

**ACGME Program Requirements for
Graduate Medical Education
in Aerospace Medicine**

Proposed new requirements; posted for review and comment February 14, 2022

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2 **Proposed ACGME Program Requirements for Graduate Medical Education**
3 **in Aerospace Medicine**

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5 **Common Program Requirements (Residency) are in BOLD**
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7 Where applicable, text in italics describes the underlying philosophy of the requirements in that
8 section. These philosophic statements are not program requirements and are therefore not
9 citable.

10
11 **Introduction**

12
13 **Int.A.** *Graduate medical education is the crucial step of professional*
14 *development between medical school and autonomous clinical practice. It*
15 *is in this vital phase of the continuum of medical education that residents*
16 *learn to provide optimal patient care under the supervision of faculty*
17 *members who not only instruct, but serve as role models of excellence,*
18 *compassion, professionalism, and scholarship.*

19
20 *Graduate medical education transforms medical students into physician*
21 *scholars who care for the patient, family, and a diverse community; create*
22 *and integrate new knowledge into practice; and educate future generations*
23 *of physicians to serve the public. Practice patterns established during*
24 *graduate medical education persist many years later.*

25
26 *Graduate medical education has as a core tenet the graded authority and*
27 *responsibility for patient care. The care of patients is undertaken with*
28 *appropriate faculty supervision and conditional independence, allowing*
29 *residents to attain the knowledge, skills, attitudes, and empathy required*
30 *for autonomous practice. Graduate medical education develops physicians*
31 *who focus on excellence in delivery of safe, equitable, affordable, quality*
32 *care; and the health of the populations they serve. Graduate medical*
33 *education values the strength that a diverse group of physicians brings to*
34 *medical care.*

35
36 *Graduate medical education occurs in clinical settings that establish the*
37 *foundation for practice-based and lifelong learning. The professional*
38 *development of the physician, begun in medical school, continues through*
39 *faculty modeling of the effacement of self-interest in a humanistic*
40 *environment that emphasizes joy in curiosity, problem-solving, academic*
41 *rigor, and discovery. This transformation is often physically, emotionally,*
42 *and intellectually demanding and occurs in a variety of clinical learning*
43 *environments committed to graduate medical education and the well-being*
44 *of patients, residents, fellows, faculty members, students, and all members*
45 *of the health care team.*

46
47 **Int.B. Definition of Specialty**

48
49 The medical specialty of aerospace medicine focuses on the health of a
50 population group consisting of the operational crews and passengers of air and

51 space vehicles, and the support personnel who are required to operate such
52 vehicles.

53
54 **Int.C. Length of Educational Program**

55
56 Educational programs in aerospace medicine are configured in 24-month and 36-
57 month formats. The latter includes 12 months of education in fundamental clinical
58 skills of medicine, and both include 24 months of education in clinical aerospace
59 medicine (PM-1 and PM-2). ^{(Core)*}

60
61 **I. Oversight**

62
63 **I.A. Sponsoring Institution**

64
65 *The Sponsoring Institution is the organization or entity that assumes the*
66 *ultimate financial and academic responsibility for a program of graduate*
67 *medical education, consistent with the ACGME Institutional Requirements.*

68
69 *When the Sponsoring Institution is not a rotation site for the program, the*
70 *most commonly utilized site of clinical activity for the program is the*
71 *primary clinical site.*

72
Background and Intent: Participating sites will reflect the health care needs of the community and the educational needs of the residents. A wide variety of organizations may provide a robust educational experience and, thus, Sponsoring Institutions and participating sites may encompass inpatient and outpatient settings including, but not limited to a university, a medical school, a teaching hospital, a nursing home, a school of public health, a health department, a public health agency, an organized health care delivery system, a medical examiner's office, an educational consortium, a teaching health center, a physician group practice, federally qualified health center, or an educational foundation.

73
74 **I.A.1. The program must be sponsored by one ACGME-accredited**
75 **Sponsoring Institution.** ^(Core)

76
77 **I.B. Participating Sites**

78
79 *A participating site is an organization providing educational experiences or*
80 *educational assignments/rotations for residents.*

81
82 **I.B.1. The program, with approval of its Sponsoring Institution, must**
83 **designate a primary clinical site.** ^(Core)

84
85 **I.B.2. There must be a program letter of agreement (PLA) between the**
86 **program and each participating site that governs the relationship**
87 **between the program and the participating site providing a required**
88 **assignment.** ^(Core)

89
90 **I.B.2.a) The PLA must:**

91
92 **I.B.2.a).(1) be renewed at least every 10 years; and,** ^(Core)

93
94 **I.B.2.a).(2)** be approved by the designated institutional official
95 **(DIO).** *(Core)*

96
97 **I.B.3.** The program must monitor the clinical learning and working
98 environment at all participating sites. *(Core)*

99
100 **I.B.3.a)** At each participating site there must be one faculty member,
101 designated by the program director as the site director, who
102 is accountable for resident education at that site, in
103 collaboration with the program director. *(Core)*

104

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

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

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

105
106 **I.B.4.** The program director must submit any additions or deletions of
107 participating sites routinely providing an educational experience,
108 required for all residents, of one month full time equivalent (FTE) or
109 more through the ACGME's Accreditation Data System (ADS). *(Core)*

110
111 **I.C.** The program, in partnership with its Sponsoring Institution, must engage in
112 practices that focus on mission-driven, ongoing, systematic recruitment
113 and retention of a diverse and inclusive workforce of residents, fellows (if
114 present), faculty members, senior administrative staff members, and other
115 relevant members of its academic community. *(Core)*

116

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

117

118 **I.D. Resources**

119
120 **I.D.1. The program, in partnership with its Sponsoring Institution, must**
121 **ensure the availability of adequate resources for resident education.**
122 **(Core)**

123
124 **I.D.1.a) Programs must have a flight training program. (Core)**
125

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

129
130 **I.D.2.a) access to food while on duty; (Core)**

131
132 **I.D.2.b) safe, quiet, clean, and private sleep/rest facilities available**
133 **and accessible for residents with proximity appropriate for**
134 **safe patient care; (Core)**
135

Background and Intent: Care of patients within a hospital or health system occurs continually through the day and night. Such care requires that residents function at their peak abilities, which requires the work environment to provide them with the ability to meet their basic needs within proximity of their clinical responsibilities. Access to food and rest are examples of these basic needs, which must be met while residents are working. Residents should have access to refrigeration where food may be stored. Food should be available when residents are required to be in the hospital overnight. Rest facilities are necessary, even when overnight call is not required, to accommodate the fatigued resident.

136
137 **I.D.2.c) clean and private facilities for lactation that have refrigeration**
138 **capabilities, with proximity appropriate for safe patient care;**
139 **(Core)**
140

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

141
142 **I.D.2.d) security and safety measures appropriate to the participating**
143 **site; and, (Core)**
144

145 **I.D.2.e) accommodations for residents with disabilities consistent**
146 **with the Sponsoring Institution's policy. (Core)**
147

148 **I.D.3. Residents must have ready access to specialty-specific and other**
149 **appropriate reference material in print or electronic format. This**
150 **must include access to electronic medical literature databases with**
151 **full text capabilities. (Core)**
152

- 153 I.D.4. The program’s educational and clinical resources must be adequate
154 to support the number of residents appointed to the program. (Core)
155
- 156 I.E. The presence of other learners and other care providers, including, but not
157 limited to, residents from other programs, subspecialty fellows, and
158 advanced practice providers, must enrich the appointed residents’
159 education. (Core)
160
- 161 I.E.1. The program must report circumstances when the presence of other
162 learners has interfered with the residents’ education to the DIO and
163 Graduate Medical Education Committee (GMEC). (Core)
164

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

- 165
- 166 II. Personnel
- 167
- 168 II.A. Program Director
- 169
- 170 II.A.1. There must be one faculty member appointed as program director
171 with authority and accountability for the overall program, including
172 compliance with all applicable program requirements. (Core)
173
- 174 II.A.1.a) The Sponsoring Institution’s GMEC must approve a change in
175 program director. (Core)
176
- 177 II.A.1.b) Final approval of the program director resides with the
178 Review Committee. (Core)
179

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

- 180
- 181 II.A.1.c) The program must demonstrate retention of the program
182 director for a length of time adequate to maintain continuity
183 of leadership and program stability. (Core)
184

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

185

186 **II.A.2. The program director and, as applicable, the program’s leadership**
187 **team, must be provided with support adequate for administration of**
188 **the program based upon its size and configuration.** (Core)

189
190 **II.A.2.a)** Program leadership, in aggregate, must be provided with support
191 equal to a dedicated minimum time as specified below for
192 administration of the program. This may be time spent by the
193 program director only or divided between the program director and
194 one or more associate (or assistant) program directors. (Core)

195
196 **II.A.2.a).(1)** Programs with up to seven approved resident positions
197 must be provided with a minimum of 20 percent time.
198 Programs with seven or more approved resident positions
199 must be provided with a minimum of 20 percent time and
200 an additional one percent time for each approved position.
201 (Core)
202

Specialty-Specific Background and Intent: The additional one percent time is for each approved resident position in the program, not just the approved resident positions over seven. For example, a program with an approved complement of seven resident positions must be provided at least 27 percent time for program leadership. A program approved for 20 resident positions must be provided with at least 40 percent time for program leadership; and a program approved for 35 resident positions must be provided with at least 55 percent time for program leadership.

203
Background and Intent: To achieve successful graduate medical education, individuals serving as education and administrative leaders of residency programs, as well as those significantly engaged in the education, supervision, evaluation, and mentoring of residents, must have sufficient dedicated professional time to perform the vital activities required to sustain an accredited program.

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

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

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

204
205 **II.A.3. Qualifications of the program director:**
206

207 **II.A.3.a)** must include specialty expertise and at least three years of
208 documented educational and/or administrative experience, or
209 qualifications acceptable to the Review Committee; ^(Core)
210

Background and Intent: Leading a program requires knowledge and skills that are established during residency and subsequently further developed. The time period from completion of residency until assuming the role of program director allows the individual to cultivate leadership abilities while becoming professionally established. The three-year period is intended for the individual's professional maturation.

