Accreditation Council for
Graduate Medical Education

ACGME Program Requirements for Graduate Medical Education in Urology

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Common Program Requirements are in BOLD

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

Introduction

Int.A. **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. Urology ~~is the specialty that~~ evaluates and treats patients with disorders of the genitourinary tract, including the adrenal gland and external genitalia. Specialists in this discipline must demonstrate knowledge of the basic and clinical sciences related to the normal and diseased genitourinary system, as well as attendant skills in medical and surgical therapy. Residency programs must educate physicians in the prevention and treatment of genitourinary disease, including the diagnosis, medical, and surgical management, and reconstruction of the genitourinary tract.

Int.C. Duration and Scope of Education

The educational program in urology must be 60 months in length. (Core)

~~A minimum of 48 months of clinical urology education is required. Within the final 24 months of urology education, residents must serve at least 12 months as a chief resident.~~ (Core)

I. Institutions

I.A. Sponsoring Institution

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)

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.A.1. The program director must devote at least 20 percent of his or her professional effort to the administrative and educational activities of the program and receive corresponding financial support for this time. (Core)

I.A.2. The program director must not be required to generate clinical or other income to finance this administrative time. (Core)

I.B. Participating Sites

I.B.1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years. (Core)

The PLA should:

I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for residents; (Detail)

I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document; (Detail)

I.B.1.c) specify the duration and content of the educational experience; and, (Detail)

I.B.1.d) state the policies and procedures that will govern resident education during the assignment. (Detail)

I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS). (Core)

I.B.3. ~~Assignments at participating sites must be of sufficient length to ensure a quality educational experience, and should provide sufficient opportunity for continuity of care. Although the number of participating sites may vary, all participating sites must demonstrate the ability to promote the program goals.~~ (Core)

I.B.4. ~~The inclusion of more than four~~ Addition of participating sites for required rotations must be based on sound educational rationale and approved in advance by the Review Committee. ~~Two or more residents should rotate to each participating site to maintain peer interaction.~~ (~~Detail~~Core)

I.B.4.a) Assignments to distant sites 30 miles or greater from the primary clinical site must be justified on the basis of educational resources that are not available at the ~~sponsoring institution~~ primary clinical site or at a nearby participating site (i.e., within 30 miles of the primary clinical site). (~~Detail~~ Core)

II. Program Personnel and Resources

II.A. Program Director

II.A.1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. (Core)

II.A.1.a) The program director must submit this change to the ACGME via the ADS. (Core)

II.A.2. The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability. (Detail)

II.A.2.a) The program director should continue in his or her position for a minimum of six years. (Detail)

II.A.2.b) An absence of three months or more for the program director must be reported to the Review Committee. In such situations, an interim program director must be appointed and approved by the Review Committee. (Core)

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

II.A.3.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee; (Core)

II.A.3.b) **current certification in the specialty by the American Board of** Urology**, or specialty qualifications that are acceptable to the Review Committee;** (Core)

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

II.A.3.d) documented clinical and teaching skills and scholarly ~~expertise~~activity in urology; and, (Core)

II.A.3.e) a minimum of four years of experience in urology after attainment of board certification or qualifications acceptable to the Review Committee. (Core)

II.A.4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. (Core)

The program director must:

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

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

II.A.4.b).(1) The local site director must be a urologist in good standing at the participating site and have the majority of his or her practice at that site~~;~~. (Core)

II.A.4.b).(2) ~~The local site director must be responsible for the education of the residents at the participating site; and,~~ ~~(Detail)~~

II.A.4.b).(3) ~~The local site director must be responsible for the supervision of all educational and clinical activities of the program at that site.~~ ~~(Detail)~~

II.A.4.c) approve the selection of program faculty as appropriate; (Core)

II.A.4.d) evaluate program faculty; (Core)

II.A.4.e) approve the continued participation of program faculty based on evaluation; (Core)

II.A.4.f) monitor resident supervision at all participating sites; (Core)

II.A.4.g) prepare and submit all information required and requested by the ACGME. (Core)

II.A.4.g).(1) This includes but is not limited to the program application forms and annual program updates to the ADS, and ensure that the information submitted is accurate and complete. (Core)

II.A.4.h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution; (Detail)

II.A.4.i) **provide verification of residency education for all residents, including those who leave the program prior to completion;** (Detail)

II.A.4.j) **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.j).(1) **distribute these policies and procedures to the residents and faculty;** (Detail)

II.A.4.j).(2) **monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;** (Core)

II.A.4.j).(3) **adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,** (Detail)

II.A.4.j).(4) **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.k) **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.l) **comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;** (Detail)

II.A.4.m) **be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;** (Detail)

