ACGME Program Requirements for Graduate Medical Education in Vascular Surgery (Integrated)

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ACGME Program Requirements for Graduate Medical Education in Vascular Surgery (Integrated)

Common Program Requirements (Residency) are in BOLD

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

The "Specialty-Specific Background and Intent" text in the boxes below provide detail regarding the intention behind specific requirements, as well as guidance on how to implement the requirements in a way that supports excellence in residency education. Programs will note that the Vascular Surgery Subspecialty FAQs companion document has been integrated into this document and, where appropriate, guidance is given on additional Review Committee resource information.

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

45 ***of patients, residents, fellows, faculty members, students, and all members***
46 ***of the health care team.***
47
48 **Int.B. Definition of Specialty**
49
50 Vascular surgery is the surgical specialty involving diseases of the arterial,
51 venous, and lymphatic circulatory systems, exclusive of those circulatory vessels
52 intrinsic to the heart and intracranial vessels. Specialists in this discipline
53 demonstrate ~~not only~~ the knowledge, skills, and understanding of the medical
54 science relative to the vascular system, ~~but also~~ as well as mature technical skills
55 and surgical judgment.
56
57 **Int.C. Length of Educational Program**
58
59 The educational program in vascular surgery for integrated programs must be 60
60 months in length. (Core)
61
62 **I. Oversight**
63
64 **I.A. Sponsoring Institution**
65
66 ***The Sponsoring Institution is the organization or entity that assumes the***
67 ***ultimate financial and academic responsibility for a program of graduate***
68 ***medical education, consistent with the ACGME Institutional Requirements.***
69
70 ***When the Sponsoring Institution is not a rotation site for the program, the***
71 ***most commonly utilized site of clinical activity for the program is the***
72 ***primary clinical site.***
73

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.

74
75 **I.A.1. The program must be sponsored by one ACGME-accredited**
76 **Sponsoring Institution. (Core)***
77
78 **I.B. Participating Sites**
79
80 ***A participating site is an organization providing educational experiences or***
81 ***educational assignments/rotations for residents.***
82
83 **I.B.1. The program, with approval of its Sponsoring Institution, must**
84 **designate a primary clinical site. (Core)**
85

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 must:**

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

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

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**

I.B.4. **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 ACGME's Accreditation Data System (ADS).** (Core)

I.B.5. Participating sites ~~must be in geographic proximity~~ should be geographically proximate to the primary clinical site to allow all residents to attend joint conferences, basic science lectures, and morbidity and mortality reviews on a regular and documented basis at a central location. (Core)

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I.B.5.a) Geographically remote participating sites must provide audiovisual access to conferences and lectures at the central location or document provision of an equivalent educational program of lectures and conferences. ~~If the sites are geographically so remote that joint conferences cannot be held, an equivalent educational program of lectures and conferences at the participating site must be fully documented.~~ (Core)

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

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

I.D. Resources

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

I.D.1.a) These resources must include:

I.D.1.a).(1) a common office space for residents that includes a sufficient number of computers and adequate workspace at the primary clinical site; (Core)

I.D.1.a).(2) software resources for production of presentations, manuscripts, and portfolios; and, (Core)

I.D.1.a).(3) online radiographic and laboratory reporting systems at the primary clinical site and all participating sites. (Core)

I.D.1.b) The facility used to provide residents with experience in interpretation of non-invasive vascular laboratory testing must be accredited by a recognized organization that would allow residency graduates to fulfill the requirements of eligibility for specialty board certification. (Core)

I.D.1.b).(1) The laboratory ~~should~~ must be currently accredited in extracranial cerebrovascular, peripheral arterial and peripheral venous testing, and ~~should have~~ must provide substantial experience in abdominal and visceral vascular imaging. (Detail)

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I.D.1.c) ~~In the absence of accreditation of all testing modules (i.e. venous, arterial, cerebrovascular, visceral) substantial experience in each testing modality must be demonstrated, and full accreditation in all modules achieved within two years from the time of the most recent annual program update. (Detail)~~

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

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

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

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.

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

Background and Intent: Sites must provide private and clean locations where 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).

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

I.D.2.e) accommodations for residents with disabilities consistent with the Sponsoring Institution’s policy. (Core)

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

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Specialty-Specific Background and Intent: The Review Committee interprets "ready access" to mean availability at all clinical sites utilized by the program.

196
197 **I.D.4.** **The program's educational and clinical resources must be adequate**
198 **to support the number of residents appointed to the program.** (Core)
199
200 I.D.4.a) An accredited vascular surgery program must be conducted in an
201 institution(s) that can document a sufficient breadth of patient care
202 that routinely cares for patients with a broad spectrum of vascular
203 diseases and conditions. (Core)
204
205 I.D.4.b) In addition, these institutions must include facilities and staff
206 members for a variety of other services that provide a critical role
207 in the care of patients with vascular conditions, including
208 cardiovascular services, critical care services, general surgery
209 services, nephrology services, neurology services, and radiology
210 services. ~~There must be the capability to perform both open and~~
211 ~~endovascular procedures of sufficient breadth and volume to~~
212 ~~support the program.~~ (Core)
213
214 I.D.4.c) The institutional volume and variety of open and endovascular
215 operative experience must be adequate to ensure a sufficient
216 number and distribution of complex cases (as determined by the
217 Review Committee) for each resident in the program. (Core)
218
219 **I.E.** **The presence of other learners and other care providers, including, but not**
220 **limited to, residents from other programs, subspecialty fellows, and**
221 **advanced practice providers, must enrich the appointed residents'**
222 **education.** (Core)
223
224 **I.E.1.** **The program must report circumstances when the presence of other**
225 **learners has interfered with the residents' education to the DIO and**
226 **Graduate Medical Education Committee (GMEC).** (Core)
227

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.

228
229 **II. Personnel**
230
231 **II.A. Program Director**
232
233 **II.A.1.** **There must be one faculty member appointed as program director**
234 **with authority and accountability for the overall program, including**
235 **compliance with all applicable program requirements.** (Core)
236
237 **II.A.1.a)** **The Sponsoring Institution's GMEC must approve a change in**
238 **program director.** (Core)

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239
240 **II.A.1.b)** **Final approval of the program director resides with the**
241 **Review Committee.** **(Core)**
242

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.

243
244 **II.A.1.c)** **The program must demonstrate retention of the program**
245 **director for a length of time adequate to maintain continuity**
246 **of leadership and program stability.** **(Core)**
247
248 II.A.1.c).(1) The term of appointment must be for the length of the
249 program plus one year. (Detail)
250

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.

251
252 **II.A.2.** **At a minimum, the program director must be provided with the**
253 **salary support required to devote 20 percent FTE of non-clinical**
254 **time to the administration of the program.** **(Core)**
255
256 II.A.2.a) The program director must be provided a minimum of 20 percent
257 protected time for program administration. (Core)
258
259 II.A.2.b) Program directors who oversee both an integrated and an
260 independent vascular surgery program must be provided a
261 minimum of 10 percent additional protected time for administration
262 of the integrated program. (Core)
263
264 II.A.2.c) Program directors who oversee both an independent and an
265 integrated vascular surgery program which, combined, have 10 or
266 more residents/fellows must appoint an associate program
267 director. (Core)
268
269 II.A.2.d) ~~Program directors must devote at least 50 percent of his or her~~
270 ~~time to program management and administration. (Core)~~
271

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

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

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

272

Specialty-Specific Background and Intent: Programs are advised that the Common Program Requirements specify that protected time is specifically for the administration of the program and not for clinical activities. The program is further advised that the Program Requirements for the independent and integrated vascular surgery programs are two distinct sets of requirements. If a single program director has responsibility for both program formats, the applicable protected time is outlined in II.A.2. of both sets of Program Requirements.

273
274 **II.A.3.** **Qualifications of the program director:**
275
276 **II.A.3.a)** **must include specialty expertise and at least three years of**
277 **documented educational and/or administrative experience, or**
278 **qualifications acceptable to the Review Committee;** (Core)
279

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.

280
281 **II.A.3.b)** **must include current certification in the specialty for which**
282 **they are the program director by the American Board of**
283 Surgery **or by the American Osteopathic Board of** Surgery**, or**
284 **specialty qualifications that are acceptable to the Review**
285 **Committee;** (Core)
286
287 **II.A.3.c)** **must include current medical licensure and appropriate**
288 **medical staff appointment; and,** (Core)
289
290 **II.A.3.d)** **must include ongoing clinical activity.** (Core)
291

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.

292
293 **II.A.4.** **Program Director Responsibilities**
294

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295 **The program director must have responsibility, authority, and**
296 **accountability for: administration and operations; teaching and**
297 **scholarly activity; resident recruitment and selection, evaluation,**
298 **and promotion of residents, and disciplinary action; supervision of**
299 **residents; and resident education in the context of patient care.** **(Core)**
300
301 **II.A.4.a)** **The program director must:**
302
303 **II.A.4.a).(1)** **be a role model of professionalism;** **(Core)**
304

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.

305
306 **II.A.4.a).(2)** **design and conduct the program in a fashion**
307 **consistent with the needs of the community, the**
308 **mission(s) of the Sponsoring Institution, and the**
309 **mission(s) of the program;** **(Core)**
310

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.

311
312 **II.A.4.a).(3)** **administer and maintain a learning environment**
313 **conducive to educating the residents in each of the**
314 **ACGME Competency domains;** **(Core)**
315

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.

316
317 **II.A.4.a).(4)** **develop and oversee a process to evaluate candidates**
318 **prior to approval as program faculty members for**
319 **participation in the residency program education and**
320 **at least annually thereafter, as outlined in V.B.;** **(Core)**
321

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322 **II.A.4.a).(5)** **have the authority to approve program faculty members for participation in the residency program education at all sites; (Core)**
323
324
325
326 **II.A.4.a).(6)** **have the authority to remove program faculty members from participation in the residency program education at all sites; (Core)**
327
328
329
330 **II.A.4.a).(7)** **have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program; (Core)**
331
332
333

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.

