

ACGME Program Requirements for Graduate Medical Education in Clinical Biochemical Genetics

Proposed focused revision; posted for review and comment January 31, 2022

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1 **Proposed ACGME Program Requirements for Graduate Medical Education**
2 **in Clinical Biochemical Genetics**

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4 **Common Program Requirements (Post-Doctoral Education Program) are in BOLD**

5
6 Where applicable, text in italics describes the underlying philosophy of the requirements in that
7 section. These philosophic statements are not program requirements and are therefore not
8 citable.

9
10 **Introduction**

11
12 **Int.A.** *Graduate medical education in a medical-related field is the crucial step of*
13 *professional development between medical school or graduate school and*
14 *autonomous contributions to clinical care. It is in this vital phase of the*
15 *continuum of medical-related education that post-doctoral fellows learn to*
16 *contribute to 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 *This education transforms medical students or graduate students into*
21 *specialists who contribute to the care for the patient, family, and a diverse*
22 *community; create and integrate new knowledge into practice; and educate*
23 *future generations of specialists to serve the public. Practice patterns*
24 *established during graduate medical education persist many years later.*

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

35
36 *This education occurs in clinical settings that establish the foundation for*
37 *practice-based and lifelong learning. The professional development of the*
38 *specialist, begun in pre-doctoral education, continues through faculty*
39 *modeling of the effacement of self-interest in a humanistic environment*
40 *that emphasizes joy in curiosity, problem-solving, academic rigor, and*
41 *discovery. This transformation is often physically, emotionally, and*
42 *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, post-doctoral fellows, fellows, faculty members,*
45 *students, and all members of the health care team.*

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

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49 Clinical biochemical genetics is a laboratory-based discipline that focuses on the
50 screening, diagnosis, evaluation, and management of patients with inborn errors
51 of metabolism and their families. Clinical biochemical genetics programs provide

52 post-doctoral education in the skills and knowledge necessary to perform and
53 interpret biochemical analyses relevant to the diagnosis and management of
54 human genetic diseases. Upon successful completion of such a program, clinical
55 biochemical geneticists have the skills and knowledge to function as technical
56 supervisors of clinical laboratories and clinical consultants in the diagnosis and
57 treatment of patients with these types of disorders, and may, in many
58 jurisdictions, be deemed qualified to direct specialty laboratories.

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

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62 The educational program in clinical biochemical genetics must be 24 months in
63 length. ^{(Core)*}

64
65 **I. Oversight**

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67 **I.A. Sponsoring Institution**

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

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

76
77
78 **Background and Intent: Participating sites will reflect the health care needs of the**
79 **community and the educational needs of the post-doctoral fellows. A wide variety of**
80 **organizations may provide a robust educational experience and, thus, Sponsoring**
81 **Institutions and participating sites may encompass inpatient and outpatient settings**
82 **including, but not limited to a university, a medical school, a teaching hospital, a**
83 **nursing home, a school of public health, a health department, a public health agency,**
84 **an organized health care delivery system, a medical examiner's office, an educational**
85 **consortium, a teaching health center, a physician group practice, federally qualified**
86 **health center, or an educational foundation.**

87
88
89 **I.A.1. The program must be sponsored by one ACGME-accredited**
90 **Sponsoring Institution. ^(Core)**

91
92 **I.B. Participating Sites**

*A participating site is an organization providing educational experiences or
educational assignments/rotations for post-doctoral fellows.*

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

I.B.1.a) Institutions sponsoring clinical biochemical genetics programs
should also sponsor ACGME-accredited programs in medical
genetics and genomics. ^(Core)

- 93 **I.B.2.** There must be a program letter of agreement (PLA) between the
94 program and each participating site that governs the relationship
95 between the program and the participating site providing a required
96 assignment. ^(Core)
97
- 98 **I.B.2.a)** The PLA must:
99
- 100 **I.B.2.a).(1)** be renewed at least every 10 years; and, ^(Core)
101
- 102 **I.B.2.a).(2)** be approved by the designated institutional official
103 (DIO). ^(Core)
104
- 105 **I.B.3.** The program must monitor the clinical learning and working
106 environment at all participating sites. ^(Core)
107
- 108 **I.B.3.a)** At each participating site there must be one faculty member,
109 designated by the program director as the site director, who
110 is accountable for post-doctoral fellow education at that site,
111 in collaboration with the program director. ^(Core)
112

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

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

- Identifying the faculty member(s) who will assume educational and supervisory responsibility for post-doctoral fellows
- Specifying the responsibilities for teaching, supervision, and formal evaluation of post-doctoral fellows
- Specifying the duration and content of the educational experience
- Stating the policies and procedures that will govern post-doctoral fellow education during the assignment

- 113
- 114 **I.B.4.** The program director must submit any additions or deletions of
115 participating sites routinely providing an educational experience,
116 required for all post-doctoral fellows, of one month full time
117 equivalent (FTE) or more through the ACGME's Accreditation Data
118 System (ADS). ^(Core)
119
- 120 **I.C.** The program, in partnership with its Sponsoring Institution, must engage in
121 practices that focus on mission-driven, ongoing, systematic recruitment
122 and retention of a diverse and inclusive workforce of post-doctoral fellows,
123 residents and fellows (if present), faculty members, senior administrative

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staff members, and other relevant members of its academic community.
(Core)

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).

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I.D. Resources

I.D.1. The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for post-doctoral fellow education. (Core)

I.D.1.a) All laboratories affiliated with the program must be Clinical Laboratory Improvement Amendment (CLIA)-certified. (Core)

I.D.1.b) Laboratory facilities and resources appropriate for the discipline must be available to post-doctoral fellows at on-site laboratories, including:

I.D.1.b).(1) education facilities, to include office space, meeting rooms, classrooms, laboratory space, and research facilities; (Core)

I.D.1.b).(2) appropriate instrumentation to perform biochemical genetics testing; and, (Core)

I.D.1.b).(3) access to computer-based genetic interpretive tools and systems. (Core)

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

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

I.D.2.b) safe, quiet, clean, and private sleep/rest facilities available and accessible for post-doctoral fellows with proximity appropriate for safe patient care; (Core)

Background and Intent: Contributions to care of patients within a hospital or health system occur continually through the day and night. Such care requires that post-doctoral fellows 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 post-doctoral fellows are working. Post-doctoral fellows should have access to refrigeration where food may be stored. Food should be available when post-doctoral fellows are required to be in the hospital overnight. Rest facilities are

necessary, even when overnight call is not required, to accommodate the fatigued post-doctoral fellow.

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

Background and Intent: Sites must provide private and clean locations where post-doctoral fellows 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 post-doctoral fellow with the continued contributions to 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 post-doctoral fellow and the fellow's family, as outlined in VI.C.1.d).(1).

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

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- I.D.2.e) accommodations for post-doctoral fellows with disabilities consistent with the Sponsoring Institution's policy. (Core)

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

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- I.D.4. The program's educational and clinical resources must be adequate to support the number of post-doctoral fellows appointed to the program. (Core)

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- I.E. The presence of other learners and other care providers, including, but not limited to, post-doctoral fellows from other programs, residents, subspecialty fellows, and advanced practice providers must enrich the appointed post-doctoral fellows' education. (Core)

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- I.E.1. The program must report circumstances when the presence of other learners has interfered with the post-doctoral fellows' education to the DIO and Graduate Medical Education Committee (GMEC). (Core)

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 specialists and their learners enriches the learning environment. Programs have a responsibility to monitor the learning environment to ensure that post-doctoral fellows' education is not compromised by the presence of other providers and learners.

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II. Personnel

II.A. Program Director

195 II.A.1. There must be one faculty member appointed as program director
196 with authority and accountability for the overall program, including
197 compliance with all applicable program requirements. (Core)

198
199 II.A.1.a) The Sponsoring Institution's GMEC must approve a change in
200 program director. (Core)

201
202 II.A.1.b) Final approval of the program director resides with the
203 Review Committee. (Core)

204

Background and Intent: While the ACGME recognizes the value of input from numerous individuals in the management of a post-doctoral education program, a single individual must be designated as program director and have overall responsibility for the post-doctoral education 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.

205

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

209

Background and Intent: The success of post-doctoral education program 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.

210

211 II.A.2. The program director and, as applicable, the program's leadership
212 team, must be provided with support adequate for administration of
213 the program based upon its size and configuration. (Core)

214

215 II.A.2.a) Program leadership, in aggregate, must be provided with support
216 equal to a dedicated minimum of 20 percent time. This may be
217 time spent by the program director only or divided among the
218 program director and one or more associate (or assistant)
219 program directors. At a minimum, the program director must be
220 provided with the salary support required to devote 10 percent
221 FTE of non-clinical time to the administration of the program. (Core)

222

Background and Intent: To achieve successful graduate medical education, individuals serving as education and administrative leaders of post-doctoral education programs, as well as those significantly engaged in the education, supervision, evaluation, and mentoring of post-doctoral fellows, 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 post-doctoral fellow 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 post-

doctoral education 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.

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

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

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

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

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

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II.A.3.b) must include current certification in the specialty for which they are the program director by the American Board of Medical Genetics and Genomics (ABMGG) if available for their field of study, or specialty qualifications that are acceptable to the Review Committee; (Core)

[Note that while the Common Program Requirements deem certification by a certifying board of the American Osteopathic Association (AOA) acceptable, there is no AOA board that offers certification in this specialty]

II.A.3.b).(1) The program director must be certified by the ABMGG and actively participating in the ABMGG's Continuing Certification Maintenance of Certification (MOC) Program in clinical biochemical genetics. (Core)

247 **II.A.3.c)** must include appropriate medical staff or institutional
248 appointment; and, ^(Core)

249
250 **II.A.3.d)** must include ongoing contributions to clinical care. ^(Core)
251

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

252
253 **II.A.3.e)** The program director should be a full-time faculty member, and
254 must be based at the primary clinical site. ^{(Detail)†}
255

256 **II.A.4. Program Director Responsibilities**

257
258 **The program director must have responsibility, authority, and**
259 **accountability for: administration and operations; teaching and**
260 **scholarly activity; post-doctoral fellow recruitment and selection,**
261 **evaluation, and promotion of post-doctoral fellows, and disciplinary**
262 **action; supervision of post-doctoral fellows; and post-doctoral**
263 **fellow education in the context of contributions to patient care.** ^(Core)
264

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

266 **II.A.4.a).(1) be a role model of professionalism;** ^(Core)
267
268

Background and Intent: The program director, as the leader of the program, must serve as a role model to post-doctoral fellows in addition to fulfilling the technical aspects of the role. As post-doctoral fellows 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 contributions, 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.

269
270 **II.A.4.a).(2) design and conduct the program in a fashion**
271 **consistent with the needs of the community, the**
272 **mission(s) of the Sponsoring Institution, and the**
273 **mission(s) of the program;** ^(Core)
274

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.