II.A.4.n) **obtain review and approval of the sponsoring institution's GMEC/DIO before submitting information or requests to the ACGME, including:** (Core)

II.A.4.n).(1) **all applications for ACGME accreditation of new programs;** (Detail)

II.A.4.n).(2) **changes in resident complement;** (Detail)

II.A.4.n).(3) **major changes in program structure or length of training;** (Detail)

II.A.4.n).(4) **progress reports requested by the Review Committee;** (Detail)

II.A.4.n).(5) **requests for increases or any change to resident duty hours;** (Detail)

II.A.4.n).(6) **voluntary withdrawals of ACGME-accredited programs;** (Detail)

II.A.4.n).(7) **requests for appeal of an adverse action; and,** (Detail)

II.A.4.n).(8) **appeal presentations to a Board of Appeal or the ACGME.** (Detail)

II.A.4.o) **obtain DIO review and co-signature on all program application forms, as well as any correspondence or document submitted to the ACGME that addresses:** (Detail)

II.A.4.o).(1) **program citations, and/or,** (Detail)

II.A.4.o).(2) **request for changes in the program that would have significant impact, including financial, on the program or institution.** (Detail)

II.A.4.p) ensure that the operative procedures performed by residents are entered in the ACGME Case Log System; and, (Core)

II.A.4.p).(1) The program director must review the Case Logs of each resident at least semi-annually and at graduation to ensure an even distribution, volume, and variety of operative experiences. (Core)

II.A.4.p).(2) ~~The annual and final logs must be signed by both the resident and the program director as a statement of their accuracy.~~ (Core)

II.A.4.p).(3) Upon graduation, the program director must ~~submit~~ provide each resident~~'s~~ with his or her final aggregate Case Log ~~of the urology years to the ACGME~~. (Core)

II.A.4.q) ~~conduct and document ongoing and final reviews of operative logs with residents to ensure an even distribution, volume, and variety of operative experiences;~~ (Detail)

II.A.4.r) notify each resident in writing, prior to admission, of the required length of the educational program, including both accredited and non-accredited time. (Core)

II.A.4.r).(1) The educational program's required length ~~may~~must not be changed without mutual agreement with the resident, unless there is a significant break in his or her educational

program or unless the resident requires remedial education. (Core)

II.A.4.r).(2) ~~All educational program length changes for any resident must be approved in advance by the Review Committee; (Core)~~

II.B. Faculty

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

The faculty must:

II.B.1.a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents, and (Core)

II.B.1.b) administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas. (Core)

II.B.2. The physician faculty must have current certification in the specialty by the American Board of Urology**, or possess qualifications judged acceptable to the Review Committee.** (Core)

II.B.2.a) To provide a ~~diverse~~well-rounded educational experience, ~~several~~ faculty members should have subspecialty education and concentrate their practice in one or more of the following urological domains: voiding dysfunction; female urology; reconstruction, oncology; calculus disease; pediatrics; sexual dysfunction; and infertility. (Detail)

II.B.2.b) The faculty should include individuals with experience with the following urologic techniques: endo-urology; minimally-invasive intra-abdominal and pelvic surgical techniques (such as laparoscopy and robotic surgery); major flank and pelvic surgery; urologic imaging; and microsurgery. (~~Core~~Detail)

II.B.2.c) ~~Residents should have clinical interaction with faculty members having expertise in geriatrics, infectious disease, renovascular disease, renal transplantation, trauma, interventional radiology, plastic surgery, and medical oncology.~~ (Detail)

II.B.2.d) In addition to the program director, there must be ~~at least~~a minimum of two core clinical urology faculty members who devote sufficient time to supervise and teach the residents, and who are committed fully to the educational objectives of the ~~residency~~ program. (Core)

II.B.2.e) There must be a core faculty-to-resident ratio of at least 1:2 ~~in the total program~~. (Core)

II.B.2.e).(1) ~~The program director must be counted as one of the faculty members in determining this ratio.~~ (Core)

II.B.2.e).(2) ~~The program director must notify the Review Committee if the number of clinical urology faculty members drops below three, or if the ratio falls below 1:2 and remains below that level longer than one year.~~ (Core)

II.B.3. The physician faculty must possess current medical licensure and appropriate medical staff appointment. (Core)

II.B.4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)

II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component. (Core)

II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. (Detail)

II.B.5.b) Some members of the faculty should also demonstrate scholarship by one or more of the following:

II.B.5.b).(1) peer-reviewed funding; (Detail)

II.B.5.b).(2) publication of original research or review articles in peer reviewed journals, or chapters in textbooks; (Detail)

II.B.5.b).(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or, (Detail)