334
335 **II.A.4.a).(8)** **submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; (Core)**
336
337
338 **II.A.4.a).(9)** **provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s); (Core)**
339
340
341
342 **II.A.4.a).(10)** **provide a learning and working environment in which residents have the opportunity to raise concerns and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; (Core)**
343
344
345
346
347
348 **II.A.4.a).(11)** **ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process; (Core)**
349
350
351
352 **II.A.4.a).(12)** **ensure the program's compliance with the Sponsoring Institution's policies and procedures for due process when action is taken to suspend or dismiss, not to promote, or not to renew the appointment of a resident; (Core)**
353
354
355
356
357

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.

358

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359 **II.A.4.a).(13)** **ensure the program's compliance with the Sponsoring**
360 **Institution's policies and procedures on employment**
361 **and non-discrimination;** **(Core)**
362
363 **II.A.4.a).(13).(a)** **Residents must not be required to sign a non-**
364 **competition guarantee or restrictive covenant.**
365 **(Core)**
366
367 **II.A.4.a).(14)** **document verification of program completion for all**
368 **graduating residents within 30 days;** **(Core)**
369
370 **II.A.4.a).(15)** **provide verification of an individual resident's**
371 **completion upon the resident's request, within 30**
372 **days; and,** **(Core)**
373

> **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.**

374
375 **II.A.4.a).(16)** **obtain review and approval of the Sponsoring**
376 **Institution's DIO before submitting information or**
377 **requests to the ACGME, as required in the Institutional**
378 **Requirements and outlined in the ACGME Program**
379 **Director's Guide to the Common Program**
380 **Requirements.** **(Core)**
381
382 **II.B.** **Faculty**
383
384 ***Faculty members are a foundational element of graduate medical education***
385 ***– faculty members teach residents how to care for patients. Faculty***
386 ***members provide an important bridge allowing residents to grow and***
387 ***become practice-ready, ensuring that patients receive the highest quality of***
388 ***care. They are role models for future generations of physicians by***
389 ***demonstrating compassion, commitment to excellence in teaching and***
390 ***patient care, professionalism, and a dedication to lifelong learning. Faculty***
391 ***members experience the pride and joy of fostering the growth and***
392 ***development of future colleagues. The care they provide is enhanced by***
393 ***the opportunity to teach. By employing a scholarly approach to patient***
394 ***care, faculty members, through the graduate medical education system,***
395 ***improve the health of the individual and the population.***
396
397 ***Faculty members ensure that patients receive the level of care expected***
398 ***from a specialist in the field. They recognize and respond to the needs of***
399 ***the patients, residents, community, and institution. Faculty members***
400 ***provide appropriate levels of supervision to promote patient safety. Faculty***
401 ***members create an effective learning environment by acting in a***
402 ***professional manner and attending to the well-being of the residents and***
403 ***themselves.***

404

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.

405
406 **II.B.1.** **At each participating site, there must be a sufficient number of**
407 **faculty members with competence to instruct and supervise all**
408 **residents at that location.** **(Core)**
409
410 II.B.1.a) ~~In addition to the program director, there must be, for each~~
411 ~~approved residency position, at least one full-time faculty member~~
412 ~~whose major function is teaching and supervising residents in the~~
413 ~~program.~~ (Core)
414
415 II.B.1.b) The members of the physician faculty must reflect sufficient
416 diversity of interest and capability to represent the many facets of
417 vascular surgery. (Detail)
418
419 **II.B.2.** **Faculty members must:**
420
421 **II.B.2.a)** **be role models of professionalism;** **(Core)**
422
423 **II.B.2.b)** **demonstrate commitment to the delivery of safe, quality,**
424 **cost-effective, patient-centered care;** **(Core)**
425

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.

426
427 **II.B.2.c)** **demonstrate a strong interest in the education of residents;**
428 **(Core)**
429
430 **II.B.2.d)** **devote sufficient time to the educational program to fulfill**
431 **their supervisory and teaching responsibilities;** **(Core)**
432
433 **II.B.2.e)** **administer and maintain an educational environment**
434 **conducive to educating residents;** **(Core)**
435
436 **II.B.2.f)** **regularly participate in organized clinical discussions,**
437 **rounds, journal clubs, and conferences; and,** **(Core)**
438
439 **II.B.2.g)** **pursue faculty development designed to enhance their skills**
440 **at least annually:** **(Core)**
441

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

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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.

442
443 **II.B.2.g).(1)** **as educators;** **(Core)**
444
445 **II.B.2.g).(2)** **in quality improvement and patient safety;** **(Core)**
446
447 **II.B.2.g).(3)** **in fostering their own and their residents' well-being;**
448 **and,** **(Core)**
449
450 **II.B.2.g).(4)** **in patient care based on their practice-based learning**
451 **and improvement efforts.** **(Core)**
452

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

453
454 **II.B.3.** **Faculty Qualifications**
455
456 **II.B.3.a)** **Faculty members must have appropriate qualifications in**
457 **their field and hold appropriate institutional appointments.**
458 **(Core)**
459
460 **II.B.3.b)** **Physician faculty members must:**
461
462 **II.B.3.b).(1)** **have current certification in the specialty by the**
463 **American Board of** Surgery **or the American**
464 **Osteopathic Board of** Surgery**, or possess**
465 **qualifications judged acceptable to the Review**
466 **Committee.** **(Core)**
467
468 **II.B.3.c)** **Any non-physician faculty members who participate in**
469 **residency program education must be approved by the**
470 **program director.** **(Core)**
471

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.

472
473 **II.B.4.** **Core Faculty**
474

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475 **Core faculty members must have a significant role in the education**
476 **and supervision of residents and must devote a significant portion**
477 **of their entire effort to resident education and/or administration, and**
478 **must, as a component of their activities, teach, evaluate, and**
479 **provide formative feedback to residents.** **(Core)**
480

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.

481
482 **II.B.4.a)** **Core faculty members must be designated by the program**
483 **director.** **(Core)**
484
485 **II.B.4.b)** **Core faculty members must complete the annual ACGME**
486 **Faculty Survey.** **(Core)**
487
488 II.B.4.c) In addition to the program director, there must be a minimum of
489 four board-certified vascular surgeons and one board-certified
490 general surgeon designated as core faculty members. (Core)
491
492 II.B.4.d) For programs with 10 or more approved residency positions, there
493 must be, in addition to the program director, a minimum of one
494 core faculty member for each approved position. (Core)
495
496 II.B.4.d).(1) The majority of those core faculty members must be board-
497 certified vascular surgeons. (Core)
498
499 II.B.4.d).(2) There must be a minimum of one board-certified general
500 surgeon designated as a core faculty member. (Core)
501
502 **II.C. Program Coordinator**
503
504 **II.C.1.** **There must be a program coordinator.** **(Core)**
505
506 **II.C.2.** **At a minimum, the program coordinator must be supported at 50**
507 **percent FTE for administration of the program.** **(Core)**
508
509 II.C.2.a) Additional support must be provided based on program size as
510 follows: (Core)
511

Number of Approved Resident Positions	Minimum FTE Required
1-9	0.5
10 or more	1.0

512
513 II.C.2.b) A program with 20 or more residents must provide the program
514 coordinator with additional administrative support. (Core)

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515

Specialty-Specific Background and Intent: Support for a single coordinator who has responsibility for both an integrated vascular surgery program and an independent vascular surgery program is addressed in II.C.2. of the Program Requirements for each of those program formats and is cumulative.

516

Background and Intent: Fifty percent FTE is defined as two-and-a-half (2.5) days per week.

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

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

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

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

517
518 **II.D. Other Program Personnel**
519
520 **The program, in partnership with its Sponsoring Institution, must jointly**
521 **ensure the availability of necessary personnel for the effective**
522 **administration of the program.** (Core)
523

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.

524
525 **III. Resident Appointments**
526
527 **III.A. Eligibility Requirements**
528
529 **III.A.1. An applicant must meet one of the following qualifications to be**
530 **eligible for appointment to an ACGME-accredited program:** (Core)
531

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532 **III.A.1.a)** **graduation from a medical school in the United States or**
533 **Canada, accredited by the Liaison Committee on Medical**
534 **Education (LCME) or graduation from a college of**
535 **osteopathic medicine in the United States, accredited by the**
536 **American Osteopathic Association Commission on**
537 **Osteopathic College Accreditation (AOACOCA); or,** **(Core)**
538
539 **III.A.1.b)** **graduation from a medical school outside of the United**
540 **States or Canada, and meeting one of the following additional**
541 **qualifications:** **(Core)**
542
543 **III.A.1.b).(1)** **holding a currently valid certificate from the**
544 **Educational Commission for Foreign Medical**
545 **Graduates (ECFMG) prior to appointment; or,** **(Core)**
546
547 **III.A.1.b).(2)** **holding a full and unrestricted license to practice**
548 **medicine in the United States licensing jurisdiction in**
549 **which the ACGME-accredited program is located.** **(Core)**
550
551 **III.A.2.** **All prerequisite post-graduate clinical education required for initial**
552 **entry or transfer into ACGME-accredited residency programs must**
553 **be completed in ACGME-accredited residency programs, AOA-**
554 **approved residency programs, Royal College of Physicians and**
555 **Surgeons of Canada (RCPSC)-accredited or College of Family**
556 **Physicians of Canada (CFPC)-accredited residency programs**
557 **located in Canada, or in residency programs with ACGME**
558 **International (ACGME-I) Advanced Specialty Accreditation.** **(Core)**
559
560 **III.A.2.a)** **Residency programs must receive verification of each**
561 **resident's level of competency in the required clinical field**
562 **using ACGME, CanMEDS, or ACGME-I Milestones evaluations**
563 **from the prior training program upon matriculation.** **(Core)**
564

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.

