ACGME Program Requirements for Graduate Medical Education in Otolaryngology – Head and Neck Surgery

ACGME-approved focused revision: June 13, 2020; effective July 1, 2020

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ACGME Program Requirements for Graduate Medical Education in Otolaryngology – Head and Neck Surgery

Common Program Requirements (Residency) are in BOLD

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

Introduction

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

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

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

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

Int.B. **Definition of Specialty**

Otolaryngologists provide comprehensive medical and surgical care to patients with diseases and disorders that affect the ears, the respiratory and upper alimentary systems, and related structures of the head and neck.

52 **Int.C. Length of Educational Program**
53
54 The educational program in otolaryngology – head and neck surgery must be 60
55 months in length. (Core)*
56
57 **I. Oversight**
58
59 **I.A. Sponsoring Institution**
60
61 ***The Sponsoring Institution is the organization or entity that assumes the***
62 ***ultimate financial and academic responsibility for a program of graduate***
63 ***medical education, consistent with the ACGME Institutional Requirements.***
64
65 ***When the Sponsoring Institution is not a rotation site for the program, the***
66 ***most commonly utilized site of clinical activity for the program is the***
67 ***primary clinical site.***
68

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

69
70 **I.A.1. The program must be sponsored by one ACGME-accredited**
71 **Sponsoring Institution. (Core)***
72
73 **I.B. Participating Sites**
74
75 ***A participating site is an organization providing educational experiences or***
76 ***educational assignments/rotations for residents.***
77
78 **I.B.1. The program, with approval of its Sponsoring Institution, must**
79 **designate a primary clinical site. (Core)**
80
81 **I.B.2. There must be a program letter of agreement (PLA) between the**
82 **program and each participating site that governs the relationship**
83 **between the program and the participating site providing a required**
84 **assignment. (Core)**
85
86 **I.B.2.a) The PLA must:**
87
88 **I.B.2.a).(1) be renewed at least every 10 years; and, (Core)**
89
90 **I.B.2.a).(2) be approved by the designated institutional official**
91 **(DIO). (Core)**
92

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93 **I.B.3.** **The program must monitor the clinical learning and working**
94 **environment at all participating sites.** **(Core)**
95
96 **I.B.3.a)** **At each participating site there must be one faculty member,**
97 **designated by the program director as the site director, who**
98 **is accountable for resident education at that site, in**
99 **collaboration with the program director.** **(Core)**
100

> **Background and Intent: While all residency programs must be sponsored by a single ACGME-accredited Sponsoring Institution, many programs will utilize other clinical settings to provide required or elective training experiences. At times it is appropriate to utilize community sites that are not owned by or affiliated with the Sponsoring Institution. Some of these sites may be remote for geographic, transportation, or communication issues. When utilizing such sites the program must ensure the quality of the educational experience. The requirements under I.B.3. are intended to ensure that this will be the case.**
>
> **Suggested elements to be considered in PLAs will be found in the ACGME Program Director's Guide to the Common Program Requirements. These include:**
> - **Identifying the faculty members who will assume educational and supervisory responsibility for residents**
> - **Specifying the responsibilities for teaching, supervision, and formal evaluation of residents**
> - **Specifying the duration and content of the educational experience**
> - **Stating the policies and procedures that will govern resident education during the assignment**

101
102 **I.B.4.** **The program director must submit any additions or deletions of**
103 **participating sites routinely providing an educational experience,**
104 **required for all residents, of one month full time equivalent (FTE) or**
105 **more through the ACGME's Accreditation Data System (ADS).** **(Core)**
106
107 I.B.5. The addition of any participating site must be approved by the Review
108 Committee prior to assigning any residents to that site. (Core)
109

> Specialty-Specific Background and Intent: Guidelines for site change requests are available on the Documents and Resources page of the Otolaryngology – Head and Neck Surgery section of the ACGME website, in the document "Participating Site Change Guidelines."

110
111 **I.C.** **The program, in partnership with its Sponsoring Institution, must engage in**
112 **practices that focus on mission-driven, ongoing, systematic recruitment**
113 **and retention of a diverse and inclusive workforce of residents, fellows (if**
114 **present), faculty members, senior administrative staff members, and other**
115 **relevant members of its academic community.** **(Core)**
116

> **Background and Intent: It is expected that the Sponsoring Institution has, and programs implement, policies and procedures related to recruitment and retention of minorities underrepresented in medicine and medical leadership in accordance with the Sponsoring Institution's mission and aims. The program's annual evaluation must**

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include an assessment of the program's efforts to recruit and retain a diverse workforce, as noted in V.C.1.c).(5).(c).

117
118 **I.D. Resources**
119
120 **I.D.1. The program, in partnership with its Sponsoring Institution, must**
121 **ensure the availability of adequate resources for resident education.**
122 **(Core)**
123
124 I.D.1.a) There must be space and equipment for the educational program,
125 including 24-hour computer access with Internet, classrooms with
126 audiovisual and other educational aids, meeting rooms, and office
127 space for residents. ~~(Detail)~~ (Core)
128
129 I.D.1.b) There must be current information technology readily available for
130 clinical care. ~~(Detail)~~ (Core)
131
132 I.D.1.c) Each participating site must provide beds and operating time
133 sufficient for the needs of the service and for resident education.
134 (Core)
135
136 I.D.1.d) Residents must have access to outpatient facilities that provide
137 clinics and office space for education in the regular pre-operative
138 evaluation and postoperative follow-up of cases for which each
139 resident has responsibility. (Core)
140
141 I.D.1.e) Technologically-current equipment considered necessary for
142 diagnosis and treatment must be available. (Core)
143
144 I.D.1.f) There should be clinical services in the related fields of
145 anesthesiology, emergency medicine, internal medicine,
146 neurological surgery, neurology, ophthalmology, pathology,
147 pediatrics, and radiology. ~~(Detail)~~ (Core)
148
149 **I.D.2. The program, in partnership with its Sponsoring Institution, must**
150 **ensure healthy and safe learning and working environments that**
151 **promote resident well-being and provide for: (Core)**
152
153 **I.D.2.a) access to food while on duty; (Core)**
154
155 **I.D.2.b) safe, quiet, clean, and private sleep/rest facilities available**
156 **and accessible for residents with proximity appropriate for**
157 **safe patient care; (Core)**
158

Background and Intent: Care of patients within a hospital or health system occurs continually through the day and night. Such care requires that residents function at their peak abilities, which requires the work environment to provide them with the ability to meet their basic needs within proximity of their clinical responsibilities. Access to food and rest are examples of these basic needs, which must be met while residents are working. Residents should have access to refrigeration where food may be stored. Food should be available when residents are required to be in the hospital

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159
160 **I.D.2.c)** **clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care;** **(Core)**
161
162
163

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

164
165 **I.D.2.d)** **security and safety measures appropriate to the participating site; and,** **(Core)**
166
167
168 **I.D.2.e)** **accommodations for residents with disabilities consistent with the Sponsoring Institution's policy.** **(Core)**
169
170
171 **I.D.3.** **Residents 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)**
172
173
174
175
176 **I.D.4.** **The program's educational and clinical resources must be adequate to support the number of residents appointed to the program.** **(Core)**
177
178
179 I.D.4.a) There must be a variety of adult and pediatric medical and surgical patients available to allow development of resident competency in patient care. (Core)
180
181
182
183 **I.E.** **The presence of other learners and other care providers, including, but not limited to, residents from other programs, subspecialty fellows, and advanced practice providers, must enrich the appointed residents' education.** **(Core)**
184
185
186
187
188 **I.E.1.** **The program must report circumstances when the presence of other learners has interfered with the residents' education to the DIO and Graduate Medical Education Committee (GMEC).** **(Core)**
189
190
191

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

192
193 **II. Personnel**

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194
195 **II.A. Program Director**
196
197 **II.A.1. There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core)**
198
199
200
201 **II.A.1.a) The Sponsoring Institution's GMEC must approve a change in program director. (Core)**
202
203
204 **II.A.1.b) Final approval of the program director resides with the Review Committee. (Core)**
205
206

Background and Intent: While the ACGME recognizes the value of input from numerous individuals in the management of a residency, a single individual must be designated as program director and made responsible for the program. This individual will have dedicated time for the leadership of the residency, and it is this individual's responsibility to communicate with the residents, faculty members, DIO, GMEC, and the ACGME. The program director's nomination is reviewed and approved by the GMEC. Final approval of program directors resides with the Review Committee.

207
208 **II.A.1.c) The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability. (Core)**
209
210
211

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

212
213 **II.A.2. At a minimum, the program director must be provided with the salary support required to devote 20 percent FTE of non-clinical time to the administration of the program. (Core)**
214
215
216

Background and Intent: Twenty percent FTE is defined as one day per week.

"Administrative time" is defined as non-clinical time spent meeting the responsibilities of the program director as detailed in requirements II.A.4.-II.A.4.a).(16).

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

217
218 **II.A.3. Qualifications of the program director:**
219
220 **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)**
221
222
223

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

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

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

II.A.3.b) **must include current certification in the specialty for which they are the program director by the American Board of** Otolaryngology-Head and Neck Surgery (ABOHNS) **or by the American Osteopathic Boards of** Ophthalmology and Otorhinolaryngology Head and Neck Surgery (AOBOOHNS)**, or specialty qualifications that are acceptable to the Review Committee;** **(Core)**

II.A.3.b).(1) The Review Committee accepts only ABOHNS or AOBOOHNS certification. (Core)

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

II.A.3.d) **must include ongoing clinical activity; and,** **(Core)**

II.A.3.e) must include evidence of periodic updates of knowledge and skills to discharge the roles and responsibilities for teaching, supervision, and formal evaluation of residents. ~~(Detail)~~ (Core)

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

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

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

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

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

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Background and Intent: The program director, as the leader of the program, must serve as a role model to residents in addition to fulfilling the technical aspects of the role. As residents are expected to demonstrate compassion, integrity, and respect for others, they must be able to look to the program director as an exemplar. It is of utmost importance, therefore, that the program director model outstanding professionalism, high quality patient care, educational excellence, and a scholarly approach to work. The program director creates an environment where respectful discussion is welcome, with the goal of continued improvement of the educational experience.

258
259 **II.A.4.a).(2)** **design and conduct the program in a fashion**
260 **consistent with the needs of the community, the**
261 **mission(s) of the Sponsoring Institution, and the**
262 **mission(s) of the program;** (Core)
263

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.

264
265 **II.A.4.a).(3)** **administer and maintain a learning environment**
266 **conducive to educating the residents in each of the**
267 **ACGME Competency domains;** (Core)
268

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

269
270 **II.A.4.a).(4)** **develop and oversee a process to evaluate candidates**
271 **prior to approval as program faculty members for**
272 **participation in the residency program education and**
273 **at least annually thereafter, as outlined in V.B.;** (Core)
274
275 **II.A.4.a).(5)** **have the authority to approve program faculty**
276 **members for participation in the residency program**
277 **education at all sites;** (Core)
278
279 **II.A.4.a).(6)** **have the authority to remove program faculty**
280 **members from participation in the residency program**
281 **education at all sites;** (Core)
282
283 **II.A.4.a).(7)** **have the authority to remove residents from**
284 **supervising interactions and/or learning environments**
285 **that do not meet the standards of the program;** (Core)

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286

Background and Intent: The program director has the responsibility to ensure that all who educate residents effectively role model the Core Competencies. Working with a resident is a privilege that is earned through effective teaching and professional role modeling. This privilege may be removed by the program director when the standards of the clinical learning environment are not met.

