Accreditation Council for Graduate Medical Education

The Program Directors' Guide
to the
Common Program Requirements
(Residency)

(Version 1.0 June 20, 2019)

Editorial revision 1.0: updated January 31, 2020

Accreditation Council for Graduate Medical Education

Mission
We improve health care and population health by assessing and advancing the quality of resident physicians' education through accreditation.

Vision
We imagine a world characterized by:
- A structured approach to evaluating the competency of all residents and fellows,
- Motivated physician role models leading all GME programs,
- High quality, supervised, humanistic clinical educational experience, with customized formative feedback,
- Clinical learning environments characterized by excellence in clinical care, safety, and professionalism,
- Residents and fellows achieving specialty specific proficiency prior to graduation,
- Residents and fellows are prepared to be Virtuous Physicians who place the needs and well-being of patients first.

ACGME Values
- Honesty and Integrity
- Excellence and Innovation
- Accountability and Transparency
- Fairness and Equity
- Stewardship and Service
- Engagement of Stakeholders
- Leadership and Collaboration

The Program Directors' Guide to the Common Program Requirements (Residency)

PDF Version

The Program Directors' Guide to the Common Program Requirements is a living document that will regularly and periodically be updated. Please refer to the most recent version on the ACGME website to ensure the content is current.

This PDF version is downloadable and can be printed. If referencing a printed version, periodically check the website to ensure that the information is current.

An eBook version of the Guide is available in the ACGME's online learning portal, Learn at ACGME. Members of the GME community who do not yet have access to Learn at ACGME can register for an account at www.acgme.org/distancelearning.

Learn at ACGME is a repository of educational resources available free of charge to members of the GME community.

The ACGME is pleased to provide this Program Directors' Guide to the Common Program Requirements.

The Guide should serve as a resource, and the content within it is designed to serve as helpful guidance and not to be interpreted as additional requirements.

This is not meant to be read cover to cover in one sitting, but to be referenced as needed throughout the academic year.

The search function allows users to enter key words to quickly locate information.

Listings in the Table of Contents are also clickable and can be used to access a specific topic area in the guide.

Note that every set of specialty-specific Program Requirements includes content specific and unique to the specialty or subspecialty. This is not addressed in this guide. The specialty-specific FAQs and other resource documents provided by the respective Review Committee should be consulted; these are available on the specialty's section of the ACGME website. Contact the Review Committee staff with specific questions.

Format:
  a. The requirements themselves, as well as background and intent and philosophy, are on the pages with a blue background.
  b. The guidelines are on the pages with a white background.

c. There are multiple screenshots of what data entry screens look like within the ACGME's Accreditation Data System (ADS). Many of these are expected to change as the new Common Program Requirements are rolled out. The Guide will be updated periodically as these changes occur.

Program Directors' Guide to the Common Program Requirements (Residency) Contents

REQUIREMENTS

Fonts in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

Introduction

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

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

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

Graduate medical education occurs in clinical settings that establish the foundation for practice-based and lifelong learning. The professional development of the physician, begun in medical school, continues through faculty modeling of the effacement of self-interest in a humanistic environment that emphasizes joy in curiosity, problem-solving, academic rigor, and discovery. This transformation is often physically, emotionally, and intellectually demanding and occurs in a variety of clinical learning environments

committed to graduate medical education and the well-being of patient, residents, fellows, faculty members, students, and all members of the health care team.

GUIDANCE

Introduction A (Int.A.) is not a requirement, but is a philosophic statement that embodies the meaning and purpose of graduate medical education. It describes why graduate medical education is important and why programs must ensure that residents and fellows are provided with the best education possible.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement

Requirements below are subject to citation July 1, 2019

Int.B.   Definition of Specialty

              [The Review Committee must further specify]

GUIDANCE

Introduction B (Int.B.)

For the specific definition of a particular specialty, refer to the current specialty-specific Program Requirements, which can be found on the Program Requirements and FAQs and Applications page of the specialty's section on the ACGME website.

For example, this link brings you to the specialty-specific section for Orthopaedic Surgery: https://www.acgme.org/Specialties/Overview/pfcatid/14. From this page, click on "Program Requirements and FAQs and Applications" in the right-hand menu on the page, then click on the Program Requirements document under the "Currently in Effect" header.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement

Requirements below are subject to citation July 1, 2019

Int.C.   Length of educational program

            [The Review Committee must further specify]

GUIDANCE

Introduction C (Int.C.)

For the length of educational program for a particular specialty, refer to the current specialty-specific Program Requirements, which can be found on the Program Requirements, FAQs and Applications page of the specialty's section on the ACGME website.

For example, this link brings you to the specialty-specific section for Orthopaedic Surgery: https://www.acgme.org/Specialties/Overview/pfcatid/14. From this page, click on "Program Requirements and FAQs and Applications" in the right-hand menu on the page, then click on the Program Requirements document under the "Currently in Effect" header.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

I.   Oversight

I.A.   Sponsoring Institution

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

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

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

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

GUIDANCE

Sponsorship and Sponsoring Institution Accreditation

ACGME Common Program Requirement I.A.1 corresponds with ACGME Institutional Requirement I.A.1: "Residency and fellowship programs accredited by the [ACGME] must function under the authority and oversight of one Sponsoring Institution. Oversight of resident/fellow assignments and of the quality of the learning and working environment by the Sponsoring Institution extends to all participating sites."

Sponsorship of a program includes responsibility for oversight of the Sponsoring Institution's and all accredited programs' compliance with the applicable ACGME requirements, and the assurance of the resources necessary for graduate medical education.

The ACGME Board of Directors delegates authority for accrediting Sponsoring Institutions to the Institutional Review Committee. The ACGME's primary point of contact with each Sponsoring Institution is the designated institutional official (DIO).

For more information about Sponsoring Institutions, refer to the ACGME Institutional Requirements and Frequently Asked Questions for Institutional Reviews.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

I.B. Participating Sites

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

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

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

GUIDANCE

Primary Clinical Site Designations and Sponsoring Institution Approval

The Common Program Requirements define a program's primary clinical site as "the most commonly utilized site of clinical activity for the program." In a program's Accreditation Data System (ADS) profile, the designated primary clinical site can be found in the "Sites" tab (marked as "Primary" under "Participating Site Information"). In applications for ACGME accreditation, programs are directed to identify one of their participating sites as the primary clinical site. A Sponsoring Institution's approval of the primary clinical site designation is implicit in submissions of participating site information in ADS. The ACGME does not currently provide a standardized format for documenting institutional approval of these designations. Refer to specific-specialty Program Requirements for additional information.

What does this look like in ADS?
All rotation sites may be entered but only required sites appear.

NOTE that the ADS format may change to match the changes in the Common Program Requirements.

The definition of a participating site as it appears in ADS: An organization (or entity) providing educational experiences or educational assignments/rotations for residents/fellows. Examples of sites include a teaching hospital which includes its ambulatory clinics and related facilities, a private medical practice or group practice, a nursing home, a school of public health, a health department, a federally qualified health center, a public health agency, a health maintenance organization (HMO), a medical examiner's office, a consortium or an educational foundation. There may be a need to indicate the site as "clinical" in rare occasions. A clinical site exists when the sponsor of a program is in a different site (location) than the PRIMARY clinical site out of which the program operates.

Notes:
1. The table requesting information for the primary clinical site is followed by tables that allow you to enter information for other participating sites.
2. Each of the site information tables is followed by a request for information regarding program letters of agreement (PLAs) and PLA components for the particular site (see section on PLA: Requirements I.B.2.a) and I.B.3.).
3. Additional information requested includes "Date Added to ADS as Rotation Site."
4. Once information is entered and saved, the program can print a report of the information.

Below is an example of a screen for data entry for participating site information in ADS:

Request New Participating Site

1. Site Information

Institution Name:

List the physical address instead of PO boxes, etc (if possible)

Address Line 1:	Address Line 2:	Address Line 3:

City:	State:	Zip Code:
	Select	

Website URL:

Is this site a recognized healthcare entity by any of the following (check all that apply):
☐ Joint Commission
☐ Community Health Accreditation Program (CHAP)
☐ Accreditation Commission for Health Care (ACHC)
☐ DNV
☐ State regulatory commission
☐ Medicare Direct - CMS
☐ HFAP
☐ None
☐ Other:

Ownership or Control Type:
Select

Identifying the Most Commonly Utilized Participating Site

A program should follow its Sponsoring Institution's methods for identifying the primary clinical site. Typically, the "most commonly utilized" participating site is that which has the highest count of resident/fellow full-time equivalents in a program over an academic year, assuming a full and evenly distributed resident/fellow complement. There are different sources of information that may be used to determine which participating site is most commonly utilized by a program. For residency/fellowship programs that provide

education in hospital settings and receive reimbursement from the Centers for Medicare and Medicaid (CMS) for direct graduate medical education (DGME or DME) and indirect medical education (IME), hospital cost reports may help to quantify utilization. It is also possible to use a program's block diagram to estimate distribution of resident/fellow education among the participating sites.

[Avoiding Common Errors in the ADS Annual Update: Creating an Effective Block Schedule Video](#)

Participating sites may be located in an inpatient or outpatient setting. Examples of participating sites include:

a. Hospitals, including outpatient clinics and related facilities
b. Private practice
c. Nursing home
d. Health department
e. Federally qualified health center
f. Public health agency
g. An organized health care delivery system
h. Health maintenance organization (HMO)
i. Medical Examiner's office

Specialty- and Subspecialty-Specific Requirements for Primary Clinical Sites

Whatever method is used to calculate utilization, a program must also ensure the presence of other specialties and/or programs at the primary clinical site, as required in specialty- and subspecialty-specific Program Requirements. Questions about specialty and subspecialty requirements or expectations for the primary clinical site should be directed to staff members of the relevant Review Committee.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

I.B.   Participating Sites

I.B.2.a)   The PLA <u>must</u>:

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 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

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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)

[The Review Committee may further specify]

GUIDANCE

Definition - The program letter of agreement (PLA) is a written document that addresses graduate medical education responsibilities between a program and a site other than the Sponsoring Institution at which residents have required educational experiences.

1. Program directors are responsible for PLAs, and designated institutional officials (DIOs) are required to review and approve all PLAs.
2. PLAs are not required for sites used for elective rotations.
3. PLAs are not required for sites that are under the governance of the Sponsoring Institution.

The purpose of PLAs is to ensure that residents and fellows are provided with an appropriate educational experience and to protect them from undue service requirements that do not enrich their education. They also ensure an understanding of common expectations, the nature of the experience, and the responsibilities of the participating site.

1. The program director must submit information regarding all participating sites that provide a required educational experience of one month or more.
2. The program director must submit all information in ADS for participating sites that have been added or deleted.
3. It is the responsibility of the program director to be up-to-date on specialty-specific requirements that the Review Committee may have further specified.

Suggested elements for a PLA:

1. Duration and content of the educational experience
2. The goals and objectives for the assignment
3. Identify the faculty members who will assume educational and supervisory responsibility for residents during their rotation
4. Specific responsibilities of the supervising faculty members for teaching, supervision, and formal evaluation of residents/fellows
5. Description of how residents/fellows provide confidential evaluation of faculty members and the rotation
6. List of the policies and procedures that will govern resident/fellow education during the assignment
7. Considerations for travel time and distance to the participating site, and when the program should consider providing the residents and fellows accommodations proximal to the participating site
8. A description of how the residents or fellows can participate in core didactic activities at the primary clinical site during the rotation at the participating site
9. Duration and content of the educational experience
10. The goals and objectives for the assignment
11. Identify the faculty members who will assume educational and supervisory responsibility for residents during their rotation

12. Specific responsibilities of the supervising faculty members for teaching, supervision, and formal evaluation of residents/fellows
13. Description of how residents/fellows provide confidential evaluation of faculty members and the rotation
14. List of the policies and procedures that will govern resident/fellow education during the assignment
15. Considerations for travel time and distance to the participating site, and when the program should consider providing the residents and fellows accommodations proximal to the participating site
16. A description of how the residents or fellows can participate in core didactic activities at the primary clinical site during the rotation at the participating site

What does the PLA information look like in the Accreditation Data System (ADS)? Below are screenshots of information requested for participating sites. Ignore the checked boxes or circles.

NOTE that the ADS format may change to match the changes in the Common Program Requirements.

Site Name: ⓘ

Primary Clinical Site:
Advocate Christ Medical Center

Required Rotation:
◉ Yes
○ No

Do all residents rotate through this site?
◉ Yes
○ No

Program Letter of Agreement (PLA) exists between program and site?
◉ Yes
○ No
○ N/A (site under governance of sponsoring institution)

Program Letter of Agreement (PLA) Date: ⓘ
05/26/2019

R   (diagram):

Y1	Y2	Y3	Y4	Y5
8.0	8.0	8.0	8.0	8.0

D   o Prima   al Site

Miles	Minutes
8.0	8.0

E   scribe t   nt of the educational experience (addressing faculty coverage, volume/variety of clinical experience, site support and educational impact):

Which of the following are available within your institution for residents (check all that apply):

- ☑ Safe, quiet, clean, and private sleep/rest facilities available and accessible with proximity appropriate for safe patient care
- ☑ Shower
- ☐ Secure areas (lockers or rooms that can be locked)
- ☑ Access to food
- ☑ Parking accessible to site
- ☑ Internet Access
- ☑ Reasonable accommodations for residents/fellows with disabilities consistent with the Sponsoring Institution's policy
- ☐ Clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care
- ☐ None of the Above

Suggested Checklist (not exhaustive)	
	Are there PLAs for all required participating sites?
	Has the duration and content of the educational experience been defined?
	Are there goals and objectives for the rotation?
	Has the program identified a site director and supervising faculty member(s) at the participating sites?
	Is there a description of the specific responsibilities of the supervising faculty member(s) for teaching, supervision and evaluation of the residents?
	Is there a description of how the residents or fellows provide confidential evaluations of faculty members and the rotation?
	Is there a process by which the program monitors the clinical learning and working environment at all participating sites?
	Has the PLA been approved and signed by the DIO?
	Has the PLA been signed by program director and the participating site director?
	If applicable, has the program addressed the need for accommodations for the residents or fellows close to the participating sites?
	If applicable, is there a description of how the residents or fellows participate in core didactic activities at the primary site during the rotation?
	Is the PLA being renewed every 10 years? If changes have been made to participating sites prior to the 10-year renewal (deletion, addition, change in experience), has the program director provided an update in ADS?

Examples of rotations that require a PLA:

1. One-month rotation in a pediatric inpatient unit in a children's hospital required by family medicine
2. One-month rotation in rheumatology required by internal medicine
3. One-month rotation in an emergency department with a Level 1 trauma center required by emergency medicine
4. One-month osteopathic neuromuscular medicine inpatient experience with an individual or group osteopathic neuromusculoskeletal medicine practice
5. Geriatric continuity of care experience in a nursing home throughout the academic year required for all family medicine residents

6. Two-week required emergency medicine rotation in a Poison Control Center

Potential Citations:

1. Failure to have fully implemented PLA for each required activity
2. Failure to have required signatures on the PLA
3. Failure to renew PLA every 10 years; failure to provide updates in ADS for all changes in the interim
4. Failure to complete required elements of a PLA
5. Program director has no oversight for faculty members and activities at the participating site
6. Lack of goals and objectives for the required activity at the participating site

Sample of a PLA from the Association of American Medical Colleges (AAMC): (This template was formulated by the AAMC to allow editing. **Version 11.3.2017**)

NOTES:

1. The form below is a sample. The ACGME does not require its use.

2. The AAMC may make changes to the template. The reader is advised to check the AAMC website for updates.

AAMC Version 11.3.2017

PROGRAM LETTER OF AGREEMENT (AAMC)

> **This Program Letter of Agreement is used to implement the AAMC Uniform Terms and Conditions which address important legal and business terms between the Sponsoring Institution and the Participating Site. The Uniform Terms and Conditions include provisions on the administration of the residency program; resident salaries and benefits; immunizations, criminal background checks, licensure, access to resources, resident supervision and evaluation, insurance coverage, HIPAA and other important issues. This Program Letter of Agreement should not be signed before reading and fully understanding the AAMC Uniform Terms and Conditions.**

This Program Letter of Agreement is the residency training affiliation agreement between the Sponsoring Institution and the Participating Site with respect to a clinical training experience for the Sponsoring Institution's assigned residents, and the agreement of the parties to abide by all terms and conditions of the AAMC Uniform Terms and Conditions [dated Month DD, 20YY] which is hereby incorporated by

reference, without modification or exception except as specified below. Any conflict between this Program Letter of Agreement and the AAMC Uniform Terms and Conditions are to be interpreted in favor of this Program Letter of Agreement.

This Program Letter of Agreement is effective from _____/_____/_____, and will remain in effect for five years or until updated or changed by the Sponsoring Institution and the Participating Site or terminated by either party.

1. **Parties**

   Sponsoring Institution:

   Participating Site:

2. **Persons Responsible for Education and Supervision**

   Program Director at Sponsoring Institution:

   Site Director at Participating Site:

   Other faculty at Participating Site (by name or general group):

   The above named people are responsible for the education and supervision of the residents while rotating at the Participating Site.

3. **Responsibilities**

The faculty at Participating Site must provide appropriate supervision of residents in patient care activities and maintain a learning environment conducive to educating the residents in the competency areas identified by ACGME or other applicable accrediting bodies. Supervision must provide safe and effective care to patients; ensure development of skills, knowledge, and attitudes required to enter the unsupervised practice of medicine and establish a foundation for continued professional growth. The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment and document this evaluation at the completion of the assignment.

4. **Goals and Objectives of the Educational Experiences**

The goals and objectives of the educational experiences have been developed according to ACGME Residency Program Requirements or other applicable accrediting bodies, and [include the following goals and objectives.] **or** [are specified in the Resident Handbook, pg. ____.] **or** [are delineated in the attached document.]

The Program Director, Site Director and the program faculty at the Participating Site are together responsible for the day-to-day activities of the residents during the course of the educational experiences at the Participating Site in furtherance of the goals and objectives.

5. Policies, Rules and Regulations that Govern Resident Education

Residents will be under the general direction of their Sponsoring Institution Program's Policy and Procedure Manual regarding educational matters as well the Participating Site's policies, rules and regulations regarding patient care activities.

6. Financial Responsibility

Select one of the three options below:

☐ Sponsoring Institution Responsible Financially
Sponsoring Institution or its affiliate as otherwise described under Section 7 herein shall continue to employ the residents and is responsible for the payment of any salary and compensation to the residents, as well as providing or requiring health insurance coverage and workers compensation coverage, and withholding all applicable taxes. Sponsoring Institution understands that its residents will not be covered by or entitled to any social security, unemployment compensation, retirement, pension and/or any other benefits programs or workers' compensation program offered or provided by Participating Site, and no resident shall have any right, title or claim to participate in the same. Agreement to any additional sharing of expenses for any specific rotation shall be set forth in [below.] **or** [in Exhibit ___, attached.]

Or

☐ Participating Site Responsible Financially
Sponsoring Institution or its affiliate as otherwise described under Section 7 herein shall continue to employ the residents and is responsible for the payment of any salary and compensation to the residents, as well as providing or requiring health insurance coverage and workers compensation coverage, and withholding all applicable taxes. Sponsoring Institution understands that its residents will not be covered by or entitled to any social security, unemployment compensation, retirement, pension and/or any other benefits programs or workers' compensation program offered or provided by Participating Site, and no resident shall have any right, title or claim to participate in the same. Since Sponsoring Institution cannot claim the residents on its cost report for graduate medical education reimbursement from the CMS, the Participating Site shall reimburse Sponsoring Institution or its

affiliate as may be described under Section 7 herein for the applicable pro rata portion of any resident's salary and benefits. Sponsoring Institution or its affiliate as otherwise described under Section 7 herein may provide the Participating Site an invoice for payment, which shall be paid by Participating Site within ninety (90) days of the date that such invoice is posted in the U.S. mail or other agreed upon means. Any additional expenses for any specific Rotation shall be set forth in [Exhibit ___, attached.]

Or

☐ Financial Responsibility
Sponsoring Institution and Participating Site agree to the following terms regarding cost sharing with respect to costs associated with the education of residents: [insert terms].

7. Other Modifications or Exceptions to the AAMC Uniform Residency Training Terms and Conditions

Modifications or Exceptions (if none, please indicate by writing "none"):

The individuals executing this program letter of agreement are authorized to sign on behalf of their institutions and certify that their institutions have accepted the AAMC Uniform Terms and Conditions for Program Letters of Agreement and further agree to comply with its terms except as noted above.

Sponsoring Institution: _____

By: _____ Signature: _____

Title: _____ Program Director: _____

Date: _____

Address: _____

_____

Participating Site: _____

By: _____   Signature: _____

Title: _____   Site Director: _____

Date: _____

Address: _____

_____

Additional Necessary Party: _____

By: _____   Signature: _____

Title: _____   Site Director: _____

Date: _____

Address: _____

_____

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019.

Note: Because this requirement addresses the need for recruitment and retention to be consistent with institutional and program missions, which likely already exist, it is not anticipated that programs will require an extended period of time for implementation.

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).

V.C.   Program Evaluation and Improvement

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

GUIDANCE

As noted in the table of implementation dates:

https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidencyImplementationTable.pdf

Although the requirements related to missions and aims are new, the expectation is that most Sponsoring Institutions will have defined mission statements pertaining to diversity. While most, if not all institutions have policies regarding diversity, it is understood that these will serve as a starting point, and there are aspects of this requirement that could take considerable time to produce quantifiable results. So, the initial emphasis will be on process, not numerical outcomes. The definition of diversity is intended to parallel that of the Association of American Medical Colleges' philosophy on Underrepresented in Medicine, which permits flexibility in defining the target groups for diversity based on the service demographic of the institution that is underrepresented relative to the institutional workforce for a given role. This should always include underrepresented minority individuals (Native Americans/Alaska Natives/Native Hawaiians; Blacks or African Americans; Latin individuals of Puerto Rican or Mexican descent), but may also include others who are members of underrepresented subcategories of groups that are well-represented based on the field (e.g. women in certain fields, certain Asian groups in certain parts of the country; disabled individuals)

To further expand on the background and Intent section: It is expected that the Sponsoring Institution and its programs have, and implement, policies and procedures related to recruitment and retention of individuals underrepresented in medicine and medical leadership in accordance with the Sponsoring Institution's mission and aims. The population of individuals considered underrepresented in medicine will include racial and ethnic minority individuals reflective of the institution's service area, but may also include others the program or institution deems underrepresented in medicine in the service area or in the discipline in general. A core element of a program's annual evaluation, noted in V.C.1.c).(5).(c). workforce diversity, must include an assessment of the demographic population in the area served by the program and its efforts to recruit and retain a diverse workforce of individuals who are underrepresented in medicine reflective of the service area population in the roles clarified in I.C. (i.e. residents, fellows, faculty members, senior GME administrative staff, and other relevant members of its academic community)

A Planning Committee on Diversity in Graduate Medical Education was formed by the ACGME Board of Directors, and the first meeting was convened on February 19, 2018. The group charge was as follows:

The planning committee will consider current practices in US graduate medical education focused on enhancing the clinical learning environment as it pertains to diversity inclusion. The immediate focus of the committee will be to consider data

regarding demographic diversity in residency and fellowship training with respect to specialty; and, then to determine where significant disparity presently exists so as to determine mechanisms to achieve more equitable access to training in those domains. A further focus of the planning committee will be to assess the current data regarding the clinical learning environment as it pertains to experiences of diverse trainees so as to establish whether there are particular risks to learning and well-being for these individuals due to the nature of their treatment while in training; and, then to determine mechanisms to mitigate the sources of these risks. A final focus of the planning committee will be to assess how potential changes with respect to diversity in graduate medical education can be used to address health disparities in the US. The product of this work will be to present a series of recommendations to the ACGME board for its consideration so as to use the resources available through its leadership in accreditation and medical education to effect change in the clinical learning environment as it pertains to diversity and health disparities.

The Planning Committee on Diversity in GME reviewed an extensive bibliography (Appendix 1), and below is the summary.

Summary

Minority Representation in the Physician Workforce

In total, the literature shows that individuals from populations underrepresented in medicine (URiM) continue to make up a disproportionately smaller percentage of the physician workforce relative to their representation in the US population. Whites and certain Asian American groups comprise greater proportions of medical students, residents, and faculty than African Americans, Native Americans and Latinx Americans, respectively. African American males are particularly underrepresented in medicine, and represent only a third of all African American physicians in training. In addressing this disparity in education, a challenge is the medical education "pipeline," with minority individuals, particularly African American men, accounting for a disproportionately smaller percentage of individuals enrolled in and completing postsecondary education.

To complete the pipeline metaphor, minorities have greater leakiness from the pipeline that occurs in all phases of medical education with attrition rates above 15% for underrepresented minorities students, over 3-fold that of others. Underrepresented students are lost because of inadequate preparation for college and lower performance on standardized examinations. Cohn et al. 2003 showed the direct correlation between MCAT performance and parental income for medical school matriculants in part explaining the differential for underrepresented minority students. However, once matriculated, underrepresented students have higher attrition than others during medical school. Proportionately, more minority students go unmatched when applying for residency. And once in residency, underrepresented minority students withdraw and are dismissed at disproportionately higher rates. Thus, efforts to recruit underrepresented minorities have to be paired with efforts to retain them at all levels.

Efforts to increase minority representation in medicine focused on education-pipeline interventions, such as the Association of American Medical Colleges' *Project 3000 by 2000*. Its goal was to have 3000 underrepresented minorities in the nation's first-year medical school classes by the year 2000. However, shortly after its inception, efforts to challenge affirmative action in a number of states took place in the mid- to late-1990s. As a consequence, minority representation in some areas in medicine went relatively unchanged for much of the past four decades. In graduate medical education, the relative percentage of African American, Latinx, and Native American residency graduates has held flat for the past 15 years despite the expansion in the number of medical schools and class size nationally.

Impact of Minority Physicians on the Health of Minority Patients

There is considerable literature to support the position that underrepresented minority physicians serve a disproportionately large percentage of minority and poor patients compared to non-underrepresented physicians. Additionally, several important studies over a sustained period have indicated that racial and ethnic congruence between patient and physician results in increased trust, better patient adherence to medical advice, increased patient satisfaction, and improved communication between the patient and physician. Mistrust of physicians and the medical establishment is a real phenomenon that causes certain minority patients to act in violation of their own self-interest and either postpone care, fail to adhere to medical advice or seek alternative medical solutions for imminently treatable disease.

Recent work by Alsan et al. 2018 has shown that several healthcare outcomes are improved when there is racial congruence between patient and physician, such as increased time spent with patients, writing longer notes, an increased propensity for patients to return for follow-up appointments, and increased therapeutic success. Projections from this analysis have offered a way to improve health in minority communities through workforce solutions. The expressed desire to practice in underserved and minority communities among minority physicians-in-training is far greater than that of other comparable individuals. Practice patterns after completion of training support the actualization of this desire.

However, training a more diverse healthcare workforce has salutary effects on other learners in the educational environment aside from the mere provision of access to minority individuals. Cohen et al. in 2002 wrote that health care professionals cannot become culturally competent solely by reading textbooks and listening to lectures. They must be educated in environments that are emblematic of the diverse society they will be called upon to serve. Evidence supports the finding that physicians who train in a more diverse clinical learning environment feel more comfortable in caring for minority patients than those who train in less diverse cohorts of learners. The deficit of underrepresented minority individuals in training today is so extremely disproportionate relative to the societal need that a workforce solution seeking only to produce more

minority physicians as a single approach will be insufficient. Therefore, the need to provide inclusive learning environments where all learners can benefit from the diverse knowledge of their colleagues is essential to prepare physicians of the future. Cultural competence is important in allowing physicians to provide culturally sensitive and appropriate care to all patients, regardless of their minority status.

The Liaison Committee on Medical Education recognized the importance providing diverse learners in the healthcare workforce a number of years ago when it set forth a provision to diversify undergraduate medical education with an accreditation standard that mirrors the new ACGME Common Program Requirement. The target was the entry of early learners onto the pathway leading to a career in medicine. This has fostered creative approaches to engage communities and students at all premedical levels to consider and prepare for a career in medicine. Graduate Medical Education has frequently stood on the sidelines rather than actively engaging with its undergraduate medical colleagues in helping create a pathway into medicine for diverse learners. Sponsoring institutions frequently have erected barriers to participation in healthcare learning experiences for younger students who are restricted from patient areas. The unintended consequence is that students who are fully capable of being trained to protect health information are banned because of age at a time when attracting the best and brightest into medicine is essential. These barriers need to be examined and removed where they serve no reasonable purpose, in the interest of fostering the pipeline of diverse learners into the field of medicine at a point early enough to influence career outcomes. Further, programs that have not actively considered diversity as a factor in determining what makes a program useful to their communities now have the impetus to strive to identify learners who will contribute to eliminating health disparities.

The process of creating a resident physician is long and today suitable candidates are scarce. That is why active participation on the part of the program with its sponsoring institution in development of learners at any pre-residency stage will fulfill the core requirement of I.C. with respect to residents and fellows. Those programs and sponsoring institutions affiliated with LCME accredited medical schools will have readily identifiable sources of science-technology-engineering-math high school level pipeline programs, college enrichment programs, and post-baccalaureate programs with which they can align and make more productive. However, half of the sponsoring institutions accredited by ACGME do not have established relationships with medical schools accredited by LCME and will have to identify community partners in their areas or develop their own programs in order to be compliant with I.C. The ACGME is working to help programs to identify potential community partners in their environs, many that heretofore have not attempted to establish a connection with a medical institution in their community out of fear of being rejected. Of course, if a program or sponsoring institution does not elect to participate in development of pre-residency learners through pipeline initiatives, it is encouraged to demonstrate its success at consistently recruiting

a diverse class of residents and fellows and to document its approach in its annual update.

New Common Program Requirement I.C. also includes faculty in the description of physicians included in the diverse workforce initiative. Minority faculty tend to engage in research and discovery that directly impacts minority health more consistently than other physicians. Increased faculty diversity also has the potential to result in increased participation of minorities in clinical trials as well as to expand the current research agenda making it more inclusive. Even with the low number of current trainees, GME has the opportunity work to increase faculty diversity by helping to track current residents into academic careers. Demonstration of efforts to effectively mentor, develop and provide opportunities to current residents and fellows that lead to academic careers can be documented in the annual program evaluation.

Experience of Women and Minority Learners and Faculty

Regardless of the type of minority status, including racial/ethnic and sex/gender, members of minorities report overt discrimination, having to contend with different levels of expectations in the training environment, and social isolation. Many minority residents perceive that they are punished more harshly for the same transgressions as other learners. Many trainees suffer from imposter syndrome wherein they internalize social signals in the environment that they do not belong. This can be reinforced by subtle events, termed "microaggressions" (low-level, covert acts of aggression), "microinsults," and "microinvalidations." Often bystanders, including faculty, peers and colleagues observe these events, but ignore, minimize, or are afraid to address these occurrences instead of intervening. Programs and sponsoring institutions are charged in new requirement I.C. to make the workforce inclusive, which may suggest specific training of the community in ways to minimize these occurrences and what bystanders may do when they encounter such events. Ally training, implicit bias training and anti-racism/sexism training may be helpful in creating more inclusive learning environments. As mentioned, social isolation and feeling a lack of a support system are other common themes in the reports of the experience of all types of minority participants in medical education. Recent studies still show a considerable degree of gender identity concealment for sexual and gender minority students and residents. Forming groups with common interests or supporting diversity committees within an institution or program may help to increase a sense of belonging for residents who are risk of social marginalization.

Women now make up a sizable proportion of medical students. While female students learn how to confront and respond to inappropriate behavior from male patients, these students do not feel equipped to respond to the unprofessional behavior of male supervisors, resulting in feelings of guilt and resignation over time that such events will be a part of their professional experience. Women and underrepresented minorities continue to make up a lower percentage of tenured faculty in academic medicine, with males at the highest percentage. There are pay differences, lower academic

progression and promotion rates for female and minority faculty. Women from underrepresented minority groups and PhDs perceive a double disadvantage. While women currently make up one-half of medical school graduates, women, along with individuals of color, continue to be underrepresented in leadership positions, with one consequence being a lack of leadership role models for women and minority individuals. When women and minority faculty are given leadership positions, these frequently are "minority-focused," "nurturing" or "advocacy" roles.

In 2007, Dyrbye and colleagues reported a lower prevalence of burnout and depressive symptoms in minority medical students, in general; however this was different for minority students who reported a race-related incident that adversely affected their medical school experience. Such students were more likely to demonstrate burn out and low-quality of life indices. Burned out learners may perform at a lower level and their performance, even in the absence of the biased assessment they already fear, will reflect poorer performance. In some studies, minority medical students report a lower sense of personal accomplishment. The intersection between inclusivity and performance is important for programs and sponsoring institutions to assess because the attrition from medical education described for minority individuals may be directly related to the learning environment.

Despite emphasis on a diverse learning environment, some learners from underrepresented minorities question whether their institutions truly value having a diverse group of learners and faculty. Many learners report they believe a lack of diversity on their own campus was a barrier to recruiting and retaining minority candidates, and commented on the institution's limited social, academic, and financial support, as well as inadequate efforts to recruit minority students. Again, having a chief diversity officer position at an institution; creating and supporting a diversity committee within the institution and department; and, actively engaging minority individuals in the learning environment to help to eliminate barriers to success in recruitment and retention are all key elements employed by the most inclusive programs. Finally, AAMC has an interesting new tool, the Diversity Engagement Survey (https://www.aamc.org/what-we-do/mission-areas/diversity-inclusion/engagement-survey), to assess the climate at your institution with respect to diversity

Guidelines and additional references for help in implementation of this requirement are forthcoming. Please check back.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement

Requirements below are subject to citation July 1, 2019
*Requirements I.D.2.e) are subject to citation July 1, 2020

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)

               [The Review Committee must further specify]

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) (Subject to citation July 1, 2020)

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)

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

[The Review Committee may further specify]

GUIDANCE

Access to Food, Sleep/Rest Facilities, and Lactation Facilities

Programs are expected to partner with their Sponsoring Institutions to ensure residents/fellows have adequate access to food, sleep/rest facilities, and lactation facilities, and to ensure appropriate safety and security measures are in place at all participating sites. Interpretations of the requirements for space may depend on the attributes of a participating site and the needs of residents/fellows when they are assigned to that site.

Sleep/rest facilities and lactation facilities should be clean and free of vermin.

At different participating sites, there may be differences in how residents/fellows perceive features of sleep/rest facilities (e.g., gender-based usage, bunking). There may also be differing expectations for sleep/rest facilities based on the type of resident assignment (e.g., overnight call, outpatient clinic). Because of site-, program-, and resident/fellow-specific factors, the ACGME does not provide uniform specifications for the physical space of sleep/rest and lactation facilities beyond the qualities indicated in the requirements and the associated guidance in the requirements' "Background and Intent." When assessing whether sleep/rest and lactation facilities are substantially compliant with the requirements, Sponsoring Institutions and programs should elicit feedback from the residents/fellows who use them.

Similarly, Sponsoring Institutions and programs may take different approaches to ensuring safety, security, and access to food, depending upon the nature of resident/fellow assignments and the availability of resources at participating sites. It is important for Sponsoring Institutions and programs to obtain resident/fellow input when evaluating these aspects of clinical learning environments.

When assessing a program's compliance, Review Committees place emphasis on what is reported by site visitors from their interviews and/or observations.

Accommodations for Residents/Fellows with Disabilities

Programs must work with their Sponsoring Institutions to ensure compliance with institutional policies related to resident/fellow requests for accommodation of disabilities. Common Program Requirements I.D.2, I.D.2.e) are companions of ACGME Institutional Requirement IV.H.4: "The Sponsoring Institution must have a policy, not necessarily

GME-specific, regarding accommodations for disabilities consistent with all applicable laws and regulations."

Laws and regulations concerning requests for accommodation of disabilities include Title I of the [Americans with Disabilities Act](#) and related enforcement guidance published by the [U.S. Equal Employment Opportunity Commission](#). Other federal, state, and local laws and regulations may also apply. It is common for program directors, coordinators, residents/fellows, faculty members, and designated institutional officials to collaborate with human resources, legal departments, and/or institutional officers/committees to manage requests for accommodation.

Reference Material

Sponsoring Institutions and programs must ensure that residents and fellows have access to medical literature that supports their clinical and educational work. Common Program Requirement I.D.3 is parallel to ACGME Institutional Requirement II.E.2: "Faculty members and residents/fellows must have ready access to specialty-/subspecialty-specific electronic medical literature databases and other current reference material in print or electronic format."

Review Committee members are aware that the availability of a computer or mobile device with internet access alone may provide access to a wide range of relevant reference material. Many Sponsoring Institutions and programs purchase subscriptions to information resources and services to supplement open access materials. As with other programmatic resources, interpretation of the requirement may depend on unique circumstances of participating sites, programs, faculty members, and residents/fellows. Residents/fellows and faculty members may provide valuable input to Sponsoring Institutions and programs regarding the adequacy of available medical literature resources.

Resources to Support the Number of Residents/Fellows

Programs, in partnership with their Sponsoring Institutions, must ensure there are resources to support the number of residents/fellows they appoint. If a program fails to demonstrate that it has the capacity to provide each resident/fellow with a sufficient educational experience, a Review Committee may reduce that program's approved complement ([ACGME Policies and Procedures](#), Section 18.90).

REQUIREMENTS

Fonts in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2020

I.D.   Resources

     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).

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

> 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.

GUIDANCE

Section VI: The Learning and Working Environment has been expanded to include greater attention to both patient safety and resident and faculty member well-being.

Section II: Resources – A requirement to provide facilities for lactation has been added.

It is critical to acknowledge that the time for residency/fellowship often overlaps with the time for starting and raising families. This overlap may serve as a common source of stress for residents and fellows.

Rooms for lactation and other personal health care must provide privacy and refrigeration and be close enough to the clinical setting to be of use for residents and fellows who need them. Therefore, simply using a restroom as a facility for lactation or for medication administration would not meet the standard of cleanliness. Refrigeration capabilities are essential for storage. In addition, the availability of a computer and telephone will allow residents and fellows, if necessary, to provide continued attention to patient care while attending to their personal health care needs.

Interpretation of the requirement for "close proximity to clinical responsibilities" is left to the program and the institution. The requirements do not dictate a specific distance or a time element for the resident to get from the lactation facility or room for personal health care needs to the clinical location. Instead, institutions and programs are urged to consider the circumstances. For example, a busy, high-intensity clinical location, such as the intensive care unit, might require that the lactation room is in a location that allows immediate access to the patient care area, whereas a clinical location that is less busy or intense will not require such proximity. In addition, it is not necessary for the lactation or other personal health care needs facility to be solely dedicated to resident/fellow use.

With regard to residents and fellows being given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours, residents should give adequate notice if possible, and requests should be handled in a professional manner. See section VI.C.1.d.(1).

REQUIREMENTS

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Common Program Requirement

Requirements below are subject to citation July 1, 2019

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

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

> 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.

GUIDANCE

Although other learners and advanced practice providers can, and frequently do, enhance resident education, there are certainly circumstances in which they interfere with that process. One example of such interference is the interposition of a fellow or an advanced practice provider in the communication of an attending physician faculty member and the resident (or resident team) in such a manner that the resident(s) does (do) not gain the educational benefit of direct communication with the attending physician faculty member. Another example is a fellow repeatedly performing procedures which the resident is expected to develop competence.

Situations of this type frequently involve a degree of intra- or inter-departmental disagreement on educational responsibilities. In the case of advanced care providers, they may also impact decisions made by the administration of the clinical site. The designated institutional official (DIO) and Graduate Medical Education Committee (GMEC) may be very helpful to the involved program(s) in arriving at an equitable and mutually beneficial solution to the issue.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

II.   Personnel

II.A.   Program Director

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

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.

GUIDANCE

For this requirement, the Task Force wishes to emphasize that the program director has accountability for the entire program, *including compliance with all applicable program requirements*.

In the ACGME's accreditation model (the Next Accreditation System, or NAS), all Common Program Requirements were categorized as **Core**, **Outcome**, or **Detail**. In addition, periodic reviews or biopsies of programs were replaced by continuous observation and annual review. The goals are to ensure that problems are identified and addressed early, and to ensure that programs in substantial compliance with the requirements are able to innovate.
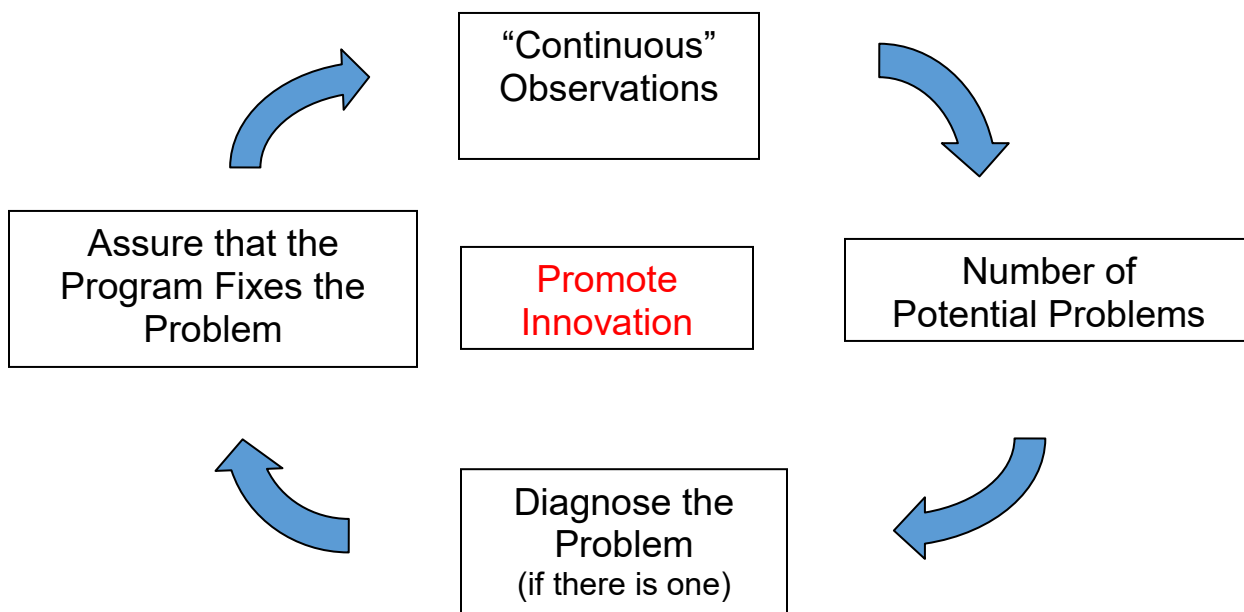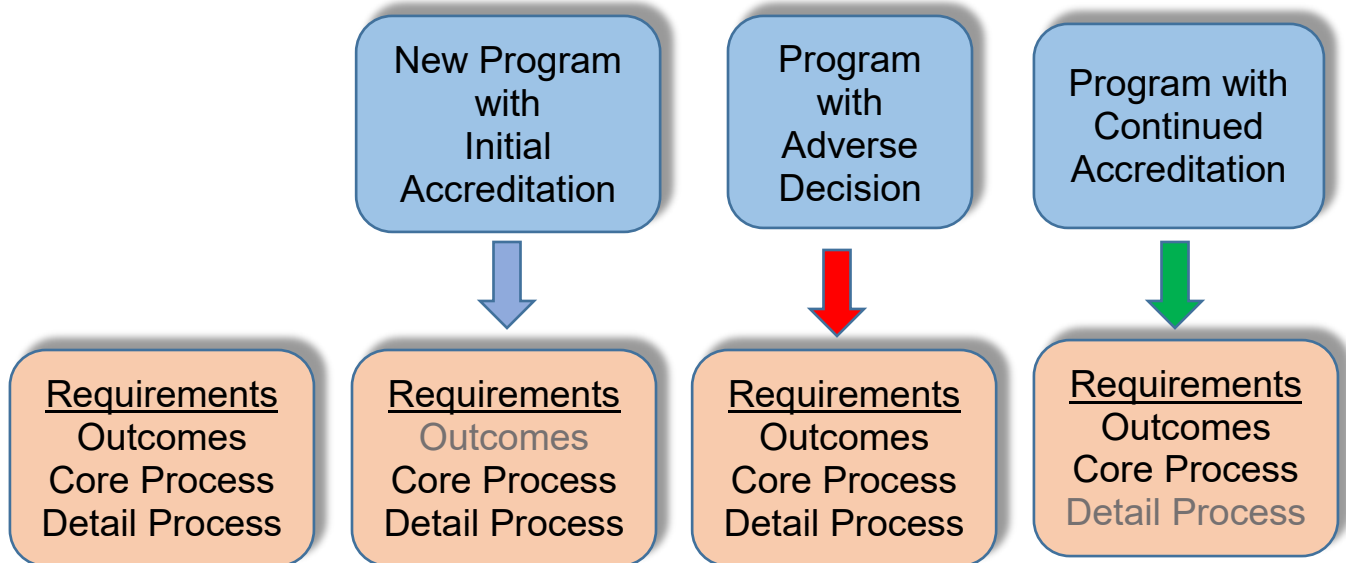
Core Requirement: is a requirement that defines structure, resource, or process elements *essential* to every graduate medical educational program. ALL programs must adhere to these requirements.

Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education. ALL programs must adhere to these requirements. It is important to note that new programs with Initial Accreditation will not have outcomes (no graduates as of yet).

Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core requirement. Programs in substantial compliance with the applicable Program Requirements, or those with Continued Accreditation, may innovate and use alternative or innovative approaches to meet Detail requirements.

The program director must ensure compliance with all applicable program requirements and understand the program requirement categorization of Core, Outcome, or Detail. As noted, programs with Continued Accreditation can use innovative methods to meet Detail requirements.

REQUIREMENTS

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Common Program Requirement:

Requirements below are subject to citation July 1, 2019

II.   Personnel

II.A.   Program Director

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

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

    II.A.1.b)   Final approval of the program director resides with the Review Committee.[(Core)]

> 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.

GUIDANCE

There are multiple components to Common Program Requirement II.A. (Program Director). The Common Program Requirements Task Force specifically requested that this guideline address the requirements for the appointment of the program director. While ALL components of the program director requirements are effective July 1, 2019, guidelines for requirements such as experience, qualifications, and retention will be addressed in the guidelines at a later date. The CPR and guidelines for program director support is provided in the next section

The Review Committees want to help programs succeed. One essential element of program success is having a qualified individual as program director. Based on years of cumulative experience with both programs that are successful and those that are not so successful, many Review Committees have developed minimal qualifications for program directors in the specialty. Although the proposed program director has already been approved by the Sponsoring Institution's GMEC, final approval rests with the Review Committee.

For appointment of a new program director, the Sponsoring Institution Graduate Medical Education Committee (GMEC) must first approve the change. Following approval by the Sponsoring Institution GMEC, the DIO will enter the recommendation into the Accreditation Data System (ADS), and the following message is posted on the ADS page:

Program Director subject to RC approval

In addition, ADS generates a letter to the program as follows:

ACGME ADS NOTICE: Program Director Change Completed [xxxxxxxxxx]

The program listed below has completed a program director change in ADS.

Program: [xxxxxxxxxx] – Program Name
Sponsor: [xxxx] – Sponsor Name
New PD: New PD Name
Former PD: Former PD Name

Programs will have to check with the appropriate review committee staff to determine whether the new program director appointment has been approved.

REQUIREMENTS

Text in italics are "philosophic" statements
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Common Program Requirement

Requirements below are subject to citation July 1, 2019

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

[The Review Committee may further specify]

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.

GUIDANCE

The Common Program Requirements list the many roles and responsibilities of the program director. Most program directors, however, have responsibilities *not* listed in the Requirements. These include recruitment of residents, resident retention, budgeting program resources, maintenance of program morale, disciplinarian, coach, confidant, counselor, and many others. It takes years to understand and develop a level of expertise in each of those roles. It may also take years for program directors to develop effective working relationships with all of the individuals they work with in the program director role, including the designated institutional official, program faculty members, faculty members and leaders in related educational programs, administrators at the clinical sites in which residents rotate, and others. For these reasons, continuity in the program director role is often associated with success of the program.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

II.A.   Program Director

II.A.2.   At a minimum, the program director must be provided with the salary support required to devote 20 percent FTE (at least eight hours per week) of non-clinical time to the administration of the program. [Core]

[The Review Committee may further specify]

[The Review Committee may further specify regarding support for associate program director(s)]

GUIDANCE

Full-Time Equivalent, Percent Effort, and Hours per Week
For the purpose of this requirement, one program director full-time equivalent (FTE) is equal to 40 hours per week dedicated to a program director role. Twenty percent of a program director's work effort (or 0.2 FTE) is therefore equal to eight hours per week of non-clinical work that a program director devotes to a program.

Non-Clinical Time
Non-clinical time devoted to program administration, also referred to as "administrative time", is defined as non-clinical time spent meeting the responsibilities of the program director as detailed in Common Program Requirements II.A.4.-II.A.4.a).(16).

Protected Time
One effective means of demonstrating substantial compliance with this requirement is to establish and document at least eight hours per week of "protected time" for the program director during regular business hours. Protected time is an accommodation that allows the program director to devote most or all his or her efforts to the program, with limited or no responsibilities for patient care or clinical supervision. The program director, regardless of specialty, requires defined protected time to perform the many non-clinical responsibilities to lead and manage the program.

The parameters of protected time are sometimes specified in agreements that determine compensation and other terms of program directors' appointments.

Salary Support and Sponsoring Institutions
A Sponsoring Institution is not necessarily the entity that provides salary support directly to a program director, and in many cases, a program director's employer is not a Sponsoring Institution. However, each accredited Sponsoring Institution is accountable to the ACGME's Institutional Review Committee for ensuring that a program director receives salary support in substantial compliance with this requirement, even when that Sponsoring Institution does not provide the program director's compensation (see ACGME Institutional Requirements II.B, II.B.1 below).

Related Institutional Requirements:

II.B.   Program Administration: The Sponsoring Institution, in collaboration with each ACGME-accredited program must ensure that:
II.B.1.   The program director(s) has (have) sufficient financial support and protected time to effectively carry out his/her (their) educational administrative, and leadership responsibilities, as described in the Intuitional, Common and specialty-subspecialty-specific Program Requirements; (Core)

What does this look like in the Accreditation Data System (ADS)?

 NOTE that the ADS format may change to match the changes in the Common Program Requirements.

To enter the program director's information, select from the drop-down list of active faculty members, select the program director's name, and enter the information accordingly, as shown in the screenshots below. The fields will be pre-populated if you have previously entered the information. Please ignore response selections.

General Information

Salutation:

First Name: ⓘ   Middle Initial: Last Name: Suffix:

Convert to Non-Physician

Degrees: ⓘ

Program Specific Title:

Email address for communicating with ACGME:

National Provider ID: ⓘ

Primary Institution: ⓘ

[⌄]

Date First Appointed Faculty Member in this program:

[⌄] [⌄] [⌄] [▦] [✕]

Date Left Program or Made Inactive:

[⌄] [⌄] [⌄] [▦] [✕]

Year Started Teaching in this Specialty (Anesthesiology):

[⌄]

Year Started Teaching in Graduate Medical Education (GME):

[⌄]

Define the faculty member's role in the program with regard to Osteopathic Recognition:

Program faculty members provide specialty/subspecialty education to residents in the program and are subject to the faculty requirements established in the program requirements for the specialty/subspecialty.

Osteopathic faculty members provide osteopathic education to designated osteopathic residents and are subject to the osteopathic faculty requirements established in the Osteopathic Recognition Requirements.

Some faculty members may fulfill both roles.

[⌄]

Is this faculty member core?
◉ Yes
○ No

Is also Chair of Department?
○ Yes
◉ No

Medical School

Type of medical school:

[⌄]

Available Medical Schools:

[⌄]

Medical School Graduation Year:

[⌄]

Other School Name:

[   ]

All sections must be completed. The program director or faculty certification information is frequently incomplete or outdated, resulting in citations from the Review Committee

Specialty Certification

Certification Type:
Specialty:
Other Specialty:
Original Certification Year:
Certification Status:
Expiration Year:

Edit   🗑   ↑   ↓

Certification Type:
Specialty:
Other Specialty:
Original Certification Year:
Certification Status:
Expiration Year:

Edit   🗑   ↑   ↓

+ Add

Faculty Hours

Number of hours per week faculty member devotes to this program's activities in the following:

Clinical supervision of residents ⓘ   Administration of the program ⓘ

Research/scholarly activity with residents ⓘ   Didactics/teaching with residents ⓘ

Total hours devoted to this program:

Case Log Attendings

Active:

○ Yes

◉ No

⌃ back to top

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement

Requirements below are subject to citation July 1, 2019

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

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

> Background and Intent: Leading a program requires knowledge and skills that are established during residency and subsequently further developed. The time period from completion of residency until assuming the role of program director allows the individual to cultivate leadership abilities while becoming professionally established. The three-year period is intended for the individual's professional maturation.
>
> The broad allowance for educational and/or administrative experience recognizes that strong leaders arise through diverse pathways. These areas of expertise are important when identifying and appointing a program director. The choice of a program director should be informed by the mission of the program and the needs of the community.
>
> In certain circumstances, the program and Sponsoring Institution may propose and the Review Committee may accept a candidate for program director who fulfills these goals but does not meet the three-year minimum.

II.A.3.b)   must include current certification in the specialty for which they are the program director by the American Board of _____ or by the American Osteopathic Board of _____, or specialty qualifications that are acceptable to the Review Committee; (Core)

[The Review Committee may further specify acceptable specialty qualifications or that only ABMS and AOA certification will be considered acceptable]

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

II.A.3.d)   must include ongoing clinical activity. (Core)

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

[The Review Committee may further specify additional program director qualifications]

GUIDANCE

Some Review Committees will accept *only* certification in the appropriate specialty by an American Board of Medical Specialties member board or the American Osteopathic Association as a qualification of a program director. Other Review Committees will accept other qualifications for the program director. These may include a "board eligible" status, fellowship in the Royal College of Physicians and Surgeons of Canada, certification by other international bodies or tenure in rank as a faculty member.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement

Requirements below are subject to citation July 1, 2019

II.A.4.   Program Director Responsibilities

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

GUIDANCE

Simply put, the program director is *the* person who is ultimately responsible for the program.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement

Requirements below are subject to citation July 1, 2019

II.A.4.   Program Director Responsibilities

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

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

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

> 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.

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

> 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.

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

> 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.

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

II.A.4.a).(5)   have the authority to approve program faculty members for participation in the residency program education at all sites; (Core)

II.A.4.a).(6)   have the authority to remove program faculty members from participation in the residency program education at all sites; (Core)

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)

> 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.

GUIDANCE

Simply put, the program director is *the* person who is ultimately responsible for the program.

[The program director must:]

II.A.4.a).(1) and (3) be a role model of professionalism; and administer and maintain a learning environment conducive to educating the residents in each of the ACGME Competency domains.

NOTE: While the guidelines below fall under requirements II.A.4.a).(1) and II.A.4.a).(3), they are not actual requirements. The intent of this section is to emphasize the importance of the program director and faculty leadership as noted in the Background and Intent Section. These elements include role modeling of professionalism, high quality patient care, educational excellence and scholarly approach to work.

While this section is not tied to a requirement and you may want to skip it and move on, we urge you to read on and look up some or all of the references. Hopefully, you'll find some inspiration in your professional work that is related to mentorship, humanism and leadership.

Leadership:

The concept of program director and faculty leadership takes many forms, and is important whether the program is big or small. The designation of faculty leadership can be a formal or an informal process, but what is most important is the composition of this group. The group can be composed of physicians and non-physicians who know the residents or fellows well, have frequent interactions with them, and most importantly, can serve as role models in clinical care, professionalism, and scholarship. In addition, they can serve as a sounding board for the program director and help in shaping the program.

As ACGME President and CEO Dr. Thomas J. Nasca stated in the article **Nasca, Thomas J. "Professionalism and Its Implications for Governance and Accountability of Graduate Medical Education in the United States."** *JAMA* **313, no. 18 (December 2015): 1801.** Graphic available at https://doi.org/10.1001/jama.2015.3738)

"The philosophical roots of professionalism include the Hippocratic tradition of medicine as a moral enterprise; the transition of medicine from guild to profession with a commitment to competence, altruism, and public trust; and the responsibility of the profession to prepare the next generation of physicians to serve the public."
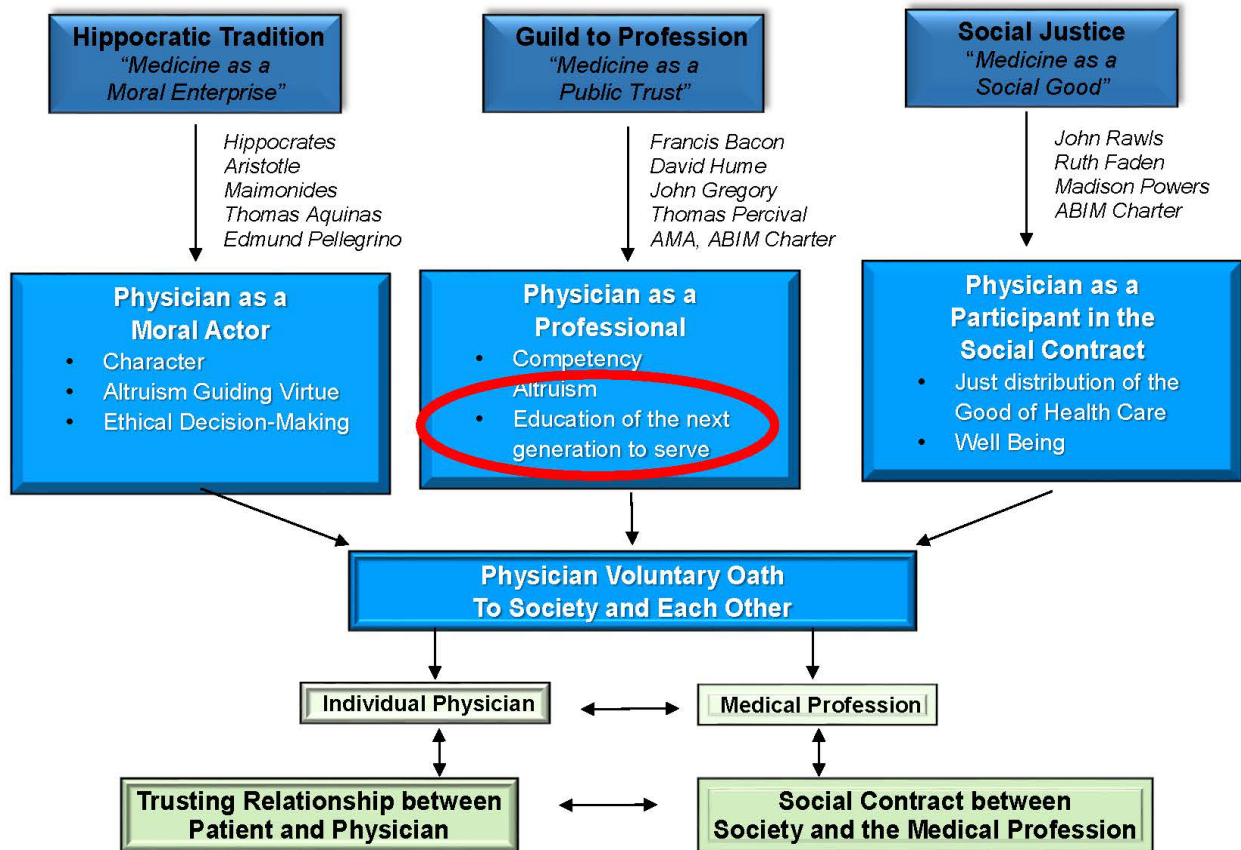
Mentorship:

While there are many articles that define and describe mentoring and mentorship, there are a number of characteristics that constitute this relationship. Mentorship is a long-term relationship between a more senior person (mentor) and a less experienced person (mentee). While both benefit from the relationship, it is generally established for the betterment of the mentee. According to Sambunjak and Marusic (**Sambunjak, Dario, and Ana Marušić. "Mentoring."** *JAMA* **302, no. 23 (2009): 2591.** https://doi.org/10.1001/jama.2009.1858, mentorship includes three components: helping mentees acquire and integrate new learning; managing a personal aspect of transitional states; and maximizing the mentee's potential to become a fulfilled and achieving practitioner. Mentorship therefore helps keep the promise that a physician makes to educate the next generation of physicians to serve patients.

Tjan (**Tjan, Anthony K. "What the Best Mentors Do." Harvard Business Review, December 5, 2017.** https://hbr.org/2017/02/what-the-best-mentors-do) interviewed scores of leaders and concluded that successful mentors have four characteristics: 1) They put the relationship before the mentorship; 2) They focus on character rather than competency and on shaping character, values, self-awareness, empathy and capacity

for respect; 3) They "shout loudly with optimism, and keep quiet with cynicism"; and 4) They are more loyal to their mentees than to the companies.

Additional Reference:

1. Sambunjak, Dario, Sharon E. Straus, and Ana Marušić. "Mentoring in Academic Medicine." *JAMA* 296, no. 9 (June 2006): 1103. https://doi.org/10.1001/jama.296.9.1103.

2. Lacombe, Michael A. "Recent Advances." *The American Journal of Medicine* 88, no. 4 (1990): 407–8. https://doi.org/10.1016/0002-9343(90)90497-2.
   See full article below:

In a hospital cafeteria, 2 residents were arguing over lunch. Oblivious to the high-tech plastic and steel surrounding them, they were locked in a heated, and unwinnable battle: what was the single most important discovery in the history of medicine? Understand that these were modern doctors with fashionable ideas and a trendy impatience with history. They had long since discarded Harvey's dissections, Morton's anesthesia, and Koch's postulates. The first resident, a latter day traditionalist, argued for the discovery of antibiotics. Eating his salad with his fingers in a grand display of entitlement, he began his argument: "There is no doubt that the dawn of the antibiotic era is indisputably the beginning of modern medicine. Domagk's sulfonamides, Waksman's streptomycin, Fleming's penicillin, all gave physicians something more to do than simply monitor the dying patient. Antibiotics gave us credibility, a bona fide raison d' etre. And
beyond that, their discovery has spawned the whole discipline of infectious disease, whose premise, the treatment of disease by biochemical means, has in turn fathered other disciplines as well". Eminently pleased with himself, he leaned back in his chair.

The second resident, more modernistic than the first prided himself on his intuitive leaps and lateral thinking. He could hardly settle for any such simplistic solution from history as his colleague had proposed. His cleverness made him positively bubble forth. "Antibiotics are important and they have their place, but they are so crude. Consider their toxicity, the emergence of resistance and the very enigma of AIDS. Antibiotics are merely an interim measure. No my friend, you miss the obvious". In fact, he believed that his solution was not all that obvious, but understatement would magnify his own genius. "The discovery of the computer is the Rosetta stone for medicine. Regard the computer's application in medical research.
Think of the microchips used in autoanalyzers, in monitoring devices, and in nuclear scanning. Consider what the CT scan has done just in the field of neurology alone. And that only scratches the surface. We can implant microchips in occipital lobes to enable the blind to see. We can use microchips in electronic limbs for amputees. And imagine the microprocessor-coordinated cochlear implants for the deaf, artificial kidneys and programmable pacemakers.
Even genetic engineering depends upon computers to direct genetic analyses and sequencing." Enough was enough. He had won and he knew it. He now sat back smugly.

At the end of their table sat an old man in a long white coat. He too ate his salad with his fingers. He had forgotten his fork. To this elderly physician, the first resident appealed: "What do you think sir? He asked condescendingly. What would you consider medicine's greatest achievement?" The old man returned a leaf of lettuce to his salad bowl, wiped his

fingers with a napkin and considered both residents with absent regard. He began to speak, reconsidered and looked away and out the windows, and then remembered that he had been asked a question.

"You are both correct as far as you go, which isn't very far, which therefore makes you both wrong, I suppose. And the correct answer to your question may be found really in your asking me, or in your need of asking me, rather more correctly, and in my compulsion to answer you, or rather history's compelling me to do so, more exactly."

Alzheimer's, thought the first resident. Korsakoff's, thought the second resident. But the old man only munched on a celery stalk, looked away briefly as if to summon his facilities, and then turned his attention to his salad again. Huh? Asked the first resident. I beg your pardon, asked the second.

"The mentor" whispered the old man. What? Both residents replied in unison. The old gentleman wiped his lips, placed both hands on the table, stared off, and began.

"The mentor is medicine's single greatest achievement, though no one set out to invent this idea to win any prize. It started, I am sure, long before Hippocrates, though he's gotten most of the press for it. But just stop and consider Hippocrates himself. There he is sitting in his robe, surrounded by colonnades, fist under his chin, lounging on some piece of marble. Through observation, by sheer power of thought he's trying to make a science out of what had been only magic and religion. Pretty soon he has a group of young people sitting around him as well, all wanting to learn what he, Hippocrates knows to be important. So he teaches them all he knows, which is what you're supposed to do when you're a mentor. And then he sends them out into the world. They teach others in turn, each of them becoming a mentor for students as Hippocrates had been for them. And everywhere they go, teaching students, treating patients, as Hippocrates had taught them to do. Hippocrates is right there at their elbows, making sure they do it the right way, and with style.

And so it goes through history – from Aristotle to Herophilus, from Galen to Vesalius, Bernard, Pasteur, Whipple, and…well, you know history as well as I do". The old man continued. "Look what happens with this mentor business. You have teachers each with students numbering in the thousands, all linked with each other down through the ages – forming a vast, dendritic coalescence of medical knowledge. Why, you have to be proud just to belong to it, just to be allowed to pass on a few bits and pieces of information yourself! You begin to think of yourself as some living page out of a grand medical textbook. And what happens to those young doctors when they are adrift in the world? Do their mentors desert them? Not on your life! A student meets a patient with congestive heart failure, and old man Withering is right there with him, telling him how much foxglove to grind up. Or a young doctor is dealt a baffling case, with an endless array of signs and symptoms, and all of a sudden Sydenham is sitting on her shoulder, making sure she takes down the patient's history correctly and that the observations are precisely made.

And so it's been for me these long years. I've carried my mentor everywhere. If I get sloppy, I wonder "what would he think of me now?" And if I am in a tight spot clinically, he prods me back to the literature. When I am impatient with my patients, I remember his patience with me. When I'm asked to teach, I do so willingly because that is what he did. When I begin to doubt myself I remember his belief in me. And if I am ready to quit, I can see him standing there before me in his long white coat with stern look and stethoscope, and I go on.

What has he been for me, this mentor of mine? He's been like a father to me, but more than a father. He has been my companion in medicine, to help me through the loneliness that medicine can bring and to share with me the joy that medicine can be. My mentor has, through me and those of my students cared decently and compassionately for countless patients. When I have cured a patient or two, why, so has he. And so has Cushing and Koch before him. Yes sir, the mentor is medicine's best invention. All of us doctors need one. That's what it's all about. I hope you boys have one yourselves".

The old man stopped, looked off, and smiled at some distant memory. The residents at the next table had turned to listen to him as well. The old man got up to leave, nodding to them all. He had a gleam in his eye, a radiance about him. He straightened his shoulders, raised his chin and turned with a quote: "Observation, reason, human understanding, courage – these make the physician. Men must be taught as if you taught them not, and things unknown proposed as things forgot". Now the old man turned back to the two residents at his table, nodded to them, put his head down and turned to walk away. Suddenly he remembered a final quotation and turned back to them all with a smile: "A man who is not fond of students and who does not suffer their foibles gladly, misses the greatest zest in life". With a hand to his breast, the old man gave a slight bow, turned and shuffled away.

Humanism

1. Chou, Carol M., Katherine Kellom, and Judy A. Shea. "Attitudes and Habits of Highly Humanistic Physicians." *Academic Medicine* 89, no. 9 (2014): 1252–58. https://doi.org/10.1097/acm.0000000000000405.
2. Montgomery, Lynda L, Sana Loue , and Kurt C Stange. "Linking the Heart and the Head: Humanism and Professionalism in Medical Education and Practice." *Family Medicine* 49, no. 5 (May 2017): 378–83. https://www.ncbi.nlm.nih.gov/pubmed/28535319.

Humanism in health care is characterized by a respectful and compassionate relationship between physicians and their patients. It reflects attitudes and behaviors that are sensitive to the values and the cultural and ethnic backgrounds of others. The humanistic health care professional has two key attributes: altruism and empathy. Chou et. al stated that "Humanism in medicine combines scientific knowledge and skills with respectful, compassionate care that is sensitive to the values, autonomy and cultural backgrounds of patients and their families."

Evidence demonstrates that compassion and empathy are critical components of good medicine. When provided with humanistic care, patients are more likely to adhere to their treatment regimens, and this adherence makes it more likely that they adhere to preventive practices and may heal more quickly. Studies indicate that the characteristics of humanism can be taught. While Chou et. al acknowledged this, they sought to determine how humanism can be maintained in a world of increasing demands and technologies. They interviewed faculty members in internal medicine who had been identified by the residents to be excellent role models for humanism. They found three themes: attitudes needed to sustain humanism included humility, curiosity, standard of behavior ("I treat patients the way I would want to be treated"), importance for the patient, importance for the physician (joy in caring for patients), and more than just the

disease ("my role is being there with and for the patient"); <u>habits</u> included self-reflection, seeking a connection with the patients, teaching/role modeling ("knowing that I'm responsible not just for the patients in front of me, but modeling how my students and residents are going to treat their patients."), balance, and mindfulness and spiritual practices; and humanism and maintenance of humanism in medical practice takes <u>effort</u>. Many of the physicians interviewed noted that humanism takes deliberate, intentional work, and identified the need for environmental support. While one may conclude that the work that goes into deliberative practice of humanism imposes additional workload on physicians that leads to burnout, the physicians in the study believed that humanism, as represented by the joy in caring for patients and educating residents, actually was a deterrent to burnout.

Program Requirement II.A.4.a).(2) design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program.

This requirement is new to the Common Program Requirements effective in 2019.

The aim of the requirement is to bring intentionality to the development, design, and implementation of each residency program in consideration of the needs and desires of its stakeholders. It is probably not realistic for a small program based in a critical access hospital to hold as its mission the production of the next generation of physician scientists. Likewise, it is probably not realistic for a program based in a very large quaternary referral hospital in a major metropolitan area to hold as its mission the production of physicians who will bring care to medically underserved areas.

It is probably accurate to assume that most programs have not in the past developed and clearly articulated their mission with the input of the communities they serve, their residents, their Sponsoring Institution, and others. Although the process may prove to be time consuming, it will likely prove rewarding for all involved. Once developed, the mission of the program should periodically be re-evaluated for potential improvement, again incorporating input from stakeholders.

Program Requirements II.A.4.a).(4) to II.A.4.a).(6) provide the program director with the authority to evaluate and approve program faculty members for participation in the education of residents and fellows.

This applies to faculty members at the primary and participating sites. It is important that faculty members who participate in the education of residents and fellows are interested in and dedicated to the program.

Program Requirement II.A.4.a).(6) grants the program director the authority to remove program faculty members from participation in the residency or fellowship program at all sites.

This requirement is often misunderstood. It does not mean the program director can terminate the employment of a faculty member. What this requirement means is that the program director has the authority to remove a faculty member from the teaching service. For example, if a faculty member is consistently reported as being unable to or refusing to teach, berates the residents, and is generally not available for educational activities, the program director may decide to remove the faculty member from the teaching service. However, the faculty member may still continue with other clinical and administrative responsibilities within the department as delineated by the Chair.

Program Requirement II.A.4.a).(7) addresses that the program director has the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program.

For example, residents might be assigned to a participating site for a one-month rotation, where they report that they are only there to provide service. Faculty members at the site do not provide supervision, evaluation, or education and are not available. The program director may decide to discontinue the rotation and have the residents rotate to another participating site that can provide the educational experience.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

II.   Personnel

II.A.   Program Director

II.A.4.   Program Director Responsibilities

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

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

GUIDANCE

The submission of incomplete and/or inaccurate information by a program is likely one of the most common citations given by the Review Committees. Examples include (but are not limited to:

1. Program Letter of Agreement (PLA): non-existent, outdated, does not have the appropriate components, lacking requisite signatures, or participating sites are not listed.
2. Incorrect block diagram
3. Program director and faculty qualifications
4. Incorrectly completed curriculum vitae or faculty roster
   a. Board certification status
5. Scholarly activity information left blank
6. Inadequate responses to citations
7. Lack of goals and objectives, or goals and objectives that are not level- or rotation-specific
8. Inappropriate levels of supervision
9. Missing clinical experience information (no patient data)
10. "Site Visitor had to spend a significant amount of time during the site visit to make clarifications, corrections and look for missing information."

In an effort to help program directors with this process, the Senior Vice Presidents for Accreditation and the Distance Learning Department created three brief videos to help with: 1) Creating a block diagram; 2) Responding to Citations; and 3) Providing information for scholarly activities.

Block Diagrams:

<u>What do you see in ADS?</u> When you are completing an application form for a new program, you will see instructions for completing a block diagram. Subsequently, you may need to update the block diagram to reflect changes in the program.

NOTE that the ADS format may change to match the changes in the Common Program Requirements.

Guide to Construction of a Block Diagram

A block diagram is a representation of the rotation schedule for a resident in a given postgraduate year. It offers information on the type, location, length, and variety of rotations for that year. The block diagram shows the rotations a resident would have in a given year; it does not represent the order in which they occur. There should be only one block diagram for each year of education. The block diagram should not include resident names.

- Create and upload a PDF of your program's block diagram using the information below as a guide.

- Two common models of the block diagram exist: the first is organized by month; the second divides the year into 13 four-week blocks. Rotations may span several of these time segments, particularly for subspecialty programs. Both models must indicate how vacation time is taken. This can be done by allocating a time block to vacation, or by indicating this in a "Notes" section accompanying the block diagram. Examples of other less common models are also provided below.

- In constructing the block diagram, include the **participating site** in which a rotation takes place, as well as the **name of the rotation**. If the name of the rotation does not clearly indicate the nature of the rotation, then clarifying information should be provided as a footnote to the block diagram or elsewhere in the document.

- **Group the rotations by site**. For example, list all of the rotations in Site 1 first, followed by all of the rotations in Site 2, etc. The site numbers listed in the Accreditation Data System (ADS) should be used to create the block diagram.

- When "elective" time is shown in the block diagram, the choice of elective rotations available for residents should be listed below the diagram. Elective rotations do not require a participating site.

- Clinical rotations for some specialties may also include structured outpatient time. For each rotation, the percentage of time the resident spends in outpatient activities should

be noted.

- Clinical rotations for some specialties may also include structured research time. The fourth line of the schedule should be used to represent the percentage of time devoted to structured research on a clinical rotation. If a block is purely research, it should be labeled as such, and should *not* be associated with a participating site.

- If needed, additional information to aid in understanding your program's block diagram may be entered in a "Notes" section at the end of the Block Diagram Data Collection Form.

Sample Block Diagrams

Block Diagram 1 [1] *In this example, the year's rotations are divided into 12 (presumably one-month) clinical rotations. Rotations may include structured outpatient or research time and electives.*

Block	1	2	3	4	5	6	7	8	9	10	11	12
Site	Site 1	Site 1	Site 1	Site 1	Site 1	Site 2	Site 2	Site 2	Site 2	Site 3	Site 3	
Rotation Name	Wards	Wards	ER	CCU	ICU	Wards	ER	ICU	Clinic	Wards	Clinic	Elec/Vac
% Outpatient	20	20	100	0	0	40	100	0	100	20	100	
% Research	0	0	0	0	0	0	0	0	0	0	0	

Block Diagram 2 [1] *In this example, the year's rotations are divided into 13 equal (presumably four-week) clinical rotations. Rotations may include structured outpatient or research time, and electives.*

Block	1	2	3	4	5	6	7	8	9	10	11	12	13
Site	Site 1	Site 1	Site 1	Site 1	Site 1	Site 2	Site 2	Site 2	Site 2	Site 3	Site 3	Site 3	
Rotation Name	Wards	Wards	ER	CCU	ICU	Wards	Wards	ICU	Clinic	Wards	Wards	Clinic	Elec/Vac
% Outpatient	30	30	100	0	0	20	20	0	100	0	0	100	
% Research	0	0	0	0	0	0	0	0	0	0	0	0	

Block Diagram 3 [1] *In this example, the year's rotations are divided into six blocks of equal duration. One of the blocks is used for an elective, which can be chosen from a list of elective rotations and a vacation month.*

Block	1	2	3	4	5	6
Site	Site 1	Site 1	Site 2	Site 2	Site 3	
Rotation Name	CCU	Med. Outpt.	Wards	ER	Wards	Elective/Vacation
% Outpatient	0	100	0	100	0	
% Research	0	0	0	0	0	

Notes | Possible electives:
Cardiology Inpatient Site 1 | Pulmonary Disease Inpatient Site 2 | Gastroenterology Inpatient Site 3
Cardiology Outpatient Site 2 | Pulmonary Disease Outpatient Site 3 | Gastroenterology Outpatient Site 1

Block Diagram 4 [1] *In this example for a subspecialty program, the year's rotations are divided into four equal blocks. Structured research time comprises 40% of the resident's time on the specialty outpatient month. There is one three-month block devoted entirely to research.*

Block	1	2	3	4
Site	Site 1	Site 2	Site 2	
Rotation Name	Specialty Outpatient	Specialty Outpatient	Wards	Research
% Outpatient	100	100	0	
% Research	0	40	0	100

(1) In any block diagram, there must be a formal allocation for vacation time. If not shown in the diagram, a "Notes" section must indicate how vacation time is taken.

Note that both the Urology and Obstetrics and Gynecology Review Committees have created fillable block diagrams for their specialties. Those block diagrams can be found in the links below. Before completing the downloadable block diagrams, the Review

Committees of Urology and Obstetrics and Gynecology strongly urge you to review the instructions prior to data entry.

Urology Fillable Block Diagrams

Obstetrics and Gynecology Fillable Block Diagrams

ADS Annual Update:

As you all know, you receive an email from the ACGME ADS staff each year with a reminder that you have to perform your annual program update. The screen shows a series of topics with drop-down lists, and the program information indicates that you have to upload the current block diagram:

The Review Committee Uses for Block Diagram:
1. Indicates rotation length(s) used
2. Summary of time spent in each program site
3. Summary of time spent on each rotation type
4. Identifies elective time

The block diagram clearly illustrates the rotation length (or lengths) utilized by a program. The rotation length has educational implications in that the longer the rotation, the greater the opportunity for the instructors on that rotation to observe and assess the resident in order to provide more accurate evaluations and more specific feedback. The rotation length also has clinical implications in that shorter rotations result in a greater number of team turnovers.

The block diagram also provides (in probably the most concise format available), a summary statement of how much time a resident in a given program spends in each of the clinical sites utilized by that program and clearly illustrates what specific experiences are gained at each of those sites.

A well-done block diagram then, also, illustrates how much *cumulative* time a resident spends in particular required clinical experience or subspecialty area cumulatively through all of the clinical sites utilized by the program.

Program Uses for the Block Diagram:
1. Ensure that Program Requirements are met
2. Ensure that Certifying Board requirements are met
3. May be useful in recruitment
4. Necessary for permanent complement increase

The block diagram helps the program ensure that program requirements are being met. Many certifying boards require that candidates have fulfilled certain chronological

educational requirements. It may be as simple as a total number of months of aggregate clinical months. It may also be a detailed requirement for a certain number of months of clinical experience.

A well-done block diagram provides potential applicants a quick but detailed snapshot of what they could expect throughout the years of their training if they entered that particular program.

When a program is contemplating or requesting a permanent increase in its resident complement, block diagrams created for each of the years anticipated to be required for the transition to the new full resident complement are extremely useful. In this way, the program can ensure that each rotation and clinical site will have an appropriate number of residents (Goldilocks rule: not too many, not too few) at any time during the transition. And it can ensure that each resident completing the program during the transition has met all chronological experience requirements of the certifying board. It also helps the Review Committee understand the local implications of the requested complement increase and demonstrates to the Review Committee that the program has thought through the implications in detail.

Institutional (DIO) Use for the Block Diagram:
The block diagram provides the institution or DIO with a structure for oversight and plan resources for curricular and other resources.

Rotation schedules are very important for use in the program by the residents, the faculty and others. But, rotation schedules are NOT block diagrams and are not what is requested by the ACGME. A block diagram does not show a rotation schedule for each individual.

A Block Diagram **IS**
1. Typical rotations assigned each program year
2. Flexible in showing rotation lengths
3. Able to show other important information:
    a. Inpatient time on a rotation
    b. Outpatient time on a rotation
    c. Research time on a rotation
    d. Names of site directors
    e. Rotation(s) offering particular required experience(s)

A block diagram shows each of the rotations that a resident will typically be assigned in each postgraduate year as she or he passes through a program. It shows the amount of time that the resident will spend on each of these rotations and the clinical sites in which those rotations will occur.
A block diagram is flexible in that it can show rotations as short as one week or as long

as several months. It can be used to convey other important information about the structure of the program.

TIPS:
1. Show program name and number
2. Clearly identify each clinical site
3. Site numbers must be consistent
4. Clearly explain any abbreviations
5. Clearly explain any local jargon
6. Differentiate rotations with the same name
7. Identify rotations for key clinical experience

Curriculum Vitae and Faculty Information

What do you see in ADS?

NOTE that the ADS format may change to match the changes in the Common Program Requirements.

Faculty CV:

WebADS Instructions: The faculty information varies by specialty. Below is a core block of text:

For Specialties and Subspecialties:
List all faculty who have a role in the education of residents/fellows with competence to instruct and supervise. List the Program Director first.

All faculty must:

- Be role models of professionalism
- Demonstrate commitment to the delivery of safe, quality, cost effective, patient-centered care
- Demonstrate a strong interest in the education of residents
- Devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities
- Administer and maintain an educational environment conducive to educating residents
- Regularly participate in organized clinical discussions, rounds, journal clubs, and conferences
- Pursue faculty development designed to enhance their skills at least annually
- Establish and maintain an environment of inquiry and scholarship

Below are screenshots that show data points for faculty information in ADS:

Faculty CV

Personal Information

Name:
Title:
Degrees:
Medical School:
Degree Date:

Graduate Medical Education

Program Name:
Specialty:
From:
To:

Edit ✖

Add

Licensures

State / Province:
Expiration:

Edit ✖

Add

Academic Appointments

Please list the past ten years of academic appointments, beginning with your current position. ✖

Name:
From:
To:

Edit ✖

Add

Concise Summary of Role/Responsibilities in Program

Edit ✖

Current Professional Activities / Committees

Please list up to ten activities and committees within the past five years. ✖

Name:
From:
To:

Edit ✖

Add

Bibliographies

Please list the most representative Peer Reviewed Publications / Journal Articles from the last 5 years, with a limit of 10. ✕

Bibliography Text: [Edit] [✕]

Bibliography Text: [Edit] [✕]

[   ] [Add PMID] [Add Text]

Articles

Please list selected review articles, chapters and/or textbooks from the past 5 years, with a limit of 10. Separate entries with a double line break. Do not leave blank. If none, please enter NONE. ✕

[Edit]

Participation in Local, Regional and National Activities / Presentations / Abstracts / Grants

Please list participation in local, regional and national activities/presentations from the past 5 years, with a limit of 10. Separate entries with a double line break. Do not leave blank. If none, please enter NONE. ✕

[Edit]

Following data entry for faculty CVs, the information will be displayed in table format as shown in the sample below:

Physician Curriculum Vitae

First Name: rac	MI:	Last Name: hats

Present Position: test pd change

Medical School Name:

Degree Awarded		Year Completed:

Graduate Medical Education Program Name: tes

Specialty/Field: Allergy and immunology			Date From:	Date To: ......

Certification(s)				Current Licensure Data	
Certification	Type	Original Year	Status	Date of Expiration	State

Academic Appointments - List the past ten years, beginning with your current position.		
Start Date	End Date	Description of Position(s)

Concise Summary of Role in Program:

Current Professional Activities / Committees (limit of 10):

Selected Bibliography - Most representative Peer Reviewed Publications / Journal Articles from the last 5 years (limit of 10):

Selected Review Articles, Chapters and / or Textbooks from the last 5 years (limit of 10):

Participation in Local, Regional, and National Activities / Presentations / Abstracts / Grants from the last 5 years (limit of 10):

Explain equivalent qualifications for RC consideration:

Faculty Roster: Below are the key terms:

1. **Filtering faculty:** The Faculty tab defaults to all active faculty. To view physicians, non-physicians, core or inactive faculty only, change the filter at the top of the list.
2. **Adding Faculty:** To add faculty (physician or non-physician) - click the "Add Faculty" button. For specialties that use case logs, DO NOT enter attendings on this page unless the attending is also a faculty member. To add case log attendings, click the "Case Log Attendings" button on the right hand side of the screen or go to the "Case Logs tab".
3. **Removing Faculty:** If a faculty member is no longer active in the program, click "Edit" next to the faculty member's name and enter a "Date Left Program". The faculty member will then be moved to "Past/Inactive Faculty".
4. **Sort/Reorder:** To sort physician faculty, click the "Reorder" button. This screen will allow you to sort physician faculty only.
5. **Physician/Non-physician data entry error:** If a faculty member was entered in error as a physician/non-physician, you can convert the faculty member by clicking "Edit" next to the faculty name and clicking the button to "Convert" to physician or non-physician.
6. **Core Faculty:** Core faculty members must have a significant role in the education and supervision of residents and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents. 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.
7. **Chair of Department:** For programs that have a Department Chair, indicate the faculty member who is the Department Chair by clicking "Edit" next to the faculty member's name (or add a new faculty member) and indicate "Yes" for the question "Is also Chair of Department?". This will remove the Department Chair designation for any previously selected faculty member.

8. **Non physician faculty** roster instructions also vary by specialty, but since non-physicians can be core faculty, please refer to the instructions above.

Faculty may be designated as **core** faculty at the discretion of the program director. Core faculty must have a significant role in the education and supervision of residents/fellows and must devote a significant portion of their entire effort to resident/fellow education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents/fellows.

Example of a list for core faculty:

Name	Core	Degree	Primary Institution	Specialty / Field	No. of Years Teaching in This Specialty / GME

NOTE: The faculty roster itself (on the print out) varies by specialty. For example, some specialties list a breakdown by "hours", and others do not.

Name	Core	Primary / Site Director Institution	Certification(s)					Years Teaching Specialty / GME	Average Hours Per Week Spent On			
			Certification	Type	Original Year	Status	Expiration Year		Clinical Supervision	Admin	Didactic Teaching	Research
D. Director, MD, PhD (Program Director)	N	7 / N/A	Psychiatry	ABMS Certified	2013	O		8 / 8	0	25	1	5

Annual Update:

1. Update the Program Director certification information
2. Enter profile information for all physician and non-physician faculty.
3. Enter all required CV information for your physician faculty and ALL non-physician faculty (required by your specialty).
4. Complete all information and ensure dates are accurate.
5. Note number limitations for current professional activities, selected bibliography, review articles, chapters and/or textbooks.
6. For physician and non-physician faculty rosters, provide accurate information, including certification, whether core faculty, and time spent in the program.