565
566 **III.A.3.** **A physician who has completed a residency program that was not**
567 **accredited by ACGME, AOA, RCPSC, CFPC, or ACGME-I (with**
568 **Advanced Specialty Accreditation) may enter an ACGME-accredited**
569 **residency program in the same specialty at the PGY-1 level and, at**
570 **the discretion of the program director of the ACGME-accredited**
571 **program and with approval by the GMEC, may be advanced to the**
572 **PGY-2 level based on ACGME Milestones evaluations at the ACGME-**
573 **accredited program. This provision applies only to entry into**
574 **residency in those specialties for which an initial clinical year is not**
575 **required for entry.** **(Core)**
576

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577 **III.B. The program director must not appoint more residents than approved by**
578 **the Review Committee.** **(Core)**
579
580 **III.B.1. All complement increases must be approved by the Review**
581 **Committee.** **(Core)**
582
583 **III.C. Resident Transfers**
584
585 **The program must obtain verification of previous educational experiences**
586 **and a summative competency-based performance evaluation prior to**
587 **acceptance of a transferring resident, and Milestones evaluations upon**
588 **matriculation.** **(Core)**
589
590 III.C.1. Resident transfers into an integrated vascular surgery program must be
591 approved in advance by the Review Committee. (Core)
592
593 III.C.2. To be eligible for transfer at the PGY-2 level, residents must have
594 satisfactorily completed a minimum of one year in an ACGME-accredited
595 program in surgery, integrated vascular surgery, or integrated thoracic
596 surgery. (Core)
597
598 III.C.3. To be eligible for transfer at the PGY-3 level, residents must have
599 satisfactorily completed a minimum of two years in an ACGME-accredited
600 integrated vascular surgery program, or a combination of a minimum of
601 one year in an ACGME-accredited program in surgery or integrated
602 thoracic surgery and a minimum of one year in an ACGME-accredited
603 integrated vascular surgery program. (Core)
604
605 III.C.4. To be eligible for transfer at the PGY-4 level, residents must have
606 satisfactorily completed a minimum of three years in an ACGME-
607 accredited integrated vascular surgery program, or a combination of a
608 minimum of one year in an ACGME-accredited program in surgery or
609 integrated thoracic surgery and a minimum of two years in an ACGME-
610 accredited Integrated Vascular Surgery program. (Core)
611
612 **IV. Educational Program**
613
614 ***The ACGME accreditation system is designed to encourage excellence and***
615 ***innovation in graduate medical education regardless of the organizational***
616 ***affiliation, size, or location of the program.***
617
618 ***The educational program must support the development of knowledgeable, skillful***
619 ***physicians who provide compassionate care.***
620
621 ***In addition, the program is expected to define its specific program aims consistent***
622 ***with the overall mission of its Sponsoring Institution, the needs of the community***
623 ***it serves and that its graduates will serve, and the distinctive capabilities of***
624 ***physicians it intends to graduate. While programs must demonstrate substantial***
625 ***compliance with the Common and specialty-specific Program Requirements, it is***
626 ***recognized that within this framework, programs may place different emphasis on***
627 ***research, leadership, public health, etc. It is expected that the program aims will***

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628 *reflect the nuanced program-specific goals for it and its graduates; for example, it*
629 *is expected that a program aiming to prepare physician-scientists will have a*
630 *different curriculum from one focusing on community health.*
631
632 **IV.A. The curriculum must contain the following educational components:** (Core)
633
634 **IV.A.1. a set of program aims consistent with the Sponsoring Institution's**
635 **mission, the needs of the community it serves, and the desired**
636 **distinctive capabilities of its graduates;** (Core)
637
638 **IV.A.1.a) The program's aims must be made available to program**
639 **applicants, residents, and faculty members.** (Core)
640
641 **IV.A.2. competency-based goals and objectives for each educational**
642 **experience designed to promote progress on a trajectory to**
643 **autonomous practice. These must be distributed, reviewed, and**
644 **available to residents and faculty members;** (Core)
645

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.

646
647 **IV.A.3. delineation of resident responsibilities for patient care, progressive**
648 **responsibility for patient management, and graded supervision;** (Core)
649

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.

650
651 **IV.A.4. a broad range of structured didactic activities;** (Core)
652
653 **IV.A.4.a) Residents must be provided with protected time to participate**
654 **in core didactic activities.** (Core)
655

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

656

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657 **IV.A.5.** **advancement of residents' knowledge of ethical principles**
658 **foundational to medical professionalism; and, (Core)**
659
660 **IV.A.6.** **advancement in the residents' knowledge of the basic principles of**
661 **scientific inquiry, including how research is designed, conducted,**
662 **evaluated, explained to patients, and applied to patient care. (Core)**
663
664 **IV.B. ACGME Competencies**
665

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.

666
667 **IV.B.1.** **The program must integrate the following ACGME Competencies**
668 **into the curriculum: (Core)**
669
670 **IV.B.1.a)** **Professionalism**
671
672 **Residents must demonstrate a commitment to**
673 **professionalism and an adherence to ethical principles. (Core)**
674
675 **IV.B.1.a).(1)** **Residents must demonstrate competence in:**
676
677 **IV.B.1.a).(1).(a)** **compassion, integrity, and respect for others;**
678 **(Core)**
679
680 **IV.B.1.a).(1).(b)** **responsiveness to patient needs that**
681 **supersedes self-interest; (Core)**
682

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.

683
684 **IV.B.1.a).(1).(c)** **respect for patient privacy and autonomy; (Core)**
685
686 **IV.B.1.a).(1).(d)** **accountability to patients, society, and the**
687 **profession; (Core)**
688
689 **IV.B.1.a).(1).(e)** **respect and responsiveness to diverse patient**
690 **populations, including but not limited to**
691 **diversity in gender, age, culture, race, religion,**
692 **disabilities, national origin, socioeconomic**
693 **status, and sexual orientation; (Core)**
694
695 **IV.B.1.a).(1).(f)** **ability to recognize and develop a plan for one's**
696 **own personal and professional well-being; and,**
697 **(Core)**

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698
699 **IV.B.1.a).(1).(g)** **appropriately disclosing and addressing conflict or duality of interest.** **(Core)**
700
701
702 **IV.B.1.b)** **Patient Care and Procedural Skills**
703

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.

704
705 **IV.B.1.b).(1)** **Residents must be able to provide patient care that is**
706 **compassionate, appropriate, and effective for the**
707 **treatment of health problems and the promotion of**
708 **health.** **(Core)**
709
710 IV.B.1.b).(1).(a) Residents must demonstrate manual dexterity
711 appropriate for their educational levels. (Core)
712
713 IV.B.1.b).(1).(b) Residents must develop and execute patient care
714 plans appropriate for their educational levels. (Core)
715
716 **IV.B.1.b).(2)** **Residents must be able to perform all medical,**
717 **diagnostic, and surgical procedures considered**
718 **essential for the area of practice.** **(Core)**
719
720 IV.B.1.b).(2).(a) Residents must develop competence in performing
721 operative procedures in the following ~~defined~~ list of
722 defined categories:
723
724 IV.B.1.b).(2).(a).(i) abdominal; (Core)
725
726 IV.B.1.b).(2).(a).(ii) cerebrovascular; (Core)
727
728 IV.B.1.b).(2).(a).(iii) complex; (Core)
729
730 IV.B.1.b).(2).(a).(iv) endovascular aneurysm repair; (Core)
731
732 IV.B.1.b).(2).(a).(v) endovascular diagnostic; (Core)
733
734 IV.B.1.b).(2).(a).(vi) endovascular therapeutic; and, (Core)
735

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IV.B.1.b).(2).(a).(vii) peripheral. (Core)

IV.B.1.b).(2).(b) Residents must develop competence in patient management, including determining an appropriate diagnosis and operative plan, providing pre-operative care, and directing post-operative care. (Core)

IV.B.1.b).(2).(c) Residents must develop competence in assessing the vascular portion of angiography, computed tomography (CT) scanning, ~~and~~ magnetic resonance imaging (MRI), and magnetic resonance angiogram (MRA) images. (Core)

IV.B.1.b).(2).(d) Residents must demonstrate the ability to accurately interpret non-invasive vascular laboratory studies. (Core)

IV.B.1.b).(2).(d).(i) This experience must include the range and number of non-invasive studies that would allow ~~residency or fellowship~~ graduates to fulfill the requirements of eligibility for specialty board certification. (Core)

IV.B.1.c) Medical Knowledge

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

IV.B.1.c).(1) Residents must demonstrate knowledge of ~~the fundamental sciences, including~~ anatomy, biology, embryology, microbiology, physiology, and pathology as they relate to the pathophysiology, diagnosis, and treatment of vascular lesions. (Core)

IV.B.1.c).(2) Residents must demonstrate knowledge of the methods and techniques of angiography, CT scanning, ~~and~~ MRI, MRA, and other vascular imaging modalities. (Core)

IV.B.1.c).(3) Residents must demonstrate ~~the ability to apply~~ knowledge of the roles of different specialists and other health care professionals in overall patient management. (Core)

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

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

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787

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.

788
789 **IV.B.1.d).(1)** **Residents must demonstrate competence in:**
790
791 **IV.B.1.d).(1).(a)** **identifying strengths, deficiencies, and limits in**
792 **one's knowledge and expertise; (Core)**
793
794 **IV.B.1.d).(1).(b)** **setting learning and improvement goals; (Core)**
795
796 **IV.B.1.d).(1).(c)** **identifying and performing appropriate learning**
797 **activities; (Core)**
798
799 **IV.B.1.d).(1).(d)** **systematically analyzing practice using quality**
800 **improvement methods, and implementing**
801 **changes with the goal of practice improvement;**
802 **(Core)**
803
804 **IV.B.1.d).(1).(e)** **incorporating feedback and formative**
805 **evaluation into daily practice; (Core)**
806
807 **IV.B.1.d).(1).(f)** **locating, appraising, and assimilating evidence**
808 **from scientific studies related to their patients'**
809 **health problems; and, (Core)**
810
811 **IV.B.1.d).(1).(g)** **using information technology to optimize**
812 **learning. (Core)**
813
814 **IV.B.1.e)** **Interpersonal and Communication Skills**
815
816 **Residents must demonstrate interpersonal and**
817 **communication skills that result in the effective exchange of**
818 **information and collaboration with patients, their families,**
819 **and health professionals. (Core)**
820
821 **IV.B.1.e).(1)** **Residents must demonstrate competence in:**
822
823 **IV.B.1.e).(1).(a)** **communicating effectively with patients,**
824 **families, and the public, as appropriate, across**
825 **a broad range of socioeconomic and cultural**
826 **backgrounds; (Core)**
827

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

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

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

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

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

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

849

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.