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

287
288 **II.A.4.a).(8)** **submit accurate and complete information required**
289 **and requested by the DIO, GMEC, and ACGME;** (Core)
290
291 **II.A.4.a).(9)** **provide applicants who are offered an interview with**
292 **information related to the applicant's eligibility for the**
293 **relevant specialty board examination(s);** (Core)
294
295 **II.A.4.a).(10)** **provide a learning and working environment in which**
296 **residents have the opportunity to raise concerns and**
297 **provide feedback in a confidential manner as**
298 **appropriate, without fear of intimidation or retaliation;**
299 (Core)
300
301 **II.A.4.a).(11)** **ensure the program's compliance with the Sponsoring**
302 **Institution's policies and procedures related to**
303 **grievances and due process;** (Core)
304
305 **II.A.4.a).(12)** **ensure the program's compliance with the Sponsoring**
306 **Institution's policies and procedures for due process**
307 **when action is taken to suspend or dismiss, not to**
308 **promote, or not to renew the appointment of a**
309 **resident;** (Core)
310

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

311
312 **II.A.4.a).(13)** **ensure the program's compliance with the Sponsoring**
313 **Institution's policies and procedures on employment**
314 **and non-discrimination;** (Core)
315
316 **II.A.4.a).(13).(a)** **Residents must not be required to sign a non-**
317 **competition guarantee or restrictive covenant.**
318 (Core)
319
320 **II.A.4.a).(14)** **document verification of program completion for all**
321 **graduating residents within 30 days;** (Core)
322

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II.A.4.a).(15) **provide verification of an individual resident's completion upon the resident's request, within 30 days; and,** (Core)

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

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

II.B. Faculty

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

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

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

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

II.B.1.a) In addition to the program director, there should be at least two other FTE faculty members with qualifications to include: ~~(Detail)~~(Core)

II.B.1.a).(1) specialty expertise and documented educational and administrative experience acceptable to the Review Committee; and, ~~(Detail)~~(Core)

II.B.1.a).(2) appropriate medical staff appointment. ~~(Detail)~~(Core)

II.B.2. Faculty members must:

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

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

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

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

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

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

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

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

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

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

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

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

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403 **II.B.2.g).(4)** **in patient care based on their practice-based learning**
404 **and improvement efforts.** (Core)
405

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

406
407 II.B.2.g).(5) A faculty member serving as a local site director must have
408 major clinical responsibilities at that site. (Core)
409
410 **II.B.3.** **Faculty Qualifications**
411
412 **II.B.3.a)** **Faculty members must have appropriate qualifications in**
413 **their field and hold appropriate institutional appointments.**
414 **(Core)**
415
416 **II.B.3.b)** **Physician faculty members must:**
417
418 **II.B.3.b).(1)** **have current certification in the specialty by the**
419 **American Board of** Otolaryngology-Head and Neck
420 Surgery **or the American Osteopathic Boards of**
421 Ophthalmology and Otorhinolaryngology Head and Neck
422 Surgery**, or possess qualifications judged acceptable**
423 **to the Review Committee.** (Core)
424
425 **II.B.3.c)** **Any non-physician faculty members who participate in**
426 **residency program education must be approved by the**
427 **program director.** (Core)
428

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

429
430 **II.B.4.** **Core Faculty**
431
432 **Core faculty members must have a significant role in the education**
433 **and supervision of residents and must devote a significant portion**
434 **of their entire effort to resident education and/or administration, and**
435 **must, as a component of their activities, teach, evaluate, and**
436 **provide formative feedback to residents.** (Core)
437

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Background and Intent: Core faculty members are critical to the success of resident education. They support the program leadership in developing, implementing, and assessing curriculum and in assessing residents' progress toward achievement of competence in 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, including completion of the annual ACGME Faculty Survey.

438
439 **II.B.4.a)** **Core faculty members must be designated by the program**
440 **director.** (Core)
441
442 **II.B.4.b)** **Core faculty members must complete the annual ACGME**
443 **Faculty Survey.** (Core)
444
445 II.B.4.c) There must be at least five core faculty members who are
446 ABOHNS or AOBOOHNS certified in otolaryngology – head and
447 neck surgery. (Core)
448
449 **II.C. Program Coordinator**
450
451 **II.C.1. There must be a program coordinator.** (Core)
452
453 **II.C.2. At a minimum, the program coordinator must be supported at 50**
454 **percent FTE for administrative time.** (Core)
455

Background and Intent: Fifty percent FTE is defined as two-and-a-half days per week.

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 titled by the institution. This person will frequently manage the day-to-day operations of the program and serve as an important liaison with 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 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. Program coordinators are expected to develop unique knowledge of the ACGME and Program Requirements, policies, and procedures. Program coordinators assist the program director in accreditation efforts, educational programming, and support of residents.

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

456
457 **II.D. Other Program Personnel**
458

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459 **The program, in partnership with its Sponsoring Institution, must jointly**
460 **ensure the availability of necessary personnel for the effective**
461 **administration of the program.** (Core)
462
463 II.D.1. This ~~should~~ must include speech pathologists, audiologists, and/or
464 balance therapists necessary for carrying out audiologic and vestibular
465 testing and rehabilitation. ~~(Detail)~~(Core)
466

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.

467
468 **III. Resident Appointments**
469
470 **III.A. Eligibility Requirements**
471
472 **III.A.1. An applicant must meet one of the following qualifications to be**
473 **eligible for appointment to an ACGME-accredited program:** (Core)
474
475 **III.A.1.a) graduation from a medical school in the United States or**
476 **Canada, accredited by the Liaison Committee on Medical**
477 **Education (LCME) or graduation from a college of**
478 **osteopathic medicine in the United States, accredited by the**
479 **American Osteopathic Association Commission on**
480 **Osteopathic College Accreditation (AOACOCA); or,** (Core)
481
482 **III.A.1.b) graduation from a medical school outside of the United**
483 **States or Canada, and meeting one of the following additional**
484 **qualifications:** (Core)
485
486 **III.A.1.b).(1) holding a currently valid certificate from the**
487 **Educational Commission for Foreign Medical**
488 **Graduates (ECFMG) prior to appointment; or,** (Core)
489
490 **III.A.1.b).(2) holding a full and unrestricted license to practice**
491 **medicine in the United States licensing jurisdiction in**
492 **which the ACGME-accredited program is located.** (Core)
493
494 **III.A.2. All prerequisite post-graduate clinical education required for initial**
495 **entry or transfer into ACGME-accredited residency programs must**
496 **be completed in ACGME-accredited residency programs, AOA-**
497 **approved residency programs, Royal College of Physicians and**
498 **Surgeons of Canada (RCPSC)-accredited or College of Family**
499 **Physicians of Canada (CFPC)-accredited residency programs**
500 **located in Canada, or in residency programs with ACGME**
501 **International (ACGME-I) Advanced Specialty Accreditation.** (Core)
502
503 **III.A.2.a) Residency programs must receive verification of each**
504 **resident's level of competency in the required clinical field**

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505 **using ACGME, CanMEDS, or ACGME-I Milestones evaluations**
506 **from the prior training program upon matriculation.** (Core)
507

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

508
509 **III.A.3.** **A physician who has completed a residency program that was not**
510 **accredited by ACGME, AOA, RCPSC, CFPC, or ACGME-I (with**
511 **Advanced Specialty Accreditation) may enter an ACGME-accredited**
512 **residency program in the same specialty at the PGY-1 level and, at**
513 **the discretion of the program director of the ACGME-accredited**
514 **program and with approval by the GMEC, may be advanced to the**
515 **PGY-2 level based on ACGME Milestones evaluations at the ACGME-**
516 **accredited program. This provision applies only to entry into**
517 **residency in those specialties for which an initial clinical year is not**
518 **required for entry.** (Core)
519
520 **III.B.** **The program director must not appoint more residents than approved by**
521 **the Review Committee.** (Core)
522
523 **III.B.1.** **All complement increases must be approved by the Review**
524 **Committee.** (Core)
525
526 III.B.2. If a vacancy in a program's resident complement is filled, it should be
527 filled at the same level in which it occurs. Exceptions must be approved
528 by the Review Committee. ~~(Detail)~~(Core)
529
530 **III.C.** **Resident Transfers**
531
532 **The program must obtain verification of previous educational experiences**
533 **and a summative competency-based performance evaluation prior to**
534 **acceptance of a transferring resident, and Milestones evaluations upon**
535 **matriculation.** (Core)
536
537 III.C.1. The Review Committee for Otolaryngology – Head and Neck Surgery
538 does not allow transfer into an ACGME-accredited otolaryngology – head
539 and neck surgery program at the PGY-2 level or above from a RCPSC-
540 accredited program. (Core)
541
542 **IV.** **Educational Program**
543
544 ***The ACGME accreditation system is designed to encourage excellence and***
545 ***innovation in graduate medical education regardless of the organizational***
546 ***affiliation, size, or location of the program.***
547
548 ***The educational program must support the development of knowledgeable, skillful***
549 ***physicians who provide compassionate care.***

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550
551 ***In addition, the program is expected to define its specific program aims consistent***
552 ***with the overall mission of its Sponsoring Institution, the needs of the community***
553 ***it serves and that its graduates will serve, and the distinctive capabilities of***
554 ***physicians it intends to graduate. While programs must demonstrate substantial***
555 ***compliance with the Common and specialty-specific Program Requirements, it is***
556 ***recognized that within this framework, programs may place different emphasis on***
557 ***research, leadership, public health, etc. It is expected that the program aims will***
558 ***reflect the nuanced program-specific goals for it and its graduates; for example, it***
559 ***is expected that a program aiming to prepare physician-scientists will have a***
560 ***different curriculum from one focusing on community health.***
561
562 **IV.A. The curriculum must contain the following educational components: (Core)**
563
564 **IV.A.1. a set of program aims consistent with the Sponsoring Institution's**
565 **mission, the needs of the community it serves, and the desired**
566 **distinctive capabilities of its graduates; (Core)**
567
568 **IV.A.1.a) The program's aims must be made available to program**
569 **applicants, residents, and faculty members. (Core)**
570
571 **IV.A.2. competency-based goals and objectives for each educational**
572 **experience designed to promote progress on a trajectory to**
573 **autonomous practice. These must be distributed, reviewed, and**
574 **available to residents and faculty members; (Core)**
575

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

576
577 **IV.A.3. delineation of resident responsibilities for patient care, progressive**
578 **responsibility for patient management, and graded supervision; (Core)**
579

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

580
581 **IV.A.4. a broad range of structured didactic activities; (Core)**
582
583 **IV.A.4.a) Residents must be provided with protected time to participate**
584 **in core didactic activities. (Core)**
585

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

586
587 **IV.A.5.** **advancement of residents' knowledge of ethical principles**
588 **foundational to medical professionalism; and, (Core)**
589
590 **IV.A.6.** **advancement in the residents' knowledge of the basic principles of**
591 **scientific inquiry, including how research is designed, conducted,**
592 **evaluated, explained to patients, and applied to patient care. (Core)**
593
594 **IV.B. ACGME Competencies**
595

