Accreditation Council for
Graduate Medical Education

ACGME
Common Program Requirements (Residency)

ACGME approved major revision: June 10, 2018; effective: July 1, 2019

Common Program Requirements (Residency) Contents

Introduction 3
Int.A. Preamble 3
Int.B. Definition of Specialty 4
Int.C. Length of Educational Program 4
I. Oversight 4
I.A. Sponsoring Institution 4
I.B. Participating Sites 5
I.C. Recruitment 6
I.D. Resources 6
I.E. Other Learners and Other Care Providers 7
II. Personnel 8
II.A. Program Director 8
II.B. Faculty 14
II.C. Program Coordinator 17
II.D. Other Program Personnel 18
III. Resident Appointments 18
III.A. Eligibility Requirements 18
III.B. Number of Residents 22
III.C. Resident Transfers 22
IV. Educational Program 22
IV.A. Curriculum Components 23
IV.B. ACGME Competencies 24
IV.C. Curriculum Organization and Resident Experiences 29
IV.D. Scholarship 29
V. Evaluation 31
V.A. Resident Evaluation 31
V.B. Faculty Evaluation 35
V.C. Program Evaluation and Improvement 36
VI. The Learning and Working Environment 41
VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability 41
VI.B. Professionalism 46
VI.C. Well-Being 48
VI.D. Fatigue Mitigation 51
VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care 52
VI.F. Clinical Experience and Education 53

©2018 Accreditation Council for Graduate Medical Education (ACGME)

Common Program Requirements (Residency)

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.

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

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.

~~Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.~~

~~The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the~~

~~domains of clinical competency requires the resident physician to assume personal responsibility for the care of individual patients. For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept--graded and progressive responsibility--is one of the core tenets of American graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.~~

Int.B. Definition of Specialty

[The Review Committee must further specify]

Int.C. Length of Educational Program

[The Review Committee must further specify]

I. Oversight ~~Institutions~~

I.A. Sponsoring Institution

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

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

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.

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

~~One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating sites. (Core)*~~

©2018 Accreditation Council for Graduate Medical Education (ACGME)

~~The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program. (Core)~~

I.B. Participating Sites

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

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

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

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

I.B.2.a) The PLA ~~should~~ must:

I.B.2.a).(1) be renewed at least every ~~five~~ 10 years; and, (Core)

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

~~I.B.2.a).(3) identify the faculty who will assume both educational and supervisory responsibilities for residents; (Detail)~~

~~I.B.2.a).(4) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document; (Detail)~~

~~I.B.2.a).(5) specify the duration and content of the educational experience; and, (Detail)~~

~~I.B.2.a).(6) state the policies and procedures that will govern resident education during the assignment. (Detail)~~

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

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

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

142
143 I.B.4. The program director must submit any additions or deletions of
144 participating sites routinely providing an educational experience, required
145 for all residents, of one month full time equivalent (FTE) or more through
146 the ACGME's Accreditation Data System (ADS). (Core)
147
148 [The Review Committee may further specify][As further specified by the
149 Review Committee]
150
151 I.C. The program, in partnership with its Sponsoring Institution, must engage in
152 practices that focus on mission-driven, ongoing, systematic recruitment and
153 retention of a diverse and inclusive workforce of residents, fellows (if present),
154 faculty members, senior administrative staff members, and other relevant
155 members of its academic community. (Core)
156

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

157
158 I.D. Resources
159
160 I.D.1. The institution and the program must jointly ensure The program, in
161 partnership with its Sponsoring Institution, must ensure the availability of
162 adequate resources for resident education, as defined in the specialty
163 program requirements. (Core) [Moved here from II.D.]
164
165 [The Review Committee must further specify] [As further specified by the
166 Review Committee]
167
168 I.D.2. The program, in partnership with its Sponsoring Institution, must ensure
169 healthy and safe learning and working environments that promote
170 resident well-being and provide for: (Core)
171
172 I.D.2.a) access to food while on duty; (Core)
173

174 I.D.2.b) safe, quiet, clean, and private sleep/rest facilities available and
175 accessible for residents with proximity appropriate for safe patient
176 care; (Core)
177

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

178
179 I.D.2.c) clean and private facilities for lactation that have refrigeration
180 capabilities, with proximity appropriate for safe patient care; (Core)
181

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).

182
183 I.D.2.d) security and safety measures appropriate to the participating site;
184 and, (Core)
185
186 I.D.2.e) accommodations for residents with disabilities consistent with the
187 Sponsoring Institution's policy. (Core)
188
189 I.D.3. Medical Information Access
190
191 Residents must have ready access to specialty-specific and other
192 appropriate reference material in print or electronic format. This must
193 include access to electronic medical literature databases with full text
194 search capabilities should be available. (CoreDetail) [Moved here from II.E.]
195
196 I.D.4. The program's educational and clinical resources must be adequate to
197 support the number of residents appointed to the program. (Core) [Moved
198 here from III.B.]
199
200 [The Review Committee may further specify] [As further specified by the
201 Review Committee]
202
203 I.E. Appointment of Fellows and Other Learners
204
205 The presence of other learners and other care providers, (including, but not
206 limited to, residents from other specialties programs, subspecialty fellows, and
207 advanced practice providers ,PhD students, and nurse practitioners), in the
208 program must not interfere with enrich the appointed residents' education. (Core)
209 [Moved here from III.D.]

©2018 Accreditation Council for Graduate Medical Education (ACGME)

210
211 I.E.1. The program director must report circumstances when the presence of
212 other learners has interfered with the residents' education to the DIO and
213 Graduate Medical Education Committee (GMEC) in accordance with
214 Sponsoring Institution guidelines. (CoreDetail) [Moved here from III.D.1.]
215
216 [As further specified by the Review Committee]
217

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.

218
219 II. Program Personnel and Resources
220
221 II.A. Program Director
222
223 II.A.1. There must be one faculty member appointed as a single program
224 director with authority and accountability for the operation of the overall
225 program, including compliance with all applicable program requirements.
226 (Core)
227
228 II.A.1.a) The Sponsoring Institution's GMEC must approve a change in
229 program director. (Core)
230
231 II.A.1.a).(1) The program director must submit this change to the
232 ACGME via the ADS. (Core)
233
234 [As further specified by the Review Committee]
235
236 II.A.1.b) Final approval of the program director resides with the Review
237 Committee. (Core)
238

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.

239
240 II.A.1.c) The program must demonstrate retention of the program director
241 should continue in his or her position for a length of time adequate
242 to maintain continuity of leadership and program stability. (CoreDetail)
243
244 [The Review Committee may further specify]
245

©2018 Accreditation Council for Graduate Medical Education (ACGME)

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.

246
247 II.A.2. At a minimum, the program director must be provided with the salary
248 support required to devote 20 percent FTE (at least eight hours per week)
249 of non-clinical time to the administration of the program. (Core)
250
251 [The Review Committee may further specify]
252
253 [The Review Committee may further specify regarding support for
254 associate program director(s)]
255
256 II.A.3. Qualifications of the program director must include:
257
258 II.A.3.a) must include requisite specialty expertise and at least three years
259 of documented educational and/or administrative experience, or
260 qualifications acceptable to the Review Committee; (Core)
261

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.

262
263 II.A.3.b) must include current certification in the specialty for which they are
264 the program director by the American Board of _____ or by the
265 American Osteopathic Board of _____, or specialty qualifications
266 that are acceptable to the Review Committee; and, (Core)
267
268 [The Review Committee may further specify acceptable specialty
269 qualifications or that only ABMS and AOA certification will be
270 considered acceptable]
271
272 II.A.3.c) must include current medical licensure and appropriate medical
273 staff appointment; and, (Core)
274
275 [As further specified by the Review Committee]
276
277 II.A.3.d) must include ongoing clinical activity. (Core)

278

> 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.

279
280 [The Review Committee may further specify additional program director
281 qualifications] [As further specified by the Review Committee]
282
283 II.A.4. Program Director Responsibilities
284
285 The program director must have responsibility, authority, and
286 accountability for: administration and operations; teaching and scholarly
287 activity; resident recruitment and selection, evaluation, and promotion of
288 residents, and disciplinary action; supervision of residents; and resident
289 education in the context of patient care. (Core)
290
291 II.A.4.a) The program director must:
292
293 II.A.4.a).(1) be a role model of professionalism; (Core)
294

> 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.

295
296 II.A.4.a).(2) design and conduct the program in a fashion consistent
297 with the needs of the community, the mission(s) of the
298 Sponsoring Institution, and the mission(s) of the program;
299 (Core)
300

> 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.

301
302 II.A.4.a).(3) administer and maintain a learning an educational
303 environment conducive to educating the residents in each
304 of the ACGME Competency domains areas; (Core)
305

> 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.

306

©2018 Accreditation Council for Graduate Medical Education (ACGME)

307 II.A.4.a).(4) develop and oversee a process to evaluate candidates
308 prior to approval as program faculty members for
309 participation in the residency program education and at
310 least annually thereafter, as outlined in V.B.; (Core)
311
312 II.A.4.a).(5) have the authority to approve program faculty members for
313 participation in the residency program education at all
314 sites; approve the selection of program faculty as
315 appropriate; (Core)
316
317 II.A.4.a).(6) have the authority to remove program faculty members
318 from participation in the residency program education at all
319 sites; approve the continued participation of program
320 faculty based on evaluation; (Core)
321
322 II.A.4.a).(7) have the authority to remove residents from supervising
323 interactions and/or learning environments that do not meet
324 the standards of the program; (Core)
325

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.