275

276 II.A.4.a).(3) administer and maintain a learning environment
277 conducive to educating the post-doctoral fellows in
278 each of the ACGME Competency domains; ^(Core)
279

Background and Intent: The program director may establish a leadership team to assist in the accomplishment of program goals. Post-doctoral education 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.

280
281 II.A.4.a).(4) develop and oversee a process to evaluate candidates
282 prior to approval as program faculty members for
283 participation in the post-doctoral education program
284 and at least annually thereafter, as outlined in V.B.;
285 ^(Core)
286

287 II.A.4.a).(5) have the authority to approve program faculty
288 members for participation in the post-doctoral
289 education program at all sites; ^(Core)
290

291 II.A.4.a).(6) have the authority to remove program faculty
292 members from participation in the post-doctoral
293 education program at all sites; ^(Core)
294

295 II.A.4.a).(7) have the authority to remove post-doctoral fellows
296 from supervising interactions and/or learning
297 environments that do not meet the standards of the
298 program; ^(Core)
299

Background and Intent: The program director has the responsibility to ensure that all who educate post-doctoral fellows effectively role model the Core Competencies. Working with a post-doctoral fellow 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 post-doctoral fellows.

300
301 II.A.4.a).(8) submit accurate and complete information required
302 and requested by the DIO, GMEC, and ACGME; ^(Core)
303

304 II.A.4.a).(9) provide applicants who are offered an interview with
305 information related to the applicant's eligibility for the
306 relevant board certification examination(s); ^(Core)
307

308 II.A.4.a).(10) provide a learning and working environment in which
309 post-doctoral fellows have the opportunity to raise
310 concerns and provide feedback in a confidential

- 311 manner as appropriate, without fear of intimidation or
 312 retaliation; ^(Core)
 313
 314 **II.A.4.a).(11)** ensure the program's compliance with the Sponsoring
 315 Institution's policies and procedures related to
 316 grievances and due process; ^(Core)
 317
 318 **II.A.4.a).(12)** ensure the program's compliance with the Sponsoring
 319 Institution's policies and procedures for due process
 320 when action is taken to suspend or dismiss, not to
 321 promote, or not to renew the appointment of a post-
 322 doctoral fellow; ^(Core)
 323

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 post-doctoral fellows.

- 324
 325 **II.A.4.a).(13)** ensure the program's compliance with the Sponsoring
 326 Institution's policies and procedures on employment
 327 and non-discrimination; ^(Core)
 328
 329 **II.A.4.a).(13).(a)** Post-doctoral fellows must not be required to
 330 sign a non-competition guarantee or restrictive
 331 covenant. ^(Core)
 332
 333 **II.A.4.a).(14)** document verification of program completion for all
 334 graduating post-doctoral fellows within 30 days; ^(Core)
 335
 336 **II.A.4.a).(15)** provide verification of an individual post-doctoral
 337 fellow's completion upon the post-doctoral fellow's
 338 request, within 30 days; and, ^(Core)
 339

Background and Intent: Primary verification of graduate medical education in a medical-related field is important to credentialing of specialists 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 post-doctoral fellows who have previously completed the program. Post-doctoral fellows who leave the program prior to completion also require timely documentation of their summative evaluation.

- 340
 341 **II.A.4.a).(16)** obtain review and approval of the Sponsoring
 342 Institution's DIO before submitting information or
 343 requests to the ACGME, as required in the Institutional
 344 Requirements and outlined in the ACGME Program
 345 Director's Guide to the Common Program
 346 Requirements. ^(Core)
 347
 348 **II.B. Faculty**
 349

350 *Faculty members are a foundational element of graduate medical education*
351 *– faculty members teach post-doctoral fellows how to contribute to care for*
352 *patients. Faculty members provide an important bridge allowing post-*
353 *doctoral fellows to grow and become prepared to provide clinical care,*
354 *ensuring that patients receive the highest quality of care. They are role*
355 *models for future generations of specialists by demonstrating compassion,*
356 *commitment to excellence in teaching and patient care, professionalism,*
357 *and a dedication to lifelong learning. Faculty members experience the pride*
358 *and joy of fostering the growth and development of future colleagues. The*
359 *care they provide is enhanced by the opportunity to teach. By employing a*
360 *scholarly approach to patient care, faculty members, through the graduate*
361 *medical education system, improve the health of the individual and the*
362 *population.*

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

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

- 372
373 **II.B.1.** At each participating site, there must be a sufficient number of
374 **faculty members with competence to instruct and supervise all post-**
375 **doctoral fellows at that location.** ^(Core)
376
377 **II.B.2.** Faculty members must:
378
379 **II.B.2.a)** be role models of professionalism; ^(Core)
380
381 **II.B.2.b)** demonstrate commitment to the delivery of safe, quality,
382 **cost-effective, patient-centered care;** ^(Core)
383

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 post-doctoral education. Faculty members model these goals and continually strive for improvement in care and cost, embracing a commitment to the care of the patient and the community they serve.

- 384
385 **II.B.2.c)** demonstrate a strong interest in the education of post-
386 **doctoral fellows;** ^(Core)
387
388 **II.B.2.d)** devote sufficient time to the educational program to fulfill
389 **their supervisory and teaching responsibilities;** ^(Core)
390
391 **II.B.2.e)** administer and maintain an educational environment
392 **conducive to educating post-doctoral fellows;** ^(Core)

- 393
 394 **II.B.2.f)** regularly participate in organized clinical discussions,
 395 rounds, journal clubs, and conferences; and, ^(Core)
 396
 397 **II.B.2.g)** pursue faculty development designed to enhance their skills
 398 at least annually: ^(Core)
 399

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 post-doctoral education program faculty in the aggregate.

- 400
 401 **II.B.2.g).(1)** as educators; ^(Core)
 402
 403 **II.B.2.g).(2)** in quality improvement and patient safety; ^(Core)
 404
 405 **II.B.2.g).(3)** in fostering their own and their post-doctoral fellows'
 406 well-being; and, ^(Core)
 407
 408 **II.B.2.g).(4)** as contributors to patient care based on their practice-
 409 based learning and improvement efforts. ^(Core)
 410

Background and Intent: Practice-based learning serves as the foundation for the practice of medicine. Through a systematic analysis of one's participation in care 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 post-doctoral fellows in practice-based learning.

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 412 **II.B.3. Faculty Qualifications**
 413
 414 **II.B.3.a)** Faculty members must have appropriate qualifications in
 415 their field and hold appropriate institutional appointments.
 416 ^(Core)
 417
 418 **II.B.3.a).(1)** Faculty members must have current certification in the
 419 discipline by the ABMGG, or possess qualifications judged
 420 acceptable to the Review Committee. ^(Core)
 421
 422 **II.B.3.a).(2)** Associate program directors must be actively participating
 423 in the ABMGG MOC program in the specialty in which they
 424 are certified. ^(Core)
 425
 426 **II.B.3.b)** Faculty members must:
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 428 **II.B.3.b).(1)** have current certification in the specialty by the
 429 American Board of Medical Genetics and Genomics, if
 430 available for their field of study, or possess

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qualifications judged acceptable to the Review Committee. ^(Core)

[Note that while the Common Program Requirements deem certification by a certifying board of the American Osteopathic Association (AOA) acceptable, there is no AOA board that offers certification in this specialty]

II.B.3.c) Faculty members responsible for post-doctoral fellow education in biochemical genetics must have current ABMGG certification in clinical biochemical genetics. ^(Core)

II.B.4. Core Faculty

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

Background and Intent: Core faculty members are critical to the success of post-doctoral fellow education. They support the program leadership in developing, implementing, and assessing curriculum, mentoring post-doctoral fellows, and assessing post-doctoral fellows' 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 post-doctoral fellows, and also participate in non-clinical activities related to post-doctoral fellow education and program administration. Examples of these non-clinical activities include, but are not limited to, interviewing and selecting post-doctoral fellow applicants, providing didactic instruction, mentoring post-doctoral fellows, simulation exercises, completing the annual ACGME Faculty Survey, and participating on the program's Clinical Competency Committee, Program Evaluation Committee, and other GME committees.

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II.B.4.a) **Core faculty members must be designated by the program director.** ^(Core)

II.B.4.b) **Core faculty members must complete the annual ACGME Faculty Survey.** ^(Core)

II.B.4.c) The program must have at least three core faculty members. ^(Core)

II.C. Program Coordinator

II.C.1. **There must be a program coordinator.** ^(Core)

465 **II.C.2. The program coordinator must be provided with dedicated time and**
466 **support adequate for administration of the program based upon its**
467 **size and configuration.** (Core)

468
469 **II.C.2.a)** ~~At a minimum, t~~The program coordinator must be provided with
470 supported at equal to a dedicated minimum of 40 20 percent time
471 FTE for the administration of the program. If the Sponsoring
472 Institution also sponsors an ACGME-accredited laboratory
473 genetics and genomics program, the 10 percent FTE for
474 administrative time can be shared between both programs. (Core)
475

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 post-doctoral fellows.

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 post-doctoral fellows may not require a full-time coordinator; one coordinator may support more than one program.

476
477 **II.D. Other Program Personnel**

478
479 **The program, in partnership with its Sponsoring Institution, must jointly**
480 **ensure the availability of necessary personnel for the effective**
481 **administration of the program.** (Core)

482
483 **II.D.1.** Genetic counselors, nurses, dieticians, lab technologists and other health
484 care professionals who are involved in the provision of clinical and
485 medical biochemical genetics services should be available to collaborate
486 on a regular basis with post-doctoral fellows. (Detail)
487

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.