II.B.5.b).(4) participation in national committees or educational organizations. (Detail)

II.B.5.c) Faculty should encourage and support residents in scholarly activities. (Core)

II.C. Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program. (Core)

II.C.1. The program must include a program coordinator who devotes a minimum of 20 percent of his or her effort per every five residents in the program. (Core)

II.D. Resources

The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements. (Core)

II.D.1. There must be adequate space and equipment for the educational program, including meeting rooms and classrooms with audiovisual and other educational aids; appropriate office space for residents; diagnostic, therapeutic, and research facilities; and outpatient facilities, clinic, and office space accessible to residents for pre-operative evaluation and post-operative follow-up. (Core)

II.D.2. Clinical facilities must contain state-of-the-art equipment to perform diagnostic and therapeutic procedures. (Core)

II.D.2.a) Equipment to perform the following procedures must be available: flexible cystoscopy; ureteroscopy; percutaneous endoscopy; percutaneous renal access~~, extracorporeal shock wave lithotripsy~~; ultrasonography and biopsy; fluoroscopy; laparoscopy~~, and~~; laser therapy; and renal and prostate ultrasound. (Core)

II.D.2.b) Urodynamic equipment ~~should~~must be present. (Core)

II.D.2.c) Video imaging ~~should~~must be available to allow adequate supervision and education during endoscopic procedures. (Core)

II.D.3. A sufficient number and variety of inpatient ambulatory adult and pediatric patients with urologic disease must be available for resident education. (Core)

II.E. Medical Information Access

Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available. (Detail)

III. Resident Appointments

III.A. Eligibility Criteria

The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements. (Core)

III.A.1. Eligibility Requirements – Residency Programs

III.A.1.a) All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency

programs, or in Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada. Residency programs must receive verification of each applicant's level of competency in the required clinical field using ACGME or CanMEDS Milestones assessments from the prior training program. (Core)

III.A.1.a).(1) Program policies for resident selection should recognize the value and importance of recruiting qualified female and underrepresented minority students to urology. (Detail)

III.A.1.a).(2) ~~The prerequisite for admission to a urology residency program is a minimum of one year of education in an ACGME-accredited surgery program or an RCPSC-accredited surgery program located in Canada.~~ (Core)

III.A.1.a).(2).(a) ~~Based on educational objectives, two years of general surgery is an alternative format. During these one or two years, residents must spend a minimum of three months in general surgery, as well as a minimum of three months in the core surgical rotations of critical care, vascular surgery, or trauma. Additional clinical assignments must enhance the resident education and prepare residents for the practice of urology. If there is only a single year of general surgery, dedicated research time during that period is not allowed. The educational program for the general surgery period is developed by the program director of the respective surgery residency program with the input and approval of the respective urology program director.~~ (Detail)

III.A.1.b) **A physician who has completed a residency program that was not accredited by ACGME, RCPSC, or CFPC may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director at the ACGME-accredited program may be advanced to the PGY-2 level based on ACGME Milestones assessments at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry.** (Core)

III.A.1.c) **A Review Committee may grant the exception to the eligibility requirements specified in Section III.A.2.b) for residency programs that require completion of a prerequisite residency program prior to admission.** (Core)

III.A.1.d) **Review Committees will grant no other exceptions to these eligibility requirements for residency education.** (Core)

III.A.2. **Eligibility Requirements – Fellowship Programs**

All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, or in an RCPSC-accredited or CFPC- accredited residency program located in Canada. (Core)

III.A.2.a) **Fellowship programs must receive verification of each entering fellow's level of competency in the required field using ACGME or CanMEDS Milestones assessments from the core residency program.** **(Core)**

III.A.2.b) **Fellow Eligibility Exception**

A Review Committee may grant the following exception to the fellowship eligibility requirements:

An ACGME-accredited fellowship program may accept an exceptionally qualified applicant, who does not satisfy the eligibility requirements listed in Sections III.A.2. and III.A.2.a), but who does meet all of the following additional qualifications and conditions:** (Core)

III.A.2.b).(1) **Assessment by the program director and fellowship selection committee of the applicant's suitability to enter the program, based on prior training and review of the summative evaluations of training in the core specialty; and** (Core)

III.A.2.b).(2) **Review and approval of the applicant's exceptional qualifications by the GMEC or a subcommittee of the GMEC; and** (Core)

III.A.2.b).(3) **Satisfactory completion of the United States Medical Licensing Examination (USMLE) Steps 1, 2, and, if the applicant is eligible, 3, and;** (Core)

III.A.2.b).(4) **For an international graduate, verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification; and,** (Core)