326
327 II.A.4.a).(8) prepare and submit accurate and complete all information
328 required and requested by the DIO, GMEC, and ACGME;
329 (Core)
330
331 II.A.4.a).(8).(a) This includes but is not limited to the program
332 application forms and annual program updates to
333 the ADS, and ensure that the information submitted
334 is accurate and complete. (Core)
335
336 II.A.4.a).(9) provide applicants who are offered an interview with
337 information related to the applicant's eligibility for the
338 relevant specialty board examination(s); (Core)
339
340 II.A.4.a).(10) provide a learning and working environment in which
341 residents have the opportunity to raise concerns and
342 provide feedback in a confidential manner as appropriate,
343 without fear of intimidation or retaliation; (Core)
344
345 II.A.4.a).(11) ensure the program's compliance with the Sponsoring
346 Institution's policies and procedures related to grievances,
347 and due process procedures as set forth in the Institutional
348 Requirements and implemented by the sponsoring

349 ~~institution~~; (Core~~Detail~~)
350
351 II.A.4.a).(12) ensure the program's compliance with the Sponsoring
352 Institution's policies and procedures for due process when
353 action is taken to suspend or dismiss, not to promote, or
354 not to renew the appointment of a resident; (Core)
355

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.

356
357 II.A.4.a).(13) ensure the program's compliance with the Sponsoring
358 Institution's policies and procedures on employment and
359 non-discrimination; (Core)
360
361 II.A.4.a).(13).(a) Residents must not be required to sign a non-
362 competition guarantee or restrictive covenant. (Core)
363
364 II.A.4.a).(14) document verification of program completion for all
365 graduating residents within 30 days; (Core)
366
367 II.A.4.a).(15) provide verification of an individual resident's completion
368 upon the resident's request, within 30 days~~ residency~~
369 ~~education for all residents, including those who leave the~~
370 ~~program prior to completion~~; and, (Core~~Detail~~)
371

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.

372
373 II.A.4.a).(16) obtain review and approval of the Sponsoring Institution's
374 ~~GMEC/~~DIO before submitting information or requests to
375 the ACGME, as required in the Institutional Requirements
376 and outlined in the ACGME Program Director's Guide to
377 the Common Program Requirements~~, including~~. (Core)
378
379 ~~II.A.4.a).(16).(a) all applications for ACGME accreditation of new~~
380 ~~programs; (Detail)~~
381
382 ~~II.A.4.a).(16).(b) changes in resident complement; (Detail)~~
383
384 ~~II.A.4.a).(16).(c) major changes in program structure or length of~~
385 ~~training; (Detail)~~
386
387 ~~II.A.4.a).(16).(d) progress reports requested by the Review~~
388 ~~Committee; (Detail)~~
389

~~II.A.4.a).(16).(e) requests for increases or any change to resident duty hours; (Detail)~~

~~II.A.4.a).(16).(f) voluntary withdrawals of ACGME-accredited programs; (Detail)~~

~~II.A.4.a).(16).(g) requests for appeal of an adverse action; and, (Detail)~~

II.A.4.a).(16).(h) ~~appeal presentations to a Board of Appeal or the ACGME. (Detail)~~

~~II.A.4.a).(17) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program; (Core)~~

~~II.A.4.a).(18) approve a local director at each participating site who is accountable for resident education; (Core)~~

~~II.A.4.a).(19) evaluate program faculty; (Core)~~

II.A.4.a).(20) ~~monitor resident supervision at all participating sites; (Core)~~

~~II.A.4.a).(21) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, (Core)~~

~~and, to that end, must:~~

~~II.A.4.a).(21).(a) distribute these policies and procedures to the residents and faculty; (Detail)~~

~~II.A.4.a).(21).(b) monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements; (Core)~~

~~II.A.4.a).(21).(c) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and, (Detail)~~

~~II.A.4.a).(21).(d) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue. (Detail)~~

~~II.A.4.a).(22) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged; (Detail)~~

~~II.A.4.a).(23) comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of~~

©2018 Accreditation Council for Graduate Medical Education (ACGME)

441 residents, disciplinary action, and supervision of residents; (Detail)
442
443
444 II.A.4.a).(24) be familiar with and comply with ACGME and Review
445 Committee policies and procedures as outlined in the
446 ACGME Manual of Policies and Procedures; (Detail)
447
448 II.A.4.a).(25) obtain DIO review and co-signature on all program
449 application forms, as well as any correspondence or
450 document submitted to the ACGME that addresses: (Detail)
451
452 II.A.4.a).(25).(a) program citations, and/or, (Detail)
453
454 II.A.4.a).(25).(b) request for changes in the program that would have
455 significant impact, including financial, on the
456 program or institution. (Detail)
457
458 [As further specified by the Review Committee]
459
460 II.B. Faculty
461
462 *Faculty members are a foundational element of graduate medical education –*
463 *faculty members teach residents how to care for patients. Faculty members*
464 *provide an important bridge allowing residents to grow and become practice-*
465 *ready, ensuring that patients receive the highest quality of care. They are role*
466 *models for future generations of physicians by demonstrating compassion,*
467 *commitment to excellence in teaching and patient care, professionalism, and a*
468 *dedication to lifelong learning. Faculty members experience the pride and joy of*
469 *fostering the growth and development of future colleagues. The care they provide*
470 *is enhanced by the opportunity to teach. By employing a scholarly approach to*
471 *patient care, faculty members, through the graduate medical education system,*
472 *improve the health of the individual and the population.*
473
474 *Faculty members ensure that patients receive the level of care expected from a*
475 *specialist in the field. They recognize and respond to the needs of the patients,*
476 *residents, community, and institution. Faculty members provide appropriate*
477 *levels of supervision to promote patient safety. Faculty members create an*
478 *effective learning environment by acting in a professional manner and attending*
479 *to the well-being of the residents and themselves.*
480

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.

481
482 II.B.1. At each participating site, there must be a sufficient number of faculty
483 members with competence documented qualifications to instruct and
484 supervise all residents at that location. (Core)
485
486 [The Review Committee may further specify]
487
488 II.B.2. The Faculty members must:

489
490 II.B.2.a) be role models of professionalism; (Core)
491
492 II.B.2.b) demonstrate commitment to the delivery of safe, quality, cost-
493 effective, patient-centered care; (Core)
494

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.

495
496 II.B.2.c) demonstrate a strong interest in the education of residents; (Core)
497
498 II.B.2.d) devote sufficient time to the educational program to fulfill their
499 supervisory and teaching responsibilities; and to demonstrate a
500 strong interest in the education of residents; and, (Core)
501
502 II.B.2.e) administer and maintain an educational environment conducive to
503 educating residents in each of the ACGME competency areas.;
504 (Core)
505
506 II.B.2.f) The faculty must regularly participate in organized clinical
507 discussions, rounds, journal clubs, and conferences; and, (CoreDetail)
508
509 II.B.2.g) pursue faculty development designed to enhance their skills at
510 least annually: (Core)
511

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.

512
513 II.B.2.g).(1) as educators; (Core)
514
515 II.B.2.g).(2) in quality improvement and patient safety; (Core)
516
517 II.B.2.g).(3) in fostering their own and their residents' well-being; and,
518 (Core)
519
520 II.B.2.g).(4) in patient care based on their practice-based learning and
521 improvement efforts. (Core)
522

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

©2018 Accreditation Council for Graduate Medical Education (ACGME)

faculty members to serve as role models for residents in practice-based learning.

523
524 [The Review Committee may further specify additional faculty
525 responsibilities]
526
527 II.B.3. Faculty Qualifications
528
529 II.B.3.a) The Non-physician fFaculty members must have appropriate
530 qualifications in their field and hold appropriate institutional
531 appointments. (Core)
532
533 [The Review Committee may further specify]
534
535 II.B.3.b) The Physician faculty members must:
536
537 II.B.3.b).(1) have current certification in the specialty by the American
538 Board of _____ or the American Osteopathic Board of
539 _____, or possess qualifications judged acceptable to the
540 Review Committee. (Core)
541
542 II.B.3.b).(2) The physician faculty must possess current medical
543 licensure and appropriate medical staff appointment. (Core)
544
545 [The Review Committee may further specify additional
546 qualifications] [As further specified by the Review Committee]
547
548 II.B.3.c) Any non-physician faculty members who participate in residency
549 program education must be approved by the program director.
550 (Core)
551
552 [The Review Committee may further specify]
553

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.

554
555 II.B.4. Core Faculty
556
557 Core faculty members must have a significant role in the education and
558 supervision of residents and must devote a significant portion of their
559 entire effort to resident education and/or administration, and must, as a
560 component of their activities, teach, evaluate, and provide formative
561 feedback to residents. (Core)
562

©2018 Accreditation Council for Graduate Medical Education (ACGME)

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.

563
564 II.B.4.a) Core faculty members must be designated by the program
565 director. (Core)
566
567 II.B.4.b) Core faculty members must complete the annual ACGME Faculty
568 Survey. (Core)
569
570 [The Review Committee must specify the minimum number of core faculty
571 and/or the core faculty-resident ratio]
572
573 II.B.5. ~~The faculty must establish and maintain an environment of inquiry and~~
574 ~~scholarship with an active research component. (Core)~~
575
576 II.B.5.a) ~~Some members of the faculty should also demonstrate~~
577 ~~scholarship by one or more of the following:~~
578
579 ~~II.B.5.a).(1) peer-reviewed funding; (Detail)~~
580
581 ~~II.B.5.a).(2) publication of original research or review articles in peer~~
582 ~~reviewed journals, or chapters in textbooks; (Detail)~~
583
584 ~~II.B.5.a).(3) publication or presentation of case reports or clinical series~~
585 ~~at local, regional, or national professional and scientific~~
586 ~~society meetings; or, (Detail)~~
587
588 ~~II.B.5.a).(4) participation in national committees or educational~~
589 ~~organizations. (Detail)~~
590
591 II.B.6. ~~Faculty should encourage and support residents in scholarly activities.~~
592 ~~(Core)~~
593
594 ~~[As further specified by the Review Committee]~~
595
596 [The Review Committee may specify requirements specific to associate
597 program director(s)]
598
599 II.C. Program Coordinator
600
601 II.C.1. There must be a program coordinator. (Core)
602
603 II.C.2. At a minimum, the program coordinator must be supported at 50 percent
604 FTE (at least 20 hours per week) for administrative time. (Core)
605
606 [The Review Committee may further specify]
607

©2018 Accreditation Council for Graduate Medical Education (ACGME)

Background and Intent: 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.