Example of inadequately completed CVs:
The CV (page 1) below was completed in **2017**. Arrows indicate the problems, including boxes left blank, and outdated information.

Mary	W	Lieh-Lai		
Present Position: Pediatric Critical Care Fellowship Program Director				
Medical School Name:				
Degree Awarded:		Year Completed:		
Graduate Medical Education Program Name: Wayne State University/Children's Hospital of Michigan				
Specialty/Field: Pediatric Critical Care Medicine		Date From:		Date To:

Certification Information				Current Licensure Data	
Specialty	Certification Year	Certification Status	Re-Cert Year	State	Date of Expiration
Pediatrics	1985	Permanent		Michigan	
Pediatric Critical Care Medicine	1987	1995	2002		

Academic Appointments - List the past ten years, beginning with your current position.		
Start Date	End Date	Description of Position(s)
7/1/84	6/30/88	Director, PICU. Assistant Professor of Pediatrics, Georgetown University
7/1/88	6/30/95	Assistant Professor of Pediatrics, Wayne State University
7/1/95	Present	Assistant Professor of Pediatrics, Wayne State University

Concise Summary of Role in Program:
Division Chief, Critical Care Medicine and Director of Pediatric Critical Care Medicine Fellowship Program

The CV (page 2) below was completed in **2017**. Instructions ask that you list bibliography from the last *five years, limit to 10*. These are all more than 5 years old, and there are more than 10 listed:

Selected Bibliography - Most representative Peer Reviewed Publications / Journal Articles
from the last 5 years (limit of 10):

1. Lieh-Lai, M., Sarnaik, A.P., Newton, J.F., Miceli, J.N., Hook, J.B., Fleischmann, L.E., Kauffman, R.E.: Metabolism and Pharmacokinetics of Acetaminophen in a Severely Poisoned Young Child. J. of Pediatrics, 105:125-128, 1984.
2. Sarnaik, A.P., Preston, G., Lieh-Lai, M., Eisenbrey, A.B.: Intracranial Pressure and Cerebral Perfusion Pressure in Near-Drowning. Crit. Care Med., 13:224-227, 1985.
3. Meert, K., Heidemann, S., Lieh-Lai, M., Sarnaik, A.P.: Clinical Characteristics of Respiratory Syncytial Virus Infections in Healthy Versus Previously Compromised Host. Pediatric Pulmonology, 7:167-170, 1989.
4. Meert, K., Lieh-Lai, M., Sarnaik, I., Sarnaik, A.: Role of Intensive Care in Managing Childhood Cancer. Amer. J. Clin. Oncol. 14:379-382, 1991. Abstracted in Clinical Digest.
5. Lieh-Lai, M., Moylan, P., Sarnaik, A., Theodorou, A., Meert, K.: Limitations of the Glasgow Coma Scale in Predicting Outcome in Children with Traumatic Brain Injury. Journal of Pediatrics, 120:195-199, 1992.
6. Meert, K., Gelmini, M., Lieh-Lai, M., Sarnaik, A. P.: Metabolic Response to Severe Head Injury. Clinical Intensive Care, 3:111-115, 1992.
7. Klein, M.D., Wittlesey, G.C., Lieh-Lai, M.: Extracorporeal Membrane Oxygenation (ECMO) for Pulmonary Parenchymal Disease in Older Children. Pediatr Surg Int, 8:283-293, 1993.
8. Meert, K., Sarnaik, A.P., Gelmini, M., Lieh-Lai, M.: Aerosolized Ribavirin in Mechanically Ventilated Infants with Respiratory Syncytial Virus Lower Respiratory Tract Disease: A Prospective, double-blind randomized trial. Crit Care Med, 22:566-572, 1994.
9. Biglin, K., Faraon, M., Constance, T., Lieh-Lai, M.: Drug-induced torsades de pointes: a possible interaction of terfenadine and erythromycin. The Annals of Pharmacotherapy, 28:282, 1994.
10. Kertoy, Marilyn K., Guest, C., McVittie, A., Waters, R., Quart, E., Lieh-Lai, M.: Acoustic, Perceptual, and Phonetic Analysis of Two Children with a History of Long-term Tracheostomy. Journal of Medical Speech-Language Pathology.2:293-300, 1994.
11. Sarnaik, A., Meert, K., Pappas, M., Simpson, P., Lieh-Lai, M., Heidemann, S.: Predicting Outcome in Children with Severe Acute Respiratory Failure Treated with High Frequency Ventilation. Crit Care Med, 24:1396-1402, 1996.
12. Pappas, M., Sarnaik, A., Meert, K., Hasan, R., Lieh-Lai, M.: Idiopathic Pulmonary Hemorrhage in Infancy: Clinical Features and Management with High Frequency Ventilation. Chest, 110:553-555, 1996.
13. Dharnidharka, V., Lieh-Lai, M., Sarnaik, A., Clapp, S.: A Child with Cardiogenic Shock and Supraventriuclar Tachycardia Presenting in Normal Sinus Rhythm. Pediatric Emergency Care, 12: 420-421, 1996.

The CV below was completed in 2012, and "follows" the instructions:

Mary	W	Lieh-Lai

Present Position: Program Director, Pediatric Critical Care Medicine Fellowship. Professor of Pediatrics

Medical School Name: University of Santo Tomas, Manila, Philippines

Degree Awarded: M.D.	Year Completed: 1975

Graduate Medical Education Program Name: Children's Hospital of Michigan Critical Care Medicine Fellowship Program

Specialty/Field: Pediatric Critical Care Medicine	Date From: 7/1/82	Date To:6/30/84

Certification Information				Current Licensure Data	
Specialty	Certification Year	Certification Status	Re-Cert Year	State	Date of Expiration
Pediatrics	1985	Permanent	N/A	Michigan	2020
Pediatrics Critical Care Medicine	1987	Re-certified	2012	Michigan	2022

Academic Appointments - List the past ten years, beginning with your current position.		
Start Date	End Date	Description of Position(s)
8/18/2011	Present	Professor of Pediatrics, Wayne State University School of Medicine
1/1/1998	Present	Director, Critical Care Medicine Fellowship Program
7/1/20018	Present	Director, Clinical Pharmacology Fellowship Program
3/1/1990	6/2008	Director, Intensive Care Unit
10/1/03	3/31/2012	Co-Chief, Division of Critical Care Medicine
1/1/2007	Present	Designated Institutional Official

Concise Summary of Role in Program:
Program Director for Pediatric Critical Care Medicine Fellowship program – directs all activities of the fellowship including interviewing and appointing fellows, appointment of core faculty, coordinating curricular activities that include didactics, clinical experiences, rotations, and evaluation of fellows, faculty and the program

Current Professional Activities / Committees (limit of 10):
1. American Academy of Pediatrics, Section of Critical Care Executive Committee
2. ACGME – Critical Care Medicine Appeals Committee
3. Member, American Board of Pediatrics, Sub-Board of Critical Care Medicine
4. American Academy of Pediatrics PREP-ICU Editorial Board
5. Chair, Children's Hospital of Michigan Pharmacy and Therapeutics Committee

> Less than 10 listed

Selected Bibliography - Most representative Peer Reviewed Publications / Journal Articles from the last 5 years (limit of 10):

> Last 5 years, less than 10

1. Perumal O, Khandare J, Kohle P, Lieh-Lai M, Kannan S, Kannan RM. Effects of branching architecture and linker on the activity of hyperbranched polymer-drug conjugates. Bioconjugate Chemistry. 2009 Apr 29. [Epub ahead of print], Bioconjug Chem. 2009 May 20;20(5):842-6.
2. Bassett D. Fusao H, Gao XF, Kannan R, Kerr J, Doyon-Reale N, Wilson S, and Lieh-Lai M: Reversal of methylprednisolone effects in allergen-exposed female Balb/C Mice J Toxicol Environ Health, Part A; 2010; 11:711-724
3. Inapagolla R, Guru BR, Kurtoglu YE, Gao X, Lieh-Lai M; Bassett DJP, Kannan R: In vivo efficacy of dendrimer-methylprednisolone conjugate formulation for the treatment of lung inflammation. Internat J Pharmaceutics, 2010; 399: 140-147
4. Mastropietro CW, Rossi NF, Clark JA, Chen HP, Walters H, Delius R, Lieh-Lai M, Sarnaik A. Relative Deficiency in Arginine Vasopressin in Children after Cardiopulmonary Bypass. Crit Care Med, 2010; 38(10): 2052-8.
5. Cashen K, Gupta P, Lieh-Lai M, Mastropietro CW. Infants with Single Ventricle Physiology in the Emergency Department: Are Physicians Prepared? *Journal of Pediatrics*. Epub ahead of print: Mar 9 2011(doi:10.1016/j.jpeds.2011.01.031)
6. Du W, Tutag Lehr V, Lieh-Lai M, Koo W, Ward RM, Rieder MJ, Van Den Anker JN, Reeves, JH, Mathew M, Lulic-Botica M and Aranda JV: An Algorithm to Detect Adverse Drug Reactions in the Neonatal Intensive Care Unit: A New Approach. J Clin Pharmacol,online: http://jcp.sagepub.com/content/early/2012/01/17/0091270011433327

Selected Review Articles, Chapters and / or Textbooks from the last 5 years (limit of 10):

> Last 5 years, less than 10

1. Lieh-Lai M and Sarnaik A: Therapeutic Considerations in Pediatric Intensive Care, Pediatric Pharmacology, Therapeutic Principles in Practice, 4th edition. Yaffe and Aranda, eds., Lippincott, Williams and Wilkins, 2011
2. Sarnaik A and Lieh-Lai M: Drowning, Pediatric Critical Care, 4th edition. Fuhrman and Zimmerman, eds. Elsevier, 2011
3. Lieh-Lai M, Goodman D, Valentine K, Fiedor-Hamilton M: Educating the Intensivist, Pediatric Critical Care, 4th edition. Fuhrman and Zimmerman, eds. Elsevier, 2011

Participation in Local, Regional, and National Activities / Presentations / Abstracts / Grants from the last 5 years - this does not include attending a meeting or conference.
(limit of 10):
National Activities:

> Last 5 years, total is less than 10

January 2007-2009	Society of Critical Care Medicine Pediatric Executive Committee
January 2012 - Jul 2012	Member, American Board of Pediatrics, Sub-board of Critical Care Medicine
January 2011	NICHD New Drug Delivery Systems (NDDS) Working Group

Abstract Presentations:
1. Heidemann, SM, Meert KL, Lieh-Lai MW, Sarnaik AP: Pressure control is associated with greater alveolar ventilation and increased lung production of IL-6 and IL-8 compared to volume control ventilation. Presented at the SCCM 2008
2. Arnous N, Rajan DS, Salimnia H, Asmar B, Lieh-Lai M, Shanti CM, Fairfax MR: Human Blood Abrogates the Antimicrobial Effect of Silver Sulfadiazine: Approaches to Determining the Responsible Component. 2011 Robert Lindberg Award at the 43rd Annual American Burn

Sample citation language regarding Goals and Objectives:

The curriculum must include competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form. (Core)

The Committee noted that the goals and objectives for the _____ experience were not organized by level of training.

Sample citation language regarding Supervision:

Many faculty do not provide appropriate supervision of residents in the care of inpatients.

Many of the faculty on the private teaching service do not provide appropriate level of supervision of residents for the care of inpatients. They conduct rounds independent of residents, do not communicate about patient care, and do not provide a reliable means of contact, are all indications of lack of appropriate supervision.

Sample citation language regarding the concern that the site visitor had to spend a significant amount of time correcting information:

At the time of the site visit, the program had to provide multiple corrections to the faculty roster, site listing, and rotation times as reflected in the block diagram, etc. The Committee noted the importance of having accurate data available to the site visitor as not to take away that critical time for correcting accreditation materials.

Avoiding Common Errors in the ADS Annual Update-Responding to Citations Video

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

II.   Personnel

II.A.   Program Director

II.A.4   Program Director Responsibilities

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

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]

GUIDANCE

II.A.4.a).(9) According to the Memorandum of Understanding among the ACGME, American Osteopathic Association (AOA), and Association of American Colleges of Osteopathic Medicine (AACOM), AOA-approved programs have until June 30, 2020 to transition to ACGME accreditation. However, *individuals* who entered into AOA-approved residency or fellowship programs may be affected by the transition for several years *after* 2020. Furthermore, with the transition to a single GME accreditation system, the number of individuals completing ACGME-accredited programs who will be eligible to be certified by AOA boards has exponentially increased. Finally, the Common Program Requirements that are effective July 1, 2019 expand eligibility for ACGME-accredited fellowship programs to an unprecedented level. The permutations and combinations of educational pathways and board-determined eligibility standards is somewhat mind boggling. The following is an attempt to delineate some of those educational pathways and their effects on board eligibility.

Note that eligibility to enter an ACGME-accredited residency or fellowship program is under the control of the ACGME, and is clearly expressed in the ACGME Program Requirements. Eligibility for certification in a specialty or subspecialty is individually determined by more than 40 different American Board of Medical Specialties (ABMS) and AOA boards, and can be changed at any time by any of those boards. Accordingly, the ACGME cannot provide accurate, up-to-date, one-stop shopping for the criteria for certification. It is the responsibility of the program director to ascertain for, and convey to an applicant the pertinent eligibility criteria in any given specialty or subspecialty.

Residency
1. Applying to enter residency directly from medical school
    A. Assuming acceptance to and completion of the program, the individual should be eligible for specialty certification.
        1) MDs and DOs would be eligible for certification by an ABMS member board.
        2) DOs may be eligible for certification by an AOA board. The program director should check with the applicable AOA specialty board to determine eligibility.

2. Applying to transfer from one program that has been ACGME-accredited throughout the resident's tenure there to another ACGME-accredited program
    A. Assuming acceptance to and completion of the program, the individual should be eligible for specialty certification.
        1) MDs and DOs would be eligible for certification by an ABMS member board.
        2) DOs may be eligible for certification by an AOA board. The program director should check with the applicable AOA specialty board to determine eligibility.

3. Applying to transfer from an AOA-approved program to an ACGME-accredited program

    A. Assuming acceptance to and completion of the program, the individual should be eligible for specialty certification.

        1) The individual may be eligible for certification by an ABMS member board. The program director should check with the applicable ABMS member board to determine eligibility.

        2) The individual may be eligible for certification by an AOA board. The program director should check with the applicable AOA specialty board to determine eligibility.

4. Applying to transfer from a program that is currently ACGME accredited but that was AOA approved when the resident entered the program

    A. Assuming acceptance to and completion of the program, the individual should be eligible for specialty certification.

        1) The individual may be eligible for certification by an ABMS member board. The program director should check with the applicable ABMS member board to determine eligibility.

        2) The individual may be eligible for certification by an AOA board. The program director should check with the applicable AOA specialty board to determine eligibility.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement

Requirements below are subject to citation July 1, 2019

II.   Personnel

II.A   Program Director

II.A.4.   Program Director Responsibilities

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

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)

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)

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)

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.

II.A.4.a).(13)   ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; (Core)

II.A.4.a).(13).(a)   Residents must not be required to sign a non-competition guarantee or restrictive covenant. (Core)

GUIDANCE

Processes for Raising Concerns, Providing Feedback, and Submitting Grievances

There must be both institutional and programmatic processes that support residents and fellows in raising concerns and providing feedback confidentially. Typically, residents/fellows should first attempt to address concerns within their programs. In some programs, chief residents, junior faculty members, or administrators facilitate communication between residents and program leaders by conveying residents' confidential concerns and feedback. In program evaluations and by other means, programs may also solicit residents'/fellows' concerns and feedback confidentially in writing.

If attempts to address concerns within programs do not succeed, residents/fellows must be able to raise concerns or provide feedback confidentially through institutional mechanisms. (See ACGME Institutional Requirement III.A.) These mechanisms may include specific, confidential reporting processes related to patient safety events, supervision concerns, or professionalism issues. They may also involve the designated institutional official (DIO), other institutional officers, and/or groups such as resident/fellow forums or the Graduate Medical Education Committee (GMEC).

"Each Sponsoring Institution must have a policy that outlines the procedures for submitting and processing resident/fellow grievances at the program and institutional level and that minimizes conflicts of interest" (ACGME Institutional Requirement IV.D). This requirement ensures that there are formal processes through which residents/fellows may address concerns about their education or clinical learning environments. Sponsoring Institutions and programs must manage conflicts of interest of individuals or groups who make decisions in grievance processes. Program directors should contact their DIOs if they have questions about a Sponsoring Institution's or program's grievance procedures.

The Institutional Review Committee and/or the specialty-specific Review Committees are likely to look into potential noncompliance with these requirements that may be indicated in the results of ACGME Resident/Faculty Surveys, or complaints or concerns submitted to the ACGME.

Actions against Residents/Fellows and Due Process

See related requirement V.A.1: Feedback and Evaluation

Each program must determine criteria for promotion and/or renewal of a resident's/fellow's appointment. Sponsoring Institutions "must ensure that each [program] provides a resident/fellow with a written notice of intent when that resident's/fellow's agreement [of appointment] will not be renewed, when that resident/fellow will not be promoted to the next level of training, or when that resident/fellow will be dismissed" (ACGME Institutional Requirements IV.C.1, IV.C.1.a).

Due process must be provided to residents/fellows, in compliance with institutional policy, whenever a resident/fellow is suspended or dismissed from a program, or whenever a program decides not to promote or renew the appointment of a resident/fellow. Questions about the institutional policy should be directed to the Sponsoring Institution's DIO. Programs and Sponsoring Institutions are not required to provide due process in the remediation of residents/fellows through probation, warning, or other locally defined disciplinary or academic actions that are not identified in the requirement.

It is common for program directors, coordinators, residents/fellows, faculty members, and DIOs to collaborate with human resources, legal departments, and/or institutional officers/committees in order to ensure compliance with institutional policy related to actions against residents/fellows and due process..

Employment and Discrimination

Laws and regulations concerning employment and discrimination include, but are not limited to, those whose enforcement is overseen by the U.S. Equal Employment Opportunity Commission. Other federal, state, and local laws and regulations may also apply. It is common for program directors, coordinators, residents/fellows, faculty members, and DIOs to collaborate with human resources, legal departments, and/or institutional officers/committees in order to ensure compliance with institutional policy related to employment and discrimination.

Non-Competition Guarantees and Restrictive Covenants

Programs, participating sites, and Sponsoring Institutions must not enter into restrictive covenants or non-competition guarantees with residents/fellows appointed in ACGME-accredited programs. The participation of residents/fellows in graduate medical education must not be contingent upon such contractual provisions, which are used to limit residents'/fellows' professional options after completing their programs.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

II.   Personnel

II.A.   Program Director

II.A.4.   Program Director Responsibilities

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

II.A.4.a).(14)   document verification of program completion for all graduating residents within 30 days; [Core]

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

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

GUIDANCE

It is important to the resident or fellow who has completed the program, to the program itself, and to the Sponsoring Institution that program completion be verified in a timely manner. The ACGME does not specify exactly what must be included in such verification, nor does it require that any particular format be utilized for such verification.

The Verification of Graduate Medical Education Training (VGMET) was jointly developed by the American Hospital Association, the National Association of Medical Staff Services and the Organization of Program Directors Associations, along with the ACGME. It is designed to satisfy national credentialing standards. Furthermore, it is designed to be completed once (and only once) by the program director, and then copied and re-utilized in perpetuity. Note that the VGMET was not designed or intended for applications for licensure or certification. As of this writing, the VGMET and instructions for its use can be found at https://www.namss.org/NEWS/VerificationofGraduateMedicalEducationTraining.aspx.

National Association of Medical Staff Services (NAMSS)

Background and Instructions

In an effort to improve and streamline the credentialing process, the Accreditation Council for Graduate Medical Education (ACGME), American Hospital Association (AHA), National Association Medical Staff Services (NAMSS), and Organization of Program Director Associations (OPDA) have collaborated to create a standardized "Verification of Graduate Medical Education Training" (VGMET). The VGMET form is not intended to meet the requirements for licensure. Please use this supplied form from the Federation Credentials Verification Service (FCVS) for licensure purposes. This can be used whether the physician is using FCVS or is seeking licensure independently.

The VGMET form has three sections:

Section One: Verification of graduate medical education training. Completed for all.

Section Two: Additional comments as needed.

Section Three: Attestation.

For 2016 and future graduates:

The form would be completed **once** by the program director at the time of completion of the internship, residency or fellowship (separate form for each training program completed).

The signed form would be placed in the trainee's file. The form would be photocopied and sent with Cover Letter 2 (see below) to hospitals or other organizations requesting verification of training. NOTE: A program may continue to use their own form for those residents or fellows who graduated prior to 2016.

The form would be completed **once** – if and when a program receives a request for verification of training.

- The current program director (often not the PD at the time of graduation) would review the file and complete the form based on information contained therein. He/she would sign and date the form and send to the requesting hospital with Cover Letter 2 (see below).

- Thereafter, that form would be used in response to all requests for training verification – a photocopy of the form, and a signed dated cover letter attesting that the form accurately reflects information about the trainee in the file.

Note that verification of training forms created and completed prior to 2016 can continue to be used. There is no need to transpose these forms to the current version.

Cover Letter 1

NOTE: Verification of graduate medical education training. Completed for all

**CONFIDENTIAL AND PRIVILEGED
PEER REVIEW DOCUMENT**

[Date]

[Residency Program Director]
[Organization]
[Address 1]
[Address 2]
[City, State Zip]

**Re: [Name of Trainee]
[DOB or NPI]**

Dear Dr. [Residency Program Director Name]:

The above-referenced individual has applied for medical staff appointment and/or clinical privileges at [name of requesting entity]. This individual has indicated that he/she received training at your institution.

Your assistance in completing the enclosed form is greatly appreciated. Please fax or e-mail the completed form to [name of requesting department] at [facsimile #] and [e-mail address of requesting entity]. The individual named above has signed the enclosed authorization and release form that authorizes you to provide this information.

Should you have any questions, please contact this department at [requesting department phone number]. Thank you in advance for your immediate attention to this request.

Sincerely,

[Name]

[Title]

Enclosures: (i) Verification of Graduate Medical Education Training Form
             (ii) Authorization and Release Form

Cover Letter 2

Note: Additional comments as needed

VERIFICATION OF GRADUATE MEDICAL EDUCATION & TRAINING CONFIDENTIAL AND PRIVILEGED

PEER REVIEW DOCUMENT

[Date]

Re:

[Name of Trainee]
[DOB or NPI]
[Residency or fellowship program]
[Training Dates 1]
[Training Dates 2 (if applicable)]

[Hospital or credentialing organization]
[Department/Program]
[Organization]
[Address 1]
[Address 2]
[City, State Zip]

Dear [Hospital or credentialing organization]:

The above-referenced physician trained at this institution in this program and during the dates referenced above. The enclosed Verification of Graduate Medical Education Training Form summarizes this individual's performance during that period of training.

This form:
_____was completed at the time the trainee left the program,

or

_____was completed by the current program director, based on a review of the trainee's file, after the trainee had left the program, and is sent to you upon receipt of a signed authorization and release form by the former trainee.

This cover letter attests that the enclosed information contains a complete and accurate summary of the trainee's performance in this program. We are unable to provide information about training or practice after completion of this program, and trust that you will obtain that information from the appropriate programs/institutions.

Sincerely,

[Program Director or Institutional Official]
[Title]
[Organization]
[Address 1]
[Address 2]
[City, State Zip]

Enclosures: (i) Verification of Graduate Medical Education & Training Form

VERIFICATION OF GRADUATE MEDICAL EDUCATION & TRAINING

Section I: Verification of training and performance during training (*To be completed for EACH trainee*)		
Trainee's Full Name: Click here to enter text.	DOB: Click here to enter	NPI: Click here to enter

Program Specialty or Subspecialty:

☐Preliminary Program: Click here to enter text. **Date From/To:** mm/dd/yyyy (Start) – mm/dd/yyyy (End).
☐Core Residency Program: Click here to enter text. **Date From/To:** mm/dd/yyyy (Start) – mm/dd/yyyy (End).
☐Fellowship Program: Click here to enter text. **Date From/To:** mm/dd/yyyy (Start) – mm/dd/yyyy (End).

Training Program Accreditation:☐ACGME   ☐AOA   ☐Other

If marked "other," please indicate accreditation type or list "none:" Click here to enter text.

Program ID #: Click here to enter text.

Did the above-named trainee successfully complete the training program which she/he entered?
☐Yes   ☐No

> In addition to completion of full specialty training, completion of a transitional year or a planned preliminary year(s) would constitute completion of a program.

(If NO, please provide an explanation in the "Additional Comments" section below or enclose a separate document.)

Was the trainee subject to any of the following during training?

(i)	Conditions or restrictions beyond those generally associated with the training regimen at your facility;	☐Yes	☐No
(ii)	Involuntary leave of absence;	☐Yes	☐No
(iii)	Suspension;	☐Yes	☐No
(iv)	Non-promotion/non-renewal;	☐Yes	☐No
(v)	Dismissal; or	☐Yes	☐No
(vi)	Resignation.	☐Yes	☐No

(If YES to any of the above, please provide an explanation in the "Additional Comments" section below or enclose a separate document.)

Upon completion of the training program, the individual was deemed to have demonstrated sufficient competence in the specialty/subspecialty to enter practice without direct supervision.

☐Yes   ☐No   ☐N/A

(If NO, please provide an explanation in the "Additional Comments" section below or enclose a separate document.)

Did the program endorse this trainee as meeting the qualifications necessary for admission to the specialty's board certification examination?   ☐Yes ☐No ☐N/A

If NO, indicate the reason(s):

☐ This trainee was a preliminary resident.

☐ Trainee was not eligible for certification.

☐ Trainee involuntarily or voluntarily left this program before completion. *

☐ No certification is available for this subspecialty.

☐ Other. *

Please provide an explanation in the "Additional Comments" section below or enclose a separate document.

Section II: Additional Comments

Please utilize this comment area to provide additional information in response to any of the questions noted above on this form. *(If additional space is needed, please enclose a separate document.)*

Click here to enter text.

Section III: Attestation

The information provided on this form is based on review of available training records and

evaluations. Signature: Click here to enter text.

Printed Name: Click here to enter text.

GME Title: Click here to enter text.

Professional Credentials: Click here to enter text.

Phone Number: Click here to enter text.

Email: Click here to enter text.

In an effort to improve and streamline the credentialing process, the Accreditation Council for Graduate Medical Education (ACGME), American Hospital Association (AHA), National Association Medical Staff Services (NAMSS), and Organization of Program Directors Associations (OPDA) have collaborated to create a standardized "Verification of Graduate Medical Education Training (VGMET)" form designed to be completed once at the completion of training (or at the first opportunity thereafter when the program is asked to complete a verification/credentialing form).This VGMET is then time-stamped and inserted in the trainee's file. This time-stamped form, along with a cover letter from the current program director or institutional official, serves as the program's verification of training. The form will not include detailed lists of current procedural or technical competencies.

NOTE: THE VGMET FORM IS NOT INTENDED TO MEET REQUIREMENTS FOR LICENSURE. PLEASE USE THIS SUPPLIED FORM FROM THE FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS) FOR LICENSURE PURPOSES. THIS CAN BE USED WHETHER THE PHYSICIAN IS USING FCVS OR IS SEEKING LICENSURE INDEPENDENTLY.

This requirement DOES NOT MEAN that programs should share residents' Milestones information with certifying bodies. See V.A.2.a).(1)

Milestones can and should be utilized in the determination by a program director that an individual resident or fellow has satisfactorily completed the program and is able to engage in autonomous practice of the specialty or subspecialty. However, it is not required that the resident's attainment of a specific level on the Milestones be specified in the program director's verification of program completion. The Milestones were not created or intended for use in such high-stakes applications as credentialing, certification, and licensure. Therefore, the ACGME actively discourages specification of Milestones achievement in verification of program completion. See: https://www.acgme.org/Portals/0/PDFs/Milestones/UseofIndividualMilestonesDatabyExternalEntitiesforHighStakesDecisions.pdf?ver=2018-04-12-110745-440

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

II.   Personnel

II.A.   Program Director

II.A.4.   Program Director Responsibilities

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

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

GUIDANCE

The table below shows a list of items that need approval from the ACGME, DIO, and the Graduate Medical Education Committee (GMEC).

		May be submitted directly from the **program** to the ACGME without approval of the DIO or GMEC	Must be approved by the **DIO** prior to being submitted to the ACGME	Must be approved by the **GMEC** prior to being submitted to the ACGME
Institutional Requirements (Effective July 1, 2015)				
IR I.B.4.b).(3)	Applications for ACGME accreditation of new programs			X
IR I.B.4.b).(4)	Requests for permanent changes in resident/fellow complement			X
IR I.B.4.b).(5)	Major changes in each of its ACGME-accredited programs' structure or duration of education			X
IR I.B.4.b).(6)	Additions and deletions of each of its ACGME-accredited programs' participating sites			X
IR I.B.4.b).(7)	Appointment of new program directors			X
IR I.B.4.b).(8)	Progress reports requested by a Review Committee			X
IR I.B.4.b).(10)	Requests for exceptions to clinical and educational work hour requirements			X
IR I.B.4.b).(11)	Voluntary withdrawal of ACGME program accreditation			X
IR I.B.4.b).(12)	Requests for appeal of an adverse action by a Review Committee			X
IR I.B.4.b).(13)	Appeal presentations to an ACGME Appeals Panel			X
Residency Program Requirements (Effective July 1, 2019)				
PR I.B.2.a).(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		X	

	participating site providing a required assignment. The PLA must be approved by the DIO.			
PR 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. NOTE: See IR I.B.4.b).(6) (above).			X
PR I.E.1.	The program must report circumstances when the presence of other learners has interfered with the residents' education to the DIO and GMEC.		X (NOT submitted to the ACGME)	X (NOT submitted to the ACGME)
PR II.A.1.a)	The Sponsoring Institution's GMEC must approve a change in program director.			X
PR II.A.4.a).(8)	The program director must submit accurate and complete information required and requested by the DIO, GMEC, and ACGME.	X	X	X
PR II.A.4.a).(16)	The program director must obtain review and approval of the Sponsoring Institution's DIO before submitting information or requests to the ACGME, as required in the Institutional Requirements and outlined in the ACGME Program Director's Guide to the Common Program Requirements.		X	
PR III.A.3.	A physician who has completed a residency program that was not accredited by the ACGME, AOA, RCPSC, CFPC, or ACGME-I (with Advanced Specialty Accreditation) may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director of the ACGME-accredited program and with approval by the GMEC, may be advanced to the PGY-2 level based on ACGME Milestones evaluations conducted by the ACGME-accredited program. *This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry.*			X
PR III.A.4.a).(2)	An ACGME-accredited residency program may accept an exceptionally qualified international graduate applicant who does			X

	not satisfy the eligibility requirements listed in III.A.1.-III.A.3., but who does meet all of the following additional qualifications and conditions: review and approval of the applicant's exceptional qualifications by the GMEC.			
PR V.C.1.e.(2)	The annual review, including the action plan, must be submitted to the DIO.		X	
PR V.C.2.a)	The program must complete a Self-Study prior to its 10-Year Accreditation Site Visit. A summary of the Self-Study must be submitted to the DIO.		X	
PR VI.F.4.c).(2)	A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale. Prior to submitting the request to the Review Committee, the program director must obtain approval from the Sponsoring Institution's GMEC and DIO.		X	X

Resources for Sponsoring Institutions

1. Roles and Responsibilities of a Sponsoring Institution Video

Note: The above link will take you to the Roles and Responsibilities of a Sponsoring Institution course, which is also housed in Learn at ACGME, the ACGME's online learning portal. GME community members who have not yet created a free account in Learn at ACGME will need to create one before they are able to access the course.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement

Requirements below are subject to citation July 1, 2019
*Requirements II.B.2.g.(1)-(4) Faculty Development subject to citation July 1, 2020

II.B. Faculty

Faculty members are a foundational element of graduate medical education – faculty members teach residents how to care for patients. Faculty members provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population. Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves.

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

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

[The Review Committee may further specify]

II.B.2.   Faculty members must:

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

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

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

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

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

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

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

*Requirement II.B.2.g), II.B.2.g) (1) to (4) are subject to citation July 1, 2020

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

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

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

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

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

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

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.

[The Review Committee may further specify additional faculty responsibilities]

GUIDANCE

II.B. Faculty

One of the most important elements of a residency program is the faculty, which has the responsibility to provide high-quality patient care and teach that level of care to the residents and fellows. Simply being a competent clinician is not enough. Faculty members must also be competent to teach and provide graded supervision and have the interest and skills to teach. These skills include teaching at the patient bedside, providing appropriate feedback, and the ability to assess how the resident or fellow is performing. These skills are not innate or taught during routine medical education and must be learned, informally from more experienced faculty members or in workshops or through other types of faculty development activities. The need for these skills is the basis for the newly added Common Program Requirement for faculty development.

II.B.1. Sufficient number of faculty members

The requirement exists to ensure each program provides enough competent faculty members to teach and supervise residents at each and every participating site. Participating sites cannot be selected solely on the availability of a specific procedure or particular patient care experiences; the selection must also consider the availability of faculty members who have the interest, ability, and the commitment to educate residents/fellows.

II.B.2.a)-c) Faculty members must be role models of professionalism and demonstrate commitment to the delivery of safe, quality, cost-effective, patient-centered care.

In addition to being role models, faculty members must also have a strong interest in the education of residents. Researchers A. Keith W. Brownell and Luc Côté used a modified Dillman technique to determine how residents learned about professionalism. The research showed respondents learned the most about professionalism from observing faculty member role models.

Brownell, A. Keith W., and Luc Côté. "Senior Residents' Views on the Meaning of Professionalism and How They Learn about It." Academic Medicine 76, no. 7 (2001): 734–37. https://doi.org/10.1097/00001888-200107000-00019.

II.B.2.d) devote sufficient time to the educational program

In addition to demonstrating commitment to the educational program, faculty members must also have sufficient time to fulfill their responsibilities. Some faculty members may need defined protected time to fulfill their responsibilities, while other clinical faculty members can supervise and teach within their defined assignments. Sufficient time for

resident education is a shared responsibility of the individual faculty member and the department or institution. Pressure for clinical productivity must not preclude sufficient time to teach and supervise residents in the program.

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

An educational environment is much more than instructing residents about what actions to take for a particular patient. An environment geared toward resident education allows time for questions and discussion about patients and the underlying reasons for evidence-based medical decision making. This should include appropriate discussions about the evidence-based references, pathophysiology, and rationale— not necessarily for every single decision but enough to maintain an environment of constant learning.

II.B.2.f) regularly participate in organized clinical discussion, rounds, journal clubs, and conferences

Not every faculty member has to participate in the didactic components of the program, but every formal didactic session should include experienced faculty members who can provide commentary and clinical insights from their patient care experiences. It would be inappropriate to have residents consistently leading organized didactic experiences without a faculty presence.

*II.B.2.g).(1)-(4) pursue faculty development designed to enhance their skills at least annually. The four areas include: skills as an educator, in quality improvement and patient safety, in fostering their own and their residents' well-being, and in patient care based on their practice-based learning and improvement efforts.

While this requirement will not be subject to citation until July 1, 2020, programs must initiate efforts to provide faculty development activities as soon as possible. Faculty members must improve their own skills through faculty development activities at least annually, not only as clinicians but in one of the four areas listed. This does not preclude faculty development in other important areas such as clinical knowledge, leadership, team building, communications, and patient relationships.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement

Requirements below are subject to citation July 1, 2019

II.B.3.   Faculty Qualifications

II.B.3.a)   Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)

[The Review Committee may further specify]

II.B.3.b)   Physician faculty members must:

II.B.3.b).(1)   have current certification in the specialty by the American Board of _____ or the American Osteopathic Board of _____, or possess qualifications judged acceptable to the Review Committee. (Core)

[The Review Committee may further specify additional qualifications]

II.B.3.c)   Any non-physician faculty members who participate in residency program education must be approved by the program director. (Core)

[The Review Committee may further specify]

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.

GUIDANCE

II.B.3.a) faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments

Minimum measurable faculty member qualifications include specialty or subspecialty board certification, having a license to practice, and the ability to obtain hospital staff privileges. There are other qualifications such as expertise in a given field or experience as an educator. For those faculty members who do not have American Board of Medical Specialty (ABMS) or American Osteopathic Association (AOA) board certification, the individual Review Committee may consider exceptions and accept other qualifications.

II.B.3.b) physician faculty must have current certification in the specialty by the ABMS or AOA, or possess qualifications judged acceptable to the Review Committee.

Board certification is a broadly accepted qualification. Certain faculty members who are not board certified by the ABMS or AOA however, may possess other qualifications acceptable to the Review Committee. For example, a physician may have certification in another country with expertise in a specific field, and publications and other achievements, such that departmental leadership decides to recruit the individual as a faculty member. In such cases, the Review Committee will make the final determination if the individual meets the requirements to be a faculty member.

II.B.3.c) Any non-physician faculty members who participate in residency program education must be approved by the program director.

The program director may determine that non-physicians are important contributors to the program and should be appointed to the faculty. These individuals may bring specialized expertise in public health, patient safety, laboratory science, pharmacology, a specific procedural skill, and/or other important aspects of medicine.

As stated in the 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.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement

Requirements below are subject to citation July 1, 2019

II.B.4.   Core Faculty

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

> 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.

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

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

[The Review Committee must specify the minimum number of core faculty and/or the core faculty-resident ratio]

[The Review Committee may specify requirements specific to associate program director(s)]

GUIDANCE

II.B.4. Core Faculty

Core faculty members have additional responsibilities specific to the educational program. These individuals may be associate program directors, participating site directors, conference organizers, or subspecialty experts responsible for a segment of the curriculum. They may be members of the Program Evaluation Committee and/or Clinical Competency Committee, have expertise in medical education, or be clinicians dedicated to the program who are developing into future educational leaders. In the past, the core faculty members were expected to provide a minimum of 15 hours per week to the program. In the new Common Program Requirements, it is the responsibility of the program director to determine who among the faculty best meet the needs of the program and designate them as core faculty members.

As stated in the 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.

The annual Faculty Survey is one of the instruments used to assess the program. Core faculty members have the commitment to the program and work closely enough with the residents to know how they are learning and progressing. It is this knowledge that allows them to reflect on the program and provide an accurate assessment in the Faculty Survey.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement

Requirements below are subject to citation July 1, 2019

II.C.   Program Coordinator

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

II.C.2.   At a minimum, the program coordinator must be supported at 50 percent FTE (at least 20 hours per week) for administrative time. (Core)

                        [The Review Committee may further specify]

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

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

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

II.D.   Other Program Personnel

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

[The Review Committee may further specify]

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.

GUIDANCE

II.C. Program Coordinator

The Background and Intent explains the rationale for the requirement for administrative support. The term "program coordinator" is used to describe a broad class of administrative staff members who work with the program director, faculty members, and residents.

While the requirement defines a minimum time commitment, the responsibilities of program coordinators vary depending on the specialty and size of the program, and include many activities in addition to their work related to the ACGME Requirements. The ACGME understands that each Sponsoring Institution will determine the appropriate level of program coordinator skill and assignments, the number of individuals acting as program coordinators, and their reporting relationships. Programs with fewer residents may not require a full-time coordinator, allowing one coordinator to support more than one program. The expectation, however, is that the number of coordinators and amount of support provided are adequate and support the well-being of the coordinator, the program director, residents and faculty members.

II.D. Other Program Personnel

The Background and Intent explains that in addition to program coordinators, there will likely be others needed to help in the administration of a program. These individuals may include project managers, experts in education and/or communication, and those with clerical skills. These individuals may provide support for more than one program in more than one discipline.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

III.   Resident Appointments

III.A.   Eligibility Requirements

III.A.1.   An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program: (Core)

III.A.1.a)   graduation from a medical school in the United States or Canada, accredited by the Liaison Committee on Medical Education (LCME) or graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA); or, (Core)

III.A.1.b)   graduation from a medical school outside of the United States or Canada, and meeting one of the following additional qualifications: (Core)

III.A.1.b).(1)   holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core)

III.A.1.b).(2)   holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core)

III.A.2.   All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, AOA-approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada, or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation. (Core)

III.A.2.a)   Residency programs must receive verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation. (Core)

[The Review Committee may further specify prerequisite postgraduate clinical education]

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.

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

III.A.4.   Resident Eligibility Exception

The Review Committee for _____ will allow the following exception to the resident eligibility requirements: (Core)

[Note: A Review Committee may permit the eligibility exception if the specialty requires completion of a prerequisite residency program prior to admission. If this language is not applicable, this section will not appear in the specialty-specific requirements.]

III.A.4.a)   An ACGME-accredited residency program may accept an exceptionally qualified international graduate applicant who does not satisfy the eligibility requirements listed in III.A.1.-III.A.3., but who does meet all of the following additional qualifications and conditions: (Core)

III.A.4.a).(1)   evaluation by the program director and residency selection committee of the applicant's suitability to

enter the program, based on prior training and review of the summative evaluations of this training; and, (Core)

III.A.4.a).(2)   review and approval of the applicant's exceptional qualifications by the GMEC; and, (Core)

III.A.4.a).(3)   verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification. (Core)

III.A.4.b)   Applicants accepted through this exception must have an evaluation of their performance by the Clinical Competency Committee within 12 weeks of matriculation. (Core)

III.B.   The program director must not appoint more residents than approved by the Review Committee. (Core)

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

[The Review Committee may further specify minimum complement numbers]

Background and Intent: Temporary increases in complement in order to facilitate resident well-being or remediation will be approved. There are a variety of reasons why residents may need to extend their training. Temporary complement increases for reasons of family leave are almost always approved by the Review Committee, irrespective of length. Requests of eight weeks or less require mere notification and are automatically approved by the Review Committee for programs with a status of Continued Accreditation. Temporary requests for longer than eight weeks for other reasons will require review of the Review Committee. If residents are not full-time with the program, the resident complement should reflect the FTE.

III.C.   Resident Transfers

The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring resident, and Milestones evaluations upon matriculation. (Core)

[The Review Committee may further specify]

GUIDANCE:

In addition to the Common Program Requirements related to resident/fellow eligibility requirements, program directors must comply with the policies and procedures of the Sponsoring Institution and the ACGME Institutional Requirements for resident/fellow recruitment (IR IV.A.1.-IV.2.c).(3), selection (IR IV.A.3.-IV.A.3.a), and appointment (IR IV.B.1.-IV.2.l)) and IV.C.1.a)-IV.C.1.b)).

See requirement IV.A.1. for additional information.

III.A. Eligibility Requirements

The following links below contain helpful information about residency/fellowship eligibility requirements:

United States: Liaison Committee on Medical Education (LCME) Doctor of Medicine (MD) graduates
http://lcme.org/about/

United States: American Osteopathic Association (AOA) Commission on Osteopathic College Accreditation (AOA-COCA) Doctor of Osteopathic Medicine (DO) graduates
https://osteopathic.org/accreditation/

Canada: Committee on Accreditation of Canadian Medical Schools (CACMS) jointly with LCME Doctor of Medicine (MD) graduates
https://afmc.ca/accreditation

In the transition to a single graduate medical education (GME) accreditation system, AOA-approved programs have until June 30, 2020 to attain ACGME accreditation. Individuals who have completed residency in an AOA-approved program that has received ACGME-accreditation may be eligible for American Board of Medical Specialties (ABMS), or AOA board certification.