III.A.2.b).(5) **Applicants accepted by this exception must complete fellowship Milestones evaluation (for the purposes of establishment of baseline performance by the Clinical Competency Committee), conducted by the receiving fellowship program within six weeks of matriculation. This evaluation may be waived for an applicant who has completed an ACGME International-accredited**

residency based on the applicant's Milestones evaluation conducted at the conclusion of the residency program. (Core)

III.A.2.b).(5).(a) **If the trainee does not meet the expected level of Milestones competency following entry into the fellowship program, the trainee must undergo a period of remediation, overseen by the Clinical Competency Committee and monitored by the GMEC or a subcommittee of the GMEC. This period of remediation must not count toward time in fellowship training.** (Core)

**** An exceptionally qualified applicant has (1) completed a non-ACGME-accredited residency program in the core specialty, and (2) demonstrated clinical excellence, in comparison to peers, throughout training. Additional evidence of exceptional qualifications is required, which may include one of the following: (a) participation in additional clinical or research training in the 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.**

III.B. Number of Residents

The program's educational resources must be adequate to support the number of residents appointed to the program. (Core)

III.B.1. **The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements.** (Core)

III.B.2. Any ~~change~~increase in the number of residents~~, whether permanent or temporary,~~ must receive the prior approval of the Review Committee. (Core)

III.B.2.a) ~~Requests~~A request for ~~changes~~an increase in the resident complement of a program must be based on a strong educational rationale. (Core)

III.B.2.a).(1) The program must have a status of Continued Accreditation to request an increase in the resident complement. (Core)

III.B.2.a).(2) The program must demonstrate sufficient clinical volume for the increased complement, adequate faculty-to-resident ratio, and an appropriate plan for integrating new residents into the program. (Core)

III.B.2.b) ~~A vacancy in a resident complement, if filled, must be at the same level in which the vacancy occurs, unless otherwise approved by the Review Committee.~~ (Core)

III.C. Resident Transfers

III.C.1. 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 of the transferring resident. (Detail)

III.C.2. 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)

III.D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' education. (Core)

III.D.1. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines. (Detail)

III.D.2. A log that details the operative experience of all fellows (accredited and non-accredited) who may impact the core urology residents' experience must be maintained and be available for review by the Review Committee upon request. (Core)

III.D.2.a) ~~If a program's residents rotate to a participating site that offers an accredited or non-accredited fellowship program, the operative log of the fellow(s) at that site must be maintained.~~ (Core)

IV. Educational Program

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

IV.A.1. Overall educational goals for the program, which the program must make available to residents and faculty; (Core)

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty at least annually, in either written or electronic form; (Core)

IV.A.3. Regularly scheduled didactic sessions; (Core)

IV.A.3.a) The curriculum must include didactic instruction in the core domains of:

IV.A.3.a).(1) calculus disease; (Core)

IV.A.3.a).(2) female pelvic medicine; (Core)

IV.A.3.a).(3) geriatric urology; (Core)

IV.A.3.a).(4) infertility and sexual dysfunction; (Core)

IV.A.3.a).(5) pediatric urology; (Core)

IV.A.3.a).(6) reconstruction; (Core)

IV.A.3.a).(7) urologic oncology; ~~and,~~ (Core)

IV.A.3.a).(8) urologic trauma; and, (Core)

IV.A.3.a).(9) voiding dysfunction. (Core)

IV.A.4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and, (Core)

IV.A.5. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum: (Core)

IV.A.5.a) Patient Care and Procedural Skills

IV.A.5.a).(1) Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. (Outcome)

IV.A.5.a).(2) Residents must be able to competently perform all medical, diagnostic and surgical procedures considered essential for the area of practice. Residents: **(Outcome)**

IV.A.5.a).(2).(a) must ~~develop~~ demonstrate competence in providing direct patient care with increasing levels of responsibility in patient management as they advance through the program; (Outcome)

IV.A.5.a).(2).(b) must, under supervision, demonstrate competence in providing for the total care of the patient, including initial evaluation, establishment of diagnosis, selection of appropriate therapy,

providing that therapy, and management of complications; (Outcome)

IV.A.5.a).(2).(c) must ~~develop~~ demonstrate competence in providing continuity of patient care through pre-~~operative~~ and post-operative clinics and inpatient contact; ~~and,~~ (Outcome)

IV.A.5.a).(2).(c).(i) When residents participate in pre-~~operative~~ and post-operative care in a clinic or private office setting, the program director must ensure that the resident functions with an appropriate degree of responsibility under supervision. (Outcome)

IV.A.5.a).(2).(d) must be given responsibility ~~based upon~~commensurate with their individual knowledge, problem-solving ability, technical skills, experience, and the severity and complexity of each patient's status~~.~~; and, (Outcome)