608
609 II.D. Other Program Personnel
610
611 The ~~institution and the~~ program, in partnership with its Sponsoring Institution,
612 must jointly ensure the availability of ~~all~~ necessary ~~professional, technical, and~~
613 ~~clerical~~ personnel for the effective administration of the program. (Core)
614
615 [The Review Committee may further specify] ~~[As further specified by the Review~~
616 ~~Committee]~~
617

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.

618
619 III. Resident Appointments
620
621 III.A. Eligibility ~~Criteria~~ Requirements
622
623 III.A.1. ~~The program director must comply with the criteria for resident eligibility~~
624 ~~as specified in the Institutional Requirements. (Core)~~ An applicant must
625 meet one of the following qualifications to be eligible for appointment to
626 an ACGME-accredited program: (Core)
627
628 III.A.1.a) graduation from a medical school in the United States or Canada,
629 accredited by the Liaison Committee on Medical Education
630 (LCME) or graduation from a college of osteopathic medicine in
631 the United States, accredited by the American Osteopathic
632 Association Commission on Osteopathic College Accreditation
633 (AOACOCA); or, (Core)
634

©2018 Accreditation Council for Graduate Medical Education (ACGME)

635 III.A.1.b) graduation from a medical school outside of the United States or
636 Canada, and meeting one of the following additional qualifications:
637 (Core)
638
639 III.A.1.b).(1) holding a currently valid certificate from the Educational
640 Commission for Foreign Medical Graduates (ECFMG) prior
641 to appointment; or, (Core)
642
643 III.A.1.b).(2) holding a full and unrestricted license to practice medicine
644 in the United States licensing jurisdiction in which the
645 ACGME-accredited program is located. (Core)
646
647 III.A.2. All prerequisite post-graduate clinical education required for initial entry or
648 transfer into ACGME-accredited residency programs must be completed
649 in ACGME-accredited residency programs, AOA-approved residency
650 programs, ~~or in~~ Royal College of Physicians and Surgeons of Canada
651 (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-
652 accredited residency programs located in Canada, or in residency
653 programs with ACGME International (ACGME-I) Advanced Specialty
654 Accreditation. (Core)
655
656 III.A.2.a) Residency programs must receive verification of each ~~applicant's~~
657 resident's level of competency in the required clinical field using
658 ACGME, CanMEDS, or ACGME-I Milestones evaluations
659 ~~assessments~~ from the prior training program upon matriculation.
660 (Core)
661
662 [The Review Committee may further specify prerequisite
663 postgraduate clinical education]
664

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.

665
666 III.A.3. A physician who has completed a residency program that was not
667 accredited by ACGME, AOA, RCPSC, CFPC, or ACGME-I (with
668 Advanced Specialty Accreditation) may enter an ACGME-accredited
669 residency program in the same specialty at the PGY-1 level and, at the
670 discretion of the program director of the ACGME-accredited program and
671 with approval by the GMEC, may be advanced to the PGY-2 level based
672 on ACGME Milestones evaluations ~~assessments~~ at the ACGME-
673 accredited program. This provision applies only to entry into residency in
674 those specialties for which an initial clinical year is not required for entry.
675 (Core)
676
677 III.A.4. Resident Eligibility Exception
678
679 The Review Committee for _______ will allow the following exception to
680 the resident eligibility requirements: (Core)

©2018 Accreditation Council for Graduate Medical Education (ACGME)

681
682 [Note: A Review Committee may permit the eligibility exception if the
683 specialty requires completion of a prerequisite residency program prior to
684 admission. If this language is not applicable, this section will not appear in
685 the specialty-specific requirements.]
686
687 III.A.4.a) An ACGME-accredited residency program may accept an
688 exceptionally qualified international graduate applicant who does
689 not satisfy the eligibility requirements listed in III.A.1.-III.A.3., but
690 who does meet all of the following additional qualifications and
691 conditions: (Core)
692
693 III.A.4.a).(1) evaluation by the program director and residency selection
694 committee of the applicant's suitability to enter the
695 program, based on prior training and review of the
696 summative evaluations of this training; and, (Core)
697
698 III.A.4.a).(2) review and approval of the applicant's exceptional
699 qualifications by the GMEC; and, (Core)
700
701 III.A.4.a).(3) verification of Educational Commission for Foreign Medical
702 Graduates (ECFMG) certification. (Core)
703
704 III.A.4.b) Applicants accepted through this exception must have an
705 evaluation of their performance by the Clinical Competency
706 Committee within 12 weeks of matriculation. (Core)
707
708 III.A.4.c) ~~A Review Committee may grant the exception to the eligibility~~
709 ~~requirements specified in Section III.A.2.b) for residency programs~~
710 ~~that require completion of a prerequisite residency program prior~~
711 ~~to admission. (Core)~~
712
713 III.A.4.d) ~~Review Committees will grant no other exceptions to these~~
714 ~~eligibility requirements for residency education. (Core)~~
715
716 III.A.5. ~~Eligibility Requirements – Fellowship Programs~~ [Section moved to
717 Common Program Requirements (Fellowship)]
718
719 ~~All required clinical education for entry into ACGME-accredited fellowship~~
720 ~~programs must be completed in an ACGME-accredited residency~~
721 ~~program, or in an RCPSC-accredited or CFPC- accredited residency~~
722 ~~program located in Canada. (Core)~~
723
724 III.A.5.a) ~~Fellowship programs must receive verification of each entering~~
725 ~~fellow's level of competency in the required field using ACGME or~~
726 ~~CanMEDS Milestones assessments from the core residency~~
727 ~~program. (Core)~~
728
729 III.A.5.b) ~~Fellow Eligibility Exception~~
730
731 ~~A Review Committee may grant the following exception to the~~

732 fellowship eligibility requirements:
733
734 An ACGME-accredited fellowship program may accept an
735 exceptionally qualified applicant**, who does not satisfy the
736 eligibility requirements listed in Sections III.A.2. and III.A.2.a), but
737 who does meet all of the following additional qualifications and
738 conditions: (Core)
739
740 III.A.5.c) Assessment by the program director and fellowship selection
741 committee of the applicant's suitability to enter the program, based
742 on prior training and review of the summative evaluations of
743 training in the core specialty; and (Core)
744
745 III.A.5.c).(1) Review and approval of the applicant's exceptional
746 qualifications by the GMEC or a subcommittee of the
747 GMEC; and (Core)
748
749 III.A.5.c).(2) Satisfactory completion of the United States Medical
750 Licensing Examination (USMLE) Steps 1, 2, and, if the
751 applicant is eligible, 3, and; (Core)
752
753 III.A.5.c).(3) For an international graduate, verification of Educational
754 Commission for Foreign Medical Graduates (ECFMG)
755 certification; and, (Core)
756
757 III.A.5.c).(4) Applicants accepted by this exception must complete
758 fellowship Milestones evaluation (for the purposes of
759 establishment of baseline performance by the Clinical
760 Competency Committee), conducted by the receiving
761 fellowship program within six weeks of matriculation. This
762 evaluation may be waived for an applicant who has
763 completed an ACGME International-accredited residency
764 based on the applicant's Milestones evaluation conducted
765 at the conclusion of the residency program. (Core)
766
767 III.A.5.c).(4).(a) If the trainee does not meet the expected level of
768 Milestones competency following entry into the
769 fellowship program, the trainee must undergo a
770 period of remediation, overseen by the Clinical
771 Competency Committee and monitored by the
772 GMEC or a subcommittee of the GMEC. This
773 period of remediation must not count toward time in
774 fellowship training. (Core)
775
776 ** An exceptionally qualified applicant has (1) completed a non-
777 ACGME-accredited residency program in the core specialty, and
778 (2) demonstrated clinical excellence, in comparison to peers,
779 throughout training. Additional evidence of exceptional
780 qualifications is required, which may include one of the following:
781 (a) participation in additional clinical or research training in the
782 specialty or subspecialty; (b) demonstrated scholarship in the

~~specialty or subspecialty; (c) demonstrated leadership during or after residency training; (d) completion of an ACGME-International-accredited residency program.~~

~~[Each Review Committee will decide no later than December 31, 2013 whether the exception specified above will be permitted. If the Review Committee will not allow this exception, the program requirements will include the following statement]:~~

III.A.5.d) ~~The Review Committee for _____ does not allow exceptions to the Eligibility Requirements for Fellowship Programs in Section III.A.2.~~ ~~(Core)~~

III.B. ~~Number of Residents~~

The program director must ~~may~~ not appoint more residents than approved by the Review Committee~~, unless otherwise stated in the specialty-specific requirements~~. (Core)

III.B.1. All complement increases must be approved by the Review Committee. (Core)

[The Review Committee may further specify minimum complement numbers] ~~[As further specified by the Review Committee]~~

III.C. Resident Transfers

~~Before accepting a resident who is transferring from another program,~~ The program ~~director~~ must obtain ~~written or electronic~~ verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring resident, and Milestones evaluations upon matriculation. (Core~~Detail~~)

[The Review Committee may further specify]

