensity, and work compression that impacts resident well-being; (Core)~~

Note: This requirement has been modified and moved to 4.11.

6.19. The program must have a plan for preventing burnout and promoting well-

being among residents that takes into account information from the annual ACGME Resident and Faculty Surveys.

Note: This requirement incorporates 6.19.a. and 6.19.b.

[Link to Guidance Statement]

~~**6.19.a. evaluating workplace safety data and addressing the safety of residents and faculty members; (Core)**~~

Note: This requirement has been modified and moved to 1.8.e. and 6.19.

~~**6.19.b. policies and programs that encourage optimal resident and faculty member well-being; and, (Core)**~~

Note: This requirement has been modified and moved to 6.19.

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

[Link to Guidance Statement]

6.21. The program, in partnership with its Sponsoring Institution, must provide systems to support residents experiencing physical and/or mental health conditions that may impair their safety and/or ability to provide safe patient care. This responsibility includes educating residents and faculty members in how to recognize those symptoms and how to access appropriate care.

Note: This requirement combines 6.21.a.- 6.21.a.3.

[Link to Guidance Statement]

~~**6.21.a. education of residents and faculty members in:**~~

Note: This requirement has been modified and combined into 6.21.

~~**6.21.a.1. identification of the symptoms of burnout, depression, and substance use disorders, suicidal ideation, or potential for violence, including means to assist those who experience these conditions; (Core)**~~

Note: This requirement has been modified and combined into 6.21.

~~6.21.a.2. recognition of these symptoms in themselves and how to seek appropriate care; and, (Core)~~

~~Note: This requirement has been modified and combined into 6.21.~~

~~6.21.a.3. access to appropriate tools for self-screening. (Core)~~

~~Note: This requirement has been modified and combined into 6.21.~~

~~6.21.b. providing access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)~~

6.22. ~~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.~~ **The program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities.** ~~(Core)~~

~~6.22.a. The program must have policies and procedures in place to ensure coverage of patient care and ensure continuity of patient care. (Core)~~

~~Note: This requirement has been modified and incorporated into 6.23.~~

~~6.22.b. These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work. (Core)~~

~~Note: This requirement has been modified and incorporated into 6.23.~~

6.23. **The program must have a policy describing how planned appointments during work hours, unanticipated absences, and leave are requested and covered.**

Note: This requirement incorporated 6.22.a. and 6.22.b.

[Link to Guidance Statement]

~~6.24. Fatigue Mitigation~~

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

~~6.25. 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)~~

Note: This requirement has been modified and moved to 1.8.c.

~~6.26. 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)~~

~~[Optimal clinical workload may be further specified by each Review Committee]~~

Note: This requirement has been modified and moved to 4.12.

~~6.27. Teamwork~~

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

~~[The Review Committee may further specify]~~

Note: This requirement has been moved to 6.4.

~~6.28. Transitions of Care~~

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

Note: This requirement has been modified and moved to 4.10.

~~6.28.a. Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety. (Core)~~

Note: This requirement has been modified and moved to 4.10.

~~6.28.b. Programs must ensure that residents are competent in communicating with team members in the hand-off process. (Outcome)~~

Note: This requirement has been modified and moved to 4.8.

Clinical ~~Experience~~ and Educational Work Hours

[Link to Guidance Statement]

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

Maximum Hours of Clinical and Educational Work per Week

6.29. ~~Maximum Hours of Clinical and Educational Work per Week~~
Clinical and educational work hours must be limited to no more than 80 hours per week, when averaged over a maximum of four weeks~~ ~~period~~ and within the span of a single clinical assignment/rotation.~~, including~~ This includes all in-house clinical and educational activities, clinical work done from home, and all moonlighting. ~~(Core)~~

[Link to Guidance Statement]

Note: Upon approval and implementation of the Common Program Requirements, existing specialty-specific requirements in this section will be deleted.

Mandatory Time Free of Clinical Work and Education

~~**6.30. Mandatory Time Free of Clinical Work and Education**~~
~~**Residents should have eight hours off between scheduled clinical work and education periods.** (Detail)~~

6.31. **Residents must have at least ~~14~~ 12 hours free of clinical work and education after 24 hours of in-house call.** ~~(Core)~~

[Link to Guidance Statement]

6.32. **Residents must be scheduled for a minimum of one day (a period of 24 consecutive hours) in seven free of clinical work and required education, ~~(~~when averaged over a maximum of four weeks~~)~~ and within the span of a single clinical assignment/rotation. At-home call cannot be assigned on these free days.** ~~(Core)~~

[Link to Guidance Statement]

Note: Upon approval and implementation of the Common Program Requirements, existing specialty-specific requirements in this section will be deleted.

Maximum Clinical Work and Education Period Length

6.33. ~~**Maximum Clinical Work and Education Period Length**~~
Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. ~~(Core)~~

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

[Link to Guidance Statement]

Note: Upon approval and implementation of the Common Program Requirements, existing specialty-specific requirements in this section will be deleted.

~~**6.34. Clinical and Educational Work Hour Exceptions**~~
~~**In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events.** (Detail)~~

~~**6.34.a. These additional hours of care or education must be counted toward the 80-hour weekly limit.** (Detail)~~

Note: Upon approval and implementation of the Common Program Requirements, existing specialty-specific requirements in this section will be deleted.

~~**6.35. 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.**~~

~~**6.35.a. In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the *ACGME Manual of Policies and Procedures*.** (Detail)~~

Note: Upon approval and implementation of the Common Program Requirements, existing specialty-specific requirements in this section will be deleted.

Moonlighting

6.36. ~~Moonlighting~~

Moonlighting must not interfere with the resident's ability to achieve the goals and objectives of the educational program, ~~and must not interfere with the resident's~~their clinical and academic progress, or their fitness for work, nor compromise patient safety. ~~(Core)~~

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

6.36.b. **PGY-1 residents are not permitted to moonlight. ~~(Core)~~**

Note: Upon approval and implementation of the Common Program Requirements, existing specialty-specific requirements in this section will be deleted.

~~6.37. In-House Night Float~~

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

~~[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.]~~

Note: Upon approval and implementation of the Common Program Requirements, existing specialty-specific requirements in this section will be deleted.

~~6.38. Maximum In-House On-Call Frequency~~

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

Note: Upon approval and implementation of the Common Program Requirements, existing specialty-specific requirements in this section will be deleted.

At-Home Call

6.39. ~~At-Home Call~~

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

~~(Core)~~

[Link to Guidance Statement]

6.39.a. **At-home call must not be so frequent or ~~taxing~~ of such intensity as to preclude adequate rest or reasonable personal time for each resident. Programs that utilize at-home call must define the patient care activities that must be counted as work hours, and must maintain a process to monitor workload intensity and make adjustments as needed.** ~~(Core)~~

[Link to Guidance Statement]

~~[The Review Committee may further specify under any requirement in 6.29. – 6.39.]~~

Note: Upon approval and implementation of the Common Program Requirements, existing specialty-specific requirements in this section will be deleted.

Common Program Requirements Guidance Document

Section 1

Sponsoring Institution

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

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

Participating Sites

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

Guidance: Participating sites will reflect the health care needs of the community and the educational needs of the residents. A wide variety of settings 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, a federally qualified health center, or an educational foundation.

Participating Sites

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

~~**[The Review Committee may further specify]**~~

Note: Upon approval and implementation of the Common Program Requirements, existing specialty-specific requirements in this section will be deleted.