IV.A.5.a).(2).(e) must develop competence in the following core techniques:

IV.A.5.a).(2).(e).(i) endo-urology; (Outcome)

IV.A.5.a).(2).(e).(ii) major open flank and pelvic surgery; (Outcome)

IV.A.5.a).(2).(e).(iii) ~~microsurgery;~~ (Outcome)

IV.A.5.a).(2).(e).(iv) minimally-invasive intra-abdominal and pelvic surgical techniques including, laparoscopy and robotics; (Outcome)

IV.A.5.a).(2).(e).(v) perineal and genital surgery; and, (Outcome)

IV.A.5.a).(2).(e).(vi) urologic imaging including fluoroscopy, ~~interventional radiology,~~ and ultrasound. (Outcome)

IV.A.5.a).(3) ~~must demonstrate procedural competence by performing~~Each graduating resident must perform the minimum number of essential operative cases and case categories as established by the Review Committee. (Core)

IV.A.5.b) Medical Knowledge

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

IV.A.5.b).(1) must ~~develop~~demonstrate knowledge of the following curricular topics:

IV.A.5.b).(1).(a) bioethics; (Outcome)

IV.A.5.b).(1).(b) biostatistics; (Outcome)

IV.A.5.b).(1).(c) calculus disease; (Outcome)

IV.A.5.b).(1).(d) epidemiology; (Outcome)

IV.A.5.b).(1).(e) evidence-based medicine; (Outcome)

IV.A.5.b).(1).(f) female pelvic medicine; (Outcome)

IV.A.5.b).(1).(g) infectious disease; (Outcome)

IV.A.5.b).(1).(h) infertility and sexual dysfunction;(Outcome)

IV.A.5.b).(1).(i) geriatrics; (Outcome)

IV.A.5.b).(1).(j) medical oncology; (Outcome)

IV.A.5.b).(1).(k) patient safety and quality improvement; (Outcome)

IV.A.5.b).(1).(l) pediatric urology; (Outcome)

IV.A.5.b).(1).(m) plastic surgery; (Outcome)

IV.A.5.b).(1).(n) pre-~~operative~~, intra-~~operative~~, and post-operative~~, and,~~ aspects of:

IV.A.5.b).(1).(n).(i) endoscopic-urology; (Outcome)

IV.A.5.b).(1).(n).(ii) major open flank and pelvic surgery; (Outcome)

IV.A.5.b).(1).(n).(iii) microsurgery; (Outcome)

IV.A.5.b).(1).(n).(iv) minimally-invasive intra-abdominal and pelvic surgical techniques, including laparoscopy and robotic surgery; (Outcome)

IV.A.5.b).(1).(n).(v) perineal and genital surgery; and, (Outcome)

IV.A.5.b).(1).(n).(vi) urologic imaging, including fluoroscopy, interventional radiology, and ultrasound. (Outcome)

IV.A.5.b).(1).(o) radiation safety; (Outcome)

IV.A.5.b).(1).(p) reconstruction; (Outcome)

IV.A.5.b).(1).(q) renal transplantation; (Outcome)

IV.A.5.b).(1).(r) renovascular disease; (Outcome)

IV.A.5.b).(1).(s) trauma; (Outcome)

IV.A.5.b).(1).(t) urologic oncology; and, (Outcome)

IV.A.5.b).(1).(u) voiding dysfunction. (Outcome)

IV.A.5.c) Practice-based Learning and Improvement

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

Residents are expected to develop skills and habits to be able to meet the following goals:

IV.A.5.c).(1) identify strengths, deficiencies, and limits in one's knowledge and expertise; (Outcome)

IV.A.5.c).(2) set learning and improvement goals; (Outcome)

IV.A.5.c).(3) identify and perform appropriate learning activities; (Outcome)

IV.A.5.c).(4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; (Outcome)

IV.A.5.c).(5) incorporate formative evaluation feedback into daily practice; (Outcome)

IV.A.5.c).(6) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems; (Outcome)

IV.A.5.c).(7) use information technology to optimize learning; and, (Outcome)

IV.A.5.c).(8) participate in the education of patients, families, students, residents and other health professionals. (Outcome)

IV.A.5.d) Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Outcome)

Residents are expected to:

IV.A.5.d).(1) **communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;** (Outcome)

IV.A.5.d).(2) **communicate effectively with physicians, other health professionals, and health related agencies;** (Outcome)

IV.A.5.d).(3) **work effectively as a member or leader of a health care team or other professional group;** (Outcome)

IV.A.5.d).(4) **act in a consultative role to other physicians and health professionals; and,** (Outcome)