III.C.1. ~~A program director must provide timely verification of residency education and summative performance evaluations for residents who may leave the program prior to completion.~~ ~~(Detail)~~

IV. Educational Program

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

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

In addition, the program is expected to define its specific program aims consistent with the overall mission of its Sponsoring Institution, the needs of the community it serves and that its graduates will serve, and the distinctive capabilities of physicians it intends to graduate. While programs must demonstrate substantial compliance with the Common

©2018 Accreditation Council for Graduate Medical Education (ACGME)

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

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

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

IV.A.1.a) The program's aims must be made ~~Overall educational goals for the program, which the program must make~~ available to program applicants, residents, and faculty members. (Core)

IV.A.2. competency-based goals and objectives for each ~~assignment at each~~ educational ~~level~~ experience designed to promote progress on a trajectory to autonomous practice.~~, which the program must distribute~~ These must be distributed, reviewed, and available to residents and faculty members ~~at least annually, in either written or electronic form~~; (Core)

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

IV.A.3. delineation of resident responsibilities for patient care, progressive responsibility for patient management, and graded supervision;~~ of residents over the continuum of the program; and,~~ (Core)

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

IV.A.4. a broad range of structured didactic activities~~ regularly scheduled didactic sessions~~; (Core)

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

> Background and Intent: It is intended that residents will participate in structured didactic activities. It is recognized that there may be circumstances in which this is not possible. Programs should define core didactic activities for which time is protected and the circumstances in which residents may be excused from these didactic activities. Didactic activities may include, but are not limited to, lectures, conferences, courses, labs,

©2018 Accreditation Council for Graduate Medical Education (ACGME)

asynchronous learning, simulations, drills, case discussions, grand rounds, didactic teaching, and education in critical appraisal of medical evidence.

868
869 IV.A.5. advancement of residents' knowledge of ethical principles foundational to
870 medical professionalism; and, (Core)
871
872 IV.A.6. advancement in The curriculum must advance the residents' knowledge
873 of the basic principles of research scientific inquiry, including how
874 research is designed, conducted, evaluated, explained to patients, and
875 applied to patient care. (Core) [Moved here from IV.B.1.]
876
877 IV.B. ACGME Competencies
878

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.

879
880 IV.B.1. The program must integrate the following ACGME Competencies into the
881 curriculum: (Core)
882
883 IV.B.1.a) Professionalism
884
885 Residents must demonstrate a commitment to carrying out
886 professional responsibilities professionalism and an adherence to
887 ethical principles. (OutcomeCore)
888
889 IV.B.1.a).(1) Residents must are expected to demonstrate competence
890 in:
891
892 IV.B.1.a).(1).(a) compassion, integrity, and respect for others;
893 (OutcomeCore)
894
895 IV.B.1.a).(1).(b) responsiveness to patient needs that supersedes
896 self-interest; (OutcomeCore)
897

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.

898
899 IV.B.1.a).(1).(c) respect for patient privacy and autonomy;
900 (OutcomeCore)
901
902 IV.B.1.a).(1).(d) accountability to patients, society, and the
903 profession; (OutcomeCore)
904
905 IV.B.1.a).(1).(e) respect sensitivity and responsiveness to diverse

©2018 Accreditation Council for Graduate Medical Education (ACGME)

906 patient populations, including but not limited to
907 diversity in gender, age, culture, race, religion,
908 disabilities, national origin, socioeconomic status,
909 and sexual orientation; (~~Outcome~~Core)
910
911 IV.B.1.a).(1).(f) ability to recognize and develop a plan for one's
912 own personal and professional well-being; and,
913 (Core)
914
915 IV.B.1.a).(1).(g) appropriately disclosing and addressing conflict or
916 duality of interest. (Core)
917
918 ~~[As further specified by the Review Committee]~~
919
920 IV.B.1.b) Patient Care and Procedural Skills
921

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.

922
923 IV.B.1.b).(1) Residents must be able to provide patient care that is
924 compassionate, appropriate, and effective for the treatment
925 of health problems and the promotion of health. ~~Residents:~~
926 (~~Outcome~~Core)
927
928 [The Review Committee must further specify] ~~[As further~~
929 ~~specified by the Review Committee]~~
930
931 IV.B.1.b).(2) Residents must be able to ~~competently~~ perform all
932 medical, diagnostic, and surgical procedures considered
933 essential for the area of practice. ~~Residents:~~ (~~Outcome~~Core)
934
935 [The Review Committee may further specify] ~~[As further~~
936 ~~specified by the Review Committee]~~
937
938 IV.B.1.c) Medical Knowledge
939
940 Residents must demonstrate knowledge of established and
941 evolving biomedical, clinical, epidemiological and social-
942 behavioral sciences, as well as the application of this knowledge
943 to patient care. ~~Residents:~~ (~~Outcome~~Core)
944
945 [The Review Committee must further specify] ~~[As further specified~~

946 by the Review Committee]
947
948 IV.B.1.d) Practice-based Learning and Improvement
949
950 Residents must demonstrate the ability to investigate and evaluate
951 their care of patients, to appraise and assimilate scientific
952 evidence, and to continuously improve patient care based on
953 constant self-evaluation and lifelong learning. (OutcomeCore)
954

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.

955
956 IV.B.1.d).(1) Residents must demonstrate competence in are expected
957 to develop skills and habits to be able to meet the following
958 goals:
959
960 IV.B.1.d).(1).(a) identifying identify strengths, deficiencies, and limits
961 in one's knowledge and expertise; (OutcomeCore)
962
963 IV.B.1.d).(1).(b) setting set learning and improvement goals;
964 (OutcomeCore)
965
966 IV.B.1.d).(1).(c) identifying identify and performing perform
967 appropriate learning activities; (OutcomeCore)
968
969 IV.B.1.d).(1).(d) systematically analyzing analyze practice using
970 quality improvement methods, and implementing
971 implement changes with the goal of practice
972 improvement; (OutcomeCore)
973
974 IV.B.1.d).(1).(e) incorporating incorporate feedback and formative
975 evaluation feedback into daily practice; (OutcomeCore)
976
977 IV.B.1.d).(1).(f) locating, appraising, and assimilating locate,
978 appraise, and assimilate evidence from scientific
979 studies related to their patients' health problems;
980 and, (OutcomeCore)
981
982 IV.B.1.d).(1).(g) using use information technology to optimize
983 learning. (OutcomeCore)
984
985 IV.B.1.d).(1).(h) participate in the education of patients, families,
986 students, residents and other health professionals.
987 (Outcome)
988
989 [The Review Committee may further specify by adding to the list of

990 sub-competencies] ~~[As further specified by the Review~~
991 ~~Committee]~~
992
993 IV.B.1.e) Interpersonal and Communication Skills
994
995 Residents must demonstrate interpersonal and communication
996 skills that result in the effective exchange of information and
997 collaboration with patients, their families, and health professionals.
998 (~~Outcome~~Core)
999
1000 IV.B.1.e).(1) Residents must demonstrate competence in ~~are expected~~
1001 ~~to~~:
1002
1003 IV.B.1.e).(1).(a) communicating ~~communicate~~ effectively with
1004 patients, families, and the public, as appropriate,
1005 across a broad range of socioeconomic and cultural
1006 backgrounds; (~~Outcome~~Core)
1007
1008 IV.B.1.e).(1).(b) communicating ~~communicate~~ effectively with
1009 physicians, other health professionals, and health-
1010 related agencies; (~~Outcome~~Core)
1011
1012 IV.B.1.e).(1).(c) working ~~work~~ effectively as a member or leader of a
1013 health care team or other professional group;
1014 (~~Outcome~~Core)
1015
1016 IV.B.1.e).(1).(d) educating patients, families, students, residents,
1017 and other health professionals; (Core)
1018
1019 IV.B.1.e).(1).(e) acting ~~act~~ in a consultative role to other physicians
1020 and health professionals; and, (~~Outcome~~Core)
1021
1022 IV.B.1.e).(1).(f) maintaining ~~maintain~~ comprehensive, timely, and
1023 legible medical records, if applicable. (~~Outcome~~Core)
1024
1025 IV.B.1.e).(2) Residents must learn to communicate with patients and
1026 families to partner with them to assess their care goals,
1027 including, when appropriate, end-of-life goals. (Core)
1028
1029 [The Review Committee may further specify by adding to the list of
1030 sub-competencies] ~~[As further specified by the Review~~
1031 ~~Committee]~~
1032

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.

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

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 ~~in the system~~ to provide optimal health care. (~~Outcome~~Core)

IV.B.1.f).(1) Residents must demonstrate competence in ~~are expected to~~:

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

> 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.

IV.B.1.f).(1).(b) coordinating ~~coordinate~~ patient care across ~~within~~ the health care ~~systems~~ continuum and beyond as relevant to their clinical specialty; (~~Outcome~~Core)

> 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.

IV.B.1.f).(1).(c) advocating ~~advocate~~ for quality patient care and optimal patient care systems; (~~Outcome~~Core)

IV.B.1.f).(1).(d) working ~~work~~ in interprofessional teams to enhance patient safety and improve patient care quality; (~~Outcome~~Core)

IV.B.1.f).(1).(e) participating ~~participate~~ in identifying system errors and implementing potential systems solutions; (~~Outcome~~Core)

IV.B.1.f).(1).(f) incorporating ~~incorporate~~ considerations of value, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate; and, (~~Outcome~~Core)

IV.B.1.f).(1).(g) understanding health care finances and its impact on individual patients' health decisions. (Core)

©2018 Accreditation Council for Graduate Medical Education (ACGME)

1074 IV.B.1.f).(2) Residents must learn to advocate for patients within the health care system to achieve the patient's and family's care goals, including, when appropriate, end-of-life goals. (Core)

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

IV.C. Curriculum Organization and Resident Experiences

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

[The Review Committee must further specify]

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.