1.6.a. **have an approved program letter of agreement (PLA) between the program and each participating site;**

Note: This requirement has been modified and moved from 1.3.

1.6.b. **have a site director, designated by the program director, who is a faculty member accountable for resident education at that site, in collaboration with the program director;**

Note: This requirement has been modified and moved from 1.5.

1.6.c. **submit a request for a change in participating sites to the Sponsoring Institution's Graduate Medical Education Committee (GMEC) for review and approval, including educational rationale, and, when applicable, information regarding distance and travel time and support for housing needs; and,**

1.6.d. **enter participating site changes into the ACGME's Accreditation Data System (ADS) after GMEC review and approval.**

Guidance: Suggested elements of a PLA could include:

- Identifying the site director, as well as 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, learning objectives, and content of the educational experience
- Stating the policies and procedures that will govern resident education during the assignment, including financial arrangements and malpractice coverage

The requirement that the DIO must ensure approval of the PLA provides the ability for the DIO to be the approver, or to delegate this responsibility to another individual. In either case, the DIO is responsible for ensuring that the approval occurs.

It is recommended that the PLAs be reviewed regularly and updated as needed.

1.8. **The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for:**

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

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

Guidance: Care of patients within a hospital or health system occurs continually throughout 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. The expectation for access to food while on duty includes the expectation that residents have access to refrigeration where food may be stored, and that food is available when residents are required to be in the hospital overnight.

In terms of sleep/rest facilities, regardless of whether overnight call is required, rest facilities are necessary to accommodate the fatigued resident. In some circumstances, depending on the site and the residents' clinical responsibilities and schedules, call rooms may not be required so long as another type of rest facility with dedicated, safe, quiet space is available.

1.8.c. **safe options for residents who may be too fatigued to safely return home;**

Note: This requirement has been modified and moved from 6.25.

Guidance: It is recognized that the provision of safe options for fatigued residents may vary across programs. For instance, while programs in urban areas may provide fatigued residents with transportation home, this approach might create significantly greater logistical challenges for programs located in rural areas. The requirement provides flexibility for programs to identify the options that work best while ensuring that resident safety needs are met.

1.8.d. **time free from clinical and educational duties during work hours to address lactation needs, and clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care;** ~~(Core)~~

Guidance: The program is required to provide lactating residents with time free from their clinical and educational responsibilities for this purpose, without requiring the resident to work an extended shift to make up for this time away.

1.10. **Ancillary support services must be sufficient to prevent routine reliance on residents to fulfill non-physician obligations.**

Note: This requirement has been modified and moved from 6.16.a.

Guidance: 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.

Section 2

2.7. **The program director must provide applicants who are offered an interview, and residents upon matriculation into the program, with information related to eligibility and options for specialty board examination(s) for the appropriate American Board of Medical Specialties (ABMS) member board(s) and/or American Osteopathic Association (AOA) certifying board(s).**

~~[This requirement may be omitted at the discretion of the Review Committee]~~

Note: This requirement and bracketed language have been modified and moved from 2.15.l.

Upon approval and implementation of the Common Program Requirements, this requirement cannot be omitted by Review Committees.

2.7.a. **The program director must also provide information related to eligibility for other specialty board examinations upon request of a resident.**

Guidance: Due to the variability and complexity of options and eligibility for certification for an individual resident in a given specialty, it is essential that the program director ensures that each resident receives information regarding their eligibility for the relevant AOA and ABMS examinations. Because this information is readily available on the website for each certifying board, it is not expected that this requirement will create significant burden for program directors.

Qualifications of the Program Director

2.11. ~~**Qualifications of the Program Director**~~
The program director must possess specialty expertise and ~~at least three years of~~ documented educational and/or administrative experience supporting the acquisition of the knowledge and skills required to be an effective program leader., ~~or qualifications acceptable to the Review Committee.~~ ~~(Core)~~

2.11.a. **If the program director has less than three years of educational and/or administrative experience, a mentoring plan specifying the assigned mentor, frequency of meetings, and duration of the mentorship period must be developed, documented, and overseen by the GMEC or DIO.**

Guidance: 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 broad allowance for educational and/or administrative experience recognizes that strong leaders arise through a variety of pathways. These areas of expertise are important when identifying and appointing a program director. The choice of a program director will be informed by the mission of the program and the needs of the community. In circumstances where the newly designated program director has less than three years of administrative and/or educational experience, the required mentoring plan provides essential support as the individual develops the skills and knowledge needed to succeed in the role. Such mentorship arrangements already exist in many programs and institutions, and the ACGME will provide mentorship plan templates as a resource for programs upon implementation of the revised Common Program Requirements.

2.12. **The program director must possess current certification in the specialty for which they are the program director by the American Board of _____ or by the American Osteopathic Board of __, ~~or specialty qualifications that are acceptable to the Review Committee.~~** ~~(Core)~~ **If an individual is not eligible for certification by either entity, GMEC approval must be obtained following the process described in the Guidance Statement.**

~~[The Review Committee may further specify acceptable specialty qualifications or that only ABMS and AOA certification will be considered acceptable]~~

[The Review Committee may specify that ABMS/AOA certification in a related

subspecialty is acceptable]

Note: Upon approval and implementation of the Common Program Requirements, existing specialty-specific requirements in this section will be deleted.

Guidance: Criteria for consideration of individuals who do not have current certification by the applicable ABMS member board and/or AOA certifying board will be developed and added to this guidance document following approval of the revised Common Program Requirements. Comments received regarding the proposed change to this requirement will help inform the development of these criteria.

2.14. **The program director and, as applicable, the program's leadership team, must be provided with support adequate for administration of the program. Decisions regarding allocation of this support must be based upon program size, complexity, and configuration/format(s), and fluctuating program and Sponsoring Institution needs.**

[The Review Committee must further specify minimum dedicated time for program administration, and may specify regarding what portion of the program leadership FTE must be allocated solely to the program director, and what portion may be distributed among the assistant/associate program director(s) and/or program director and assistant/associate program director(s)]

Note: This requirement and bracketed language have been modified and moved from 2.10.

Guidance: A review of the support provided to program leadership for administration of the program may be initiated upon request of the DIO, program director, or Review Committee, and/or at the time of a Special Review or major program changes. The program, in partnership with its Sponsoring Institution, may need to adjust the amount of support provided to meet program needs. Factors to be considered include, but are not limited to program director turnover, major program changes, organizational changes impacting graduate medical education, program requirement changes, and ACGME Resident and Faculty Survey results.

The requirements are in no way intended to create a one-size-fits-all standard. Therefore, providing the minimum time specified without careful consideration of the needs of the program is not compliant with the requirements. If there is evidence that the dedicated time for program leadership is not sufficient for effective administration of the program, the program may be cited for non-compliance, regardless of whether the minimum percentage specified in the requirement has been met.

Most specialty-specific requirements addressing required support are structured with increases based on the number of approved resident positions, which has been identified as a potential barrier for development of new programs. To address this concern, compliance with the support requirements for new programs will be based on the number of filled positions for a duration of time equal to the length of the program. For example, if the program length is three years, the program will be required to provide the support required for the number of filled resident positions for the first three years following the effective date of Initial Accreditation. Starting in the fourth year, the program will be assessed based on the number of approved positions.