While program accreditation is under the purview of the ACGME, individual board certification is under the jurisdiction of the individual certifying boards. For individual specialty board qualifying information, program directors and residents and fellows must communicate with the particular certifying board.

The requirements for resident/fellow eligibility are self-explanatory.
Information regarding residents in the program must be entered into ACGME's Accreditation Data System (ADS).

NOTE that the ADS format may change to match the changes in the Common Program Requirements.

These instructions to enter residents' information are in ADS:

Residents still in the program: To confirm residents, click the column header "Year in Program" to sort residents by year of training. Then select all residents that are currently still active in the program who have advanced to the next year of training. Use the checkboxes next to their name to make your selections. Once you have selected the group of residents you would like to update, scroll to the bottom of the screen and select "Change status to Active Full time & increment year in program 1 year". The selected residents will be moved to the Active category. Make any corrections within the individual resident record under the current academic year.

Residents who have completed all accredited training and are successfully promoted: To confirm residents, click the column header "Year in Program" to sort residents by year of training. Then select all residents that have completed training/are successfully promoted. Use the checkboxes next to their name to make your selections. Once you have selected the group of residents you would like to update, scroll to the bottom of the screen and select "Change status to Completed All Accredited Training (for this specialty) – successfully promoted". The selected residents will be moved to the Completed Training category. Make any corrections within the individual resident record under the current academic year.

Residents who have left the program (transferred/withdrawn/dismissed/other): To confirm residents, click the "Edit" button to the right of the resident name, scroll down to the "Resident Status" section and select the appropriate resident status from the dropdown menu. Save your changes.

Residents who use Case Logs: Programs must complete graduates annually and verify the completion of case log data prior to the Data Verification Deadline. This date is displayed in the Important Dates box in ADS. Not all specialties/subspecialties have a deadline.

Note: Below are examples of screens in ADS used for entering resident information. Ignore selections in yes/no choices.

‹ Back To Resident/Fellows

Resident Detail -

1. Resident Information

First Name: ⓘ   Middle Initial: Last Name: Suffix:

Social Security Number: Date of Birth: National Provider ID: ⓘ

                                                                                      Search National Provider ID ›

Type of medical school from which this resident graduated:

Available Medical Schools:

Month/Year Degree Received: USMLE ID (Optional):

2. Resident Status

Current Status:

3. Resident Details

Type of Position: Year In Program:

Email Address: ⓘ

Personal Email address (for ADS access post-graduation):

Is this resident participating in the osteopathic-focused track?

◉ Yes

○ No

Enter the years of prior Osteopathic-focused training within an ACGME-accredited program with Osteopathic Recognition:

[   ]

Start Date: **Expected Completion:**

[⌄] [⌄] [⌄] ✕   [⌄] [⌄] [⌄] ✕

Did this resident have prior training in another accredited/approved program (other than in this program)?

○ Yes

◉ No

Did this resident start the program in year one (at the beginning of the program - no transfer credit)?

◉ Yes

○ No

Did this resident complete prerequisite, preliminary training to enter the first year of this program (as a PGY-2 or higher)?

○ Yes

◉ No

Gender: **Race/Ethnicity:**

[Select   ⌄]   [Select   ⌄]

---

4. Comments

If you would like to make comments concerning any additions/changes to the above information, please enter it in the box below:

[   ]

---

5. Username

[   ]

Below is an example of a report of your Resident Roster once information has been entered:

	Last	First	Year in Program	Status	Start	End	
•••	Lamborghini	Marshall	1	Unconfirmed	7/18/2018	7/31/2022	
•••	Mitsubi	Nagaraya	1	Unconfirmed	9/1/2017	8/31/2020	
•••	Test	RaquelNoelle	2	Unconfirmed	7/7/2016	10/17/2023	
•••	Allen	Tim	3	Unconfirmed	1/2/2015	3/5/2018	⚠ 🔒 ✳
•••	Mcginn	Flint	3	Unconfirmed	3/17/2018	3/19/2020	
•••	Saba	Maria Raquel	3	Unconfirmed	7/1/2015	6/30/2018	

Unconfirmed [6]

Filter Results

🖶 Print

The table below provides definitions of the different resident statuses:

Current Status:

Unconfirmed

Unconfirmed
Unconfirmed
Active
Active Full time
Active Part time
Started Program Off-Cycle
Completed Training
Completed All Accredited Training (for this specialty) - successfully promoted
Inactive
In Program but Doing Research/Other Training (intends to resume accredited training in this program)
Not in Program Yet and/or Doing Preliminary Year Elsewhere
Leave of Absence
Left Program
Completed All Accredited Training (for this specialty) - with unsuccessful demonstration of competence
Withdrew from Program
Transferred to Another Program (prior to completing required training)
Dismissed
Deceased

---

2. Resident Status

Current Status:

Transferred to Another Program (prior to completing required training)

Date resident actually left or completed program: ⓘ

[   ]

Specialty transferring to:

Select a Specialty

Within the same sponsoring institution?
○ Yes
○ No

Did you provide resident records to the new program?
○ Yes
○ No

III.A.2. All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, AOA-approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada, or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation.

This requirement describes exceptions to the general requirement in III.A.2. (See below) for ACGME or other acceptable accreditation for all prerequisite education and training. It only applies to an individual who has graduated from a residency in the same specialty. The resident should expect to enter at the PG1 level, but if the resident is performing at a higher competency level that can be demonstrated by Milestone evaluation (https://www.acgme.org/What-We-Do/Accreditation/Milestones/Overview/articleid/4536), the resident can be advanced to the PGY-2. The resident and program director should confirm individual board eligibility with the applicable certifying board(s).

A bit more about ACGME-I Advanced Specialty Accreditation:

1. Accreditation Preparedness Assessment – An assessment is conducted to determine readiness for ACGME-I accreditation.
2. Sponsoring Institution Accreditation – Evaluation is based on international standards that require institutional responsibility and oversight of sponsored programs and specify institutional infrastructure expectations. A mock site visit is conducted, and subsequently followed by an accreditation site visit.
3. Accreditation of Residency/Fellowship Programs: Following attainment of Institutional Accreditation, residency/fellowship programs can begin the accreditation application process. Program accreditation is assessed on compliance with two sets of requirements: the International Foundational Requirements and the International Advanced Specialty Requirements. It is possible for a program to receive International Foundational Accreditation but not Advanced Specialty Accreditation. In order to achieve International Advanced Specialty Accreditation, the program must first achieve International Foundational Accreditation. Both Foundational and Advanced Specialty Accreditation can be attained at the same time. This step requires a mock site visit and an accreditation site visit.

III.A.2.a) Residency programs must receive verification of each resident's level of competence in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation. (Core)

[The Review Committee may further specify prerequisite postgraduate clinical education]

In order to verify the competence of each resident, all prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be verified by the program director. One of the following may be used as applicable:

ACGME Milestones Evaluations
ACGME-I Milestones Evaluations
CanMEDS Evaluations

The Review Committee may further specify the type of prerequisite post-graduate education needed to be eligible to matriculate into a specialty program. Check the specialty-specific prerequisites found in the specialty specific requirements.

For additional information regarding ACGME-I Advanced Specialty Accreditation, visit: https://www.acgme-i.org/Accreditation-Process/Overview.

III.A.4. Resident Eligibility Exception

The Review Committee for _____ will allow the following exception to the resident eligibility requirements: (Core)

[Note: A Review Committee may permit the eligibility exception if the specialty requires completion of a prerequisite residency program prior to admission. If this language is not applicable, this section will not appear in the specialty-specific requirements.]

Some specialties will allow exceptions to resident eligibility. Review the information at: ACGME Review Committee Eligibility Decisions. Review Committees that allow exceptions require completion of a prerequisite residency education before entering into the program.

Eligibility Criteria for Specialty Certification

Check with ABMS American Board of Medical Specialties and AOA Board Certification
for the most up-to-date information on eligibility for board certification.

 The information below was provided by the ABMS on June 2019 and may change. Refer to the ABMS website to confirm the information.

Table 1 - ABMS Requirements*

Eligibility for Specialty Certification by ABMS Member Boards during the transition period to a single accreditation system: Training Program Accreditation Status* as of June 2019.

ABMS Member Board*	Training and Program Accreditation Status*
American Board of Allergy and Immunology	Two full years in an ACGME accredited Allergy and Immunology training program AND must be eligible to take the certifying examination for either the American Board of Internal Medicine or the American Board of Pediatrics. In 2016, the ACGME approved Allergy and Immunology training programs accredited by the American Osteopathic Association to be approved for dual accreditation. Graduates of a dually accredited program are now eligible to apply for admission to the ABAI Certification Examination in Allergy and Immunology. Therefore, candidates with one year of training in an AOA accredited program and one year of training in an ACGME accredited program may be considered for admission to the A & I examination. Candidates who submit appropriate documentation will be reviewed by the ABAI Ethics and Professionalism Committee to ensure their training meets the requirements for admission to the examination.

ABMS Member Board*	Training and Program Accreditation Status*
American Board of Anesthesiology CA = Clinical Anesthesia	The CA 1-3 years of training are spent as a resident enrolled with the ABA by no more than two ACGME-accredited anesthesiology residency programs in the U.S. or its territories. An ACGME-accredited program includes the sponsoring (parent) institution and major participating institutions (i.e., institutions that have an RRC-approved integration or affiliation agreement with the sponsoring institution). All three years of CA training must occur in programs that are accredited by the ACGME for the entire period of training. All physicians who graduate from an AOA approved anesthesiology residency program on or after the date the program receives full ACGME accreditation will receive ABA credit for the CA 1-3 years of satisfactory training in the newly accredited program
American Board of Colon and Rectal Surgery	Not applicable. There are no AOA accredited training programs.
American Board of Dermatology	Training program must achieve ACGME accreditation prior to completion.
American Board of Emergency Medicine	Training program must achieve ACGME accreditation prior to completion.
American Board of Family Medicine	A time-limited exemption during the transition period will be offered (through 2022) to allow osteopathic family physicians that have completed three years of an AOA-accredited family medicine residency training program to be eligible for ABFM specialty certification.
American Board of Internal Medicine	Training program must achieve ACGME accreditation prior to trainee's completion of the program. In addition, the Program Director must be certified by ABIM, or other ABMS member board if applicable, by the completion of the transition period (2016-2021) to a single accreditation system. Beginning in 2022, only training programs with program directors certified by ABIM, or other ABMS board if applicable, will be eligible for certification by ABIM.
American Board of Medical Genetics and Genomics	There are no AOA-accredited residency programs in Medical Genetics and Genomics. A minimum of one year of GME training in either an ACGME-accredited program or a program in the ACGME pre-accreditation phase with 12 months of direct patient care is required prior to beginning the Medical Genetics and Genomics residency.

ABMS Member Board*	Training and Program Accreditation Status*
American Board of Neurological Surgery	Neurosurgery training is 84 months in total. There are 54 months of "core" Neurosurgery training which must be completed in an ACGME accredited training program. For the 30 months of research or elective time, there is flexibility depending upon the quality of the clinical or research experience. It is not necessary for this experience to be in an ACGME accredited program. However, written approval from the ABNS is required for any off site elective experiences. The ABNS works collaboratively with the ACGME when questions arise to insure high quality training.
American Board of Nuclear Medicine	Not applicable. There are no AOA accredited Nuclear Medicine training programs.
American Board of Obstetrics and Gynecology	Training program must achieve ACGME accreditation prior to completion.
American Board of Ophthalmology	All training must be in an ACGME accredited training program.
American Board of Orthopaedic Surgery	All training must be in an ACGME accredited training program.
American Board of Otolaryngology – Head and Neck Surgery	All training must be in an ACGME accredited training program.
American Board of Pathology	Not applicable. There are no AOA accredited training programs in Pathology.
American Board of Pediatrics	All training must be in an ACGME accredited training program.
American Board of Physical Medicine and Rehabilitation	Through June 30, 2020, the ABPMR will recognize AOA–accredited training as acceptable toward internship-level PM&R residency training. Due to the impact of the Single Accreditation System, the ABPMR will recognize physicians who completed at least 36 months of AOA–accredited PM&R training as eligible for certification in circumstances where ACGME accreditation was granted by the time of program completion. Program completion must have occurred July 1, 2015, and forward to coincide with the Single Accreditation System.
American Board of Plastic Surgery	All training must be in an ACGME accredited training program.
American Board of Preventive Medicine	PGY-1 year can take place in an AOA accredited program. Years 2 and 3 must be in an ACGME accredited training program.
American Board of Psychiatry and Neurology	Training program must achieve ACGME accreditation prior to completion.

ABMS Member Board*	Training and Program Accreditation Status*
American Board of Radiology	The resident must have at least 36 months of diagnostic radiology training <u>after</u> the program is accredited by the ACGME to be eligible for the ABR Core exam and subsequent Certifying exam.
American Board of Surgery	The final three years of the basic five year Surgery residency must be in an ACGME accredited training program.
American Board of Thoracic Surgery	The last 3 years of a surgical residency (PGY 3-5) must be completed in an ACGME-accredited program followed by completion of an ACGME-accredited thoracic surgical residency.
American Board of Urology	All training must be in an ACGME accredited training program.
The above requirements are limited to the training program itself. Please see individual ABMS Member Board websites for comprehensive summary of all requirements for board eligibility.	
*Table Provided by ABMS, Last Revised – June 2019	

Note that the information below was provided by the AOA on September 2018 and may change – please refer to the AOA website to confirm the information.

Board Certification during Transition to Single GME Accreditation System
The Table below shows AOA training eligibility requirements for specialty certification during the five-year transition period to a single graduate medical education accreditation system. The AOA provides a pathway for osteopathic physicians (be they AOA or ACGME trained) to sit for AOA board examinations in the areas for which it certifies. For AOA programs that achieve ACGME accreditation during the transition, all current osteopathic residents will receive AOA approval following completion of training, which will satisfy the AOA board training eligibility requirements.

During the transition, the ABMS boards will offer certification to osteopathic physicians under specific circumstances. Please see individual ABMS Member Board websites for a comprehensive summary of all requirements for Board eligibility. Note that the rules for entering advanced ACGME training are established by the ACGME. Those rules may allow a trainee to enter advanced ACGME training, but do not guarantee the trainee would be eligible to sit for the ABMS board examination.

This is a general overview. There may be additional specific requirements - contact the specific certifying board for additional eligibility criteria.

AOA Board Certification Requirements*	
Training Eligibility Criteria for Specialty Certification*	
AOA Member Board	Training Eligibility Requirements for AOA Certification
Allergy and Immunology - Joint Examination	Completed an AOA-approved or ACGME-accredited training program.
American Osteopathic Board of Anesthesiology	Completed an AOA-approved or ACGME-accredited training program.
American Osteopathic Board of Dermatology	Completed an AOA-approved or ACGME-accredited training program.
American Osteopathic Board of Emergency Medicine	Completed an AOA-approved or ACGME accredited training program. ACGME training must be four years in length.
American Osteopathic Board of Family Physicians	Completed an AOA-approved or ACGME-accredited training program.
American Osteopathic Board of Internal Medicine	Completed an AOA-approved or ACGME-accredited training program.
American Osteopathic Board of Neurology and Psychiatry	Completed an AOA-approved or ACGME-accredited training program.

American Osteopathic Board of Neuromusculoskeletal Medicine	Completed an AOA-approved or ACGME-accredited training program.
American Osteopathic Board of Surgery: Neurological Surgery	Completed an AOA-approved or ACGME-accredited training program.
American Osteopathic Board of Nuclear Medicine	Completed an AOA-approved or ACGME-accredited training program.
American Osteopathic Board of Obstetrics and Gynecology	Completed an AOA-approved or ACGME-accredited training program.
American Osteopathic Board of Ophthalmology and Otolaryngology	Completed an AOA-approved or ACGME-accredited training program.
American Osteopathic Board of Orthopedic Surgery	Completed an AOA-approved or ACGME-accredited training program.
American Osteopathic Board of Pathology	Completed an AOA-approved or ACGME-accredited training program.
American Osteopathic Board of Pediatrics	Completed an AOA-approved or ACGME-accredited training program.
American Osteopathic Board of Physical Medicine and Rehabilitation	Completed an AOA-approved or ACGME-accredited training program.
American Osteopathic Board of Preventive Medicine	Completed an AOA-approved or ACGME-accredited training program.
American Osteopathic Board of Surgery: Plastic and Reconstructive Surgery	Completed an AOA-approved or ACGME-accredited training program.
American Osteopathic Board of Radiology	Completed an AOA-approved or ACGME-accredited training program.
American Osteopathic Board of Surgery	Completed an AOA-approved or ACGME-accredited training program.
American Osteopathic Board of Surgery: Thoracic and Cardiovascular Surgery	Completed an AOA-approved or ACGME-accredited training program.
American Osteopathic Board of Surgery: Urological Surgery	Completed an AOA-approved or ACGME-accredited training program.

 IMPORTANT TO NOTE:

The ACGME provides accreditation to programs, NOT board certification to individuals. Applicants may mistakenly assume that acceptance to an ACGME-accredited program ensures American Board of Medical Specialties (ABMS) board certification or AOA board certification eligibility. This is not the case, and program directors MUST make this clear to all applicants through a letter that both parties should sign.

See draft sample letters below.

DRAFT SAMPLE LETTER: Letter from Program Director to the Applicant

Eligibility for Board Certification to Applicants to the Program

Date:

To: Residency Applicants
Re: Eligibility for Board Certification

Dear:

As part of your application and interview for a potential residency position in our program, this letter is to notify you that this program is accredited by the Accreditation Council for Graduate Medical Education (ACGME) and you meet the ACGME requirements for matriculation in our program.

Upon graduating from our program, most of our residency graduates seek board certification from the American Board of _____ or the American Osteopathic Board of _____. Board certification is a separate process from residency training and has additional requirements. Some board organizations require that you complete *all* of your education in an ACGME-accredited residency. If *part* of your residency education occurred in a non-ACGME-accredited program, even if it was approved by the American Osteopathic Association or accredited by the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, or the Advanced Specialty accreditation by ACGME International (ACGME-I), there is a possibility that you may not be eligible for board certification at completion of your education.

It is important that you contact the appropriate certifying board to understand your eligibility for board certification before you accept a position for residency training (if offered) at our institution.

Please contact the American Board of _____ at (website URL) or American Osteopathic Board of _____ at (website).

I have read this letter and understand the requirements for board certification.

_____   _____
Applicant Name   Applicant Signature/Date

_____   _____
Program Director Name   Program Director Signature/Date

DRAFT SAMPLE LETTER:

Sample Letter from the Program Director to the Applicant: Residency

[Date]

Dear [Ms./Mr./Dr.] [Last Name]:

I am writing this letter to you in compliance with ACGME Program Requirement II.A.4.a).(9):
The program director must provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s)

[ ]   The relevant American Board of Medical Specialties (ABMS) member board is the American Board of [Specialty]. Taking into account the path of your medical education, to date, and assuming your acceptance to, satisfactory performance in, and completion of this program, you [ ] would [ ] would not be eligible for certification by the American Board of [Specialty].

[ ]   The relevant American Osteopathic Association board is the American Osteopathic Board of [Specialty]. Taking into account the path of your medical education, to date, and assuming your acceptance to, satisfactory performance in, and completion of this program, you [ ] would [ ] would not be eligible for certification by the American Osteopathic Board of [Specialty].

[ ]   There is no relevant ABMS member board in [Specialty].

[ ]   The is no relevant AOA board in [Specialty]

Sincerely,

[Program Director Name]
Program Director in [Specialty]
[Institution Name]

Note: Information for resident complement increases or transfers are included in the resident roster reports.

III.B. Complement Increases

Complement increases can be permanent or temporary. The Review Committee scrutinizes all requests for permanent increases thoroughly in light of the clinical, educational, and other resources available to the program. Programs request temporary increases for many reasons, including remediation, resident/fellow well-being, medical leave, and family leave.

Complement increase requests are handled in different ways by different Review Committees. Discuss complement increases with ACGME Review Committee staff members.

There are a variety of reasons why residents and fellows may need to extend their educational program. Temporary complement increases for reasons of family leave are frequently approved by the Review Committee. Temporary requests for longer than eight weeks for other reasons will require review by the Committee.

Program directors are strongly encouraged to contact their GME office and the applicable specialty certifying board for guidance on resident/fellow leave, remediation, and any type of extended education, as this varies from one certifying board to another.

III.C. Resident Transfers

Residents are considered transferring residents under several conditions including:

- When moving from one program to another within the same or different sponsoring institution
- When entering as a post-graduate year (PGY)-2 in a program requiring a preliminary year, regardless that the resident was accepted to the preliminary year and the specialty program as part of the match (e.g., accepted to both the preliminary program and the specialty program upon graduation from medical school).

Before accepting a transferring resident, the "receiving" program director must obtain written or electronic verification of prior education from the program from which the resident is transferring.

Documentation includes evaluations, rotations completed, procedural/operative experience if applicable, and a summative competency-based performance evaluation. While a Milestones evaluation cannot be used in the decision to accept a transferring resident, a Milestones evaluation must be completed upon matriculation

Documentation for eligibility and resident transfers: The information for all new and transferring residents must be provided through ADS.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement

Requirements below are subject to citation July 1, 2019

IV. Educational Program

> *The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.*
>
> *The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.*
>
> *In addition, the program is expected to define its specific program aims consistent with the overall mission of its Sponsoring Institution, the needs of the community it serves and that its graduates will serve, and the distinctive capabilities of physicians it intends to graduate. While programs must demonstrate substantial compliance with the Common and specialty-specific Program Requirements, it is recognized that within this framework, programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-specific goals for it and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from one focusing on community health.*

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

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

IV.A.1.a)   The program's aims must be made available to program applicants, residents, and faculty members. [Core]

IV.A.2.	competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice. These must be distributed, reviewed, and available to residents and faculty members; (Core)

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

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

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

IV.A.4.	a broad range of structured didactic activities; (Core)

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

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

IV.A.5.	advancement of residents' knowledge of ethical principles foundational to medical professionalism; and, (Core)

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

GUIDANCE

The Common Program Requirements do not list detailed curricular elements for each specialty. Those can be found in the specialty-specific Program Requirements. The overarching goal for the Common Program Requirements related to the educational program is to ensure that programs provide a framework for the following:

1. A comprehensive education for residents and fellows pertinent to the specific aims and mission of the Sponsoring Institution, the program, and the community it serves.
2. A program that supports the development of knowledgeable, skillful, and compassionate physicians capable of independent practice.

Program Aims:

As part of the Self-Study process, programs have to develop aims in an effort to add context to the program's expectations and focus on aspects such as:

1. What types of residents and fellows is the program educating?
2. What are their future roles in the community?

Having aims allows the program to construct curricular elements that address particular career options (clinical practice, research, primary care, or health policy and advocacy). For example, a program in a rural community might focus their resident education on issues relevant to that community, while a program in an institution whose goal may be to produce physician-scientists, might want to provide more education in research. The Program Evaluation Committee should play a central role in the development of program aims and ensure that the program is working towards them.

[ACGME Self-Study](#)

The ACGME program Self-Study was started in 2013, as part of the Next Accreditation System. The goal of the Self-Study is to have programs conduct an objective and comprehensive evaluation of the residency or fellowship program. With the Annual Program Evaluation as one of the key elements of this process. To provide context for the Self-Study, there are two concepts to be considered: 1) that the program determines its aims; and, 2) that the program provides an assessment of the institutional, local, regional, and even national environments relevant to the program to determine opportunities and threats. It is expected that participants in the process include leadership, residents and fellows (if present), graduates of the program, and others who interact closely with the residents and fellows.

From the Self-Study section of the ACGME website:

"Aims are program and institutional leaders' views of key expectations for the program, as well as how the program differentiates itself from other programs in the same specialty/subspecialty. Aims may focus on the types of trainees recruited by the program, or on preparing graduates for particular careers (clinical practice, academics, research, or primary care). Aims may also include other objectives, such as providing care for underserved patients, involvement in health policy or advocacy, population health, or scholarship that generates new knowledge.

Program aims should be vetted with program and institutional leadership, and in some institutions, setting aims will be an institution-level initiative. In setting aims, programs should generally take a longer-term strategic view. However, aims may change over time. Factors such as a shift in program focus initiated by institutional or department leadership, changes in local or national demand for a resident workforce with certain capabilities, or new opportunities to train residents and fellows in a different setting may prompt revision of program aims."

The Program Self-Study: Developing Program Aims

This PowerPoint presentation includes a definition of aims, why they are important, a breakdown of the Self-Study process, and examples of aims.

Defining Program Aims

- Set aims as part of self-identified annual improvement process
    - Who are our residents/fellows?
    - What do we prepare them for?
        - Fellowship
        - Academic practice
        - Leadership and other roles
    - Who are the patients/populations we care for?

Resident participation is critical:

- After all, they are the beneficiaries of the educational program
- They have firsthand knowledge of areas that need improvement (in the trenches)
- Double benefit:
    - Residents help improve their own education
    - Resident participation in "educational QI effort" can be used to meet the requirement for resident involvement in quality and safety improvement

Examples of Program Aims

1. Provide a comprehensive three-year curriculum to enable residents to learn tertiary, secondary, and primary care skills in all settings.
2. Educate residents to be excellent practitioners of medically-directed anesthesiology in an anesthesia care team model.
3. Train individuals with expertise in population health and serving medically underserved.
4. Produce excellent, independent practitioners who will be local and national leaders, and for academic careers.

Benefits of Defining Program Aims

1. Suggests a relevant dimension of the program
   a. What kinds of graduates do we produce for what kinds of practice settings and roles?

2. Allows for a more "tailored" approach to creating a learning environment
   a. Focusing on specific aims can produce highly desirable "graduates" that match patient and health care system needs
   Hodges, Brian David. "A Tea-Steeping or i-Doc Model for Medical Education?" *Academic Medicine* 85 (2010). https://doi.org/10.1097/acm.0b013e3181f12f32.

3. Enhances the focus on functional capabilities of graduating residents
   a. Fits with a Milestones-based approach to assessment

Need to Identify Strengths and Improvements:

1. Citations, areas for improvement, and other information from the ACGME
2. The Annual Program Evaluation
3. Other program/institutional data sources
4. Data from all sources considered for the entire period between Self-Studies/Self-Study site visits

Examples of Opportunities

1. Relationship with Federally Qualified Health Center to start new primary care track
2. Assess/enhance relationship with other programs/departments, such as comprehensive cross specialty patient safety initiative
3. Caring for a socioeconomically disadvantaged population for developing a curriculum about the socioeconomic determinants of health
4. New educational technology to bridge the gap between faculty teaching approaches and the desires of millennial learners

Examples of Threats

1. Reductions in federal support for GME, loss of key faculty members, or loss of participating sites that provide access to important patient populations.
2. Gaps in faculty capabilities
3. Impact of potential cuts in GME financing
4. Clinical burden of faculty members: affects time and energy for teaching and mentoring residents

Role of the Program Evaluation Committee (PEC)

The PEC should participate actively in:
- planning, developing, implementing, and evaluating educational activities
- reviewing and making recommendations for revision of competency-based curriculum goals and objectives (the action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes)
- addressing areas of non-compliance with ACGME requirements
- reviewing the program annually using evaluations of faculty members, residents/fellows, and others
- preparing a written plan of action
- documenting initiatives to improve performance in the outlined areas
- delineating how the action plan will be measured and monitored

Tracking Improvements in Response to the Self-Study Process

- Design and implement solutions
- Identify individual or group that will be responsible
- Identify and secure resources
- Timeline
- Follow-up is key: ensure all issues addressed
- Documentation to facilitate ongoing tracking
  - Example: A simple spreadsheet recording improvements achieved and ongoing priorities
- Record over multiple years of improvement

Guralnick, Susan, Tamika Hernandez, Mark Corapi, Jamie Yedowitz-Freeman, Stanislaw Klek, Jonathan Rodriguez, Nicholas Berbari, Kathryn Bruno, Kara Scalice, and Linda Wade. "The ACGME Self-Study—An Opportunity, Not a Burden." *Journal of Graduate Medical Education* 7, no. 3 (2015): 502–5. https://doi.org/10.4300/jgme-d-15-00241.1.

It bears re-emphasizing that while Common Program Requirement IV.A.1 requires that the program develop a set of program aims consistent with its mission and the community it serves, the Review Committees will *not* evaluate the specifics of the program aims for accreditation purposes.

Goals and Objectives:

The program must design competency-based, level-specific goals and objectives for each educational experience to ensure that faculty members and residents are aware of the purpose of a particular rotation in meeting their educational needs.

What are goals and objectives?
- A goal is an overarching principle that guides decision making.
- Objectives are specific, measurable steps that can be taken to meet the goal.

Benjamin Bloom created a taxonomy of measurable verbs that help to describe observable knowledge, skills, attitudes, behaviors and abilities. The theory of "Bloom's Taxonomy of Measurable Verbs" is based on the premise that there are observable action levels that can help explicitly define what a student must do to demonstrate learning.

https://www.marquette.edu/assessment/includes/documents/BloomsTaxonomyActionVerbs.pdf

Bloom's Taxonomy Action Verbs

Definitions	Knowledge	Comprehension	Application	Analysis	Synthesis	Evaluation
Bloom's Definition	Remember previously learned information.	Demonstrate an understanding of the facts.	Apply knowledge to actual situations.	Break down objects or ideas into simpler parts and find evidence to support generalizations.	Compile component ideas into a new whole or propose alternative solutions.	Make and defend judgments based on internal evidence or external criteria.
Verbs	• Arrange • Define • Describe • Duplicate • Identify • Label • List • Match • Memorize • Name • Order • Outline • Recognize • Relate • Recall • Repeat • Reproduce • Select • State	• Classify • Convert • Defend • Describe • Discuss • Distinguish • Estimate • Explain • Express • Extend • Generalized • Give example(s) • Identify • Indicate • Infer • Locate • Paraphrase • Predict • Recognize • Rewrite • Review • Select • Summarize • Translate	• Apply • Change • Choose • Compute • Demonstrate • Discover • Dramatize • Employ • Illustrate • Interpret • Manipulate • Modify • Operate • Practice • Predict • Prepare • Produce • Relate • Schedule • Show • Sketch • Solve • Use • Write	• Analyze • Appraise • Breakdown • Calculate • Categorize • Compare • Contrast • Criticize • Diagram • Differentiate • Discriminate • Distinguish • Examine • Experiment • Identify • Illustrate • Infer • Model • Outline • Point out • Question • Relate • Select • Separate • Subdivide • Test	• Arrange • Assemble • Categorize • Collect • Combine • Comply • Compose • Construct • Create • Design • Develop • Devise • Explain • Formulate • Generate • Plan • Prepare • Rearrange • Reconstruct • Relate • Reorganize • Revise • Rewrite • Set up • Summarize • Synthesize • Tell • Write	• Appraise • Argue • Assess • Attach • Choose • Compare • Conclude • Contrast • Defend • Describe • Discriminate • Estimate • Evaluate • Explain • Judge • Justify • Interpret • Relate • Predict • Rate • Select • Summarize • Support • Value

The information in the table indicates what one would expect for a particular item. For example, under knowledge, an individual remembers previously-learned information. For application, an individual is able to use his or her knowledge to solve a problem. The words included in the list are concise, explicit, and can be measured.

Common mistakes in creating goals and objectives include:

1. Using vague verbs and phrases that cannot be measured. Words to avoid include:
   - believe,
   - comprehend,
   - know,
   - perceive,
   - recognize, and
   - understand.

   Phrases to avoid include:
   - appreciation for,
   - capable of,
   - familiar with, and
   - knowledge of.

2. Avoiding level-specific or competency-based goals and objectives.

A useful mnemonic to use in writing goals and objectives (developed from the 1981 paper "There's a S.M.A.R.T. Way to Write Management's Goals and Objectives," written by George T. Doran):

S - Specific
M - Measurable
A - Attainable
R - Relevant
T – Time-bound

Goals and objectives must be competency-based and level-specific. For example, a post-graduate year (PGY)-1 resident has to demonstrate the ability to independently perform a complete history and physical examination as part of patient care competency. As part of the same patient care competency, a PGY-3 resident in a three-year program has to demonstrate the ability to guide and supervise a PGY-1 resident in obtaining a complete history and physical examination and take an active role in the formulation of diagnostic and treatment plans.

Goals and objectives must be distributed, reviewed, and available to residents and faculty members to ensure an understanding of learning expectations.

Resident Responsibilities and Graded Supervision:

Also refer to Section VI.A.2. Supervision and Accountability

> *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.*

The responsibilities of the residents and their supervision must be clearly delineated. As stated in sections VI.A.2.a).(1).(a)-(b), each resident must have an identifiable and appropriately credentialed and privileged attending physician who is responsible and accountable for the patient's care. This and the contact information for the attending physician must be made available to residents, faculty members, and other members of the health care team.

As stated in section 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 education and ability, as well as patient complexity and acuity. Progressive authority and conditional independence is a privilege and must be assigned by the program director and faculty members. The Clinical Competency Committee (CCC) is key in helping the program director assign progressive authority based on criteria established by the program and Milestones assessments. In addition, supervising faculty members during each specific rotation can help assess the skills of each resident.

The Common Program Requirements underscore the philosophy behind the different levels of supervision:

> VI.A.2.b) *Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member, fellow, or senior resident physician, either on site or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.*

Distinct levels of supervision are defined (section VI.A.2.c)), and include direct, indirect supervision, and oversight. While supervision is critical to the development of a resident or fellow, there is also such a thing as "over-supervision", which occurs when more

advanced residents and fellows who are deemed capable are never allowed to make independent decisions and provide autonomous care. This is detrimental to the development of skills, knowledge and attitudes required to enter the unsupervised practice of medicine.

An additional dimension to supervision is continuity. Because of multiple constraints, faculty members are increasingly adopting shorter assignments. One-week faculty rotations are common, with some even taking assignments that last two to three days. These brief supervision assignments make it impossible for the faculty member to have any continuity to assess the residents' knowledge and skills, and the residents do not benefit from any meaningful interactions with the faculty member. There is evidence that short faculty supervision assignments are detrimental to patient care:

> Bernabeo, Elizabeth C., Matthew C. Holtman, Shiphra Ginsburg, Julie R. Rosenbaum, and Eric S. Holmboe. "Lost in Transition: The Experience and Impact of Frequent Changes in the Inpatient Learning Environment." *Academic Medicine* 86, no. 5 (2011): 591–98. https://doi.org/10.1097/acm.0b013e318212c2c9.

Structured Didactic Activities:

For a detailed list of specialty-specific curricular elements, refer to the specialty sections on the ACGME website. There are many forms of didactic activities, including lectures, workshops, courses, simulation with feedback, case discussions, grand rounds, board review, and journal club. Faculty presence, participation, and leadership is key. In addition, residents and fellows must be provided with the opportunity to participate in didactic activities. While residents and fellows may occasionally miss didactic activities because of priorities related to patient care, it is important that the program provide protected time to allow their attendance. Residents on rotations at a distant site should be given the opportunity to participate in didactic activities through the internet, via recorded conferences and other means.

Program leadership should conduct periodic reviews of the program's curriculum to determine if adjustments need to be made. For example, new treatment protocols or concepts may need to be incorporated. If Milestones reports and in-training examination results consistently indicate that a significant portion of residents and fellows are not performing well in a topic, the program leaders should look to address that knowledge deficiency in the didactic curriculum.

Ethical Principles Foundational to Medical Professionalism

"The good physician knows his patients through and through, and his knowledge is bought dearly. Time, sympathy, and understanding must be lavishly dispensed, but the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine. One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient."

Dr. Francis M. Peabody
Boston, 1927

"It is essential, therefore, that physicians understand clearly that to serve the goals of medicine, they have a responsibility to continue to care for their patients when they can no longer prescribe a particular form of treatment or offer the likelihood of a cure."

Dr. Michael E. Whitcomb
What Does It Mean to Be a Physician?
Academic Medicine Vol 82, October 2007

Professionalism is at the core of being a physician. Yet, teaching it is difficult and evaluating professionalism presents significant challenges. There are many factors that influence the erosion of professionalism. These include state control, corporate demands, and an overemphasis on income and power. Some argue that the loss of ethics and morals cause this erosion, and therefore propose that medical professionalism cannot be taught separately from ethical principles, morality, and emotional intelligence.

In order to teach professionalism, the key components must be identified. The American Academy of Pediatrics lists the following important parts of professionalism:

- Honesty/Integrity
- Reliability/Responsibility
- Respect for Others
- Compassion/Empathy
- Self-Improvement
- Self-Awareness/Knowledge of Limits
- Communication/Collaboration
- Altruism/Advocacy

Providing residents and fellows with lists of what comprises professionalism, however, is likely not an effective way to teach this competency. Lists are meaningless and easily forgotten in the absence of context. While important in providing specific concepts,

didactic lectures may not have an impact in the long run. Researchers A. Keith W. Brownell and Luc Côté ([Keith W. Brownell, A & Cote, Luc. (2001). Senior Residents' Views on the Meaning of Professionalism and How They Learn about It. Academic medicine: journal of the Association of American Medical Colleges. 76. 734-7. 10.1097/00001888-200107000-00019.](#)) surveyed senior residents on their views about the meaning of professionalism and how they learned about it, and determined that the majority of them learned the most from observing role models. While good role models and mentors are essential for the education of residents and fellows, there is no way to guarantee their presence. In addition, role modeling as a method of teaching professionalism has been criticized as imprecise and lacking structure. Teaching professionalism is a multi-step process and should include:

- A definition of the expected behaviors as to what is and is not acceptable. Policies should include process, reporting, due process, remediation, follow-up, and documentation.
- Assessment should include formative and summative feedback. Any negative feedback should include a discussion of what the consequences are, along with a remediation and follow-up plan. Evaluations should be solicited from multiple sources, including patients and families, other health care providers, chief residents and peers. All evaluations must be reviewed by the CCC and taken into account in their deliberations.
- Remember that professional behavior is expected of faculty members as well, and it is important to include education regarding ethical principles and professionalism in faculty development.

Examples of Linking Professionalism Values to Specific Behaviors

Values	Behaviors
Responsibility	- Follows through on tasks - Arrives on time
Maturity	- Accepts blame for failure - Does not make inappropriate demands - Is not abusive and critical in times of stress
Communication Skills	- Listens well - Is not hostile, derogatory, sarcastic - Is not loud or disruptive
Respect	- Maintains patient confidentiality - Is patient - Is sensitive to physical/emotional needs - Is not biased/discriminatory

Jim Wagner, University of Texas Southwestern Medical School as included in: Kirk, Lynne M. "Professionalism in Medicine: Definitions and Considerations for Teaching." Baylor University Medical Center Proceedings 20, no. 1 (2007): 13–16. https://doi.org/10.1080/08998280.2007.11928225.

Some programs provide didactic lectures on professionalism at orientation without follow-up activities. While it is important to introduce this concept to residents and fellows when they enter the program, the efforts to educate them on professionalism should be ongoing and incorporated into their education throughout residency and fellowship to ensure a lifelong commitment to this critical aspect of being a physician.

Basic principles of scientific inquiry, including how research is designed, conducted, evaluated, explained to patients, and applied to patient care

The curriculum must include education in basic principles of scholarship. Components include:

- Animal Investigation Committee procedures,
- basic research design,
- basic statistics,
- data collection and spreadsheet entry,
- evidence-based literature review,
- Institutional Review Board procedures,
- medical writing,
- obtaining informed consent from patients/families, and
- presentation skills.

There are many ways to provide these curricular elements. There can be a structure that allows coverage of the topics at a monthly session over a one-year period. The program director does not have to teach these sessions by himself/herself. This is an opportunity for collaboration, where experts in the topic can be invited to speak. There are many web-based curricula for teaching these topics. In addition, there are courses provided by the medical school or the Institutional Review Board or the Animal Investigation Committee. The National Institutes of Health may also be a good resource. In addition, Web-based resources and textbooks for the conduct of evidence-based literature review and for quality improvement and patient safety studies are widely available.

Key to this process is faculty mentorship. While there may be some residents and fellows who begin the program with a plan and know what research they want to do, many do not. They need guidance from faculty mentors who can help them design and conduct a study, gather and analyze data, and write up results for presentation or publication. Faculty members also need to be involved or even lead journal club and other scholarly activities.

The goal of the requirement for scholarship as stated in the background and intent of Common Program Requirements Section IV.D.is:

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 use 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 they understand the benefits and limits of the medical literature,
• when appropriate, disseminating scholarly learning in a peer-reviewed manner (publication or presentation), and
• 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. It cannot be over-emphasized that the program has to provide an environment of scholarship to educate residents and fellows to continue this the methods of scholarly approach in their practice.

Introduction
ACGME Competencies and Milestones

IV.B.   ACGME Competencies

> 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.

[The ACGME Milestones Guidebook](#)

What are Milestones?

In general terms, a milestone is simply a significant point in development. The
Milestones in graduate medical education (GME) provide narrative descriptions of the
ACGME Competencies and subcompetencies along a developmental continuum.
Simply stated, the Milestones describe performance levels residents and fellows are
expected to demonstrate for skills, knowledge, and behaviors in the six clinical
competency domains. They lay out a framework of observable behaviors and other
attributes associated with a resident's or fellow's development as a physician.

The Milestones describe the learning trajectory within a subcompetency that takes the
resident or fellow from a beginner in the specialty or subspecialty, to a highly proficient
resident or fellow or early practitioner. Milestones are different from many other
assessments because there is an opportunity for the learner to demonstrate the
attainment of aspirational levels of the subcompetency, and they allow for a shared
understanding of the expectations of faculty members for the learner. Milestones can
provide a framework for all GME programs providing some assurance that graduating
residents and fellows across the US have attained a high level of competence.

It is also important to recognize what the Milestones are not. First and foremost, they do
not describe or represent a complete description of a clinical discipline. They represent
the core of a discipline, but programs will need to use good judgment to fill in the gaps
in curriculum and assessment. It is essential that the Milestones do not serve as
curricula in and of themselves, but rather guide a thoughtful analysis of curriculum to
identify strengths and gaps. Even for those specialties that developed more general
subcompetencies, there was an understanding that the Milestones would not cover all
areas essential to the unsupervised practice of medicine. Second, they are not tools
designed to negatively affect program accreditation. The Milestones are intended for
formative purposes to help learners, programs, and the Review Committees improve
educational, assessment, and accreditation processes.

Anatomy of the Milestones Tool:

Milestone

Subcompetency

Developmental progression or set of milestones

Systems-based Practice 3: Physician Role in Healthcare System (AP/CP)				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Identifies key components of the complex healthcare system (e.g., hospital, skilled nursing facility, finance, personnel, technology)	Describes how components of a complex healthcare system are inter-related, and how this impacts patient care	Discusses how individual practice affects the broader system (e.g., test utilization, turn-around time)	Manages various components of the complex healthcare system to provide efficient and effective patient care and transition of care	Advocates for or leads systems change that enhances high value, efficient and effective patient care and transition of care
Describes basic health payment systems, including (e.g., government, private, public, uninsured care) and practice models	Documents testing detail and explains the impact of documentation on billing and reimbursement	Engages with clinicians and/or patients in shared-decision making, such as use of preauthorization for complex testing	Practices and advocates for cost effective patient care with consideration of the limitations of each patient's payment model	Participates in health policy advocacy activities
Comments:	☐	☐	☐	☐	☐	☐	☐	☐	Not Yet Completed Level 1 ☐

Milestone

Selecting a response box in the middle of a level implies that milestones in that level and in lower levels have been substantially demonstrated.

Selecting a response box on the line in between levels indicates that milestones in lower levels have been substantially demonstrated as well as **some** milestones in the higher level(s).