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

[The Review Committee may further specify]

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

IV.D. Scholarship

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

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

IV.D.1. Program Responsibilities

©2018 Accreditation Council for Graduate Medical Education (ACGME)

1119 IV.D.1.a) The program must demonstrate evidence of scholarly activities
1120 consistent with its mission(s) and aims. (Core)
1121
1122 IV.D.1.b) The ~~sponsoring institution and~~ program, in partnership with its
1123 Sponsoring Institution, must ~~should~~ allocate adequate ~~educational~~
1124 resources to facilitate resident and faculty involvement in scholarly
1125 activities. (Core~~Detail~~)
1126
1127 [The Review Committee may further specify] ~~[As further specified~~
1128 ~~by the Review Committee]~~
1129
1130 IV.D.1.c) The program must advance residents' knowledge and practice of
1131 the scholarly approach to evidence-based patient care. (Core)
1132

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

Elements of a scholarly approach to patient care include:

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

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

1133
1134 IV.D.2. Faculty Scholarly Activity
1135
1136 IV.D.2.a) Among their scholarly activity, programs must demonstrate
1137 accomplishments in at least three of the following domains: (Core)
1138
1139 - Research in basic science, education, translational
1140 science, patient care, or population health
1141 - Peer-reviewed grants
1142 - Quality improvement and/or patient safety initiatives
1143 - Systematic reviews, meta-analyses, review articles,
1144 chapters in medical textbooks, or case reports
1145 - Creation of curricula, evaluation tools, didactic educational
1146 activities, or electronic educational materials
1147 - Contribution to professional committees, educational
1148 organizations, or editorial boards

©2018 Accreditation Council for Graduate Medical Education (ACGME)

1149 • Innovations in education
1150
1151 IV.D.2.b) The program must demonstrate dissemination of scholarly activity
1152 within and external to the program by the following methods:
1153
1154 [Review Committee will choose to require either IV.D.2.b).(1) or
1155 both IV.D.2.b).(1) and IV.D.2.b).(2)]
1156

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.

1157
1158 IV.D.2.b).(1) faculty participation in grand rounds, posters, workshops,
1159 quality improvement presentations, podium presentations,
1160 grant leadership, non-peer-reviewed print/electronic
1161 resources, articles or publications, book chapters,
1162 textbooks, webinars, service on professional committees,
1163 or serving as a journal reviewer, journal editorial board
1164 member, or editor; (Outcome)‡
1165
1166 IV.D.2.b).(2) peer-reviewed publication. (Outcome)
1167
1168 IV.D.3. Residents~~'~~ Scholarly Activity
1169
1170 IV.D.3.a) Residents must ~~should~~ participate in scholarship ~~scholarly activity~~.
1171 (Core)
1172
1173 [The Review Committee may further specify] ~~[As further specified~~
1174 ~~by the Review Committee]~~
1175
1176 V. Evaluation
1177
1178 V.A. Resident Evaluation
1179
1180 V.A.1. Feedback and Evaluation ~~Formative Evaluation~~
1181

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

©2018 Accreditation Council for Graduate Medical Education (ACGME)

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.

1182
1183 V.A.1.a) Faculty members must directly observe, evaluate, and frequently
1184 provide feedback on resident performance during each rotation or
1185 similar educational assignment. ~~The faculty must evaluate~~
1186 ~~resident performance in a timely manner during each rotation or~~
1187 ~~similar educational assignment, and document this evaluation at~~
1188 ~~completion of the assignment.~~ (Core)
1189

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.

1190
1191 V.A.1.b) Evaluation must be documented at the completion of the
1192 assignment. (Core)
1193
1194 V.A.1.b).(1) For block rotations of greater than three months in
1195 duration, evaluation must be documented at least every
1196 three months. (Core)
1197
1198 V.A.1.b).(2) Longitudinal experiences, such as continuity clinic in the
1199 context of other clinical responsibilities, must be evaluated
1200 at least every three months and at completion. (Core)
1201
1202 V.A.1.c) The program must provide an objective ~~assessments~~ performance
1203 evaluation based on the Competencies and ~~of competence in~~
1204 ~~patient care and procedural skills, medical knowledge, practice-~~
1205 ~~based learning and improvement, interpersonal and~~
1206 ~~communication skills, professionalism, and systems-based~~
1207 ~~practice based on~~ the specialty-specific Milestones, and must:

©2018 Accreditation Council for Graduate Medical Education (ACGME)

1208 (Core)

1209

1210 V.A.1.c).(1) use multiple evaluators (e.g., faculty members, peers,
1211 patients, self, and other professional staff members); and,
1212 (~~Detail~~Core)

1213

1214 V.A.1.c).(2) provide that information to the Clinical Competency
1215 Committee for its synthesis of progressive resident
1216 performance and improvement toward unsupervised
1217 practice. (Core)

1218

1219 ~~V.A.1.c).(3) document progressive resident performance improvement~~
1220 ~~appropriate to educational level; and, (Core)~~

1221

1222 ~~V.A.1.c).(4) provide each resident with documented semiannual~~
1223 ~~evaluation of performance with feedback. (Core)~~

1224

1225 V.A.1.d) The program director or their designee, with input from the Clinical
1226 Competency Committee, must:

1227

1228 V.A.1.d).(1) meet with and review with each resident their documented
1229 semi-annual evaluation of performance, including progress
1230 along the specialty-specific Milestones; (Core)

1231

1232 V.A.1.d).(2) assist residents in developing individualized learning plans
1233 to capitalize on their strengths and identify areas for
1234 growth; and, (Core)

1235

1236 V.A.1.d).(3) develop plans for residents failing to progress, following
1237 institutional policies and procedures. (Core)

1238

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.

1239

1240 V.A.1.e) At least annually, there must be a summative evaluation of each
1241 resident that includes their readiness to progress to the next year
1242 of the program, if applicable. (Core)

1243

©2018 Accreditation Council for Graduate Medical Education (ACGME)

V.A.1.f) The evaluations of a resident's performance must be accessible for review by the resident~~, in accordance with institutional policy~~. (Core~~Detail~~)

[The Review Committee may further specify under any requirement in V.A.1.-V.A.1.f)]

V.A.2. Final ~~Summative~~ Evaluation

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

V.A.2.a).(1) The specialty-specific Milestones, and when applicable the specialty-specific Case Logs, must be used as ~~one of the~~ tools to ensure residents are able to engage in autonomous practice ~~core professional activities without supervision~~ upon completion of the program. (Core)

V.A.2.a).(2) The final ~~this~~ evaluation must:

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~~Detail~~)

V.A.2.a).(2).(b) verify that the resident has demonstrated ~~sufficient competence~~ the knowledge, skills, and behaviors necessary to enter autonomous practice~~ without direct supervision~~; (Core~~Detail~~)

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

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

~~V.A.2.a).(2).(e) document the resident's performance during the final period of education. (Detail)~~

V.A.3. A Clinical Competency Committee must be appointed by the program director. ~~The program director must appoint the Clinical Competency Committee.~~ (Core)

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

V.A.3.a).(1) ~~The program director may appoint additional members of the Clinical Competency Committee. These~~ Additional members must be faculty members from the same program or other programs, or other health professionals

1295 who have extensive contact and experience with the
1296 program's residents in patient care and other health care
1297 settings. (Core)
1298

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.

1299
1300 V.A.3.a).(2) Chief residents who have completed core residency
1301 programs in their specialty and are eligible for specialty
1302 board certification may be members of the Clinical
1303 Competency Committee. (Core)
1304
1305 V.A.3.b) There must be a written description of the responsibilities of the
1306 Clinical Competency Committee. (Core) The Clinical Competency
1307 Committee should must:
1308
1309 V.A.3.b).(1) review all resident evaluations at least semi-annually; (Core)
1310
1311 V.A.3.b).(2) determine each resident's progress on achievement of the
1312 specialty-specific Milestones prepare and ensure the
1313 reporting of Milestones evaluations of each resident semi-
1314 annually to ACGME; and, (Core)
1315
1316 V.A.3.b).(3) meet prior to the residents' semi-annual evaluations and
1317 advise the program director regarding each resident's
1318 progress, including promotion, remediation, and dismissal.
1319 (CoreDetail)
1320
1321 V.B. Faculty Evaluation
1322
1323 V.B.1. At least annually, tThe program must have a process to evaluate each
1324 faculty member's performance as it relates to the educational program at
1325 least annually. (Core)
1326

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

©2018 Accreditation Council for Graduate Medical Education (ACGME)

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.

1327
1328 V.B.1.a) This evaluation must These evaluations should include a review of
1329 the faculty member's clinical teaching abilities, engagement with
1330 commitment to the educational program, participation in faculty
1331 development related to their skills as an educator, clinical
1332 performance knowledge, professionalism, and scholarly activities.
1333 (CoreDetail)
1334
1335 V.B.1.b) This evaluation must include at least annual written, anonymous,
1336 and confidential evaluations by the residents. (CoreDetail)
1337
1338 V.B.2. Faculty members must receive feedback on their evaluations at least
1339 annually. (Core)
1340
1341 V.B.3. Results of the faculty educational evaluations should be incorporated into
1342 program-wide faculty development plans. (Core)
1343

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.