Faculty

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

2.20. Faculty members must regularly participate in organized clinical discussions, rounds, journal clubs, ~~and~~or conferences. ~~(Core)~~

Guidance: Faculty participation in clinical discussions, rounds, journal clubs, and conferences is an important component of resident education and supports an environment of inquiry. While faculty presence at all of these planned activities is essential, it is not expected that every faculty member attend every activity.

2.21. Faculty members must pursue faculty development designed to enhance their skills at least annually.~~:~~ ~~(Core)~~

Guidance: Faculty development is intended to describe structured programming developed for the purpose of enhancing transference of knowledge, skills, and behaviors 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 program. Faculty development programming is to be reported for the residency program faculty in the aggregate.

The program will determine faculty development areas of focus based on the needs of the program and faculty members. Areas to be addressed may include, but are not limited to, the following:

- Principles of competency-based assessment and feedback
- Enhancement of faculty members' skills as educators and assessors
- Fostering faculty member and resident well-being
- Patient care based on the faculty members' practice-based learning and improvement efforts

Physician Faculty Members

2.24. ~~Physician Faculty Members~~

Physician faculty members must have current certification in the specialty by the American Board of __or the American Osteopathic Board of _____. If an individual is not eligible for certification by either entity, GMEC approval must be obtained following the process described in the Guidance Statement.~~, or possess qualifications judged acceptable to the Review Committee.~~ ~~(Core)~~

[The Review Committee may specify that ABMS/AOA certification in a related subspecialty is acceptable]

[The Review Committee may further specify:

(1) additional faculty qualifications unrelated to 2.2410.; and/or,

(2) requirements regarding non-physician faculty members.]

2.24.a. **Any other specialty or subspecialty physician faculty members must have current certification in their specialty or subspecialty by the appropriate ABMS member board or AOA certifying board. If an individual is not eligible for certification by either entity, GMEC approval must be obtained following the process described in the Guidance Statement., or possess qualifications judged acceptable to the Review Committee. (Core)**

[The Review Committee may further specify regarding the need for other specialty or subspecialty physician faculty members, and unrelated to 2.2410.]

Guidance: Criteria for consideration of individuals who do not have current certification by the applicable ABMS member board and/or AOA certifying board will be developed and added to this guidance document following approval of the revised Common Program Requirements. Comments received regarding the proposed change to this requirement will help inform the development of these criteria.

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

[The Review Committee must specify the minimum number of core faculty and/or the core faculty-resident ratio]

Note: This bracketed language has been modified and moved to 2.25.

[The Review Committee may further specify either one of the following:

1. **requirements regarding dedicated time and support for core faculty members' non-clinical responsibilities related to resident education and/or administration of the program; or,**

2. **requirements regarding the role and responsibilities of core faculty members, including both clinical and non-clinical activities, and the corresponding time commitment required to meet those responsibilities.]**

[The Review Committee may specify requirements specific to associate program director(s), unrelated to 2.2410.]

If the Review Committee adds requirements as described in number (1) above, the Review Committee may choose to include the following in the resource document:

> **Guidance:** Provision of support for the time required for the core faculty members' responsibilities related to resident education and/or administration of the program, as well as 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. It is important to remember that the dedicated time and support requirement is a minimum, recognizing that, depending on the unique needs of the program, additional support may be warranted. The need to ensure adequate resources, including adequate support and dedicated time for the core faculty members, is also addressed in Institutional Requirement 2.2.b. The amount of support and dedicated time needed for individual programs will vary based on a number of factors and may exceed the minimum specified in the applicable specialty-specific Program Requirements.

If the Review Committee adds requirements as described in number (2) above, the following Background and Intent must be included:

> **Guidance:** The core faculty time requirements address the role and responsibilities of core faculty members, including both clinical and non-clinical activities, and the corresponding time to meet those responsibilities. The requirements do not address how this is accomplished, and do not mandate dedicated or protected time for these activities. Programs, in partnership with their Sponsoring Institutions, will determine how compliance with the requirements is achieved.

Graduate Medical Education Administrative Professional

2.26. ~~**Program Coordinator**~~
There must be ~~a program coordinator~~at least one graduate medical education (GME) administrative professional. ~~(Core)~~

> **Guidance:** Each program requires a lead administrative professional, 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 GME administrative professionals by the ACGME.
>
> The GME administrative professional is a key member of the leadership team and is critical to the success of the program. As such, the GME administrative professional role requires skills in leadership and personnel management appropriate to the complexity of the program. These professionals are expected to develop in-depth knowledge of the ACGME Program Requirements and the ACGME, including policies and procedures. GME administrative professionals assist the program director in meeting accreditation requirements, educational programming, and support of residents.
>
> Programs, in partnership with their Sponsoring Institutions, are encouraged to support the professional development of their GME administrative professionals and avail them of opportunities for both professional and personal growth. Programs with fewer

residents may not require a full-time GME administrative professional; one GME administrative professional may support more than one program. Conversely, large programs may require more than one full-time administrative professional for adequate support.

2.26.a. **The ~~program coordinator~~ GME administrative professional must be provided with dedicated time and support adequate for administration of the program. Decisions regarding allocation of this support must be based upon ~~its~~ program size, complexity, and configuration/format(s), and fluctuating program and Sponsoring Institution needs. ~~(Core)~~**

[The Review Committee must further specify minimum dedicated time for the ~~program coordinator~~ GME administrative professional]

Guidance: The requirements do not address the source of funding required to provide the specified salary support.

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

A review of the support provided for the GME administrative professional(s) may be initiated upon request of the DIO, program director, or Review Committee, and/or at the time of a Special Review or major program changes. The program, in partnership with its Sponsoring Institution, may need to adjust the amount of support provided to meet program needs. Factors to be considered include, but are not limited to: program director turnover, major program changes, organizational changes impacting GME, program requirement changes, and ACGME Resident and Faculty Survey results.

The requirements are in no way intended to create a one-size-fits-all standard. Therefore, providing the minimum time specified without careful consideration of the needs of the program is not compliant with the requirements. If there is evidence that the dedicated time for the GME administrative professional(s) is not sufficient for effective administration of the program, the program may be cited for non-compliance, regardless of whether the minimum percentage specified in the requirement has been met.

Most specialty-specific requirements addressing required support are structured with increases based on the number of approved resident positions, which has been identified as a potential barrier for development of new programs. To address this concern, compliance with the support requirements for new programs will be based on the number of filled positions for a duration of time equal to the length of the program. For example, if the program length is three years, the program will be required to provide

the support required for the number of filled resident positions for the first three years following the effective date of Initial Accreditation. Starting in the fourth year, the program will be assessed based on the number of approved positions.

Section 3

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

Guidance: 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 that entrants into ACGME-accredited programs from ACGME-I programs have attained the prerequisite milestones for this training, they must be from programs that have ACGME-I Advanced Specialty Accreditation.

3.4.b. **Prior to accepting a transfer resident, the program must provide the transferring resident with a written description of the impact of the transfer on their eligibility for their intended specialty board's initial certification.**

Note: This requirement has been modified and moved from 3.7.

Guidance: This requirement does not apply to transitional year or preliminary year residents moving into a categorical program.