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

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

211
212 **II.A.3.b)** must include current certification in the specialty for which
213 they are the program director by the American Board of
214 Preventive Medicine or by the American Osteopathic Board of
215 Preventive Medicine, or specialty qualifications that are
216 acceptable to the Review Committee; ^(Core)

217
218 **II.A.3.c)** must include current medical licensure and appropriate
219 medical staff appointment; and, ^(Core)

220
221 **II.A.3.d)** must include ongoing clinical activity. ^(Core)
222

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

223
224 **II.A.4.** **Program Director Responsibilities**

225
226 The program director must have responsibility, authority, and
227 accountability for: administration and operations; teaching and
228 scholarly activity; resident recruitment and selection, evaluation,
229 and promotion of residents, and disciplinary action; supervision of
230 residents; and resident education in the context of patient care. ^(Core)

231
232 **II.A.4.a)** The program director must:

233
234 **II.A.4.a).(1)** be a role model of professionalism; ^(Core)
235

Background and Intent: The program director, as the leader of the program, must serve as a role model to residents in addition to fulfilling the technical aspects of the role. As residents are expected to demonstrate compassion, integrity, and respect for

others, they must be able to look to the program director as an exemplar. It is of utmost importance, therefore, that the program director model outstanding professionalism, high quality patient care, educational excellence, and a scholarly approach to work. The program director creates an environment where respectful discussion is welcome, with the goal of continued improvement of the educational experience.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

II.B. Faculty

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

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

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

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

II.B.2. Faculty members must:

II.B.2.a) be role models of professionalism; ^(Core)

II.B.2.b) demonstrate commitment to the delivery of safe, quality, cost-effective, patient-centered care; ^(Core)

347

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

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349

**II.B.2.c) demonstrate a strong interest in the education of residents;
(Core)**

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352

**II.B.2.d) devote sufficient time to the educational program to fulfill
their supervisory and teaching responsibilities; (Core)**

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**II.B.2.e) administer and maintain an educational environment
conducive to educating residents; (Core)**

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**II.B.2.f) regularly participate in organized clinical discussions,
rounds, journal clubs, and conferences; and, (Core)**

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361

**II.B.2.g) pursue faculty development designed to enhance their skills
at least annually: (Core)**

362

363

Background and Intent: Faculty development is intended to describe structured programming developed for the purpose of enhancing transference of knowledge, skill, and behavior from the educator to the learner. Faculty development may occur in a variety of configurations (lecture, workshop, etc.) using internal and/or external resources. Programming is typically needs-based (individual or group) and may be specific to the institution or the program. Faculty development programming is to be reported for the residency program faculty in the aggregate.

364

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II.B.2.g).(1) as educators; (Core)

366

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II.B.2.g).(2) in quality improvement and patient safety; (Core)

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**II.B.2.g).(3) in fostering their own and their residents' well-being;
and, (Core)**

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

373

374

Background and Intent: Practice-based learning serves as the foundation for the practice of medicine. Through a systematic analysis of one's practice and review of the literature, one is able to make adjustments that improve patient outcomes and care. Thoughtful consideration to practice-based analysis improves quality of care, as well as patient safety. This allows faculty members to serve as role models for residents in practice-based learning.

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376

II.B.3. Faculty Qualifications

377

378 **II.B.3.a) Faculty members must have appropriate qualifications in**
379 **their field and hold appropriate institutional appointments.**
380 **(Core)**

381
382 **II.B.3.b) Physician faculty members must:**

383
384 **II.B.3.b).(1) have current certification in the specialty by the**
385 **American Board of Preventive Medicine or the American**
386 **Osteopathic Board of Preventive Medicine, or possess**
387 **qualifications judged acceptable to the Review**
388 **Committee. (Core)**

389
390 **II.B.3.c) Any non-physician faculty members who participate in**
391 **residency program education must be approved by the**
392 **program director. (Core)**
393

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

394
395 **II.B.4. Core Faculty**

396
397 **Core faculty members must have a significant role in the education**
398 **and supervision of residents and must devote a significant portion**
399 **of their entire effort to resident education and/or administration, and**
400 **must, as a component of their activities, teach, evaluate, and**
401 **provide formative feedback to residents. (Core)**
402

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

403

- 404 **II.B.4.a)** **Core faculty members must be designated by the program**
 405 **director.** ^(Core)
 406
- 407 **II.B.4.b)** **Core faculty members must complete the annual ACGME**
 408 **Faculty Survey.** ^(Core)
 409
- 410 **II.B.4.c)** Not including the program director, programs with up to eight
 411 residents must have a minimum of two core faculty members, and
 412 programs with more than eight residents must have a core faculty
 413 member-to-resident ratio of at least one-to-four. ^(Core)
 414
- 415 **II.C. Program Coordinator**
 416
- 417 **II.C.1.** **There must be a program coordinator.** ^(Core)
 418
- 419 **II.C.2.** **The program coordinator must be provided with dedicated time and**
 420 **support adequate for administration of the program based upon its**
 421 **size and configuration.** ^(Core)
 422
- 423 **II.C.2.a)** The program coordinator must be provided with support equal to a
 424 dedicated minimum of 50 percent time for administration of the
 425 program. ^(Core)
 426

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

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

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

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

- 427
 428 **II.D. Other Program Personnel**
 429

430 The program, in partnership with its Sponsoring Institution, must jointly
431 ensure the availability of necessary personnel for the effective
432 administration of the program. ^(Core)
433

Background and Intent: Multiple personnel may be required to effectively administer a program. These may include staff members with clerical skills, project managers, education experts, and staff members to maintain electronic communication for the program. These personnel may support more than one program in more than one discipline.

434
435 **III. Resident Appointments**
436

437 **III.A. Eligibility Requirements**
438

439 **III.A.1. An applicant must meet one of the following qualifications to be**
440 **eligible for appointment to an ACGME-accredited program: ^(Core)**
441

442 **III.A.1.a) graduation from a medical school in the United States or**
443 **Canada, accredited by the Liaison Committee on Medical**
444 **Education (LCME) or graduation from a college of**
445 **osteopathic medicine in the United States, accredited by the**
446 **American Osteopathic Association Commission on**
447 **Osteopathic College Accreditation (AOACOCA); or, ^(Core)**
448

449 **III.A.1.b) graduation from a medical school outside of the United**
450 **States or Canada, and meeting one of the following additional**
451 **qualifications: ^(Core)**
452

453 **III.A.1.b).(1) holding a currently valid certificate from the**
454 **Educational Commission for Foreign Medical**
455 **Graduates (ECFMG) prior to appointment; or, ^(Core)**
456

457 **III.A.1.b).(2) holding a full and unrestricted license to practice**
458 **medicine in the United States licensing jurisdiction in**
459 **which the ACGME-accredited program is located. ^(Core)**
460

461 **III.A.2. All prerequisite post-graduate clinical education required for initial**
462 **entry or transfer into ACGME-accredited residency programs must**
463 **be completed in ACGME-accredited residency programs, AOA-**
464 **approved residency programs, Royal College of Physicians and**
465 **Surgeons of Canada (RCPSC)-accredited or College of Family**
466 **Physicians of Canada (CFPC)-accredited residency programs**
467 **located in Canada, or in residency programs with ACGME**
468 **International (ACGME-I) Advanced Specialty Accreditation. ^(Core)**
469

470 **III.A.2.a) Residency programs must receive verification of each**
471 **resident's level of competency in the required clinical field**
472 **using ACGME, CanMEDS, or ACGME-I Milestones evaluations**
473 **from the prior training program upon matriculation. ^(Core)**
474

- 475 III.A.2.b) Residents entering a 24-month program that does not include
 476 education in fundamental clinical skills of medicine must have
 477 successfully completed at least 12 months of clinical education in
 478 a residency program that satisfies III.A.2. (Core)
 479
- 480 III.A.2.b).(1) PGY-1 resident experience must include at least 10
 481 months of direct patient care in both inpatient and
 482 outpatient settings. (Core)
 483
- 484 III.A.2.c) To be eligible for appointment at the PM-2 level, residents must
 485 have completed:
 486
- 487 III.A.2.c).(1) a residency program that satisfies the requirements in
 488 III.A.2.; and, (Core)
 489
- 490 III.A.2.c).(1).(a) This must include at least 10 months of direct
 491 patient care in both inpatient and outpatient
 492 settings. (Core)
 493
- 494 III.A.2.c).(2) at least 50 percent of the requirements for a Master of
 495 Public Health or another equivalent degree. (Core)
 496

Background and Intent: Programs with ACGME-I Foundational Accreditation or from institutions with ACGME-I accreditation do not qualify unless the program has also achieved ACGME-I Advanced Specialty Accreditation. To ensure entrants into ACGME-accredited programs from ACGME-I programs have attained the prerequisite milestones for this training, they must be from programs that have ACGME-I Advanced Specialty Accreditation.

- 497
- 498 **III.A.3. A physician who has completed a residency program that was not**
 499 **accredited by ACGME, AOA, RCPSC, CFPC, or ACGME-I (with**
 500 **Advanced Specialty Accreditation) may enter an ACGME-accredited**
 501 **residency program in the same specialty at the PGY-1 level and, at**
 502 **the discretion of the program director of the ACGME-accredited**
 503 **program and with approval by the GMEC, may be advanced to the**
 504 **PGY-2 level based on ACGME Milestones evaluations at the ACGME-**
 505 **accredited program. This provision applies only to entry into**
 506 **residency in those specialties for which an initial clinical year is not**
 507 **required for entry. (Core)**
 508
- 509 **III.A.4. Resident Eligibility Exception**
 510
- 511 **The Review Committee for Preventive Medicine will allow the**
 512 **following exception to the resident eligibility requirements (for**
 513 **residents entering the program via III.A.2.c)): (Core)**
 514
- 515 **III.A.4.a) An ACGME-accredited residency program may accept an**
 516 **exceptionally qualified international graduate applicant who**
 517 **does not satisfy the eligibility requirements listed in III.A.1.-**
 518 **III.A.3., but who does meet all of the following additional**
 519 **qualifications and conditions: (Core)**