1344
1345 V.C. Program Evaluation and Improvement
1346
1347 V.C.1. The program director must appoint the Program Evaluation Committee to
1348 conduct and document the Annual Program Evaluation as part of the
1349 program's continuous improvement process. (Core)
1350
1351 V.C.1.a) The Program Evaluation Committee must be composed of at least
1352 two program faculty members, at least one of whom is a core
1353 faculty member, and should include at least one resident. (Core)
1354
1355 V.C.1.b) Program Evaluation Committee must have a written description of
1356 its responsibilities must include:
1357
1358 V.C.1.b).(1) acting as an advisor to the program director, through

©2018 Accreditation Council for Graduate Medical Education (ACGME)

1359 program oversight; (Core)
1360
1361 V.C.1.b).(2) review of the program's self-determined goals and
1362 progress toward meeting them; (Core)
1363
1364 V.C.1.b).(3) guiding ongoing program improvement, including
1365 development of new goals, based upon outcomes; and,
1366 (Core)
1367
1368 V.C.1.b).(4) review of the current operating environment to identify
1369 strengths, challenges, opportunities, and threats as related
1370 to the program's mission and aims. (Core)
1371
1372 ~~V.C.1.b).(5) should participate actively in:~~
1373
1374 ~~V.C.1.b).(5).(a) planning, developing, implementing, and evaluating~~
1375 ~~educational activities of the program; (Detail)~~
1376
1377 ~~V.C.1.b).(5).(b) reviewing and making recommendations for~~
1378 ~~revision of competency-based curriculum goals and~~
1379 ~~objectives; and, (Detail)~~
1380
1381 ~~V.C.1.b).(5).(c) addressing areas of non-compliance with ACGME~~
1382 ~~standards; and, (Detail)~~
1383
1384 V.C.1.b).(5).(d) ~~reviewing the program annually using evaluations~~
1385 ~~of faculty, residents, and others, as specified below.~~
1386 ~~(Detail)~~
1387
1388 V.C.1.b).(6) ~~The program, through the PEC, must document formal,~~
1389 ~~systematic evaluation of the curriculum at least annually,~~
1390 ~~and is responsible for rendering a written, annual program~~
1391 ~~evaluation. (Core)~~
1392

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.

1393
1394 V.C.1.c) The Program Evaluation Committee should consider the following
1395 elements in its assessment of the program~~The program must~~
1396 ~~monitor and track each of the following areas~~:
1397
1398 V.C.1.c).(1) curriculum; (Core)
1399
1400 V.C.1.c).(2) outcomes from prior Annual Program Evaluation(s); (Core)
1401
1402 V.C.1.c).(3) ACGME letters of notification, including citations, Areas for
1403 Improvement, and comments; (Core)

©2018 Accreditation Council for Graduate Medical Education (ACGME)

1404
1405 V.C.1.c).(4) quality and safety of patient care; (Core)
1406
1407 V.C.1.c).(5) aggregate resident and faculty:
1408
1409 V.C.1.c).(5).(a) well-being; (Core)
1410
1411 V.C.1.c).(5).(b) recruitment and retention; (Core)
1412
1413 V.C.1.c).(5).(c) workforce diversity; (Core)
1414
1415 V.C.1.c).(5).(d) engagement in quality improvement and patient
1416 safety; (Core)
1417
1418 V.C.1.c).(5).(e) scholarly activity; (Core)
1419
1420 V.C.1.c).(5).(f) ACGME Resident and Faculty Surveys; and, (Core)
1421
1422 V.C.1.c).(5).(g) written evaluations of the program. (Core)
1423
1424 V.C.1.c).(6) aggregate resident:
1425
1426 V.C.1.c).(6).(a) achievement of the Milestones; (Core)
1427
1428 V.C.1.c).(6).(b) in-training examinations (where applicable); (Core)
1429
1430 V.C.1.c).(6).(c) board pass and certification rates~~graduate~~
1431 ~~performance, including performance of program~~
1432 ~~graduates on the certification examination~~; and,
1433 (Core)
1434
1435 V.C.1.c).(6).(d) graduate ~~resident~~ performance. (Core)
1436
1437 V.C.1.c).(7) aggregate faculty:
1438
1439 V.C.1.c).(7).(a) evaluation; and, (Core)
1440
1441 V.C.1.c).(7).(b) professional ~~faculty~~ development. (Core)
1442
1443 ~~V.C.1.c).(8) program quality; and, (Core)~~
1444
1445 ~~V.C.1.c).(8).(a) Residents and faculty must have the opportunity to~~
1446 ~~evaluate the program confidentially and in writing at~~
1447 ~~least annually, and (Detail)~~
1448
1449 ~~V.C.1.c).(8).(b) The program must use the results of residents' and~~
1450 ~~faculty members' assessments of the program~~
1451 ~~together with other program evaluation results to~~
1452 ~~improve the program. (Detail)~~
1453
1454 ~~V.C.1.c).(9) progress on the previous year's action plan(s). (Core)~~

©2018 Accreditation Council for Graduate Medical Education (ACGME)

1455
1456 V.C.1.d) The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)

1460 V.C.1.e) The annual review, including the action plan, must:

1462 V.C.1.e).(1) be distributed to and discussed with the members of the teaching faculty and the residents; and, (Core)

1465 V.C.1.e).(2) be submitted to the DIO. (Core)

1467 V.C.1.f) ~~The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section V.C.2., as well as delineate how they will be measured and monitored. (Core)~~

1472 ~~V.C.1.f).(1) The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes. (Detail)~~

1475 V.C.2. The program must complete a Self-Study prior to its 10-Year Accreditation Site Visit. (Core)

1478 V.C.2.a) A summary of the Self-Study must be submitted to the DIO. (Core)

1479

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.

1480
1481 V.C.3. *One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.*

1485 *The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.*

1490 V.C.3.a) For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)

1495

©2018 Accreditation Council for Graduate Medical Education (ACGME)

1496 V.C.3.b) For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)

1502 V.C.3.c) For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)

1508 V.C.3.d) For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)

1514 V.C.3.e) For each of the exams referenced in V.C.3.a)-d), any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty. (Outcome)

> 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.

1521 V.C.3.f) Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years earlier. (Core)

> 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.

1525
1526 VI. The Learning and Working Environment
1527
1528 *Residency education must occur in the context of a learning and working environment*
1529 *that emphasizes the following principles:*
1530
1531 • *Excellence in the safety and quality of care rendered to patients by residents today*
1532
1533 • *Excellence in the safety and quality of care rendered to patients by today's residents*
1534 *in their future practice*
1535
1536 • *Excellence in professionalism through faculty modeling of:*
1537
1538 o *the effacement of self-interest in a humanistic environment that supports the*
1539 *professional development of physicians*
1540
1541 o *the joy of curiosity, problem-solving, intellectual rigor, and discovery*
1542
1543 • *Commitment to the well-being of the students, residents, faculty members, and all*
1544 *members of the health care team*
1545

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.

1546
1547 VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability
1548
1549 VI.A.1. Patient Safety and Quality Improvement
1550
1551 *All physicians share responsibility for promoting patient safety and*
1552 *enhancing quality of patient care. Graduate medical education must*

©2018 Accreditation Council for Graduate Medical Education (ACGME)

1553 *prepare residents to provide the highest level of clinical care with*
1554 *continuous focus on the safety, individual needs, and humanity of their*
1555 *patients. It is the right of each patient to be cared for by residents who are*
1556 *appropriately supervised; possess the requisite knowledge, skills, and*
1557 *abilities; understand the limits of their knowledge and experience; and*
1558 *seek assistance as required to provide optimal patient care.*
1559
1560 *Residents must demonstrate the ability to analyze the care they provide,*
1561 *understand their roles within health care teams, and play an active role in*
1562 *system improvement processes. Graduating residents will apply these*
1563 *skills to critique their future unsupervised practice and effect quality*
1564 *improvement measures.*
1565
1566 *It is necessary for residents and faculty members to consistently work in a*
1567 *well-coordinated manner with other health care professionals to achieve*
1568 *organizational patient safety goals.*
1569
1570 VI.A.1.a) Patient Safety
1571
1572 VI.A.1.a).(1) Culture of Safety
1573
1574 *A culture of safety requires continuous identification of*
1575 *vulnerabilities and a willingness to transparently deal with*
1576 *them. An effective organization has formal mechanisms to*
1577 *assess the knowledge, skills, and attitudes of its personnel*
1578 *toward safety in order to identify areas for improvement.*
1579
1580 VI.A.1.a).(1).(a) The program, its faculty, residents, and fellows
1581 must actively participate in patient safety systems
1582 and contribute to a culture of safety. (Core)
1583
1584 VI.A.1.a).(1).(b) The program must have a structure that promotes
1585 safe, interprofessional, team-based care. (Core)
1586
1587 VI.A.1.a).(2) Education on Patient Safety
1588
1589 Programs must provide formal educational activities that
1590 promote patient safety-related goals, tools, and
1591 techniques. (Core)
1592

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

1593
1594 VI.A.1.a).(3) Patient Safety Events
1595
1596 *Reporting, investigation, and follow-up of adverse events,*
1597 *near misses, and unsafe conditions are pivotal*
1598 *mechanisms for improving patient safety, and are essential*
1599 *for the success of any patient safety program. Feedback*
1600 *and experiential learning are essential to developing true*

©2018 Accreditation Council for Graduate Medical Education (ACGME)