Resident Complement

3.5. ~~**Resident Complement**~~

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

[The Review Committee may further specify regarding designation of preliminary and categorical resident positions~~minimum complement numbers~~]

Guidance: Programs are required to request approval of all complement changes, whether temporary or permanent, by the Review Committee through the Accreditation Data System (ADS). Permanent increases require prior approval from the Review Committee and temporary increases greater than 90 days in duration may also require approval. For additional information, reference the specialty-specific instructions for requesting a complement increase found in the "Documents and Resources" page of the applicable specialty section of the ACGME website.

Section 4

Educational Program

Guidance: The ACGME accreditation system is designed to encourage excellence and innovation in GME regardless of the organizational affiliation, size, or location of the program. The educational program will support the development of knowledgeable, skillful physicians who provide compassionate care.

Review Committees recognize that programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-specific goals for the program and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from one focusing on community health.

Educational Components

4.2. ~~Educational Components~~

The curriculum must contain the following educational components:

~~4.2.a. a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates, which must be made available to program applicants, residents, and faculty members;~~ ~~(Core)~~

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

Guidance: The trajectory to autonomous practice is documented by competency-based assessments. Milestones are one tool in documenting the progression toward increasing independence. They are considered formative and are used to identify learning needs. Milestones data may lead to focused or general curricular revision in any given program or to individualized learning plans for any specific resident. In a competency-based framework, resident responsibilities will be determined based on documented progression.

~~4.2.c. delineation of resident responsibilities for patient care, progressive responsibility for patient management, and graded supervision;~~ ~~(Core)~~

4.2.d. a broad range of structured ~~didactic~~ educational activities, including but not limited to didactic and clinical experiences.~~; and,~~ ~~(Core)~~

Guidance: It is intended that residents will participate in structured educational activities. It is recognized that there may be circumstances in which this is not possible. Programs will define core educational activities for which time is protected and the circumstances in which residents may be excused from these didactic activities. Educational 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.

ACGME Competencies

Guidance: 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 described through the Milestones for each specialty. For more information on competencies and Milestones, refer to the Milestones Guidebook on this webpage.

The program's assessment of resident competence in each of the six competency domains will be guided by the Milestones and include consideration of resident performance as it relates to the components listed below for each competency. Upon implementation of the new Common Program Requirements, this guidance document will be expanded to include the existing specialty-specific components in each of the six Core Competencies.

ACGME Competencies – Professionalism

4.3. ~~**ACGME Competencies – Professionalism**~~

~~**Residents must demonstrate a commitment to**~~ **The program must provide instruction and assessment of residents' professionalism and adherence to ethical principles, including in the use of technology (e.g., artificial intelligence).** ~~**(Core)**~~

Components of Professionalism

- Compassion, integrity, and respect for others;
- Responsiveness to patient needs that supersedes self-interest;
- Cultural awareness;
- Respect for patient privacy and autonomy;
- Accountability to patients, society, and the profession;
- Respect and responsiveness to heterogeneous patient populations, including but not limited to gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation;
- Ability to recognize and develop a plan for one's own personal and professional well-being; and,
- Appropriately disclosing and addressing conflict or duality of interest.

ACGME Competencies – Patient Care and Procedural Skills

4.4.-5. Components of Patient Care
[Will be defined by the Review Committee]

ACGME Competencies – Medical Knowledge

4.6. Components of Medical Knowledge
[Will be defined by the Review Committee]

ACGME Competencies – Practice-Based Learning and Improvement

4.7. ~~**ACGME Competencies – Practice-Based Learning and Improvement Residents must demonstrate the**~~**The program must provide instruction in and assessment of residents' ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on ~~constant self-evaluation~~ informed self-assessment and lifelong learning.** ~~**(Core)**~~

Components of Practice-Based Learning and Improvement

- Identifying strengths, deficiencies, and limits in one's knowledge and expertise;
- Setting learning and improvement goals;
- Identifying and performing appropriate learning activities;
- Systematically analyzing practice using quality improvement methods, including activities aimed at reducing health care disparities, and implementing changes with the goal of practice improvement;
- Incorporating feedback and formative evaluation into daily practice; and,
- Locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems.

ACGME Competencies – Interpersonal and Communication Skills

4.8. ~~**ACGME Competencies – Interpersonal and Communication Skills Residents must demonstrate interpersonal and communication skills that result in the**~~ **The program must provide instruction in and assessment of residents' ability to effectively exchange ~~of~~ information and collaborate~~ion~~ with ~~patients, their families, and health professionals~~ different individuals and teams, including patient hand-offs.** ~~**(Core)**~~

Note: This requirement has been modified and moved from 6.28.b.

Components of Interpersonal and Communication Skills

- Communicating effectively with patients and patients' families, as appropriate, across a broad range of socioeconomic circumstances, cultural backgrounds, and language capabilities, learning to engage interpretive services as required to provide appropriate care to each patient;
- Communicating effectively with physicians, other health professionals, and health-related agencies;
- Working effectively as a member or leader of a health care team or other professional group;
- Educating patients, patients' families, students, other residents, and other health professionals;
- Acting in a consultative role to other physicians and health professionals;
- Maintaining comprehensive, timely, and legible health care records, if applicable; and,
- Communicating with patients and patients' families to partner with them to assess their care goals, including, when appropriate, end-of-life goals.

ACGME Competencies – Systems-Based Practice

4.9. ~~**ACGME Competencies – Systems-Based Practice**~~

The program ~~Residents~~ must provide instruction in and assessment of residents' understanding of health system resources in the context of ~~demonstrate an awareness of and responsiveness to the larger context and system of health care, including~~ the social determinants of health,~~,~~ ~~as well as~~ and their ability to call effectively ~~collaborate with other providers and use~~ on those resources to provide optimal health care, including the use of existing and emerging technologies (e.g., artificial intelligence). ~~(Core)~~

Components of Systems-Based Practice

- Working effectively in various health care delivery settings and systems relevant to one's clinical specialty;
- Coordinating patient care across the health care continuum and beyond as relevant to one's clinical specialty;
- Advocating for quality patient care and optimal patient care systems;
- Participating in identifying system errors and implementing potential systems solutions;
- Incorporating considerations of value, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate;
- Understanding health care finances and their impact on individual patients' health decisions;
- Using tools and techniques that promote patient safety and disclosure of patient safety events (real or simulated); and,
- Advocating for patients within the health care system to achieve the patient's and patient's family's care goals, including, when appropriate, end-of-life goals.

Curriculum Organization and Resident Experiences

4.10. ~~**Curriculum Structure**~~

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

Assignment of rotations must be structured to minimize the frequency of rotational transitions, and rotations must be of sufficient length to provide a quality educational experience, defined by continuity of patient care, ongoing supervision, longitudinal relationships with faculty members, and meaningful assessment and feedback.

Note: This requirement has been modified and moved from 6.28. and 6.28.a.

[The Review Committee ~~must~~ may further specify]

Guidance: In some specialties, frequent rotational transitions, inadequate continuity of faculty member supervision, and dispersed patient locations within the hospital have adversely affected optimal resident education and effective team-based care. The need for patient care continuity varies from specialty to specialty and by clinical situation and may be addressed by the individual Review Committee.

4.11. **The program must provide an environment that ensures appropriate patient care responsibilities, with attention to scheduling, work intensity, and work compression, considering resident competence and patient complexity.**

Note: This requirement has been modified and moved from 6.16.b. and 6.18.a.