- 488
489 **III. Post-Doctoral Fellow Appointments**
490
491 **III.A. Eligibility Requirements**
492
493 **III.A.1. An applicant must meet one of the following qualifications to be**
494 **eligible for appointment to an ACGME-accredited program:** ^(Core)
495
496 **III.A.1.a) graduation from a medical school in the United States or**
497 **Canada, accredited by the Liaison Committee on Medical**
498 **Education (LCME); graduation from a college of osteopathic**
499 **medicine in the United States, accredited by the American**
500 **Osteopathic Association Commission on Osteopathic College**
501 **Accreditation (AOACOCA); or graduation from an accredited**
502 **doctoral program in a clinically related discipline; or,** ^(Core)
503
504 **III.A.1.a).(1) Post-doctoral fellows entering clinical biochemical genetics**
505 **programs must hold an MD, DO, or PhD (or equivalent)**
506 **degree.** ^(Core)
507
508 **III.A.1.a).(1).(a) The PhD (or equivalent) degree must be in either**
509 **genetics or a related field.** ^(Core)
510
511 **III.A.1.b) graduation from a medical school outside of the United**
512 **States or Canada, and holding a currently valid certificate**
513 **from the Educational Commission for Foreign Medical**
514 **Graduates (ECFMG) prior to appointment.** ^(Core)
515
516 **III.B. The program director must not appoint more post-doctoral fellows than**
517 **approved by the Review Committee.** ^(Core)
518
519 **III.B.1. All complement increases must be approved by the Review**
520 **Committee.** ^(Core)
521
522 **III.C. Post-Doctoral Fellow Transfers**
523
524 **The program must obtain verification of previous educational experiences**
525 **and a summative competency-based performance evaluation prior to**
526 **acceptance of a transferring post-doctoral fellow, and Milestones**
527 **evaluations upon matriculation.** ^(Core)
528
529 **IV. Educational Program**
530
531 ***The ACGME accreditation system is designed to encourage excellence and***
532 ***innovation in graduate medical education regardless of the organizational***
533 ***affiliation, size, or location of the program.***
534
535 ***The educational program must support the development of knowledgeable, skillful***
536 ***specialists who contribute to compassionate care.***
537

538 *In addition, the program is expected to define its specific program aims consistent*
539 *with the overall mission of its Sponsoring Institution, the needs of the community*
540 *it serves and that its graduates will serve, and the distinctive capabilities of*
541 *specialists it intends to graduate. While programs must demonstrate substantial*
542 *compliance with the Common and specialty-specific Program Requirements, it is*
543 *recognized that within this framework, programs may place different emphasis on*
544 *research, leadership, public health, etc. It is expected that the program aims will*
545 *reflect the nuanced program-specific goals for it and its graduates.*

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

548
549 **IV.A.1.** a set of program aims consistent with the Sponsoring Institution's
550 mission, the needs of the community it serves, and the desired
551 distinctive capabilities of its graduates; ^(Core)

552
553 **IV.A.1.a)** The program's aims must be made available to program
554 applicants, post-doctoral fellows, and faculty members. ^(Core)

555
556 **IV.A.2.** competency-based goals and objectives for each educational
557 experience designed to promote progress on a trajectory to
558 autonomous practice. These must be distributed, reviewed, and
559 available to post-doctoral fellows and faculty members; ^(Core)

560

Background and Intent: The trajectory to autonomous practice is documented by Milestones evaluation. The Milestones detail the progress of a post-doctoral fellow 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 post-doctoral fellow.

561
562 **IV.A.3.** delineation of post-doctoral fellow responsibilities for patient care,
563 progressive responsibility for contributions to patient care, and
564 graded supervision; ^(Core)

565

Background and Intent: These responsibilities may generally be described by year in the program 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 and a learner needing more time to accomplish a certain task may do so in a focused rather than global manner.

566
567 **IV.A.4.** a broad range of structured didactic activities; ^(Core)

568
569 **IV.A.4.a)** Post-doctoral fellows must be provided with protected time to
570 participate in core didactic activities. ^(Core)

571

Background and Intent: It is intended that post-doctoral fellows 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 post-doctoral fellows 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.

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IV.A.5. advancement of post-doctoral fellows' knowledge of ethical principles foundational to medical professionalism; and, ^(Core)

IV.A.6. advancement in the post-doctoral fellows' knowledge of the basic principles of scientific inquiry, including how research is designed, conducted, evaluated, explained to patients, and applied to patient care. ^(Core)

IV.B. ACGME Competencies

Background and Intent: The Competencies provide a conceptual framework describing the required domains for a trusted specialist to enter autonomous practice. These Competencies are core to the practice of all specialists, 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

Post-doctoral fellows must demonstrate a commitment to professionalism and an adherence to ethical principles. ^(Core)

IV.B.1.a).(1) Post-doctoral fellows 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 care 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 specialist would be better for the situation based on skill set or knowledge base.

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606

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)

- 607 **IV.B.1.a).(1).(e)** respect and responsiveness to diverse patient
608 populations, including but not limited to
609 diversity in gender, age, culture, race, religion,
610 disabilities, national origin, socioeconomic
611 status, and sexual orientation; ^(Core)
612
- 613 **IV.B.1.a).(1).(f)** ability to recognize and develop a plan for one's
614 own personal and professional well-being; and,
615 ^(Core)
616
- 617 **IV.B.1.a).(1).(g)** appropriately disclosing and addressing
618 conflict or duality of interest. ^(Core)
619
- 620 **IV.B.1.b) Patient Care and Procedural Skills**
621

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 specialist's well-being as a means to improve patient care and reduce burnout among residents, post-doctoral fellows, fellows, and practicing specialists.

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.

- 622
- 623 **IV.B.1.b).(1)** **Post-doctoral fellows must be able to contribute to**
624 **patient care in a way that is compassionate,**
625 **appropriate, and effective for the treatment of health**
626 **problems and the promotion of health. ^(Core)**
627
- 628 **IV.B.1.b).(1).(a)** Post-doctoral fellows must demonstrate
629 competence in:
630
- 631 **IV.B.1.b).(1).(a).(i)** pre-analytic, quality control, analytic, and
632 interpretive laboratory skills; and, ^(Core)
633
- 634 **IV.B.1.b).(1).(a).(ii)** post-analytic reporting skills. ^(Core)
635
- 636 **IV.B.1.b).(2)** **Post-doctoral fellows must be able to perform all**
637 **procedures considered essential for the area of**
638 **practice. ^(Core)**
639
- 640 **IV.B.1.b).(2).(a)** Post-doctoral fellows must demonstrate
641 competence in the principles and techniques of
642 specimen selection, sample preparation, analysis,
643 and results interpretation and reporting for: ^(Core)
644

645	IV.B.1.b).(2).(a).(i)	acylcarnitine analysis; (Core)
646		
647	IV.B.1.b).(2).(a).(ii)	amino acid analysis; (Core)
648		
649	IV.B.1.b).(2).(a).(iii)	enzyme-based analysis; and, (Core)
650		
651	IV.B.1.b).(2).(a).(iv)	organic acid analysis. (Core)

652
653 **IV.B.1.c) Medical Knowledge**

654
655 **Post-doctoral fellows must demonstrate knowledge of**
656 **established and evolving biomedical, clinical, epidemiological**
657 **and social-behavioral sciences, as well as the application of**
658 **this knowledge in their contributions to patient care. (Core)**

659		
660	IV.B.1.c).(1)	Post-doctoral fellows must demonstrate knowledge of
661		general principles of biology and genetics as related to
662		biochemical genetics, including: (Core)
663		
664	IV.B.1.c).(1).(a)	biochemical pathways and how they interrelate;
665		(Core)
666		
667	IV.B.1.c).(1).(b)	enzyme kinetics; and, (Core)
668		
669	IV.B.1.c).(1).(c)	principles of population-based screening. (Core)
670		
671	IV.B.1.c).(2)	Post-doctoral fellows must demonstrate knowledge of the
672		clinical, biochemical, pathophysiologic, diagnostic, and
673		treatment features of biochemical genetic conditions,
674		including disorders of: (Core)
675		
676	IV.B.1.c).(2).(a)	carbohydrate metabolism (e.g., glycogen storage
677		disorders); (Core)
678		
679	IV.B.1.c).(2).(b)	cofactor and metal metabolism and transport (e.g.,
680		B12 deficiency); (Core)
681		
682	IV.B.1.c).(2).(c)	complex molecule metabolism (e.g., lysosomal
683		storage disorders, and congenital disorders of
684		glycosylation); (Core)
685		
686	IV.B.1.c).(2).(d)	energy metabolism (e.g., mitochondrial
687		myopathies); (Core)
688		
689	IV.B.1.c).(2).(e)	small molecule metabolism (e.g., neurotransmitter
690		disorders); and, (Core)
691		
692	IV.B.1.c).(2).(f)	treatment options for all metabolic disorders. (Core)
693		

694 IV.B.1.c).(3) Post-doctoral fellows must demonstrate knowledge of the
695 principles and applications of newborn screening and
696 confirmatory follow-up testing and reporting. (Core)

697
698 **IV.B.1.d) Practice-based Learning and Improvement**
699

700 **Post-doctoral fellows must demonstrate the ability to**
701 **investigate and evaluate their contributions to the care of**
702 **patients, to appraise and assimilate scientific evidence, and**
703 **to continuously improve patient care based on constant self-**
704 **evaluation and lifelong learning. (Core)**
705

Background and Intent: Practice-based learning and improvement is one of the defining characteristics of being a specialist. 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 specialist develop the habits of mind required to continuously pursue quality improvement, well past the completion of post-doctoral education.

706
707 **IV.B.1.d).(1) Post-doctoral fellows must demonstrate competence**
708 **in:**

709
710 **IV.B.1.d).(1).(a) identifying strengths, deficiencies, and limits in**
711 **one's knowledge and expertise; (Core)**

712
713 **IV.B.1.d).(1).(b) setting learning and improvement goals; (Core)**

714
715 **IV.B.1.d).(1).(c) identifying and performing appropriate learning**
716 **activities; (Core)**

717
718 **IV.B.1.d).(1).(d) systematically analyzing their contributions to**
719 **care using quality improvement methods, and**
720 **implementing changes with the goal of practice**
721 **improvement; (Core)**

722
723 **IV.B.1.d).(1).(e) incorporating feedback and formative**
724 **evaluation into daily practice; (Core)**

725
726 **IV.B.1.d).(1).(f) locating, appraising, and assimilating evidence**
727 **from scientific studies related to their patients'**
728 **health problems; and, (Core)**

729
730 **IV.B.1.d).(1).(g) using information technology to optimize**
731 **learning. (Core)**

732
733 **IV.B.1.e) Interpersonal and Communication Skills**
734

- 735 Post-doctoral fellows must demonstrate interpersonal and
 736 communication skills that result in the effective exchange of
 737 information and collaboration with patients, their families,
 738 and health professionals. ^(Core)
 739
 740 **IV.B.1.e).(1)** Post-doctoral fellows must demonstrate competence
 741 in:
 742
 743 **IV.B.1.e).(1).(a)** communicating effectively with patients,
 744 families, and the public, as appropriate, across
 745 a broad range of socioeconomic and cultural
 746 backgrounds; ^(Core)
 747
 748 **IV.B.1.e).(1).(b)** communicating effectively with physicians,
 749 other health professionals, and health-related
 750 agencies; ^(Core)
 751
 752 **IV.B.1.e).(1).(c)** working effectively as a member or leader of a
 753 health care team or other professional group;
 754 ^(Core)
 755
 756 **IV.B.1.e).(1).(d)** educating patients, families, students, and
 757 other health professionals; ^(Core)
 758
 759 **IV.B.1.e).(1).(e)** acting in a consultative role to other physicians
 760 and health professionals; and, ^(Core)
 761
 762 **IV.B.1.e).(1).(f)** maintaining comprehensive, timely, and legible
 763 medical records, if applicable. ^(Core)
 764
 765 **IV.B.1.e).(2)** Post-doctoral fellows must learn to communicate,
 766 through collaborators in care or directly, with patients
 767 and families, to partner with them to assess their care
 768 goals. ^(Core)
 769

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. Post-doctoral fellows must learn to participate effectively and compassionately in contributing to 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.