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

596
597 **IV.B.1.** **The program must integrate the following ACGME Competencies**
598 **into the curriculum: (Core)**
599
600 **IV.B.1.a)** **Professionalism**
601
602 **Residents must demonstrate a commitment to**
603 **professionalism and an adherence to ethical principles. (Core)**
604
605 **IV.B.1.a).(1)** **Residents must demonstrate competence in:**
606
607 **IV.B.1.a).(1).(a)** **compassion, integrity, and respect for others;**
608 **(Core)**
609
610 **IV.B.1.a).(1).(b)** **responsiveness to patient needs that**
611 **supersedes self-interest; (Core)**
612

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

613
614 **IV.B.1.a).(1).(c)** **respect for patient privacy and autonomy; (Core)**
615
616 **IV.B.1.a).(1).(d)** **accountability to patients, society, and the**
617 **profession; (Core)**

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

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

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

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

> **Background and Intent: Quality patient care is safe, effective, timely, efficient, patient-centered, equitable, and designed to improve population health, while reducing per capita costs. (See the Institute of Medicine [IOM]'s *Crossing the Quality Chasm: A New Health System for the 21st Century*, 2001 and Berwick D, Nolan T, Whittington J. *The Triple Aim: care, cost, and quality. Health Affairs.* 2008; 27(3):759-769.). In addition, there should be a focus on improving the clinician's well-being as a means to improve patient care and reduce burnout among residents, fellows, and practicing physicians.**
>
> **These organizing principles inform the Common Program Requirements across all Competency domains. Specific content is determined by the Review Committees with input from the appropriate professional societies, certifying boards, and the community.**

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

IV.B.1.b).(1).(a) Residents must demonstrate competence in care that is: (Core)

IV.B.1.b).(1).(a).(i) culturally sensitive; (Core)

IV.B.1.b).(1).(a).(ii) situationally sensitive; and, (Core)

IV.B.1.b).(1).(a).(iii) specific to the particular patient's/family's needs. (Core)

IV.B.1.b).(1).(b) Residents must demonstrate ~~proficiency~~ competence in formulating differential diagnoses of conditions affecting the head and neck; (Core) [Moved from IV.B.1.b).(2).(b)]

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655 IV.B.1.b).(1).(c) Residents must demonstrate competence in care that is accurate in diagnosis and treatment care options. (Core)

659 IV.B.1.b).(1).(d) Residents must demonstrate competence in interpreting data and developing patient care plans for the following diagnostic procedures: (Core)

663 IV.B.1.b).(1).(d).(i) audiology testing; (Core) [Moved from IV.B.1.b).(2).(a).(ii)]

666 IV.B.1.b).(1).(d).(ii) histopathology studies; (Core) [Moved from IV.B.1.b).(2).(a).(v)]

669 IV.B.1.b).(1).(d).(iii) imaging studies of the head and neck; (Core) [Moved from IV.B.1.b).(2).(a).(vi)]

672 IV.B.1.b).(1).(d).(iv) laboratory testing; (Core) [Moved from IV.B.1.b).(2).(a).(vi)]

675 IV.B.1.b).(1).(d).(v) sleep studies; (Core) [Moved from IV.B.1.b).(2).(a).(viii)]

678 IV.B.1.b).(1).(d).(vi) speech and voice testing; and, (Core)

680 IV.B.1.b).(1).(d).(vii) vestibular testing. (Core) [Moved from IV.B.1.b).(2).(a).(x)]

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

687 IV.B.1.b).(2).(a) Residents must demonstrate competence ~~proficiency~~ in performing and interpreting the data resulting ~~gathering and interpretation in areas including~~ from the following diagnostic procedures: (Core)

693 IV.B.1.b).(2).(a).(i) allergy testing; (Core)

695 IV.B.1.b).(2).(a).(ii) clinical history and exam; (Core) [Moved from IV.B.1.b).(2).(a).(iii)]

698 IV.B.1.b).(2).(a).(iii) facial analysis; and, (Core) [Moved from IV.B.1.b).(2).(a).(iv)]

701 IV.B.1.b).(2).(a).(iv) smell and taste testing.~~; and,~~ (Core) [Moved from IV.B.1.b).(2).(a).(ix)]

704 IV.B.1.b).(2).(b) Residents must demonstrate ~~proficiency~~ competence in surgical (including peri-operative)

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706 and non-surgical management and treatment of
707 conditions affecting the head and neck, including:
708 (Core) [Moved from IV.B.1.b).(2).(c)]
709
710 IV.B.1.b).(2).(b).(i) aerodigestive foreign body obstruction; (Core)
711 [Moved from IV.B.1.b).(2).(c).(i)]
712
713 IV.B.1.b).(2).(b).(ii) allergic and immunologic disorders; (Core)
714 [Moved from IV.B.1.b).(2).(c).(ii)]
715
716 IV.B.1.b).(2).(b).(iii) chemoreceptive disorders; (Core) [Moved from
717 IV.B.1.b).(2).(c).(iii)]
718
719 IV.B.1.b).(2).(b).(iv) voice, speech, and swallowing disorders;
720 (Core) [Moved from IV.B.1.b).(2).(c).(iv)]
721
722 IV.B.1.b).(2).(b).(v) disorders related to the geriatric population;
723 (Core) [Moved from IV.B.1.b).(2).(c).(v)]
724
725 IV.B.1.b).(2).(b).(vi) endocrine disorders related to the thyroid
726 and parathyroid; (Core) [Moved from
727 IV.B.1.b).(2).(c).(vi)]
728
729 IV.B.1.b).(2).(b).(vii) facial plastic and reconstructive disorders;
730 (Core) [Moved from IV.B.1.b).(2).(c).(vii)]
731
732 IV.B.1.b).(2).(b).(viii) idiopathic disorders (Core) [Moved from
733 IV.B.1.b).(2).(c).(viii)]
734
735 IV.B.1.b).(2).(b).(ix) infectious and inflammatory disorders; (Core)
736 [Moved from IV.B.1.b).(2).(c).(ix)]
737
738 IV.B.1.b).(2).(b).(x) metabolic disorders; (Core) [Moved from
739 IV.B.1.b).(2).(c).(x)]
740
741 IV.B.1.b).(2).(b).(xi) neoplastic disorders; (Core) [Moved from
742 IV.B.1.b).(2).(c).(xi)]
743
744 IV.B.1.b).(2).(b).(xii) neurologic disorders related to the head and
745 neck; (Core) [Moved from IV.B.1.b).(2).(c).(xii)]
746
747 IV.B.1.b).(2).(b).(xiii) pain; (Core) [Moved from IV.B.1.b).(2).(c).(xiii)]
748
749 IV.B.1.b).(2).(b).(xiv) pediatric and congenital disorders; (Core)
750 [Moved from IV.B.1.b).(2).(c).(xiv)]
751
752 IV.B.1.b).(2).(b).(xv) sleep disorders; (Core) [Moved from
753 IV.B.1.b).(2).(c).(xv)]
754
755 IV.B.1.b).(2).(b).(xvi) traumatic disorders; (Core) [Moved from
756 IV.B.1.b).(2).(c).(xvi)]

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IV.B.1.b).(2).(b).(xvii) vascular disorders; and, (Core) [Moved from IV.B.1.b).(2).(c).(xvii)]

IV.B.1.b).(2).(b).(xviii) vestibular and hearing disorders. (Core) [Moved from IV.B.1.b).(2).(c).(xviii)]

IV.B.1.b).(2).(c) Residents should demonstrate competence~~y~~ in performing otolaryngologic procedures, including: (Core)

IV.B.1.b).(2).(c).(i) airway management; (Core)

IV.B.1.b).(2).(c).(ii) computer-assisted navigation; (Core)

IV.B.1.b).(2).(c).(iii) endoscopy of the upper aerodigestive tract; (Core)

IV.B.1.b).(2).(c).(iv) laser usage; (Core)

IV.B.1.b).(2).(c).(v) local and regional anesthesia; (Core)

IV.B.1.b).(2).(c).(vi) resuscitation; (Core)

IV.B.1.b).(2).(c).(vii) stroboscopy; and, (Core)

IV.B.1.b).(2).(c).(viii) universal precautions. (Core)

IV.B.1.c) Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. (Core)

IV.B.1.c).(1) Residents must demonstrate knowledge appropriate for unsupervised practice of otolaryngology – head and neck surgery as defined by the ABOHNS curriculum. (Core)

IV.B.1.c).(2) Residents must demonstrate knowledge of anatomy through procedural skills demonstrated in cadaver dissection, temporal bone lab, and/or surgical simulator labs. (Core)

IV.B.1.d) Practice-based Learning and Improvement

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

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

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

808
809 **IV.B.1.d).(1)** **Residents must demonstrate competence in:**
810
811 **IV.B.1.d).(1).(a)** **identifying strengths, deficiencies, and limits in**
812 **one's knowledge and expertise; (Core)**
813
814 **IV.B.1.d).(1).(b)** **setting learning and improvement goals; (Core)**
815
816 **IV.B.1.d).(1).(c)** **identifying and performing appropriate learning**
817 **activities; (Core)**
818
819 **IV.B.1.d).(1).(d)** **systematically analyzing practice using quality**
820 **improvement methods, and implementing**
821 **changes with the goal of practice improvement;**
822 **(Core)**
823
824 **IV.B.1.d).(1).(e)** **incorporating feedback and formative**
825 **evaluation into daily practice; (Core)**
826
827 **IV.B.1.d).(1).(f)** **locating, appraising, and assimilating evidence**
828 **from scientific studies related to their patients'**
829 **health problems; and, (Core)**
830
831 **IV.B.1.d).(1).(g)** **using information technology to optimize**
832 **learning. (Core)**
833
834 **IV.B.1.e)** **Interpersonal and Communication Skills**
835
836 **Residents must demonstrate interpersonal and**
837 **communication skills that result in the effective exchange of**
838 **information and collaboration with patients, their families,**
839 **and health professionals. (Core)**
840
841 **IV.B.1.e).(1)** **Residents must demonstrate competence in:**
842
843 **IV.B.1.e).(1).(a)** **communicating effectively with patients,**
844 **families, and the public, as appropriate, across**
845 **a broad range of socioeconomic and cultural**
846 **backgrounds; (Core)**
847

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848 **IV.B.1.e).(1).(b)** **communicating effectively with physicians, other health professionals, and health-related agencies;** (Core)

852 **IV.B.1.e).(1).(c)** **working effectively as a member or leader of a health care team or other professional group;** (Core)

856 **IV.B.1.e).(1).(d)** **educating patients, families, students, residents, and other health professionals;** (Core)

859 **IV.B.1.e).(1).(e)** **acting in a consultative role to other physicians and health professionals; and,** (Core)

862 **IV.B.1.e).(1).(f)** **maintaining comprehensive, timely, and legible medical records, if applicable.** (Core)

865 **IV.B.1.e).(2)** **Residents must learn to communicate with patients and families to partner with them to assess their care goals, including, when appropriate, end-of-life goals.** (Core)

870 IV.B.1.e).(3) Residents must develop and present educational materials to the public. (Core)

872

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

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

873

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

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

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

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

887

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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.