Guidance: The Common Program Requirements do not define "appropriate patient care responsibilities" as this is variable by specialty and PGY level. Review Committees may provide further detail regarding patient care responsibilities in the applicable specialty-specific Program Requirements and accompanying guidance statements. However, all programs, regardless of specialty, are expected to carefully assess how the assignment of patient care responsibilities can affect work compression, especially at the PGY-1 level.

4.12. **The clinical responsibilities for each resident must be based on patient safety, assessments of resident ability, severity and complexity of patient illness/condition, and available support services.**

[Optimal clinical workload may be specified by the Review Committee]

Note: This requirement has been modified and moved from 6.26.

Guidance: Programs are expected to ensure that patient care responsibilities, scheduling, workload, and work compression are managed to support safe patient care. It is essential that assignments are appropriate for the resident's level of competence and the complexity of the patients under their care.

Planned Educational Activities

4.14. ~~**Didactic and Clinical Experiences**~~

Residents must be provided with protected time from clinical responsibilities to participate in ~~core didactic~~ planned educational activities. ~~(Core)~~

[The Review Committee may specify required didactic and clinical experiences]

Guidance: To ensure that residents have protected time, it is the responsibility of the program to structure resident schedules such that residents have no clinical responsibilities that overlap with their scheduled educational activities, and that there is coverage for clinical care so that residents are not pulled away to provide care as needed.

Inquiry and Scholarship

Guidance: As members of the profession of medicine, physicians demonstrate the ability to extend their influence beyond the clinic, bedside, or operating room and help direct the future of their field. This can be done by research, quality improvement, service on committees, continuing education presentations, or other activities that move the knowledge and practice of their

specialty forward. It is important for skills in these areas to be incorporated in the trainee experience and demonstrated by the faculty.

The Common Program Requirements address two essential components of scholarship: (1) an environment of inquiry, which focuses on activities within a program and that encourage continuous questioning, critical thinking, and the use of evidence-based practices; and (2) scholarly activity, which focuses on activities external to the program with the goal of expanding medical knowledge, promoting lifelong learning, and translating research into practice. Combined, these two key components of scholarship reflect the dichotomy of education of oneself and educating others.

Environment of Inquiry

4.17. **The program must establish and maintain an environment of inquiry in which the program director and faculty foster resident acquisition of relevant skills, including the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice principles of lifelong learning.**

Guidance: "Environment of Inquiry" refers to things faculty members and residents are expected to incorporate into their work on a regular basis. There is no reporting requirement related to establishing and maintaining an environment of inquiry.

4.17.a. **To maintain this environment of inquiry, the faculty and residents must participate in the following activities:**

- **Scheduled educational events designed to develop competence in analysis and interpretation of medical literature;**
- **Clinical teaching by the faculty that regularly references reliable, relevant information which supports patient care and a critical appraisal of medical evidence; and,**
- **Regular presentations by faculty members and residents to discuss the application of current evidence as applicable to the specialty and patient care.**

Scholarly Activity

4.18. ~~**Faculty Scholarly Activity**~~

~~**Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains:** (Core)~~ **The program, in partnership with its Sponsoring Institution, must allocate adequate resources for, and must demonstrate evidence of, resident and faculty involvement in scholarly activities.**

Program scholarly activity must include:

Note: This requirement combines 4.16. and 4.16.a.

Guidance: Information regarding reporting requirements will be provided prior to

implementation of the revised Common Program Requirements.

4.18.a. **Completion of at least one of the activities listed below by each core and other required faculty member at least once every three years:**

- **Creation and delivery of curricula, including didactic presentations**

  Note: This requirement has been modified and moved from a bullet below.

- **Creation of assessment or program evaluation tools**

  Note: This requirement has been modified and moved from a bullet below.

- **Delivery of local, regional, or national presentations**
- **Service on institutional, regional, or national professional committees, educational organizations, or editorial boards**

  Note: This requirement has been modified and moved from a bullet below.

- **Conducting Rresearch in basic science, education, translational science, patient care, or population health**
- **~~Peer-reviewed~~ Authoring submitted grants in education/training, scientific research, or service ~~grants~~**
- **Leading a ~~Q~~quality improvement and/or patient safety initiative~~s~~**
- **Authoring a submitted original research article, ~~S~~systematic review~~s~~, meta-analysies, review article~~s~~, chapter~~s~~ in a medical textbook, or case report~~s~~**
- **Meaningful participation in advocacy for improvements such as local, regional, national, and/or global health care or public health policy**
- **~~Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials~~**

  Note: This requirement has been modified and moved to bullets above.

- **~~Contribution to professional committees, educational organizations, or editorial boards~~**

  Note: This requirement has been modified and moved to bullets above.

- **~~Innovations in education~~**

Guidance: In the context of this requirement, participation in advocacy extends beyond advocating for patients. Examples of advocacy include testifying before congress about maternal care; working as a consultant for local government on drafting legislation for safety regulations for children; developing policy briefs; serving on policy committees or task force for specialty societies; and research and advocacy work to submit a resolution for the American Medical Association (AMA), for example.

4.18.b. **Completion of at least one of the activities listed below by each resident prior to graduation from the program:**

- **Creation and delivery of curricula, including didactic presentations**
- **Creation of assessment or program evaluation tools**
- **Delivery of local, regional, or national presentations**
- **Service on institutional, regional, or national professional committees, educational organizations, or editorial boards**
- **Conducting research in basic science, education, translational science, patient care, or population health**
- **Authoring submitted grants in education/training, scientific research, or service**
- **Leading a quality improvement and/or patient safety initiative**
- **Authoring a submitted original research article, systematic review, meta-analysis, review article, chapter in a medical textbook, or case report**
- **Meaningful participation in advocacy for improvements such as local, regional, national, and/or global health care or public health policy**

Guidance: In the context of this requirement, participation in advocacy extends beyond advocating for patients. Examples of advocacy include testifying before congress about maternal care; working as a consultant for local government on drafting legislation for safety regulations for children; developing policy briefs; serving on policy committees or task force for specialty societies; and research and advocacy work to submit a resolution for the AMA, for example.

Section 5

Resident Assessment

5.1. ~~**Resident Evaluation: Feedback and Evaluation**~~

A Clinical Competency Committee (CCC) must be appointed by the program director to review all resident assessments at least semi-annually and advise the program director regarding each resident's progress on specialty-specific Milestones.

Note: This requirement combines 5.12. and 5.12.c-e.

5.1.a. **At a minimum, the CCC must include three members of the program**

faculty who have extensive contact and experience with the program's residents.

Note: This requirement has been modified and combines 5.12.a. and 5.12.b.

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

Considerations for small programs: 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.

Additional CCC members: There may be additional members of the CCC. Chief residents who have completed core residency programs in their specialty may be members of the CCC.

5.2. **The program must have a comprehensive system of objective assessment that is reviewed and updated annually; that is competency-based and specialty-specific (including specialty-specific Case Logs, when applicable); that involves multiple assessors (e.g., faculty members, peers, patients, self, and other professional staff members); and which informs CCC actions. This program of assessment must include a plan for structured growth toward autonomous practice.**

Note: This requirement combines 5.3.b.-5.3.b.2.

Guidance: A comprehensive system of assessment is a foundation for competency-based medical education. Feedback, formative assessment, and summative assessment compare intentions with accomplishments, enabling the transformation of a neophyte physician to one with growing expertise.

Formative and summative assessment have distinct definitions. Formative assessment 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 assessments 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 assessment is evaluating a resident's learning by comparing the residents

against the goals and objectives of the rotation and program, respectively. Summative assessment is utilized to make decisions about promotion to the next level of training, or program completion.