IV.A.5.d).(5) **maintain comprehensive, timely, and legible medical records, if applicable.** (Outcome)

IV.A.5.e) **Professionalism**

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. (Outcome)

Residents are expected to demonstrate:

IV.A.5.e).(1) **compassion, integrity, and respect for others;** (Outcome)

IV.A.5.e).(2) **responsiveness to patient needs that supersedes self-interest;** (Outcome)

IV.A.5.e).(3) **respect for patient privacy and autonomy;** (Outcome)

IV.A.5.e).(4) **accountability to patients, society and the profession; and,** (Outcome)

IV.A.5.e).(5) **sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.** (Outcome)

IV.A.5.f) **Systems-based Practice**

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other

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

Residents are expected to:

IV.A.5.f).(1) **work effectively in various health care delivery settings and systems relevant to their clinical specialty;** (Outcome)

IV.A.5.f).(2) **coordinate patient care within the health care system relevant to their clinical specialty;** (Outcome)

IV.A.5.f).(3) **incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;** (Outcome)

IV.A.5.f).(4) **advocate for quality patient care and optimal patient care systems;** (Outcome)

IV.A.5.f).(5) **work in interprofessional teams to enhance patient safety and improve patient care quality; and, (**Outcome)

IV.A.5.f).(6) **participate in identifying system errors and implementing potential systems solutions.** (Outcome)

IV.A.6. Curriculum Organization and Resident Experiences

IV.A.6.a) The program director must be responsible for the design, implementation, and oversight of the Uro-1 (PGY-1) year. The Uro-1 year must include: (Core)

IV.A.6.a).(1) at least six months of structured education in rotations designed to foster competence in basic surgical skills, the peri-operative care of surgical patients, and inter-disciplinary patient care coordination, including: (Core)

IV.A.6.a).(1).(a) at least three months of general surgery; and, (Core)

IV.A.6.a).(1).(b) at least three months of core surgical training in surgical subspecialty areas (e.g., surgical critical care, trauma, and vascular surgery). (Core)

IV.A.6.a).(2) at least a four week assignment on each non-urology rotation; and, (Core)

IV.A.6.a).(3) at least three months of urology rotations designed to develop competence in basic urological skills, general care of the urology patient both in the in-patient and ambulatory setting, management of urology patients in the emergency department, and a foundation of urology knowledge. (Core)

IV.A.6.b) Uro-2 (PGY-1) through Uro-5 (PGY-5) years must include 48 months of progressive education dedicated to didactic, clinical, and surgical urology. (Core)

IV.A.6.b).(1) Within the final 24 months of urology education, residents must serve at least 12 months as a chief resident. (Core)

IV.A.6.b).(1).(a) The clinical and academic experience as a chief resident should prepare the resident for an independent practice of urology. (Detail)

IV.A.6.b).(1).(b) ~~As such, t~~This chief resident experience should include management of patients with complex urologic disease, advanced procedures, and, with appropriate supervision, a high level of responsibility and independence. (Detail)

IV.A.6.c) ~~ensure that the d~~Didactic conferences must include:

IV.A.6.c).(1) ~~combined~~ morbidity and mortality ~~conferences for all participating sites~~; (Core)

IV.A.6.c).(2) urological imaging review ~~conferences~~; and, (Core)

IV.A.6.c).(3) ~~urological pathology conferences; and,~~ (Core)

IV.A.6.c).(4) journal review. (Core)

IV.A.6.d) ~~maintain a list of conferences.~~ (Core)

IV.A.6.d).(1) Didactic ~~C~~conferences must be well-attended by residents and core faculty members, and the list of conferences must include the date, conference topic, the name of the presenter(s), and the names of the faculty members and residents present for each conference. (Core)

IV.B. Residents' Scholarly Activities

IV.B.1. The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. (Core)

IV.B.2. Residents should participate in scholarly activity. (Core)

IV.B.2.a) A research rotation in the clinical years must not occur during the Uro-1 or Uro-5 year. Dedicated research time must not exceed 16 weeks in the eligible (Uro-2, Uro-3, and Uro-4) accredited years. (Core)

IV.B.2.b) ~~Residents must demonstrate scholarly activity, including manuscript preparation, lectures, teaching activities, abstracts,~~

~~and/or active performance of research or participation in clinical studies and reviews.~~ ~~(Outcome)~~

IV.B.2.c) ~~Research included in the clinical years should not exceed a maximum of six months, and regular clinical duties must be assigned concurrently.~~ ~~(Core)~~

IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities. (Detail)

V. Evaluation

V.A. Resident Evaluation

V.A.1. The program director must appoint the Clinical Competency Committee. (Core)

V.A.1.a) At a minimum the Clinical Competency Committee must be composed of three members of the program faculty. (Core)

V.A.1.a).(1) The program director may appoint additional members of the Clinical Competency Committee.