- 520
521 **III.A.4.a).(1)** evaluation by the program director and residency
522 selection committee of the applicant’s suitability to
523 enter the program, based on prior training and review
524 of the summative evaluations of this training; and, ^(Core)
525
526 **III.A.4.a).(2)** review and approval of the applicant’s exceptional
527 qualifications by the GMEC; and, ^(Core)
528
529 **III.A.4.a).(3)** verification of Educational Commission for Foreign
530 Medical Graduates (ECFMG) certification. ^(Core)
531
532 **III.A.4.b)** Applicants accepted through this exception must have an
533 evaluation of their performance by the Clinical Competency
534 Committee within 12 weeks of matriculation. ^(Core)
535
536 **III.B.** The program director must not appoint more residents than approved by
537 the Review Committee. ^(Core)
538
539 **III.B.1.** All complement increases must be approved by the Review
540 Committee. ^(Core)
541
542 **III.C.** Resident Transfers
543
544 The program must obtain verification of previous educational experiences
545 and a summative competency-based performance evaluation prior to
546 acceptance of a transferring resident, and Milestones evaluations upon
547 matriculation. ^(Core)
548
549 **IV. Educational Program**
550
551 *The ACGME accreditation system is designed to encourage excellence and*
552 *innovation in graduate medical education regardless of the organizational*
553 *affiliation, size, or location of the program.*
554
555 *The educational program must support the development of knowledgeable, skillful*
556 *physicians who provide compassionate care.*
557
558 *In addition, the program is expected to define its specific program aims consistent*
559 *with the overall mission of its Sponsoring Institution, the needs of the community*
560 *it serves and that its graduates will serve, and the distinctive capabilities of*
561 *physicians it intends to graduate. While programs must demonstrate substantial*
562 *compliance with the Common and specialty-specific Program Requirements, it is*
563 *recognized that within this framework, programs may place different emphasis on*
564 *research, leadership, public health, etc. It is expected that the program aims will*
565 *reflect the nuanced program-specific goals for it and its graduates; for example, it*
566 *is expected that a program aiming to prepare physician-scientists will have a*
567 *different curriculum from one focusing on community health.*
568
569 **IV.A.** The curriculum must contain the following educational components: ^(Core)
570

571 **IV.A.1.** a set of program aims consistent with the Sponsoring Institution’s
572 mission, the needs of the community it serves, and the desired
573 distinctive capabilities of its graduates; ^(Core)

574
575 **IV.A.1.a)** The program’s aims must be made available to program
576 applicants, residents, and faculty members. ^(Core)

577
578 **IV.A.2.** competency-based goals and objectives for each educational
579 experience designed to promote progress on a trajectory to
580 autonomous practice. These must be distributed, reviewed, and
581 available to residents and faculty members; ^(Core)

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

583
584 **IV.A.3.** delineation of resident responsibilities for patient care, progressive
585 responsibility for patient management, and graded supervision; ^(Core)

Background and Intent: These responsibilities may generally be described by PGY level and specifically by Milestones progress as determined by the Clinical Competency Committee. This approach encourages the transition to competency-based education. An advanced learner may be granted more responsibility independent of PGY level and a learner needing more time to accomplish a certain task may do so in a focused rather than global manner.

587
588 **IV.A.4.** a broad range of structured didactic activities; ^(Core)

589
590 **IV.A.4.a)** Residents must be provided with protected time to participate
591 in core didactic activities. ^(Core)

Background and Intent: It is intended that residents will participate in structured didactic activities. It is recognized that there may be circumstances in which this is not possible. Programs should define core didactic activities for which time is protected and the circumstances in which residents may be excused from these didactic activities. Didactic activities may include, but are not limited to, lectures, conferences, courses, labs, asynchronous learning, simulations, drills, case discussions, grand rounds, didactic teaching, and education in critical appraisal of medical evidence.

593
594 **IV.A.5.** advancement of residents’ knowledge of ethical principles
595 foundational to medical professionalism; and, ^(Core)

596
597 **IV.A.6.** advancement in the residents’ knowledge of the basic principles of
598 scientific inquiry, including how research is designed, conducted,
599 evaluated, explained to patients, and applied to patient care. ^(Core)

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IV.B. ACGME Competencies

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

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

IV.B.1.a) Professionalism

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

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

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

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

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

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

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

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

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

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

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

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

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

641		
642	IV.B.1.b).(1)	Residents must be able to provide patient care that is
643		compassionate, appropriate, and effective for the
644		treatment of health problems and the promotion of
645		health. <small>(Core)</small>
646		
647	IV.B.1.b).(1).(a)	If the prerequisite clinical education is integrated
648		into a 36-month program format, residents must
649		demonstrate competence in:
650		
651	IV.B.1.b).(1).(a).(i)	obtaining a comprehensive medical history;
652		<small>(Core)</small>
653		
654	IV.B.1.b).(1).(a).(ii)	performing a comprehensive physical
655		examination; <small>(Core)</small>
656		
657	IV.B.1.b).(1).(a).(iii)	assessing a patient’s medical conditions;
658		<small>(Core)</small>
659		
660	IV.B.1.b).(1).(a).(iv)	making appropriate use of diagnostic
661		studies and tests; <small>(Core)</small>
662		
663	IV.B.1.b).(1).(a).(v)	integrating information to develop a
664		differential diagnosis; and, <small>(Core)</small>
665		
666	IV.B.1.b).(1).(a).(vi)	developing, implementing, and evaluating a
667		treatment plan. <small>(Core)</small>
668		
669	IV.B.1.b).(1).(b)	Residents must demonstrate competence in:
670		
671	IV.B.1.b).(1).(b).(i)	assessing and responding to individual and
672		population risks for common occupational
673		and environmental disorders; <small>(Core)</small>
674		
675	IV.B.1.b).(1).(b).(ii)	conducting research for innovative solutions
676		to health problems; <small>(Core)</small>
677		

678	IV.B.1.b).(1).(b).(iii)	diagnosing and investigating medical problems and medical hazards in the community; (Core)
679		
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682	IV.B.1.b).(1).(b).(iv)	directing individuals to needed personal health services; (Core)
683		
684		
685	IV.B.1.b).(1).(b).(v)	informing and educating populations about health threats and risks; (Core)
686		
687		
688	IV.B.1.b).(1).(b).(vi)	planning and evaluating the medical portion of emergency preparedness programs and training exercises; (Core)
689		
690		
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692	IV.B.1.b).(1).(b).(vii)	providing clinical preventive medicine services, including the ability to: (Core)
693		
694		
695	IV.B.1.b).(1).(b).(vii).(a)	diagnose and treat medical problems and chronic conditions for both individuals and populations; (Core)
696		
697		
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699		
700	IV.B.1.b).(1).(b).(vii).(b)	apply primary, secondary, and tertiary preventive approaches to individual and population-based disease prevention and health promotion; and, (Core)
701		
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706	IV.B.1.b).(1).(b).(vii).(c)	evaluate the effectiveness of clinical preventive services for both individuals and populations. (Core)
707		
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710	IV.B.1.b).(1).(b).(viii)	developing policies and plans to support individual and community health efforts; (Core)
711		
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714	IV.B.1.b).(1).(b).(ix)	advising in the development of air and space flight equipment, biomedical equipment, and vehicles for flight and space flight; techniques for enhancing human performance; and techniques of crew resource management; (Core)
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721	IV.B.1.b).(1).(b).(x)	applying or granting exceptions to medical standards and facilitating the prevention, early diagnosis, and treatment of health hazards; (Core)
722		
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725		
726	IV.B.1.b).(1).(b).(xi)	conducting aeromedical research into health, safety, human factors, and
727		

728		biomedical engineering aspects of the flight environment; ^(Core)
729		
730		
731	IV.B.1.b).(1).(b).(xii)	developing and applying medical care standards and programs and evaluating the physiologic effects of aviation, spaceflight, and austere environments, including: ^(Core)
732		
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736	IV.B.1.b).(1).(b).(xii).(a)	conducting longitudinal health studies on pilots, astronauts, and others who work in austere environments; ^(Core)
737		
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741	IV.B.1.b).(1).(b).(xii).(b)	developing medical standards and waiver criteria for work in austere environments; ^(Core)
742		
743		
744		
745	IV.B.1.b).(1).(b).(xii).(c)	developing medical treatment protocols for illnesses and injuries in austere environments; ^(Core)
746		
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748		
749	IV.B.1.b).(1).(b).(xii).(d)	drafting government or corporate aeromedical or spaceflight medical standards, waiver criteria, or clinical practice guidelines; and, ^(Core)
750		
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754	IV.B.1.b).(1).(b).(xii).(e)	conducting research on medical conditions in pilots, astronauts, and others who work in austere environments. ^(Core)
755		
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759	IV.B.1.b).(1).(b).(xiii)	identifying appropriate patients for aeromedical transport, and providing guidance for safe aeromedical transport of patients; ^(Core)
760		
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763		
764	IV.B.1.b).(1).(b).(xiv)	managing aerospace and general medical problems in aerospace personnel; and, ^(Core)
765		
766		
767	IV.B.1.b).(1).(b).(xv)	providing safety information and education and conducting the medical aspects of any mishap investigation, including making recommendations to prevent recurrences. ^(Core)
768		
769		
770		
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772		
773	IV.B.1.b).(2)	Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. ^(Core)
774		
775		
776		
777	IV.B.1.c)	Medical Knowledge
778		

779 **Residents must demonstrate knowledge of established and**
780 **evolving biomedical, clinical, epidemiological and social-**
781 **behavioral sciences, as well as the application of this**
782 **knowledge to patient care.** (Core)
783
784 IV.B.1.c).(1) Residents must demonstrate competence in their
785 knowledge of all content areas included in the required
786 graduate courses for completion of the program. (Core)
787
788 IV.B.1.c).(2) Residents must demonstrate competence in their
789 knowledge of factors that impact the health of individuals
790 and populations, including:
791
792 IV.B.1.c).(2).(a) lifestyle management; and, (Core)
793
794 IV.B.1.c).(2).(b) social determinants of health. (Core)
795
796 IV.B.1.c).(3) Residents must demonstrate competence in their
797 knowledge of the use of available technology such as
798 telemedicine to reduce health disparities. (Core)
799
800 IV.B.1.c).(4) Residents must demonstrate competence in their
801 knowledge of principles of:
802
803 IV.B.1.c).(4).(a) accident investigation/risk management and
804 mitigation; (Core)
805
806 IV.B.1.c).(4).(b) global health and travel medicine; (Core)
807
808 IV.B.1.c).(4).(c) identification and mitigation of workplace hazards;
809 (Core)
810
811 IV.B.1.c).(4).(d) principles of aviation and space medicine; and, (Core)
812
813 IV.B.1.c).(4).(e) toxicology. (Core)
814
815 **IV.B.1.d) Practice-based Learning and Improvement**
816
817 **Residents must demonstrate the ability to investigate and**
818 **evaluate their care of patients, to appraise and assimilate**
819 **scientific evidence, and to continuously improve patient care**
820 **based on constant self-evaluation and lifelong learning.** (Core)
821