888
889 **IV.B.1.f).(1).(b)** **coordinating patient care across the health care**
890 **continuum and beyond as relevant to their**
891 **clinical specialty; (Core)**
892

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.

893
894 **IV.B.1.f).(1).(c)** **advocating for quality patient care and optimal**
895 **patient care systems; (Core)**
896
897 **IV.B.1.f).(1).(d)** **working in interprofessional teams to enhance**
898 **patient safety and improve patient care quality;**
899 **(Core)**
900
901 **IV.B.1.f).(1).(e)** **participating in identifying system errors and**
902 **implementing potential systems solutions; (Core)**
903
904 **IV.B.1.f).(1).(f)** **incorporating considerations of value, cost**
905 **awareness, delivery and payment, and risk-**
906 **benefit analysis in patient and/or population-**
907 **based care as appropriate; and, (Core)**
908
909 **IV.B.1.f).(1).(g)** **understanding health care finances and its**
910 **impact on individual patients' health decisions.**
911 **(Core)**
912
913 **IV.B.1.f).(2)** **Residents must learn to advocate for patients within**
914 **the health care system to achieve the patient's and**
915 **family's care goals, including, when appropriate, end-**
916 **of-life goals. (Core)**
917
918 **IV.C.** **Curriculum Organization and Resident Experiences**
919
920 **IV.C.1.** **The curriculum must be structured to optimize resident educational**
921 **experiences, the length of these experiences, and supervisory**
922 **continuity. (Core)**
923
924 IV.C.1.a) Clinical rotations during the PGY-2-5 should be at least six weeks
925 in length, and must be at least four weeks in length. (Core)
926

Background and Intent: In some specialties, frequent rotational transitions, inadequate continuity of faculty member supervision, and dispersed patient locations within the hospital have adversely affected optimal resident education and effective

team-based care. The need for patient care continuity varies from specialty to specialty and by clinical situation, and may be addressed by the individual Review Committee.

927
928 **IV.C.2.** **The program must provide instruction and experience in pain**
929 **management if applicable for the specialty, including recognition of**
930 **the signs of addiction.** (Core)
931
932 IV.C.3. PGY-1 residents must participate in clinical and didactic activities in which
933 they: (Core)
934
935 IV.C.3.a) assess, plan, and initiate treatment of adult and pediatric patients
936 with surgical and/or medical problems; (Core)
937
938 IV.C.3.b) care for patients of all ages with surgical and medical
939 emergencies, multiple organ system trauma, soft tissue wounds,
940 nervous system injuries and diseases, and peripheral vascular
941 and thoracic injuries; (Core)
942
943 IV.C.3.c) care for critically-ill surgical and medical patients in the intensive
944 care unit and emergency room settings; (Core)
945
946 IV.C.3.d) participate in the pre-, intra-, and post-operative care of surgical
947 patients; and, (Core)
948
949 IV.C.3.e) participate in surgical anesthesia in hospital and ambulatory care
950 settings, including evaluation of anesthetic risks and the
951 management of intra-operative anesthetic complications. (Core)
952
953 IV.C.4. The PGY-1 ~~year~~ must include:
954
955 IV.C.4.a) six months of structured education on non-otolaryngology - head
956 and neck surgery rotations designed to foster ~~proficiency~~
957 development of competence in the peri-operative care of surgical
958 patients, inter-disciplinary care coordination, and airway
959 management skills; and, (Core)
960
961 IV.C.4.a).(1) The total time a resident is assigned to any one non-
962 otolaryngology – head and neck surgery rotation must be
963 at least four weeks and must not exceed two months. (Core)
964
965 IV.C.4.a).(2) Rotations must be selected from the following: anesthesia;
966 emergency medicine; general surgery; neurological
967 surgery; neuroradiology; ophthalmology; oral-maxillofacial
968 surgery; pediatric surgery; plastic surgery; radiation
969 oncology; and vascular surgery. (Core)
970
971 IV.C.4.a).(2).(a) This must include a surgical or medical intensive
972 care rotation. (Core)
973

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974 IV.C.4.a).(2).(b) A one month or four-week night float rotation is permitted but must have structured educational goals and objectives, and the resident must be evaluated during and at the end of the rotation. (Core)

979 IV.C.4.b) six months of otolaryngology – head and neck surgery rotations designed to develop ~~proficiency~~ competence in basic surgical skills, general care of otolaryngology – head and neck surgery patients both in the inpatient setting and in the outpatient clinics, management of otolaryngology – head and neck surgery patients in the emergency department, and cultivation of an otolaryngology – head and neck surgery knowledge base. (Core)

987 IV.C.5. The PGY-2-5 ~~years~~ must include 48 months of progressive education in otolaryngology – head and neck surgery. (Core)

990 IV.C.6. Each resident must spend a 12-month period as chief resident on the otolaryngology – head and neck surgery clinical service at the primary clinical site or one of the participating sites of the Sponsoring Institution during the last 24 months of the educational program. (Core)

Specialty-Specific Background and Intent: The 12-month period as chief may take place during the PGY-4 or the PGY-5. The Review Committee believes this will provide programs with greater flexibility in meeting the educational needs of each individual resident. Some residents may be ready to begin a focus on their anticipated subspecialty area during their final year, and thus would complete their chief year during the PGY-4, while others may need the PGY-4 to focus on achievement of specific milestones before beginning as chief resident during the PGY-5.

996 IV.C.7. The educational program must provide at least three months of a structured research experience for residents. (Core)

999 IV.C.7.a) While the three-month research experience need not be contiguous, each research rotation should not be less than one month in length. (Core)

1003 IV.C.7.a).(1) Programs seeking to design a research curriculum with dedicated research experiences less than one month in length must first obtain approval from the Review Committee. (Core)

1008 IV.C.7.b) The primary focus of this experience must be research and not clinical service or education. (Core)

1011 IV.C.7.b).(1) Concurrent clinical responsibilities must be limited. (Core)

1013 IV.C.7.c) The research experience must include instruction in research methods and design, as well as outcome assessment. (Core)

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IV.C.8. The didactic curriculum must include cyclical presentation of core specialty knowledge supplemented by the addition of breakthrough information. (Core)

IV.C.9. Educational conferences must include grand rounds, quality improvement conferences, morbidity and mortality conferences, and tumor conferences. (Core)

IV.C.9.a) Faculty members must participate in the preparation and presentation of educational conferences. (Core)

IV.C.9.b) Residents must attend educational conferences. (Core)

IV.C.9.b).(1) Each resident should attend at least 75 percent of the scheduled and held educational conferences. ~~(Detail)~~(Core)

IV.C.9.b).(2) Educational conferences must be evaluated. ~~(Detail)~~(Core)

IV.C.9.c) Didactic topics must include: basic sciences as relevant to the head and neck and upper-aerodigestive system; allergy and immunology; anatomy; biochemistry; cell biology; the communication sciences, including audiology, speech and language pathology, and the voice sciences, as they relate to laryngology; embryology; genetics; microbiology; pathology; pharmacology; physiology; rhinology; and the chemical senses, endocrinology, and neurology, as they relate to the head and neck. ~~(Detail)~~(Core)

IV.C.9.c).(1) Anatomy should include the study and dissection of anatomic specimens, including the temporal bone, and procedural skills laboratories, along with appropriate lectures and other formal sessions. (Detail)

IV.C.9.c).(2) Pathology should include formal instruction in correlative pathology, including gross and microscopic pathology relating to the head and neck. (Detail)

IV.C.9.c).(2).(a) Residents should study and discuss with the pathology service tissues removed at operations and autopsy material. (Detail)

IV.C.10. Resident Supervision and Patient Care Experiences

IV.C.10.a) Residents must have experience with state-of-the-art advances and emerging technology in otolaryngology - head and neck surgery. (Core)

IV.C.10.b) Residents must perform a sufficient number, variety, and complexity of surgical procedures to ensure education in the entire scope of the specialty. (Core)

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1067 IV.C.10.b).(1) Residents must have essentially equivalent distributions of
1068 case categories and procedures. (Core)
1069
1070 IV.C.10.c) Residents must have a broad range of experience in
1071 otolaryngology - head and neck surgery through outpatient care.
1072 This must include: (Core)
1073
1074 IV.C.10.c).(1) exposure to clinical aspects of diagnosis, medical and/or
1075 surgical therapy, and prevention of and rehabilitation from
1076 diseases, neoplasms, deformities, disorders, and/or
1077 injuries of the ears, upper respiratory and upper alimentary
1078 systems, face, jaws, and other head and neck systems; to
1079 head and neck oncology; and to facial plastic and
1080 reconstructive surgery; (Core)
1081
1082 IV.C.10.c).(2) evaluating patients, establishing provisional diagnoses,
1083 and initiating preliminary treatment plans; and, (Core)
1084
1085 IV.C.10.c).(3) providing follow-up care and evaluating the results of
1086 surgical care. (Core)
1087
1088 IV.C.10.d) Residents should have experience in the management of office
1089 practice. (Detail)
1090
1091 IV.C.10.e) Residents must have experience in the emergency care of
1092 critically-ill and injured patients with otolaryngologic conditions.
1093 (Core)
1094
1095 IV.C.10.f) Each resident must have patient care responsibility
1096 commensurate with his or her knowledge, problem-solving ability,
1097 manual skills, and experience, as well as with the severity and
1098 complexity of each patient's status. (Core)
1099
1100 IV.C.10.f).(1) This must include experience as assistant surgeon and
1101 resident supervisor. (Core)
1102
1103 IV.C.10.f).(2) All levels of surgical intervention must be recorded in the
1104 ACGME Case Log System. (Core)
1105
1106 IV.C.11. International Rotations
1107
1108 IV.C.11.a) International rotations must be approved by the program director.
1109 (Core)
1110
1111 IV.C.11.b) The total time spent in international rotations should be no more
1112 than one month over the five-year program. (Detail)
1113
1114 IV.C.11.c) All institutional policies and procedures that govern the program at
1115 the sponsoring institution must continue to be in effect for
1116 residents during an international rotation. (Core)
1117

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1118 IV.C.11.d) Surgical procedures completed during an international rotation
1119 must not be counted toward meeting the required minima of
1120 procedures. (Core)
1121
1122 **IV.D. Scholarship**
1123
1124 ***Medicine is both an art and a science. The physician is a humanistic***
1125 ***scientist who cares for patients. This requires the ability to think critically,***
1126 ***evaluate the literature, appropriately assimilate new knowledge, and***
1127 ***practice lifelong learning. The program and faculty must create an***
1128 ***environment that fosters the acquisition of such skills through resident***
1129 ***participation in scholarly activities. Scholarly activities may include***
1130 ***discovery, integration, application, and teaching.***
1131
1132 ***The ACGME recognizes the diversity of residencies and anticipates that***
1133 ***programs prepare physicians for a variety of roles, including clinicians,***
1134 ***scientists, and educators. It is expected that the program's scholarship will***
1135 ***reflect its mission(s) and aims, and the needs of the community it serves.***
1136 ***For example, some programs may concentrate their scholarly activity on***
1137 ***quality improvement, population health, and/or teaching, while other***
1138 ***programs might choose to utilize more classic forms of biomedical***
1139 ***research as the focus for scholarship.***
1140
1141 **IV.D.1. Program Responsibilities**
1142
1143 **IV.D.1.a) The program must demonstrate evidence of scholarly**
1144 **activities consistent with its mission(s) and aims. (Core)**
1145
1146 **IV.D.1.b) The program, in partnership with its Sponsoring Institution,**
1147 **must allocate adequate resources to facilitate resident and**
1148 **faculty involvement in scholarly activities. (Core)**
1149
1150 **IV.D.1.c) The program must advance residents' knowledge and**
1151 **practice of the scholarly approach to evidence-based patient**
1152 **care. (Core)**
1153