- 770
 771 **IV.B.1.e).(3)** Post-doctoral fellows must generate comprehensive and
 772 timely laboratory reports. ^(Core)
 773
 774 **IV.B.1.f)** **Systems-based Practice**
 775

776 Post-doctoral fellows must demonstrate an awareness of and
777 responsiveness to the larger context and system of health
778 care, including the social determinants of health, as well as
779 the ability to effectively collaborate with other providers and
780 use resources to provide optimal health care. ^(Core)
781

782 **IV.B.1.f).(1)** Post-doctoral fellows must demonstrate competence
783 in:
784

785 **IV.B.1.f).(1).(a)** working effectively in various health care
786 delivery settings and systems relevant to their
787 clinical specialty; ^(Core)
788

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.

789
790 **IV.B.1.f).(1).(a).(i)** Post-doctoral fellows must:
791

792 **IV.B.1.f).(1).(a).(i).(a)** participate in interactions with
793 external regulatory agencies,
794 including any inspections of the labs
795 during their training; ^(Core)
796

797 **IV.B.1.f).(1).(a).(i).(b)** demonstrate knowledge of the
798 function and interaction of laboratory
799 information systems, electronic
800 health records, and billing systems;
801 and, ^(Core)
802

803 **IV.B.1.f).(1).(a).(i).(c)** demonstrate expertise in their
804 knowledge of basic economic and
805 business principles needed to
806 function effectively in the practice
807 setting. ^(Core)
808

809 **IV.B.1.f).(1).(b)** helping to coordinate patient care across the
810 health care continuum and beyond as relevant
811 to their specialty; ^(Core)
812

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.

813
814 **IV.B.1.f).(1).(c)** advocating for quality patient care and optimal
815 patient care systems; ^(Core)
816

- 817 **IV.B.1.f).(1).(d)** working in interprofessional teams to enhance
818 patient safety and improve patient care quality;
819 (Core)
820
- 821 **IV.B.1.f).(1).(e)** participating in identifying system errors and
822 implementing potential systems solutions; (Core)
823
- 824 **IV.B.1.f).(1).(f)** incorporating considerations of value, cost
825 awareness, delivery and payment, and risk-
826 benefit analysis in patient and/or population-
827 based care as appropriate; (Core)
828
- 829 **IV.B.1.f).(1).(g)** understanding health care finances and its
830 impact on individual patients' health decisions;
831 (Core)
832
- 833 **IV.B.1.f).(1).(h)** actively participating in laboratory inspections; and,
834 (Core)
835
- 836 **IV.B.1.f).(1).(i)** participating in laboratory quality management,
837 including quality control and quality assurance. (Core)
838
- 839 **IV.B.1.f).(2)** **Post-doctoral fellows must learn to advocate for**
840 **patients within the health care system, directly or**
841 **through collaboration with other providers, to achieve**
842 **the patient's and family's care goals. (Core)**
843
- 844 **IV.C. Curriculum Organization and Post-Doctoral Fellow Experiences**
845
- 846 **IV.C.1. The curriculum must be structured to optimize post-doctoral fellow**
847 **educational experiences, the length of these experiences, and**
848 **supervisory continuity. (Core)**
849
- 850 **IV.C.1.a) The program must ensure:**
851
- 852 **IV.C.1.a).(1) adequate supervision during times of transition and hand-**
853 **offs; (Core)**
854
- 855 **IV.C.1.a).(2) continuity of supervision at all participating sites; and, (Core)**
856
- 857 **IV.C.1.a).(3) exposure to and sufficient time in specialty clinics for post-**
858 **doctoral fellows. (Core)**
859

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

860

- 861 IV.C.2. A program in clinical biochemical genetics must provide the necessary
862 formal education and clinical laboratory-based experience to allow post-
863 doctoral fellows to develop the knowledge, skills, and professional
864 attitudes required for the practice in the field. ^(Core)
865
- 866 IV.C.2.a) There must be a minimum of 18 months in the clinical biochemical
867 laboratory, to include: ^(Core)
868
- 869 IV.C.2.a).(1) a four-week rotation in laboratory genetics and genomics;
870 ^(Core)
871
- 872 IV.C.2.a).(2) clinical rotations or experience in the laboratory; and, ^(Core)
873
- 874 IV.C.2.a).(3) didactic course work and other educational opportunities.
875 ^(Core)
876
- 877 IV.C.2.b) Development of clinical laboratory methods or tests should be a
878 component of training. ^(Detail)
879
- 880 IV.C.2.c) There must be no more than six months of activities designed to
881 gain additional clinical or research skills, including additional
882 rotations to learn new skills or assays, development of new
883 assays in the laboratory, or to complete a research project
884 pertinent to the field of clinical biochemical genetics. ^(Core)
885
- 886 IV.C.3. Post-doctoral fellows should gain experience in a wide array of
887 techniques at the primary on-site laboratory. ^(Core)
888
- 889 IV.C.4. Direct Patient Experience in Medical Genetics and Genomics
890
- 891 IV.C.4.a) Post-doctoral fellows must have direct exposure to the clinical
892 evaluation of patients, medical decision making, and genetic
893 counseling. ^(Core)
894
- 895 IV.C.4.a).(1) Post-doctoral fellows must participate in a minimum of 10
896 patient case conferences and the equivalent of 10 half-day
897 metabolic clinics (i.e., 40 hours). ^(Core)
898
- 899 IV.C.4.a).(2) Post-doctoral fellows should have direct exposure to
900 patients with inborn errors of metabolism in the inpatient
901 and/or outpatient setting. ^(Detail)
902
- 903 IV.C.5. Didactic Education
904
- 905 The didactic curriculum must include:
906
- 907 IV.C.5.a) clinical teaching conferences, to include formal sessions on
908 clinical laboratory topics, medical genetics and genomics rounds,
909 journal clubs, and follow-up conferences for genetic clinics; and,
910 ^(Core)
911

912	IV.C.5.b)	lectures or other didactic sessions on the following topics
913		including: (Core)
914		
915	IV.C.5.b).(1)	basic mechanisms of inheritance, to include sex
916		chromosomes, autosomes, and mitochondrial DNA; (Core)
917		
918	IV.C.5.b).(2)	basic molecular biology techniques pertinent to clinical
919		testing and understanding genetic research; (Core)
920		
921	IV.C.5.b).(3)	Bayesian analysis and other methods of genetic risk
922		assessment; (Core)
923		
924	IV.C.5.b).(4)	behavior of genes in a population, to include Hardy
925		Weinberg equilibria of alleles; (Core)
926		
927	IV.C.5.b).(5)	bioinformatic approaches to interpreting molecular test
928		results, to include methods to assign causation to novel
929		findings; (Core)
930		
931	IV.C.5.b).(6)	disorders of amino acid metabolism; (Core)
932		
933	IV.C.5.b).(7)	disorders of carbohydrate metabolism; (Core)
934		
935	IV.C.5.b).(8)	disorders of fatty acid oxidation; (Core)
936		
937	IV.C.5.b).(9)	DNA, RNA, and protein chemistry, to include DNA repair;
938		(Core)
939		
940	IV.C.5.b).(10)	gene expression and mechanisms of regulation of genes
941		and genomes, to include epigenetic regulation; (Core)
942		
943	IV.C.5.b).(11)	genetic counseling; (Core)
944		
945	IV.C.5.b).(12)	genetic linkage, mapping, and association studies; (Core)
946		
947	IV.C.5.b).(13)	human embryology and development; (Core)
948		
949	IV.C.5.b).(14)	inheritance of complex traits and genetic variation; (Core)
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951	IV.C.5.b).(15)	lysosomal storage diseases; (Core)
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953	IV.C.5.b).(16)	management of IEM (acute and long-term); (Core)
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955	IV.C.5.b).(17)	mechanisms of chromosomal rearrangement; (Core)
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957	IV.C.5.b).(18)	mitochondrial disorders; (Core)
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959	IV.C.5.b).(19)	molecular diagnosis; (Core)
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961	IV.C.5.b).(20)	molecular organization of the genome, to include molecular
962		evolution mechanisms; (Core)

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964	IV.C.5.b).(21)	peroxisomal disorders and other inborn errors of metabolism (IEM); ^(Core)
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967	IV.C.5.b).(22)	population and newborn screening; ^(Core)
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969	IV.C.5.b).(23)	principles of biochemical genetics and metabolism; ^(Core)
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971	IV.C.5.b).(24)	principles of replication, recombination, and segregation of alleles during meiosis; and, ^(Core)
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974	IV.C.5.b).(25)	the cell cycle and molecular genetics of cancer. ^(Core)
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976	IV.C.6.	Research seminars should be provided as part of the educational experience. ^(Core)
977		
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979	IV.C.7.	Other Educational Opportunities
980		
981		Post-doctoral fellows should participate in a minimum of 20 hours over a period of 24 months in other educational opportunities, such as seminars, journal clubs, rotations in a clinical chemistry laboratory, topics of which should broadly relate to clinical biochemical genetics and genomics education. ^(Detail)
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987	IV.D.	Scholarship
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989		<i>Medicine is both an art and a science. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through post-doctoral fellow participation in scholarly activities. Scholarly activities may include discovery, integration, application, and teaching.</i>
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996		<i>The ACGME recognizes the diversity of post-doctoral education programs and anticipates that programs prepare specialists for a variety of roles, including contributors to clinical care, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.</i>
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1006	IV.D.1.	Program Responsibilities
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1008	IV.D.1.a)	The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. ^(Core)
1009		
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1011	IV.D.1.b)	The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate post-doctoral fellow and faculty involvement in scholarly activities. ^(Core)
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IV.D.1.c)

The program must advance post-doctoral fellows' knowledge and practice of the scholarly approach to evidence-based contributions to patient care. ^(Core)

Background and Intent: The scholarly approach can be defined as a synthesis of teaching, learning, and research with the aim of encouraging curiosity and critical thinking based on an understanding of physiology, pathophysiology, diagnostic testing, 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, dissemination of new knowledge, and teaching, all faculty members are responsible for advancing post-doctoral fellows' scholarly approach to contributions to patient care.

Elements of a scholarly approach to patient care include:

- **Asking meaningful questions to stimulate post-doctoral fellows to utilize learning resources to identify appropriate testing and interpretation of clinical investigation, and contribute to a differential diagnosis, a diagnostic algorithm, and treatment plan**
- **Challenging the evidence that the post-doctoral fellows use to reach their medical contributions 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 post-doctoral fellow 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 post-doctoral fellows to be scholarly teachers.