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

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

822		
823	IV.B.1.d).(1)	Residents must demonstrate competence in:
824		
825	IV.B.1.d).(1).(a)	identifying strengths, deficiencies, and limits in
826		one’s knowledge and expertise; (Core)
827		
828	IV.B.1.d).(1).(b)	setting learning and improvement goals; (Core)
829		
830	IV.B.1.d).(1).(c)	identifying and performing appropriate learning
831		activities; (Core)
832		
833	IV.B.1.d).(1).(d)	systematically analyzing practice using quality
834		improvement methods, and implementing
835		changes with the goal of practice improvement;
836		(Core)
837		
838	IV.B.1.d).(1).(e)	incorporating feedback and formative
839		evaluation into daily practice; (Core)
840		
841	IV.B.1.d).(1).(f)	locating, appraising, and assimilating evidence
842		from scientific studies related to their patients’
843		health problems; (Core)
844		
845	IV.B.1.d).(1).(g)	using information technology to optimize
846		learning; (Core)
847		
848	IV.B.1.d).(1).(h)	using information technology for reference retrieval,
849		statistical analysis, graphic display, database
850		management, and communication; (Core)
851		
852	IV.B.1.d).(1).(i)	using epidemiologic principles and biostatistics
853		methods, including the ability to: (Core)
854		
855	IV.B.1.d).(1).(i).(i)	characterize the health of a community; (Core)
856		
857	IV.B.1.d).(1).(i).(ii)	conduct a virtual or actual outbreak or
858		cluster investigation; (Core)
859		
860	IV.B.1.d).(1).(i).(iii)	evaluate a surveillance system and
861		interpret, monitor, and act on surveillance
862		data for prevention of disease and injury in
863		workplaces and populations; (Core)
864		
865	IV.B.1.d).(1).(i).(iv)	measure, organize, or improve a public
866		health service; (Core)
867		
868	IV.B.1.d).(1).(i).(v)	select and conduct appropriate statistical
869		analyses; and, (Core)

870		
871	IV.B.1.d).(1).(i).(vi)	translate epidemiologic findings into a
872		recommendation for a specific intervention.
873		(Core)
874		
875	IV.B.1.d).(1).(j)	designing and conducting an epidemiologic study;
876		and, (Core)
877		
878	IV.B.1.d).(1).(k)	conducting an advanced literature search for
879		research on a preventive medicine topic. (Core)
880		
881	IV.B.1.e)	Interpersonal and Communication Skills
882		
883		Residents must demonstrate interpersonal and
884		communication skills that result in the effective exchange of
885		information and collaboration with patients, their families,
886		and health professionals. (Core)
887		
888	IV.B.1.e).(1)	Residents must demonstrate competence in:
889		
890	IV.B.1.e).(1).(a)	communicating effectively with patients,
891		families, and the public, as appropriate, across
892		a broad range of socioeconomic and cultural
893		backgrounds; (Core)
894		
895	IV.B.1.e).(1).(b)	communicating effectively with physicians,
896		other health professionals, and health-related
897		agencies; (Core)
898		
899	IV.B.1.e).(1).(c)	working effectively as a member or leader of a
900		health care team or other professional group;
901		(Core)
902		
903	IV.B.1.e).(1).(d)	educating patients, families, students,
904		residents, and other health professionals; (Core)
905		
906	IV.B.1.e).(1).(e)	acting in a consultative role to other physicians
907		and health professionals; and, (Core)
908		
909	IV.B.1.e).(1).(f)	maintaining comprehensive, timely, and legible
910		medical records, if applicable. (Core)
911		
912	IV.B.1.e).(2)	Residents must learn to communicate with patients
913		and families to partner with them to assess their care
914		goals, including, when appropriate, end-of-life goals.
915		(Core)
916		

<p>Background and Intent: When there are no more medications or interventions that can achieve a patient’s goals or provide meaningful improvements in quality or length of life, a discussion about the patient’s goals, values, and choices surrounding the end of life is one of the most important conversations that can occur. Residents must learn to</p>

participate effectively and compassionately in these meaningful human interactions, for the sake of their patients and themselves.

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

917
918 IV.B.1.e).(3) Residents must demonstrate competence in educating
919 passengers and physicians about the medical conditions
920 that make flight hazardous, and in serving as a passenger
921 advocate to promote flight safety. ^(Core)
922

923 **IV.B.1.f) Systems-based Practice**
924
925 **Residents must demonstrate an awareness of and**
926 **responsiveness to the larger context and system of health**
927 **care, including the social determinants of health, as well as**
928 **the ability to call effectively on other resources to provide**
929 **optimal health care.** ^(Core)
930

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

932
933 **IV.B.1.f).(1).(a) working effectively in various health care**
934 **delivery settings and systems relevant to their**
935 **clinical specialty;** ^(Core)
936

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

937
938 **IV.B.1.f).(1).(b) coordinating patient care across the health care**
939 **continuum and beyond as relevant to their**
940 **clinical specialty;** ^(Core)
941

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

942
943 **IV.B.1.f).(1).(c) advocating for quality patient care and optimal**
944 **patient care systems;** ^(Core)
945

946 **IV.B.1.f).(1).(d) working in interprofessional teams to enhance**
947 **patient safety and improve patient care quality;**
948 ^(Core)
949

950 **IV.B.1.f).(1).(e) participating in identifying system errors and**
951 **implementing potential systems solutions;** ^(Core)
952

953	IV.B.1.f).(1).(f)	incorporating considerations of value, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate; ^(Core)
954		
955		
956		
957		
958	IV.B.1.f).(1).(g)	understanding health care finances and its impact on individual patients' health decisions; ^(Core)
959		
960		
961		
962	IV.B.1.f).(1).(h)	engaging with community partners to identify and solve health problems; ^(Core)
963		
964		
965	IV.B.1.f).(1).(i)	conducting program and needs assessments, and prioritizing activities using objective, measurable criteria, including epidemiologic impact and cost-effectiveness; ^(Core)
966		
967		
968		
969		
970	IV.B.1.f).(1).(j)	identifying and reviewing laws and regulations relevant to the resident's assignments; ^(Core)
971		
972		
973	IV.B.1.f).(1).(k)	identifying organizational decision-making structures, stakeholders, styles, and processes; ^(Core)
974		
975		
976		
977	IV.B.1.f).(1).(l)	management and administration, including the ability to: ^(Core)
978		
979		
980	IV.B.1.f).(1).(l).(i)	assess data and formulate policy for a given health issue; ^(Core)
981		
982		
983	IV.B.1.f).(1).(l).(ii)	assess the human and financial resources for the operation of a program or project; ^(Core)
984		
985		
986		
987	IV.B.1.f).(1).(l).(iii)	apply and use management information systems; and, ^(Core)
988		
989		
990	IV.B.1.f).(1).(l).(iv)	plan, manage, and evaluate health services to improve the health of a defined population using quality improvement and assurance systems. ^(Core)
991		
992		
993		
994		
995	IV.B.1.f).(1).(m)	analyzing policy options for their health impact and economic costs; and, ^(Core)
996		
997		
998	IV.B.1.f).(1).(n)	participating in the evaluation of applicants and the performance of staff members, and understanding the legal and ethical use of this information in decisions for hiring, managing, and discharging staff members. ^(Core)
999		
1000		
1001		
1002		
1003		

1004 **IV.B.1.f).(2)** **Residents must learn to advocate for patients within**
1005 **the health care system to achieve the patient's and**
1006 **family's care goals, including, when appropriate, end-**
1007 **of-life goals.** ^(Core)
1008

1009 **IV.C. Curriculum Organization and Resident Experiences**
1010

1011 **IV.C.1. The curriculum must be structured to optimize resident educational**
1012 **experiences, the length of these experiences, and supervisory**
1013 **continuity.** ^(Core)
1014

1015 IV.C.1.a) Rotations in direct patient care should be of sufficient length to
1016 allow residents to develop skills in providing ongoing, prevention-
1017 oriented care. ^{(Detail)†}
1018

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

1019
1020 **IV.C.2. The program must provide instruction and experience in pain**
1021 **management if applicable for the specialty, including recognition of**
1022 **the signs of addiction.** ^(Core)
1023

1024 IV.C.3. If the prerequisite clinical education is integrated into a 36-month program
1025 format, the PGY-1 must provide broad education in fundamental clinical
1026 skills of medicine relevant to the practice of preventive medicine. ^(Core)
1027

1028 IV.C.3.a) The program director must oversee and ensure the quality of
1029 didactic and clinical education in the PGY-1. ^(Core)
1030

1031 IV.C.3.b) At least 10 months of the PGY-1 must include experience
1032 providing direct patient care in the inpatient and outpatient settings
1033 in family medicine, internal medicine, obstetrics and gynecology,
1034 pediatrics, or surgery. ^(Core)
1035

1036 IV.C.4. The program must assess the knowledge, skills, and competence of each
1037 incoming resident as they relate to the educational goals of the program.
1038 ^(Core)
1039

1040 IV.C.4.a) This should include a self-assessment, an in-service examination,
1041 and a structured interview or other method to assess knowledge,
1042 skills, and competence. ^(Detail)
1043

1044 IV.C.4.b) The assessment should be used by the program director and
1045 faculty members to guide development of an individualized
1046 educational plan for each resident, which should: ^(Detail)
1047