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

Elements of a scholarly approach to patient care include:

- **Asking meaningful questions to stimulate residents to utilize learning resources to create a differential diagnosis, a diagnostic algorithm, and treatment plan**
- **Challenging the evidence that the residents use to reach their medical decisions so that they understand the benefits and limits of the medical literature**

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- **When appropriate, dissemination of scholarly learning in a peer-reviewed manner (publication or presentation)**
- **Improving resident learning by encouraging them to teach using a scholarly approach**

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

1154
1155 **IV.D.2. Faculty Scholarly Activity**
1156
1157 **IV.D.2.a)** **Among their scholarly activity, programs must demonstrate**
1158 **accomplishments in at least three of the following domains:**
1159 **(Core)**
1160
1161 - **Research in basic science, education, translational**
1162 **science, patient care, or population health**
1163 - **Peer-reviewed grants**
1164 - **Quality improvement and/or patient safety initiatives**
1165 - **Systematic reviews, meta-analyses, review articles,**
1166 **chapters in medical textbooks, or case reports**
1167 - **Creation of curricula, evaluation tools, didactic**
1168 **educational activities, or electronic educational**
1169 **materials**
1170 - **Contribution to professional committees, educational**
1171 **organizations, or editorial boards**
1172 - **Innovations in education**
1173
1174 **IV.D.2.b)** **The program must demonstrate dissemination of scholarly**
1175 **activity within and external to the program by the following**
1176 **methods:**
1177

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

1178
1179 **IV.D.2.b).(1)** **faculty participation in grand rounds, posters,**
1180 **workshops, quality improvement presentations,**
1181 **podium presentations, grant leadership, non-peer-**
1182 **reviewed print/electronic resources, articles or**
1183 **publications, book chapters, textbooks, webinars,**
1184 **service on professional committees, or serving as a**

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1185 **journal reviewer, journal editorial board member, or**
1186 **editor;** (Outcome)‡
1187
1188 **IV.D.2.b).(2) peer-reviewed publication.** (Outcome)
1189
1190 **IV.D.3. Resident Scholarly Activity**
1191
1192 **IV.D.3.a) Residents must participate in scholarship.** (Core)
1193
1194 IV.D.3.a).(1) The research experience (Program Requirement IV.C.7)
1195 should result in a completed manuscript suitable for
1196 publication in a peer-reviewed journal. (Outcome)
1197
1198 **V. Evaluation**
1199
1200 **V.A. Resident Evaluation**
1201
1202 **V.A.1. Feedback and Evaluation**
1203

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

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

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

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

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

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

1204
1205 **V.A.1.a) Faculty members must directly observe, evaluate, and**
1206 **frequently provide feedback on resident performance during**
1207 **each rotation or similar educational assignment.** (Core)

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

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, such as continuity clinic in the context of other clinical responsibilities, 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 resident performance and improvement toward unsupervised practice. (Core)**

V.A.1.d) **The program director or their designee, with input from the Clinical Competency Committee, must:**

V.A.1.d).(1) **meet with and review with each resident the documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones; (Core)**

V.A.1.d).(1).(a) This must include review of ~~his or her~~ the resident's cumulative operative experience at least semiannually to ensure balanced progress towards achieving experience with a variety and complexity of surgical procedures. (Core)

V.A.1.d).(2) **assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and, (Core)**

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V.A.1.d).(3) **develop plans for residents failing to progress, following institutional policies and procedures.** **(Core)**

> **Background and Intent: Learning is an active process that requires effort from the teacher and the learner. Faculty members evaluate a resident's performance at least at the end of each rotation. The program director or their designee will review those evaluations, including their progress on the Milestones, at a minimum of every six months. Residents should be encouraged to reflect upon the evaluation, using the information to reinforce well-performed tasks or knowledge or to modify deficiencies in knowledge or practice. Working together with the faculty members, residents should develop an individualized learning plan.**
>
> **Residents who are experiencing difficulties with achieving progress along the Milestones may require intervention to address specific deficiencies. Such intervention, documented in an individual remediation plan developed by the program director or a faculty mentor and the resident, will take a variety of forms based on the specific learning needs of the resident. However, the ACGME recognizes that there are situations which require more significant intervention that may alter the time course of resident progression. To ensure due process, it is essential that the program director follow institutional policies and procedures.**

V.A.1.e) **At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable.** **(Core)**

V.A.1.e).(1) Residents must participate in existing national examinations. (Core)

V.A.1.e).(1).(a) Use of the annual Otolaryngology – Head and Neck Surgery Training Examination is strongly suggested.

V.A.1.e).(1).(b) An analysis of the results of these testing programs must be limited to guiding ~~the~~ faculty members in assessing the strengths and weaknesses of the program and individual residents. (Core)

V.A.1.e).(2) The faculty must meet annually to provide collective evaluation of each resident, including surgical competence~~y~~, and must provide an annual summative report for each resident. (Core)

V.A.1.f) **The evaluations of a resident's performance must be accessible for review by the resident.** **(Core)**

V.A.2. **Final Evaluation**

V.A.2.a) **The program director must provide a final evaluation for each resident upon completion of the program.** **(Core)**

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1286 **V.A.2.a).(1)** **The specialty-specific Milestones, and when applicable the specialty-specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program.** **(Core)**

1292 **V.A.2.a).(2)** **The final evaluation must:**

1294 **V.A.2.a).(2).(a)** **become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy;** **(Core)**

1299 **V.A.2.a).(2).(b)** **verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice;** **(Core)**

1303 **V.A.2.a).(2).(c)** **consider recommendations from the Clinical Competency Committee; and,** **(Core)**

1306 **V.A.2.a).(2).(d)** **be shared with the resident upon completion of the program.** **(Core)**

1309 **V.A.3.** **A Clinical Competency Committee must be appointed by the program director.** **(Core)**

1312 **V.A.3.a)** **At a minimum, the Clinical Competency Committee must include three members of the program faculty, at least one of whom is a core faculty member.** **(Core)**

1316 **V.A.3.a).(1)** **Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents.** **(Core)**

1320

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

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

1321

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1322 **V.A.3.b)** **The Clinical Competency Committee must:**
1323
1324 **V.A.3.b).(1)** **review all resident evaluations at least semi-annually;**
1325 **(Core)**
1326
1327 **V.A.3.b).(2)** **determine each resident's progress on achievement of**
1328 **the specialty-specific Milestones; and, (Core)**
1329
1330 **V.A.3.b).(3)** **meet prior to the residents' semi-annual evaluations**
1331 **and advise the program director regarding each**
1332 **resident's progress. (Core)**
1333
1334 **V.B.** **Faculty Evaluation**
1335
1336 **V.B.1.** **The program must have a process to evaluate each faculty**
1337 **member's performance as it relates to the educational program at**
1338 **least annually. (Core)**
1339

Background and Intent: The program director is responsible for the education program and for whom delivers it. While the term "faculty" may be applied to physicians within a given institution for other reasons, it is applied to residency program faculty members only through approval by a program director. The development of the faculty improves the education, clinical, and research aspects of a program. Faculty members have a strong commitment to the resident and desire to provide optimal education and work opportunities. Faculty members must be provided feedback on their contribution to the mission of the program. All faculty members who interact with residents desire feedback on their education, clinical care, and research. If a faculty member does not interact with residents, feedback is not required. With regard to the diverse operating environments and configurations, the residency program director may need to work with others to determine the effectiveness of the program's faculty performance with regard to their role in the educational program. All teaching faculty members should have their educational efforts evaluated by the residents in a confidential and anonymous manner. Other aspects for the feedback may include research or clinical productivity, review of patient outcomes, or peer review of scholarly activity. The process should reflect the local environment and identify the necessary information. The feedback from the various sources should be summarized and provided to the faculty on an annual basis by a member of the leadership team of the program.

1340
1341 **V.B.1.a)** **This evaluation must include a review of the faculty member's**
1342 **clinical teaching abilities, engagement with the educational**
1343 **program, participation in faculty development related to their**
1344 **skills as an educator, clinical performance, professionalism,**
1345 **and scholarly activities. (Core)**
1346
1347 **V.B.1.b)** **This evaluation must include written, anonymous, and**
1348 **confidential evaluations by the residents. (Core)**
1349
1350 **V.B.2.** **Faculty members must receive feedback on their evaluations at least**
1351 **annually. (Core)**
1352

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1353 **V.B.3.** **Results of the faculty educational evaluations should be**
1354 **incorporated into program-wide faculty development plans.** (Core)
1355

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

1356
1357 **V.C.** **Program Evaluation and Improvement**
1358
1359 **V.C.1.** **The program director must appoint the Program Evaluation**
1360 **Committee to conduct and document the Annual Program**
1361 **Evaluation as part of the program's continuous improvement**
1362 **process.** (Core)
1363
1364 **V.C.1.a)** **The Program Evaluation Committee must be composed of at**
1365 **least two program faculty members, at least one of whom is a**
1366 **core faculty member, and at least one resident.** (Core)
1367
1368 **V.C.1.b)** **Program Evaluation Committee responsibilities must include:**
1369
1370 **V.C.1.b).(1)** **acting as an advisor to the program director, through**
1371 **program oversight;** (Core)
1372
1373 **V.C.1.b).(2)** **review of the program's self-determined goals and**
1374 **progress toward meeting them;** (Core)
1375
1376 **V.C.1.b).(3)** **guiding ongoing program improvement, including**
1377 **development of new goals, based upon outcomes;**
1378 **and,** (Core)
1379
1380 **V.C.1.b).(4)** **review of the current operating environment to identify**
1381 **strengths, challenges, opportunities, and threats as**
1382 **related to the program's mission and aims.** (Core)
1383

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

1384
1385 **V.C.1.c)** **The Program Evaluation Committee should consider the**
1386 **following elements in its assessment of the program:**
1387
1388 **V.C.1.c).(1)** **curriculum;** (Core)
1389
1390 **V.C.1.c).(2)** **outcomes from prior Annual Program Evaluation(s);**
1391 (Core)