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IV.D.2.

Faculty Scholarly Activity

IV.D.2.a)

Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: ^(Core)

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

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

Background and Intent: For the purposes of education, metrics of scholarly activity represent one of the surrogates for the program’s effectiveness in the creation of an environment of inquiry that advances the post-doctoral fellows’ scholarly approach to their contributions 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 programs in the same specialty or field.

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

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IV.D.3. Post-Doctoral Fellow Scholarly Activity

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IV.D.3.a) Post-doctoral fellows must participate in scholarship. (Core)

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IV.D.3.a).(1) Each post-doctoral fellow must demonstrate scholarship through at least one scientific presentation, abstract, or publication. (Core)

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V. Evaluation

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V.A. Post-Doctoral Fellow Evaluation

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V.A.1. Feedback and Evaluation

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Background and Intent: Feedback is ongoing information provided regarding aspects of one’s performance, knowledge, or understanding. The faculty empower post-doctoral fellows 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 post-doctoral fellow learning* and providing ongoing feedback that can be used by post-doctoral fellows to improve their learning in the context of provision of patient care or other educational opportunities. More specifically, formative evaluations help:

- **post-doctoral fellows identify their strengths and weaknesses and target areas that need work**

- program directors and faculty members recognize where post-doctoral fellows are struggling and address problems immediately

Summative evaluation is *evaluating a post-doctoral fellow's learning* by comparing the post-doctoral fellows 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 post-doctoral fellows or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the post-doctoral education program.

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

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

Background and Intent: Faculty members should provide feedback frequently throughout the course of each rotation. Post-doctoral fellows 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 post-doctoral fellows who have deficiencies that may result in a poor final rotation evaluation.

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

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

V.A.1.b).(2) Longitudinal experiences must be evaluated at least every three months and at completion. (Core)

V.A.1.c) The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones, and must: (Core)

V.A.1.c).(1) use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, (Core)

V.A.1.c).(2) provide that information to the Clinical Competency Committee for its synthesis of progressive post-

- 1126 **V.A.2.a).(1)** The specialty-specific Milestones, and, when
 1127 applicable, the specialty-specific Case Logs, must be
 1128 used as tools to ensure post-doctoral fellows are able
 1129 to engage in autonomous practice upon completion of
 1130 the program. ^(Core)
 1131
- 1132 **V.A.2.a).(2)** The final evaluation must:
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- 1134 **V.A.2.a).(2).(a)** become part of the post-doctoral fellow’s
 1135 permanent record maintained by the institution,
 1136 and must be accessible for review by the post-
 1137 doctoral fellow in accordance with institutional
 1138 policy; ^(Core)
 1139
- 1140 **V.A.2.a).(2).(b)** verify that the post-doctoral fellow has
 1141 demonstrated the knowledge, skills, and
 1142 behaviors necessary to enter autonomous
 1143 practice; ^(Core)
 1144
- 1145 **V.A.2.a).(2).(c)** consider recommendations from the Clinical
 1146 Competency Committee; and, ^(Core)
 1147
- 1148 **V.A.2.a).(2).(d)** be shared with the post-doctoral fellow upon
 1149 completion of the program. ^(Core)
 1150
- 1151 **V.A.3.** A Clinical Competency Committee must be appointed by the
 1152 program director. ^(Core)
 1153
- 1154 **V.A.3.a)** At a minimum, the Clinical Competency Committee must
 1155 include three members of the program faculty, at least one of
 1156 whom is a core faculty member. ^(Core)
 1157
- 1158 **V.A.3.a).(1)** Additional members must be faculty members from
 1159 the same program or other programs, or other health
 1160 professionals who have extensive contact and
 1161 experience with the program’s post-doctoral fellows.
 1162 ^(Core)
 1163

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 post-doctoral fellow 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 post-doctoral fellow 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 post-doctoral fellows. 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.

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1165 **V.A.3.b) The Clinical Competency Committee must:**
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1167 **V.A.3.b).(1) review all post-doctoral fellow evaluations at least**
1168 **semi-annually; (Core)**
1169
1170 **V.A.3.b).(2) determine each post-doctoral fellow's progress on**
1171 **achievement of the specialty-specific Milestones; and,**
1172 **(Core)**
1173
1174 **V.A.3.b).(3) meet prior to the post-doctoral fellows' semi-annual**
1175 **evaluations and advise the program director regarding**
1176 **each post-doctoral fellow's progress. (Core)**
1177
1178 **V.B. Faculty Evaluation**
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1180 **V.B.1. The program must have a process to evaluate each faculty**
1181 **member's performance as it relates to the educational program at**
1182 **least annually. (Core)**
1183

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 specialists within a given institution for other reasons, it is applied to post-doctoral education 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 post-doctoral fellow 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 post-doctoral fellows desire feedback on their education, clinical care, and research. If a faculty member does not interact with post-doctoral fellows, feedback is not required. With regard to the diverse operating environments and configurations, the post-doctoral education 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 post-doctoral fellows in a confidential and anonymous manner. Other aspects for the feedback may include research or clinical productivity, review of patient outcomes, or peer review of scholarly activity. The process should reflect the local environment and identify the necessary information. The feedback from the various sources should be summarized and provided to the faculty on an annual basis by a member of the leadership team of the program.

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1185 **V.B.1.a) This evaluation must include a review of the faculty member's**
1186 **clinical teaching abilities, engagement with the educational**
1187 **program, participation in faculty development related to their**
1188 **skills as an educator and clinical specialist, professionalism,**
1189 **and scholarly activities. (Core)**
1190
1191 **V.B.1.b) This evaluation must include written, confidential evaluations**
1192 **by the post-doctoral fellows. (Core)**

- 1193
1194 **V.B.2. Faculty members must receive feedback on their evaluations at least**
1195 **annually. (Core)**
1196
1197 **V.B.3. Results of the faculty educational evaluations should be**
1198 **incorporated into program-wide faculty development plans. (Core)**
1199

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 post-doctoral fellows’ future contributions to clinical care. Therefore, the program has the responsibility to evaluate and improve the program faculty members’ teaching, scholarship, professionalism, and quality care contributions. This section mandates annual review of the program’s faculty members for this purpose, and can be used as input into the Annual Program Evaluation.

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1201 **V.C. Program Evaluation and Improvement**
1202
1203 **V.C.1. The program director must appoint the Program Evaluation**
1204 **Committee to conduct and document the Annual Program**
1205 **Evaluation as part of the program’s continuous improvement**
1206 **process. (Core)**
1207
1208 **V.C.1.a) The Program Evaluation Committee must be composed of at**
1209 **least two program faculty members, at least one of whom is a**
1210 **core faculty member, and at least one post-doctoral fellow.**
1211 **(Core)**
1212
1213 **V.C.1.b) Program Evaluation Committee responsibilities must include:**
1214
1215 **V.C.1.b).(1) acting as an advisor to the program director, through**
1216 **program oversight; (Core)**
1217
1218 **V.C.1.b).(2) review of the program’s self-determined goals and**
1219 **progress toward meeting them; (Core)**
1220
1221 **V.C.1.b).(3) guiding ongoing program improvement, including**
1222 **development of new goals, based upon outcomes;**
1223 **and, (Core)**
1224
1225 **V.C.1.b).(4) review of the current operating environment to identify**
1226 **strengths, challenges, opportunities, and threats as**
1227 **related to the program’s mission and aims. (Core)**
1228

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

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1230	V.C.1.c)	The Program Evaluation Committee should consider the
1231		following elements in its assessment of the program:
1232		
1233	V.C.1.c).(1)	curriculum; ^(Core)
1234		
1235	V.C.1.c).(2)	outcomes from prior Annual Program Evaluation(s);
1236		^(Core)
1237		
1238	V.C.1.c).(3)	ACGME letters of notification, including citations,
1239		Areas for Improvement, and comments; ^(Core)
1240		
1241	V.C.1.c).(4)	quality and safety of patient care; ^(Core)
1242		
1243	V.C.1.c).(5)	aggregate post-doctoral fellow and faculty:
1244		
1245	V.C.1.c).(5).(a)	well-being; ^(Core)
1246		
1247	V.C.1.c).(5).(b)	recruitment and retention; ^(Core)
1248		
1249	V.C.1.c).(5).(c)	workforce diversity; ^(Core)
1250		
1251	V.C.1.c).(5).(d)	engagement in quality improvement and patient
1252		safety; ^(Core)
1253		
1254	V.C.1.c).(5).(e)	scholarly activity; ^(Core)
1255		
1256	V.C.1.c).(5).(f)	ACGME Resident and Faculty Surveys; and,
1257		^(Core)
1258		
1259	V.C.1.c).(5).(g)	written evaluations of the program. ^(Core)
1260		
1261	V.C.1.c).(6)	aggregate post-doctoral fellow:
1262		
1263	V.C.1.c).(6).(a)	achievement of the Milestones; ^(Core)
1264		
1265	V.C.1.c).(6).(b)	in-training examinations (where applicable);
1266		^(Core)
1267		
1268	V.C.1.c).(6).(c)	board pass and certification rates; and, ^(Core)
1269		
1270	V.C.1.c).(6).(d)	graduate performance. ^(Core)
1271		
1272	V.C.1.c).(7)	aggregate faculty:
1273		
1274	V.C.1.c).(7).(a)	evaluation; and, ^(Core)
1275		
1276	V.C.1.c).(7).(b)	professional development. ^(Core)
1277		
1278	V.C.1.d)	The Program Evaluation Committee must evaluate the
1279		program's mission and aims, strengths, areas for
1280		improvement, and threats. ^(Core)

- 1281
 1282 **V.C.1.e)** The annual review, including the action plan, must:
 1283
 1284 **V.C.1.e).(1)** be distributed to and discussed with the members of
 1285 the teaching faculty and the post-doctoral fellows;
 1286 and, ^(Core)
 1287
 1288 **V.C.1.e).(2)** be submitted to the DIO. ^(Core)
 1289
 1290 **V.C.2.** The program must complete a Self-Study prior to its 10-Year
 1291 Accreditation Site Visit. ^(Core)
 1292
 1293 **V.C.2.a)** A summary of the Self-Study must be submitted to the DIO.
 1294 ^(Core)
 1295