The Purpose and Function of Milestones

User	Function for User
Residents and Fellows	• Provide a descriptive roadmap for education • Provide transparency of performance requirements • Encourage informed self-assessment and self-directed learning • Facilitate better feedback to the learner • Encourage self-directed feedback seeking behaviors
Residency and Fellowship Programs	• Guide curriculum and assessment tool development • Provide meaningful framework for Clinical Competency Committees (e.g., create shared mental model) • Provide more explicit expectations of residents and fellows • Support better systems of assessment • Enhance opportunity for early identification of underperformers
ACGME	• Accreditation: enables continuous monitoring of programs and lengthening of site visit cycles • Public accountability: Milestones are reported at a aggregated national level on competency outcomes • Community of practice for evaluation and research, with focus on continuous improvement
Certification Boards	• Enable research to improve certification processes

Several key aspects about the use of the Milestones deserve special attention. First, the Milestones reported to the ACGME were not designed to be used as evaluation forms for specific rotations or experiences, especially short rotations less than three months in length. The Reporting Milestones are designed to guide a synthetic judgment of progress twice a year. However, using language from the Milestones may be helpful as part of a mapping exercise to determine which Competencies are best covered in specific rotation and curricular experiences. Second, the Reporting Milestones can also be used for guided self-assessment and reflection by the resident/fellow in preparation for feedback sessions and in creating individual learning plans. Residents and fellows should use the Milestones for self-assessment with input and feedback from a faculty advisor, mentor, or program director. Residents and fellows should not judge themselves on the Milestones in isolation. Milestones feedback is most effective when performed in dialogue between a learner and faculty advisor. Third, the Milestones can be useful in faculty development. They can help faculty members recognize their performance expectations of learners, more explicitly assess the trajectory of skill progression in their specialty, and discern how best to assess a learner's performance. Finally, it is imperative that programs remember that the Milestones are not inclusive of the broader curriculum, and limiting assessments to the Milestones could leave many topics without proper and essential assessment and evaluation.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement

Requirements below are subject to citation July 1, 2019

IV.B.   ACGME Competencies

> 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.

IV.B.1.   The program must integrate the following ACGME Competencies into the curriculum: (Core)

IV.B.1.a)   Professionalism

              Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)

IV.B.1.a).(1)   Residents must demonstrate competence in:

IV.B.1.a).(1).(a)   compassion, integrity, and respect for others; (Core)

IV.B.1.a).(1).(b)   responsiveness to patient needs that supersedes self-interest; (Core)

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

IV.B.1.a).(1).(c)   respect for patient privacy and autonomy; (Core)

IV.B.1.a).(1).(d)	accountability to patients, society, and the profession; (Core)
IV.B.1.a).(1).(e)	respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation; (Core)
IV.B.1.a).(1).(f)	ability to recognize and develop a plan for one's own personal and professional well-being; and, (Core)
IV.B.1.a).(1).(g)	appropriately disclosing and addressing conflict or duality of interest. (Core)

GUIDANCE

"The good physician knows his patients through and through, and his knowledge is bought dearly. Time, sympathy and understanding must be lavishly dispensed, but the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine. One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient."

<div align="right">

Dr. Francis M. Peabody
Boston, 1927

</div>

"It is essential, therefore, that physicians understand clearly that to serve the goals of medicine, they have a responsibility to continue to care for their patients when they can no longer prescribe a particular form of treatment or offer the likelihood of a cure."

<div align="right">

Dr. Michael E. Whitcomb
What does it mean to be a Physician?
Academic Medicine Vol 82, October 2007

</div>

Professionalism is at the core of being a physician, yet, teaching it is difficult and evaluation of professionalism presents significant challenges. There are many factors that influence the erosion of professionalism, and these include state control, corporate demands, and overemphasis on income and power. Some argue that the loss of ethics and morals underlie this erosion, and therefore propose that medical professionalism cannot be taught separately from ethical principles, morality and emotional intelligence.

The components of professionalism of physicians is best summarized by the relationship chart created by ACGME President and CEO Dr. Thomas J. Nasca, published in *JAMA* in 2015:

Traditions Contributing to the American Concept of Professionalism
Nasca, T.J. Viewpoint. **JAMA. 2015. 313(18):1801-1802.**
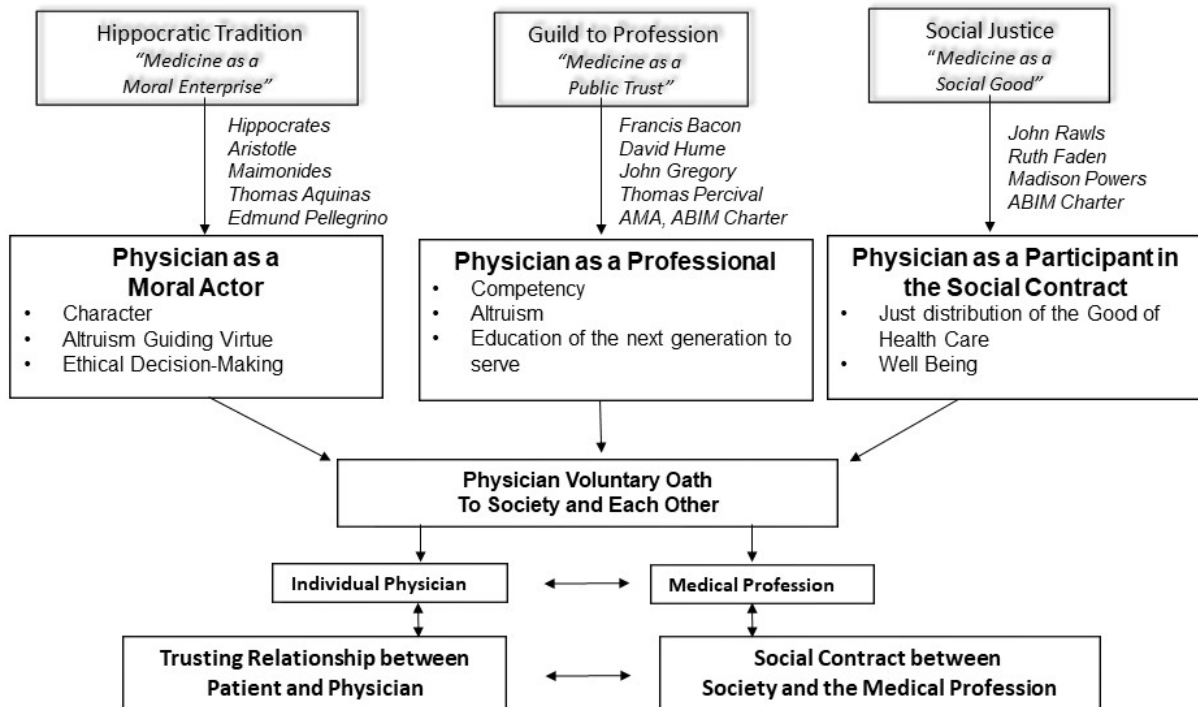
Dr. Nasca states: "the philosophical roots of professionalism include the Hippocratic tradition of medicine as a moral enterprise; the transition of medicine from guild to profession with a commitment to competence, altruism, and public trust; and the responsibility of the profession to prepare the next generation of physicians to serve the public."

Often neglected in this equation is physician wellness. A physician who is unwell is unlikely able to provide good care.

The American Academy of Pediatrics lists the following important elements of professionalism:

- Honesty/Integrity
- Reliability/Responsibility
- Respect for Others
- Compassion/Empathy
- Self-Improvement
- Self-Awareness/Knowledge of Limits
- Communication/Collaboration
- Altruism/Advocacy

These elements of professionalism must be addressed in the program curriculum. A one-hour lecture provided at resident orientation is likely inadequate. Programs have reported more success with simulation, workshops, and case discussions. Some have incorporated education on professionalism into morbidity and mortality conferences and review of medication errors. More importantly, repeated sessions throughout the years of the educational program provide reminders of the elements of professionalism and keep the residents and fellows on track. Since role modeling of professionalism by faculty members is key to the professional behavior of residents and fellows, it is just as important to incorporate professionalism in faculty development sessions.

A related requirement: II.A.4.a) and II.A.4.a).(1): The program director must be a role model of professionalism.

Examples of linking professionalism values to specific behaviors:

Values	Behaviors
Responsibility	• Follows through on tasks • Arrives on time
Maturity	• Accepts blame for failure • Does not make inappropriate demands • Is not abusive and critical in times of stress
Communication Skills	• Listens well • Is not hostile, derogatory, sarcastic • Is not loud or disruptive
Respect	• Maintains patient confidentiality • Is patient • Is sensitive to physical/emotional needs • Is not biased/discriminatory

Jim Wagner, The University of Texas Southwestern Medical School in Kirk L Professionalism in medicine: definitions and considerations for teaching. Bayl Univ Med Cent, 2007; 20:13-16

Below is an example of a form used for the evaluation of professionalism. The checklist was created by the American Academy of Pediatrics. The ACGME does not require the use of this form.

Evaluation of Professionalism – American Academy of Pediatrics

Components of Professionalism	Meets Expectations	Needs Improvement	Cannot Assess
1. Honesty/Integrity Is truthful with patients, peers, and in professional work (e.g. documentation, communication, presentations, research)	☐	☐	☐
2. Reliability/responsibility Is accountable to patients and colleagues. Can be counted on to complete assigned duties and tasks. Accepts responsibility for errors.	☐	☐	☐
3. Respectful of others Talks about and treats all persons with respect and regard for their individual worth and dignity. Is fair and non-discriminatory. Routinely inquires about or expresses awareness of the emotional, personal, family, and cultural influences on patient well-being and their rights and choices of medical Care; is respectful of other members of the health care team. Maintains confidentiality.	☐	☐	☐
4. Compassion/empathy Listens attentively and responds humanely to patient's and family members' concerns; provides appropriate relief of pain, discomfort or anxiety.	☐	☐	☐
5. Self-improvement Regularly contributes to patient care in educational conferences with information from current professional literature, seeks to learn from errors, aspires to excellence through self-evaluation and acceptance of the critiques of others.	☐	☐	☐
6. Self-awareness/knowledge of limits Recognizes need for guidance and supervision when faced with new or complex responsibility; Is thoughtful of the impact of one's behavior on others and cognizant of appropriate professional boundaries.	☐	☐	☐
7. Communication/collaboration Works cooperatively and communicates effectively to achieve common patient care and educational goals of all involved health care providers.	☐	☐	☐
8. Altruism/advocacy Adheres to best interest of the patient; puts best interest of the patient above self interest and the interest of other parties.	☐	☐	☐

Reference:

Brownell AKW and Cote Luc: Senior Residents' Views on the Meaning of Professionalism and How They Learn About it. Acad Med, 2001; 76:734-737
> More than 90 percent of the residents surveyed stated that contact with positive role models was their preferred method of learning about professionalism.

The requirements for Professionalism competencies are specialty specific. For a particular specialty, refer to the Program Requirements and FAQs and Applications page of the specialty section on the ACGME website.

In addition, milestones are used to assess the progression of a resident in specific competencies. To access a specific set of milestones, click on the link below:

https://www.acgme.org/Specialties

Select the specialty, and click on the "Milestones" on the right-handed menu on the page, and select from the list of milestones.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

IV.B.   ACGME Competencies

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

Background and Intent: Quality patient care is safe, effective, timely, efficient, patient-centered, equitable, and designed to improve population health, while reducing per capita costs. (See the Institute of Medicine [IOM]'s *Crossing the Quality Chasm: A New Health System for the 21st Century*, 2001 and Berwick D, Nolan T, Whittington J. *The Triple Aim: care, cost, and quality. Health Affairs.* 2008; 27(3):759-769.). In addition, there should be a focus on improving the clinician's well-being as a means to improve patient care and reduce burnout among residents, fellows, and practicing physicians.

These organizing principles inform the Common Program Requirements across all Competency domains. Specific content is determined by the Review Committees with input from the appropriate professional societies, certifying boards, and the community.

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

                            [The Review Committee must further specify]

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

                            [The Review Committee may further specify]

GUIDANCE

The requirements for Patient Care and Procedural Skills competencies are specialty specific. For a particular specialty, refer to the Program Requirements and FAQs and Applications page of the specialty section on the ACGME website.

In addition, milestones are used to assess the progression of a resident in specific competencies. To access a specific set of milestones, click on the link below:

https://www.acgme.org/Specialties

Select the specialty, and click on the "Milestones" on the right-handed menu on the page, and select from the list of milestones.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

IV.B.   ACGME Competencies

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)

[The Review Committee must further specify]

GUIDANCE

The requirements for Medical Knowledge competencies are specialty specific. For a particular specialty, refer to the Program Requirements and FAQs and Applications page of the specialty section on the ACGME website.

For example, this link brings you to the Emergency Medicine section of the ACGME website: https://www.acgme.org/Specialties/Overview/pfcatid/7.

From here, click on "Program Requirements and FAQs and Applications" in the right-hand menu, and then on the Program Requirements document under the "Currently in Effect" header. There are detailed lists of curricular elements, the types of didactics, and resident experience.

The requirements for Patient Care and Procedural Skills competencies are specialty specific. In addition, milestones are used to assess the progression of a resident in specific competencies. To access a specific set of milestones, click on the link below:

https://www.acgme.org/Specialties

Select the specialty, and click on the "Milestones" on the right-handed menu on the page, and select from the list of milestones.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

IV.B.   ACGME Competencies

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)

> 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.

IV.B.1.d).(1)   Residents must demonstrate competence in:

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

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

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

IV.B.1.d).(1).(d)   systematically analyzing practice using quality improvement methods, and implementing changes with the goal of practice improvement; (Core)

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

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

IV.B.1.d).(1).(g)   using information technology to optimize learning. (Core)

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

GUIDANCE

The Competency of Practice-based Learning and Improvement is best developed in an environment that provides residents with enough information to investigate and evaluate the care of their patients. The environment needs to support open and honest attempts to improve, and not punish errors or mistakes as personal weakness.

To identify strengths, deficiencies, and limitations, residents should learn to self-reflect to answer the question: How can I improve care for my patients? This may include single patients, such as at a case conference during which residents present on individual patients they have cared for, and reflect on how they may improve on that care for a similar patient in the future. A more systematic approach requires residents to receive information about the outcomes of their care for a larger sample of their patients. This information may show how a resident follows a specific protocol or clinical guideline for a defined group of patients. Examples include the number of patients who receive certain care in a sepsis bundle, or the complication rate for a certain procedure. It is not required that each resident have a personal project, but some measures may require institutional assistance to tie the activity to a larger departmental goal.

Learning and improvement goals can be formulated after a resident determines what to improve and may follow a deliberate process like a "Plan-Do Study-Act" cycle under the guidance of a faculty member to systematically analyze the resident's practice. This may be performed in conjunction with the ongoing quality improvement efforts of the Sponsoring Institution.

Residents constantly receive feedback and suggestions. They may wish to target a certain behavior for improvement over the course of a month, or try out suggestions for improvement, and consider how to analyze and incorporate these improvements into practice.

Locating and assimilating evidence may occur while a resident is preparing for upcoming case presentations, or during the actual care of a patient using a Cochrane review or a PubMed search or other clinical references. A resident may need to learn how an individual patient's circumstances fits into the larger knowledge base, and how to use published literature to fit the scenario. This may incorporate activities such as literature review for case conferences or journal club where critical review of literature is demonstrated and learned.

The requirements for Practice-Based Learning and Improvement competencies are specialty specific. For a particular specialty, refer to the Program Requirements and FAQs and Applications page of the specialty section on the ACGME website.

In addition, milestones are used to assess the progression of a resident in specific competencies. To access a specific set of milestones, click on the link below:

https://www.acgme.org/Specialties

Select the specialty, and click on the "Milestones" on the right-handed menu on the page, and select from the list of milestones.

RESOURCES

1. "Practice-Based Learning and Improvement: ACGME Core Competencies." 2016. NEJM Knowledge . November 18, 2016. https://knowledgeplus.nejm.org/blog/practice-based-learning-and-improvement/.

   A description of why practice-based learning is important and how it fits into lifelong learning.

2. "Practice-Based Learning - ACGME Competencies." n.d. University of Maryland Medical Center. https://www.umms.org/ummc/pros/gme/acgme-competencies/practice-based-learning.

   An example of the resources compiled at one institution to address practice-based learning and the key components of:
   - Life-long learning and practice improvement (self-reflection)
   - Appraisal and assimilation of scientific literature (EBM)
   - Able to implement quality improvement
   - Actively participate in the education of others

3. Bernabeo, Elizabeth, Sarah Hood, William Iobst, Eric Holmboe, and Kelly Caverzagie. 2013. "Optimizing the Implementation of Practice Improvement Modules in Training: Lessons from Educators." *Journal of Graduate Medical Education* 5 (1): 74–80. https://doi.org/10.4300/jgme-d-11-00281.1.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

IV.B.   ACGME Competencies

IV.B.1.e)   Interpersonal and Communication Skills

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

IV.B.1.e).(1)   Residents must demonstrate competence in:

IV.B.1.e).(1).(a)   communicating effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; (Core)

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

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

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

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

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

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)

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

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.

GUIDANCE

The ability to communicate is one of the basic tenets of the physician-patient relationship, and an important component of professionalism. Yet, education related to communication skills is frequently neglected. Apart from medical knowledge and the ability to provide good patient care, the physician needs communication skills in many aspects of their practice.

1. The physician and the patient:
   a. History taking and physical examination – ability to elicit pertinent information, and the capacity to listen attentively to what a patient/family member has to say.
   b. Explaining medical information, such as diagnosis, complications, and treatment (surgical and medical).
   c. Instructions related to prescriptions: we are all too familiar with patients taking medications incorrectly because of inadequate instructions.
   d. Delivering bad news
   e. Discharge instructions
   f. Sensitivity to different cultural and socioeconomic backgrounds
   g. Respect for privacy and confidentiality
   h. Obtaining informed consent for procedures or study participation
   i. End-of-life decisions
2. Physician to physician or other health care workers:
   a. Consultations
   b. Sign-outs
   c. Patient transfers
3. Written and other communication
   a. Medical records
   b. Procedure notes
   c. Consults
   d. Transfers
   e. Lectures and presentations

It is well known that good communication skills improve patient satisfaction and treatment adherence, and reduce medication errors. There has been a significant increase in teaching communication skills in medical school and residency programs. Many of the models focus on several aspects of communication:

- skills-based: word usage, approach to patients and families
- content-based: patient interviewing, obtaining informed consent
- advanced encounters: delivering bad news, disclosing medication errors
- interaction-focused: physician-patient and/or physician-family; interprofessional

Techniques used to teach interpersonal and communication skills include:

- Role play
- Standardized patients
- Simulation
- Real-life experiences such as during mortality/morbidity review

References:

1. Peterson, Eleanor B., Kimberly A. Boland, Kristina A. Bryant, Tara F. Mckinley, Melissa B. Porter, Katherine E. Potter, and Aaron W. Calhoun. 2016. "Development of a Comprehensive Communication Skills Curriculum for Pediatrics Residents." *Journal of Graduate Medical Education* 8 (5): 739–46. https://doi.org/10.4300/jgme-d-15-00485.1.
2. Sullivan, Amy M, Laura K Rock, Nina M Gadmer, Diana E Norwich, and Richard M. Schwartzstein. 2016. "The Impact of Resident Training on Communication with Families in the ICU: Resident and Family Outcomes." *Annals of the American Thoracic Society*. https://doi.org/10.1513/annalsats.201508-495oc.
3. Wild, Dorothea, Haq Nawaz, Saif Ullah, Christina Via, William Vance, and Paul Petraro. 2018. "Teaching Residents to Put Patients First: Creation and Evaluation of a Comprehensive Curriculum in Patient-Centered Communication." *BMC Medical Education* 18 (1). https://doi.org/10.1186/s12909-018-1371-3.

While many of the efforts in teaching communication skills are successful, there is evidence that success also depends on human variables. The ability to develop effective communication skills is dependent of a number of human factors. These include:

- Individual characteristics: sociodemographic, professional and personal experiences, health, burnout, depersonalization, ability to cope, psychological characteristics and technological demands
- Contextual characteristics: professional and personal environments
- Pre-training communication skills

Reference: Bragard, Isabelle, Isabelle Merckaert, Yves Libert, Nicole Delvaux, Anne-Marie Etienne, Serge Marchal, Christine Reynaert, Darius Razavi: Communication Skills Training for Residents: Which Variables Predict Learning of Skills? Open J Med Psychol, 2012; 1:68-75.

Some patient comments regarding negative communication experiences:

"I wish he would face me instead of the computer"

"She seemed in a hurry, and did not have time to listen to my fears about the surgery"

"He seemed to be hiding something when he told me about the medication mistake"

"I felt like I did not matter, my concerns were ignored"

"He seemed in a hurry to pull the plug on my dad, so he could get on to the next task"

Below is an example of Internal Medicine Subspecialty Milestones evaluation of Interpersonal and Communication Skills

https://www.acgme.org/Portals/0/PDFs/Milestones/InternalMedicineSubspecialtyMilestones.pdf?ver=2015-11-06-120527-673

Version 10/2014   Internal Medicine Subspecialty Milestones: ACGME Report Worksheet

21. Communicates effectively with patients and caregivers. (ICS1)

Not Yet Assessable	Critical Deficiencies			Ready for unsupervised practice	Aspirational
	Ignores patient preferences for plan of care Makes no attempt to engage patient in shared decision-making Routinely engages in antagonistic or counter-therapeutic relationships with patients and caregivers	Engages patients in discussions of care plans and respects patient preferences when offered by the patient, but does not actively solicit preferences Attempts to develop therapeutic relationships with patients and caregivers but is inconsistently successful Defers difficult or ambiguous conversations to others	Engages patients in shared decision-making in uncomplicated conversations Requires assistance facilitating discussions in difficult or ambiguous conversations Requires guidance or assistance to engage in communication with persons of different socioeconomic and cultural backgrounds	Identifies and incorporates patient preference in shared decision-making in complex patient care conversations and the plan of care Quickly establishes a therapeutic relationship with patients and caregivers, including persons of different socioeconomic and cultural backgrounds	Role-models effective communication and development of therapeutic relationships in both routine and challenging situations Models cross-cultural communication and establishes therapeutic relationships with persons of diverse socioeconomic and cultural backgrounds Assists others with effective communication and development of therapeutic relationships
☐	☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐

Comments:

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

IV.B.   ACGME Competencies

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

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

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

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

> Background and Intent: Medical practice occurs in the context of an increasingly complex clinical care environment where optimal patient care requires attention to compliance with external and internal administrative and regulatory requirements.

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

> Background and Intent: Every patient deserves to be treated as a whole person. Therefore it is recognized that any one component of the health care system does not meet the totality of the patient's needs. An appropriate transition plan requires coordination and forethought by an interdisciplinary team. The patient benefits from proper care and the system benefits from proper use of resources.

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

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

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

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

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

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

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

GUIDANCE

Physicians are increasingly dependent on the health care system to support their patients, and need to optimize this system for the benefit of their patients. At the same time, physicians can significantly influence the health care system to ensure appropriate support for patients and their families. During residency and fellowship, most residents and fellows work passively in these settings, but their curriculum must provide education on how they can actively and positively impact the system in future practice. Residents and fellows should be prepared to answer the question: How can I help to improve the system of care?

There are many ways residents and fellows can participate in specialty-specific didactics or discussions regarding their practice environment or institution-wide, multi-specialty, or multi-disciplinary discussions. Residents may participate in one or more intuitional or program committees seeking to address health care system issues. The learning activities can be longitudinal or as part of regularly scheduled workshops.

RESOURCES

1. "Systems-Based Practice: ACGME Core Competencies (Part 4 of 7)." 2016. NEJM Knowledge . November 18, 2016. https://knowledgeplus.nejm.org/blog/acgme-core-competencies-systems-based-practice/.

2. Christopher Nabors, Stephen J. Peterson, Roger Weems, Leanne Forman, Arif Mumtaz, Randy Goldberg, Kausik Kar, Joseph A. Borges, Ida Doctor, Orpha Lubben, Nisha Pherwani, William H. Frishman, (*2011*) A Multidisciplinary Approach for Teaching Systems-Based Practice to Internal Medicine Residents. Journal of Graduate Medical Education: March 2011, Vol. 3, No. 1, pp. 75-80.https://doi.org/10.4300/JGME-D-10-00037.1

3. Johnson, Julie K, Stephen H Miller, and Sheldon D Horowitz. 2008. "Systems-Based Practice: Improving the Safety and Quality of Patient Care by Recognizing and Improving the Systems in Which We Work." In *Advances in Patient Safety: New Directions and Alternative Approaches (Vol. 2: Culture and Redesign)*. Vol. 2. Rockville, MD: Agency for Healthcare Research and Quality (US). https://www.ncbi.nlm.nih.gov/books/NBK43731/#_ncbi_dlg_citbx_NBK43731

4. Wachtel, Ruth E. and Franklin Dexter. "Curriculum Providing Cognitive Knowledge and Problem-Solving Skills for Anesthesia Systems-Based Practice." *Journal of Graduate Medical Education* 2, no. 4, (2010) 624-632. https://doi.org/10.4300/JGME-D-10-00064.1

The requirements for Systems-Based Practice competencies are specialty specific. For a particular specialty, refer to the Program Requirements and FAQs and Applications page of the specialty section on the ACGME website.

In addition, milestones are used to assess the progression of a resident in specific competencies. To access a specific set of milestones, click on the link below:

https://www.acgme.org/Specialties

Select the specialty, and click on the "Milestones" on the right-handed menu on the page, and select from the list of milestones.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

IV.C.   Curriculum Organization and Resident Experiences

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

                 [The Review Committee must further specify]

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

GUIDANCE

Curriculum content and organization and resident experiences are specialty specific. Programs are required to optimize all educational experiences, the length of the experiences, supervision, and evaluation.

The requirements for curricular content and resident experiences are specialty specific. For a particular specialty, refer to the Program Requirements and FAQs and Applications page of the specialty section on the ACGME website.

From the specialty's Overview page, click on "Program Requirements and FAQs and Applications" in the right-hand menu, then click on the Program Requirements document under the "Currently in Effect" header. The curricular elements and required residency experiences for the residency program are provided in detail.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

IV.   Educational Program

IV.C.   Curriculum Organization and Resident Experiences

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

         [The Review Committee may further specify]

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

GUIDANCE

The education of residents, fellows, and faculty members in prescribing opioids for chronic pain must include the multiple facets of therapy, and not focus on a single aspect of therapy. The importance of this overall approach is best summarized by the introductory paragraph of the Centers for Disease Control and Prevention (CDC) guideline for prescribing opioids for chronic pain:

> Centers for Disease Control and Prevention
> Morbidity and Mortality Weekly Report
> Recommendations and Reports. Vol 65/No. 1, March 18, 2016
> Dowell D, Haegerich TM and Chou R: Division of Unintentional Injury Prevention
> National Center for Injury prevention and Control, CDC, Atlanta, Georgia
>
> CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016
>
> The guideline provides recommendations for primary care clinicians who are prescribing opioids for chronic pain *outside of active cancer treatment, palliative care, and end-of-life care.*
>
> The CDC guideline addresses:
> 1. When to initiate or continue opioids for chronic pain;
> 2. Opioid selection, dosage, duration, follow-up, and discontinuation; and
> 3. Assessing risk and addressing harms of opioid use.
>
> CDC developed the guideline using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) framework and recommendations are made on the basis of a systematic review of the scientific evidence while considering benefits and harms, values and preferences, and resource allocation. CDC obtained input from experts, stakeholders, the public, peer reviewers, and a federally chartered advisory committee. It is important that patients receive appropriate pain treatment with careful consideration of the benefits and risks of treatment options. This guideline is intended to improve communication between clinicians and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder, overdose, and death. CDC has provided a checklist for prescribing opioids for chronic pain (Http://stacks.cdc.gov/view/cdc/38025) as well as a website (http://www.cdc.gov/drugoverdose/prescribingresources.html) with additional tools to guide clinicians in implementing the recommendation.
>
> The CDC has extensive recommendations for opioid describing that can be used as a basis for pain treatment curriculum in residency and fellowship education. In summary, the following recommendations for prescribing opioids for chronic pain:

Determining When to Initiate or Continue Opioids for Chronic Pain

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

Assessing Risk and Addressing Harms of Opioid Use

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

At the American Academy of Family Physicians Symposium on March 23-27, 2018 (https://www.aafp.org/events/pdw-rps.html), Dr. Tim Munzing asked:

"What are the things that are vitally important when we're seeing patients, and what can we teach our residents to help them when they are considering prescribing opioids or other controlled substances?"

Dr. Munzing further pointed out there are universal precautions for opioid prescribing:

- Evaluate the need
- Assess the risk
- Select the specific opioid treatment
- Discuss with the patient, get a written agreement and informed consent
- Monitor the patient closely
- Document thoroughly

At the same symposium, Dr. Kara Cummins emphasized a number of red flags that prescribers of opioids should look for, including:

- Early refills
- Medications greater than 100 mg/day
- Multiple concurrent prescribers
- Multiple pharmacies
- Drug combinations such as an opioid, a benzodiazepine and carisoprodol
- Escalating dosing by the prescriber
- Escalating prescriptions by the patient
- Patients driving a long way for an office visit when there is a doctor down the street.
- Multiple family members on the same opiate medication, especially when it is the husband and wife.

Dr. Cummins noted that the education of residents on opioid prescribing should become "part of the DNA of our teaching programs," Adding that the pain management curriculum must include:

- Didactic lectures
- Specific modules that residents have to complete
- Chart reviews and small-group discussions about difficult patients

The ACGME suggests that the education of residents, fellows, and faculty members regarding opioid prescribing should not be limited to a one-time didactic lecture. This education should be woven into the fabric of residency and fellowship education and training. Below are suggested references for curriculum development, including the CDC guidelines for prescribing opioids for chronic pain.

1. [CDC Guidelines for Prescribing Opioids for Chronic Pain in the United States, 2016](#)

The CDC guidelines (linked above) for prescribing opioids provide comprehensive information, including background, suggestions, rationale, and review of the literature, as well as recommendations for education of physicians.

2. [Caution: Avoid abrupt decrease or discontinuation of prescribed opioids](#)

The FDA identifies harm reported from sudden discontinuation of opioid pain Medicines, and requires label changes to guide prescribers on gradual, individualized tapering. April 9, 2019.

3. [Medications for Opioid Use Disorder. Treatment Improvement Protocol (TIP) 63. SAMHSA, 2018](#)

This guide provides comprehensive overview and guidance on issues related to Opioid Use Disorder: signs and symptoms; diagnostic criteria; co-occurrence with other

substance use disorders; and prevention and treatment, including opioid withdrawal techniques, pharmacotherapies, tapering opioids, and non-pharmacologic interventions.

4. Tapering. Tapering prescribed opioid doses to safer levels, or to discontinuation. For patients who need either less opioid medication, or for whom the risk of opioid pharmacotherapy is too great, consideration of a patient-centered tapering protocol may be an appropriate alternative to dose continuation or pharmacotherapy for an associated Opioid Use Disorder.

5. Articles of Interest

Lembke , Anna, Keith Humphreys , and Jordan Newmark. "Weighing the Risks and Benefits of Chronic Opioid Therapy." *American Family Physician* 93, no. 12 (June 16, 2016): 982-90. https://www.ncbi.nlm.nih.gov/pubmed/27304767

Salsitz, Edwin A. "Chronic Pain, Chronic Opioid Addiction: a Complex Nexus." *Journal of Medical Toxicology* 12, no. 1 (2015): 54-57. https://doi.org/10.1007/s13181-015-0521-9.

6. The ACGME-Accredited Multidisciplinary Subspecialty of Addiction Medicine

The ACGME Program Requirements for Graduate Medical Education in Addiction Medicine (subspecialty) provide detailed curricular elements related to medical knowledge and patient care that might be useful in defining curricular and didactic substance use disorder experiences for residents and fellows.

What does this mean for graduate medical education?

•   Our graduates will be the prescribers of opioids for the next 40 years.
•   Each of us must be part of the solution.
•   Clinical learning environments must use protocols and procedures that are:

    •   evidence-based
    •   customized to the needs of the clinical disorders of the populations served
    •   effective in teaching residents how to:

        •   prevent addiction wherever possible while effectively treating pain
        •   recognize addiction in its earliest stages
        •   function effectively in systems of care for effective pain relief as well s addiction treatment
        •   use non-pharmacologic means wherever possible
        •   participate in clinical trials of new non-opioid pain relief

Videos available free online:

Stanford University Online CME Courses

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

IV.D.   Scholarship

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

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

IV.D.1.   Program Responsibilities

IV.D.1.a)   The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)

IV.D.1.b)   The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities. (Core)

[The Review Committee may further specify]

IV.D.1.c)   The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. (Core)

Background and Intent: The scholarly approach can be defined as a synthesis of teaching, learning, and research with the aim of encouraging curiosity and critical thinking based on an understanding of physiology, pathophysiology, 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.

GUIDANCE

IV.D.2. and IV.D.3 Faculty and Resident Scholarly Activity

In addition to the guidance on faculty member and resident scholarly activity, this section provides some guidance for program responsibilities related to scholarship.

IV.D.1. Program Responsibilities

IV.D.1.a) ***The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims***. While it certainly can, scholarly activity does not always mean basic science research. The program must determine what its missions and aims are, and match scholarly activities accordingly. For example, a program located in a rural environment may want to focus on meeting the needs of the community, and advance scholarly efforts on quality improvement measures that would benefit the people it serves. On the other hand, a large cancer center in an urban institution may want to recruit faculty members and residents whose primary research focus is in a basic science laboratory.

IV.D.1.b) Resources to facilitate resident and faculty member involvement in scholarly activities depend on the type of scholarship activities. For example, the work taking place in a basic science laboratory or the conduct of large clinical trials may need significant personnel, laboratory, and other resources. There are many scholarly activities that might not require such resources. One important universal factor in providing resources is time. Faculty members and residents and fellows may need protected time away from clinical activities to spend on scholarly activity.

IV.D.1.c) This requirement is explained by what is stated in the 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.*

The scholarly approach does not always mean involvement in basic science research. The intent is to create an environment of scholarship to encourage critical thinking in providing patient care. For example, discussing the rationale for a new and expensive therapeutic option; discontinuing a "popular" treatment option based on evidence it provides no benefits; adapting an approach to early discontinuation of central venous catheters or bladder catheters when these devices are no longer essential for the care of the patient; or the judicious use of antibiotics. These scholarly approaches are all designed to instill curiosity and critical thinking in patient care. There is evidence that fostering this mindset in residents and fellows during residency and fellowship implants lifelong habits that persevere 40 to 50 years after graduation from the program.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

IV.   Educational Program

IV.D.   Scholarship

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

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

IV.D.2.   Faculty Scholarly Activity

IV.D.2.a)   Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core)

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

- Contribution to professional committees, educational organizations, or editorial boards
- Innovations in education

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

[Review Committee will choose to require either IV.D.2.b).(1) or both IV.D.2.b).(1) and IV.D.2.b).(2)]

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)

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.

The requirement for faculty scholarship is closely linked to the program responsibility of ensuring that the residents and fellows are provided with a scholarly environment (as listed below in IV.D.1.and IV.D.1.a)-c))**.**

IV.D.1.   Program Responsibilities

IV.D.1.a)   The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)

IV.D.1.b)   The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities. (Core)

IV.D.1.c)   The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. [Core]

> Background and Intent: The scholarly approach can be defined as a synthesis of teaching, learning, and research with the aim of encouraging curiosity and critical thinking based on an understanding of physiology, pathophysiology, 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.

GUIDANCE

What does the faculty scholarly activity template look like in the Accreditation Data System (ADS)?

NOTE that the ADS format may change to match the changes in the Common Program Requirements.

Below are examples of screens showing where to enter faculty members' scholarly activities.

Anesthesiology - Chicago, IL

‹ Back To Faculty Scholarly Activity

Edit Scholarly Info for Elton John MBBS   ✖ Cancel

Did Elton John MBBS have Scholarly Activity for academic year 2018 - 2019:
◉ Yes
◯ No

Pub Med IDs
Pub Med Ids (assigned by PubMed) for articles published between 7/1/2018 and 6/30/2019. Pub Med ID (PMID) is an unique number assigned to each PubMed record. The PubMed Central reference number (PMCID) is different from the PubMed reference number (PMID). PubMed Central is an index of full-text papers, while PubMed is an index of abstracts.

PMID 1	PMID 2	PMID 3	PMID 4
Osteopathic Focused	Osteopathic Focused	Osteopathic Focused	Osteopathic Focused

Other Publications
Number of articles without PMIDs, non-peer reviewed publications, peer-reviewed publications which are not recognized by the National Library of Medicine, and activities related to item-writing (eg. board examination questions) between 7/1/2018 and 6/30/2019 that incorporated osteopathic medicine.

Conference Presentations
Number of abstracts, posters, and presentations at international, national, state, or regional meetings between 7/1/2018 and 6/30/2019 that incorporated osteopathic medicine.

Other Presentations
Number of other presentations (grand rounds, invited professorships), materials developed (such as computer-based modules) between 7/1/2018 and 6/30/2019 that incorporated osteopathic medicine.

Edit Scholarly Info for Elton John MBBS   ✖ Cancel

Chapters / Textbooks

Number of chapters or textbooks published between 7/1/2018 and 6/30/2019 that incorporated osteopathic medicine

[   ]

Grant Leadership

Number of grants for which faculty member had a leadership role (PI, Co-PI, or site director) between 7/1/2018 and 6/30/2019 that incorporated osteopathic medicine.

[   ]

Leadership or Peer Review Role

Active leadership role (such as serving on committees or governing boards) in international, national, state, or regional medical organizations or served as reviewer or editorial board member for a peer-reviewed journal between 7/1/2018 and 6/30/2019 that incorporated osteopathic medicine.

◉ Yes
○ No

Formal Courses

Responsible for seminars, conference series, or course coordination (such as arrangement of presentations and speakers, organization of materials). This includes developing training modules for medical students, residents, fellows and other health professionals (eg. simulation). Program didactics and/or conferences are not considered formal courses between 7/1/2018 and 6/30/2019 that incorporated osteopathic medicine.

○ Yes
◉ No

Domains

Which of the following domains has this faculty member demonstrated accomplishments in the previous academic year?

Response Required

☐ 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-analysis, 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
☐ None of the above

⌃ back to top

Note: The list and instructions below for faculty members' scholarly activities are from a table in ADS:

Faculty Scholarly Activity:

PubMedIDs: (Enter up to 4) Pub Med Ids (assigned by PubMed) for articles published between 7/1/XXXX and 6/30/YYYY. Pub Med ID (PMID) is a unique number assigned to each PubMed record. The PubMed Central reference number (PMCID) is different from the PubMed reference number (PMID). PubMed Central is an index of full-text papers, while PubMed is an index of abstracts.

Other Publications: Number of articles without PMIDs, non-peer reviewed publications, peer-reviewed publications which are not recognized by the National Library of Medicine, and activities related to item-writing (eg. board examination questions) between 7/1/XXXX and 6/30/YYYY.

Conference Presentations: Number of abstracts, posters, and presentations at international, national, state, or regional meetings between 7/1/XXXX and 6/30/YYYY.

Other Presentations: Number of other presentations (grand rounds, invited professorships), materials developed (such as computer-based modules) between 7/1/XXXX and 6/30/YYYY.

Chapters/Textbooks: Number of chapters or textbooks published between 7/1/XXXX and 6/30/YYYY.

Grant Leadership: Number of grants for which faculty member had a leadership role (PI, Co-PI, or site director) between 7/1/XXXX and 6/30/YYYY.

Leadership or Peer-Review Role: Active leadership role (such as serving on committees or governing boards) in international, national, state, or regional medical organizations or served as reviewer or editorial board member for a peer-reviewed journal between 7/1/XXXX and 6/30/YYYY.

Formal Courses: Responsible for seminars, conference series, or course coordination (such as arrangement of presentations and speakers, organization of materials). This includes developing training modules for medical students, residents, fellows and other health professionals (eg. simulation). Program didactics and/or conferences are not considered formal courses between 7/1/XXXX and 6/30/YYYY.

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[Avoiding Common Errors in the ADS Annual Update-Entering Scholarly Activity into ADS Video](#)

Scholarly activity demonstrates to the Review Committees that:

• faculty members have the skills to analyze and utilize new knowledge
• the program has the ability to teach those skills to residents and fellows
• an environment of scholarship exists in the program

"Education must prepare students to be independent, self-reliant human beings. But education, at its best, also must help students go beyond their private interests, gain a more integrative view of knowledge, and relate their learning to the realities of life."

-Ernest Boyer

An environment of scholarship:

• Leads to the creation of new knowledge
• Encourages lifelong learning
• Creates a mindset of inquiry
    ○ Might reduce "jumping on any bandwagon that comes along"
    ○ Mindful practice: for example – antibiotic stewardship, infection control, and careful consideration of new (and expensive) drugs before use

Boyer's Models of Scholarship:

• The scholarship of *DISCOVERY*
    • Traditional definition: research
    • Search for new knowledge
    • Discovery of new information and new models
    • Sharing discoveries through scholarly publication

• The scholarship of *INTEGRATION*
    • Integration of knowledge from different sources
    • Presents overview of findings in a resource topic
    • Bringing findings together from different disciplines to discover convergence
    • Identify trends and see knowledge in new ways
    • Examples: professional development workshops, literature reviews, meta-analysis, quality improvement projects.

• The scholarship of *APPLICATION*
    • Discovering ways that new knowledge can be used to solve real world problems
    • New intellectual problems can arise out of the very act of application
    • Examples: translational research, development of community activities that link with academic work, development of centers for study or service, quality improvement projects

- The scholarship of *TEACHING*
    - Search for innovative approaches and best practices to develop skills and disseminate knowledge
    - Examples: courses; innovative teaching materials; educational research; instructional activities; publication of books or other teaching materials; quality improvement projects; digital scholarship, including open education resources (Massively Open Online Course or MOOCs, Khan Academy, digital publishing and providing courses in Blackboard®, Bridge®, and Moodle®)

While there is undeniable value of scholarly activity, such as the publication of peer-reviewed journal articles, and presentation of basic science research at national conferences, other activities are equally valuable. Scholarship is not for its own sake, but as a proxy for the creation of a clinical learning environment that encourages an environment of inquiry and an evidence-based, scholarly approach to patient care.

As stated in the philosophical statement above, the following bears repeating:

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 life-long learning. The program and its faculty must create an **environment** *that fosters the acquisition of such skills through resident/fellow participation in scholarly activities.*

And…

It is expected that **a program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves**. *For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while others might use more classic forms of biomedical research as the focus for scholarship.*

It is important to share that the Common Program Requirements Task Force considered this requirement at length and concluded that "one size does not fit all." There is wide variability in programs and the communities they serve, and the Review Committees should consider this difference when evaluating programs. For example, a program that exists in a remote, rural community might want to focus on primary care training, and may not want, or may not have the resources, to put together a million-dollar laboratory to study some characteristics of a murine model of disease. Instead, it may want to focus its efforts on improving vaccination rates, or increasing compliance with diabetes care, or determining how to deal with an opioid epidemic in the community.

Two additional points:

1) The Review Committees have been asked to refrain from using FAQs to set the minima for scholarship requirements.

2) If a program sends its residents to a one-month rotation at a participating site where faculty members produce a large amount of scholarly activity, it would be improper for the program to "claim" and list all the scholarly activities at that participating site. Doing so does not meet substantial compliance with the requirement to create an environment of scholarship. The idea behind this requirement is that residents and fellows be "immersed" in this environment of scholarship and inquiry throughout their educational programs. Therefore, scholarly activity listed should be from the primary clinical site.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

IV.   Educational Program

IV.D.   Scholarship

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

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

IV.D.3.   Resident Scholarly Activity

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

              [The Review Committee may further specify]

> 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. <u>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</u>, 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.