850

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

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

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

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

864

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.

865

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866 **IV.B.1.f).(1).(b)** **coordinating patient care across the health care**
867 **continuum and beyond as relevant to their**
868 **clinical specialty;** **(Core)**
869

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.

870
871 **IV.B.1.f).(1).(c)** **advocating for quality patient care and optimal**
872 **patient care systems;** **(Core)**
873
874 **IV.B.1.f).(1).(d)** **working in interprofessional teams to enhance**
875 **patient safety and improve patient care quality;**
876 **(Core)**
877
878 **IV.B.1.f).(1).(e)** **participating in identifying system errors and**
879 **implementing potential systems solutions;** **(Core)**
880
881 **IV.B.1.f).(1).(f)** **incorporating considerations of value, cost**
882 **awareness, delivery and payment, and risk-**
883 **benefit analysis in patient and/or population-**
884 **based care as appropriate; and,** **(Core)**
885
886 **IV.B.1.f).(1).(g)** **understanding health care finances and its**
887 **impact on individual patients' health decisions.**
888 **(Core)**
889
890 **IV.B.1.f).(2)** **Residents must learn to advocate for patients within**
891 **the health care system to achieve the patient's and**
892 **family's care goals, including, when appropriate, end-**
893 **of-life goals.** **(Core)**
894
895 **IV.C.** **Curriculum Organization and Resident Experiences**
896
897 **IV.C.1.** **The curriculum must be structured to optimize resident educational**
898 **experiences, the length of these experiences, and supervisory**
899 **continuity.** **(Core)**
900
901 IV.C.1.a) Residents' clinical rotations must be a minimum of four weeks in
902 duration. (Core)
903

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.

904

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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)**

IV.C.3. The following conferences must exist:

IV.C.3.a) a review, held at least biweekly, of all current complications and deaths, including radiological and pathological correlation of surgical specimens and autopsies when relevant; (Detail)

IV.C.3.b) a course or a structured series of conferences to ensure coverage of the basic and clinical sciences fundamental to vascular surgery, as well as ~~in~~ the technological advances that relate to vascular surgery and the care of patients with vascular diseases; (Detail)

IV.C.3.c) regular organized clinical teaching; and, (Detail)

IV.C.3.d) a regular review of recent literature in a journal club format. (Detail)

IV.C.4. Residents must actively participate in the planning and presentation of required conferences. (Core)

IV.C.4.a) Each resident must ~~participate in~~ attend at least 75 percent of all required conferences. (Detail)

IV.C.4.b) At least 50 percent of the core faculty, in aggregate, must attend program conferences. ~~Participation by the members of the faculty in program conferences must in aggregate be at least 50 percent.~~ (Detail)

IV.C.5. The curriculum for each resident ~~in an integrated program~~ must include:

IV.C.5.a) 18 months of core surgical education experience, which may include: general surgery, cardiac surgery, thoracic surgery, congenital cardiac surgery, cardiothoracic surgery, critical care, urology, gynecology, neurological surgery, plastic surgery, burn surgery, trauma, surgical critical care, pediatric surgery, abdominal and alimentary tract surgery, basic and advanced laparoscopic skills, head and neck and endocrine surgery, surgical oncology, and transplantation; (Core)

IV.C.5.a).(1) This experience must include: documented educational experiences in core surgical education, including pre- and post-operative evaluation and care; critical care and trauma management; and basic technical experience in skin and soft tissue, abdomen and alimentary track, airway management, laparoscopic surgery, and thoracic surgery. (Core)

IV.C.5.b) 30 months of documented educational experiences concentrated in vascular surgery; and, (Core)

IV.C.5.c) 12 months of documented educational experiences that may be a combination of: (Core)

IV.C.5.c).(1) a maximum of six months of vascular surgery-related rotations (e.g., “vascular medicine” cardiology, interventional radiology); (Core)

IV.C.5.c).(2) a maximum of six months in additional core surgery rotations; (Core)

IV.C.5.c).(3) ~~up to~~ a maximum of 12 months of vascular surgery rotations; and, (Core)

IV.C.5.c).(4) a maximum of six months of dedicated research experience. (Core)

IV.C.6. The final two years of residency education (i.e., PGY-4 and PGY-5) must occur in the same program. (Core) ~~Residents in an integrated program must complete the last two years of their vascular surgery education in the same institution, whether that is at the primary clinical site. (Core)~~

IV.C.7. Residents ~~in an integrated program should~~ must perform a minimum of 500 operations, to include 250 major vascular reconstructive procedures. (Core)

IV.C.7.a) Operative experience in excess of 1500 total cases must be justified by the program director. (Core)

IV.C.8. The curriculum for ~~residents in all programs~~ each resident must include a final year with chief resident responsibility on the vascular surgery service at the primary clinical site or at a participating site. (Core)

IV.C.8.a) A vascular surgery fellow and a chief resident in an integrated vascular surgery program may function together on the same service but must not have primary responsibility for the same patients. ~~Although a senior vascular surgery resident in an integrated program may function with a chief resident in general surgery on the same service with the same junior residents, they must not have primary responsibility for the same patients.~~ (Core)

IV.C.8.b) A senior resident in an integrated vascular surgery program and a chief resident in a general surgery residency program may function together on the same service but must not have primary responsibility for the same patients. (Core)

IV.C.9. Resident experiences must include:

IV.C.9.a) primary responsibility for continuity of patient care, including ambulatory care, inpatient care, referral and consultation, and utilization of community resources; (Core)

IV.C.9.b) progressive senior surgical responsibilities in the total care of vascular surgery patients, including pre-operative evaluation, therapeutic decision-making, operative experience, and post-operative management; (Core)

IV.C.9.c) participation in providing consultation with faculty member supervision. (Core)

IV.C.9.c).(1) Residents should have clearly defined educational responsibilities for other residents, medical students, and professional personnel. (Detail)

IV.C.9.c).(1).(a) ~~These teaching experiences should correlate~~ Teaching by vascular surgery residents should include correlation of basic biomedical knowledge with the clinical aspects of vascular surgery. (Detail)

IV.C.9.d) experience in the application, assessment, and limitations of non-invasive vascular diagnostic techniques; and, (Core)

IV.C.9.d).(1) The program must provide didactic and clinical training ~~regarding~~ in non-invasive vascular diagnostic testing and interpretation. (Detail)

IV.C.9.d).(2) ~~Training~~ Such education must not be achieved solely through attendance at off-site review or test preparation courses. (Detail)

IV.C.9.e) experience with outpatient activities. (Detail)

IV.C.9.e).(1) Residents must devote an average of at least one half-day per week ~~should be devoted~~ to ~~these~~ outpatient activities. ~~(Detail)~~(Core)

IV.C.10. When justified by experience, senior residents should serve as teaching assistants to more junior residents in vascular or general surgery. ~~Experience as teaching assistants, when operative experience justifies a teaching role, should be provided.~~ (Detail)

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.

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1057 ***The ACGME recognizes the diversity of residencies and anticipates that***
1058 ***programs prepare physicians for a variety of roles, including clinicians,***
1059 ***scientists, and educators. It is expected that the program's scholarship will***
1060 ***reflect its mission(s) and aims, and the needs of the community it serves.***
1061 ***For example, some programs may concentrate their scholarly activity on***
1062 ***quality improvement, population health, and/or teaching, while other***
1063 ***programs might choose to utilize more classic forms of biomedical***
1064 ***research as the focus for scholarship.***
1065
1066 **IV.D.1. Program Responsibilities**
1067
1068 **IV.D.1.a) The program must demonstrate evidence of scholarly**
1069 **activities consistent with its mission(s) and aims.** (Core)
1070
1071 **IV.D.1.b) The program, in partnership with its Sponsoring Institution,**
1072 **must allocate adequate resources to facilitate resident and**
1073 **faculty involvement in scholarly activities.** (Core)
1074
1075 **IV.D.1.c) The program must advance residents' knowledge and**
1076 **practice of the scholarly approach to evidence-based patient**
1077 **care.** (Core)
1078

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.**

1079
1080 **IV.D.2. Faculty Scholarly Activity**
1081
1082 **IV.D.2.a) Among their scholarly activity, programs must demonstrate**
1083 **accomplishments in at least three of the following domains:**
1084 (Core)

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

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

Background and Intent: For the purposes of education, metrics of scholarly activity represent one of the surrogates for the program's effectiveness in the creation of an environment of inquiry that advances the 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.

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

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

IV.D.3. **Resident Scholarly Activity**

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

IV.D.3.a).(1) Residents must have instruction in critical thinking, design of experiments, and evaluation of data. (Detail)

IV.D.3.a).(2) Residents should participate in clinical and/or laboratory research. (Detail)

V. Evaluation

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1126
1127 **V.A. Resident Evaluation**
1128
1129 **V.A.1. Feedback and Evaluation**
1130

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

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

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

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

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

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

1131
1132 **V.A.1.a) Faculty members must directly observe, evaluate, and**
1133 **frequently provide feedback on resident performance during**
1134 **each rotation or similar educational assignment.** (Core)
1135

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.