End-of-rotation and end-of-year assessments have both summative and formative components. Information from a summative assessment can be used formatively when residents or faculty members use it to guide their efforts.

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

Guidance: 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. Faculty members will 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 assessment.

5.4. Faculty members must perform, and provide to the resident in a timely fashion, a written assessment of resident performance after completion of each educational assignment.

Note: This requirement has been modified and moved from 5.3.a.

5.5. For ~~block rotations~~ experiences greater than three months in duration, assessment ~~evaluation~~ must be documented and provided to the resident at least every three months.

Note: This requirement has been modified and moved from 5.3.a.1.-2.

5.6. The program director or their designee, with input from the CCC, must meet ~~with~~ and review with each resident their documented semi-annual ~~evaluation~~ assessment of performance, including progress along the specialty-specific Milestones and Case Logs, as applicable. ~~(Core)~~

5.7. The program director or their designee, with input from the CCC, must assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth. ~~(Core)~~

5.8. The program director or their designee, with input from the CCC, must develop plans for residents failing to progress, following institutional policies and procedures. ~~(Core)~~

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

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

Guidance: Learning is an active process that requires effort from the teacher and the learner. Faculty members assess a resident's performance at least at the end of each rotation. The program director or their designee will review those assessments, including their progress on the Milestones, at a minimum of every six months. Residents should be encouraged to reflect upon the assessment, 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.

Faculty Assessment

5.13. ~~**Faculty Evaluation**~~

The program must have a process to assess~~evaluate~~ each faculty member's performance as it relates to the educational program and provide feedback to the faculty member at least annually. ~~(Core)~~

Note: This requirement has been modified and moved from 5.13.c.

Guidance: The program director is responsible for the educational program and all educators. While the term "faculty" may be applied to physicians within a given institution for other reasons, it is applied to residency program faculty members only through approval by a program director. The development of the faculty improves the education, clinical, and research aspects of a program. Faculty members have a strong commitment to the residents and desire to provide optimal education and work opportunities. It is required that faculty members be provided feedback on their contribution to the mission of the program. All faculty members who interact with residents desire feedback on their education, clinical care, and research. If a faculty member does not interact with residents, feedback is not required. With regard to the varied operating environments and configurations, the residency program director may need to work with others to determine the effectiveness of the program's faculty performance with regard to their role in the educational program. Other aspects for the feedback may include research or clinical productivity, review of patient outcomes, or peer review of scholarly activity, as applicable.

~~5.13.a.~~ ~~This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities.~~ ~~(Core)~~

5.13.b. **This assessment~~evaluation~~ must include written, anonymous, and confidential assessments~~evaluations~~ by the residents.** ~~(Core)~~

~~5.13.c.~~ ~~Faculty members must receive feedback on their evaluations at least annually.~~ ~~(Core)~~

Note: This requirement has been modified and moved to 5.13.

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

Guidance: 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 of 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.

Program Evaluation and Improvement

5.14. ~~Program Evaluation and Improvement~~

The program director must appoint ~~the~~ a Program Evaluation Committee (PEC), ~~to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process.~~ ~~(Core)~~ ~~**Program Evaluation Committee responsibilities must include**~~ **responsible for the review of ~~the current operating environment to identify~~ program strengths, challenges, opportunities, and threats, as related to the program's mission and aims.** ~~(Core)~~

Note: This requirement has been combined with 5.14.d.

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

5.14.a. **The ~~Program Evaluation Committee~~ PEC must include, at a minimum, ~~be composed of at least~~ two program faculty members~~, at least one of whom is a core faculty member,~~ and ~~at least~~ one resident.** ~~(Core)~~

5.14.b. **The PEC must complete an Annual Program Evaluation that defines annual program improvement goals, and considers: 1) program outcomes; 2) the results of the ACGME Resident/Fellow and Faculty Surveys; and 3) written, anonymous, and confidential program evaluations by residents and faculty members. ~~Program Evaluation Committee responsibilities must include review of the program's self-determined goals and progress toward meeting them.~~ ~~(Core)~~**

Note: This requirement incorporates 5.14.c. and 5.14.e.

~~**5.14.c.** **Program Evaluation Committee responsibilities must include guiding ongoing program improvement, including development of new goals, based upon outcomes.** (Core)~~

Note: This requirement is incorporated into 5.14.b.

~~**5.14.d.** **Program Evaluation Committee responsibilities must include review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims.** (Core)~~

Note: This requirement has been modified and incorporated into 5.14.

~~**5.14.e.** **The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate resident and faculty written evaluations of the program, and other relevant data in its assessment of the program.** (Core)~~

Note: This requirement has been incorporated into 5.14.b.

~~**5.14.f.** **The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats.** (Core)~~

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

Guidance: While the ACGME Resident and Faculty Surveys are essential components of the Annual Program Evaluation, consideration of this data alone is insufficient for an effective evaluation of the program. Additional evaluation of program effectiveness and outcomes may include consideration of the following:

- Curriculum
- ACGME Letters of Notification, including citations, Areas for Improvement, and comments
- Quality and safety of patient care

- Aggregate resident and faculty well-being; recruitment and retention; engagement in quality improvement and patient safety; and scholarly activity
- Aggregate resident Milestones evaluations, and achievement on in-training examinations (where applicable), board pass and certification rates, and graduate performance
- Milestones progression
- Cases/procedures
- Prior Annual Program Evaluation(s)
- Aggregate resident written assessments of the faculty, and resident and faculty written evaluations of the program
- The assessment system
- Faculty development needs
- Other relevant data

Board Certification

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

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

5.15. ~~**Board Certification**~~

For ~~specialties in which the~~ ABMS member board and/or AOA certifying board ~~offer(s) an annual~~ written exam performance, ~~in the preceding three years,~~ for two out of the three most recent board exam administrations, the program's ~~aggregate~~ pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty or equal to or above 80 percent if the bottom fifth percentile is below that threshold.
~~**(Outcome)**~~

[For specialties with multi-part exams, the Review Committee may further specify which exam will be the basis for this requirement.]

Guidance: Programs will not be cited for noncompliance with this requirement based on graduate performance on the certifying examinations for a single year. Rather, compliance is based on review of performance data for the most recent three-year period. If the program's pass rate does not meet the required threshold in at least two out of three years, the program may receive a citation. In this circumstance, the Review Committee expects that the program will develop an improvement plan.

Specialty Percentile for First-Time Pass Rate at Least 2 of Past 3 Years	Absolute Percent First-Time Pass Rate at Least 2 of Past 3 Years	Compliant?
Above 5th percentile for specialty (i.e. in the top 95% of program pass rates for specialty)	At least 80% Passed	Yes
Above 5th percentile for specialty (i.e. in	Under 80% Passed	Yes

the top 95% of program pass rates for specialty)		
Below 5th percentile for specialty (i.e. in the bottom 5% of program pass rates for specialty)	At least 80% Passed	Yes
Below 5th percentile for specialty (i.e. in the bottom 5% of program pass rates for specialty)	Under 80% Passed	No

NOTE: Pass rate calculations are per year, not averaged. For example, if a program's pass rate is above the fifth percentile and at least 80 percent for two of the past three years, it will not receive a citation even if the pass rate in the third year is zero percent.