The requirement for faculty scholarship is closely linked to the program responsibility of ensuring that the residents and fellows are provided with a scholarly environment (as listed below in IV.D.1.and IV.D.1.a)-c))**.**

IV.D.1.   Program Responsibilities

IV.D.1.a)   The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)

IV.D.1.b)   The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities. (Core)

IV.D.1.c)   The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. (Core)

Background and Intent: The scholarly approach can be defined as a synthesis of teaching, learning, and research with the aim of encouraging curiosity and critical thinking based on an understanding of physiology, pathophysiology, 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.

GUIDANCE

What does the resident scholarly activity template look like in the Accreditation Data System (ADS)?

NOTE that the ADS format may change to match the changes in the Common Program Requirements.

Below are examples of screens showing where to enter residents' scholarly activities.

Anesthesiology - Chicago, IL

‹ Back To Resident Scholarly Activity

Edit Scholarly Info for Hey Tumaku ✖ Cancel

Did Hey Tumaku have Scholarly Activity for academic year 2018 - 2019:

◉ Yes
○ No

Pub Med IDs

Pub Med Ids (assigned by PubMed) for articles published between 7/1/2018 and 6/30/2019. List up to 3. Pub Med ID (PMID) is an unique number assigned to each PubMed record. This is generally an 8 character numeric number. The PubMed Central reference number (PMCID) is different from the PubMed reference number (PMID). PubMed Central is an index of full-text papers, while PubMed is an index of abstracts. *If this resident is Osteopathic Designated, use the checkboxes (if applicable) to indicate an article that was focused on osteopathic medicine.*

PMID 1	PMID 2	PMID 3

Other Publications

Number of articles without PMIDs, non-peer reviewed publications, peer-reviewed publications which are not recognized by the National Library of Medicine, and activities related to item-writing between 7/1/2018 and 6/30/2019

The Other Publications Field is Required.

Conference Presentations

Number of abstracts, posters, and presentations given at international, national, or regional meetings between 7/1/2018 and 6/30/2019

The Conference / Presentations Field is Required.

Chapters / Textbooks

Number of chapters or textbooks published between 7/1/2018 and 6/30/2019

[   ]

The Chapters/Textbooks Field is Required.

Participated in Research

Participated in funded or non-funded basic science or clinical outcomes research project between 7/1/2018 and 6/30/2019

○ Yes
○ No

Please select Yes or No.

Teaching / Presentations

Lecture, or presentation (such as grand rounds or case presentations) of at least 30 minute duration within the sponsoring institution or program between 7/1/2018 and 6/30/2019

○ Yes
○ No

Please select Yes or No.

⌃ back to top

Resident Scholarly Activity Template:

- Provide the information
- If there are no activities in a particular column, say so – do not leave blank
- Note the information requested is for ONE YEAR

Note: The list and instructions below for residents' scholarly activities are from a table in ADS.

Resident/Fellow Scholarly Activity:

PubMedIDs: (Enter up to 3) Pub Med Ids (assigned by PubMed) for articles published between 7/1/XXXX and 6/30/YYYY. List up to 3. Pub Med ID (PMID) is a unique number assigned to each PubMed record. This is generally an 8 character numeric number. The PubMed Central reference number (PMCID) is different from the PubMed reference number (PMID). PubMed Central is an index of full-text papers, while PubMed is an index of abstracts. **IF APPLICABLE:** If this resident is Osteopathic Designated, use the checkboxes (if applicable) to indicate an article that was focused on osteopathic medicine.

Other Publications: Number of articles without PMIDs, non-peer reviewed publications, peer-reviewed publications which are not recognized by the National Library of Medicine, and activities related to item-writing between 7/1/XXXX and 6/30/YYYY.

Conference Presentations: Number of abstracts, posters, and presentations given at international, national, or regional meetings between 7/1/XXXX and 6/30/YYYY.

Chapters Textbooks: Number of chapters or textbooks published between 7/1/XXXX and 6/30/YYYY.

Participated in Research: Participated in funded or non-funded basic science or clinical outcomes research project between 7/1/XXXX and 6/30/YYYY.

Teaching Presentations: Lecture, or presentation (such as grand rounds or case presentations) of at least 30 minute duration within the sponsoring institution or program between 7/1/XXXX and 6/30/YYYY.

[Avoiding Common Errors in the ADS Annual Update-Entering Scholarly Activity into ADS Video](#)

Resident/fellow scholarly activity demonstrates to the Review Committees that:

- the program has the ability to teach scholarship activity skills to residents/fellows
- an environment of scholarship exists in the program

"Education must prepare students to be independent, self-reliant human beings. But education, at its best, also must help students go beyond their private interests, gain a more integrative view of knowledge, and relate their learning to the realities of life."

-Ernest Boyer

An environment of scholarship:

- Leads to the creation of new knowledge
- Encourages lifelong learning
- Creates a mindset of inquiry
    - Might reduce "jumping on any bandwagon that comes along"
    - Mindful practice: for example – antibiotic stewardship, infection control, and careful consideration of new (and expensive) drugs before use

Boyer's Models of Scholarship:

- The scholarship of *DISCOVERY*
    - Traditional definition: research
    - Search for new knowledge
    - Discovery of new information and new models
    - Sharing discoveries through scholarly publication

- The scholarship of *INTEGRATION*
    - Integration of knowledge from different sources
    - Presents overview of findings in a resource topic
    - Bringing findings together from different disciplines to discover convergence
    - Identify trends and see knowledge in new ways
    - Examples: professional development workshops, literature reviews, meta-analysis, quality improvement projects

- The scholarship of *APPLICATION*
    - Discovering ways that new knowledge can be used to solve real world problems
    - New intellectual problems can arise out of the very act of application
    - Examples: translational research, development of community activities that link with academic work, development of centers for study or service, quality improvement projects

- The scholarship of *TEACHING*
    - Search for innovative approaches and best practices to develop skills and disseminate knowledge
    - Examples: courses; innovative teaching materials; educational research; instructional activities; publication of books or other teaching materials; quality improvement projects; digital scholarship, including open education resources (Massively Open Online Course or MOOCs, Khan Academy, digital publishing and providing courses in Blackboard®, Bridge®, and Moodle®)

While there is undeniable value of scholarly activity, such as the publication of peer-reviewed journal articles, and presentation of basic science research at national conferences, other activities are equally valuable. Scholarship is not for its own sake, but as a proxy for the creation of a clinical learning environment that encourages an environment of inquiry and an evidence-based, scholarly approach to patient care.

As stated in the philosophical statement above, the following bears repeating:

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 life-long learning. The program and its faculty must create an environment that fosters the acquisition of such skills through resident/fellow participation in scholarly activities.

And…

*It is expected that **a program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves**. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while others might choose to use more classic forms of biomedical research as the focus for scholarship.*

It is important to share that the Common Program Requirements Task Force considered this requirement at length and concluded that "one size does not fit all." There is wide variability in programs and the communities they serve, and the Review Committees should consider this difference when evaluating programs. For example, a program that exists in a remote, rural community might want to focus on primary care training, and may not want, or may not have the resources, to put together a million-dollar laboratory

to study some characteristics of a murine model of disease. Instead, it may want to focus its efforts on improving vaccination rates, or increasing compliance with diabetes care, or determining how to deal with an opioid epidemic in the community.

Two additional points:

1) The Review Committees have been asked to refrain from using FAQs to set the minima for scholarship requirements.

2) If a program sends its residents to a one-month rotation at a participating site where the faculty members, residents, and fellows produce a large amount of scholarly activity, it would be improper for the program to "claim" and list all the scholarly activities at that participating site. Doing so does not meet substantial compliance with the requirement to creating an environment of scholarship. The idea behind this requirement is that residents and fellows be "immersed" in this environment of scholarship and inquiry throughout their educational programs. Therefore, resident and fellow scholarly activity listed should be from the primary clinical site.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

V.   Evaluation

V.A.   Resident Evaluation

V.A.1.   Feedback and Evaluation

> 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.

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

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

V.A.1.b)	Evaluation must be documented at the completion of the assignment. (Core)
V.A.1.b).(1)	For block rotations of greater than three months in duration, evaluation must be documented at least every three months. (Core)
V.A.1.b).(2)	Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion. (Core)
V.A.1.c)	The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones, and must: (Core)
V.A.1.c).(1)	use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, (Core)
V.A.1.c).(2)	provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. (Core)
V.A.1.d)	The program director or their designee, with input from the Clinical Competency Committee, must:
V.A.1.d).(1)	meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones; (Core)

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

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

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

V.B. Faculty Evaluation

V.B.2. Faculty members must receive feedback on their evaluations at least annually. (Core)

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

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.

V.C. Program Evaluation and Improvement

V.C.1. The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)

V.C.1.a) The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident. (Core)

V.C.1.b) Program Evaluation Committee responsibilities must include:

V.C.1.b).(1) acting as an advisor to the program director, through program oversight; (Core)

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.2.	The program must complete a Self-Study prior to its 10-Year Accreditation Site Visit. (Core)
V.C.2.a)	A summary of the Self-Study must be submitted to the DIO. (Core)

> 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.

V.C.3.	One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.
	The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.
V.C.3.a)	For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of

those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)

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

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

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

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

Background and Intent: Setting a single standard for pass rate that works across specialties is not supportable based on the heterogeneity of the psychometrics of different examinations. By using a percentile rank, the performance of the lower five percent (fifth percentile) of programs can be identified and set on a path to curricular and test preparation reform.

There are specialties where there is a very high board pass rate that could leave successful programs in the bottom five percent (fifth percentile) despite admirable performance. These high-performing programs should not be cited, and V.C.3.e) is designed to address this.

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

Background and Intent: It is essential that residency programs demonstrate knowledge and skill transfer to their residents. One measure of that is the qualifying or initial certification exam pass rate. Another important parameter of the success of the program is the ultimate board certification rate of its graduates. Graduates are eligible for up to seven years from residency graduation for initial certification. The ACGME will calculate a rolling three-year average of the ultimate board certification rate at seven years post-graduation, and the Review Committees will monitor it.

The Review Committees will track the rolling seven-year certification rate as an indicator of program quality. Programs are encouraged to monitor their graduates' performance on board certification examinations.

In the future, the ACGME may establish parameters related to ultimate board certification rates.

GUIDANCE

The requirements included in this section are generally self-explanatory, including descriptions of evaluation frequency and when they should be performed. Requirements for evaluation of residents, faculty members, and the program are listed. Specific areas regarding evaluation that the Common Program Requirements Task Force wanted to address separately in this guidebook can be found via the links below.

Links:
V.A.1.d).(2): Individual Learning Plan
V.A.1. Resident Evaluation – Feedback and Evaluation, including adverse actions such as probation and termination
V.A.2. Final Evaluation – includes article on "milestones not to be used by external entities for high stakes decisions
V.A.2.a) Final evaluation language
V.A.3. Clinical Competency Committee
V.B.1. Faculty Evaluation
V.C.1. Program Evaluation and Program Evaluation Committee
V.C.1.c) Program Evaluation and Improvement, aggregate graduate performance
V.C.2. Self-study
V.C.3. Board certification
V.C.3.f: Programs must report board certification status annually….

V.A.1.a) Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment

It cannot be overemphasized that direct observation is key to the evaluation of resident performance and progress. Evaluation and feedback can be provided during the provision of clinical care, or in any of the six required Competency areas. Faculty members have many responsibilities that sometimes require short clinical rotations of five days or less; it is important to note that continuity of observation is just as important, even in short rotations, to allow the faculty members to know the resident and for the resident to know the faculty members.

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

Timely faculty member completion of resident evaluation following completion of an assignment is crucial to a resident's development. Evaluation must address strengths and areas of improvement.

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

This requirement is self-explanatory.

V.A.1.b).(2) Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion.

This requirement is self-explanatory.

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

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

In addition to faculty members, residents interact with many other health providers, including nurses, physician assistants, other physicians, residents, fellows, peers, and patients. The input of the relevant individuals or groups is needed to provide an overall picture of resident performance. Notably, residents asked to provide a self-evaluation using the Milestones have been shown to develop a better perspective of their own performance.

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

V.A.3. Clinical Competency Committee

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

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

V.A.2.a).(1) Milestones and Sharing Externally

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

The summative evaluation of each resident and their readiness to progress to the next year of the program should be discussed by the Clinical Competency Committee

V.A.3. Clinical Competency Committee

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

Board Certification

In specialties that offer an annual written board examination, the three-year rolling average for first-time takers passing the written board examination will be calculated for each program and ranked against other programs in the specialty. Those programs above the fifth percentile in that ranking will not be cited by the Review Committee for failure to meet the required standard for this program outcome measure.

In specialties that offer a written board examination only on a biennial basis, the six-year rolling average for first-time takers passing the written board examination will be calculated for each program and ranked against other programs in the specialty. Those programs above the fifth percentile in that ranking will not be cited by the Review Committee for failure to meet the required standard for this program outcome measure.

In specialties that offer an annual oral board examination, the three-year rolling average for first-time takers passing the oral board examination will be calculated for each program and ranked against other programs in the specialty. Those programs above the fifth percentile in that ranking will not be cited by the Review Committee for failure to meet the required standard for this program outcome measure.

In specialties that offer an oral board examination only on a biennial basis, the six-year rolling average for first-time takers passing the oral board examination will be calculated for each program and ranked against other programs in the specialty. Those programs above the fifth percentile in that ranking will not be cited by the Review Committee for failure to meet the required standard for this program outcome measure.

Review the statement of Background and Intent (above). If a program ranks at or below the bottom fifth percentile of programs nationally in that specialty but still achieves a pass rate equal to or greater than 80 percent, it will not be cited by the Review Committee for failure to meet the required standard for this program outcome measure.

As noted in Common Program Requirement V.C.3., one measure of the effectiveness of an educational program is the *ultimate* success of its graduates in acquiring board certification. Historically, the ACGME used the first-time pass rate as the only metric with respect to the outcome of board certification. The ACGME will continue to use the first-time board examination pass rate as an important metric of program outcome, however, it is exploring the possibility of also incorporating as a metric the ultimate success of graduates in achieving board certification. To that end, it will begin to collect and analyze the board certification status of individuals who completed an ACGME-accredited program seven years earlier. The seven-year period was identified for this metric because that is the limit of board eligibility following completion of ACGME-accredited graduate medical education for the majority of certifying boards.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

V.   Evaluation

V.A.   Resident Evaluation

V.A.1.   Feedback and Evaluation

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

GUIDANCE

This requirement was written with the intention of ensuring that the program director and faculty members help residents and fellows in developing individualized learning plans (ILPs) to capitalize on their strengths and identify any areas that need additional support or effort.

Generally, ILPs include self-assessment and reflection, career goals, development of plans to achieve the goal(s), assessment of progress towards the goal(s), and revising/generating new goals. The ILP is a living document that must be reviewed to ensure progress and refocus as needed. Goals can be short-term or long-term, or both. ILPs help residents/fellows learn the concepts of life-long learning and practice-based learning and improvement.

Barriers to successful implementation of ILP (identified by residents):
1. Difficulty in self-reflection
2. Environmental strain: fatigued, time constraints
3. Competing demands: personal and work
4. Difficulty with goal generation

Difficulties in developing a plan and plan implementation:
1. Not seeing the patient population needed for clinical goals
2. Not having the time to consistently looking and reviewing the plan with their mentor
3. Created goals that cannot be tracked (lack of objective measures)

References:
1. Li, Su-Ting T., and Ann E. Burke. "Individualized Learning Plans: Basics and Beyond." *Academic Pediatrics* 10, no. 5 (2010): 289–92. https://doi.org/10.1016/j.acap.2010.08.002.
2. Li, Su-Ting T., Debora A. Paterniti, John Patrick T. Co, and Daniel C. West. "Successful Self-Directed Lifelong Learning in Medicine: A Conceptual Model Derived From Qualitative Analysis of a National Survey of Pediatric Residents." *Academic Medicine* 85, no. 7 (2010): 1229–36. https://doi.org/10.1097/acm.0b013e3181e1931c.

The American Board of Pediatrics has long required residents to have ILPs that are created with the help of program faculty members. Below is a link to a sample ILP adapted from an instrument developed by Dr. Theodore Sectish – the reference is listed in the sample plan.
https://www.uab.edu/medicine/obgynresidency/images/PDFs/Mentoring_ILP.pdf

Individualized Learning Plan

Resident's Name: _____

SECTION 1: Self-Assessment   *Please take this opportunity to reflect on your strengths (i.e., **"I do this well."**) and weaknesses (i.e. **"I could definitely improve."**) in regards to the 6 core competencies. This activity is designed to help you to create a learning plan for the upcoming academic year. Indicate each with a check mark.*

[This self-assessment is an adaptation of an instrument developed by Theodore C. Sectish, MD, Director, Residency Training Program in Pediatrics, Stanford University School of Medicine *(Ambulatory Pediatrics Vol 5, No 5, September-October 2005, pages 298-301).*]

Competency	Attributes/Abilities	Strength	Weakness
Patient Care (Clinical Skills)	Gathering essential and accurate info about the patient		
	Making informed diagnostic and therapeutic decisions		
	Developing and carrying out management plans		
	Performing medical procedures		
	Counseling patients and families		
	Providing effective primary care and anticipatory guidance		
	Using technology to optimize patient care		
Patient Care (Surgical Skills)	Pre-op preparation		
	Surgical ability and confidence		
	Complication management		
Medical Knowledge	Knowing the basic and clinical supportive sciences appropriate to ObGyn		
	Critically evaluating and applying current medical info and scientific evidence for patient care		
Practice-Based Learning and Improvement	Using life-long learning skills, including information technology, to improve knowledge, skills and practice		
	Analyzing practice to recognize strengths, deficiencies and limits in knowledge and expertise		
	Using feedback to improve performance		
	Applying evidence to patient care		
	Participating in the education of patients, families, students, residents and other health professionals		
Interpersonal and Communication Skills	Communicating effectively with patients and families		
	Communicating effectively with other health professionals		
	Teamwork		
	Acting in a consultative role to other health professionals		
	Maintaining comprehensive, timely and legible medical records		
Professionalism	Demonstrating respect, compassion, integrity and honesty		
	Demonstrating a responsiveness to the needs of patients and society that supercedes self-interest		
	Demonstrating accountability to patients, society and the profession		
	Adherence to ethical principles		
	Sensitivity to a diverse patient population		
Systems-Based Practice	Knowing types of medical practice and delivery systems		
	Practicing cost-effective health care		
	Advocating for quality patient care and assisting patients in dealing with system complexities		
	Advocating for health promotion and disease prevention		
	Acknowledging medical errors and examining systems to prevent them		

Competency *(circle competency goal addresses):* **PC   MK   PBL   ICS   Prof   SBP**

Short-Term Goal 3:

Strategies to achieve Goal 3:

Competencies addressed by goals *(circle all competencies for which you have written goals. By the end of your 3rd year, all 6 competencies should have been covered.)*

As a PGY1	As a PGY2	As a PGY3
Patient Care	Patient Care	Patient Care
Medical Knowledge	Medical Knowledge	Medical Knowledge
Practice-Based Learning	Practice-Based Learning	Practice-Based Learning
Interpersonal / Communication Skills	Interpersonal / Communication Skills	Interpersonal / Communication Skills
Professionalism	Professionalism	Professionalism
Systems-Based Practice	Systems-Based Practice	Systems-Based Practice

_____   _____
Resident Signature   Date   Mentor Signature   Date

REQUIREMENTS

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Common Program Requirement:

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V.A.   Resident Evaluation

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> 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.

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

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

Background and Intent: Learning is an active process that requires effort from the teacher and the learner. Faculty members evaluate a resident's performance at least at the end of each rotation. The program director or their designee will review those evaluations, including their progress on the Milestones, at a minimum of every six months. Residents should be encouraged to reflect upon the evaluation, using the information to reinforce well-performed tasks or knowledge or to modify deficiencies in knowledge or practice. Working together with the faculty members, residents should develop an individualized learning plan.

Residents who are experiencing difficulties with achieving progress along the Milestones may require intervention to address specific deficiencies. Such intervention, documented in an individual remediation plan developed by the program director or a faculty mentor and the resident, will take a variety of forms based on the specific learning needs of the resident. However, the ACGME recognizes that there are situations which require more significant intervention that may alter the time course of resident progression. To ensure due process, it is essential that the program director follow institutional policies and procedures.

GUIDANCE

DOCUMENTATION IS CRITICAL!

The goal of these processes is to help residents and fellows in difficulty to succeed.

Milestones assessments and evaluations by the Clinical Competency Committee are essential to the early identification of residents and fellows in difficulty.

We have included references to some studies that address the issue of residents failing to progress:

Yao, David C. Scott M. Wright. "National Survey of Internal Medicine Residency Program Directors Regarding Problem Residents." *JAMA* 284, no. 9 (June 2000): 1099. https://doi.org/10.1001/jama.284.9.1099.

The authors conducted a national survey of internal medicine residency program directors to evaluate the prevalence of residents having difficulty. They use the American Board of Internal Medicine (ABIM) definition of a "problem resident" as one who demonstrates a significant enough problems that requires intervention by someone of authority, usually the program director or chief resident.

They identified that the problem is often manifested in one or more of the ABIM's seven areas that relate to:
1. Clinical competency
2. Medical knowledge
3. Clinical Skills
4. Humanistic qualities
5. Professional attitudes and behaviors
6. Medical care
7. Moral and ethical behavior

Two hundred ninety-eight of 404 residency program directors responded to the survey.

Study outcome measures: prevalence of problem residents, type of problems encountered; factors associated with identification and management of problem residents.

Prevalence (academic year 1998-1999) was 6.9%
94% of programs had problem residents
Most frequent reported difficulties: medical knowledge, poor clinical judgment
Problem residents rarely identified themselves

The authors concluded that nearly all internal medicine residency programs in the study had problem residents whose presenting characteristics and underlying issues were diverse and complex.

Smith, Jessica, Monica Lypson, Mark Silverberg, Moshe Weizberg, Tiffany Murano, Michael Lukela, and Sally Santen. "Defining Uniform Processes for Remediation, Probation and Termination in Residency Training." *Western Journal of Emergency Medicine* **18, no. 1 (2017): 110–13. https://doi.org/10.5811/westjem.2016.10.31483.**

The authors state that: "It is important that residency programs identify trainees who progress appropriately, as well as identify residents who fail to achieve educational milestones as expected so they may be remediated. The process of remediation varies greatly across training programs, due in part to the lack of standardized definitions for good standing, remediation, probation and termination."

The authors provided standardized definitions for terms used in remediation, probation and termination related to residency education as listed below:

Informal Remediation: First step in the process when warning signs of problems exist but not so significant that formal remediation is warranted. This is a critical time to start documentation of the process to determine if there is an eventual need to escalate to a formal remediation process. Many programs have developed documentation templates or standard language, and completed forms or email notifications to the resident are placed in the resident's file. Some create confidential notes placed in "shadow files" which are destroyed once the remediation process is completed successfully.
It is important to engage the program director, Clinical Competency Committee, and resident at this stage.

Formal Remediation: the next step in the management of residents in difficulty. This step is implemented when the resident fails to correct identified deficiencies during informal remediation or when the deficiencies are so significant that the step of informal remediation is skipped.

> Components of formal remediation:
>   1. Document the need for formal remediation and inform the resident in writing. It is important that the resident read and sign a formal document. The document must also be signed by the program director.
>   2. Provide the resident with program and institutional grievance and due process policies.
>   3. Determine length of time of formal remediation: decided by the program director and the CCC. Do not leave open-ended – there must be a target date.

4. Create a correction plan with expected outcomes – there must be specific targets based on the deficiencies.
5. Include a timeframe for reassessment and the consequences of not meeting the expected outcome within the time frame.
6. All documentation must be placed in the resident's file.
7. Notify the GME office (and DIO)

Probation:

Probation is started when a resident fails to correct deficiencies identified during formal remediation. Sometimes a program and the CCC may decide to place a resident in immediate probation if the problems are significant enough.
Some programs set a limit to the period of formal remediation to 6 months, where lack of improvement then leads to probation.

Notes related to probation:
1. Period of probation has to be definite, not open-ended.
2. Must follow due process, especially if non-renewal or termination is being considered.
3. The same points listed in formal remediation need to be followed: dates, target outcome, consequences of not meeting the requirements and documentation.
4. GME office MUST be involved. Others include program director, CCC, Department Chair, and faculty members assigned to remediate the resident.
5. The legal department must be involved.
6. Probation must be disclosed in the final verification of graduate medical education training (VGMET) form, employment letters and letters of references.
7. If the resident does not meet the requirements outlined in the letter of probation, the program may choose non-renewal of contract, or termination.

Termination:

A resident may be terminated if he/she fails to meet the terms of probation. In some instances, a resident may be terminated immediately if the problem is severe enough.

Again, documentation is crucial.

Those involved in the process of probation must be involved in this process. In addition, if there is a house officer union, a representative of the union needs to be involved.

Termination must be disclosed in the final Verification of Graduate Medical Education Training (VGMET) form, employment letters, and letters of references.

Dupras, Denise M., Randall S. Edson, Andrew J. Halvorsen, Robert H. Hopkins, and Furman S. Mcdonald. "'Problem Residents': Prevalence, Problems and Remediation in the Era of Core Competencies." *The American Journal of Medicine* **125, no. 4 (2012): 421–25. https://doi.org/10.1016/j.amjmed.2011.12.008.**

The authors studied the prevalence of residents in difficulty, and the problems associated with placing a resident in remediation. They suggested a change of terms from "problem residents" to "residents in difficulty"

The authors conducted a survey of Association of Program Directors in Internal Medicine
> 372 = 97.1% of 383 US categorical IM programs
> 268 (72%) completed survey, 197 reported RID
> 3.5% = 532/15,031, mean of 2.9/program

They noted that factors that correlated with subsequent need for probation/remediation included low:
> ITE – In-Training Examination scores
> USMLE scores

Residents in difficulty were most frequently identified by faculty (#1), and also by supervising/chief residents, program directors, fellows, and nurses

The most common deficiencies of residents in difficulty identified in this study included:
- Patient care (53%)
- Medical knowledge (48%)
- Organization/prioritization, communication (40%)
- Professionalism (41%)
- Majority (77%) had MULTIPLE deficiencies

The most common contributing factors to residents having difficulty in the study were:
- Depression
- Anxiety
- personality disorders

Some of the less common contributing factors to residents having difficulty included:
- learning disability
- illness
- substance abuse
- divorce

In this study, the authors noted that actions taken by program directors to address residents in difficulty included:

- remediation (including repeating rotation or entire year)
- disciplinary action
- probation
- dismissal

In this study, only 34.5% of program directors retrospectively identified warning signs.

Conclusions:

- Majority of residents in difficulty have deficiencies in multiple competencies
- Medical knowledge and patient care deficiencies much easier to remediate
- Deficiencies in professionalism common (41%)
- Respond poorly to remediation
- Concern: unprofessional behavior in residents predictive of future disciplinary action by specialty boards

Cosco, D., D. Dupras, M. So, E. Lee, J. Schneider, and R. Edson "Look on the Bright Side: Case Studies in Successful Remediation of Problem Learners. Tools for Faculty and Staff/Remediation." *Academic Medicine Insight*, 12 no. 3 (2014).

Cosco et al studied cases where remediation of problem learners was successful and identified some key steps:

1. Identification of the issue (competency-based)
2. Multiple sources of learner assessment
3. Early feedback and intervention
4. Resident reflection with buy-in
5. Specific remediation goals with outlined consequences for failure to meet goals
6. Frequent follow-up
7. Group effort
8. Thorough documentation

Papadakis, Maxine A., Gerald K. Arnold, Linda L. Blank, Eric S. Holmboe, and Rebecca S. Lipner. "Performance during Internal Medicine Residency Training and Subsequent Disciplinary Action by State Licensing Boards." *Annals of Internal Medicine* 148, no. 11 (March 2008): 869. https://doi.org/10.7326/0003-4819-148-11-200806030-00009.

Papadakis et al evaluated the incidence of subsequent disciplinary action by state licensing board according to performance during residency training and concluded that poor performance on behavioral and cognitive measures during residency are associated with greater risk for state licensing board actions against practicing physicians at every point on a performance continuum. These findings support the ACGME standards for professionalism and cognitive performance and the development of best practices to remediate these deficiencies.

Lefebvre, Cedric, Kelly Williamson, Peter Moffett, Angela Cummings, Beth Gianopulos, Elizabeth Winters, and Mitchell Sokolosky. "Legal Considerations in the Remediation and Dismissal of Graduate Medical Trainees." *Journal of Graduate Medical Education* **10, no. 3 (2018): 253–57. https://doi.org/10.4300/jgme-d-17-00813.1.**

Lefebvre et al reviewed the legal considerations in placing residents in remediation or dismissing them from the program, and have the following summary points:

1. Sponsoring Institutions and their programs must provide residents and fellows with due process in cases of contract non-renewal, non-promotion, suspension or dismissal
2. Adherence to remediation policy, use of phases of remediation language, and documentation of all phases of remediation are important to optimize outcomes and limit legal liability when dismissal occurs.
3. Programs are generally on solid legal ground when they exercise due process for the remediated resident or fellow, when they take actions based on educational standards and patient safety, and when they only disclose educational records to inquiring parties in good faith.
4. Courts have consistently declined to consider the tort of educational malpractice.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

V.   Evaluation

V.A.   Resident Evaluation

V.A.2.   Final Evaluation

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

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

GUIDANCE

Milestones evaluation is an educational and formative assessment methodology designed to help promote improvement in every specialty and subspecialty graduate medical education program in the United States. The Milestones were not designed or intended for use by external entities, such as state medical licensing boards or credentialing entities, to inform or make high stakes decisions. The ACGME is concerned that graduate medical education programs may artificially inflate individual Milestones assessment data if the Milestones are used for high stakes decisions. Their value would risk being lost as an honest and valuable assessment tool for continuous improvement and professional development.

1. Specialty-specific Milestones are educational and formative assessment tools that can be used to help programs determine if residents/fellows are able to engage in independent practice upon completion of the educational program.

2. Case Logs, when applicable, can also be used by programs to determine if residents/fellows are able to engage in independent practice upon completion of the educational program.

3. The Milestones were not designed or intended for use by external entities, such as state medical licensing boards or credentialing entities, to inform or make high stakes decisions.

4. The Milestones for all specialties and subspecialties can be found at: https://www.acgme.org/What-We-Do/Accreditation/Milestones/Milestones-by-Specialty?articleid=6194.

5. The Milestones are designed only for use in evaluation of residents or fellows in the context of their participation in ACGME-accredited residency or fellowship programs. The Milestones provide a framework for the assessment of the development of the resident/fellow physician in key dimensions of the elements of physician competence in a specialty or subspecialty. They neither represent the entirety of the dimensions of the six domains of physician competence, nor are they designed to be relevant in any other context.

6. The "Ready for Unsupervised Practice" (Level 4) milestones are designed as the graduation target but do not represent a graduation requirement. Making decisions about readiness for graduation is the purview of the residency program director. (See the Milestones FAQs for further discussion of this issue: "Can a resident/fellow graduate if he or she does not reach every milestone?") Study of Milestones performance data will be required before the ACGME and its partners will be able to determine whether the "Ready for Unsupervised Practice" milestones and all other milestones are in the appropriate stage within the developmental framework, and whether Milestone data are of sufficient quality to be used for high stakes decisions.

Answers to Frequently Asked Questions about the Milestones are available on the Resources page of the Milestones section of the ACGME website: https://www.acgme.org/What-We-Do/Accreditation/Milestones/Resources

Introduction to Assessment Video

>Note: The above link will take you to the Introduction to Assessment course, which is also housed in Learn at ACGME, the ACGME's online learning portal. GME community members who have not yet created a free account in Learn at ACGME will need to create one before they are able to access the course.

NOTE: Program directors are urged to read the article below as it addresses concerns regarding use of the Milestones in ways for which they were not designed.

Use of Individual Milestones Data by External Entities for High Stakes Decisions - A Function for Which they Are not Designed or Intended

(See full article below)

April 5, 2018

Use of Individual Milestones Data by External Entities for High Stakes Decisions - A Function for which they are not Designed or Intended
Eric Holmboe, MD
ACGME Chief Research, Milestone Development, and Evaluation Officer

Abstract
The Milestones are a new educational and formative assessment methodology designed to help promote improvement in every specialty and subspecialty graduate medical education program in the United States. Milestones were not designed or intended for use by external entities, such as state medical licensing boards or credentialing entities, to inform or make high stakes decisions. The ACGME is concerned that graduate medical education programs may artificially inflate individual Milestones assessment data if the Milestones are used for high stakes decisions. Their value would risk being lost as an honest and valuable training assessment tool for continuous improvement and professional development.

The Milestones
The Milestones are an attempt to create a common language of professional development of resident and fellow physicians in each medical specialty and subspecialty. In July 2013, they were first implemented in residency programs by the ACGME in seven specialties, and subsequently they have been incorporated into accredited residency and fellowship programs in all specialties and subspecialties in the United States.[1]

The primary goal of the Milestones is to drive improvement in educational experiences and assessment of residents and fellows in diverse clinical teaching settings across the country.

Milestones are narrative descriptions of the development of resident and fellow abilities in each of the six clinical Competencies defined by the ACGME and the American Board of Medical Specialties (ABMS):

- Practice-based Learning and Improvement
- Patient Care and Procedural Skills
- Systems-based Practice
- Medical Knowledge
- Interpersonal and Communication Skills
- Professionalism

Although these six domains of clinical competency are common to all specialties and subspecialties, the Milestones' developmental narratives are tailored to each specialty.[1]

[1] In Academic Year 2017-2018, there are approximately 134,000 residents and fellows in almost 10,000 residency and fellowship programs in the United States.

Residents and fellows are periodically assessed on the Milestones as they progress from the beginning to completion of a residency or fellowship program. The results serve as one of many guides for program personnel to chart the educational course of each resident and fellow. To be effective in this regard, the assessments must be rigorous, accurate, and honest.

Currently, over 150 sets of specialty and subspecialty Milestones have been completed and are in use in all ACGME-accredited residency and fellowship programs in the United States. The ACGME estimates that, to date, over 900 physicians and other experts throughout the United States have contributed over 27,000 volunteer hours in the development of the specialty and subspecialty Milestones.

The Milestones have been recognized by the public and the physician community in the United States as a promising approach to transforming graduate medical education. As highlighted in the 2014 National Academy of Medicine report, *Graduate Medical Education that Meets the Nation's Health Needs*:

> The ACGME is currently implementing its "Next Accreditation System" (NAS) for all specialties. The new system was specifically developed to enhance the ability of the accreditation process to promote the training of physicians for practice in the 21st century. Assessments of educational outcomes and the clinical learning environment are key components of the NAS and are based on six core competencies—patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice.[2]

Much work remains to be done to determine the extent to which the Milestones are useful and valid tools for use in residency and fellowship programs. However, based upon what has been learned, drafting is about to begin on the next version of the Milestones, with completion of all revised specialty and subspecialty Milestones targeted for between 2018 and 2023.

Intended Use of the Milestones in Residencies and Fellowships

The Milestones provide a framework (i.e., a frame of reference or rubric) for a required periodic assessment of a resident or fellow in relation to a developmental description of attainment of

specific, more granular sub-competencies over the course of the training curriculum. They guide the judgment of the program and the faculty members evaluating the residents and fellows in their respective programs; they do not and were not intended to represent (1) the totality of a specialty or subspecialty discipline, (2) complete assessment of all knowledge, skills, and attitudes, or (3) a complete overall determination of a resident's or fellow's abilities. Moreover, they are tools used to provide an interim identification of progress in competency areas toward that necessary for unsupervised practice.

[2] *Graduate Medical Education that Meets the Nation's Health Needs*, page 47, National Academy of Medicine (2014).

There is currently no "expected" or established rate of resident or fellow progression in Milestones achievement. Different residents and fellows learn different skills and concepts in different orders and at different rates. This is explicitly recognized in a position statement of the Federation of State Medical Boards from 1998 and still in effect today:

> According to the ACGME, today there is wide variation in the timing and sequence of the various training elements among the 7000+ residency programs in the United States, and it is therefore impossible for state medical boards to discern, prior to completion of postgraduate training, which applicants for licensure have achieved appropriate training that qualifies them for a full and unrestricted license to practice medicine.[3]

ACGME-accredited residency and fellowship programs prepare the next generation of physicians, and the program directors of these programs are expected to attest to the preparedness of those who successfully complete their programs to serve the public independently in their respective specialties and subspecialties.

In the Milestones framework, everything else prior to the program director's final judgment of readiness or non-readiness for independent practice is interim; the responsibility for the final judgment rests with the program director and supersedes all interim assessments. The ACGME's accreditation requirements recognize the centrality of the program and program director's overall judgment relating to an individual resident's/fellow's readiness or non-readiness for independent practice.

The judgment of the program, using a comprehensive and multifaceted approach to assessment, is paramount in determining the readiness of a resident or fellow to enter practice. The ACGME is sometimes asked whether a resident's Milestones data supersede a program director's judgment of readiness or non-readiness for independent practice. In fact, the reverse is true. As stated above, a program director's final, holistic, overall judgment at the end of the residency program supersedes all interim assessments, as it represents the summative evaluation of the knowledge, skills, attitudes, and behaviors of the graduating resident at the time of graduation.

As noted above, the ACGME is already beginning a process to revise the Milestones. The rationale for revising the Milestones relates to their primary purpose: to facilitate the improvement of programs and guide more effective professional development. This revision process is another reason why the Milestones should not be used for high stakes decisions; once they have been revised, a new cycle of evaluation and research will begin to study the validity of the revised Milestones.

3 Position of the Federation of State Medical Boards in Support of Postgraduate Training and Licensure Standards, adopted as policy by the Federation of State Medical Boards in 1998, page 3.

Non-Intended Use of Milestones by State Medical Licensing Boards

The ACGME does not have evidence that individual Milestones data can be validly used in any other context beyond provision of individual resident and fellow feedback, especially for any higher stakes decisions.[4] In recognition of this, the following disclaimer appears at the beginning of the published Milestones in each specialty and subspecialty:

> The Milestones are designed only for use in evaluation of resident physicians in the context of their participation in ACGME-accredited residency or fellowship programs. The Milestones provide a framework for the assessment of the development of the resident physician in key dimensions of the elements of physician competency in a specialty or subspecialty. They neither represent the entirety of the dimensions of the six domains of physician competency, nor are they designed to be relevant in any other context.

"Nor are they designed to be relevant in any other context" is intended to preclude the use of the Milestones in the context of physician licensure, or any other higher stakes use.

Consistent with this, the 26 ABMS member certifying boards and the certifying boards of the American Osteopathic Association do not use individual Milestones data for the purpose of assessing physician applicants for specialty board certification. Although ACGME accreditation requirements provide for residency and fellowship use of the Milestones, the ACGME does not review identified individual Milestones data for accreditation purposes. Instead, it views the data in aggregate, using the program as the unit of analysis.

The ACGME assumes that most state medical licensing boards (including osteopathic medical boards) heed the ACGME declaration that the Milestones are not designed for any non-residency use.[5] Nevertheless, the ACGME has learned of instances in which several state medical licensing boards have requested and used individual Milestones data for their decision on an individual physician's license.

This is a non-designed and non-intended use of Milestones data. For licensure decisions after completion of a residency, it ignores the program director's judgment of readiness for independent practice upon completion of the residency. For licensure decisions before and after completion of a residency, (1) it ignores the disclaimer for this use included at the beginning of each set of Milestones; (2) it is inappropriate to compare one specialty's Milestones assessments against another, as specialty programs have different content and different durations; and (3) all states grant general licenses rather than specialty licenses, and the Milestones are specialty-specific. For licensure decisions before completion of a residency, it ignores the fact that each Milestones assessment is against the entirety of the curriculum, residency programs in the same specialty do not necessarily order the curriculum in the same way, and the same residency program may alter the order of its curriculum from year to year as part of its improvement process.

Potential Negative Consequences of Non-Intended Use of Individual Milestones Data:

State Medical Licensing Boards

One consequence of this non-designed and non-intended use of the Milestones by state medical licensing boards might be an adverse licensure decision being reversed on administrative review if Milestones data were used as part of the decision. This is a real possibility when the ACGME, as an original and continuing developer of the Milestones, clearly declares that Milestones data is not designed or intended for that purpose.

But there is a second and more universal consequence. Milestones assessment occurs within a learning context. Residency and fellowship programs use the Milestones to guide a learning course on a per-resident/per-fellow basis, as each individual physician learner progresses to clinical independence in the specialty or subspecialty. Integrity in the assessment process is necessary to the function of the learning process.

The ACGME is concerned that the graduate medical education community would artificially inflate Milestones assessment data were the Milestones to be used, or perceived to be used, for individual licensing decisions by state medical licensing boards. Their value would risk being lost as an accurate and honest training assessment tool.

Conclusion

The Milestones are a framework of assessments for the six general Competencies, intended as one among many tools to inform and guide the learner and the members of the faculty as the learner progresses through the residency or fellowship curriculum. They are not designed or intended to supplant the overall judgment of the program director as to the ability of the individual learner to perform particular clinical tasks during the residency or fellowship, or to enter the independent practice of medicine upon completion of the residency or fellowship.

It is important that the individual Milestones assessments be used and maintained within each residency and fellowship program to preserve them as robust and accurate tools in the learning process. Without such limitation of use, the residency or fellowship program might be tempted to artificially assess the individual more positively for the consumption of a state medical board, and thus jeopardize the Milestones as a learning and teaching tool.

According to its website, the Federation of State Medical Boards (FSMB) represents the 70 state medical and osteopathic licensing boards within the United States. According to its website, the "ultimate objective" of the FSMB is "to promote excellence in medical practice, licensure, and regulation as the national resource and voice on behalf of state medical boards in their protection of the public."[6] Consistent with this objective is preservation of the Milestones system through limiting its use to within each residency and fellowship program, which is the only use for which it is designed or intended.

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[6] Full quote from website of the Federation of State Medical Boards, accessed December 29, 2017: The Federation of State Medical Boards (FSMB) is a national nonprofit representing the 70 medical and osteopathic boards of the United States and its territories. Since its founding, the FSMB has grown in the range of services it provides – from assessment tools to policy documents, from credentialing to disciplinary alert services – while continuing to serve the interests of its member boards. The ultimate objective is to promote excellence in medical practice, licensure, and regulation as the national resource and voice on behalf of state medical boards in their protection of the public.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

V.   Evaluation

V.A.   Resident Evaluation

V.A.2.   Final Evaluation

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

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

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

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

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

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

GUIDANCE

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

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

This requirement is self-explanatory.

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

V.A.3.b) Clinical Competency Committee

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

Current CPR V.A.3., Summative Evaluation, V.A.3.b).(3), states that this evaluation must verify that the resident has demonstrated sufficient competence to enter practice without direct supervision. It is important for the program director to affirmatively state in the final evaluation, "I verify that Dr. [resident name] has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice." Stylistically, it is probably desirable to add the specialty or subspecialty, i.e., "…to enter autonomous practice of [specialty or subspecialty]."

It should also be noted that the evaluation specified in PR V.A.2.a).(2) is different from the verification specified in PR II.A.4.a).(14). The final evaluation, like formative and interim summative evaluations completed during the program for an individual resident, is an internal document. It is not intended to be shared outside of the program and it's Sponsoring Institution. While Milestones assessments should be used in the determination of an individual resident's ability to practice autonomously, the achievement of specific milestones by an individual resident do not necessarily need to be documented in the final evaluation.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

V.   Evaluation

V.A.   Resident Evaluation

> 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 have 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.