1601 *competence in the ability to identify causes and institute*
1602 *sustainable systems-based changes to ameliorate patient*
1603 *safety vulnerabilities.*
1604
1605 VI.A.1.a).(3).(a) Residents, fellows, faculty members, and other
1606 clinical staff members must:
1607
1608 VI.A.1.a).(3).(a).(i) know their responsibilities in reporting
1609 patient safety events at the clinical site; (Core)
1610
1611 VI.A.1.a).(3).(a).(ii) know how to report patient safety events,
1612 including near misses, at the clinical site;
1613 and, (Core)
1614
1615 VI.A.1.a).(3).(a).(iii) be provided with summary information of
1616 their institution's patient safety reports. (Core)
1617
1618 VI.A.1.a).(3).(b) Residents must participate as team members in
1619 real and/or simulated interprofessional clinical
1620 patient safety activities, such as root cause
1621 analyses or other activities that include analysis, as
1622 well as formulation and implementation of actions.
1623 (Core)
1624
1625 VI.A.1.a).(4) Resident Education and Experience in Disclosure of
1626 Adverse Events
1627
1628 *Patient-centered care requires patients, and when*
1629 *appropriate families, to be apprised of clinical situations*
1630 *that affect them, including adverse events. This is an*
1631 *important skill for faculty physicians to model, and for*
1632 *residents to develop and apply.*
1633
1634 VI.A.1.a).(4).(a) All residents must receive training in how to
1635 disclose adverse events to patients and families.
1636 (Core)
1637
1638 VI.A.1.a).(4).(b) Residents should have the opportunity to
1639 participate in the disclosure of patient safety
1640 events, real or simulated. (Detail)†
1641
1642 VI.A.1.b) Quality Improvement
1643
1644 VI.A.1.b).(1) Education in Quality Improvement
1645
1646 *A cohesive model of health care includes quality-related*
1647 *goals, tools, and techniques that are necessary in order for*
1648 *health care professionals to achieve quality improvement*
1649 *goals.*
1650

©2018 Accreditation Council for Graduate Medical Education (ACGME)

1651 VI.A.1.b).(1).(a) Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities. (Core)

1655 VI.A.1.b).(2) Quality Metrics

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

1661 VI.A.1.b).(2).(a) Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)

1665 VI.A.1.b).(3) Engagement in Quality Improvement Activities

Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.

1671 VI.A.1.b).(3).(a) Residents must have the opportunity to participate in interprofessional quality improvement activities. (Core)

1675 VI.A.1.b).(3).(a).(i) This should include activities aimed at reducing health care disparities. (Detail)

1678 VI.A.2. Supervision and Accountability

1680 VI.A.2.a) *Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.*

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

1694 VI.A.2.a).(1) Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care. (Core)

©2018 Accreditation Council for Graduate Medical Education (ACGME)

1700 VI.A.2.a).(1).(a) This information must be available to residents, faculty members, other members of the health care team, and patients. (Core)

1704 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)

1708 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 immediate availability of the supervising faculty member, fellow, or senior resident physician, either on site or by means of telephonic and/or electronic modalities. 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.*

1719 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)

1726 [The Review Committee may specify which activities require different levels of supervision.]

1729 VI.A.2.c) Levels of Supervision

1731 To promote oversight of resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision: (Core)

1735 VI.A.2.c).(1) Direct Supervision – the supervising physician is physically present with the resident and patient. (Core)

1738 VI.A.2.c).(2) Indirect Supervision:

1740 VI.A.2.c).(2).(a) with Direct Supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision. (Core)

1746 VI.A.2.c).(2).(b) with Direct Supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic

©2018 Accreditation Council for Graduate Medical Education (ACGME)

1750 and/or electronic modalities, and is available to
1751 provide Direct Supervision. (Core)
1752
1753 VI.A.2.c).(3) Oversight – the supervising physician is available to
1754 provide review of procedures/encounters with feedback
1755 provided after care is delivered. (Core)
1756
1757 VI.A.2.d) The privilege of progressive authority and responsibility,
1758 conditional independence, and a supervisory role in patient care
1759 delegated to each resident must be assigned by the program
1760 director and faculty members. (Core)
1761
1762 VI.A.2.d).(1) The program director must evaluate each resident's
1763 abilities based on specific criteria, guided by the
1764 Milestones. (Core)
1765
1766 VI.A.2.d).(2) Faculty members functioning as supervising physicians
1767 must delegate portions of care to residents based on the
1768 needs of the patient and the skills of each resident. (Core)
1769
1770 VI.A.2.d).(3) Senior residents or fellows should serve in a supervisory
1771 role to junior residents in recognition of their progress
1772 toward independence, based on the needs of each patient
1773 and the skills of the individual resident or fellow. (Detail)
1774
1775 VI.A.2.e) Programs must set guidelines for circumstances and events in
1776 which residents must communicate with the supervising faculty
1777 member(s). (Core)
1778
1779 VI.A.2.e).(1) Each resident must know the limits of their scope of
1780 authority, and the circumstances under which the resident
1781 is permitted to act with conditional independence. (Outcome)
1782

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

1783
1784 VI.A.2.e).(1).(a) Initially, PGY-1 residents must be supervised either
1785 directly, or indirectly with direct supervision
1786 immediately available. [Each Review Committee
1787 may describe the conditions and the achieved
1788 competencies under which PGY-1 residents
1789 progress to be supervised indirectly with direct
1790 supervision available.] (Core)
1791
1792 VI.A.2.f) Faculty supervision assignments must be of sufficient duration to
1793 assess the knowledge and skills of each resident and to delegate
1794 to the resident the appropriate level of patient care authority and
1795 responsibility. (Core)
1796
1797 VI.B. Professionalism
1798

©2018 Accreditation Council for Graduate Medical Education (ACGME)

1799 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)

1804 VI.B.2. The learning objectives of the program must:

1806 VI.B.2.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; (Core)

1810 VI.B.2.b) be accomplished without excessive reliance on residents to fulfill non-physician obligations; and, (Core)

1812

> 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.

1813

1814 VI.B.2.c) ensure manageable patient care responsibilities. (Core)

1816 [As further specified by the Review Committee]

1817

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

1818

1819 VI.B.3. The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)

1823 VI.B.4. Residents and faculty members must demonstrate an understanding of their personal role in the:

1826 VI.B.4.a) provision of patient- and family-centered care; (Outcome)

1828 VI.B.4.b) safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; (Outcome)

1830

©2018 Accreditation Council for Graduate Medical Education (ACGME)

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.

1831
1832 VI.B.4.c) assurance of their fitness for work, including: (Outcome)
1833

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.

1834
1835 VI.B.4.c).(1) management of their time before, during, and after clinical
1836 assignments; and, (Outcome)
1837
1838 VI.B.4.c).(2) recognition of impairment, including from illness, fatigue,
1839 and substance use, in themselves, their peers, and other
1840 members of the health care team. (Outcome)
1841
1842 VI.B.4.d) commitment to lifelong learning; (Outcome)
1843
1844 VI.B.4.e) monitoring of their patient care performance improvement
1845 indicators; and, (Outcome)
1846
1847 VI.B.4.f) accurate reporting of clinical and educational work hours, patient
1848 outcomes, and clinical experience data. (Outcome)
1849
1850 VI.B.5. All residents and faculty members must demonstrate responsiveness to
1851 patient needs that supersedes self-interest. This includes the recognition
1852 that under certain circumstances, the best interests of the patient may be
1853 served by transitioning that patient's care to another qualified and rested
1854 provider. (Outcome)
1855
1856 VI.B.6. Programs, in partnership with their Sponsoring Institutions, must provide
1857 a professional, equitable, respectful, and civil environment that is free
1858 from discrimination, sexual and other forms of harassment, mistreatment,
1859 abuse, or coercion of students, residents, faculty, and staff. (Core)
1860
1861 VI.B.7. Programs, in partnership with their Sponsoring Institutions, should have a
1862 process for education of residents and faculty regarding unprofessional
1863 behavior and a confidential process for reporting, investigating, and
1864 addressing such concerns. (Core)
1865
1866 VI.C. Well-Being
1867
1868 *Psychological, emotional, and physical well-being are critical in the development*
1869 *of the competent, caring, and resilient physician and require proactive attention*
1870 *to life inside and outside of medicine. Well-being requires that physicians retain*
1871 *the joy in medicine while managing their own real-life stresses. Self-care and*
1872 *responsibility to support other members of the health care team ~~is an~~ are*

important components of professionalism; ~~it is~~ they are also ~~a~~ skills that must be modeled, learned, and nurtured in the context of other aspects of residency training.

~~In the current health care environment, r~~Residents and faculty members are at ~~increased~~ risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as ~~they do to evaluate~~ other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. For example, a culture which encourages covering for colleagues after an illness without the expectation of reciprocity reflects the ideal of professionalism. A positive culture in a clinical learning environment models constructive behaviors, and prepares residents with the skills and attitudes needed to thrive throughout their careers.

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.

VI.C.1. ~~This~~ The responsibility of the program, in partnership with the Sponsoring Institution, to address well-being must include:

VI.C.1.a) efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; (Core)

VI.C.1.b) attention to scheduling, work intensity, and work compression that impacts resident well-being; (Core)

VI.C.1.c) evaluating workplace safety data and addressing the safety of residents and faculty members; (Core)

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

©2018 Accreditation Council for Graduate Medical Education (ACGME)

1905 VI.C.1.d) policies and programs that encourage optimal resident and faculty
1906 member well-being; and, (Core)
1907

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.

1908
1909 VI.C.1.d).(1) Residents must be given the opportunity to attend medical,
1910 mental health, and dental care appointments, including
1911 those scheduled during their working hours. (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, depression, and
1915 substance abuse. The program, in partnership with its Sponsoring
1916 Institution, must educate faculty members and residents in
1917 identification of the symptoms of burnout, depression, and
1918 substance abuse, including means to assist those who experience
1919 these conditions. Residents and faculty members must also be
1920 educated to recognize those symptoms in themselves and how to
1921 seek appropriate care. The program, in partnership with its
1922 Sponsoring Institution, must: (Core)
1923

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).