1136
1137 **V.A.1.b) Evaluation must be documented at the completion of the**
1138 **assignment.** (Core)
1139

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1140 **V.A.1.b).(1)** **For block rotations of greater than three months in**
1141 **duration, evaluation must be documented at least**
1142 **every three months.** (Core)
1143
1144 **V.A.1.b).(2)** **Longitudinal experiences, such as continuity clinic in**
1145 **the context of other clinical responsibilities, must be**
1146 **evaluated at least every three months and at**
1147 **completion.** (Core)
1148
1149 **V.A.1.c)** **The program must provide an objective performance**
1150 **evaluation based on the Competencies and the specialty-**
1151 **specific Milestones, and must:** (Core)
1152
1153 **V.A.1.c).(1)** **use multiple evaluators (e.g., faculty members, peers,**
1154 **patients, self, and other professional staff members);**
1155 **and,** (Core)
1156
1157 **V.A.1.c).(2)** **provide that information to the Clinical Competency**
1158 **Committee for its synthesis of progressive resident**
1159 **performance and improvement toward unsupervised**
1160 **practice.** (Core)
1161
1162 **V.A.1.d)** **The program director or their designee, with input from the**
1163 **Clinical Competency Committee, must:**
1164
1165 **V.A.1.d).(1)** **meet with and review with each resident their**
1166 **documented semi-annual evaluation of performance,**
1167 **including progress along the specialty-specific**
1168 **Milestones;** (Core)
1169
1170 V.A.1.d).(1).(a) The semi-annual assessment must include a
1171 review of each resident's operative experience to
1172 ensure breadth and balance of experience in the
1173 surgical care of vascular diseases. (Core)
1174
1175 V.A.1.d).(1).(a).(i) The program director must ensure that the
1176 operative experience of individual residents
1177 in the same program is comparable. (Detail)
1178
1179 **V.A.1.d).(2)** **assist residents in developing individualized learning**
1180 **plans to capitalize on their strengths and identify areas**
1181 **for growth; and,** (Core)
1182
1183 **V.A.1.d).(3)** **develop plans for residents failing to progress,**
1184 **following institutional policies and procedures.** (Core)
1185

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

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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.

1186
1187 **V.A.1.e)** **At least annually, there must be a summative evaluation of**
1188 **each resident that includes their readiness to progress to the**
1189 **next year of the program, if applicable.** (Core)
1190
1191 **V.A.1.f)** **The evaluations of a resident's performance must be**
1192 **accessible for review by the resident.** (Core)
1193
1194 **V.A.2.** **Final Evaluation**
1195
1196 **V.A.2.a)** **The program director must provide a final evaluation for each**
1197 **resident upon completion of the program.** (Core)
1198
1199 **V.A.2.a).(1)** **The specialty-specific Milestones, and when applicable**
1200 **the specialty-specific Case Logs, must be used as**
1201 **tools to ensure residents are able to engage in**
1202 **autonomous practice upon completion of the program.**
1203 (Core)
1204
1205 **V.A.2.a).(2)** **The final evaluation must:**
1206
1207 **V.A.2.a).(2).(a)** **become part of the resident's permanent record**
1208 **maintained by the institution, and must be**
1209 **accessible for review by the resident in**
1210 **accordance with institutional policy;** (Core)
1211
1212 **V.A.2.a).(2).(b)** **verify that the resident has demonstrated the**
1213 **knowledge, skills, and behaviors necessary to**
1214 **enter autonomous practice;** (Core)
1215
1216 **V.A.2.a).(2).(c)** **consider recommendations from the Clinical**
1217 **Competency Committee; and,** (Core)
1218
1219 **V.A.2.a).(2).(d)** **be shared with the resident upon completion of**
1220 **the program.** (Core)
1221
1222 **V.A.3.** **A Clinical Competency Committee must be appointed by the**
1223 **program director.** (Core)
1224

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1225 **V.A.3.a)** **At a minimum, the Clinical Competency Committee must**
1226 **include three members of the program faculty, at least one of**
1227 **whom is a core faculty member.** (Core)
1228
1229 **V.A.3.a).(1)** **Additional members must be faculty members from**
1230 **the same program or other programs, or other health**
1231 **professionals who have extensive contact and**
1232 **experience with the program's residents.** (Core)
1233

> **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.**

1234
1235 **V.A.3.b)** **The Clinical Competency Committee must:**
1236
1237 **V.A.3.b).(1)** **review all resident evaluations at least semi-annually;**
1238 (Core)
1239
1240 **V.A.3.b).(2)** **determine each resident's progress on achievement of**
1241 **the specialty-specific Milestones; and,** (Core)
1242
1243 **V.A.3.b).(3)** **meet prior to the residents' semi-annual evaluations**
1244 **and advise the program director regarding each**
1245 **resident's progress.** (Core)
1246
1247 **V.B.** **Faculty Evaluation**
1248
1249 **V.B.1.** **The program must have a process to evaluate each faculty**
1250 **member's performance as it relates to the educational program at**
1251 **least annually.** (Core)
1252

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

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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.

1253
1254 **V.B.1.a)** **This evaluation must include a review of the faculty member's**
1255 **clinical teaching abilities, engagement with the educational**
1256 **program, participation in faculty development related to their**
1257 **skills as an educator, clinical performance, professionalism,**
1258 **and scholarly activities.** (Core)
1259
1260 **V.B.1.b)** **This evaluation must include written, anonymous, and**
1261 **confidential evaluations by the residents.** (Core)
1262
1263 **V.B.2.** **Faculty members must receive feedback on their evaluations at least**
1264 **annually.** (Core)
1265
1266 **V.B.3.** **Results of the faculty educational evaluations should be**
1267 **incorporated into program-wide faculty development plans.** (Core)
1268

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.

1269
1270 **V.C.** **Program Evaluation and Improvement**
1271
1272 **V.C.1.** **The program director must appoint the Program Evaluation**
1273 **Committee to conduct and document the Annual Program**
1274 **Evaluation as part of the program's continuous improvement**
1275 **process.** (Core)
1276
1277 **V.C.1.a)** **The Program Evaluation Committee must be composed of at**
1278 **least two program faculty members, at least one of whom is a**
1279 **core faculty member, and at least one resident.** (Core)
1280
1281 **V.C.1.b)** **Program Evaluation Committee responsibilities must include:**
1282
1283 **V.C.1.b).(1)** **acting as an advisor to the program director, through**
1284 **program oversight;** (Core)
1285

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V.C.1.b).(2) **review of the program's self-determined goals and progress toward meeting them;** **(Core)**

V.C.1.b).(3) **guiding ongoing program improvement, including development of new goals, based upon outcomes; and,** **(Core)**

V.C.1.b).(4) **review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims.** **(Core)**

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.

V.C.1.c) **The Program Evaluation Committee should consider the following elements in its assessment of the program:**

V.C.1.c).(1) **curriculum;** **(Core)**

V.C.1.c).(2) **outcomes from prior Annual Program Evaluation(s);** **(Core)**

V.C.1.c).(3) **ACGME letters of notification, including citations, Areas for Improvement, and comments;** **(Core)**

V.C.1.c).(4) **quality and safety of patient care;** **(Core)**

V.C.1.c).(5) **aggregate resident and faculty:**

V.C.1.c).(5).(a) **well-being;** **(Core)**

V.C.1.c).(5).(b) **recruitment and retention;** **(Core)**

V.C.1.c).(5).(c) **workforce diversity;** **(Core)**

V.C.1.c).(5).(d) **engagement in quality improvement and patient safety;** **(Core)**

V.C.1.c).(5).(e) **scholarly activity;** **(Core)**

V.C.1.c).(5).(f) **ACGME Resident and Faculty Surveys; and,** **(Core)**

V.C.1.c).(5).(g) **written evaluations of the program.** **(Core)**

V.C.1.c).(6) **aggregate resident:**

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1331 **V.C.1.c).(6).(a)** **achievement of the Milestones;** **(Core)**
1332
1333 **V.C.1.c).(6).(b)** **in-training examinations (where applicable);**
1334 **(Core)**
1335
1336 **V.C.1.c).(6).(c)** **board pass and certification rates; and,** **(Core)**
1337
1338 **V.C.1.c).(6).(d)** **graduate performance.** **(Core)**
1339
1340 **V.C.1.c).(7)** **aggregate faculty:**
1341
1342 **V.C.1.c).(7).(a)** **evaluation; and,** **(Core)**
1343
1344 **V.C.1.c).(7).(b)** **professional development.** **(Core)**
1345
1346 **V.C.1.d)** **The Program Evaluation Committee must evaluate the**
1347 **program's mission and aims, strengths, areas for**
1348 **improvement, and threats.** **(Core)**
1349
1350 **V.C.1.e)** **The annual review, including the action plan, must:**
1351
1352 **V.C.1.e).(1)** **be distributed to and discussed with the members of**
1353 **the teaching faculty and the residents; and,** **(Core)**
1354
1355 **V.C.1.e).(2)** **be submitted to the DIO.** **(Core)**
1356
1357 **V.C.2.** **The program must complete a Self-Study prior to its 10-Year**
1358 **Accreditation Site Visit.** **(Core)**
1359
1360 **V.C.2.a)** **A summary of the Self-Study must be submitted to the DIO.**
1361 **(Core)**
1362

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.