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

V.A.3.b)   The Clinical Competency Committee must:

V.A.3.b).(1)   review all resident evaluations at least semi-annually; (Core)

V.A.3.b).(2)   determine each resident's progress on achievement of the specialty-specific Milestones; and, (Core)

V.A.3.b).(3)   meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress. (Core)

GUIDANCE

The membership of the Clinical Competency Committee (CCC) and the roles of the program director, physician and non-physician faculty members, and chief residents are outlined in the Background and Intent section preceding these requirements. The requirements are purposefully stated in general terms to allow programs flexibility to include individuals who are most appropriate locally, and to structure their meetings according to their specific needs. Of note, the role of the chief resident on the CCC is clarified. Chief residents who have completed specialty or core residency programs can be members of the CCC. For example, someone who has completed internal medicine or pediatrics residency program and is then appointed as chief resident would qualify for membership. However, chief residents in surgery are in their fifth year of the educational program and are residents, and therefore cannot be members of the CCC.

V.A.3.b).(1): If there is a disagreement in assessment between the program director and the CCC, note V.A.2 and V.A.2.a) The program director must provide a final evaluation for each resident upon completion of the program. (Core)

RESOURCES

The ACGME has provided the following online resources:

1. A handbook to provide guidance on CCC structure and function.

2. The Milestones Guidebook, which provides suggestions for effective use of Milestones assessments. In addition, the specialty and subspecialty Milestones Work Groups have begun creating Supplemental Guides (for Milestones 2.0 versions) with specific guidance in ratings of residents' performance.

3. Introduction to Milestones Interactive Course

   Note: The above link will take you to the Introduction to Milestones course, which is also housed in Learn at ACGME, the ACGME's online learning portal. GME community members who have not yet created a free account in Learn at ACGME will need to create one before they are able to access the course.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

V.   Evaluation

V.B.   Faculty Evaluation

V.B.1.   The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)

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

V.B.1.a)   This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills

as an educator, clinical performance, professionalism, and scholarly activities. (Core)

V.B.1.b)   This evaluation must include written, anonymous, and confidential evaluations by the residents. (Core)

V.B.2.   Faculty members must receive feedback on their evaluations at least annually. (Core)

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

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.

GUIDANCE

The section of the Common Program Requirements that pertains to faculty evaluation has several components:

1. Who to evaluate
2. What to evaluate: teaching abilities, engagement with the program, professionalism, and scholarly activities
3. Giving faculty members feedback on their evaluations at least annually
4. Incorporation of the educational evaluations into faculty development plans and should be part of the Annual Program Evaluation.

Who to evaluate: As stated in the Background and Intent, all faculty members who have significant interactions with the residents must receive feedback.

What to evaluate: Faculty members should be evaluated based on their role in resident education, including clinical care; teaching and research in aspects such as clinical productivity; review of patient outcomes; or peer review of scholarly activity. Sometimes, the program director may need to work with others to determine the effectiveness of faculty members' performance with regard to their role in the educational program. The process should reflect the local environment and identify the necessary information.

As noted in the Background and Intent statement, assessment of the members of the faculty is an important part of improving the teaching program. Feedback to the faculty members is important to help individual faculty members measure and increase their contribution to the mission of the program and improve their individual effectiveness as teachers. It is suggested that assessment include research and scholarly activity, their clinical work, as well as their educational activities. This specific requirement for written and confidential evaluations of faculty members is intended to collect the most honest feedback from the residents, which requires minimizing any possibility for fear of retaliation or intimidation of the residents as a result of comments made.

V.B.1.b) This evaluation must include written, anonymous, and confidential evaluations by the residents.

Programs with smaller number of residents often struggle with the maintenance of the confidentiality of a resident's evaluation. For a confidential evaluation, the reviewer is not known by the individual being evaluated, but the identity of the evaluator might be known by someone such as the program director or departmental chair. For an anonymous evaluation, the evaluator is not known by anyone, offering a higher level of security. Frequently, the anonymous evaluation is mixed with other evaluations done by others so that it is impossible to guess the individual source.

The advantage of a confidential evaluation is that someone can respond if needed to an egregious situation if it is reported or that a residency program director or departmental chair can place the information in better context. Confidential evaluations only work if the residents trust their identity will be kept secret, which requires they must have a high degree of trust in the individual who knows their identity. The trusted individual may be the program coordinator who is collecting the evaluations. The coordinator often has an informal relationship with the residents, which is seen as friendlier as or less threatening than the program director. However, the program coordinator must never be allowed to be intimidated by the program director or the faculty member in revealing the resident's identity. The trusted individual may also be the program director or department chair, who oversees the faculty member. However, they may be intimidating to a resident because of their supervisory relationship. In this instance, the trusted individual must be someone else, particularly when the resident is evaluating the program director and the department chair. Another scenario has the trusted individual being someone outside of the program, such as the designated institutional official (DIO) or an individual who reports to a different department.

The advantage of an anonymous evaluation is that it is the most reassuring to the resident. Anonymous evaluations may be accomplished by collecting them via a system that does not identify an individual resident. Because it might be possible for faculty members to guess the identity by timing when the evaluation appears, the individual comments might be collected throughout the year and batched feedback might be best given at the end of the year. For very small programs, the feedback may need to be collected over two years to accumulate a larger group of evaluations.

Confidentiality is at risk when the written evaluation contains details that might identify a specific patient or case or resident interaction that the faculty member can recall and attribute to the specific individual resident. Residents should be instructed to be general enough to preclude that level of detail. However, being too general may cause the feedback to lose its effectiveness as a quality improvement tool.

Confidential faculty evaluations are a critical piece of information to help improve the program, but are a special challenge in small programs. Some of the strategies above may help to collect that information while preserving confidentiality.

Many institutions have "home-grown" versions of faculty evaluation forms. In addition, departments may have annual evaluation forms for faculty performance that address clinical performance, role in education, and scholarship. Below are some examples.

1. **Williams, Brent C., Debra K. Litzelman, Stewart F. Babbott, Robert M. Lubitz, and Tim P. Hofer. "Validation of a Global Measure of Faculty's Clinical Teaching Performance."** *Academic Medicine* **77, no. 2 (2002): 177–80. https://doi.org/10.1097/00001888-200202000-00020**.

Created a Global Rating Scale (GRS) – single-item, five-point global measure of faculty members' clinical teaching performance previously known to be reliable. Evaluation completed by 98 senior medical residents from four academic institutions; also completed the 26-item Stanford Faculty Development questionnaire for 10 faculty members with whom they had teaching contact during residency.

The GRS correlated highly with measures of seven specific aspects of teaching effectiveness. The scale is reportedly simple to use, readily administered as part of an incentive or reward program, or for review in promotion decisions

2. **Mintz, Marcy, Danielle A. Southern, William A. Ghali, and Irene W. Y. Ma. "Validation of the 25-Item Stanford Faculty Development Program Tool on Clinical Teaching Effectiveness." *Teaching and Learning in Medicine* 27, no. 2 (March 2015): 174–81. https://doi.org/10.1080/10401334.2015.1011645**

   Domains:
   - Learning Climate
   - Control of session
   - Communication of goals
   - Promotes understanding and retention
   - Evaluation
   - Feedback
   - Promotes self-directed learning

3. **Kassis, Karyn, Rebecca Wallihan, Larry Hurtubise, Sara Goode, Margaret Chase, and John Mahan. "Milestone-Based Tool for Learner Evaluation of Faculty Clinical Teaching." *MedEdPORTAL Publications* 13 (2017). https://doi.org/10.15766/mep_2374-8265.10626.**

   Created a 10-question evaluation tool to assess clinical teaching skills with descriptive Milestones behavior anchors using a combination of the Stanford Faculty Development Clinical Teaching Model and annual ACGME Resident Survey questions.

   Conclusion: The tool provided faculty members with more meaningful teaching evaluations and feedback.

   Domains:
   Milestone 1: Establishes positive learning domain
   Milestone 2: Maintains control of educational session
   Milestone 3: Establishes learning goals
   Milestone 4: Promotes understanding and retention of knowledge and skills
   Milestone 5: Provides formative feedback
   Milestone 6: Promotes clinical reasoning
   Milestone 7: Promotes evidence-based medicine

Milestone 8: Promotes self-directed learning in learners
Milestone 9: Balances supervision and autonomy
Milestone 10: Displays professionalism

In conclusion, faculty members must receive structured feedback on their evaluations at least once a year. The feedback should include strengths and opportunities for improvement, and be considered in planning for faculty development sessions and tracked as part of the Annual Program Evaluation. For example, if residents'' evaluations of faculty members consistently show that the faculty evaluations of them are not constructive and do not provide information to help the residents improve, there might be a need to provide a faculty development session on providing evaluations.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

V. Evaluation

V.C.   Program Evaluation and Improvement

V.C.1.   The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process.

V.C.1.a)   The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident. (Core)

V.C.1.b)   Program Evaluation Committee responsibilities must include:

V.C.1.b).(1)   acting as an advisor to the program director, through program oversight; (Core)

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

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> 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 Faulty Surveys; and, (Core)

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

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

V.C.1.c.(6).(a) achievement of the Milestones; (Core)

V.C.1.c.(6).(b) in-training examinations (where applicable); (Core)

V.C.1.c.(6).(c) board pass and certification rate, and, (Core)

V.C.1.c(6).(d)   graduate performance. (Core)

V.C.1.(7)   aggregate faculty:

V.C.1.(7).(a)   evaluation; and, (Core)

V.C.1.c.(7).(b)   professional development. (Core)

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

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

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

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

GUIDANCE

Requirements for the Program Evaluation Committee (PEC) have changed in the revised Common Program Requirements. Each element is now a "core" requirement with which all programs must comply. The key to this process lies in tracking and follow-up.

The PEC must include at least two program faculty members, at least one of whom is a core faculty member, and at least one resident or fellow. Members of the PEC should know the program well and be vested in program well-being and improvement. The resident/fellow member is important because he or she "lives and works" within the context of the program.

What Does the PEC Do?

- The PEC should participate actively in:
    - planning, developing, implementing, and evaluating educational activities of the program;
    - reviewing and making recommendations for revision of competency-based curriculum goals and objectives;
    - addressing areas of non-compliance with ACGME requirements; and,
    - annually reviewing the program using evaluations of faculty members, residents, and others.
- Some PECs include review of resident/fellow Milestone assessments to determine weak points in curricular elements of the program in order to make necessary changes.
- End product: **Annual Program Evaluation**

The PEC should act as the program's own "Review Committee," looking at all the components as listed in the Common Program Requirements.

**Suggested template for internal program use in the Annual Program Evaluation.
Please note that this is a sample template. The ACGME does not require its use.**

SAMPLE Template – Annual Program Evaluation
(For Internal PROGRAM Use Only)

Program:
Date:
Academic Year:

Program Evaluation Committee Membership:
Faculty Members:
1. _____
2. _____
3. _____

Residents/Fellows:
1. _____
2. _____

Resident/Fellow Complement

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7
Positions Approved							
Current Complement							

Accreditation Status of the Program

☐ Continued Accreditation   ☐ Initial Accreditation
☐ Continued Accreditation with Warning   ☐ Initial Accreditation with Warning
☐ Probationary Accreditation   ☐ Continued Accreditation without
Outcomes

Current Program Citations

Insert Text from ACGME Letter of Notification (LON)	*Current* Program Response to Citation
1.	
2.	
3.	

Current Areas for Improvement (AFIs)

Insert Text from ACGME LON	Program Actions to Address Areas for Improvement (AFIs)
1.	
2.	
3.	

Program Aims

Aim(s)	Met (M)/Unmet (U)

Plans for Unmet Goals

1. _____
2. _____
3. _____

Strengths of the Program

1. _____
2. _____
3. _____

Challenges/Threats to the Program

1. _____
2. _____
3. _____

Opportunities for the Program

1. _____
2. _____
3. _____

Program Curriculum

Curricular Element	Action: Modify (M), Add (A) or Delete (D)	Steps Taken	Timeline for Completion

Quality Improvement (QI) and Patient Safety (PS)

QI/PS Activity	Active Role Faculty (F) Resident or Fellow (R)	Has QI/PS Improved in the Past Year? (Yes/No)	Describe Improvement, Including Efforts to Include Faculty Member(s) and Residents/Fellows	Describe QI/PS Activities that Can be Added or Improved

Well-Being and Diversity

Activity	Successes	Needs Improvement
Well-being		
Diversity		
Recruitment		
Retention		

Scholarship

Resident/Fellow/Faculty Scholarly Activities (append lists here)	If applicable, list efforts to increase scholarship

ACGME Annual Resident/Fellow Survey

Areas with Improvement	Areas with Deterioration	Plans to Address Areas of Deterioration if Applicable

ACGME Annual Faculty Survey

Areas with Improvement	Areas with Deterioration	Plans to Address Areas of Deterioration if applicable

Written Evaluations of the Program

Who provides written evaluations of the program?
- ☐ Residents/fellows in this program
- ☐ Other hospital/clinic/facility personnel
- ☐ Residents/fellows in other programs
- ☐ Faculty members in other programs
- ☐ Faculty members in this program

Areas Identified for Program Improvement	Plans for Program Improvement/Target Date

Aggregate Resident/Fellow Achievement of Milestones

Exceeded National Means	Below National Means	Plans to Improve Milestones Achievement

Aggregate Resident/Fellow Performance on In-Training Examinations (if Applicable)

Performance of Cohort this Year Compared to Prior Year	Subject Areas where Cohort Fell Short of Program Expectations	Plans to Improve Performance in the In-Training Examination

Aggregate Performance of Residents/Fellows and Graduates on Board Certification Examinations in the Specialty/Subspecialty Program

Number Eligible to Take	Number Eligible who Took the Written Examination	How Many of Those Who Took the Exam Passed?

If applicable, how does program plan to improve resident/fellow/graduate performance on the examinations in the board certification process over the next year?

Performance of Program Graduates

In what ways does the program monitor the performance of program graduates?
☐ Surveys of the graduates, themselves
☐ Surveys of the partners of the graduates
☐ Surveys of the employers of the graduates
☐ Surveys of the practice sites (hospitals, clinics, etc.) of the graduates
☐ Monitoring of the continuing board certification of the graduates
☐ Monitoring of state licensing board actions against graduates
☐ Monitoring of medico-legal actions against graduates
☐ Program does not monitor program graduates' performance

Areas for Improvement for Performance of Graduates	Plans to Address Areas Identified as Needing Improvement

Faculty Evaluation

By whom are the faculty members in this program evaluated (for their contributions to the educational program)?
☐ Medical students
☐ Residents/fellows in this program
☐ Residents/fellows in other programs
☐ Peer faculty members in this program
☐ Peer faculty members in other programs

Areas for Improvement Identified for Faculty Member Contributions to the Program	Plans to Address Areas Identified as Needing Improvement

Faculty Development Activities

List Faculty Development Activities Available in the Past Year	Percent Faculty Participation	If Applicable, How Does Program Plan to Increase Participation in Faculty Development Activities?

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

V. Evaluation

V.C.   Program Evaluation and Improvement

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

V.C.1.c).(6)   aggregate resident/fellow:

V.C.1.c).(6).(d)   graduate performance. (Core)

GUIDANCE

Aggregate Performance of Program Graduates in the Annual Program Evaluation

When conducting and documenting an Annual Program Evaluation, a Program Evaluation Committee should consider aggregated information about the performance of the program's graduates. This requirement permits flexibility to identify indicators of graduate performance that are feasible to measure and relevant to an individual program's aims.

While it may be possible to analyze a wide variety of performance information, the Program Evaluation Committee should determine objective criteria for graduate performance that have specific meanings in the context of the Annual Program Evaluation. Some criteria may be unique to the specialty or subspecialty (e.g., self-reported performance in a defined area of patient care); others may be broadly defined (e.g., proportion of graduates working in a targeted practice setting).

Some Sponsoring Institutions have standardized elements of Annual Program Evaluations that may include relevant performance indicators for graduates. Some Sponsoring Institutions also collect data that pertain to this requirement, such as what might be obtained by surveying program graduates. Program Evaluation Committees may benefit from consulting the designated institutional official (DIO) or other individuals if there is uncertainty about the Sponsoring Institution's policies and practices related to graduate performance data.

Graduate follow-up surveys are important for many reasons:
1. They provide information about the adequacy of the educational program.
2. They can help determine if program innovations and curricular changes had any impact.
3. Information regarding geographic location, practice type, employment setting, scholarly activities, and patient characteristics in the graduate's practice are critical in determining whether the program is achieving its mission. The information can be used to make changes in the curriculum and to refocus if needed.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement:

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

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

> 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.

GUIDANCE

While the Common Program Requirements specific to the Self-Study are listed in V.C.2. and V.C.2.a), it is important to note that there are components related to the program aims and the Self-Study in multiple sections of the Common Program Requirements.

Self-Study Description

The ACGME program Self-Study was established as a key component of the Next Accreditation System. With the goal of conducting an objective and comprehensive review of the program, the Self-Study is a tool for program self-reflection and strategic planning that utilizes the Annual Program Review as a foundation on which to build the in-depth, multi-year program evaluation.

Two concepts are fundamental in the development of the Self-Study:
1) Determination of the program's aims and mission; and,
2) Critical assessment of the institutional, local, regional, and even national environment (context) in which the program operates.

These lead to a thoughtful analysis of program strengths, weaknesses, opportunities and threats that will allow a program to distinguish itself from other programs in the specialty (such as highlighting differences between community and urban programs). Ultimately, the goal of the Self-Study is to provide a platform for a forward thinking and systematic approach to making program improvements.

Programs are encouraged to include a broad array of participants in the Self-Study process, including program leadership, residents/fellows, faculty members, and other stakeholders, such as program graduates, institutional and quality improvement personnel, leadership from related programs, or nursing and other health care personnel who interact closely with the residents/fellows in the program.

The Program Requirements specify that a program must conduct a Self-Study in preparation for a 10-Year Accreditation Site Visit.

Program Aims

The program is expected to develop a curriculum with specific program aims that are "consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates." While programs must demonstrate substantial compliance with the Common and specialty-specific Program Requirements, it is recognized that within this framework, programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced, program-specific goals for the program and its graduates.

Sections of the Common Program Requirements that relate to the need for program aims, the Self-Study, and the Program Evaluation Committee:

IV. Educational Program

In addition, the program is expected to define its specific program aims consistent with the overall mission of its Sponsoring Institution, the needs of the community it serves and that its graduates will serve, and the distinctive capabilities of physicians it intends to graduate. While programs must demonstrate substantial compliance with the Common and specialty-specific Program Requirements, it is recognized that within this framework, programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-specific goals for it and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from one focusing on community health.

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

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

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

IV.D. Scholarship

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

IV.D.1.a) The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. [(Core)]

V. Evaluation

V.C. Program Evaluation and Improvement

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.

The Program Evaluation Committee

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

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

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

Self-Study and Aims Resources

1. https://www.acgme.org/What-We-Do/Accreditation/Self-Study

   This link includes the Eight Steps for Conducting the ACGME Program Self-Study

2. https://www.acgme.org/Portals/0/PDFs/SelfStudy/SSSummary.docx?ver=2018-06-13-161945-220
   https://www.acgme.org/Portals/0/PDFs/SelfStudy/SSSummaryUpdate.docx?ver=2018-06-15-084339-070
   https://www.acgme.org/Portals/0/PDFs/SelfStudy/SummaryAchievements.docx

   The three links include the required Self-Study Documents.

ACGME Field Activities Presentations

Maximizing the Value of the ACGME Self-Study Process for Your Program: No Need to be Afraid by Dr. John Frohna MD, Dr. Kim Gifford, Dr. Susan Guralnick, Dr. Alex Rakowsky

To view the full webinar and download resources provides by the presenters visit: https://dl.acgme.org/learn/video/2018-summer-series-webinar-maximizing-the-value-of-the-acgme-self-study-process-for-your-program-no-need-to-be-afraid

> Note: The above link will take you to the Maximizing the Value of the ACGME Self-Study Process for Your Program webinar, which is housed in Learn at ACGME, the ACGME's online learning portal. GME community members who have not yet created a free account in Learn at ACGME will need to create one before they are able to access the course.

The ACGME Self-Study – An Opportunity, Not a Burden (*Journal of Graduate Medical Education* Sep 2015, Vol. 7, No. 3

The Annual Program Evaluation, Self-Study, and 10-Year Accreditation Site Visit: Connected Steps in Facilitating Program Improvement (*Journal of Graduate Medical Education* Feb 2017, Vol. 9, No. 1)

Improvement in Context: Exploring Aims, Improvement Priorities, and Environmental Considerations in a National Sample of Programs Using "Small Data" (*Journal of Graduate Medical Education* Dec 2017, Vol. 9, No. 6)

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

V. Evaluation

V.C.   Program Evaluation and Improvement

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

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

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

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

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

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

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

Background and Intent: Setting a single standard for pass rate that works across specialties is not supportable based on the heterogeneity of the psychometrics of different examinations. By using a percentile rank, the performance of the lower five percent (fifth percentile) of programs can be identified and set on a path to curricular and test preparation reform.

There are specialties where there is a very high board pass rate that could leave successful programs in the bottom five percent (fifth percentile) despite admirable performance. These high-performing programs should not be cited, and V.C.3.e) is designed to address this.

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

Background and Intent: It is essential that residency programs demonstrate knowledge and skill transfer to their residents. One measure of that is the qualifying or initial certification exam pass rate. Another important parameter of the success of the program is the ultimate board certification rate of its graduates. Graduates are eligible for up to seven years from residency graduation for initial certification. The ACGME will calculate a rolling three-year average of the ultimate board certification rate at seven years post-graduation, and the Review Committees will monitor it.

The Review Committees will track the rolling seven-year certification rate as an indicator of program quality. Programs are encouraged to monitor their graduates' performance on board certification examinations.

In the future, the ACGME may establish parameters related to ultimate board certification rates.

GUIDANCE

The requirements for board pass rates are self-explanatory.

Board pass rate is one outcome that can demonstrate a program is preparing its graduates for independent practice. Replacing the previous requirement of a five-year rolling average with a three-year rolling average makes the data more relevant to the most recent graduates and a more current time frame in the program. The variability in the board pass rates in programs from year to year, (especially with small programs) is taken into account by the Review Committees. While a small program may have a relatively larger negative impact on the pass rate based on one resident failing, the positive impact of those who pass will also be larger, and it will be easier for the program to improve.

For a program to receive a citation for this requirement, it would:

1) have to be in the lowest five percent of all programs in the specialty for board pass rate; and,

2) have a board pass rate below 80 percent.

That means that if there are 100 programs in a specialty or subspecialty, approximately five programs could receive that citation, but only if their individual board pass rate for graduates is below 80 percent.

The board pass rate for first-time takers will count those who pass in the numerator and those who are taking the exam for the first time in the denominator. Residency graduates who do not take the exam, or those who are taking it for the second time or more, do not count in the denominator. A resident who delays taking the examination will be counted in the year that he or she actually takes the exam.

The board pass rate for each program is reported to the ACGME directly from the American Board of Medical Specialties member board and the AOA board in that specialty. No names or other individual identifiers are reported to the ACGME.

A program might respond to a citation in board pass rate in a number of ways:

1) The program may evaluate its didactic curriculum to identify weaknesses and make efforts to improve.

2) The annual in-training examination results can be helpful in identifying content area(s) where residents did not perform well. In addition, the in-training examination helps identify those residents who are underperforming in comparison to their peers.

3) A structured certifying board examination review can be implemented, addressing content specifications of the specialty board.

4) Some residents may benefit from a more structured plan outlined in an individualized learning plan (see V.A.1.d).(2)).

5) It is important for the Program Evaluation Committee to review board certification data annually, and in-training examination performance as part of the Annual Program Review, to determine whether program changes are needed. These might include changes in the didactic curriculum and the institution of conferences to address curricular weaknesses.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide Background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2019

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

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

GUIDANCE

The ultimate board pass rate of a program's graduates is an important program outcome in addition to the rolling average first-time pass rate noted in Requirements V.3.C.a)-e). Neither should be considered in isolation. Note that most American Board of Medical Specialties boards allow up to seven years for a candidate to achieve board certification.

While the most recent three-year rolling average board pass rate may best reflect the preparation of the most recent graduates, the ultimate certification rates likely reflect the ultimate goal of the program to produce graduates who can practice independently and achieve board certification. This new requirement is intended to allow the ACGME to gather data on this information to determine its best use. The Program Evaluation Committee may also find this information valuable in assessing the program aims and goals.

The requirement does not specify a minimum for the ultimate certification rate, and programs will not be cited based on the new requirement unless they fail to provide the data requested. Programs will be deemed non-compliant with this requirement if the data are not collected and accurately reported. (See V.C.1.c).(6).(d)). If the information is not yet available from the respective certification board, the program may need to look up the certification status of its graduates from seven years ago to enter into the ACGME's Accreditation Data System.

Common Program Requirements

Section VI

NOTE: The Common Program Requirements in Section VI were approved in February 2017 and became effective July 1, 2017.

The mission and vision of the ACGME form the basis for Section VI of the Common Program Requirements.

Mission of the ACGME:
We improve health care and population health by assessing and advancing the quality of resident physician's education through accreditation.

Vision:
We imagine a world characterized by:
- A structured approach to evaluating the competency of all residents and fellows,
- Motivated physician role models leading all GME programs,
- High quality, supervised, humanistic clinical educational experience, with customized formative feedback,
- **Clinical learning environments characterized by excellence in clinical care, safety, and professionalism**,
- Residents and fellows achieving specialty specific proficiency prior to graduation,
- Residents and fellows are prepared to be Virtuous Physicians who place the needs and well-being of patients first.

VI.   The Learning and Working Environment

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

- *Excellence in the safety and quality of care rendered to patients by residents today*

- *Excellence in the safety and quality of care rendered to patients by today's residents in their future practice*

- *Excellence in professionalism through faculty modeling of:*

    o *the effacement of self-interest in a humanistic environment that supports the professional development of physicians*

    o *the joy of curiosity, problem-solving, intellectual rigor, and discovery*

- *Commitment of the well-being of the students, residents, faculty members, and all members of the health care team*

Background and Intent: The revised requirements are intended to provide greater flexibility within an established framework, allowing programs and residents more discretion to structure clinical education in a way that best supports the above principles of professional development. With this increased flexibility comes the

---

responsibility for programs and residents to adhere to the 80-hour maximum weekly limit (unless a rotation-specific exception is granted by a Review Committee), and to utilize flexibility in a manner that optimizes patient safety, resident education, and resident well-being. The requirements are intended to support the development of a sense of professionalism by encouraging residents to make decisions based on patient needs and their own well-being, without fear of jeopardizing their program's accreditation status. In addition, the proposed requirements eliminate the burdensome documentation requirement for residents to justify clinical and educational work hour variations.

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

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2017.
Requirements marked with an asterisk (*) are subject to citation July 1, 2019

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

VI.A.1.   Patient Safety and Quality Improvement

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

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

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

VI.A.1.a)   Patient Safety

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

A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and

attitudes of its personnel toward safety in order to identify areas for improvement.

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

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

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

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

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

[The Review Committee may further specify]

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

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

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

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

VI.A.1.a).(3).(a).(ii)	know how to report patient safety events, including near misses, at the clinical site; and, (Core)
*VI.A.1.a).(3).(a).(iii)	be provided with summary information of their institution's patient safety reports. (Core)

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

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

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

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

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

GUIDANCE

Much of section VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability, is addressed by the Clinical Learning Environment Review (CLER) Program. Results of CLER visits and recommendations for creating an environment for safe patient care and quality improvement are summarized in Issue Brief No. 2, which can be found on the ACGME website:

https://www.acgme.org/What-We-Do/Initiatives/Clinical-Learning-Environment-Review-CLER/Resources-and-Documents

The CLER teams collectively interviewed more than 1,000 executive leaders; 8,755 residents and fellows; 7,740 core faculty members; and 5,599 program directors at ACGME-accredited programs. Overarching themes of these visits include:

- Varying approach, degree, and capacity for engaging residents and fellows in patient safety and health care quality
- Varying degree of implementing GME in terms of these elements
- Varying degree of resources invested in these activities

From CLER Issue Brief No. 2:

"The ultimate goal of GME is to provide residents and fellows with the experiences that they need to deliver the safest and highest quality patient care and the opportunities to become well-versed enough in the science and practice of patient safety to lead improvements in patient care throughout their professional career.

In order to achieve this, they need to be able to identify risks to their patients, understand how to prioritize and mitigate those risks in a sustainable way, and know how to lead and role model these skills when they transition to independent practice. Medicine and health care delivery is continually evolving. It is therefore imperative to provide residents and fellows with lifelong skills to recognize system vulnerabilities, and to develop and implement strategies to mitigate these vulnerabilities, so that they are well prepared to meet the challenges of a continually changing health care environment throughout their careers.

The CLER Program findings demonstrate that education about patient safety has been introduced into GME. To date, much of the education has focused on didactic activities with much emphasis on online learning. There are many opportunities for Clinical Learning Environments (CLEs) to provide resident and fellow physicians with experiential learning, such as how to conduct patient safety event inquiries and translate the findings into systems-based improvements that result in better patient care.

The findings also suggest that resident and fellow physicians are beginning to engage in their CLEs' processes for reporting patient safety events. CLEs have an opportunity to build upon this engagement by increasing resident and fellow involvement in the processes of investigating events and providing feedback that results in creating and implementing plans to improve care. Lastly, it is important to note that resident and fellow physicians look to their mentors and other members of the health care team to model systems-based patient safety behaviors and lead the way in ongoing efforts to improve patient safety."

Why is it so important to teach residents and fellows safe patient care and quality improvement? Consider that the 32-year old resident today has the potential to be practicing beyond 2054. There are a number of studies that show that what residents and fellows learn during their education and training stays with them and affects their practice for many years to come.

1. **Asch, David A. "Evaluating Obstetrical Residency Programs Using Patient Outcomes."** *JAMA* **302, no. 12 (2009): 1277.**
   https://doi.org/10.1001/jama.2009.1356.
   Asch et al studied 4,906,169 deliveries by 4,124 physicians from 107 US OB residency programs. The programs were ranked based on FLEX, NBME Parts I, II, III, and USMLE Steps 1, 2, 3 scores. They found that women treated by obstetricians in the bottom quintile programs had one third higher complication rates that those from the top quintile and the effect was durable through 15-17 years after residency

2. **Chen, Candice, Stephen Petterson, Robert Phillips, Andrew Bazemore, and Fitzhugh Mullan. "Spending Patterns in Region of Residency Training and Subsequent Expenditures for Care Provided by Practicing Physicians for Medicare Beneficiaries."** *JAMA* **312, no. 22 (October 2014): 2385.**
   https://doi.org/10.1001/jama.2014.15973.

   Chen et al evaluated spending patterns in regions of residency training and their subsequent expenditures in practice based on multilevel, multivariable analysis of 2011 Medicare claims data from FM and IM residents 1992-2010. The Hospital Referral Regions (HRR) were classified based on expenditures as low-, average-, and high-spending. They determined that the spending levels during residency were associated with the same pattern of expenditures for subsequent care they provided
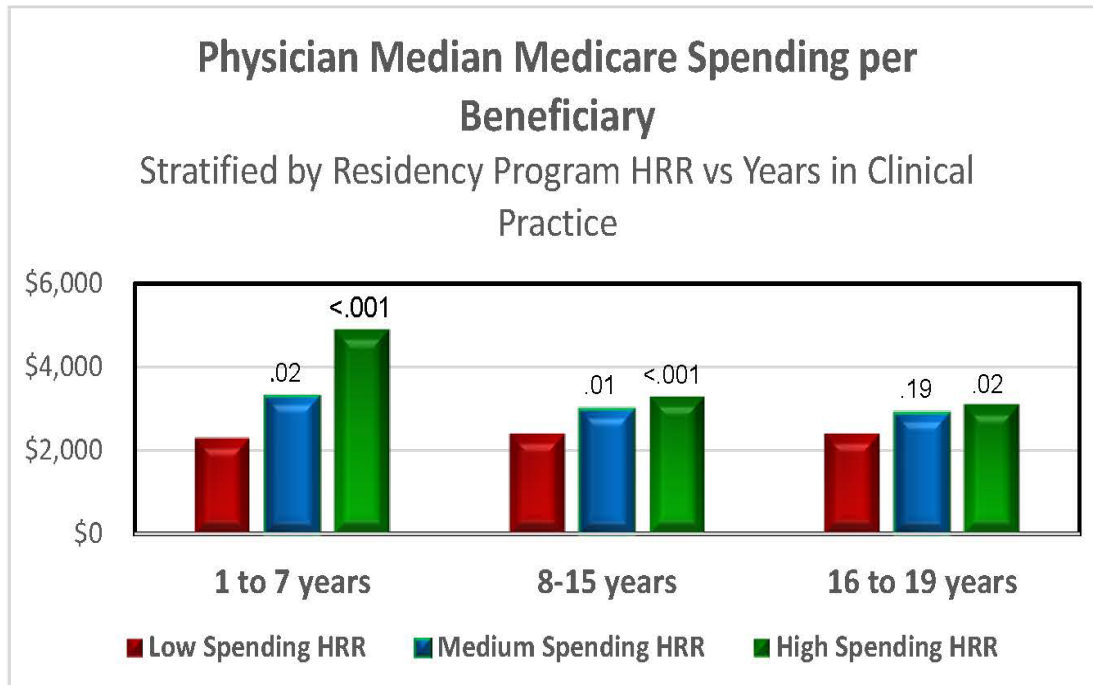
Physician Median Medicare Spending per Beneficiary
Stratified by Residency Program HRR vs Years in Clinical Practice

3. **Sirovich, Brenda E., Rebecca S. Lipner, Mary Johnston, and Eric S. Holmboe. "The Association between Residency Training and Internists' Ability to Practice Conservatively." *JAMA Internal Medicine* 174, no. 10 (January 2014): 1640. https://doi.org/10.1001/jamainternmed.2014.3337.**

   Sirovich et al evaluated the association between residency training and internist's ability to practice conservatively following graduation assessing the responses of 6,639 first-time takers of the ABIM certifying exam (357 programs). They divided the management options according to Appropriately Conservative Management (ACM) and Appropriately Aggressive Management (AAM) subscales. They defined the correct response as the least or most aggressive management strategy, and found that regardless of overall medical knowledge, internists trained at HRR (Hospital Referral Region) with lower-intensity medical practice were more likely to recognize when conservative management was appropriate and, more importantly, were capable of choosing an aggressive approach when indicated

References:
1. Leape, Lucian L. "Reporting of Adverse Events." *New England Journal of Medicine* 347, no. 20 (2002): 1633–38. https://doi.org/10.1056/nejmnejmhpr011493.

2. Nebeker, Jonathan R., Paul Barach, and Matthew H. Samore. "Clarifying Adverse Drug Events: A Clinicians Guide to Terminology, Documentation, and

Reporting." *Annals of Internal Medicine* 140, no. 10 (2004): 795. https://doi.org/10.7326/0003-4819-140-10-200405180-00009.

3. Kessler, D. A. "Introducing MEDWatch. A New Approach to Reporting Medication and Device Adverse Effects and Product Problems." *JAMA* 269, no. 21 (February 1993): 2765–68. https://doi.org/10.1001/jama.269.21.2765.

4. Gallagher, Thomas H. "Patients and Physicians Attitudes Regarding the Disclosure of Medical Errors." *JAMA* 289, no. 8 (2003): 1001. https://doi.org/10.1001/jama.289.8.1001.

5. Gallagher, Thomas H., Jane M. Garbutt, Amy D. Waterman, David R. Flum, Eric B. Larson, Brian M. Waterman, W. Claiborne Dunagan, Victoria J. Fraser, and Wendy Levinson. "Choosing Your Words Carefully." *Archives of Internal Medicine* 166, no. 15 (2006): 1585. https://doi.org/10.1001/archinte.166.15.1585.

6. White, Andrew A., Thomas H. Gallagher, Melissa J. Krauss, Jane Garbutt, Amy D. Waterman, W Claiborne Dunagan, Victoria J. Fraser, Wendy Levinson, and Eric B. Larson. "The Attitudes and Experiences of Trainees Regarding Disclosing Medical Errors to Patients." *Academic Medicine* 83, no. 3 (2008): 250–56. https://doi.org/10.1097/acm.0b013e3181636e96.

7. Chan, David K., Thomas H. Gallagher, Richard Reznick, and Wendy Levinson. "How Surgeons Disclose Medical Errors to Patients: A Study Using Standardized Patients." *Surgery* 138, no. 5 (2005): 851–58. https://doi.org/10.1016/j.surg.2005.04.015.

8. Chan, David K., Thomas H. Gallagher, Richard Reznick, and Wendy Levinson. "How Surgeons Disclose Medical Errors to Patients: A Study Using Standardized Patients." *Surgery* 138, no. 5 (2005): 851–58. https://doi.org/10.1016/j.surg.2005.04.015.

9. Gallagher, Thomas H., Jane M. Garbutt, Amy D. Waterman, David R. Flum, Eric B. Larson, Brian M. Waterman, W. Claiborne Dunagan, Victoria J. Fraser, and Wendy Levinson. "Choosing Your Words Carefully." *Archives of Internal Medicine* 166, no. 15 (2006): 1585. https://doi.org/10.1001/archinte.166.15.1585.

10. Gallagher, Thomas H. "Patients and Physicians Attitudes Regarding the Disclosure of Medical Errors." *JAMA* 289, no. 8 (2003): 1001. https://doi.org/10.1001/jama.289.8.1001.

11. Kessler, D. A. "Introducing MEDWatch. A New Approach to Reporting Medication and Device Adverse Effects and Product Problems." *JAMA* 269, no. 21 (February 1993): 2765–68. https://doi.org/10.1001/jama.269.21.2765.

12. Leape, Lucian L. "Reporting of Adverse Events." *New England Journal of Medicine* 347, no. 20 (2002): 1633–38. https://doi.org/10.1056/nejmnejmhpr011493.

13. Nebeker, Jonathan R., Paul Barach, and Matthew H. Samore. "Clarifying Adverse Drug Events: A Clinicians Guide to Terminology, Documentation, and Reporting." *Annals of Internal Medicine* 140, no. 10 (2004): 795. https://doi.org/10.7326/0003-4819-140-10-200405180-00009.

14. White, Andrew A., Thomas H. Gallagher, Melissa J. Krauss, Jane Garbutt, Amy D. Waterman, W Claiborne Dunagan, Victoria J. Fraser, Wendy Levinson, and Eric B. Larson. "The Attitudes and Experiences of Trainees Regarding Disclosing Medical Errors to Patients." *Academic Medicine* 83, no. 3 (2008): 250–56. https://doi.org/10.1097/acm.0b013e3181636e96.

CLER Recommendations for Education in Safe Patient Care, Quality Improvement, and Reporting of Adverse Events are Multi-modal:

Culture:
- Non-punitive approaches
- Identification of systems-based underlying causes
- Solutions aimed at correcting the underlying cases rather than pointing fingers at individuals

Didactics:
- Providing an overview of the risks and hazards of health care
- Common patient safety events in particular environments: for example, medication errors in high-risk areas such as the Emergency Department or ICUs, or in the operating rooms
- Prevention strategies
- How to report near misses/close calls and adverse events, including how to inform patients and families about an adverse event
- Where to find help when a patient safety event occurs

Experiential Learning
- Morbidity and mortality conferences
- Simulation activities

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2017. Requirements marked with an asterisk (*) are subject to citation July 1, 2019

VI. The Learning and Working Environment

VI.A.1.b)   Quality Improvement

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

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

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

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

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

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

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

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

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

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

[The Review Committee may further specify under any requirement in VI.A.1.b) – VI.A.1.b).(3).(a).(i)]

GUIDANCE

Much of Section VI.A., Patient Safety, Quality Improvement, Supervision, and Accountability, is addressed by the Clinical Learning Environment Review (CLER) Program. Results of CLER visits and recommendations for creating an environment for safe quality improvement are summarized in Issue Brief No. 3, which can be found on the ACGME website:

https://www.acgme.org/What-We-Do/Initiatives/Clinical-Learning-Environment-Review-CLER/Resources-and-Documents

The CLER teams collectively interviewed more than 1,000 executive leaders; 8,755 residents and fellows; 7,740 core faculty members; and 5,599 program directors at ACGME-accredited programs. Overarching themes of these visits include:

- While most residents and fellows indicated that they participate in quality improvement (QI) projects, many of those interviewed appeared to have a limited knowledge of QI concepts and the specific methods and approaches to QI employed by the institution. These include concepts such as a Plan-Do-Study-Act (PDSA) cycle.
- There were a limited number of clinical learning environments that reported an active effort to engage residents and fellows in QI efforts led by the hospital or medical center.
- Many clinical learning environments provided didactic learning, but experiential learning opportunities were uncommon.

From the CLER Issue Brief No. 3:

"If residents and fellows are to learn to improve the health of the populations they serve, they need to be aware of quality goals, such as those set by regulators, payers, and others outside the [clinical learning environment] CLE (e.g., use of universal protocol, reducing central line associated blood stream infections, catheter-associated urinary tract infections, or potentially avoidable 30-day readmissions). They should also learn to critically evaluate their CLE's own processes of patient care and how those affect patient outcomes."

Why is it so important to teach residents and fellows safe patient care and quality improvement? There are a number of studies that show that what residents and fellows learn during their education and training stays with them and affects their practice for many years to come. Consider that the 32-year old resident today has the potential to be practicing beyond 2054.

1. Asch, David A. "Evaluating Obstetrical Residency Programs Using Patient Outcomes." *JAMA* 302, no. 12 (2009): 1277. https://doi.org/10.1001/jama.2009.1356.

   - 4,906,169 deliveries
   - 4,124 physicians from 107 US OB residency programs
   - Program rankings from:
     - FLEX
     - NBME Parts I, II, III
     - USMLE Steps 1, 2, 3
   - Women treated by obstetricians in the bottom quintile had one third higher complication rates that those from the top quintile.
   - The effect was durable through 15-17 years after residency

2. Chen, Candice, Stephen Petterson, Robert Phillips, Andrew Bazemore, and Fitzhugh Mullan. "Spending Patterns in Region of Residency Training and Subsequent Expenditures for Care Provided by Practicing Physicians for Medicare Beneficiaries." *JAMA* 312, no. 22 (October 2014): 2385. https://doi.org/10.1001/jama.2014.15973.