1924
1925 VI.C.1.e).(1) encourage residents and faculty members to alert the
1926 program director or other designated personnel or
1927 programs when they are concerned that another resident,
1928 fellow, or faculty member may be displaying signs of
1929 burnout, depression, substance abuse, suicidal ideation, or
1930 potential for violence; (Core)
1931

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

©2018 Accreditation Council for Graduate Medical Education (ACGME)

programs within the institution. In cases of physician impairment, the program director or designated personnel should follow the policies of their institution for reporting.

1932
1933 VI.C.1.e).(2) provide access to appropriate tools for self-screening; and,
1934 (Core)
1935
1936 VI.C.1.e).(3) provide access to confidential, affordable mental health
1937 assessment, counseling, and treatment, including access
1938 to urgent and emergent care 24 hours a day, seven days a
1939 week. (Core)
1940

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.

1941
1942 VI.C.2. There are circumstances in which residents may be unable to attend
1943 work, including but not limited to fatigue, illness, ~~and~~ family emergencies,
1944 and parental leave. Each program must allow an appropriate length of
1945 absence for residents ~~have policies and procedures in place that ensure~~
1946 ~~coverage of patient care in the event that a resident may be~~ unable to
1947 perform their patient care responsibilities. (Core)
1948
1949 VI.C.2.a) The program must have policies and procedures in place to
1950 ensure coverage of patient care. (Core)
1951
1952 VI.C.2.b) These policies must be implemented without fear of negative
1953 consequences for the resident who is or was unable to provide the
1954 clinical work. (Core)
1955

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.

1956
1957 VI.D. Fatigue Mitigation
1958
1959 VI.D.1. Programs must:
1960
1961 VI.D.1.a) educate all faculty members and residents to recognize the signs
1962 of fatigue and sleep deprivation; (Core)
1963
1964 VI.D.1.b) educate all faculty members and residents in alertness
1965 management and fatigue mitigation processes; and, (Core)
1966

©2018 Accreditation Council for Graduate Medical Education (ACGME)

1967 VI.D.1.c) encourage residents to use fatigue mitigation processes to
1968 manage the potential negative effects of fatigue on patient care
1969 and learning. (Detail)
1970

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.

1971
1972 VI.D.2. Each program must ensure continuity of patient care, consistent with the
1973 program's policies and procedures referenced in VI.C.2–VI.C.2.b), in the
1974 event that a resident may be unable to perform their patient care
1975 responsibilities due to excessive fatigue. (Core)
1976
1977 VI.D.3. The program, in partnership with its Sponsoring Institution, must ensure
1978 adequate sleep facilities and safe transportation options for residents who
1979 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 patient
1987 illness/condition, and available support services. (Core)
1988
1989 [Optimal clinical workload may be further specified by each Review
1990 Committee.]
1991

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.

1992
1993 VI.E.2. Teamwork
1994

©2018 Accreditation Council for Graduate Medical Education (ACGME)

1995 Residents must care for patients in an environment that maximizes
1996 communication. This must include the opportunity to work as a member of
1997 effective interprofessional teams that are appropriate to the delivery of
1998 care in the specialty and larger health system. (Core)
1999
2000 [Each Review Committee will define the elements that must be present in
2001 each specialty.]
2002
2003 VI.E.3. Transitions of Care
2004
2005 VI.E.3.a) Programs must design clinical assignments to optimize transitions
2006 in patient care, including their safety, frequency, and structure.
2007 (Core)
2008
2009 VI.E.3.b) Programs, in partnership with their Sponsoring Institutions, must
2010 ensure and monitor effective, structured hand-over processes to
2011 facilitate both continuity of care and patient safety. (Core)
2012
2013 VI.E.3.c) Programs must ensure that residents are competent in
2014 communicating with team members in the hand-over process.
2015 (Outcome)
2016
2017 VI.E.3.d) Programs and clinical sites must maintain and communicate
2018 schedules of attending physicians and residents currently
2019 responsible for care. (Core)
2020
2021 VI.E.3.e) Each program must ensure continuity of patient care, consistent
2022 with the program's policies and procedures referenced in VI.C.2-
2023 VI.C.2.b), in the event that a resident may be unable to perform
2024 their patient care responsibilities due to excessive fatigue or
2025 illness, or family emergency. (Core)
2026
2027 VI.F. Clinical Experience and Education
2028
2029 *Programs, in partnership with their Sponsoring Institutions, must design an*
2030 *effective program structure that is configured to provide residents with*
2031 *educational and clinical experience opportunities, as well as reasonable*
2032 *opportunities for rest and personal activities.*
2033

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.

2034
2035 VI.F.1. Maximum Hours of Clinical and Educational Work per Week
2036
2037 Clinical and educational work hours must be limited to no more than 80
2038 hours per week, averaged over a four-week period, inclusive of all in-
2039 house clinical and educational activities, clinical work done from home,

2040 and all moonlighting. (Core)
2041

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

©2018 Accreditation Council for Graduate Medical Education (ACGME)

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.

2042
2043 VI.F.2. Mandatory Time Free of Clinical Work and Education
2044
2045 VI.F.2.a) The program must design an effective program structure that is
2046 configured to provide residents with educational opportunities, as
2047 well as reasonable opportunities for rest and personal well-being.
2048 (Core)
2049
2050 VI.F.2.b) Residents should have eight hours off between scheduled clinical
2051 work and education periods. (Detail)
2052
2053 VI.F.2.b).(1) There may be circumstances when residents choose to
2054 stay to care for their patients or return to the hospital with
2055 fewer than eight hours free of clinical experience and
2056 education. This must occur within the context of the 80-
2057 hour and the one-day-off-in-seven requirements. (Detail)
2058

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.

2059
2060 VI.F.2.c) Residents must have at least 14 hours free of clinical work and
2061 education after 24 hours of in-house call. (Core)
2062

©2018 Accreditation Council for Graduate Medical Education (ACGME)

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.

2063
2064 VI.F.2.d) Residents must be scheduled for a minimum of one day in seven
2065 free of clinical work and required education (when averaged over
2066 four weeks). At-home call cannot be assigned on these free days.
2067 (Core)
2068

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."

2069
2070 VI.F.3. Maximum Clinical Work and Education Period Length
2071
2072 VI.F.3.a) Clinical and educational work periods for residents must not
2073 exceed 24 hours of continuous scheduled clinical assignments.
2074 (Core)
2075

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.

2076
2077 VI.F.3.a).(1) Up to four hours of additional time may be used for
2078 activities related to patient safety, such as providing
2079 effective transitions of care, and/or resident education. (Core)
2080
2081 VI.F.3.a).(1).(a) Additional patient care responsibilities must not be
2082 assigned to a resident during this time. (Core)
2083

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.

2084
2085 VI.F.4. Clinical and Educational Work Hour Exceptions
2086
2087 VI.F.4.a) In rare circumstances, after handing off all other responsibilities, a
2088 resident, on their own initiative, may elect to remain or return to
2089 the clinical site in the following circumstances:
2090
2091 VI.F.4.a).(1) to continue to provide care to a single severely ill or
2092 unstable patient; (Detail)
2093
2094 VI.F.4.a).(2) humanistic attention to the needs of a patient or family; or,
2095 (Detail)
2096
2097 VI.F.4.a).(3) to attend unique educational events. (Detail)
2098
2099 VI.F.4.b) These additional hours of care or education will be counted toward
2100 the 80-hour weekly limit. (Detail)
2101

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

©2018 Accreditation Council for Graduate Medical Education (ACGME)

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.

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

VI.F.4.c).(1) In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the *ACGME Manual of Policies and Procedures.* (Core)

VI.F.4.c).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval from the Sponsoring Institution's GMEC and DIO. (Core)

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 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.

VI.F.5. Moonlighting

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

VI.F.5.b) Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core)

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

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

VI.F.6. In-House Night Float

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

[The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the

©2018 Accreditation Council for Graduate Medical Education (ACGME)

2139 Review Committee.]
2140

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.

2141
2142 VI.F.7. Maximum In-House On-Call Frequency
2143
2144 Residents must be scheduled for in-house call no more frequently than
2145 every third night (when averaged over a four-week period). (Core)
2146
2147 VI.F.8. At-Home Call
2148
2149 VI.F.8.a) Time spent on patient care activities by residents on at-home call
2150 must count toward the 80-hour maximum weekly limit. The
2151 frequency of at-home call is not subject to the every-third-night
2152 limitation, but must satisfy the requirement for one day in seven
2153 free of clinical work and education, when averaged over four
2154 weeks. (Core)
2155
2156 VI.F.8.a).(1) At-home call must not be so frequent or taxing as to
2157 preclude rest or reasonable personal time for each
2158 resident. (Core)
2159
2160 VI.F.8.b) Residents are permitted to return to the hospital while on at-home
2161 call to provide direct care for new or established patients. These
2162 hours of inpatient patient care must be included in the 80-hour
2163 maximum weekly limit. (Detail)
2164

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.

2165
2166 ***
2167 ***Core Requirements:** Statements that define structure, resource, or process elements
2168 essential to every graduate medical educational program.
2169
2170 †**Detail Requirements:** Statements that describe a specific structure, resource, or process, for
2171 achieving compliance with a Core Requirement. Programs and sponsoring institutions in
2172 substantial compliance with the Outcome Requirements may utilize alternative or innovative
2173 approaches to meet Core Requirements.
2174

©2018 Accreditation Council for Graduate Medical Education (ACGME)

2175 ‡**Outcome Requirements:** Statements that specify expected measurable or observable
2176 attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their
2177 graduate medical education.
2178
2179 **Osteopathic Recognition**
2180 For programs seeking Osteopathic Recognition for the entire program, or for a track within the
2181 program, the Osteopathic Recognition Requirements are also applicable.
2182 (http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/Osteopathic_Recogniton_Re
2183 quirements.pdf)
2184

©2018 Accreditation Council for Graduate Medical Education (ACGME)