1048	IV.C.4.b).(1)	direct the acquisition of a core set of competencies, skills,
1049		and knowledge appropriate to the objectives of the
1050		individual resident based on assessment of each resident;
1051		(Detail)
1052		
1053	IV.C.4.b).(2)	denote the courses, rotations, and activities to which the
1054		resident will be assigned in order to develop the
1055		designated clinical skills, knowledge, and competencies;
1056		and, (Detail)
1057		
1058	IV.C.4.b).(3)	be reviewed as part of the semiannual evaluation. (Detail)
1059		
1060	IV.C.5.	Residents must have educational experiences within a patient care
1061		environment that address direct clinical issues relevant to aerospace
1062		medicine. (Core)
1063		
1064	IV.C.5.a)	Each resident must have progressive responsibility for direct
1065		patient care and the management of health and provision of health
1066		care for a defined population. (Core)
1067		
1068	IV.C.6.	Residents must complete a Master of Public Health or another equivalent
1069		degree prior to completion of the residency program. (Core)
1070		
1071	IV.C.6.a)	All residents must complete graduate-level courses that include
1072		the five content areas of: epidemiology; biostatistics; health
1073		services management and administration; environmental health;
1074		and the behavioral aspects of health. (Core)
1075		
1076	IV.C.7.	Didactic conferences must be structured to facilitate interaction between
1077		faculty members and residents. (Detail)
1078		
1079	IV.C.8.	Resident education must take place in a setting where operational
1080		aeromedical problems are routinely encountered, and aerospace
1081		operations and human life support systems are under active study and
1082		development. (Core)
1083		
1084	IV.C.8.a)	Residents must have a minimum of four months of direct patient
1085		care experience during each year of the program. (Core)
1086		
1087	IV.C.8.b)	Resident experiences must include flight training that provides:
1088		(Core)
1089		
1090	IV.C.8.b).(1)	a baseline understanding of the clinical problems
1091		encountered in flight personnel; and, (Core)
1092		
1093	IV.C.8.b).(2)	development of aeromedical skills, including
1094		neurocognitive requirements and physiologic effects of
1095		flight, visual illusions of flight, spatial disorientation, the
1096		flight environment, and human factors associated with
1097		aviation. (Core)
1098		

1099 IV.C.8.c) Resident experiences should include pilot medical certification,
1100 operational flight medical support, disability assessment of pilots,
1101 and aircraft and/or spacecraft accident investigation of problems
1102 directly applicable to the specialty and the aviation/space
1103 environment. ^(Detail)
1104

1105 **IV.D. Scholarship**

1106
1107 ***Medicine is both an art and a science. The physician is a humanistic***
1108 ***scientist who cares for patients. This requires the ability to think critically,***
1109 ***evaluate the literature, appropriately assimilate new knowledge, and***
1110 ***practice lifelong learning. The program and faculty must create an***
1111 ***environment that fosters the acquisition of such skills through resident***
1112 ***participation in scholarly activities. Scholarly activities may include***
1113 ***discovery, integration, application, and teaching.***
1114

1115 ***The ACGME recognizes the diversity of residencies and anticipates that***
1116 ***programs prepare physicians for a variety of roles, including clinicians,***
1117 ***scientists, and educators. It is expected that the program's scholarship will***
1118 ***reflect its mission(s) and aims, and the needs of the community it serves.***
1119 ***For example, some programs may concentrate their scholarly activity on***
1120 ***quality improvement, population health, and/or teaching, while other***
1121 ***programs might choose to utilize more classic forms of biomedical***
1122 ***research as the focus for scholarship.***
1123

1124 **IV.D.1. Program Responsibilities**

1125
1126 **IV.D.1.a) The program must demonstrate evidence of scholarly**
1127 **activities consistent with its mission(s) and aims. ^(Core)**
1128

1129 **IV.D.1.b) The program, in partnership with its Sponsoring Institution,**
1130 **must allocate adequate resources to facilitate resident and**
1131 **faculty involvement in scholarly activities. ^(Core)**
1132

1133 **IV.D.1.b).(1) This includes providing funds for each resident to attend at**
1134 **least one national professional meeting with the**
1135 **opportunity to present original scholarship. ^(Detail)**
1136

1137 **IV.D.1.c) The program must advance residents' knowledge and**
1138 **practice of the scholarly approach to evidence-based patient**
1139 **care. ^(Core)**
1140

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

Elements of a scholarly approach to patient care include:

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

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

1141
1142 **IV.D.2. Faculty Scholarly Activity**

1143
1144 **IV.D.2.a) Among their scholarly activity, programs must demonstrate**
1145 **accomplishments in at least three of the following domains:**
1146 **(Core)**

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

1151
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1153
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1157
1158
1159
1160
1161 **IV.D.2.b) The program must demonstrate dissemination of scholarly**
1162 **activity within and external to the program by the following**
1163 **methods:**
1164

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

1165
1166 **IV.D.2.b).(1) faculty participation in grand rounds, posters,**
1167 **workshops, quality improvement presentations,**
1168 **podium presentations, grant leadership, non-peer-**

1169 reviewed print/electronic resources, articles or
1170 publications, book chapters, textbooks, webinars,
1171 service on professional committees, or serving as a
1172 journal reviewer, journal editorial board member, or
1173 editor; (Outcome)‡

1174
1175 IV.D.2.b).(2) peer-reviewed publication. (Outcome)

1176
1177 IV.D.3. Resident Scholarly Activity

1178
1179 IV.D.3.a) Residents must participate in scholarship. (Core)

1180
1181 V. Evaluation

1182
1183 V.A. Resident Evaluation

1184
1185 V.A.1. Feedback and Evaluation

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

Formative and summative evaluation have distinct definitions. Formative evaluation is *monitoring resident learning* and providing ongoing feedback that can be used by residents to improve their learning in the context of provision of patient care or other educational opportunities. More specifically, formative evaluations help:

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

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

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

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

1187
1188 V.A.1.a) Faculty members must directly observe, evaluate, and
1189 frequently provide feedback on resident performance during
1190 each rotation or similar educational assignment. (Core)

1191

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

- 1192
 1193 **V.A.1.b)** Evaluation must be documented at the completion of the
 1194 assignment. ^(Core)
 1195
 1196 **V.A.1.b).(1)** For block rotations of greater than three months in
 1197 duration, evaluation must be documented at least
 1198 every three months. ^(Core)
 1199
 1200 **V.A.1.b).(2)** Longitudinal experiences, such as continuity clinic in
 1201 the context of other clinical responsibilities, must be
 1202 evaluated at least every three months and at
 1203 completion. ^(Core)
 1204
 1205 **V.A.1.c)** The program must provide an objective performance
 1206 evaluation based on the Competencies and the specialty-
 1207 specific Milestones, and must: ^(Core)
 1208
 1209 **V.A.1.c).(1)** use multiple evaluators (e.g., faculty members, peers,
 1210 patients, self, and other professional staff members);
 1211 and, ^(Core)
 1212
 1213 **V.A.1.c).(2)** provide that information to the Clinical Competency
 1214 Committee for its synthesis of progressive resident
 1215 performance and improvement toward unsupervised
 1216 practice. ^(Core)
 1217
 1218 **V.A.1.d)** The program director or their designee, with input from the
 1219 Clinical Competency Committee, must:
 1220
 1221 **V.A.1.d).(1)** meet with and review with each resident their
 1222 documented semi-annual evaluation of performance,
 1223 including progress along the specialty-specific
 1224 Milestones; ^(Core)
 1225
 1226 **V.A.1.d).(2)** assist residents in developing individualized learning
 1227 plans to capitalize on their strengths and identify areas
 1228 for growth; and, ^(Core)
 1229
 1230 **V.A.1.d).(3)** develop plans for residents failing to progress,
 1231 following institutional policies and procedures. ^(Core)
 1232

Background and Intent: Learning is an active process that requires effort from the teacher and the learner. Faculty members evaluate a resident's performance at least at the end of each rotation. The program director or their designee will review those evaluations, including their progress on the Milestones, at a minimum of every six

months. Residents should be encouraged to reflect upon the evaluation, using the information to reinforce well-performed tasks or knowledge or to modify deficiencies in knowledge or practice. Working together with the faculty members, residents should develop an individualized learning plan.

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

- 1233
1234 **V.A.1.e)** At least annually, there must be a summative evaluation of
1235 each resident that includes their readiness to progress to the
1236 next year of the program, if applicable. ^(Core)
1237
1238 **V.A.1.f)** The evaluations of a resident’s performance must be
1239 accessible for review by the resident. ^(Core)
1240
1241 **V.A.2.** Final Evaluation
1242
1243 **V.A.2.a)** The program director must provide a final evaluation for each
1244 resident upon completion of the program. ^(Core)
1245
1246 **V.A.2.a).(1)** The specialty-specific Milestones, and when applicable
1247 the specialty-specific Case Logs, must be used as
1248 tools to ensure residents are able to engage in
1249 autonomous practice upon completion of the program.
1250 ^(Core)
1251
1252 **V.A.2.a).(2)** The final evaluation must:
1253
1254 **V.A.2.a).(2).(a)** become part of the resident’s permanent record
1255 maintained by the institution, and must be
1256 accessible for review by the resident in
1257 accordance with institutional policy; ^(Core)
1258
1259 **V.A.2.a).(2).(b)** verify that the resident has demonstrated the
1260 knowledge, skills, and behaviors necessary to
1261 enter autonomous practice; ^(Core)
1262
1263 **V.A.2.a).(2).(c)** consider recommendations from the Clinical
1264 Competency Committee; and, ^(Core)
1265
1266 **V.A.2.a).(2).(d)** be shared with the resident upon completion of
1267 the program. ^(Core)
1268
1269 **V.A.3.** A Clinical Competency Committee must be appointed by the
1270 program director. ^(Core)

1271
1272 **V.A.3.a)** **At a minimum, the Clinical Competency Committee must**
1273 **include three members of the program faculty, at least one of**
1274 **whom is a core faculty member.** (Core)

1275
1276 **V.A.3.a).(1)** **Additional members must be faculty members from**
1277 **the same program or other programs, or other health**
1278 **professionals who have extensive contact and**
1279 **experience with the program’s residents.** (Core)
1280

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

Program faculty may include more than the physician faculty members, such as other physicians and non-physicians who teach and evaluate the program’s residents. There may be additional members of the Clinical Competency Committee. Chief residents who have completed core residency programs in their specialty may be members of the Clinical Competency Committee.