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1392
1393 **V.C.1.c).(3)** **ACGME letters of notification, including citations, Areas for Improvement, and comments; (Core)**
1395
1396 **V.C.1.c).(4)** **quality and safety of patient care; (Core)**
1397
1398 **V.C.1.c).(5)** **aggregate resident and faculty:**
1399
1400 **V.C.1.c).(5).(a)** **well-being; (Core)**
1401
1402 **V.C.1.c).(5).(b)** **recruitment and retention; (Core)**
1403
1404 **V.C.1.c).(5).(c)** **workforce diversity; (Core)**
1405
1406 **V.C.1.c).(5).(d)** **engagement in quality improvement and patient safety; (Core)**
1408
1409 **V.C.1.c).(5).(e)** **scholarly activity; (Core)**
1410
1411 **V.C.1.c).(5).(f)** **ACGME Resident and Faculty Surveys; and, (Core)**
1413
1414 **V.C.1.c).(5).(g)** **written evaluations of the program. (Core)**
1415
1416 **V.C.1.c).(6)** **aggregate resident:**
1417
1418 **V.C.1.c).(6).(a)** **achievement of the Milestones; (Core)**
1419
1420 **V.C.1.c).(6).(b)** **in-training examinations (where applicable); (Core)**
1422
1423 **V.C.1.c).(6).(c)** **board pass and certification rates; and, (Core)**
1424
1425 **V.C.1.c).(6).(d)** **graduate performance. (Core)**
1426
1427 **V.C.1.c).(7)** **aggregate faculty:**
1428
1429 **V.C.1.c).(7).(a)** **evaluation; and, (Core)**
1430
1431 **V.C.1.c).(7).(b)** **professional development. (Core)**
1432
1433 **V.C.1.d)** **The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)**
1436
1437 **V.C.1.e)** **The annual review, including the action plan, must:**
1438
1439 **V.C.1.e).(1)** **be distributed to and discussed with the members of the teaching faculty and the residents; and, (Core)**
1441
1442 **V.C.1.e).(2)** **be submitted to the DIO. (Core)**

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1443
1444 **V.C.2.** **The program must complete a Self-Study prior to its 10-Year**
1445 **Accreditation Site Visit.** **(Core)**
1446
1447 **V.C.2.a)** **A summary of the Self-Study must be submitted to the DIO.**
1448 **(Core)**
1449

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

1450
1451 ***V.C.3.*** ***One goal of ACGME-accredited education is to educate physicians***
1452 ***who seek and achieve board certification. One measure of the***
1453 ***effectiveness of the educational program is the ultimate pass rate.***
1454
1455 ***The program director should encourage all eligible program***
1456 ***graduates to take the certifying examination offered by the***
1457 ***applicable American Board of Medical Specialties (ABMS) member***
1458 ***board or American Osteopathic Association (AOA) certifying board.***
1459
1460 **V.C.3.a)** **For specialties in which the ABMS member board and/or AOA**
1461 **certifying board offer(s) an annual written exam, in the**
1462 **preceding three years, the program's aggregate pass rate of**
1463 **those taking the examination for the first time must be higher**
1464 **than the bottom fifth percentile of programs in that specialty.**
1465 **(Outcome)**
1466
1467 **V.C.3.b)** **For specialties in which the ABMS member board and/or AOA**
1468 **certifying board offer(s) a biennial written exam, in the**
1469 **preceding six years, the program's aggregate pass rate of**
1470 **those taking the examination for the first time must be higher**
1471 **than the bottom fifth percentile of programs in that specialty.**
1472 **(Outcome)**
1473
1474 **V.C.3.c)** **For specialties in which the ABMS member board and/or AOA**
1475 **certifying board offer(s) an annual oral exam, in the preceding**
1476 **three years, the program's aggregate pass rate of those**
1477 **taking the examination for the first time must be higher than**
1478 **the bottom fifth percentile of programs in that specialty.**
1479 **(Outcome)**
1480
1481 **V.C.3.d)** **For specialties in which the ABMS member board and/or AOA**
1482 **certifying board offer(s) a biennial oral exam, in the preceding**

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1483 **six years, the program's aggregate pass rate of those taking**
1484 **the examination for the first time must be higher than the**
1485 **bottom fifth percentile of programs in that specialty.** (Outcome)
1486
1487 **V.C.3.e)** **For each of the exams referenced in V.C.3.a)-d), any program**
1488 **whose graduates over the time period specified in the**
1489 **requirement have achieved an 80 percent pass rate will have**
1490 **met this requirement, no matter the percentile rank of the**
1491 **program for pass rate in that specialty.** (Outcome)
1492

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.

1493
1494 **V.C.3.f)** **Programs must report, in ADS, board certification status**
1495 **annually for the cohort of board-eligible residents that**
1496 **graduated seven years earlier.** (Core)
1497

Background and Intent: It is essential that residency programs demonstrate knowledge and skill transfer to their residents. One measure of that is the qualifying or initial certification exam pass rate. Another important parameter of the success of the program is the ultimate board certification rate of its graduates. Graduates are eligible for up to seven years from residency graduation for initial certification. The ACGME will calculate a rolling three-year average of the ultimate board certification rate at seven years post-graduation, and the Review Committees will monitor it. The Review Committees will track the rolling seven-year certification rate as an indicator of program quality. Programs are encouraged to monitor their graduates' performance on board certification examinations. In the future, the ACGME may establish parameters related to ultimate board certification rates.

1498
1499 **VI. The Learning and Working Environment**
1500
1501 ***Residency education must occur in the context of a learning and working***
1502 ***environment that emphasizes the following principles:***
1503
1504 • ***Excellence in the safety and quality of care rendered to patients by residents***
1505 ***today***
1506
1507 • ***Excellence in the safety and quality of care rendered to patients by today's***
1508 ***residents in their future practice***

1509
1510 - ***Excellence in professionalism through faculty modeling of:***
1511
1512 - ***the effacement of self-interest in a humanistic environment that supports***
1513 ***the professional development of physicians***
1514
1515 - ***the joy of curiosity, problem-solving, intellectual rigor, and discovery***
1516
1517 - ***Commitment to the well-being of the students, residents, faculty members, and***
1518 ***all members of the health care team***
1519

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

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

1520
1521 **VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability**
1522
1523 **VI.A.1. Patient Safety and Quality Improvement**
1524
1525 ***All physicians share responsibility for promoting patient safety and***
1526 ***enhancing quality of patient care. Graduate medical education must***
1527 ***prepare residents to provide the highest level of clinical care with***
1528 ***continuous focus on the safety, individual needs, and humanity of***
1529 ***their patients. It is the right of each patient to be cared for by***
1530 ***residents who are appropriately supervised; possess the requisite***
1531 ***knowledge, skills, and abilities; understand the limits of their***
1532 ***knowledge and experience; and seek assistance as required to***
1533 ***provide optimal patient care.***
1534

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

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

VI.A.1.a) Patient Safety

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

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

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

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

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

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

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

VI.A.1.a).(3) Patient Safety Events

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

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1584 **VI.A.1.a).(3).(a)** **Residents, fellows, faculty members, and other clinical staff members must:**
1585
1586
1587 **VI.A.1.a).(3).(a).(i)** **know their responsibilities in reporting patient safety events at the clinical site; (Core)**
1588
1589
1590
1591 **VI.A.1.a).(3).(a).(ii)** **know how to report patient safety events, including near misses, at the clinical site; and, (Core)**
1592
1593
1594
1595 **VI.A.1.a).(3).(a).(iii)** **be provided with summary information of their institution's patient safety reports. (Core)**
1596
1597
1598
1599 **VI.A.1.a).(3).(b)** **Residents must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)**
1600
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1605
1606 **VI.A.1.a).(4)** **Resident Education and Experience in Disclosure of Adverse Events**
1607
1608
1609 ***Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for residents to develop and apply.***
1610
1611
1612
1613
1614
1615 **VI.A.1.a).(4).(a)** **All residents must receive training in how to disclose adverse events to patients and families. (Core)**
1616
1617
1618
1619 **VI.A.1.a).(4).(b)** **Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated. (Detail)**
1620
1621
1622
1623 **VI.A.1.b)** **Quality Improvement**
1624
1625 **VI.A.1.b).(1)** **Education in Quality Improvement**
1626
1627 ***A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.***
1628
1629
1630
1631
1632 **VI.A.1.b).(1).(a)** **Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities. (Core)**
1633
1634

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1635
1636 **VI.A.1.b).(2)** **Quality Metrics**
1637
1638 ***Access to data is essential to prioritizing activities for***
1639 ***care improvement and evaluating success of***
1640 ***improvement efforts.***
1641
1642 **VI.A.1.b).(2).(a)** **Residents and faculty members must receive**
1643 **data on quality metrics and benchmarks related**
1644 **to their patient populations.** **(Core)**
1645
1646 **VI.A.1.b).(3)** **Engagement in Quality Improvement Activities**
1647
1648 ***Experiential learning is essential to developing the***
1649 ***ability to identify and institute sustainable systems-***
1650 ***based changes to improve patient care.***
1651
1652 **VI.A.1.b).(3).(a)** **Residents must have the opportunity to**
1653 **participate in interprofessional quality**
1654 **improvement activities.** **(Core)**
1655
1656 **VI.A.1.b).(3).(a).(i)** **This should include activities aimed at**
1657 **reducing health care disparities.** **(Detail)**
1658
1659 **VI.A.2.** **Supervision and Accountability**
1660
1661 **VI.A.2.a)** ***Although the attending physician is ultimately responsible for***
1662 ***the care of the patient, every physician shares in the***
1663 ***responsibility and accountability for their efforts in the***
1664 ***provision of care. Effective programs, in partnership with***
1665 ***their Sponsoring Institutions, define, widely communicate,***
1666 ***and monitor a structured chain of responsibility and***
1667 ***accountability as it relates to the supervision of all patient***
1668 ***care.***
1669
1670 ***Supervision in the setting of graduate medical education***
1671 ***provides safe and effective care to patients; ensures each***
1672 ***resident's development of the skills, knowledge, and attitudes***
1673 ***required to enter the unsupervised practice of medicine; and***
1674 ***establishes a foundation for continued professional growth.***
1675
1676 **VI.A.2.a).(1)** **Each patient must have an identifiable and**
1677 **appropriately-credentialed and privileged attending**
1678 **physician (or licensed independent practitioner as**
1679 **specified by the applicable Review Committee) who is**
1680 **responsible and accountable for the patient's care.**
1681 **(Core)**
1682
1683 **VI.A.2.a).(1).(a)** **This information must be available to residents,**
1684 **faculty members, other members of the health**
1685 **care team, and patients.** **(Core)**

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1686
1687 **VI.A.2.a).(1).(b)** **Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care.** **(Core)**
1688
1689
1690
1691
1692 **VI.A.2.b)** ***Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the appropriate availability of the supervising faculty member, fellow, or senior resident physician, either on site or by means of telecommunication technology. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.***
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1702

Background and Intent: There are circumstances where direct supervision without physical presence does not fulfill the requirements of the specific Review Committee. Review Committees will further specify what is meant by direct supervision without physical presence in specialties where allowed. "Physically present" is defined as follows: The teaching physician is located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service.