5.16. **The ultimate board pass rate, which is the percentage of ABMS member board and/or AOA certifying board eligible program graduates who seek and obtain certification within seven years of completion of the program, must be at least 90 percent.**

Guidance: The ACGME's Mission is to improve health care and population health by assessing and enhancing the quality of resident and fellow physicians' education through advancements in accreditation and education. In support of this Mission, and in recognition of the ACGME's responsibility to the public, one important goal of ACGME-accredited education is to educate physicians who seek and achieve board certification.

While it is recognized that not all physicians who seek certification will pass the certifying examination on the first attempt, it is expected that nearly all of those individuals will ultimately achieve certification. A program that fails to maintain an ultimate pass rate of at least 90 percent will be subject to citation and will need to identify and correct deficiencies that contribute to failure to meet this important threshold.

Section 6

Description of The Learning and Working Environment

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

- *Excellence in the safety and quality of care provided to patients by residents today*
- *Excellence in the safety and quality of care provided to patients by today's residents in their future practice*
- *Excellence in professionalism*
- *Appreciation for the privilege of caring for patients*
- *Commitment to the well-being of the students, residents, faculty members, and all members of the health care team*

Definition of 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.

Patient Safety and Quality

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

[The Review Committee may further specify]

Note: This requirement has been moved from 6.27.

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

6.5. **The program must provide opportunities for ~~R~~resident ~~must~~ participate~~ion~~ 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.~~ Programs must facilitate/support participation for residents engaging in these activities.** ~~(Core)~~

Note: This requirement has been modified and incorporates 6.1. and 6.6.

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

This requirement is intended to ensure that residents have meaningful exposure to interprofessional clinical patient safety and quality improvement activities as part of their educational experience. Participation in these activities supports the development of systems-based practice, teamwork skills, and an understanding of how quality and safety initiatives are designed, analyzed, and implemented in clinical settings.

Programs are expected to provide access to opportunities for residents to participate as members of interprofessional teams in patient safety and quality improvement activities. These may include, but are not limited to, root cause analyses, morbidity and mortality conferences with systems-based focus, quality improvement projects, patient safety committees, or other structured activities that involve analysis and the development and implementation of improvement actions.

Residents will be supported to participate in patient safety and quality improvement events related to the care of their patients throughout their residency.

Importantly, not every resident is required to participate in these activities. However, programs will ensure that:

- Opportunities are available and visible to residents; and,
- Residents who are interested in participating are supported and facilitated in doing so (e.g., through protected time, mentorship, or integration into existing workflows).

Programs may meet this program requirement through departmental, hospital-based, or institutional activities, provided that the experiences are interprofessional in nature and include engagement in patient safety and/or quality improvement processes.

Supervision and Accountability

Guidance: The Review Committee may determine whether supervision of residents by non-physician supervisors is permitted. When supervision by non-physician supervisors is permitted by the Review Committee, it is expected that the vast majority of resident supervision will be done by physicians. Decisions around non-physician supervision should be appropriate to the context of the local environment. Appropriate non-physician supervisors will vary by specialty and may include, but are not limited to, advanced practice providers, psychologists, dentists, and pharmacists. These professionals may contribute meaningfully to education in a given specialty. For example, a clinical psychologist leading a behavior change clinic focused on tobacco cessation or healthy eating may provide a valuable educational experience in how to effectively counsel patients.

6.10. **The program must ~~demonstrate that~~ maintain and adhere to a program-specific policy that describes the appropriate level of supervision, consistent with the definitions above, for all patient care activities. ~~in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation.~~ The policy must define: ~~(Core)~~**

6.10.a. **the process by which a program assesses residents' readiness to act with conditional independence and serve in a supervisory role to junior residents;**

Note: This requirement incorporates 6.13.a., 6.13.c., and 6.14.a.

6.10.b. **the responsibility of supervising clinicians to delegate portions of care to residents based on patient need and resident skill;**

Note: This requirement has been moved and modified from 6.13.b.

6.10.c. **how and when residents must communicate with the supervising clinician regarding the complexity and acuity of the patient, including changes to patient status; and,**

Note: This requirement has been moved and modified from 6.14.

6.10.d. **the circumstances and procedures for which direct supervision is required.**

Note: This requirement has been modified and moved from 6.12.

[The Review Committee may specify:

1. **which activities require different levels of supervision; and/or,**
2. **the role and/or restrictions of non-physician supervision of residents]**

Guidance: Appropriate supervision is essential for patient safety and effective teaching. Supervision is also contextual. There is significant variability in resident-patient interactions and resident skills and abilities, even among residents in the same level of a residency program. The degree of supervision for a resident is expected to evolve progressively as the resident gains more experience, even with the same patient condition or procedure. The level of supervision for each resident must be commensurate with that resident's level of independence in practice; this level of supervision will likely vary based on factors such as patient safety, complexity, acuity, urgency, risk of serious safety events, variability in the support services at different training sites, or other pertinent variables.

It is the responsibility of the program to ensure that each resident knows the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence (graded, progressive responsibility for patient care with defined oversight). Additionally, residents and faculty members are responsible for informing each patient of their respective roles in that patient's care when providing direct patient care. It is essential that this information be available to residents, faculty members, other members of the health care team, and patients.

A supervision policy guides the progression to independent practice, in which residents experience graduated autonomy in a supportive environment. During this essential phase, residents have an opportunity to challenge themselves and exercise autonomy, which includes cognitive independence, adaptive expertise, boundary awareness, and self-assessment. Specific elements included in the program's supervision policy should be tailored to specialty-specific training and board certification requirements and other program-specific factors as needed. Examples to consider include, but are not limited to, the following:

- Faculty development expectations and resources regarding resident supervision
- The types of feedback that may be used for making supervisions determinations, on a spectrum from real-time, informal feedback to validated scale, based on program needs and specific circumstances
- The responsibility of attending physicians to communicate their expectations for resident progression.
- Required sign-off on a specified number of simulations before performing a certain procedure.
- Validated autonomy rubric (i.e., specified number of successful supervised procedures before being allowed to practice under indirect supervision)

- Expectations regarding ongoing monitoring of case logs, patient outcomes, real-time input of faculty, self-assessment by residents and peer assessment, in addition to formal CCC assessments and Milestones
- How level of competency and appropriate supervision is communicated to other members of the team, including other residents and advanced practice practitioners
- Consideration of appropriateness and program expectations of residents providing supervision to other learners

Well-Being

Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of residency training. Residents and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. A positive culture in a clinical learning environment models constructive behaviors and prepares residents with the skills and attitudes needed to thrive throughout their careers.

6.19. **The program must have a plan for preventing burnout and promoting well-being among residents that takes into account information from the annual ACGME Resident and Faculty Surveys.**

Note: This requirement incorporates 6.19.a. and 6.19.b.

Guidance: This requires an ongoing process in which programs employ a continuous quality improvement process to review survey results, develop and implement plans to address issues as needed, assess the effectiveness of these efforts, and modify as needed. See the Well-Being section of Learn at ACGME for tools and resources. (Note: A free account may be required to access some resources.)

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

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

6.21. **The program, in partnership with its Sponsoring Institution, must provide systems to support residents experiencing physical and/or mental health**

conditions that may impair their safety and/or ability to provide safe patient care. This responsibility includes educating residents and faculty members in how to recognize those symptoms and how to access appropriate care.

Note: This requirement combines 6.21.a.- 6.21.a.3.