1363
1364 ***V.C.3.*** ***One goal of ACGME-accredited education is to educate physicians***
1365 ***who seek and achieve board certification. One measure of the***
1366 ***effectiveness of the educational program is the ultimate pass rate.***
1367
1368 ***The program director should encourage all eligible program***
1369 ***graduates to take the certifying examination offered by the***

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1370 ***applicable American Board of Medical Specialties (ABMS) member***
1371 ***board or American Osteopathic Association (AOA) certifying board.***
1372
1373 **V.C.3.a)** **For specialties in which the ABMS member board and/or AOA**
1374 **certifying board offer(s) an annual written exam, in the**
1375 **preceding three years, the program's aggregate pass rate of**
1376 **those taking the examination for the first time must be higher**
1377 **than the bottom fifth percentile of programs in that specialty.**
1378 **(Outcome)**
1379
1380 **V.C.3.b)** **For specialties in which the ABMS member board and/or AOA**
1381 **certifying board offer(s) a biennial written exam, in the**
1382 **preceding six years, the program's aggregate pass rate of**
1383 **those taking the examination for the first time must be higher**
1384 **than the bottom fifth percentile of programs in that specialty.**
1385 **(Outcome)**
1386
1387 **V.C.3.c)** **For specialties in which the ABMS member board and/or AOA**
1388 **certifying board offer(s) an annual oral exam, in the preceding**
1389 **three years, the program's aggregate pass rate of those**
1390 **taking the examination for the first time must be higher than**
1391 **the bottom fifth percentile of programs in that specialty.**
1392 **(Outcome)**
1393
1394 **V.C.3.d)** **For specialties in which the ABMS member board and/or AOA**
1395 **certifying board offer(s) a biennial oral exam, in the preceding**
1396 **six years, the program's aggregate pass rate of those taking**
1397 **the examination for the first time must be higher than the**
1398 **bottom fifth percentile of programs in that specialty. (Outcome)**
1399
1400 **V.C.3.e)** **For each of the exams referenced in V.C.3.a)-d), any program**
1401 **whose graduates over the time period specified in the**
1402 **requirement have achieved an 80 percent pass rate will have**
1403 **met this requirement, no matter the percentile rank of the**
1404 **program for pass rate in that specialty. (Outcome)**
1405

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.**

1406
1407 **V.C.3.f)** **Programs must report, in ADS, board certification status**
1408 **annually for the cohort of board-eligible residents that**
1409 **graduated seven years earlier. (Core)**
1410

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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.

1411
1412 **VI. The Learning and Working Environment**
1413
1414 ***Residency education must occur in the context of a learning and working***
1415 ***environment that emphasizes the following principles:***
1416
1417 - ***Excellence in the safety and quality of care rendered to patients by residents***
1418 ***today***
1419
1420 - ***Excellence in the safety and quality of care rendered to patients by today's***
1421 ***residents in their future practice***
1422
1423 - ***Excellence in professionalism through faculty modeling of:***
1424
1425 - ***the effacement of self-interest in a humanistic environment that supports***
1426 ***the professional development of physicians***
1427
1428 - ***the joy of curiosity, problem-solving, intellectual rigor, and discovery***
1429
1430 - ***Commitment to the well-being of the students, residents, faculty members, and***
1431 ***all members of the health care team***
1432

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.

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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.

1433
1434 **VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability**
1435
1436 **VI.A.1. Patient Safety and Quality Improvement**
1437
1438-1446 ***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.***
1447
1448-1452 ***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.***
1453
1454-1456 ***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.***
1457
1458 **VI.A.1.a) Patient Safety**
1459
1460 **VI.A.1.a).(1) Culture of Safety**
1461
1462-1467 ***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.***
1468
1469-1472 **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)**
1473

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1474 **VI.A.1.a).(1).(b)** **The program must have a structure that**
1475 **promotes safe, interprofessional, team-based**
1476 **care.** (Core)
1477
1478 **VI.A.1.a).(2)** **Education on Patient Safety**
1479
1480 **Programs must provide formal educational activities**
1481 **that promote patient safety-related goals, tools, and**
1482 **techniques.** (Core)
1483

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

1484
1485 **VI.A.1.a).(3)** **Patient Safety Events**
1486
1487 ***Reporting, investigation, and follow-up of adverse***
1488 ***events, near misses, and unsafe conditions are pivotal***
1489 ***mechanisms for improving patient safety, and are***
1490 ***essential for the success of any patient safety***
1491 ***program. Feedback and experiential learning are***
1492 ***essential to developing true competence in the ability***
1493 ***to identify causes and institute sustainable systems-***
1494 ***based changes to ameliorate patient safety***
1495 ***vulnerabilities.***
1496
1497 **VI.A.1.a).(3).(a)** **Residents, fellows, faculty members, and other**
1498 **clinical staff members must:**
1499
1500 **VI.A.1.a).(3).(a).(i)** **know their responsibilities in reporting**
1501 **patient safety events at the clinical site;**
1502 (Core)
1503
1504 **VI.A.1.a).(3).(a).(ii)** **know how to report patient safety**
1505 **events, including near misses, at the**
1506 **clinical site; and,** (Core)
1507
1508 **VI.A.1.a).(3).(a).(iii)** **be provided with summary information**
1509 **of their institution's patient safety**
1510 **reports.** (Core)
1511
1512 **VI.A.1.a).(3).(b)** **Residents must participate as team members in**
1513 **real and/or simulated interprofessional clinical**
1514 **patient safety activities, such as root cause**
1515 **analyses or other activities that include**
1516 **analysis, as well as formulation and**
1517 **implementation of actions.** (Core)
1518
1519 **VI.A.1.a).(4)** **Resident Education and Experience in Disclosure of**
1520 **Adverse Events**
1521

1522 *Patient-centered care requires patients, and when*
1523 *appropriate families, to be apprised of clinical*
1524 *situations that affect them, including adverse events.*
1525 *This is an important skill for faculty physicians to*
1526 *model, and for residents to develop and apply.*
1527
1528 **VI.A.1.a).(4).(a)** **All residents must receive training in how to**
1529 **disclose adverse events to patients and**
1530 **families.** (Core)
1531
1532 **VI.A.1.a).(4).(b)** **Residents should have the opportunity to**
1533 **participate in the disclosure of patient safety**
1534 **events, real or simulated.** (Detail)†
1535
1536 **VI.A.1.b)** **Quality Improvement**
1537
1538 **VI.A.1.b).(1)** **Education in Quality Improvement**
1539
1540 *A cohesive model of health care includes quality-*
1541 *related goals, tools, and techniques that are necessary*
1542 *in order for health care professionals to achieve*
1543 *quality improvement goals.*
1544
1545 **VI.A.1.b).(1).(a)** **Residents must receive training and experience**
1546 **in quality improvement processes, including an**
1547 **understanding of health care disparities.** (Core)
1548
1549 **VI.A.1.b).(2)** **Quality Metrics**
1550
1551 *Access to data is essential to prioritizing activities for*
1552 *care improvement and evaluating success of*
1553 *improvement efforts.*
1554
1555 **VI.A.1.b).(2).(a)** **Residents and faculty members must receive**
1556 **data on quality metrics and benchmarks related**
1557 **to their patient populations.** (Core)
1558
1559 **VI.A.1.b).(3)** **Engagement in Quality Improvement Activities**
1560
1561 *Experiential learning is essential to developing the*
1562 *ability to identify and institute sustainable systems-*
1563 *based changes to improve patient care.*
1564
1565 **VI.A.1.b).(3).(a)** **Residents must have the opportunity to**
1566 **participate in interprofessional quality**
1567 **improvement activities.** (Core)
1568
1569 **VI.A.1.b).(3).(a).(i)** **This should include activities aimed at**
1570 **reducing health care disparities.** (Detail)
1571
1572 **VI.A.2.** **Supervision and Accountability**

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1573
1574 **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.***
1575
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1582
1583 ***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.***
1584
1585
1586
1587
1588
1589 **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)**
1590
1591
1592
1593
1594
1595
1596 **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)**
1597
1598
1599
1600 **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)**
1601
1602
1603
1604
1605 **VI.A.2.b)** ***Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the appropriate availability of the supervising faculty member, fellow, or senior resident physician, either on site or by means of telecommunication technology. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.***
1606
1607
1608
1609
1610
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1615

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

1616

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1617 **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)

1624 **VI.A.2.b).(2)** **The program must define when physical presence of a supervising physician is required.** (Core)

1627 **VI.A.2.c)** **Levels of Supervision**

1629 **To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:** (Core)

1633 **VI.A.2.c).(1)** **Direct Supervision:**

1635 **VI.A.2.c).(1).(a)** **the supervising physician is physically present with the resident during the key portions of the patient interaction.** (Core)

1639 **VI.A.2.c).(1).(a).(i)** **PGY-1 residents must initially be supervised directly, only as described in VI.A.2.c).(1).(a).** (Core)

1643 VI.A.2.c).(1).(a).(i).(a) The program must define those physician tasks for which PGY-1 residents may be supervised indirectly, with direct supervision available, and must define "direct supervision" in the context of the program. (Core) [Moved from VI.A.2.e).(1).(a).(i)]

1652 VI.A.2.c).(1).(a).(i).(b) The program must define those physician tasks for which PGY-1 residents must be supervised directly until they have demonstrated competence as defined by the program director, and must maintain records of such demonstrations of competence. (Core) [Moved from VI.A.2.e).(1).(a).(ii)]

1662 **VI.A.2.c).(2)** **Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.** (Core)

1667

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1668 **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)

1672 **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)

1677 **VI.A.2.d).(1)** **The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones.** (Core)

1681 **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)

1686 **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)

1692 **VI.A.2.e)** **Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s).** (Core)

1696 **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)

1700

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

1701

1702 **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)

1707 **VI.B. Professionalism**

1709 **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)

1715 **VI.B.2.** **The learning objectives of the program must:**

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1716
1717 **VI.B.2.a)** **be accomplished through an appropriate blend of supervised**
1718 **patient care responsibilities, clinical teaching, and didactic**
1719 **educational events; (Core)**
1720
1721 **VI.B.2.b)** **be accomplished without excessive reliance on residents to**
1722 **fulfill non-physician obligations; and, (Core)**
1723

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.

1724
1725 **VI.B.2.c)** **ensure manageable patient care responsibilities. (Core)**
1726

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.

1727
1728 **VI.B.3.** **The program director, in partnership with the Sponsoring Institution,**
1729 **must provide a culture of professionalism that supports patient**
1730 **safety and personal responsibility. (Core)**
1731
1732 **VI.B.4.** **Residents and faculty members must demonstrate an understanding**
1733 **of their personal role in the:**
1734
1735 **VI.B.4.a)** **provision of patient- and family-centered care; (Outcome)**
1736
1737 **VI.B.4.b)** **safety and welfare of patients entrusted to their care,**
1738 **including the ability to report unsafe conditions and adverse**
1739 **events; (Outcome)**
1740

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.