1703
1704 **VI.A.2.b).(1)** **The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation.** **(Core)**
1705
1706
1707
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1711 **VI.A.2.b).(2)** **The program must define when physical presence of a supervising physician is required.** **(Core)**
1712
1713
1714 **VI.A.2.c)** **Levels of Supervision**
1715
1716 **To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:** **(Core)**
1717
1718
1719
1720 **VI.A.2.c).(1)** **Direct Supervision:**
1721
1722 **VI.A.2.c).(1).(a)** **the supervising physician is physically present with the resident during the key portions of the patient interaction.** **(Core)**
1723
1724
1725
1726 **VI.A.2.c).(1).(a).(i)** **PGY-1 residents must initially be supervised directly, only as described in VI.A.2.c).(1).(a).** **(Core)**
1727
1728
1729

1730 VI.A.2.c).(1).(a).(i).(a) Each program must define those physician tasks for which PGY-1 residents must be supervised directly until they have demonstrated competence as defined by the program director, and must maintain records of such demonstrations of competence. (Core) [Moved from VI.A.2.e).(1).(b).(i)]

1740 VI.A.2.c).(1).(a).(i).(b) Each program must define those physician tasks for which PGY-1 residents may be supervised indirectly with direct supervision available, and must define "direct supervision" in the context of the individual program. (Core) [Moved from VI.A.2.e).(1).(b)]

1749 **VI.A.2.c).(2)** **Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision. (Core)**

1755 **VI.A.2.c).(3)** **Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. (Core)**

1759 **VI.A.2.d)** **The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. (Core)**

1764 **VI.A.2.d).(1)** **The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones. (Core)**

1768 **VI.A.2.d).(2)** **Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. (Core)**

1773 **VI.A.2.d).(3)** **Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)**

1778

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1779 **VI.A.2.e)** **Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s).** **(Core)**

1780
1781
1782
1783 **VI.A.2.e).(1)** **Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence.** **(Outcome)**

1784
1785
1786
1787

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

1788
1789 **VI.A.2.f)** **Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility.** **(Core)**

1790
1791
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1793
1794 **VI.B.** **Professionalism**

1795
1796 **VI.B.1.** **Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients.** **(Core)**

1797
1798
1799
1800
1801
1802 **VI.B.2.** **The learning objectives of the program must:**

1803
1804 **VI.B.2.a)** **be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events;** **(Core)**

1805
1806
1807
1808 **VI.B.2.b)** **be accomplished without excessive reliance on residents to fulfill non-physician obligations; and,** **(Core)**

1809
1810

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

1811
1812 **VI.B.2.c)** **ensure manageable patient care responsibilities.** **(Core)**

1813

Background and Intent: The Common Program Requirements do not define “manageable patient care responsibilities” as this is variable by specialty and PGY

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level. Review Committees will provide further detail regarding patient care responsibilities in the applicable specialty-specific Program Requirements and accompanying FAQs. However, all programs, regardless of specialty, should carefully assess how the assignment of patient care responsibilities can affect work compression, especially at the PGY-1 level.

1814

1815 **VI.B.3.** **The program director, in partnership with the Sponsoring Institution,**
1816 **must provide a culture of professionalism that supports patient**
1817 **safety and personal responsibility.** (Core)
1818
1819 **VI.B.4.** **Residents and faculty members must demonstrate an understanding**
1820 **of their personal role in the:**
1821
1822 **VI.B.4.a)** **provision of patient- and family-centered care;** (Outcome)
1823
1824 **VI.B.4.b)** **safety and welfare of patients entrusted to their care,**
1825 **including the ability to report unsafe conditions and adverse**
1826 **events;** (Outcome)
1827

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

1828
1829 **VI.B.4.c)** **assurance of their fitness for work, including:** (Outcome)
1830

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

1831
1832 **VI.B.4.c).(1)** **management of their time before, during, and after**
1833 **clinical assignments; and,** (Outcome)
1834
1835 **VI.B.4.c).(2)** **recognition of impairment, including from illness,**
1836 **fatigue, and substance use, in themselves, their peers,**
1837 **and other members of the health care team.** (Outcome)
1838
1839 **VI.B.4.d)** **commitment to lifelong learning;** (Outcome)
1840
1841 **VI.B.4.e)** **monitoring of their patient care performance improvement**
1842 **indicators; and,** (Outcome)
1843
1844 **VI.B.4.f)** **accurate reporting of clinical and educational work hours,**
1845 **patient outcomes, and clinical experience data.** (Outcome)
1846
1847 **VI.B.5.** **All residents and faculty members must demonstrate**
1848 **responsiveness to patient needs that supersedes self-interest. This**
1849 **includes the recognition that under certain circumstances, the best**

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1850 **interests of the patient may be served by transitioning that patient's**
1851 **care to another qualified and rested provider.** **(Outcome)**
1852
1853 **VI.B.6.** **Programs, in partnership with their Sponsoring Institutions, must**
1854 **provide a professional, equitable, respectful, and civil environment**
1855 **that is free from discrimination, sexual and other forms of**
1856 **harassment, mistreatment, abuse, or coercion of students,**
1857 **residents, faculty, and staff.** **(Core)**
1858
1859 **VI.B.7.** **Programs, in partnership with their Sponsoring Institutions, should**
1860 **have a process for education of residents and faculty regarding**
1861 **unprofessional behavior and a confidential process for reporting,**
1862 **investigating, and addressing such concerns.** **(Core)**
1863
1864 **VI.C. Well-Being**
1865
1866 ***Psychological, emotional, and physical well-being are critical in the***
1867 ***development of the competent, caring, and resilient physician and require***
1868 ***proactive attention to life inside and outside of medicine. Well-being***
1869 ***requires that physicians retain the joy in medicine while managing their***
1870 ***own real-life stresses. Self-care and responsibility to support other***
1871 ***members of the health care team are important components of***
1872 ***professionalism; they are also skills that must be modeled, learned, and***
1873 ***nurtured in the context of other aspects of residency training.***
1874
1875 ***Residents and faculty members are at risk for burnout and depression.***
1876 ***Programs, in partnership with their Sponsoring Institutions, have the same***
1877 ***responsibility to address well-being as other aspects of resident***
1878 ***competence. Physicians and all members of the health care team share***
1879 ***responsibility for the well-being of each other. For example, a culture which***
1880 ***encourages covering for colleagues after an illness without the expectation***
1881 ***of reciprocity reflects the ideal of professionalism. A positive culture in a***
1882 ***clinical learning environment models constructive behaviors, and prepares***
1883 ***residents with the skills and attitudes needed to thrive throughout their***
1884 ***careers.***
1885

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

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

1886

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1887 **VI.C.1.** **The responsibility of the program, in partnership with the**
1888 **Sponsoring Institution, to address well-being must include:**
1889
1890 **VI.C.1.a)** **efforts to enhance the meaning that each resident finds in the**
1891 **experience of being a physician, including protecting time**
1892 **with patients, minimizing non-physician obligations,**
1893 **providing administrative support, promoting progressive**
1894 **autonomy and flexibility, and enhancing professional**
1895 **relationships;** **(Core)**
1896
1897 **VI.C.1.b)** **attention to scheduling, work intensity, and work**
1898 **compression that impacts resident well-being;** **(Core)**
1899
1900 **VI.C.1.c)** **evaluating workplace safety data and addressing the safety of**
1901 **residents and faculty members;** **(Core)**
1902

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

1903
1904 **VI.C.1.d)** **policies and programs that encourage optimal resident and**
1905 **faculty member well-being; and,** **(Core)**
1906

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.

1907
1908 **VI.C.1.d).(1)** **Residents must be given the opportunity to attend**
1909 **medical, mental health, and dental care appointments,**
1910 **including those scheduled during their working hours.**
1911 **(Core)**
1912

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

1913
1914 **VI.C.1.e)** **attention to resident and faculty member burnout,**
1915 **depression, and substance abuse. The program, in**
1916 **partnership with its Sponsoring Institution, must educate**
1917 **faculty members and residents in identification of the**
1918 **symptoms of burnout, depression, and substance abuse,**
1919 **including means to assist those who experience these**
1920 **conditions. Residents and faculty members must also be**
1921 **educated to recognize those symptoms in themselves and**

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1922 **how to seek appropriate care. The program, in partnership**
1923 **with its Sponsoring Institution, must:** (Core)
1924

Background and Intent: Programs and Sponsoring Institutions are encouraged to review materials in order to create systems for identification of burnout, depression, and substance abuse. 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).

1925
1926 **VI.C.1.e).(1)** **encourage residents and faculty members to alert the**
1927 **program director or other designated personnel or**
1928 **programs when they are concerned that another**
1929 **resident, fellow, or faculty member may be displaying**
1930 **signs of burnout, depression, substance abuse,**
1931 **suicidal ideation, or potential for violence;** (Core)
1932

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

1933
1934 **VI.C.1.e).(2)** **provide access to appropriate tools for self-screening;**
1935 **and,** (Core)
1936
1937 **VI.C.1.e).(3)** **provide access to confidential, affordable mental**
1938 **health assessment, counseling, and treatment,**
1939 **including access to urgent and emergent care 24**
1940 **hours a day, seven days a week.** (Core)
1941

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

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

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VI.C.2. **There are circumstances in which residents 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 residents 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 patient care.** (Core)

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

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

VI.D. **Fatigue Mitigation**

VI.D.1. **Programs must:**

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

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

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

> **Background and Intent: Providing medical care to patients is physically and mentally demanding. Night shifts, even for those who have had enough rest, cause fatigue. Experiencing fatigue in a supervised environment during training prepares residents for managing fatigue in practice. It is expected that programs adopt fatigue mitigation processes and ensure that there are no negative consequences and/or stigma for using fatigue mitigation strategies.**
>
> **This requirement emphasizes the importance of adequate rest before and after clinical responsibilities. Strategies that may be used include, but are not limited to, strategic napping; the judicious use of caffeine; availability of other caregivers; time management to maximize sleep off-duty; learning to recognize the signs of fatigue, and self-monitoring performance and/or asking others to monitor performance; remaining active to promote alertness; maintaining a healthy diet; using relaxation techniques to fall asleep; maintaining a consistent sleep routine; exercising regularly; increasing sleep time before and after call; and ensuring sufficient sleep recovery periods.**

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1972 **VI.D.2.** **Each program must ensure continuity of patient care, consistent**
1973 **with the program's policies and procedures referenced in VI.C.2–**
1974 **VI.C.2.b), in the event that a resident may be unable to perform their**
1975 **patient care responsibilities due to excessive fatigue.** **(Core)**
1976
1977 **VI.D.3.** **The program, in partnership with its Sponsoring Institution, must**
1978 **ensure adequate sleep facilities and safe transportation options for**
1979 **residents who may be too fatigued to safely return home.** **(Core)**
1980
1981 **VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care**
1982
1983 **VI.E.1. Clinical Responsibilities**
1984
1985 **The clinical responsibilities for each resident must be based on PGY**
1986 **level, patient safety, resident ability, severity and complexity of**
1987 **patient illness/condition, and available support services.** **(Core)**
1988
1989 VI.E.1.a) The workload associated with optimal clinical care of surgical
1990 patients is a continuum from the moment of admission to the point
1991 of discharge. (Detail)
1992
1993 VI.E.1.b) During the residency education process, surgical teams should be
1994 made up of attending surgeons, residents at various PGY levels,
1995 medical students (when appropriate), and other health care
1996 providers. (Detail)
1997
1998 VI.E.1.c) The work of the caregiver team should be assigned to team
1999 members based on each resident's level of education, experience,
2000 and competence. (Detail)
2001