1281
1282 **V.A.3.b)** **The Clinical Competency Committee must:**

1283
1284 **V.A.3.b).(1)** **review all resident evaluations at least semi-annually;**
1285 (Core)

1286
1287 **V.A.3.b).(2)** **determine each resident’s progress on achievement of**
1288 **the specialty-specific Milestones; and,** (Core)

1289
1290 **V.A.3.b).(3)** **meet prior to the residents’ semi-annual evaluations**
1291 **and advise the program director regarding each**
1292 **resident’s progress.** (Core)

1293
1294 **V.B. Faculty Evaluation**

1295
1296 **V.B.1.** **The program must have a process to evaluate each faculty**
1297 **member’s performance as it relates to the educational program at**
1298 **least annually.** (Core)
1299

Background and Intent: The program director is responsible for the education program and for whom delivers it. While the term “faculty” may be applied to physicians within a given institution for other reasons, it is applied to residency program faculty members only through approval by a program director. The development of the faculty improves the education, clinical, and research aspects of a program. Faculty members have a strong commitment to the resident and desire to provide optimal education and work opportunities. Faculty members must be provided feedback on their contribution

to the mission of the program. All faculty members who interact with residents desire feedback on their education, clinical care, and research. If a faculty member does not interact with residents, feedback is not required. With regard to the diverse operating environments and configurations, the residency program director may need to work with others to determine the effectiveness of the program's faculty performance with regard to their role in the educational program. All teaching faculty members should have their educational efforts evaluated by the residents in a confidential and anonymous manner. Other aspects for the feedback may include research or clinical productivity, review of patient outcomes, or peer review of scholarly activity. The process should reflect the local environment and identify the necessary information. The feedback from the various sources should be summarized and provided to the faculty on an annual basis by a member of the leadership team of the program.

- 1300
1301 **V.B.1.a)** This evaluation must include a review of the faculty member's
1302 clinical teaching abilities, engagement with the educational
1303 program, participation in faculty development related to their
1304 skills as an educator, clinical performance, professionalism,
1305 and scholarly activities. (Core)
1306
1307 **V.B.1.b)** This evaluation must include written, anonymous, and
1308 confidential evaluations by the residents. (Core)
1309
1310 **V.B.2.** Faculty members must receive feedback on their evaluations at least
1311 annually. (Core)
1312
1313 **V.B.3.** Results of the faculty educational evaluations should be
1314 incorporated into program-wide faculty development plans. (Core)
1315

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

- 1316
1317 **V.C. Program Evaluation and Improvement**
1318
1319 **V.C.1.** The program director must appoint the Program Evaluation
1320 Committee to conduct and document the Annual Program
1321 Evaluation as part of the program's continuous improvement
1322 process. (Core)
1323
1324 **V.C.1.a)** The Program Evaluation Committee must be composed of at
1325 least two program faculty members, at least one of whom is a
1326 core faculty member, and at least one resident. (Core)
1327
1328 **V.C.1.b)** Program Evaluation Committee responsibilities must include:
1329
1330 **V.C.1.b).(1)** acting as an advisor to the program director, through
1331 program oversight; (Core)
1332

- 1333 **V.C.1.b).(2)** review of the program’s self-determined goals and
 1334 progress toward meeting them; ^(Core)
 1335
 1336 **V.C.1.b).(3)** guiding ongoing program improvement, including
 1337 development of new goals, based upon outcomes;
 1338 and, ^(Core)
 1339
 1340 **V.C.1.b).(4)** review of the current operating environment to identify
 1341 strengths, challenges, opportunities, and threats as
 1342 related to the program’s mission and aims. ^(Core)
 1343

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

- 1344
 1345 **V.C.1.c)** The Program Evaluation Committee should consider the
 1346 following elements in its assessment of the program:
 1347
 1348 **V.C.1.c).(1)** curriculum; ^(Core)
 1349
 1350 **V.C.1.c).(2)** outcomes from prior Annual Program Evaluation(s);
 1351 ^(Core)
 1352
 1353 **V.C.1.c).(3)** ACGME letters of notification, including citations,
 1354 Areas for Improvement, and comments; ^(Core)
 1355
 1356 **V.C.1.c).(4)** quality and safety of patient care; ^(Core)
 1357
 1358 **V.C.1.c).(5)** aggregate resident and faculty:
 1359
 1360 **V.C.1.c).(5).(a)** well-being; ^(Core)
 1361
 1362 **V.C.1.c).(5).(b)** recruitment and retention; ^(Core)
 1363
 1364 **V.C.1.c).(5).(c)** workforce diversity; ^(Core)
 1365
 1366 **V.C.1.c).(5).(d)** engagement in quality improvement and patient
 1367 safety; ^(Core)
 1368
 1369 **V.C.1.c).(5).(e)** scholarly activity; ^(Core)
 1370
 1371 **V.C.1.c).(5).(f)** ACGME Resident and Faculty Surveys; and,
 1372 ^(Core)
 1373
 1374 **V.C.1.c).(5).(g)** written evaluations of the program. ^(Core)
 1375
 1376 **V.C.1.c).(6)** aggregate resident:
 1377

- 1378 V.C.1.c).(6).(a) achievement of the Milestones; ^(Core)
1379
1380 V.C.1.c).(6).(b) in-training examinations (where applicable);
1381 ^(Core)
1382
1383 V.C.1.c).(6).(c) board pass and certification rates; and, ^(Core)
1384
1385 V.C.1.c).(6).(d) graduate performance. ^(Core)
1386
1387 V.C.1.c).(7) aggregate faculty:
1388
1389 V.C.1.c).(7).(a) evaluation; and, ^(Core)
1390
1391 V.C.1.c).(7).(b) professional development. ^(Core)
1392
1393 V.C.1.d) The Program Evaluation Committee must evaluate the
1394 program's mission and aims, strengths, areas for
1395 improvement, and threats. ^(Core)
1396
1397 V.C.1.e) The annual review, including the action plan, must:
1398
1399 V.C.1.e).(1) be distributed to and discussed with the members of
1400 the teaching faculty and the residents; and, ^(Core)
1401
1402 V.C.1.e).(2) be submitted to the DIO. ^(Core)
1403
1404 V.C.2. The program must complete a Self-Study prior to its 10-Year
1405 Accreditation Site Visit. ^(Core)
1406
1407 V.C.2.a) A summary of the Self-Study must be submitted to the DIO.
1408 ^(Core)
1409

Background and Intent: Outcomes of the documented Annual Program Evaluation can be integrated into the 10-year Self-Study process. The Self-Study is an objective, comprehensive evaluation of the residency program, with the aim of improving it. Underlying the Self-Study is this longitudinal evaluation of the program and its learning environment, facilitated through sequential Annual Program Evaluations that focus on the required components, with an emphasis on program strengths and self-identified areas for improvement. Details regarding the timing and expectations for the Self-Study and the 10-Year Accreditation Site Visit are provided in the *ACGME Manual of Policies and Procedures*. Additionally, a description of the [Self-Study process](#), as well as information on how to prepare for the [10-Year Accreditation Site Visit](#), is available on the ACGME website.

- 1410
1411 V.C.3. *One goal of ACGME-accredited education is to educate physicians*
1412 *who seek and achieve board certification. One measure of the*
1413 *effectiveness of the educational program is the ultimate pass rate.*
1414
1415 *The program director should encourage all eligible program*
1416 *graduates to take the certifying examination offered by the*

- 1417 *applicable American Board of Medical Specialties (ABMS) member*
 1418 *board or American Osteopathic Association (AOA) certifying board.*
 1419
- 1420 **V.C.3.a)** For specialties in which the ABMS member board and/or AOA
 1421 certifying board offer(s) an annual written exam, in the
 1422 preceding three years, the program’s aggregate pass rate of
 1423 those taking the examination for the first time must be higher
 1424 than the bottom fifth percentile of programs in that specialty.
 1425 (Outcome)
- 1426
- 1427 **V.C.3.b)** For specialties in which the ABMS member board and/or AOA
 1428 certifying board offer(s) a biennial written exam, in the
 1429 preceding six years, the program’s aggregate pass rate of
 1430 those taking the examination for the first time must be higher
 1431 than the bottom fifth percentile of programs in that specialty.
 1432 (Outcome)
- 1433
- 1434 **V.C.3.c)** For specialties in which the ABMS member board and/or AOA
 1435 certifying board offer(s) an annual oral exam, in the preceding
 1436 three years, the program’s aggregate pass rate of those
 1437 taking the examination for the first time must be higher than
 1438 the bottom fifth percentile of programs in that specialty.
 1439 (Outcome)
- 1440
- 1441 **V.C.3.d)** For specialties in which the ABMS member board and/or AOA
 1442 certifying board offer(s) a biennial oral exam, in the preceding
 1443 six years, the program’s aggregate pass rate of those taking
 1444 the examination for the first time must be higher than the
 1445 bottom fifth percentile of programs in that specialty. (Outcome)
- 1446
- 1447 **V.C.3.e)** For each of the exams referenced in V.C.3.a)-d), any program
 1448 whose graduates over the time period specified in the
 1449 requirement have achieved an 80 percent pass rate will have
 1450 met this requirement, no matter the percentile rank of the
 1451 program for pass rate in that specialty. (Outcome)
- 1452

Background and Intent: Setting a single standard for pass rate that works across specialties is not supportable based on the heterogeneity of the psychometrics of different examinations. By using a percentile rank, the performance of the lower five percent (fifth percentile) of programs can be identified and set on a path to curricular and test preparation reform.

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

- 1453
- 1454 **V.C.3.f)** Programs must report, in ADS, board certification status
 1455 annually for the cohort of board-eligible residents that
 1456 graduated seven years earlier. (Core)
- 1457

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

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

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

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VI. The Learning and Working Environment

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

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

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

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

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

VI.A.1. Patient Safety and Quality Improvement

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

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

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

VI.A.1.a) Patient Safety

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

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

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

1521 VI.A.1.a).(1).(b) The program must have a structure that
1522 promotes safe, interprofessional, team-based
1523 care. ^(Core)
1524

1525 VI.A.1.a).(2) Education on Patient Safety
1526
1527 Programs must provide formal educational activities
1528 that promote patient safety-related goals, tools, and
1529 techniques. ^(Core)
1530

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

1531
1532 VI.A.1.a).(3) Patient Safety Events
1533
1534 *Reporting, investigation, and follow-up of adverse*
1535 *events, near misses, and unsafe conditions are pivotal*
1536 *mechanisms for improving patient safety, and are*
1537 *essential for the success of any patient safety*
1538 *program. Feedback and experiential learning are*
1539 *essential to developing true competence in the ability*
1540 *to identify causes and institute sustainable systems-*
1541 *based changes to ameliorate patient safety*
1542 *vulnerabilities.*
1543

1544 VI.A.1.a).(3).(a) Residents, fellows, faculty members, and other
1545 clinical staff members must:

1546
1547 VI.A.1.a).(3).(a).(i) know their responsibilities in reporting
1548 patient safety events at the clinical site;
1549 ^(Core)