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

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 1297 **V.C.3.** *One goal of ACGME-accredited education is to educate specialists*
 1298 *who seek and achieve board certification. One measure of the*
 1299 *effectiveness of the educational program is the ultimate certifying*
 1300 *exam pass rate.*
 1301
 1302 *The program director should encourage all eligible program*
 1303 *graduates to take the certifying examination offered by the*
 1304 *applicable American Board of Medical Specialties (ABMS) member*
 1305 *board or American Osteopathic Association (AOA) certifying board.*
 1306
 1307 **V.C.3.a)** For specialties in which the ABMS member board and/or AOA
 1308 certifying board offer(s) an annual written exam, in the
 1309 preceding three years, the program's aggregate pass rate of
 1310 those taking the examination for the first time must be higher
 1311 than the bottom fifth percentile of programs in that specialty.
 1312 ^(Outcome)
 1313
 1314 **V.C.3.b)** For specialties in which the ABMS member board and/or AOA
 1315 certifying board offer(s) a biennial written exam, in the
 1316 preceding six years, the program's aggregate pass rate of
 1317 those taking the examination for the first time must be higher
 1318 than the bottom fifth percentile of programs in that specialty.
 1319 ^(Outcome)
 1320

- 1321 **V.C.3.c)** For specialties in which the ABMS member board and/or AOA
 1322 certifying board offer(s) an annual oral exam, in the preceding
 1323 three years, the program’s aggregate pass rate of those
 1324 taking the examination for the first time must be higher than
 1325 the bottom fifth percentile of programs in that specialty.
 1326 (Outcome)
 1327
- 1328 **V.C.3.d)** For specialties in which the ABMS member board and/or AOA
 1329 certifying board offer(s) a biennial oral exam, in the preceding
 1330 six years, the program’s aggregate pass rate of those taking
 1331 the examination for the first time must be higher than the
 1332 bottom fifth percentile of programs in that specialty. (Outcome)
 1333
- 1334 **V.C.3.e)** For each of the exams referenced in V.C.3.a)-d), any program
 1335 whose graduates over the time period specified in the
 1336 requirement have achieved an 80 percent pass rate will have
 1337 met this requirement, no matter the percentile rank of the
 1338 program for pass rate in that specialty. (Outcome)
 1339

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.

- 1340
 1341 **V.C.3.f)** Programs must report, in ADS, board certification status
 1342 annually for the cohort of board-eligible post-doctoral fellows
 1343 that graduated seven years earlier. (Core)
 1344

Background and Intent: It is essential that post-doctoral education programs demonstrate knowledge and skill transfer to their post-doctoral fellows. 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 post-doctoral education program 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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 1346 **VI. The Learning and Working Environment**

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

- ***Excellence in the safety and quality of contributions to care of patients by post-doctoral fellows today***
- ***Excellence in the safety and quality of care rendered to patients by today's post-doctoral fellows 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 specialists***
 - ***the joy of curiosity, problem-solving, intellectual rigor, and discovery***
- ***Commitment to the well-being of the students, post-doctoral fellows, 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 post-doctoral fellows 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 post-doctoral fellows 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, post-doctoral fellow education, and post-doctoral fellow well-being. The requirements are intended to support the development of a sense of professionalism by encouraging post-doctoral fellows 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 post-doctoral fellows 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 post-doctoral fellow and faculty member well-being. The requirements are intended to support programs and post-doctoral fellows 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 post-doctoral fellows. With this flexibility comes a responsibility for post-doctoral fellows and faculty members to recognize the need to hand off their contributions to care of patients to another provider when a post-doctoral fellow is too fatigued to provide safe, high quality care and for programs to ensure that post-doctoral fellows 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

1372 ***All specialists share responsibility for contributing to patient safety***
1373 ***and enhancing quality of patient care. Graduate medical education***
1374 ***in a medical-related field must prepare post-doctoral fellows to***
1375 ***provide the highest level of clinical care with continuous focus on***
1376 ***the safety, individual needs, and humanity of patients. It is the right***
1377 ***of each patient to receive contributions to their care by post-***
1378 ***doctoral fellows who are appropriately supervised; possess the***
1379 ***requisite knowledge, skills, and abilities; understand the limits of***
1380 ***their knowledge and experience; and seek assistance as required to***
1381 ***provide optimal patient care.***

1382
1383 ***Post-doctoral fellows must demonstrate the ability to analyze the***
1384 ***contributions to care they provide, understand their roles within***
1385 ***health care teams, and play an active role in system improvement***
1386 ***processes. Graduating post-doctoral fellows will apply these skills***
1387 ***to critique their future unsupervised contributions to care and effect***
1388 ***quality improvement measures.***

1389
1390 ***It is necessary for post-doctoral fellows and faculty members to***
1391 ***consistently work in a well-coordinated manner with other health***
1392 ***care professionals to achieve organizational patient safety goals.***

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1394 **VI.A.1.a) Patient Safety**

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1396 **VI.A.1.a).(1) Culture of Safety**

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1398 ***A culture of safety requires continuous identification***
1399 ***of vulnerabilities and a willingness to transparently***
1400 ***deal with them. An effective organization has formal***
1401 ***mechanisms to assess the knowledge, skills, and***
1402 ***attitudes of its personnel toward safety in order to***
1403 ***identify areas for improvement.***

1404
1405 **VI.A.1.a).(1).(a) The program, its faculty, post-doctoral fellows,**
1406 **residents, and fellows must actively participate**
1407 **in patient safety systems and contribute to a**
1408 **culture of safety. ^(Core)**

1409
1410 **VI.A.1.a).(1).(b) The program must have a structure that**
1411 **promotes safe, interprofessional, team-based**
1412 **care. ^(Core)**

1413
1414 **VI.A.1.a).(2) Education on Patient Safety**

1415
1416 **Programs must provide formal educational activities**
1417 **that promote patient safety-related goals, tools, and**
1418 **techniques. ^(Core)**

1419
1420 **Background and Intent: Optimal patient safety occurs in the setting of a coordinated interprofessional learning and working environment.**

1421	VI.A.1.a).(3)	Patient Safety Events
1422		
1423		<i>Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.</i>
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1432		
1433	VI.A.1.a).(3).(a)	Post-doctoral fellows, residents, fellows, faculty members, and other clinical staff members must:
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1435		
1436		
1437	VI.A.1.a).(3).(a).(i)	know their responsibilities in reporting patient safety events at the clinical site;
1438		<small>(Core)</small>
1439		
1440		
1441	VI.A.1.a).(3).(a).(ii)	know how to report patient safety events, including near misses, at the clinical site; and,
1442		<small>(Core)</small>
1443		
1444		
1445	VI.A.1.a).(3).(a).(iii)	be provided with summary information of their institution's patient safety reports.
1446		<small>(Core)</small>
1447		
1448		
1449	VI.A.1.a).(3).(b)	Post-doctoral fellows must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions.
1450		<small>(Core)</small>
1451		
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1455		
1456	VI.A.1.a).(4)	Post-Doctoral Fellow Education and Experience in Disclosure of Adverse Events
1457		
1458		
1459		<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 specialists to model, and for post-doctoral fellows to develop and apply.</i>
1460		
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1466	VI.A.1.a).(4).(a)	All post-doctoral fellows must receive training in how to disclose adverse events.
1467		<small>(Core)</small>
1468		
1469	VI.A.1.a).(4).(b)	Post-doctoral fellows should have the opportunity to participate in the disclosure of patient safety events, real or simulated.
1470		<small>(Detail)</small>
1471		

1472		
1473	VI.A.1.b)	Quality Improvement
1474		
1475	VI.A.1.b).(1)	Education in Quality Improvement
1476		
1477		<i>A cohesive model of health care includes quality-</i>
1478		<i>related goals, tools, and techniques that are necessary</i>
1479		<i>in order for health care professionals to achieve</i>
1480		<i>quality improvement goals.</i>
1481		
1482	VI.A.1.b).(1).(a)	Post-doctoral fellows must receive training and
1483		experience in quality improvement processes,
1484		including an understanding of health care
1485		disparities. ^(Core)
1486		
1487	VI.A.1.b).(2)	Quality Metrics
1488		
1489		<i>Access to data is essential to prioritizing activities for</i>
1490		<i>care improvement and evaluating success of</i>
1491		<i>improvement efforts.</i>
1492		
1493	VI.A.1.b).(2).(a)	Post-doctoral fellows and faculty members
1494		must receive data on quality metrics and
1495		benchmarks related to their patient populations.
1496		^(Core)
1497		
1498	VI.A.1.b).(3)	Engagement in Quality Improvement Activities
1499		
1500		<i>Experiential learning is essential to developing the</i>
1501		<i>ability to identify and institute sustainable systems-</i>
1502		<i>based changes to improve patient care.</i>
1503		
1504	VI.A.1.b).(3).(a)	Post-doctoral fellows must have the
1505		opportunity to participate in interprofessional
1506		quality improvement activities. ^(Core)
1507		
1508	VI.A.1.b).(3).(a).(i)	This should include activities aimed at
1509		reducing health care disparities. ^(Detail)
1510		
1511	VI.A.2.	Supervision and Accountability
1512		
1513	VI.A.2.a)	<i>Although the attending specialist is ultimately responsible for</i>
1514		<i>the care of the patient, every specialist shares in the</i>
1515		<i>responsibility and accountability for their efforts in the</i>
1516		<i>provision of care. Effective programs, in partnership with</i>
1517		<i>their Sponsoring Institutions, define, widely communicate,</i>
1518		<i>and monitor a structured chain of responsibility and</i>
1519		<i>accountability as it relates to the supervision of all</i>
1520		<i>contributions to patient care.</i>
1521		

1522 *Supervision in the setting of graduate medical education*
1523 *provides safe and effective contributions to care of patients;*
1524 *ensures each post-doctoral fellow's development of the*
1525 *skills, knowledge, and attitudes required to enter the*
1526 *unsupervised participation in care; and establishes a*
1527 *foundation for continued professional growth.*
1528

1529 **VI.A.2.a).(1)** Each patient must have an identifiable and
1530 appropriately-credentialed and privileged attending
1531 specialist as specified by the applicable Review
1532 Committee who is responsible and accountable for the
1533 patient's care. ^(Core)
1534

1535 **VI.A.2.a).(1).(a)** This information must be available to post-
1536 doctoral fellows, faculty members, other
1537 members of the health care team, and patients.
1538 ^(Core)
1539

1540 **VI.A.2.a).(1).(b)** Post-doctoral fellows and faculty members
1541 must ensure patients are informed of the
1542 specialist involved in their care, and of their
1543 respective roles in contributing to patient care.
1544 ^(Core)
1545

1546 **VI.A.2.b)** *Supervision may be exercised through a variety of methods.*
1547 *For many aspects of patient care, the supervising specialist*
1548 *may be a more advanced post-doctoral fellow or physician*
1549 *fellow. Other portions of care provided by the post-doctoral*
1550 *fellow can be adequately supervised by the appropriate*
1551 *availability of the supervising faculty member, fellow, or*
1552 *senior post-doctoral fellow, either on site or by means of*
1553 *telecommunication technology. Some activities require the*
1554 *physical presence of the supervising faculty member. In*
1555 *some circumstances, supervision may include post-hoc*
1556 *review of post-doctoral fellow-delivered care with feedback.*
1557