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

2002
2003 **VI.E.2. Teamwork**
2004
2005 **Residents must care for patients in an environment that maximizes**
2006 **communication. This must include the opportunity to work as a**
2007 **member of effective interprofessional teams that are appropriate to**
2008 **the delivery of care in the specialty and larger health system.** **(Core)**
2009
2010 VI.E.2.a) Effective surgical practices entail the involvement of members with
2011 a mix of complementary skills and attributes (physicians, nurses,
2012 and other staff members). Success requires both an unwavering
2013 mutual respect for those skills and contributions, and a shared
2014 commitment to the process of patient care. (Detail)

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VI.E.2.b) Residents must collaborate with fellow surgical residents, and especially with faculty members, other physicians outside of their specialty, and non-traditional health care providers, to best formulate treatment plans for an increasingly diverse patient population. ~~(Detail)~~(Core)

VI.E.2.c) Residents must assume personal responsibility to complete all tasks to which they are assigned (or which they voluntarily assume) in a timely fashion. These tasks must be completed in the hours assigned, or, if that is not possible, residents must learn and utilize the established methods for handing off remaining tasks to another member of the resident team so that patient care is not compromised. ~~(Detail)~~(Core)

VI.E.2.d) Lines of authority should be defined by programs, and all residents must have a working knowledge of these expected reporting relationships to maximize quality care and patient safety. ~~(Detail)~~(Core)

VI.E.3. Transitions of Care

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

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

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

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

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

VI.F. Clinical Experience and Education

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

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2066

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

2067
2068 **VI.F.1. Maximum Hours of Clinical and Educational Work per Week**
2069
2070 **Clinical and educational work hours must be limited to no more than**
2071 **80 hours per week, averaged over a four-week period, inclusive of all**
2072 **in-house clinical and educational activities, clinical work done from**
2073 **home, and all moonlighting.** (Core)
2074

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

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

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

Work from Home
While the requirement specifies that clinical work done from home must be counted toward the 80-hour maximum weekly limit, the expectation remains that scheduling be structured so that residents are able to complete most work on site during scheduled clinical work hours without requiring them to take work home. The new requirements acknowledge the changing landscape of medicine, including electronic health records, and the resulting increase in the amount of work residents choose to do from home. The

requirement provides flexibility for residents to do this while ensuring that the time spent by residents completing clinical work from home is accomplished within the 80-hour weekly maximum. Types of work from home that must be counted include using an electronic health record and taking calls from home. Reading done in preparation for the following day's cases, studying, and research done from home do not count toward the 80 hours. Resident decisions to leave the hospital before their clinical work has been completed and to finish that work later from home should be made in consultation with the resident's supervisor. In such circumstances, residents should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality.

During the public comment period many individuals raised questions and concerns related to this change. Some questioned whether minute by minute tracking would be required; in other words, if a resident spends three minutes on a phone call and then a few hours later spends two minutes on another call, will the resident need to report that time. Others raised concerns related to the ability of programs and institutions to verify the accuracy of the information reported by residents. The new requirements are not an attempt to micromanage this process. Residents are to track the time they spend on clinical work from home and to report that time to the program. Decisions regarding whether to report infrequent phone calls of very short duration will be left to the individual resident. Programs will need to factor in time residents are spending on clinical work at home when schedules are developed to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks. There is no requirement that programs assume responsibility for documenting this time. Rather, the program's responsibility is ensuring that residents report their time from home and that schedules are structured to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks.

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

2075
2076 **VI.F.2.** **Mandatory Time Free of Clinical Work and Education**
2077
2078 **VI.F.2.a)** **The program must design an effective program structure that**
2079 **is configured to provide residents with educational**
2080 **opportunities, as well as reasonable opportunities for rest**
2081 **and personal well-being.** (Core)
2082
2083 **VI.F.2.b)** **Residents should have eight hours off between scheduled**
2084 **clinical work and education periods.** (Detail)
2085
2086 **VI.F.2.b).(1)** **There may be circumstances when residents choose**
2087 **to stay to care for their patients or return to the**
2088 **hospital with fewer than eight hours free of clinical**
2089 **experience and education. This must occur within the**

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2090 **context of the 80-hour and the one-day-off-in-seven**
2091 **requirements.** (Detail)
2092

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

2093
2094 **VI.F.2.c)** **Residents must have at least 14 hours free of clinical work**
2095 **and education after 24 hours of in-house call.** (Core)
2096

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

2097
2098 **VI.F.2.d)** **Residents must be scheduled for a minimum of one day in**
2099 **seven free of clinical work and required education (when**
2100 **averaged over four weeks). At-home call cannot be assigned**
2101 **on these free days.** (Core)
2102

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

2103
2104 **VI.F.3.** **Maximum Clinical Work and Education Period Length**
2105
2106 **VI.F.3.a)** **Clinical and educational work periods for residents must not**
2107 **exceed 24 hours of continuous scheduled clinical**
2108 **assignments.** (Core)
2109

Background and Intent: The Task Force examined the question of "consecutive time on task." It examined the research supporting the current limit of 16 consecutive hours of time on task for PGY-1 residents; the range of often conflicting impacts of this requirement on patient safety, clinical care, and continuity of care by resident teams;

and resident learning found in the literature. Finally, it heard a uniform request by the specialty societies, certifying boards, membership societies and organizations, and senior residents to repeal this requirement. It heard conflicting perspectives from resident unions, a medical student association, and a number of public advocacy groups, some arguing for continuation of the requirement, others arguing for extension of the requirement to all residents.

Of greatest concern to the Task Force were the observations of disruption of team care and patient care continuity brought about with residents beyond the PGY-1 level adhering to differing requirements. The graduate medical education community uniformly requested that the Task Force remove this requirement. The most frequently-cited reason for this request was the complete disruption of the team, separating the PGY-1 from supervisory faculty members and residents who were best able to judge the ability of the resident and customize the supervision of patient care for each PGY-1. Cited nearly as frequently was the separation of the PGY-1 from the team, delaying maturation of clinical skills, and threatening to create a "shift" mentality in disciplines where overnight availability to patients is essential in delivery of care.

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

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

2110
2111 **VI.F.3.a).(1)** **Up to four hours of additional time may be used for**
2112 **activities related to patient safety, such as providing**
2113 **effective transitions of care, and/or resident education.**
2114 **(Core)**
2115
2116 **VI.F.3.a).(1).(a)** **Additional patient care responsibilities must not**
2117 **be assigned to a resident during this time. (Core)**
2118

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

2119
2120 **VI.F.4.** **Clinical and Educational Work Hour Exceptions**
2121

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2122 **VI.F.4.a)** **In rare circumstances, after handing off all other**
2123 **responsibilities, a resident, on their own initiative, may elect**
2124 **to remain or return to the clinical site in the following**
2125 **circumstances:**
2126
2127 **VI.F.4.a).(1)** **to continue to provide care to a single severely ill or**
2128 **unstable patient;** **(Detail)**
2129
2130 **VI.F.4.a).(2)** **humanistic attention to the needs of a patient or**
2131 **family; or,** **(Detail)**
2132
2133 **VI.F.4.a).(3)** **to attend unique educational events.** **(Detail)**
2134
2135 **VI.F.4.b)** **These additional hours of care or education will be counted**
2136 **toward the 80-hour weekly limit.** **(Detail)**
2137

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

2138
2139 **VI.F.4.c)** **A Review Committee may grant rotation-specific exceptions**
2140 **for up to 10 percent or a maximum of 88 clinical and**
2141 **educational work hours to individual programs based on a**
2142 **sound educational rationale.**
2143
2144 The Review Committee for Otolaryngology – Head and Neck
2145 Surgery will not consider requests for exceptions to the 80-hour
2146 limit to the residents' work week.
2147
2148 **VI.F.4.c).(1)** **In preparing a request for an exception, the program**
2149 **director must follow the clinical and educational work**
2150 **hour exception policy from the *ACGME Manual of***
2151 ***Policies and Procedures*.** **(Core)**
2152
2153 **VI.F.4.c).(2)** **Prior to submitting the request to the Review**
2154 **Committee, the program director must obtain approval**
2155 **from the Sponsoring Institution's GMEC and DIO.** **(Core)**
2156

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

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include rotations with alternate structures based on the nature of the specialty. DIO/GMEC approval is required before the request will be considered by the Review Committee.

2157
2158 **VI.F.5. Moonlighting**
2159
2160 **VI.F.5.a)** **Moonlighting must not interfere with the ability of the resident**
2161 **to achieve the goals and objectives of the educational**
2162 **program, and must not interfere with the resident's fitness for**
2163 **work nor compromise patient safety.** **(Core)**
2164
2165 **VI.F.5.b)** **Time spent by residents in internal and external moonlighting**
2166 **(as defined in the ACGME Glossary of Terms) must be**
2167 **counted toward the 80-hour maximum weekly limit.** **(Core)**
2168
2169 **VI.F.5.c)** **PGY-1 residents are not permitted to moonlight.** **(Core)**
2170

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).

2171
2172 **VI.F.6. In-House Night Float**
2173
2174 **Night float must occur within the context of the 80-hour and one-**
2175 **day-off-in-seven requirements.** **(Core)**
2176
2177 VI.F.6.a) Night float rotations cannot exceed two consecutive months in
2178 duration, and residents can have no more than three months of
2179 night float assignments per year. (Core)
2180
2181 VI.F.6.b) There must be at least two months between each night float
2182 rotation. (Core)
2183

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.

2184
2185 **VI.F.7. Maximum In-House On-Call Frequency**
2186
2187 **Residents must be scheduled for in-house call no more frequently**
2188 **than every third night (when averaged over a four-week period).** **(Core)**
2189 **VI.F.8. At-Home Call**
2190
2191 **VI.F.8.a)** **Time spent on patient care activities by residents on at-home**
2192 **call must count toward the 80-hour maximum weekly limit.**
2193 **The frequency of at-home call is not subject to the every-**
2194 **third-night limitation, but must satisfy the requirement for one**
2195 **day in seven free of clinical work and education, when**
2196 **averaged over four weeks.** **(Core)**
2197

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2198 **VI.F.8.a).(1)** **At-home call must not be so frequent or taxing as to**
2199 **preclude rest or reasonable personal time for each**
2200 **resident.** (Core)
2201
2202 **VI.F.8.b)** **Residents are permitted to return to the hospital while on at-**
2203 **home call to provide direct care for new or established**
2204 **patients. These hours of inpatient patient care must be**
2205 **included in the 80-hour maximum weekly limit.** (Detail)
2206

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

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

2207
2208 ***
2209 ***Core Requirements:** Statements that define structure, resource, or process elements
2210 essential to every graduate medical educational program.
2211
2212 †**Detail Requirements:** Statements that describe a specific structure, resource, or process, for
2213 achieving compliance with a Core Requirement. Programs and sponsoring institutions in
2214 substantial compliance with the Outcome Requirements may utilize alternative or innovative
2215 approaches to meet Core Requirements.
2216
2217 ‡**Outcome Requirements:** Statements that specify expected measurable or observable
2218 attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their
2219 graduate medical education.
2220
2221 **Osteopathic Recognition**
2222 For programs with or applying for Osteopathic Recognition, the Osteopathic Recognition
2223 Requirements also apply (www.acgme.org/OsteopathicRecognition).

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