1550
1551 VI.A.1.a).(3).(a).(ii) know how to report patient safety
1552 events, including near misses, at the
1553 clinical site; and, ^(Core)
1554

1555 VI.A.1.a).(3).(a).(iii) be provided with summary information
1556 of their institution's patient safety
1557 reports. ^(Core)
1558

1559 VI.A.1.a).(3).(b) Residents must participate as team members in
1560 real and/or simulated interprofessional clinical
1561 patient safety activities, such as root cause
1562 analyses or other activities that include
1563 analysis, as well as formulation and
1564 implementation of actions. ^(Core)
1565

1566 VI.A.1.a).(4) Resident Education and Experience in Disclosure of
1567 Adverse Events
1568

1569		<i>Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for residents to develop and apply.</i>
1570		
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1575	VI.A.1.a).(4).(a)	All residents must receive training in how to disclose adverse events to patients and families. ^(Core)
1576		
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1579	VI.A.1.a).(4).(b)	Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated. ^(Detail)
1580		
1581		
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1583	VI.A.1.b)	Quality Improvement
1584		
1585	VI.A.1.b).(1)	Education in Quality Improvement
1586		
1587		<i>A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.</i>
1588		
1589		
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1591		
1592	VI.A.1.b).(1).(a)	Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities. ^(Core)
1593		
1594		
1595		
1596	VI.A.1.b).(2)	Quality Metrics
1597		
1598		<i>Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.</i>
1599		
1600		
1601		
1602	VI.A.1.b).(2).(a)	Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. ^(Core)
1603		
1604		
1605		
1606	VI.A.1.b).(3)	Engagement in Quality Improvement Activities
1607		
1608		<i>Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.</i>
1609		
1610		
1611		
1612	VI.A.1.b).(3).(a)	Residents must have the opportunity to participate in interprofessional quality improvement activities. ^(Core)
1613		
1614		
1615		
1616	VI.A.1.b).(3).(a).(i)	This should include activities aimed at reducing health care disparities. ^(Detail)
1617		
1618		
1619	VI.A.2.	Supervision and Accountability

- 1620
 1621 **VI.A.2.a)** *Although the attending physician is ultimately responsible for*
 1622 *the care of the patient, every physician shares in the*
 1623 *responsibility and accountability for their efforts in the*
 1624 *provision of care. Effective programs, in partnership with*
 1625 *their Sponsoring Institutions, define, widely communicate,*
 1626 *and monitor a structured chain of responsibility and*
 1627 *accountability as it relates to the supervision of all patient*
 1628 *care.*
- 1629
 1630 *Supervision in the setting of graduate medical education*
 1631 *provides safe and effective care to patients; ensures each*
 1632 *resident's development of the skills, knowledge, and attitudes*
 1633 *required to enter the unsupervised practice of medicine; and*
 1634 *establishes a foundation for continued professional growth.*
- 1635
 1636 **VI.A.2.a).(1)** **Each patient must have an identifiable and**
 1637 **appropriately-credentialed and privileged attending**
 1638 **physician (or licensed independent practitioner as**
 1639 **specified by the applicable Review Committee) who is**
 1640 **responsible and accountable for the patient's care.**
 1641 (Core)
- 1642
 1643 **VI.A.2.a).(1).(a)** **This information must be available to residents,**
 1644 **faculty members, other members of the health**
 1645 **care team, and patients.** (Core)
- 1646
 1647 **VI.A.2.a).(1).(b)** **Residents and faculty members must inform**
 1648 **each patient of their respective roles in that**
 1649 **patient's care when providing direct patient**
 1650 **care.** (Core)
- 1651
 1652 **VI.A.2.b)** *Supervision may be exercised through a variety of methods.*
 1653 *For many aspects of patient care, the supervising physician*
 1654 *may be a more advanced resident or fellow. Other portions of*
 1655 *care provided by the resident can be adequately supervised*
 1656 *by the appropriate availability of the supervising faculty*
 1657 *member, fellow, or senior resident physician, either on site or*
 1658 *by means of telecommunication technology. Some activities*
 1659 *require the physical presence of the supervising faculty*
 1660 *member. In some circumstances, supervision may include*
 1661 *post-hoc review of resident-delivered care with feedback.*
- 1662

Background and Intent: Appropriate supervision is essential for patient safety and high-quality teaching. Supervision is also contextual. There is tremendous diversity of resident patient interactions, education and training locations, and resident skills and abilities even at the same level of the educational program. The degree of supervision is expected to evolve progressively as a resident gains more experience, even with the same patient condition or procedure. All residents have a level of supervision commensurate with their level of autonomy in practice; this level of supervision may

be enhanced based on factors such as patient safety, complexity, acuity, urgency, risk of serious adverse events, or other pertinent variables.

- 1663
1664 VI.A.2.b).(1) The program must demonstrate that the appropriate
1665 level of supervision in place for all residents is based
1666 on each resident's level of training and ability, as well
1667 as patient complexity and acuity. Supervision may be
1668 exercised through a variety of methods, as appropriate
1669 to the situation. ^(Core)
1670
- 1671 VI.A.2.b).(2) The program must define when physical presence of a
1672 supervising physician is required. ^(Core)
1673
- 1674 VI.A.2.c) Levels of Supervision
1675
1676 To promote appropriate resident supervision while providing
1677 for graded authority and responsibility, the program must use
1678 the following classification of supervision: ^(Core)
1679
- 1680 VI.A.2.c).(1) Direct Supervision:
1681
- 1682 VI.A.2.c).(1).(a) the supervising physician is physically present
1683 with the resident during the key portions of the
1684 patient interaction; or, ^(Core)
1685
- 1686 VI.A.2.c).(1).(a).(i) PGY-1 residents must initially be
1687 supervised directly, only as described in
1688 VI.A.2.c).(1).(a). ^(Core)
1689
- 1690 VI.A.2.c).(1).(b) the supervising physician and/or patient is not
1691 physically present with the resident and the
1692 supervising physician is concurrently
1693 monitoring the patient care through appropriate
1694 telecommunication technology. ^(Core)
1695
- 1696 VI.A.2.c).(2) Indirect Supervision: the supervising physician is not
1697 providing physical or concurrent visual or audio
1698 supervision but is immediately available to the
1699 resident for guidance and is available to provide
1700 appropriate direct supervision. ^(Core)
1701
- 1702 VI.A.2.c).(3) Oversight – the supervising physician is available to
1703 provide review of procedures/encounters with
1704 feedback provided after care is delivered. ^(Core)
1705
- 1706 VI.A.2.d) The privilege of progressive authority and responsibility,
1707 conditional independence, and a supervisory role in patient
1708 care delegated to each resident must be assigned by the
1709 program director and faculty members. ^(Core)
1710

- 1711 VI.A.2.d).(1) The program director must evaluate each resident's
 1712 abilities based on specific criteria, guided by the
 1713 Milestones. ^(Core)
 1714
- 1715 VI.A.2.d).(2) Faculty members functioning as supervising
 1716 physicians must delegate portions of care to residents
 1717 based on the needs of the patient and the skills of
 1718 each resident. ^(Core)
 1719
- 1720 VI.A.2.d).(3) Senior residents or fellows should serve in a
 1721 supervisory role to junior residents in recognition of
 1722 their progress toward independence, based on the
 1723 needs of each patient and the skills of the individual
 1724 resident or fellow. ^(Detail)
 1725
- 1726 VI.A.2.e) Programs must set guidelines for circumstances and events
 1727 in which residents must communicate with the supervising
 1728 faculty member(s). ^(Core)
 1729
- 1730 VI.A.2.e).(1) Each resident must know the limits of their scope of
 1731 authority, and the circumstances under which the
 1732 resident is permitted to act with conditional
 1733 independence. ^(Outcome)
 1734

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

- 1735
- 1736 VI.A.2.f) Faculty supervision assignments must be of sufficient
 1737 duration to assess the knowledge and skills of each resident
 1738 and to delegate to the resident the appropriate level of patient
 1739 care authority and responsibility. ^(Core)
 1740
- 1741 VI.B. Professionalism
- 1742
- 1743 VI.B.1. Programs, in partnership with their Sponsoring Institutions, must
 1744 educate residents and faculty members concerning the professional
 1745 responsibilities of physicians, including their obligation to be
 1746 appropriately rested and fit to provide the care required by their
 1747 patients. ^(Core)
 1748
- 1749 VI.B.2. The learning objectives of the program must:
- 1750
- 1751 VI.B.2.a) be accomplished through an appropriate blend of supervised
 1752 patient care responsibilities, clinical teaching, and didactic
 1753 educational events; ^(Core)
 1754
- 1755 VI.B.2.b) be accomplished without excessive reliance on residents to
 1756 fulfill non-physician obligations; and, ^(Core)
 1757

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

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VI.B.2.c) ensure manageable patient care responsibilities. (Core)

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

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

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

VI.B.4.a) provision of patient- and family-centered care; (Outcome)

VI.B.4.b) safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; (Outcome)

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

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

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

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

- 1782 VI.B.4.c).(2) recognition of impairment, including from illness,
 1783 fatigue, and substance use, in themselves, their peers,
 1784 and other members of the health care team. (Outcome)
 1785
 1786 VI.B.4.d) commitment to lifelong learning; (Outcome)
 1787
 1788 VI.B.4.e) monitoring of their patient care performance improvement
 1789 indicators; and, (Outcome)
 1790
 1791 VI.B.4.f) accurate reporting of clinical and educational work hours,
 1792 patient outcomes, and clinical experience data. (Outcome)
 1793
 1794 VI.B.5. All residents and faculty members must demonstrate
 1795 responsiveness to patient needs that supersedes self-interest. This
 1796 includes the recognition that under certain circumstances, the best
 1797 interests of the patient may be served by transitioning that patient's
 1798 care to another qualified and rested provider. (Outcome)
 1799
 1800 VI.B.6. Programs, in partnership with their Sponsoring Institutions, must
 1801 provide a professional, equitable, respectful, and civil environment
 1802 that is free from discrimination, sexual and other forms of
 1803 harassment, mistreatment, abuse, or coercion of students,
 1804 residents, faculty, and staff. (Core)
 1805
 1806 VI.B.7. Programs, in partnership with their Sponsoring Institutions, should
 1807 have a process for education of residents and faculty regarding
 1808 unprofessional behavior and a confidential process for reporting,
 1809 investigating, and addressing such concerns. (Core)
 1810
 1811 VI.C. Well-Being
 1812
 1813 *Psychological, emotional, and physical well-being are critical in the*
 1814 *development of the competent, caring, and resilient physician and require*
 1815 *proactive attention to life inside and outside of medicine. Well-being*
 1816 *requires that physicians retain the joy in medicine while managing their*
 1817 *own real-life stresses. Self-care and responsibility to support other*
 1818 *members of the health care team are important components of*
 1819 *professionalism; they are also skills that must be modeled, learned, and*
 1820 *nurtured in the context of other aspects of residency training.*
 1821
 1822 *Residents and faculty members are at risk for burnout and depression.*
 1823 *Programs, in partnership with their Sponsoring Institutions, have the same*
 1824 *responsibility to address well-being as other aspects of resident*
 1825 *competence. Physicians and all members of the health care team share*
 1826 *responsibility for the well-being of each other. For example, a culture which*
 1827 *encourages covering for colleagues after an illness without the expectation*
 1828 *of reciprocity reflects the ideal of professionalism. A positive culture in a*
 1829 *clinical learning environment models constructive behaviors, and prepares*
 1830 *residents with the skills and attitudes needed to thrive throughout their*
 1831 *careers.*
 1832