Guidance: Programs and Sponsoring Institutions are encouraged to review materials to create systems for identification of burnout, depression, and substance use disorders. Materials and more information are available in the Well-Being section of Learn at ACGME. (Note: A free account may be required to access some resources.)

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

The Common Program Requirement regarding 24-hour access to mental health services has been removed because it is redundant with Institutional Requirement 3.2.g.4. The expectation that the Sponsoring Institution, in partnership with the program, must provide access to confidential, affordable behavioral health care 24 hours a day, seven days a week remains unchanged. The intent is to ensure that residents have immediate access at all times to a mental health professional (psychiatrist, psychologist, Licensed Clinical Social Worker, Psychiatric 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. Additionally, the expectation that the program provide systems to support residents does not include a requirement for financial support. It is essential, however, that the program structure resident schedules in a manner that allows residents to receive care when it is needed.

6.22. ~~**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.**~~ **The program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities.** ~~**(Core)**~~

~~6.22.a.~~ ~~The program must have policies and procedures in place to ensure coverage of patient care and ensure continuity of patient care.~~ ~~(Core)~~

Note: This requirement has been modified and incorporated into 6.23.

~~6.22.b.~~ ~~These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work.~~ ~~(Core)~~

Note: This requirement has been modified and incorporated into 6.23.

6.23. **The program must have a policy describing how planned appointments during work hours, unanticipated absences, and leave are requested and covered.**

Note: This requirement incorporated 6.22.a. and 6.22.b.

Guidance: When a resident requests time away from the program, the program is responsible for communicating to the resident the potential impact of the absence on their education and board eligibility. Residents may need to extend their length of training depending on length of absence and specialty board eligibility requirements. Teammates have a responsibility to assist colleagues in need and fairly reintegrate them upon return.

Clinical and Educational Work Hours

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

Maximum Hours of Clinical and Educational Work per Week

6.29. ~~**Maximum Hours of Clinical and Educational Work per Week**~~

Clinical and educational work hours must be limited to no more than 80 hours per week, when averaged over a maximum of four weeks~~ ~~period~~ and within the span of a single clinical assignment/rotation.~~, including~~ This includes all in-house clinical and educational activities, clinical work done from home, and all moonlighting. ~~(Core)~~

Note: Upon approval and implementation of the Common Program Requirements, existing specialty-specific requirements in this section will be deleted.

Guidance: This requirement is intended to promote resident well-being, patient safety, and effective learning by establishing reasonable limits on total clinical and educational

work hours. The expectation is that residents' total work hours do not exceed 80 hours per week on average, inclusive of all clinical and educational responsibilities, clinical work performed from home, and any moonlighting.

The use of an averaging period is designed to allow for reasonable variation in weekly workloads, recognizing that certain rotations or clinical experiences may involve periods of higher intensity.

Programs are responsible for ensuring that:

- The average work hours do not exceed 80 hours per week, calculated over a four-week period or over the duration of a shorter rotation.
- This expectation applies equally to shorter rotations (e.g., two weeks); in such cases, the average across the rotation must still not exceed 80 hours per week. For example, if over the course of a four-week period, residents are assigned to two rotations, each two weeks in duration, and residents work 100 hours per week during the first rotation and 50 hours per week during the second, the program is non-compliant with the requirement because the first rotation exceeds 80 hours when averaged over the course of the rotation.

Programs are accountable for designing schedules within the rotations they oversee such that residents can remain compliant with clinical and educational work hour requirements. To ensure appropriate compliance, residents share responsibility for monitoring their work hours, including time spent in external rotations, additional clinical activities, or moonlighting. While there may be benefit to programs and institutions requiring residents to log work hours, the ACGME does not prescribe nor require logging mechanisms for resident clinical and educational work hours.

Mandatory Time Free of Clinical Work and Education

6.31. **Residents must have at least ~~14~~ 12 hours free of clinical work and education after 24 hours of in-house call.** ~~(Core)~~

6.32. **Residents must be scheduled for a minimum of one day (a period of 24 consecutive hours) in seven free of clinical work and required education, ~~(~~when averaged over a maximum of four weeks~~)~~ and within the span of a single clinical assignment/rotation. At-home call cannot be assigned on these free days.** ~~(Core)~~

Note: Upon approval and implementation of the Common Program Requirements, existing specialty-specific requirements in this section will be deleted.

Guidance: The requirement provides flexibility for programs to distribute days off in a manner that meets program and resident needs. Distributing days off so that residents have a "golden weekend," meaning a consecutive Saturday and Sunday free from work, is acceptable to meet this requirement.

Maximum Clinical Work and Education Period Length

6.33. ~~**Maximum Clinical Work and Education Period Length**~~

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

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

Note: Upon approval and implementation of the Common Program Requirements, existing specialty-specific requirements in this section will be deleted.

Guidance: 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. These 24 hours and up to an additional four hours must occur within the context of the 80-hour weekly limit, averaged over four weeks or the duration of the rotation if less than four weeks. The additional time referenced in the requirement may not be used for the care of new patients.

At-Home Call

6.39. ~~**At-Home Call**~~

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

Guidance: This requirement is intended to preserve the flexibility of at-home call while ensuring that resident workload, rest, and overall well-being are protected. Time spent performing patient care activities while on at-home call must be included in the 80-hour weekly limit, as these activities represent clinical work regardless of location.

At-home call is distinct from in-house call in that residents are not required to remain on site and may be resting; however, the expectation is that the burden of clinical work during at-home call remains reasonable and intermittent, allowing for meaningful rest periods.

The requirement also ensures that the frequency of at-home call supports compliance with the expectation of one day in seven free of clinical work and education, when averaged over four weeks or the duration of the rotation if less than four weeks.

Clarification of Intent and Appropriate Use: At-home call may not be used to circumvent other clinical and educational work hour requirements, including limits on continuous clinical work or expectations around time free of work. Scheduling structures labeled as “home call” should not functionally replicate extended in-house call or continuous overnight shifts.

6.39.a. **At-home call must not be so frequent or ~~taxing~~ of such intensity as to preclude adequate rest or reasonable personal time for each resident. Programs that utilize at-home call must define the patient care activities that must be counted as work hours, and must maintain a process to monitor workload intensity and make adjustments as needed.** ~~(Core)~~

Guidance: The requirement above addresses at-home call assigned to residents, which is distinct from clinical work a resident does from home by choice. As noted in 6.39., when a resident is taking at-home call, clinical work done during this time must count toward the 80-hour maximum weekly limit. This may include, but is not limited to, managing patient care from home, chart documentation on patients cared for during call, or interacting with other services or nursing. This would not include completion of routine, daily patient documentation notes, which are expected to be completed during the regular workday. This acknowledges the often-significant amount of time residents devote to clinical activities when taking at-home call and ensures that taking at-home call does not result in residents routinely working more than 80 hours per week. Clinical work performed from home during at-home call includes any patient care activity that requires sustained cognitive effort, clinical decision-making, or active management of patient care, and should be counted toward work hours when it represents more than brief, intermittent communication.

Activities such as reading about the next day's case, studying, or research activities do not count toward the 80-hour weekly limit.

Programs are responsible for evaluating both the frequency and intensity of at-home call to ensure alignment with the intent of providing flexibility while maintaining safe and appropriate workloads. In its evaluation of programs, the Review Committee will look at the overall impact of at-home call on resident rest and personal time.