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

1558
1559 **VI.A.2.b).(1)** The program must demonstrate that the appropriate
1560 level of supervision in place for all post-doctoral
1561 fellows is based on each post-doctoral fellow's level of
1562 training and ability, as well as patient complexity and

1563 acuity. Supervision may be exercised through a variety
1564 of methods, as appropriate to the situation. ^(Core)
1565

1566 **VI.A.2.b).(2)** The program must define when physical presence of a
1567 supervising specialist is required. ^(Core)
1568

1569 **VI.A.2.c)** Levels of Supervision

1570
1571 **To promote appropriate post-doctoral fellow supervision**
1572 **while providing for graded authority and responsibility, the**
1573 **program must use the following classification of supervision:**
1574 ^(Core)
1575

1576 **VI.A.2.c).(1)** Direct Supervision:

1577
1578 **VI.A.2.c).(1).(a)** the supervising specialist is physically present
1579 with the post-doctoral fellow during the key
1580 portions of the interactions around patient care;
1581 or, ^(Core)
1582

1583 **VI.A.2.c).(1).(a).(i)** Post-doctoral fellows must initially be
1584 supervised directly, only as described in
1585 **VI.A.2.c).(1).(a).** ^(Core)
1586

1587 **VI.A.2.c).(1).(a).(ii)** Hands-on wet lab work performed by post-
1588 doctoral fellows must be done under direct
1589 supervision where the supervising specialist
1590 is physically present. ^(Core)
1591

1592 **VI.A.2.c).(1).(b)** the supervising specialist and/or patient is not
1593 physically present with the post-doctoral fellow
1594 and the supervising specialist is concurrently
1595 monitoring the patient care through appropriate
1596 telecommunication technology. ^(Core)
1597

1598 **VI.A.2.c).(1).(b).(i)** Direct supervision through appropriate
1599 telecommunication technology must be
1600 limited to:

1601
1602 **VI.A.2.c).(1).(b).(i).(a)** discussions with faculty members,
1603 staff members, and other health care
1604 professionals regarding report
1605 interpretations; ^(Core)
1606

1607 **VI.A.2.c).(1).(b).(i).(b)** clinic appointments held via
1608 telehealth methods; and, ^(Core)
1609

1610 **VI.A.2.c).(1).(b).(i).(c)** remotely viewing laboratory data in
1611 the course of interpreting results and
1612 issuing reports. ^(Core)
1613

1614	VI.A.2.c).(2)	Indirect Supervision: the supervising specialist is not providing physical or concurrent visual or audio supervision but is immediately available to the post-doctoral fellow for guidance and is available to provide appropriate direct supervision. (Core)
1615		
1616		
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1618		
1619		
1620	VI.A.2.c).(3)	Oversight – the supervising specialist is available to provide review of post-doctoral fellow involvement in procedures/encounters, with feedback provided after care is delivered. (Core)
1621		
1622		
1623		
1624		
1625	VI.A.2.d)	The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in contributions to patient care delegated to each post-doctoral fellow must be assigned by the program director and faculty members. (Core)
1626		
1627		
1628		
1629		
1630		
1631	VI.A.2.d).(1)	The program director must evaluate each post-doctoral fellow’s abilities based on specific criteria, guided by the Milestones. (Core)
1632		
1633		
1634		
1635	VI.A.2.d).(2)	Faculty members functioning as supervising specialists must delegate portions of care involvement to post-doctoral fellows based on contributions to care needed and the skills of each post-doctoral fellow. (Core)
1636		
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1639		
1640	VI.A.2.d).(3)	Senior post-doctoral fellows should serve in a supervisory role to junior post-doctoral fellows in recognition of their progress toward independence, based on the contributions to care needed for each patient and the skills of the individual post-doctoral fellow or fellow. (Detail)
1641		
1642		
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1646		
1647	VI.A.2.e)	Programs must set guidelines for circumstances and events in which post-doctoral fellows must communicate with the supervising faculty member(s). (Core)
1648		
1649		
1650		
1651	VI.A.2.e).(1)	Each post-doctoral fellow must know the limits of their scope of authority, and the circumstances under which the post-doctoral fellow is permitted to act with conditional independence. (Outcome)
1652		
1653		
1654		
1655		

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

1656		
1657	VI.A.2.f)	Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each post-doctoral fellow and to delegate to the post-doctoral fellow the appropriate level of involvement in patient care authority and responsibility. (Core)
1658		
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- 1662
1663 **VI.B. Professionalism**
1664
1665 **VI.B.1. Programs, in partnership with their Sponsoring Institutions, must**
1666 **educate post-doctoral fellows and faculty members concerning the**
1667 **professional responsibilities of specialists, including their obligation**
1668 **to be appropriately rested and fit to provide the care required by**
1669 **their patients. ^(Core)**
1670
1671 **VI.B.2. The learning objectives of the program must:**
1672
1673 **VI.B.2.a) be accomplished through an appropriate blend of supervised**
1674 **patient care responsibilities, clinical teaching, and didactic**
1675 **educational events; ^(Core)**
1676
1677 **VI.B.2.b) be accomplished without excessive reliance on post-doctoral**
1678 **fellows to fulfill non-specialist obligations; and, ^(Core)**
1679

Background and Intent: Routine reliance on post-doctoral fellows to fulfill non-specialist obligations increases work compression for post-doctoral fellows and does not provide an optimal educational experience. Non-specialist 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 post-doctoral fellows may be expected to do any of these things on occasion when the need arises, these activities should not be performed by post-doctoral fellows routinely and must be kept to a minimum to optimize post-doctoral fellow education.

- 1680
1681 **VI.B.2.c) ensure manageable patient care responsibilities. ^(Core)**
1682

Background and Intent: The Common Program Requirements do not define “manageable patient care responsibilities” as this is variable by specialty. 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 contributions to patient care responsibilities can affect work compression, especially at the entry level.

- 1683
1684 **VI.B.3. The program director, in partnership with the Sponsoring Institution,**
1685 **must provide a culture of professionalism that supports patient**
1686 **safety and personal responsibility. ^(Core)**
1687
1688 **VI.B.4. Post-doctoral fellows and faculty members must demonstrate an**
1689 **understanding of their personal role in the:**
1690
1691 **VI.B.4.a) contributions to of patient- and family-centered care; ^(Outcome)**
1692

1693 VI.B.4.b) safety and welfare of patients entrusted to their care,
1694 including the ability to report unsafe conditions and adverse
1695 events; ^(Outcome)
1696

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 post-doctoral fellow.

1697
1698 VI.B.4.c) assurance of their fitness for work, including: ^(Outcome)
1699

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

1700
1701 VI.B.4.c).(1) management of their time before, during, and after
1702 clinical assignments; and, ^(Outcome)
1703

1704 VI.B.4.c).(2) recognition of impairment, including from illness,
1705 fatigue, and substance use, in themselves, their peers,
1706 and other members of the health care team. ^(Outcome)
1707

1708 VI.B.4.d) commitment to lifelong learning; ^(Outcome)
1709

1710 VI.B.4.e) monitoring of their contributions to patient care performance
1711 improvement indicators; and, ^(Outcome)
1712

1713 VI.B.4.f) accurate reporting of clinical and educational work hours,
1714 patient outcomes, and clinical experience data. ^(Outcome)
1715

1716 VI.B.5. All post-doctoral fellows and faculty members must demonstrate
1717 responsiveness to patient needs that supersedes self-interest. This
1718 includes the recognition that under certain circumstances, the best
1719 interests of the patient may be served by transitioning their role in
1720 that patient's care to another qualified and rested provider. ^(Outcome)
1721

1722 VI.B.6. Programs, in partnership with their Sponsoring Institutions, must
1723 provide a professional, equitable, respectful, and civil environment
1724 that is free from discrimination, sexual and other forms of
1725 harassment, mistreatment, abuse, or coercion of students, post-
1726 doctoral fellows, faculty, and staff. ^(Core)
1727

1728 VI.B.7. Programs, in partnership with their Sponsoring Institutions, should
1729 have a process for education of post-doctoral fellows and faculty
1730 regarding unprofessional behavior and a confidential process for
1731 reporting, investigating, and addressing such concerns. ^(Core)
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1733 VI.C. Well-Being

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

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

Background and Intent: The ACGME is committed to addressing 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 specialist well-being is crucial to specialists’ ability to deliver the safest, best possible care to patients. The ACGME is leveraging its resources in four key areas to support the ongoing focus on physician well-being: education, influence, research, and collaboration. Information regarding the ACGME’s ongoing efforts in this area is available on the ACGME website.

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

1755 VI.C.1.

The responsibility of the program, in partnership with the Sponsoring Institution, to address well-being must include:

1757 VI.C.1.a)

efforts to enhance the meaning that each post-doctoral fellow finds in the experience of being a specialist, including protecting time with patients, minimizing non-specialist obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; ^(Core)

1766 VI.C.1.b)

attention to scheduling, work intensity, and work compression that impacts post-doctoral fellow well-being; ^(Core)

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1769

1770 VI.C.1.c) evaluating workplace safety data and addressing the safety of
1771 post-doctoral fellows and faculty members; ^(Core)
1772

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 post-doctoral fellow 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.

1773
1774 VI.C.1.d) policies and programs that encourage optimal post-doctoral
1775 fellow and faculty member well-being; and, ^(Core)
1776

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.

1777
1778 VI.C.1.d).(1) Post-doctoral fellows must be given the opportunity to
1779 attend medical, mental health, and dental care
1780 appointments, including those scheduled during their
1781 working hours. ^(Core)
1782

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

1783
1784 VI.C.1.e) attention to post-doctoral fellow and faculty member burnout,
1785 depression, and substance use disorder. The program, in
1786 partnership with its Sponsoring Institution, must educate
1787 faculty members and post-doctoral fellows in identification of
1788 the symptoms of burnout, depression, and substance use
1789 disorder, including means to assist those who experience
1790 these conditions. Post-doctoral fellows and faculty members
1791 must also be educated to recognize those symptoms in
1792 themselves and how to seek appropriate care. The program,
1793 in partnership with its Sponsoring Institution, must: ^(Core)
1794

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

1795
1796 VI.C.1.e).(1) encourage post-doctoral fellows and faculty members
1797 to alert the program director or other designated
1798 personnel or programs when they are concerned that
1799 another post-doctoral fellow, resident, fellow, or
1800 faculty member may be displaying signs of burnout,

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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 specialists are at increased risk in these areas, it is essential that post-doctoral fellows and faculty members are able to report their concerns when another post-doctoral fellow 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. Post-doctoral fellows 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 specialist policy and any employee health, employee assistance, and/or wellness programs within the institution. In cases of specialist impairment, the program director or designated personnel should follow the policies of their institution for reporting.