1741
1742 **VI.B.4.c)** **assurance of their fitness for work, including: (Outcome)**
1743

Background and Intent: This requirement emphasizes the professional responsibility of faculty members and residents to arrive for work adequately rested and ready to care

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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.

1744
1745 **VI.B.4.c).(1)** **management of their time before, during, and after**
1746 **clinical assignments; and, (Outcome)**
1747
1748 **VI.B.4.c).(2)** **recognition of impairment, including from illness,**
1749 **fatigue, and substance use, in themselves, their peers,**
1750 **and other members of the health care team. (Outcome)**
1751
1752 **VI.B.4.d)** **commitment to lifelong learning; (Outcome)**
1753
1754 **VI.B.4.e)** **monitoring of their patient care performance improvement**
1755 **indicators; and, (Outcome)**
1756
1757 **VI.B.4.f)** **accurate reporting of clinical and educational work hours,**
1758 **patient outcomes, and clinical experience data. (Outcome)**
1759
1760 **VI.B.5.** **All residents and faculty members must demonstrate**
1761 **responsiveness to patient needs that supersedes self-interest. This**
1762 **includes the recognition that under certain circumstances, the best**
1763 **interests of the patient may be served by transitioning that patient's**
1764 **care to another qualified and rested provider. (Outcome)**
1765
1766 **VI.B.6.** **Programs, in partnership with their Sponsoring Institutions, must**
1767 **provide a professional, equitable, respectful, and civil environment**
1768 **that is free from discrimination, sexual and other forms of**
1769 **harassment, mistreatment, abuse, or coercion of students,**
1770 **residents, faculty, and staff. (Core)**
1771
1772 **VI.B.7.** **Programs, in partnership with their Sponsoring Institutions, should**
1773 **have a process for education of residents and faculty regarding**
1774 **unprofessional behavior and a confidential process for reporting,**
1775 **investigating, and addressing such concerns. (Core)**
1776
1777 **VI.C.** **Well-Being**
1778
1779 ***Psychological, emotional, and physical well-being are critical in the***
1780 ***development of the competent, caring, and resilient physician and require***
1781 ***proactive attention to life inside and outside of medicine. Well-being***
1782 ***requires that physicians retain the joy in medicine while managing their***
1783 ***own real-life stresses. Self-care and responsibility to support other***
1784 ***members of the health care team are important components of***
1785 ***professionalism; they are also skills that must be modeled, learned, and***
1786 ***nurtured in the context of other aspects of residency training.***
1787
1788 ***Residents and faculty members are at risk for burnout and depression.***
1789 ***Programs, in partnership with their Sponsoring Institutions, have the same***
1790 ***responsibility to address well-being as other aspects of resident***

1791 ***competence. Physicians and all members of the health care team share***
1792 ***responsibility for the well-being of each other. For example, a culture which***
1793 ***encourages covering for colleagues after an illness without the expectation***
1794 ***of reciprocity reflects the ideal of professionalism. A positive culture in a***
1795 ***clinical learning environment models constructive behaviors, and prepares***
1796 ***residents with the skills and attitudes needed to thrive throughout their***
1797 ***careers.***
1798

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.

1799
1800 **VI.C.1.** **The responsibility of the program, in partnership with the**
1801 **Sponsoring Institution, to address well-being must include:**
1802
1803 **VI.C.1.a)** **efforts to enhance the meaning that each resident finds in the**
1804 **experience of being a physician, including protecting time**
1805 **with patients, minimizing non-physician obligations,**
1806 **providing administrative support, promoting progressive**
1807 **autonomy and flexibility, and enhancing professional**
1808 **relationships; (Core)**
1809
1810 **VI.C.1.b)** **attention to scheduling, work intensity, and work**
1811 **compression that impacts resident well-being; (Core)**
1812
1813 **VI.C.1.c)** **evaluating workplace safety data and addressing the safety of**
1814 **residents and faculty members; (Core)**
1815

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.

1816
1817 **VI.C.1.d)** **policies and programs that encourage optimal resident and**
1818 **faculty member well-being; and, (Core)**
1819

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.

1820
1821 **VI.C.1.d).(1)** **Residents must be given the opportunity to attend**
1822 **medical, mental health, and dental care appointments,**
1823 **including those scheduled during their working hours.**
1824 **(Core)**
1825

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.

1826
1827 **VI.C.1.e)** **attention to resident and faculty member burnout,**
1828 **depression, and substance abuse. The program, in**
1829 **partnership with its Sponsoring Institution, must educate**
1830 **faculty members and residents in identification of the**
1831 **symptoms of burnout, depression, and substance abuse,**
1832 **including means to assist those who experience these**
1833 **conditions. Residents and faculty members must also be**
1834 **educated to recognize those symptoms in themselves and**
1835 **how to seek appropriate care. The program, in partnership**
1836 **with its Sponsoring Institution, must: (Core)**
1837

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).

1838
1839 **VI.C.1.e).(1)** **encourage residents and faculty members to alert the**
1840 **program director or other designated personnel or**
1841 **programs when they are concerned that another**
1842 **resident, fellow, or faculty member may be displaying**
1843 **signs of burnout, depression, substance abuse,**
1844 **suicidal ideation, or potential for violence; (Core)**
1845

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

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institution's impaired physician policy and any employee health, employee assistance, and/or wellness programs within the institution. In cases of physician impairment, the program director or designated personnel should follow the policies of their institution for reporting.

1846
1847 **VI.C.1.e).(2)** **provide access to appropriate tools for self-screening;**
1848 **and, (Core)**
1849
1850 **VI.C.1.e).(3)** **provide access to confidential, affordable mental**
1851 **health assessment, counseling, and treatment,**
1852 **including access to urgent and emergent care 24**
1853 **hours a day, seven days a week. (Core)**
1854

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.

1855
1856 **VI.C.2.** **There are circumstances in which residents may be unable to attend**
1857 **work, including but not limited to fatigue, illness, family**
1858 **emergencies, and parental leave. Each program must allow an**
1859 **appropriate length of absence for residents unable to perform their**
1860 **patient care responsibilities. (Core)**
1861
1862 **VI.C.2.a)** **The program must have policies and procedures in place to**
1863 **ensure coverage of patient care. (Core)**
1864
1865 **VI.C.2.b)** **These policies must be implemented without fear of negative**
1866 **consequences for the resident who is or was unable to**
1867 **provide the clinical work. (Core)**
1868

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.

1869
1870 **VI.D.** **Fatigue Mitigation**
1871
1872 **VI.D.1.** **Programs must:**
1873
1874 **VI.D.1.a)** **educate all faculty members and residents to recognize the**
1875 **signs of fatigue and sleep deprivation; (Core)**
1876

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1877 **VI.D.1.b)** **educate all faculty members and residents in alertness**
1878 **management and fatigue mitigation processes; and,** (Core)
1879
1880 **VI.D.1.c)** **encourage residents to use fatigue mitigation processes to**
1881 **manage the potential negative effects of fatigue on patient**
1882 **care and learning.** (Detail)
1883

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.

1884
1885 **VI.D.2.** **Each program must ensure continuity of patient care, consistent**
1886 **with the program's policies and procedures referenced in VI.C.2–**
1887 **VI.C.2.b), in the event that a resident may be unable to perform their**
1888 **patient care responsibilities due to excessive fatigue.** (Core)
1889
1890 **VI.D.3.** **The program, in partnership with its Sponsoring Institution, must**
1891 **ensure adequate sleep facilities and safe transportation options for**
1892 **residents who may be too fatigued to safely return home.** (Core)
1893
1894 **VI.E.** **Clinical Responsibilities, Teamwork, and Transitions of Care**
1895
1896 **VI.E.1.** **Clinical Responsibilities**
1897
1898 **The clinical responsibilities for each resident must be based on PGY**
1899 **level, patient safety, resident ability, severity and complexity of**
1900 **patient illness/condition, and available support services.** (Core)
1901

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.

1902

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1903 VI.E.1.a) The workload associated with optimal clinical care of surgical patients is a continuum from the moment of admission to the point of discharge. (Core)
1904
1905
1906
1907 VI.E.1.b) During the residency education process, surgical teams should be made up of attending surgeons, fellows and residents at various PG levels (when appropriate), medical students (when appropriate), and other health care providers. (Core)
1908
1909
1910
1911
1912 VI.E.1.c) The work of the caregiver team should be assigned to team members based on each member's level of education, experience, and competence. (Core)
1913
1914
1915
1916 VI.E.1.d) As residents progress through levels of increasing competence and responsibility, it is expected that work assignments will keep pace with their advancement. (Core)
1917
1918
1919
1920 **VI.E.2. Teamwork**
1921
1922 **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)**
1923
1924
1925
1926
1927 VI.E.2.a) Effective surgical practices must entail the involvement of members with a mix of complementary skills and attributes (physicians, nurses, and other staff). Success requires both an unwavering mutual respect for those skills and contributions, and a shared commitment to the process of patient care. (Core)
1928
1929
1930
1931
1932
1933 VI.E.2.b) Residents must collaborate with ~~fellow~~ other surgical residents, ~~and especially~~ with faculty, and other physicians outside of their specialty, and non-traditional health care providers, to best formulate treatment plans for an increasingly diverse patient population. (Core)
1934
1935
1936
1937
1938
1939 VI.E.2.c) Residents must assume personal responsibility to complete all tasks to which they are assigned (or which they voluntarily assume) in a timely fashion. These tasks must be completed in the hours assigned, or, if that is not possible, residents must learn and utilize the established methods for handing off remaining tasks to another member of the resident team so that patient care is not compromised. (Core)
1940
1941
1942
1943
1944
1945
1946
1947 VI.E.2.d) Lines of authority should be defined by programs, and all residents must have a working knowledge of these expected reporting relationships to maximize quality care and patient safety. (Core)
1948
1949
1950
1951
1952 **VI.E.3. Transitions of Care**
1953