V.A.1.a).(1).(a) These additional members must be physician faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents in patient care and other health care settings. (Core)

V.A.1.a).(1).(b) Chief residents who have completed core residency programs in their specialty and are eligible for specialty board certification may be members of the Clinical Competency Committee. (Core)

V.A.1.a).(2) The Clinical Competency Committee must include at least two core faculty members. (Core)

V.A.1.b) There must be a written description of the responsibilities of the Clinical Competency Committee. (Core)

V.A.1.b).(1) The Clinical Competency Committee should:

V.A.1.b).(1).(a) review all resident evaluations semi-annually; (Core)

V.A.1.b).(1).(b) prepare and ensure the reporting of Milestones evaluations of each resident semi-annually to ACGME; and, (Core)

V.A.1.b).(1).(c) **advise the program director regarding resident progress, including promotion, remediation, and dismissal.** (Detail)

V.A.2. Formative Evaluation

V.A.2.a) **The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.** (Core)

V.A.2.b) **The program must:**

V.A.2.b).(1) **provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones;** (Core)

V.A.2.b).(2) **use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);** (Detail)

V.A.2.b).(2).(a) There must be a minimum of three different ~~types~~sources of evaluations. (Detail)

V.A.2.b).(3) **document progressive resident performance improvement appropriate to educational level; and,** (Core)

V.A.2.b).(4) **provide each resident with documented semiannual evaluation of performance with feedback.** (Core)

V.A.2.c) **The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.** (Detail)

V.A.2.d) Assessment must specifically include monitoring the resident's medical knowledge by use of a formal examination such as the American Urological Association In-Service Examination or other cognitive examinations. (Core)

V.A.2.d).(1) Test results ~~must~~should be assessed annually ~~based on the specialty specific Milestones~~ and utilized to guide program curriculum and individual resident study plans. (Detail)

V.A.2.d).(2) Test results should not be used as the sole criterion of resident knowledge and should not be used as the sole criterion for promotion to a subsequent PG level. (Detail)

V.A.3. Summative Evaluation

V.A.3.a) The specialty-specific Milestones must be used as one of the tools to ensure residents are able to practice core professional activities without supervision upon completion of the program. (Core)

V.A.3.b) The program director must provide a summative evaluation for each resident upon completion of the program. (Core)

This evaluation must:

V.A.3.b).(1) 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; (Detail)

V.A.3.b).(2) document the resident's performance during the final period of education; and, (Detail)

V.A.3.b).(3) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision. (Detail)

V.B. Faculty Evaluation

V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program. (Core)

V.B.2. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities. (Detail)

V.B.3. This evaluation must include at least annual written confidential evaluations by the residents. (Detail)

V.C. Program Evaluation and Improvement

V.C.1. The program director must appoint the Program Evaluation Committee (PEC). **(Core)**

V.C.1.a) The Program Evaluation Committee:

V.C.1.a).(1) must be composed of at least two program faculty members and should include at least one resident; **(Core)**

V.C.1.a).(1).(a) The Program Evaluation Committee must include at least two core faculty members. (Core)

V.C.1.a).(2) **must have a written description of its responsibilities; and,** (Core)

V.C.1.a).(3) **should participate actively in:**

V.C.1.a).(3).(a) **planning, developing, implementing, and evaluating educational activities of the program;** (Detail)

V.C.1.a).(3).(b) **reviewing and making recommendations for revision of competency-based curriculum goals and objectives;** (Detail)

V.C.1.a).(3).(c) **addressing areas of non-compliance with ACGME standards; and,** (Detail)

V.C.1.a).(3).(d) **reviewing the program annually using evaluations of faculty, residents, and others, as specified below.** (Detail)

V.C.2. **The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written, annual program evaluation.** (Core)

The program must monitor and track each of the following areas:

V.C.2.a) **resident performance;** (Core)

V.C.2.b) **faculty development;** (Core)

V.C.2.c) **graduate performance, including performance of program graduates on the certification examination;** (Core)

V.C.2.c).(1) At least 80 percent of the program's graduates from the preceding three years who take either the American Board of Urology Qualifying Examination or the American Board of Osteopathic Surgery-Urological Surgery written qualifying examination for the first time must pass. (Outcome)

V.C.2.c).(2) The results of residents' annual objective tests (such as the In-service Examination and the Qualifying Examination) must be included in the assessment of the strengths and weaknesses of the program. (Detail)

V.C.2.d) **program quality; and,** (Core)

V.C.2.d).(1) **Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and** (Detail)

V.C.2.d).(2) **The program must use the results of residents' and faculty members' assessments of the program together with other program evaluation results to improve the program.** (Detail)

V.C.2.e) **progress on the previous year's action plan(s).** (Core)

V.C.3. **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)

V.C.3.a) **The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.** (Detail)

VI. The Learning and Working Environment

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

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

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

VI.A.1. Patient Safety and Quality Improvement

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for residents to develop and apply.