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VI.C.1.e).(2) provide access to appropriate tools for self-screening; and, ^(Core)

VI.C.1.e).(3) provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. ^(Core)

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

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

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VI.C.2. There are circumstances in which post-doctoral fellows may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and parental leave. Each program must allow an appropriate length of absence for post-doctoral fellows unable to perform their patient care responsibilities. ^(Core)

VI.C.2.a) The program must have policies and procedures in place to ensure coverage of their contributions to patient care. ^(Core)

VI.C.2.b) These policies must be implemented without fear of negative consequences for the post-doctoral fellow who is or was unable to provide the clinical work. ^(Core)

1826

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

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VI.D. Fatigue Mitigation

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VI.D.1. Programs must:

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

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

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

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1841

1842

Background and Intent: Contributing to medical care 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 post-doctoral fellows 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.

1843

1844

VI.D.2. Each program must ensure continuity of involvement with patient care, consistent with the program’s policies and procedures referenced in VI.C.2–VI.C.2.b), in the event that a post-doctoral fellow may be unable to perform their role in patient care 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 post-doctoral fellows who may be too fatigued to safely return home. ^(Core)

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

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1857 **VI.E.1. Clinical Responsibilities**
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1859 **The clinical care contributions for each post-doctoral fellow must be**
1860 **based on PGY level, patient safety, post-doctoral fellow ability,**
1861 **severity and complexity of patient illness/condition, and available**
1862 **support services.** ^(Core)
1863

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

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1865 **VI.E.2. Teamwork**
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1867 **Post-doctoral fellows must contribute to care for patients in an**
1868 **environment that maximizes communication. This must include the**
1869 **opportunity to work as a member of effective interprofessional**
1870 **teams that are appropriate to the delivery of care in the specialty**
1871 **and larger health system.** ^(Core)
1872

1873 **VI.E.3. Transitions of Care**

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1875 **VI.E.3.a) Programs must design clinical assignments to optimize**
1876 **transitions in patient care involvement, including their safety,**
1877 **frequency, and structure.** ^(Core)
1878

1879 **VI.E.3.b) Programs, in partnership with their Sponsoring Institutions,**
1880 **must ensure and monitor effective, structured hand-over**
1881 **processes to facilitate both continuity of care and patient**
1882 **safety.** ^(Core)
1883

1884 **VI.E.3.c) Programs must ensure that post-doctoral fellows are**
1885 **competent in communicating with team members in the hand-**
1886 **over process.** ^(Outcome)
1887

1888 **VI.E.3.d) Programs and clinical sites must maintain and communicate**
1889 **schedules of attending physicians and post-doctoral fellows**
1890 **currently responsible for care.** ^(Core)
1891

1892 **VI.E.3.e) Each program must ensure continuity of patient care**
1893 **contributions, consistent with the program's policies and**
1894 **procedures referenced in VI.C.2–VI.C.2.b), in the event that a**
1895 **post-doctoral fellow may be unable to perform their patient**
1896 **care responsibilities due to excessive fatigue or illness, or**
1897 **family emergency.** ^(Core)
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1899 VI.F. Clinical Experience and Education

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

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

1906 VI.F.1. Maximum Hours of Clinical and Educational Work per Week

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

Background and Intent: Programs and post-doctoral fellows 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 post-doctoral fellows to remain beyond their scheduled work periods to contribute to patient care 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 post-doctoral fellow may work in excess of 80 hours in a given week, all programs and post-doctoral fellows 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 post-doctoral fellows to work 80 hours per week and still permit post-doctoral fellows 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 post-doctoral fellows are scheduled to work fewer than 80 hours per week, which would allow post-doctoral fellows 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 post-doctoral fellows 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 post-doctoral fellows 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 post-doctoral fellows choose to do from home. The requirement provides flexibility for post-doctoral fellows to do this while ensuring that the time spent by post-doctoral fellows 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. Post-doctoral fellow 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 post-doctoral fellow's supervisor. In such circumstances, post-doctoral fellows 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 post-doctoral fellow spends three minutes on a phone call and then a few hours later spends two minutes on another call, will the post-doctoral fellow 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 post-doctoral fellows. The new requirements are not an attempt to micromanage this process. Post-doctoral fellows are to track the time they spend on clinical contributions 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 post-doctoral fellow. Programs will need to factor in time post-doctoral fellows are spending on clinical work at home when schedules are developed to ensure that post-doctoral fellows 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 post-doctoral fellows report their time from home and that schedules are structured to ensure that post-doctoral fellows are not working in excess of 80 hours per week, averaged over four weeks.

PGY-1 and PGY-2 Post-Doctoral Fellows

Post-doctoral fellows 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 post-doctoral fellows are provided with manageable workloads that can be accomplished during scheduled work hours. This includes ensuring that a post-doctoral fellow's assignments are manageable, that post-doctoral fellows have appropriate support from their clinical collaborators, and that these post-doctoral fellows are not overburdened with clerical work and/or other non-specialist duties.

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

- 1917 VI.F.2.a) The program must design an effective program structure that
1918 is configured to provide post-doctoral fellows with
1919 educational opportunities, as well as reasonable
1920 opportunities for rest and personal well-being. ^(Core)
1921
- 1922 VI.F.2.b) Post-doctoral fellows should have eight hours off between
1923 scheduled clinical work and education periods. ^(Detail)
1924
- 1925 VI.F.2.b).(1) There may be circumstances when post-doctoral
1926 fellows choose to stay to contribute to the care of
1927 patients or return to the hospital with fewer than eight
1928 hours free of clinical experience and education. This
1929 must occur within the context of the 80-hour and the
1930 one-day-off-in-seven requirements. ^(Detail)
1931

Background and Intent: While it is expected that post-doctoral fellow schedules will be structured to ensure that post-doctoral fellows are provided with a minimum of eight hours off between scheduled work periods, it is recognized that post-doctoral fellows 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 post-doctoral fellows 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.

- 1932
- 1933 VI.F.2.c) Post-doctoral fellows must have at least 14 hours free of
1934 clinical work and education after 24 hours of in-house call.
1935 ^(Core)
1936

Background and Intent: Post-doctoral fellows 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, post-doctoral fellows are encouraged to prioritize sleep over other discretionary activities.

- 1937
- 1938 VI.F.2.d) Post-doctoral fellows must be scheduled for a minimum of
1939 one day in seven free of clinical work and required education
1940 (when averaged over four weeks). At-home call cannot be
1941 assigned on these free days. ^(Core)
1942

Background and Intent: The requirement provides flexibility for programs to distribute days off in a manner that meets program and post-doctoral fellow needs. It is strongly recommended that post-doctoral fellows' 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 post-doctoral fellows 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 post-doctoral fellows 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 post-doctoral fellow 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 post-doctoral fellows must not exceed 24 hours of continuous scheduled clinical assignments. ^(Core)**
- 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 post-doctoral fellow education. ^(Core)**
- VI.F.3.a).(1).(a) Additional patient care responsibilities must not be assigned to a post-doctoral fellow during this time. ^(Core)**

Background and Intent: The additional time referenced in VI.F.3.a).(1) should not be used for contributions to the care of new patients. It is essential that the post-doctoral fellow continue to function as a member of the team in an environment where other members of the team can assess post-doctoral fellow fatigue, and that supervision for post-call post-doctoral fellows 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 post-doctoral fellow, 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 help 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 post-doctoral fellows 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 post-doctoral fellow may remain to attend a conference, or

return for a conference later in the day, only if the decision is made voluntarily. Post-doctoral fellows must not be required to stay. Programs allowing post-doctoral fellows to remain or return beyond the scheduled work and clinical education period must ensure that the decision to remain is initiated by the post-doctoral fellow and that post-doctoral fellows are not coerced. This additional time must be counted toward the 80-hour maximum weekly limit.

1978
1979 **VI.F.4.c)** **A Review Committee may grant rotation-specific exceptions**
1980 **for up to 10 percent or a maximum of 88 clinical and**
1981 **educational work hours to individual programs based on a**
1982 **sound educational rationale.**
1983
1984 The Review Committee for Medical Genetics and Genomics will
1985 not consider requests for exceptions to the 80-hour limit to a post-
1986 doctoral fellow's work week.

1988 **VI.F.5. Moonlighting**

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1990 **VI.F.5.a)** **Moonlighting must not interfere with the ability of the post-**
1991 **doctoral fellow to achieve the goals and objectives of the**
1992 **educational program, and must not interfere with the post-**
1993 **doctoral fellow's fitness for work nor compromise patient**
1994 **safety.** (Core)

1995
1996 **VI.F.5.b)** **Time spent by post-doctoral fellows in internal and external**
1997 **moonlighting (as defined in the ACGME Glossary of Terms)**
1998 **must be counted toward the 80-hour maximum weekly limit.**
1999 (Core)

2000
2001 **VI.F.5.c)** **PGY-1 post-doctoral fellows are not permitted to moonlight.**
2002 (Core)
2003

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>).

2004
2005 **VI.F.6. In-House Night Float**
2006
2007 **Night float must occur within the context of the 80-hour and one-**
2008 **day-off-in-seven requirements.** (Core)
2009

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.

2010
2011 **VI.F.7. Maximum In-House On-Call Frequency**
2012
2013 **Post-doctoral fellows must be scheduled for in-house call no more**
2014 **frequently than every third night (when averaged over a four-week**
2015 **period).** (Core)
2016

2017	VI.F.8.	At-Home Call
2018		
2019	VI.F.8.a)	Time spent on patient care activities by post-doctoral fellows on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. ^(Core)
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2026	VI.F.8.a).(1)	At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each post-doctoral fellow. ^(Core)
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2030	VI.F.8.b)	Post-doctoral fellows are permitted to return to the hospital while on at-home call to provide contributions to care directly for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit. ^(Detail)
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Background and Intent: This requirement has been modified to specify that clinical work done from home when a post-doctoral fellow is taking at-home call must count toward the 80-hour maximum weekly limit. This change acknowledges the often significant amount of time post-doctoral fellows devote to clinical activities when taking at-home call, and ensures that taking at-home call does not result in post-doctoral fellows 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 post-doctoral education programs, Review Committees will look at the overall impact of at-home call on post-doctoral fellow rest and personal time.

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2038	*Core Requirements:	Statements that define structure, resource, or process elements essential to every graduate medical educational program.
2039		
2040		
2041	†Detail Requirements:	Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.
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2046	*Outcome Requirements:	Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.
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2050	Osteopathic Recognition	
2051		For programs with or applying for Osteopathic Recognition, the Osteopathic Recognition Requirements also apply (www.acgme.org/OsteopathicRecognition).
2052		