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1954 **VI.E.3.a)** **Programs must design clinical assignments to optimize**
1955 **transitions in patient care, including their safety, frequency,**
1956 **and structure.** (Core)
1957
1958 **VI.E.3.b)** **Programs, in partnership with their Sponsoring Institutions,**
1959 **must ensure and monitor effective, structured hand-over**
1960 **processes to facilitate both continuity of care and patient**
1961 **safety.** (Core)
1962
1963 **VI.E.3.c)** **Programs must ensure that residents are competent in**
1964 **communicating with team members in the hand-over process.**
1965 (Outcome)
1966
1967 **VI.E.3.d)** **Programs and clinical sites must maintain and communicate**
1968 **schedules of attending physicians and residents currently**
1969 **responsible for care.** (Core)
1970
1971 **VI.E.3.e)** **Each program must ensure continuity of patient care,**
1972 **consistent with the program's policies and procedures**
1973 **referenced in VI.C.2-VI.C.2.b), in the event that a resident may**
1974 **be unable to perform their patient care responsibilities due to**
1975 **excessive fatigue or illness, or family emergency.** (Core)
1976
1977 **VI.F.** **Clinical Experience and Education**
1978
1979 ***Programs, in partnership with their Sponsoring Institutions, must design***
1980 ***an effective program structure that is configured to provide residents with***
1981 ***educational and clinical experience opportunities, as well as reasonable***
1982 ***opportunities for rest and personal activities.***
1983

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.

1984
1985 **VI.F.1.** **Maximum Hours of Clinical and Educational Work per Week**
1986
1987 **Clinical and educational work hours must be limited to no more than**
1988 **80 hours per week, averaged over a four-week period, inclusive of all**
1989 **in-house clinical and educational activities, clinical work done from**
1990 **home, and all moonlighting.** (Core)
1991

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.

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

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

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

During the public comment period many individuals raised questions and concerns related to this change. Some questioned whether minute by minute tracking would be required; in other words, if a resident spends three minutes on a phone call and then a few hours later spends two minutes on another call, will the resident need to report that time. Others raised concerns related to the ability of programs and institutions to verify the accuracy of the information reported by residents. The new requirements are not an attempt to micromanage this process. Residents are to track the time they spend on clinical work from home and to report that time to the program. Decisions regarding whether to report infrequent phone calls of very short duration will be left to the individual resident. Programs will need to factor in time residents are spending on clinical work at home when schedules are developed to ensure that residents are not

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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.

1992
1993 **VI.F.2. Mandatory Time Free of Clinical Work and Education**
1994
1995 **VI.F.2.a)** **The program must design an effective program structure that**
1996 **is configured to provide residents with educational**
1997 **opportunities, as well as reasonable opportunities for rest**
1998 **and personal well-being.** **(Core)**
1999
2000 **VI.F.2.b)** **Residents should have eight hours off between scheduled**
2001 **clinical work and education periods.** **(Detail)**
2002
2003 **VI.F.2.b).(1)** **There may be circumstances when residents choose**
2004 **to stay to care for their patients or return to the**
2005 **hospital with fewer than eight hours free of clinical**
2006 **experience and education. This must occur within the**
2007 **context of the 80-hour and the one-day-off-in-seven**
2008 **requirements.** **(Detail)**
2009

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.

2010
2011 **VI.F.2.c)** **Residents must have at least 14 hours free of clinical work**
2012 **and education after 24 hours of in-house call.** **(Core)**
2013

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.

2014

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2015 **VI.F.2.d)** **Residents must be scheduled for a minimum of one day in**
2016 **seven free of clinical work and required education (when**
2017 **averaged over four weeks). At-home call cannot be assigned**
2018 **on these free days.** **(Core)**
2019

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."

2020
2021 **VI.F.3.** **Maximum Clinical Work and Education Period Length**
2022
2023 **VI.F.3.a)** **Clinical and educational work periods for residents must not**
2024 **exceed 24 hours of continuous scheduled clinical**
2025 **assignments.** **(Core)**
2026

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

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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.

2027
2028 **VI.F.3.a).(1)** **Up to four hours of additional time may be used for**
2029 **activities related to patient safety, such as providing**
2030 **effective transitions of care, and/or resident education.**
2031 **(Core)**
2032
2033 **VI.F.3.a).(1).(a)** **Additional patient care responsibilities must not**
2034 **be assigned to a resident during this time. (Core)**
2035

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.

2036
2037 **VI.F.4.** **Clinical and Educational Work Hour Exceptions**
2038
2039 **VI.F.4.a)** **In rare circumstances, after handing off all other**
2040 **responsibilities, a resident, on their own initiative, may elect**
2041 **to remain or return to the clinical site in the following**
2042 **circumstances:**
2043
2044 **VI.F.4.a).(1)** **to continue to provide care to a single severely ill or**
2045 **unstable patient; (Detail)**
2046
2047 **VI.F.4.a).(2)** **humanistic attention to the needs of a patient or**
2048 **family; or, (Detail)**
2049
2050 **VI.F.4.a).(3)** **to attend unique educational events. (Detail)**
2051
2052 **VI.F.4.b)** **These additional hours of care or education will be counted**
2053 **toward the 80-hour weekly limit. (Detail)**
2054

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

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stay. Programs allowing residents to remain or return beyond the scheduled work and clinical education period must ensure that the decision to remain is initiated by the resident and that residents are not coerced. This additional time must be counted toward the 80-hour maximum weekly limit.

2055

2056 **VI.F.4.c)** **A Review Committee may grant rotation-specific exceptions**
2057 **for up to 10 percent or a maximum of 88 clinical and**
2058 **educational work hours to individual programs based on a**
2059 **sound educational rationale.**
2060
2061 The Review Committee for ~~General~~ Surgery will not accept
2062 requests for exceptions to the 80-hour limit to the residents' work
2063 week.
2064
2065 **VI.F.4.c).(1)** **In preparing a request for an exception, the program**
2066 **director must follow the clinical and educational work**
2067 **hour exception policy from the *ACGME Manual of***
2068 ***Policies and Procedures.*** **(Core)**
2069
2070 **VI.F.4.c).(2)** **Prior to submitting the request to the Review**
2071 **Committee, the program director must obtain approval**
2072 **from the Sponsoring Institution's GMEC and DIO.** **(Core)**
2073

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.

2074
2075 **VI.F.5.** **Moonlighting**
2076
2077 **VI.F.5.a)** **Moonlighting must not interfere with the ability of the resident**
2078 **to achieve the goals and objectives of the educational**
2079 **program, and must not interfere with the resident's fitness for**
2080 **work nor compromise patient safety.** **(Core)**
2081
2082 **VI.F.5.b)** **Time spent by residents in internal and external moonlighting**
2083 **(as defined in the ACGME Glossary of Terms) must be**
2084 **counted toward the 80-hour maximum weekly limit.** **(Core)**
2085
2086 **VI.F.5.c)** **PGY-1 residents are not permitted to moonlight.** **(Core)**
2087

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).

2088

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2089 **VI.F.6. In-House Night Float**
2090
2091 **Night float must occur within the context of the 80-hour and one-**
2092 **day-off-in-seven requirements.** **(Core)**
2093

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.

2094
2095 VI.F.6.a) Night float rotations must not exceed two months in succession, or
2096 three months in succession for rotations with night shifts
2097 alternating with day shifts. (Detail)
2098
2099 VI.F.6.b) There can be no more than four months of night float per year.
2100 (Detail)
2101
2102 VI.F.6.c) There must be at least two months between each night float
2103 rotation. (Detail)
2104
2105 VI.F.6.d) The total amount of night float for any resident over a five-year
2106 residency must be no more than 15 months (Detail)
2107
2108 VI.F.6.d).(1) Any rotation that requires residents to work nights in
2109 succession, is considered a night float rotation, and the
2110 total time on nights is counted toward the maximum
2111 allowable time for each resident over the five-year
2112 residency. (Core)
2113
2114 **VI.F.7. Maximum In-House On-Call Frequency**
2115
2116 **Residents must be scheduled for in-house call no more frequently**
2117 **than every third night (when averaged over a four-week period).** **(Core)**
2118
2119 **VI.F.8. At-Home Call**
2120
2121 **VI.F.8.a) Time spent on patient care activities by residents on at-home**
2122 **call must count toward the 80-hour maximum weekly limit.**
2123 **The frequency of at-home call is not subject to the every-**
2124 **third-night limitation, but must satisfy the requirement for one**
2125 **day in seven free of clinical work and education, when**
2126 **averaged over four weeks.** **(Core)**
2127
2128 **VI.F.8.a).(1) At-home call must not be so frequent or taxing as to**
2129 **preclude rest or reasonable personal time for each**
2130 **resident.** **(Core)**
2131
2132 **VI.F.8.b) Residents are permitted to return to the hospital while on at-**
2133 **home call to provide direct care for new or established**
2134 **patients. These hours of inpatient patient care must be**
2135 **included in the 80-hour maximum weekly limit.** **(Detail)**
2136

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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.

2137
2138 ***
2139
2140 *__Core Requirements__: Statements that define structure, resource, or process elements
2141 essential to every graduate medical educational program.
2142
2143 †**Detail Requirements**: Statements that describe a specific structure, resource, or process, for
2144 achieving compliance with a Core Requirement. Programs and sponsoring institutions in
2145 substantial compliance with the Outcome Requirements may utilize alternative or innovative
2146 approaches to meet Core Requirements.
2147
2148 ‡**Outcome Requirements**: Statements that specify expected measurable or observable
2149 attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their
2150 graduate medical education.
2151
2152 **Osteopathic Recognition**
2153 For programs with or applying for Osteopathic Recognition, the Osteopathic Recognition
2154 Requirements also apply (www.acgme.org/OsteopathicRecognition).

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