VI.A.1.a).(4).(a) All residents must receive training in how to disclose adverse events to patients and families. (Core)

VI.A.1.a).(4).(b) Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated. (Detail)

VI.A.1.b) **Quality Improvement**

VI.A.1.b).(1) **Education in Quality Improvement**

A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.

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

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

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

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

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.

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

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

VI.A.2. **Supervision and Accountability**

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.

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)

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)

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)

VI.A.2.a).(1).(c) The Review Committee recognizes only physician faculty members as appropriate faculty supervisors for residents. (Core)

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.***

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)

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

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

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

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

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)

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 and/or electronic modalities, and is available to provide Direct Supervision.** (Core)

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

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

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

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

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

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

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

VI.A.2.e).(1).(a) **Initially, PGY-1 residents must be supervised either directly, or indirectly with direct supervision immediately available.** (Core)

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

VI.B. Professionalism

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)

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

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

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

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

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

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

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

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

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

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

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

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

VI.B.4.e) monitoring of their patient care performance improvement indicators; and, (Outcome)

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

VI.B.5. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider. (Outcome)

VI.B.6. Programs must provide a professional, respectful, and civil environment that is free from mistreatment, abuse, or coercion of students, residents, faculty, and staff. Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a

confidential process for reporting, investigating, and addressing such concerns. (Core)

VI.C. Well-Being

In the current health care environment, residents and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician. Self-care is an important component of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of residency training. 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.

VI.C.1. This responsibility 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)

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

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

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

VI.C.1.e).(1) encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another

resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence; (Core)

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

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

VI.C.2. **There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. Each program must have policies and procedures in place that ensure coverage of patient care in the event that a resident may be unable to perform their patient care responsibilities. These policies must be implemented without fear of negative consequences for the resident who is unable to provide the clinical work. (Core)**

VI.D. Fatigue Mitigation

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

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

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

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

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

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

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

VI.E.1. **Clinical Responsibilities**

The clinical responsibilities for each resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services. (Core)

VI.E.1.a) The program director must establish written guidelines for the assignment of clinical responsibilities by ~~the~~ PGY level, including clinic volume, on-call frequency and back-up requirements, and the appropriate role in surgical procedures. (Core)

VI.E.2. Teamwork

Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty and larger health system. (Core)

VI.E.2.a) Each resident must have the opportunity to interact with nurses, ~~other specialists,~~ social workers, and ~~mid-level~~other health care providers. (Core)

VI.E.3. Transitions of Care

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

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

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

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

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

VI.F. Clinical Experience and Education

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

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

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

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

VI.F.2.a) The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being. (Core)

VI.F.2.b) Residents should have eight hours off between scheduled clinical work and education periods. (Detail)

VI.F.2.b).(1) There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements. (Detail)

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

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

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

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

VI.F.3.a).(1) Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. (Core)

VI.F.3.a).(1).(a) Additional patient care responsibilities must not be assigned to a resident during this time. (Core)

VI.F.4. Clinical and Educational Work Hour Exceptions

VI.F.4.a) In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:

VI.F.4.a).(1) **to continue to provide care to a single severely ill or unstable patient; (Detail)**

VI.F.4.a).(2) **humanistic attention to the needs of a patient or family; or, (Detail)**

VI.F.4.a).(3) **to attend unique educational events. (Detail)**

VI.F.4.b) **These additional hours of care or education will be counted toward the 80-hour weekly limit. (Detail)**

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

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

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)**

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)**

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)

VI.F.6.a) Residents cannot be assigned more than eight weeks of night float per year. (Detail)

VI.F.6.b) ~~Night float rotations must not exceed 16 weeks total during the URO-1 and URO-2 years. (Detail)~~

VI.F.7. Maximum In-House On-Call Frequency

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

VI.F.8. At-Home Call

VI.F.8.a) Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. (Core)

VI.F.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core)

VI.F.8.b) Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit. (Detail)

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*__Core Requirements:__ Statements that define structure, resource, or process elements essential to every graduate medical educational program.

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

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

Osteopathic Recognition

For programs seeking Osteopathic Recognition for the entire program, or for a track within the program, the Osteopathic Recognition Requirements are also applicable. (http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/Osteopathic_Recogniton_Requirements.pdf)