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

The ACGME also created a repository for well-being materials, assessments, presentations, and more on the [Well-Being Tools and Resources page](#) in Learn at ACGME for programs seeking to develop or strengthen their own well-being initiatives. There are many activities that programs can implement now to assess and support physician well-being. These include the distribution and analysis of culture of safety surveys, ensuring the availability of counseling services, and paying attention to the safety of the entire health care team.

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

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

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

Background and Intent: Well-being includes having time away from work to engage with family and friends, as well as to attend to personal needs and to one's own health, including adequate rest, healthy diet, and regular exercise.

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- VI.C.1.d).(1)** Residents must be given the opportunity to attend medical, mental health, and dental care appointments,

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including those scheduled during their working hours.
(Core)

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

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

Background and Intent: Programs and Sponsoring Institutions are encouraged to review materials to create systems for identification of burnout, depression, and substance use disorders. Materials and more information are available in Learn at ACGME (<https://dl.acgme.org/pages/well-being-tools-resources>).

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

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

1881

- 1882 VI.C.1.e).(2) provide access to appropriate tools for self-screening;
 1883 and, ^(Core)
 1884
 1885 VI.C.1.e).(3) provide access to confidential, affordable mental
 1886 health assessment, counseling, and treatment,
 1887 including access to urgent and emergent care 24
 1888 hours a day, seven days a week. ^(Core)
 1889

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

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

- 1890
 1891 VI.C.2. There are circumstances in which residents may be unable to attend
 1892 work, including but not limited to fatigue, illness, family
 1893 emergencies, and parental leave. Each program must allow an
 1894 appropriate length of absence for residents unable to perform their
 1895 patient care responsibilities. ^(Core)
 1896
 1897 VI.C.2.a) The program must have policies and procedures in place to
 1898 ensure coverage of patient care. ^(Core)
 1899
 1900 VI.C.2.b) These policies must be implemented without fear of negative
 1901 consequences for the resident who is or was unable to
 1902 provide the clinical work. ^(Core)
 1903

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

- 1904
 1905 VI.D. Fatigue Mitigation
 1906
 1907 VI.D.1. Programs must:
 1908
 1909 VI.D.1.a) educate all faculty members and residents to recognize the
 1910 signs of fatigue and sleep deprivation; ^(Core)
 1911
 1912 VI.D.1.b) educate all faculty members and residents in alertness
 1913 management and fatigue mitigation processes; and, ^(Core)
 1914
 1915 VI.D.1.c) encourage residents to use fatigue mitigation processes to
 1916 manage the potential negative effects of fatigue on patient
 1917 care and learning. ^(Detail)

1918

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

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

1919

1920

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

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

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

1930

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VI.E.1. Clinical Responsibilities

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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)

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1937

VI.E.1.a) The clinical workload must allow residents to develop the required competence in patient care with a focus on learning over meeting service obligations. (Detail)

1938

1939

1940

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

1941

1942

VI.E.2. Teamwork

1943

- 1944 Residents must care for patients in an environment that maximizes
 1945 communication. This must include the opportunity to work as a
 1946 member of effective interprofessional teams that are appropriate to
 1947 the delivery of care in the specialty and larger health system. ^(Core)
 1948
- 1949 **VI.E.3. Transitions of Care**
- 1950
- 1951 **VI.E.3.a) Programs must design clinical assignments to optimize**
 1952 **transitions in patient care, including their safety, frequency,**
 1953 **and structure.** ^(Core)
 1954
- 1955 **VI.E.3.b) Programs, in partnership with their Sponsoring Institutions,**
 1956 **must ensure and monitor effective, structured hand-over**
 1957 **processes to facilitate both continuity of care and patient**
 1958 **safety.** ^(Core)
 1959
- 1960 **VI.E.3.c) Programs must ensure that residents are competent in**
 1961 **communicating with team members in the hand-over process.**
 1962 ^(Outcome)
 1963
- 1964 **VI.E.3.d) Programs and clinical sites must maintain and communicate**
 1965 **schedules of attending physicians and residents currently**
 1966 **responsible for care.** ^(Core)
 1967
- 1968 **VI.E.3.e) Each program must ensure continuity of patient care,**
 1969 **consistent with the program’s policies and procedures**
 1970 **referenced in VI.C.2-VI.C.2.b), in the event that a resident may**
 1971 **be unable to perform their patient care responsibilities due to**
 1972 **excessive fatigue or illness, or family emergency.** ^(Core)
 1973
- 1974 **VI.F. Clinical Experience and Education**
- 1975
- 1976 *Programs, in partnership with their Sponsoring Institutions, must design*
 1977 *an effective program structure that is configured to provide residents with*
 1978 *educational and clinical experience opportunities, as well as reasonable*
 1979 *opportunities for rest and personal activities.*
 1980

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

- 1981
- 1982 **VI.F.1. Maximum Hours of Clinical and Educational Work per Week**
- 1983
- 1984 **Clinical and educational work hours must be limited to no more than**
 1985 **80 hours per week, averaged over a four-week period, inclusive of all**
 1986 **in-house clinical and educational activities, clinical work done from**
 1987 **home, and all moonlighting.** ^(Core)
 1988

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

Scheduling

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

Oversight

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

Work from Home

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

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

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

PGY-1 and PGY-2 Residents

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

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- VI.F.2. Mandatory Time Free of Clinical Work and Education**
- VI.F.2.a)** The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being. ^(Core)
- VI.F.2.b)** Residents should have eight hours off between scheduled clinical work and education periods. ^(Detail)
- VI.F.2.b).(1)** There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements. ^(Detail)

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

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

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Background and Intent: Residents have a responsibility to return to work rested, and thus are expected to use this time away from work to get adequate rest. In support of this goal, residents are encouraged to prioritize sleep over other discretionary activities.

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

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

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

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

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

Of greatest concern to the Task Force were the observations of disruption of team care and patient care continuity brought about with residents beyond the PGY-1 level adhering to differing requirements. The graduate medical education community uniformly requested that the Task Force remove this requirement. The most frequently-cited reason for this request was the complete disruption of the team, separating the PGY-1 from supervisory faculty members and residents who were best able to judge the ability of the resident and customize the supervision of patient care for each PGY-1. Cited nearly as frequently was the separation of the PGY-1 from the team, delaying

maturation of clinical skills, and threatening to create a “shift” mentality in disciplines where overnight availability to patients is essential in delivery of care.

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

After careful consideration of the information available, the testimony and position of all parties submitting information, and presentations to the Task Force, the Task Force removed the 16-hour-consecutive-time-on-task requirement for PGY-1 residents. It remains crucial that programs ensure that PGY-1 residents are supervised in compliance with the applicable Program Requirements, and that resident well-being is prioritized as described in Section VI.C. of these requirements.

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- VI.F.3.a).(1)** Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. (Core)
- VI.F.3.a).(1).(a)** Additional patient care responsibilities must not be assigned to a resident during this time. (Core)

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

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- VI.F.4. Clinical and Educational Work Hour Exceptions**
- VI.F.4.a)** In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:
- VI.F.4.a).(1)** to continue to provide care to a single severely ill or unstable patient; (Detail)
- VI.F.4.a).(2)** humanistic attention to the needs of a patient or family; or, (Detail)
- VI.F.4.a).(3)** to attend unique educational events. (Detail)
- VI.F.4.b)** These additional hours of care or education will be counted toward the 80-hour weekly limit. (Detail)

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

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

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

VI.F.5. Moonlighting

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

VI.F.5.b) 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)

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

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

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VI.F.6. In-House Night Float

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

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

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VI.F.7. 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)

VI.F.8. At-Home Call

- 2088 VI.F.8.a) Time spent on patient care activities by residents on at-home
 2089 call must count toward the 80-hour maximum weekly limit.
 2090 The frequency of at-home call is not subject to the every-
 2091 third-night limitation, but must satisfy the requirement for one
 2092 day in seven free of clinical work and education, when
 2093 averaged over four weeks. ^(Core)
 2094
- 2095 VI.F.8.a).(1) At-home call must not be so frequent or taxing as to
 2096 preclude rest or reasonable personal time for each
 2097 resident. ^(Core)
 2098
- 2099 VI.F.8.b) Residents are permitted to return to the hospital while on at-
 2100 home call to provide direct care for new or established
 2101 patients. These hours of inpatient patient care must be
 2102 included in the 80-hour maximum weekly limit. ^(Detail)
 2103

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

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

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- 2107 ***Core Requirements:** Statements that define structure, resource, or process elements
 2108 essential to every graduate medical educational program.
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- 2110 **†Detail Requirements:** Statements that describe a specific structure, resource, or process, for
 2111 achieving compliance with a Core Requirement. Programs and sponsoring institutions in
 2112 substantial compliance with the Outcome Requirements may utilize alternative or innovative
 2113 approaches to meet Core Requirements.
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- 2115 **‡Outcome Requirements:** Statements that specify expected measurable or observable
 2116 attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their
 2117 graduate medical education.
 2118
- 2119 **Osteopathic Recognition**
 2120 For programs with or applying for Osteopathic Recognition, the Osteopathic Recognition
 2121 Requirements also apply (www.acgme.org/OsteopathicRecognition).
 2122