   - Multilevel, multivariable analysis of 2011 Medicare claims data
   - FM, IM residents 1992-2010
   - Hospital Referral Region (HRR)
     - Low-
     - Average-
     - High-spending
   - Associated with expenditures for subsequent care they provided

Physician Median Medicare Spending per Beneficiary
Stratified by Residency Program HRR vs Years in Clinical Practice

3. Sirovich, Brenda E., Rebecca S. Lipner, Mary Johnston, and Eric S. Holmboe. "The Association Between Residency Training and Internists' Ability to Practice Conservatively." *JAMA Internal Medicine* 174, no. 10 (January 2014): 1640. https://doi.org/10.1001/jamainternmed.2014.3337.
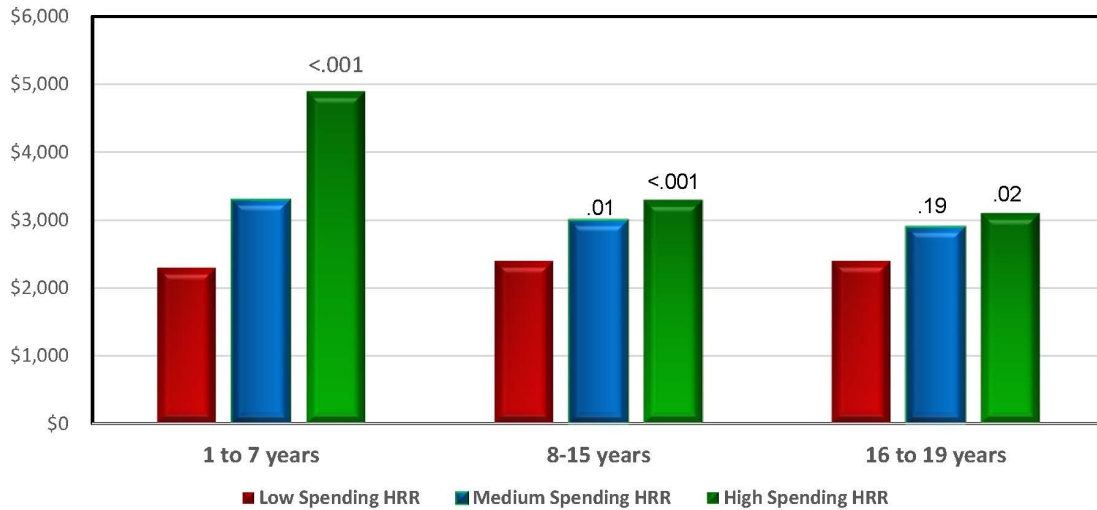
- Responses of 6,639 first-time takers of ABIM certifying exam (357 programs)
- Appropriately Conservative Management (ACM) and Appropriately Aggressive Management (AAM) subscales
- Correct response represented the least or most aggressive management strategy
- Regardless of overall medical knowledge, internists trained at HRR (Hospital Referral Region) with lower-intensity medical practice were more likely to recognize when conservative management is appropriate and, more importantly, are capable of choosing an aggressive approach when indicated

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CLER Recommendations for Graduate Medical Education in Health Care Quality

"Didactic approaches are helpful but insufficient, and data from the CLER site visits suggest that residents' and fellows' exposure to QI is often fragmented. Learners rarely have the opportunity to work through the full scope of an improvement effort. Instead, they may plan an intervention they never get to test, or implement a change with limited knowledge of the background evidence and no opportunity for follow-up evaluation. Experiential training in all phases of QI is necessary to develop the skills essential to improving health care quality.

QI is both a *systems-based and team-oriented activity*. Well-trained residents and fellows need to learn how to work with an interprofessional team to achieve sustained improvements in health care quality. Most resident-led projects, while expedient for meeting minimum educational standards, are limited in scope and can only expose the learners to some of the most basic elements of QI. Interprofessional, team-based quality improvement efforts, especially those that align with CLE priorities, provide residents and fellows with experiential learning that goes beyond basic QI methods to include developing skills and behaviors in shared leadership, communications, systems-based thinking, change management, and professionalism.

In order to optimize residents' and fellows' exposure to QI, at least some portion of their QI experience should address the populations for which they provide direct patient care. This requires timely, easy access to performance data at the level of their own patients so there is personal connection to the care processes and outcomes they are targeting for improvement. Residents and fellows also need access to support for data analysis. When this support is provided in a coordinated manner, the resulting information benefits both the resident, patients, and the CLE.

Optimal QI strategies should include *formal, reliable, and regular structural links between the efforts generated by residents, fellows, and faculty members and the CLE's staff-led efforts to improve care*. Coordinating resident and fellow QI efforts with those of the organization would benefit patients, tap into a rich resource of innovation, and provide the foundation for life-long QI success.

When CLEs *set expectations and actively work with faculty members* so that they become knowledgeable, skilled, and enthusiastically engaged in the CLE's QI efforts, it reinforces for residents and fellows the importance of QI to both their training and their future careers in patient care. While the CLER site visits focused principally on the residents and fellows, they need to learn from exemplary behaviors modeled by the faculty members who serve as their mentors."

"The ultimate goal of GME is to provide residents and fellows with the experiences that they need to deliver the safest and highest quality patient care. To accomplish this, it is essential that they become well-versed in the science and practice of health care QI and apply these skills throughout their professional careers.[6] In order to achieve this, they need to be able to engage with other members of patient care teams to continuously assess and improve the quality of care they and their teams provide."

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2017. Requirements marked with an asterisk (*) are subject to citation July 1, 2019

VI.   The Learning and Working Environment

VI.A.2.   Supervision and Accountability

August 20, 2019: [Review Committee further specification for section VI.A.2. is under review. No changes will be made to specialty-specific Program Requirements under this section until recommendations are finalized.]

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

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

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

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

VI.A.2.a).(1).(b)   Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. (Core)

VI.A.2.b)   *Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member, fellow, or senior resident physician, either on site or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.*

VI.A.2.b).(1)   The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)

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

VI.A.2.c)   Levels of Supervision

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

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

VI.A.2.c).(2)	Indirect Supervision:
VI.A.2.c).(2).(a)	with Direct Supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision. (Core)
VI.A.2.c).(2).(b)	with Direct Supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision. (Core)
VI.A.2.c).(3)	Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. (Core)
VI.A.2.d)	The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. (Core)
VI.A.2.d).(1)	The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones. (Core)
VI.A.2.d).(2)	Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. (Core)
VI.A.2.d).(3)	Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)
VI.A.2.e)	Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). (Core)

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

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

VI.A.2.e).(1).(a)   Initially, PGY-1 residents must be supervised either directly, or indirectly with direct supervision immediately available. [Each Review Committee may describe the conditions and the achieved competencies under which PGY-1 residents progress to be supervised indirectly with direct supervision available.] (Core)

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

GUIDANCE

Findings of the ACGME's Clinical Learning Environment Review (CLER) Program regarding supervision are reported in Issue Brief No. 6, which can be found on the ACGME website:

https://www.acgme.org/What-We-Do/Initiatives/Clinical-Learning-Environment-Review-CLER/Resources-and-Documents

"Across Clinical Learning Environments (CLEs), nearly all of the residents and fellows reported that they knew what they are allowed to do with and without direct supervision—a median of 100 percent.

In most CLEs (90.3 percent), the nurses interviewed on walking rounds reported that they primarily rely on trust rather than clear and objective methods for determining whether an individual resident is allowed to perform specific patient procedures without direct supervision."

"*Appropriate supervision is critical to patient safety*. These findings of the CLER visits illustrate the inconsistency of CLEs to provide nurses and other clinical staff members with explicit and accessible systems that provide detailed information on the level of supervision required of residents and fellows when performing patient procedures."

"Across most CLEs, residents, fellows, and faculty members reported an overall culture of close supervision within the GME community. CLEs also faced challenges of under- and over-supervision. Many faculty members and program directors perceived that external factors contribute to a culture of over-supervision that impeded resident and fellow readiness for clinical practice after training. The most common reason given for "over-supervision" was related to the CMS billing rules and medical liability."

"Across most CLEs, there were residents and fellows who reported that they have personally experienced, or had witnessed peers in clinical situations in which they felt there was inadequate supervision."

Examples of vulnerabilities mentioned during CLER visits include:

- When there are fewer attending physicians present on site, such as nights, weekends, and holidays
- When the resident or fellow is uncertain about when to seek support from the supervising attending physician
- When the resident or fellow is uncomfortable with contacting a specific supervising attending physician
- When the supervising physician is unavailable because of competing demands of other acute patient care situations and back-up supervision is not readily available

The issue of supervision is a complex one. While supervision is required for patient safety, there is also the need to prepare the next generation of physicians by allowing progressive authority and eventual independent practice. This balance is difficult to achieve.

CLER Conclusions and Next Steps:

"The ultimate goal of GME is to provide resident and fellow physicians with the clinical experiences necessary to acquire the knowledge, skills, and abilities that they need to deliver the safest and highest quality patient care. In order to achieve this, residents and fellows need appropriate supervision throughout their training. Providing close direct supervision provides the necessary comfort and assurance to minimize issues of patient safety for patients receiving care from residents and fellows in training. However, it is essential that residents and fellows are given the opportunity to provide care under indirect supervision to ensure that they develop into physicians who can practice independent of the training environment, and have the skills to ensure they deliver safe patient care over the 30 or more years of their clinical careers.

Patient care billing requirements, payment policies, and regulatory and accreditation rules may be influencing CLEs and residency programs to place restrictions on the amount of patient care that residents and fellows can perform without direct supervision. When this occurs, it impedes the ability of residents to progress from direct supervision through indirect supervision to successful independent practice at the completion of training. Addressing this set of issues will require a new national discussion to identify the best ways to manage these competing needs to ensure safe high quality care and the best possible GME experience.

The CLER Program findings demonstrate that residents and fellows believe that, in general, they are well supervised and know what they are allowed to do without direct supervision. It should be noted that this cycle of CLER visits was not designed to ascertain whether the residents' and fellows' beliefs about supervision are consistent with the beliefs of other members of the health care team, as well as their patients' views on supervision. The findings suggest that information about the required level of resident and fellow supervision may not be easily accessible to other members of the GME community (e.g., other residents or fellows) or other members of the clinical care team. To optimize patient safety, other members of the patient care team need to know the specific expectations for supervision of each individual resident and fellow, and need to act if there appears to be a need for closer supervision. Based on the findings from the first CLER National Report, it appears that engaging the GME community and the CLE's leadership in joint conversations to address the challenges regarding supervision of residents and fellows has the potential to greatly benefit patient care."

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)

This requirement is critical to the success of resident and fellow supervision. Because of many factors and responsibilities heaped on program directors and faculty members, they may be given short assignments of a week or even less. Short supervision assignments likely provide insufficient time for faculty members to get to know a resident or fellow to determine what their knowledge and skills are, and therefore should be avoided if possible.

There is an added complexity to the requirements for supervision – which is the increasing use of telemedicine. There are many models of telemedicine, including tele-stroke, tele-psychiatry, tele-dermatology, and tele-ophthalmology. In addition, telemedicine has been used for decades in specialties like radiology and emergency medicine. The use of telemedicine is increasingly adapted by institutions because of added patient satisfaction, ability to provide care and follow-up in remote areas, and significant cost savings. Supervision requirements in this section as they relate to telemedicine are currently under review.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2017. Requirements marked with an asterisk (*) are subject to citation July 1, 2019

VI. The Learning and Working Environment

VI.B.   Professionalism

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

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

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

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

> 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.

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

[The Review Committee may further specify]

> 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.

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

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

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

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

> 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.

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

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

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

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

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

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

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

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

VI.B.6.   Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff. (Core)

VI.B.7.   Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)

GUIDANCE

Links to Professionalism:
1. II.A.4.a).(1) The program director must be a role model of professionalism
2. IV.A.5. Educational Program - Professionalism
3. IV.B. and IV.B.1. Competencies - Professionalism
4. Milestones site:
   https://www.acgme.org/What-We-Do/Accreditation/Milestones/Overview/articleid/4536

There are many aspects of professionalism. The assessment of professionalism is included in every set of specialty or subspecialty milestones.
https://www.acgme.org/What-We-Do/Accreditation/Milestones/Overview/articleid/4536

Professionalism is at the core of being a physician, yet, teaching it is difficult. In addition to elements described in Section IV of the Common Program Requirements with regard to the educational program and the Competencies, professionalism as detailed in Section VI addresses other components.

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.

These "professional responsibilities" include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events. Patient care responsibilities provide residents and fellows experiential learning opportunities that cannot be replicated in other settings.

The age-old argument questions at what point patient care responsibilities interfere with learning because residents are required to fulfill non-physician obligations. As described in the Background and Intent section for this requirement, "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 stable patients from the wards or units for routine 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."

VI.B.2.c) [The learning objectives of the program must:] ensure manageable patient care responsibilities

"Manageable patient care responsibilities" are not defined in the Common Program Requirements. This varies by specialty, and more importantly, by PGY level. For specific requirements pertaining to patient number caps and other patient care responsibilities, refer to the specialty-specific Program Requirements at https://www.acgme.org/specialties.

VI.B.3. The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility.
(IV.B. and IV.B.a).(1).(a) to (g) Competencies Professionalism)

Professionalism includes an understanding of one's *personal* role in the management of patients as it relates to the safety and welfare of patients entrusted to the physician's care. This encompasses the ability to report unsafe conditions and adverse events. Physicians must also take responsibility to ensure that they are fit for work. As stated in the Background and Intent for this requirement: This requirement emphasizes the professional responsibility of faculty members and residents to arrive for work adequately rested and ready to care for patients. It is also the responsibility of faculty members, residents, and other members of the care team to be observant, to intervene, and/or to escalate their concern about resident and faculty member fitness for work, depending on the situation, and in accordance with institutional policies. This includes:

- Management of time before, during, and after clinical assignments
- Recognition of impairment (illness, fatigue, substance use) in themselves, their peers, and other members of the health care team
- Commitment to lifelong learning
- Monitoring patient care performance
- Accurate reporting of clinical and educational work hours (formerly referred to as duty hours), patient outcomes, and clinical experience data

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

The requirement of "responsiveness to patient needs that supersedes self-interest" may be misinterpreted as referring to continuing to provide patient care in the face of illness and fatigue, with the sense that one "just has to keep going." This is not, however, in the best interest of the patient. Fatigue and illness can contribute to medical and procedural errors. Therefore, residents and fellows should be aware that when they are ill or fatigued, it would be best to transition patient care responsibilities to another qualified and rested provider.

VI.B.6. Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty members, and staff members.

VI.B.7. Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns.

The above requirements are self-explanatory.

The ACGME Clinical Learning Environment Review (CLER) Program findings on professionalism are reported in Issue Brief No. 8, which can be found on the ACGME website:

https://www.acgme.org/What-We-Do/Initiatives/Clinical-Learning-Environment-Review-CLER/Resources-and-Documents

From this Issue Brief:

"The first cycle of CLER visits explored selected topics of professionalism, including issues of honesty, integrity, and mistreatment. Clinical Learning Environment (CLE) and GME leaders, residents and fellows, and other clinical providers reported their environment to be one that is generally respectful of one's colleagues. At the same time, a number of areas related to professionalism emerged as opportunities for improvement. Perhaps most notable was the critical issue of mistreatment. Verbal or non-verbal mistreatment, when tolerated even at very low rates of occurrence, can create a culture that does not support honest and open communication. This is true across all levels of interaction within GME. It also applies to interactions across health professions (e.g., physicians and nurses). One critical component to prevent, manage, and mitigate these issues is to establish a close working relationship that defines appropriate behavior clearly, as well as define prohibited practices. Creating a culture of professionalism within the clinical learning environment is a shared responsibility between GME and CLE leadership.

Professionalism is not solely an individual responsibility; it is shaped by the environment. Unprofessional behaviors may be an unconscious reaction to task misalignment, inconsistent expectations for accountability, or clinical productivity pressures. CLEs have a responsibility to create environments where professionalism can flourish.

Across CLEs, other aspects of professionalism, whether related to communication, documentation, or attribution, could all benefit from continual, coordinated engagement of GME and executive leadership. While general education about professionalism is ubiquitous, to date, most of the efforts appear to be passive and episodic – and appear

to be largely reactive. CLE and GME leaders need to actively collaborate to put in place systems that promote active experiential learning, proactive monitoring, and consistent approaches to addressing and eliminating unprofessional behaviors. The goal is to achieve and maintain a culture that supports safe, high quality patient care and sets an expectation for continuous professional development to ensure effective communication and cooperation among all health care providers."

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2017. Requirements marked with an asterisk (*) are subject to citation July 1, 2019

VI. The Learning and Working Environment

VI.C.   Well-Being

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

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

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

collaboration. Information regarding the ACGME's ongoing efforts in this area is available on the ACGME website.

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

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

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

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

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

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

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

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.

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

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.

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

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.

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

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

	program director or designated personnel should follow the policies of their institution for reporting.

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

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

Background and Intent: The intent of this requirement is to ensure that 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.

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

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

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

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

GUIDANCE

Tools and Resources for institutions and programs to support physician well-being are located at:

https://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being/Resources/articleid/4533

> Topics include:
> - o Tools and Resources
> - o Identifying and Addressing Burnout
> - o Promoting Well-Being
> - o Assessing and Addressing Emotional and Psychological Distress/Depression/Suicide
> - o Improving the Learning and Working Environment
> - o Coping with Tragedy
> - o Other Institutional/Partner Sites and Resources

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

I.D. Resources

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2017. Requirements marked with an asterisk (*) are subject to citation July 1, 2019

VI. The Learning and Working Environment

VI.D.   Fatigue Mitigation

VI.D.1.   Programs must:

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

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

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

Background and Intent: Providing medical care to patients is physically and mentally demanding. Night shifts, even for those who have had enough rest, cause fatigue. Experiencing fatigue in a supervised environment during training prepares fellows for managing fatigue in practice. It is expected that programs adopt fatigue mitigation processes and ensure that there are no negative consequences and/or stigma for using fatigue mitigation strategies.

This requirement emphasizes the importance of adequate rest before and after clinical responsibilities. Strategies that may be used include, but are not limited to, strategic napping; the judicious use of caffeine; availability of other caregivers; time management to maximize sleep off-duty; learning to recognize the signs of fatigue, and self-monitoring performance and/or asking others to monitor performance; remaining active to promote alertness; maintaining a healthy diet; using relaxation techniques to fall asleep; maintaining a consistent sleep routine; exercising regularly; increasing sleep time before and after call; and ensuring sufficient sleep recovery periods.

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

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

GUIDANCE

Below are links to presentations that address fatigue mitigation education:

https://sites.duke.edu/thelifecurriculum/2014/05/08/the-life-curriculum/

Results of Clinical Learning Environment Review (CLER) Program visits and recommendations relating to fatigue management, mitigation, and duty hours are summarized in Issue Brief No. 7, which can be found on the ACGME website:

https://www.acgme.org/What-We-Do/Initiatives/Clinical-Learning-Environment-Review-CLER/Resources-and-Documents

There are several points noted in this Issue Brief:

1. In general, clinical learning environments had developed and implemented some form of fatigue management for residents and fellows. Strategies included those required by accreditation standards (e.g., adherence to duty hour restrictions, availability of call rooms, and education on fatigue management), as well as other strategies (such as offering taxi rides when a resident is too tired to drive home).

2. In many clinical learning environments, residents, fellows, faculty members, and nurses reported observing resident fatigue related to factors other than the number of hours worked (e.g., periods of high patient volume or high-acuity patient care).

   a. Many faculty members and program directors focused on duty hours and did not consider other contributing factors outside of work, such as a new baby, sick family member, financial difficulties, or other stressors that could impact resident and fellow fatigue, irrespective of the hours worked.

3. In many clinical learning environments, faculty members reported a significant increase in their own fatigue.

4. Many faculty members and program directors perceived that there could be increased risk to patients due to frequent hand-offs prompted by institutional efforts to comply with duty hour requirements.

5. In most clinical learning environments, there were program directors who were aware of patient safety events that had occurred at the clinical learning environment that were related to resident fatigue. Executive leadership, GME leadership, and patient safety leadership at these sites were not always aware of these events.

6. Across many clinical learning environment, residents and fellows reported that they frequently completed their documentation in the electronic health record at home and did not always count this time when reporting their duty hours.

Most clinical learning environments have met their responsibilities to follow duty hour requirements and implemented the basic strategies required for ACGME accreditation. Nevertheless, residents, fellows, faculty members, and nurses still report instances of resident and fellow fatigue. Fatigued providers can place patients at risk for medical errors, and also jeopardize their own health (e.g., car accidents, burnout). Fatigue management is about both patient safety and provider well-being. Moreover, "fatigue" can also be a precursor to burnout or a marker for depression. Clinical learning environments should be encouraged to train residents, fellows, faculty members, and other clinical staff members to consider such factors—and not only work hours—in determining a provider's "fitness for duty."

For meaningful change to occur and be sustained, clinical learning environments have to promote a culture that focuses on prevention, early detection, and meaningful mitigation of fatigue. An appropriate culture promotes a positive response when a person acknowledges being fatigued—encouraging the person to engage back-up systems. Similarly, a supportive culture celebrates asking for help when fatigued as a sign of good clinical judgment and strength rather than of weakness. A well-functioning system would include a low threshold for residents and fellows to report fatigue and easy mechanisms to invoke a back-up system to support or relieve them of their clinical activities until rested. To overcome widespread resident and fellow reluctance to using these solutions, they must be viewed as both accessible and non-punitive—protecting both the fatigued individual and other team members who may need to assume additional clinical responsibilities until the fatigued individual is rested.

These findings demonstrate there are substantive opportunities to improve patient safety if clinical learning environments engage their frontline clinical providers, including the GME community, in re-envisioning how to more effectively prevent and manage fatigue and its impact on patient safety in their health care environments.

REQUIREMENTS

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Text in boxes provide background and Intent

Common Program Requirement:

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VI. The Learning and Working Environment

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

VI.E.1.   Clinical Responsibilities

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

[Optimal clinical workload may be further specified by each Review Committee]

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.

VI.E.2.   Teamwork

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

[The Review Committee may further specify]

VI.E.3.   Transitions of Care

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

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

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

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

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

GUIDANCE

The emphasis of Common Program Requirement Section VI.E., Clinical Responsibilities, Teamwork, and Transitions of Care, is on team-based care and transitions of care.

The Clinical Learning Environment Review (CLER) Program's Issue Brief No. 5 addresses care transitions, and can be found on the ACGME website:

https://www.acgme.org/What-We-Do/Initiatives/Clinical-Learning-Environment-Review-CLER/Resources-and-Documents

As with all of the CLER Issue Briefs, this section is preceded by a narrative. In this instance, a chief resident expresses frustration over a nursing home transfer of a critically-ill patient with an acute abdomen about whose very complicated prior medical and surgical history she had absolutely no information. This lack of knowledge by the receiving physician posed significant risks to the care of the patient. This narrative highlights the risks of communication failure when patients are transferred from one service to another, or from one institution to another.

Findings described in this Issue Brief:

1. In general, clinical learning environments are working to standardize and improve their processes for transitioning patients from the acute hospital setting to post-acute care. Residents and fellows were occasionally engaged in these efforts

2. Across clinical learning environments, executive leadership, quality and patient safety leaders, residents and fellows, faculty members, and program directors varied in the degree to which they were aligned in the transitions in care they identified as vulnerable to patient safety.

3. Most clinical learning environments did not appear to have a standardized approach to facilitating resident and fellow hand-offs at change-of-duty that included the essential elements of safe, reliable transitions of care.

4. Across clinical learning environments, a limited number of programs appeared to use formal criteria to assess residents' and fellows' skills in change-of-duty hand-offs. It was uncommon for programs to consistently engage faculty members in observing resident and fellow hand-offs.

The following is a list of elements that should be common to all hand-offs, as noted in CLER Issue Brief No. 5:

1. The creation of "to-do" lists
2. The use of "if-then" statements
3. The ability and expectation for the receiver of information to ask questions
4. "Read-back" at the end of a patient hand-off
5. Setting of expectations for when it is essential to move the hand-off to the patient's bedside

From the Issue Brief:

"In order to ensure safe patient care, residents, fellows, and faculty members need to be able to work with the other members of the health care team to identity and address challenges to consistent and reliable transitions in care. These practices are essential since health care will likely increase over time in complexity, with more providers and ways in which care is managed for each patient creating even more risks to a patient during transitions unless deliberate actions are taken to mitigate them."

What is a hand-off?
A hand-off is commonly defined as an activity for the transfer of patient information and knowledge along with authority and responsibility, from one clinician or team of clinicians to another clinician or team of clinicians during transitions of care across the continuum.

The Joint Commission defines hand-off as a "transfer and acceptance of patient care responsibility achieved through effective communication. It is a real-time process of passing patient-specific information from one caregiver to another or from one team of caregivers to another for the purpose of ensuring the continuity and safety of the patient's care."

https://www.jointcommission.org/assets/1/18/SEA_58_Hand_off_Comms_9_6_17_FINAL_(1).pdf

The Joint Commission lists the following critical elements of a hand-off:

- Sender contact information
- Illness assessment, including severity
- Patient summary, including events leading up to illness of admission, hospital course, ongoing assessment, and plan of care
- To-do action list
- Contingency plans
- Allergy list
- Code status
- Medication list
- Dated laboratory tests
- Dated vital signs

Inadequate hand-offs can result in a real potential for patient harm, from minor to severe.

There are numerous efforts across specialties, institutions, and regulatory organizations to improve hand-offs. The following links provide examples and information related to hand-offs:

1. The American College of Obstetricians and Gynecologists provided a committee opinion on communication strategies for patient hand-offs:

https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Patient-Safety-and-Quality-Improvement/Communication-Strategies-for-Patient-Handoffs?IsMobileSet=false

2. Agency for Healthcare Research and Quality:
https://psnet.ahrq.gov/primers/primer/9/Handoffs-and-Signouts

3. Standardization of Inpatient Handoff Communication – from the American Academy of Pediatrics Committee on Hospital Care
https://pediatrics.aappublications.org/content/138/5/e20162681

There are also many studies related to hand-offs. Below are a few references:

1. Abraham, Joanna, Thomas G. Kannampallil, and Vimla L. Patel. "Bridging Gaps in Handoffs: A Continuity of Care Based Approach. *Journal of Surgical Education* 65, no. 6 (2008): 476-485.
2. Cohen, Michael D, Brian Hilligoss, and André Kajdacsy-Balla Amaral. "A Handoff Is Not a Telegram: an Understanding of the Patient Is Co-Constructed." *Critical Care* 16, no. 1 (2011): 303. https://doi.org/10.1186/cc10536.
3. Solet, Darrell J., J Michael Norvell, Gale H. Rutan, and Richard M. Frankel. "Lost in Translation: Challenges and Opportunities in Physician-to-Physician Communication During Patient Handoffs." *Academic Medicine* 80, no. 12 (2005): 1094–99. https://doi.org/10.1097/00001888-200512000-00005.
4. Wohlauer, Max V., Vineet M. Arora, Leora I. Horwitz, Ellen J. Bass, Sean E. Mahar, and Ingrid Philibert. "The Patient Handoff." *Academic Medicine* 87, no. 4 (2012): 411–18. https://doi.org/10.1097/acm.0b013e318248e766.

REQUIREMENTS

Text in italics are "philosophic" statements
Text in boxes provide background and Intent

Common Program Requirement:

Requirements below are subject to citation July 1, 2017. Requirements marked with an asterisk (*) are subject to citation July 1, 2019

VI. The Learning and Working Environment

VI.F.   Clinical Experience and Education

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

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.

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

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

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

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

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

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

During the public comment period many individuals raised questions and concerns related to this change. Some questioned whether minute by minute tracking would be required; in other words, if a resident spends three minutes on a phone call and then a few hours later spends two minutes on another call, will the resident need to report

that time. Others raised concerns related to the ability of programs and institutions to verify the accuracy of the information reported by residents. The new requirements are not an attempt to micromanage this process.

Residents are to track the time they spend on clinical work from home and to report that time to the program. Decisions regarding whether to report infrequent phone calls of very short duration will be left to the individual resident. Programs will need to factor in time residents are spending on clinical work at home when schedules are developed to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks. There is no requirement that programs assume responsibility for documenting this time. Rather, the program's responsibility is ensuring that residents report their time from home and that schedules are structured to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks.

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

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

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.

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

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.

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

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."

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

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

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

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

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

The Task Force examined the impact of the request to consider 16-consecutive-hour limits for all residents, and rejected the proposition. It found that model incompatible with the actual practice of medicine and surgery in many specialties, excessively limiting in configuration of

clinical services in many disciplines, and potentially disruptive of the inculcation of responsibility and professional commitment to altruism and placing the needs of patients above those of the physician.

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

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

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

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.

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

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

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

VI.F.4.c)	A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.
VI.F.4.c).(1)	In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the *ACGME Manual of Policies and Procedures*. (Core)
VI.F.4.c).(2)	Prior to submitting the request to the Review Committee, the program director must obtain approval from the Sponsoring Institution's GMEC and DIO. (Core)

Background and Intent: The provision for exceptions for up to 88 hours per week has been modified to specify that exceptions may be granted for specific rotations if the program can justify the increase based on criteria specified by the Review Committee. As in the past, Review Committees may opt not to permit exceptions. The underlying

> philosophy for this requirement is that while it is expected that all residents should be able to train within an 80-hour work week, it is recognized that some programs may include rotations with alternate structures based on the nature of the specialty. DIO/GMEC approval is required before the request will be considered by the Review Committee.

VI.F.5.   Moonlighting

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

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

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

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

VI.F.6.   In-House Night Float

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

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

> 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.

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

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

VI.F.8.   At-Home Call

VI.F.8.a)   Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit.

The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. (Core)

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

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

[The Review Committee may further specify under any requirement in VI.F. – VI.F.8.b)]

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.

GUIDANCE

Section VI.F. of the Common Program Requirements addresses Clinical Experience and Education. In the current 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 were made in response to concerns that the 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.

The hours of clinical and educational work have received much attention and debate over the past few decades. There have been multiple iterations of the work hour requirements, each set generating significant controversy.

In a letter by ACGME President and Chief Executive Officer Dr. Thomas J. Nasca in *Health Affairs* (2008; 27(5):1484) regarding resident duty hour limits, he stated that. "the goal is not creating a better way to "watch the clock", but rather, ensuring that conditions conducive to resident learning, socialization to the medical profession, and safe and effective patient care consistently occur. This is what ACGME aims to achieve in its efforts to refine the standards and accreditation approach related to duty hours in the coming months."

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

The language contained in the requirements bears repeating: *Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period*, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting.

It is a matter of simple math that programs that regularly schedule residents to work 80 hours per week and still permit them to remain beyond their scheduled work period will undoubtedly exceed the 80-hour maximum, which would not be in substantial compliance with the requirement. The Common Program Requirement for the 80-hour maximum workweek (averaged over a four-week period) was approved in on March 10, 2017 and became effective and subject to citation July 1, 2017.

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.

In a letter to the community on January 9, 2019, Dr. Nasca emphasized the need to meet this requirement:

"As we start off the New Year, this letter is a reminder of the importance of creating a clinical learning environment that focuses on a culture of patient safety in residency and fellowship programs year round. An important component of creating that environment is compliance with the Maximum Hours of Clinical and Educational Work per Week requirement (Common Program Requirement VI.F.1.) that went into effect in July 2017. This ACGME Common Program Requirement states that "Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)"

In 2016, the ACGME requested position statements on resident and fellow work hours from every specialty society and program directors association. Without exception, specialty societies affirmed their support for the 80-hour standard, when averaged over four weeks, while requesting greater flexibility for programs and residents and fellows within those maximum hours. The ACGME provided the requested increased flexibility, but emphasized that non-compliance from the 80-hour rule would not be tolerated. In other words, with increased flexibility as introduced into the Requirements, programs will need to account for the potential for residents and fellows to remain beyond their assigned work periods when developing schedules, to avoid exceeding the 80-hour maximum weekly limit, averaged over four weeks. This responsibility rests with the program and it's Sponsoring Institution.

The ACGME Common Program Requirements' new Background and Intent for this requirement provides direction to programs and Sponsoring Institutions in this regard. "*Programs that regularly schedule residents to work 80 hours per week and still permit residents/fellows to remain beyond their scheduled work period are likely to exceed the 80-hour maximum, **which would not be in substantial compliance with the requirement**.(emphasis added) These programs should adjust schedules so that residents/fellows are scheduled to work fewer than 80 hours per week, which would allow residents/fellows to remain beyond their scheduled work period when needed without violating the 80-hour requirement. Programs may wish to consider using night float and/or making adjustments to the frequency of in-house call to ensure compliance with the 80-hour maximum weekly limit.*"

As stated in the Background and Intent on oversight responsibilities: *"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."* In June 2018, the ACGME Board of Directors reaffirmed its strict interpretation of the 80-hour rule, and program compliance for the 2017-2018 academic year is now being assessed. Accordingly, Review Committees are now meeting and reviewing annual accreditation data based on these requirements, and will be issuing citations where violations of the 80-hour limit are identified."

Some studies indicate that working more than 80 hours per week has adverse effects:

1. David Ouyang and his colleagues conducted a retrospective cohort study to determine whether housestaff working more than 80 hours per week had an impact on patient care in an inpatient general medicine service. Of the 4,767 hospitalizations reviewed, 41 percent were cared for by housestaff who worked more than 80 hours per week. These patients had a significantly higher length of stay, and a higher rate of ICU transfer. There was no association between hours worked with in-hospital mortality or 30-day readmission rates. (Ouyang, David, Jonathan H. Chen, Gomathi Krishnan, Jason Hom, Ronald Witteles, and Jeffrey Chi. "Patient Outcomes When Housestaff Exceed 80 Hours per Week." *The American Journal of Medicine* 129, no. 9 (2016). https://doi.org/10.1016/j.amjmed.2016.03.023.)

2. Desai and colleagues conducted a study of 63 internal medicine programs to determine if there were differences between residents who adhered to the 2011 ACGME duty hour policies compared to those who worked under more flexible policies that had no limits on shift length or mandatory time off between shifts. It is interesting to note that the interns in the flexible hours programs were less satisfied with their educational experience (includes educational quality and overall well-being), but their program directors were more satisfied with overall educational quality, including having time for bedside teaching. (Desai, Sanjay V., David A. Asch, Lisa M. Bellini, Krisda H. Chaiyachati, Manqing Liu, Alice L. Sternberg, James Tonascia, et al. "Education Outcomes in a Duty-Hour Flexibility Trial in Internal Medicine." *New England Journal of Medicine* 378, no. 16 (2018): 1494–1508. https://doi.org/10.1056/nejmoa1800965.)

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

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. The requirements in this category are self-explanatory.

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

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

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

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

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

Important Message

The Background and Intent section related to this requirement underwent extensive discussion by the Common Program Requirements Task Force. The group examined the question of "consecutive time on task" and the research supporting the ACGME limit of 16 consecutive hours of time on task for PGY-1 residents. There were 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, the Task Force heard a uniform request by the specialty societies, certifying boards, membership societies and organizations, and senior residents to repeal this requirement. It heard conflicting perspectives from resident unions, a medical student association, and a number of public advocacy groups, some arguing for continuation of the requirement, others arguing for extension of the requirement to all residents.

Of greatest concern to the Task Force were the observations of disruption of team care and patient care continuity brought about with residents beyond the PGY-1 level adhering to differing requirements. The graduate medical education community uniformly requested that the Task Force remove this requirement. The most frequently-cited reason for this request was the complete disruption of the team, separating the PGY-1 from supervisory faculty members and residents who were best able to judge the ability of the resident and customize the supervision of patient care for each PGY-1.

Cited nearly as frequently was the separation of the PGY-1 from the team, delaying maturation of clinical skills, and threatening to create a "shift" mentality in disciplines where overnight availability to patients is essential in delivery of care.

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

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

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

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

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

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

> VI.F.4.a) In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:
>
> > VI.F.4.a).(1) to continue to provide care to a single severely ill or unstable patient;
> >
> > VI.F.4.a).(2) humanistic attention to the needs of a patient or family; or,
> >
> > VI.F.4.a).(3) to attend unique educational events.

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

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

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

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

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. Designated Institutional Official (DIO)/Graduate Medical Education Committee (GMEC) approval is required before the request will be considered by the Review Committee.

VI.F.8. At-Home Call

There are a number of requirements related to home call.
- Time spent on patient care activities by residents at home call must count towards the 80-hour maximum.
- It is not subject to the every third night limitation, but must meet the requirement for one day in seven off.
- It must not be so frequent that it precludes rest or reasonable personal time.
- Activities such as reading about the next day's case, studying, or research activities do not count toward the 80-hour weekly limit.

One of the most common misconceptions regarding this requirement is that residents and fellows are required to record every single minute they are spending on home call answering phone calls, and providing documentation. This is not the expectation. However, program directors must ensure that time spent on home call is reasonable.

Appendix

Appendix 1.

A Literature Review on Topics Related to Diversity and Inclusion

Table of Contents

Organization of the Bibliography

This annotated bibliography of the literature on diversity and inclusion in medical education and teaching settings was compiled by staff of the Accreditation Council for Graduate Medical Education (ACGME) in early 2018. The bibliography seeks to offer a broad view across different segments of individuals in medical education and medicine or are viewed, or who view themselves, as minorities. This includes racial and ethnic minorities, sex/gender minorities, and women in some contexts. The organization of the bibliography is intended to highlight the different dimensions of this sizable body of literature. Sections are arrayed in reverse chronological order, with the newest articles first, to show the historical evolution of these topics. The bibliography opens with a section on meta-analyses, and systematic and narrative reviews on all topics in the remainder of the compilation. Bolding of selected text in the abstracts was added by the curator to emphasize important findings.

For the sections on affirmative action, representation of minority individuals in medical education, the experience of the minority physicians in the medical environment, and efforts to promote diversity and inclusion in medical education and in teaching settings, the bibliography is comprehensive and encompasses all published original research, policy discussions, and descriptions of programs. For the related subjects of cultural competence and sensitivity, and on

health disparities related to race/ethnicity or other minority status, the bibliography includes key literature to explain the interdependence of these topics with the topic of diversity and inclusion.

Summary

Minority Representation in the Physician Workforce

In total, the literature shows that individuals from populations underrepresented in medicine (URM) continue to make up a disproportionately smaller percentage of the physician workforce compared to their representation in the US population. Whites comprise greater proportions of medical students, residents, and faculty than African Americans and Latino Americans, respectively. African American males are particularly underrepresented in medicine, when compared to African American females and other minority groups. In addressing this disparity in education, a challenge is the medical education "pipeline," with minority individuals, particularly African American men accounting for a disproportionately smaller percentage of individuals enrolled in and completing postsecondary education. In addition, minorities have higher attrition rates in all phases of medical education, with attrition rates of 5 to 6.5% for all graduates, above 15% for students from underrepresented minorities (URM), and 4.0% or less for non-URM students. Students withdrawing from medical education for academic difficulties comprise 75% of URM withdrawals, compared to 57% of non-URM withdrawals.

Efforts to increase minority representation in medicine by focusing on education-pipeline interventions, such as the Association of American Medical Colleges' *Project 3000 by 2000*, did not meet their targets, due to challenges to affirmative action in a number of states in the mid to late 1990s. As a consequence, minority representation in some areas in medicine is unchanged of the past four decades. Studies of barriers to pursuit of a medical career by women and underrepresented minorities have found that aspects of the basic science curriculum, particularly chemistry, are perceived barriers for this population. Another barrier at all levels of medical education is the lack of race- and/or gender-congruent mentors and role models. Minority learners and residents also are at higher risk for adverse academic status events, as well as adverse life events that may affect their education. Another common theme in the literature includes the generally lower standardized test scores and general academic achievement for minority learners.

Experience of Women and Minority Learners and Faculty

Regardless of the type of minority status, including racial/ethnic and sex/gender, members of minorities report "microaggressions" (low-level, covert acts of aggression), "microinsults," and "microinvalidations." Often bystanders, including faculty, peers and colleagues, ignore these events, instead of intervening, suggesting a need for "ally training." In addition, feeling excluded and feeling a lack of a support system are other common themes in the reports of the experience of all types of minority participants in medical education. Recent studies still who a considerable degree of gender identity concealment for sexual and gender minority students and residents.

Although women now make up a sizable proportion of medical students, female students learn how to confront and respond to inappropriate behavior from male patients. However, these students do not feel equipped to respond to the unprofessional behavior of male supervisors, resulting in feelings of guilt and resignation over time that such events would be a part of their professional identity. Women and underrepresented minorities continue to make up a lower percentage of tenured faculty in academic medicine, with males at the highest percentage.

There are pay differences, and lower academic progression and promotion rates for female and minority faculty. Women from underrepresented minority groups and PhDs perceive a double disadvantage. While women currently make up one-half of medical school graduates, women, along with individuals of color, continue to be underrepresented in leadership positions, with one consequence a lack of leadership role models for women and minority individuals. When women and minority faculty are given leadership positions, these frequently are "minority-focused," "nurturing" or "advocacy" roles

Studies overall have found a lower prevalence of burn out and depressive symptoms in minority students, although minority students are more likely to report that a race-related incident adversely affected their medical school experience, and to cite this as a cause for burn out and low-quality of life. In some studies, minority medical students report a lower sense of personal accomplishment.

Despite emphasis on a diverse learning environment, some learners from underrepresented minorities question whether their institutions truly value having a diverse group of learners and faculty. Many learners report they think that lack of diversity in their on campus was a barrier to recruiting and retaining minority candidates, and commented on the institution's limited social, academic, and financial support, as well as inadequate efforts to recruit minority students.

Minority Physician Contributions to Addressing Health Disparities

A constant argument for diversity and inclusion is that healthcare workforce diversity enhances access for minority patients and populations, and that cultural competence is importance to allowing physicians to provide culturally sensitive and appropriate care to all patients, regardless of their minority status. The literature consistently showed a greater contribution by minority physicians to the care of minority patients, and across race and ethnicity, to the care of patients facing challenges with access to care.

An interesting sub-theme is whether it is ethical to expect this contribution to the care of underserved patients of this group of physicians.

Bias in the Learning and Working Environment

There is significant implicit and some explicit bias in the learning environment, which is expressed in implicit white-favoring bias on objectives tests; bias in assessment of women and minority learners; and norming of male stereotypes in the "ideal" learner in some specialties such as emergency medicine. There also is an overrepresentation of minorities in clinical questions in standardized tests to assess medical knowledge, with minority status used as a proxy for genetics, social class or life style factors, which contributes to bias in learners taking these tests. Finally, research shows both attentional blindness to minority members, and implicit bias in children and adults regarding minority individuals perceptions of pain, which extends to health professionals.

Systematic Reviews

Hasnain M, Massengale L, Dykens A, Figueroa E. Health disparities training in residency programs in the United States. Fam Med. 2014 Mar;46(3):186-91. Review.

BACKGROUND AND OBJECTIVES: The objective was to review and summarize extant literature on US-based graduate medical education programs to guide the development of a health disparities curriculum.

METHODS: The authors searched Medline using PubMed, Web of Science, and Embase for published literature about US-based graduate medical education programs focusing on training residents to care for underserved and vulnerable populations and to address health disparities. Articles were reviewed and selected per study eligibility criteria and summarized to answer study research questions.

RESULTS: Of 302 initially identified articles, 16 (5.4%) articles met study eligibility criteria. A majority, 15 (94%), of reported programs were from primary care; one (6.25%) was from surgery. **Eight (50%) programs reported longitudinal training; seven (44%) reported block experiences, while one (6.25%) described a one-time Internet-based module. Four (25%) programs required residents to develop and complete a research project, and six (37.5%) included community-based clinical training. All 16 programs utilized some form of evaluation to assess program impacts.**

CONCLUSIONS: There are few published reports of graduate medical education programs in the United States that focus on preparing residents to address health disparities. Reported programs are mostly from primary care disciplines. Programs vary in curricular elements, using a wide variety of training aims, learner competencies, learning activities, and evaluation methods. This review highlights the need for published reports of educational programs aimed at training residents in health disparities and underserved medicine to include the evidence for effectiveness of various training models.

Rodriguez JE, Campbell KM, Fogarty JP, Williams RL. Underrepresented minority faculty in academic medicine: a systematic review of URM faculty development. Fam Med. 2014 Feb;46(2):100-4.

BACKGROUND AND OBJECTIVES: Retention and recruitment of minority faculty members continues to be a concern of medical schools because there is higher attrition and talent loss among this group. While much has been written, there has not been a systematic review published on this topic. This is the first study to use evidence-based medicine (EBM) criteria and apply it to this issue.

METHODS: The authors searched MEDLINE, Web of Knowledge, ProQuest, and Google Scholar for papers relating to the recruitment and retention of minority faculty. They graded the evidence using the EBM criteria as defined by the American Academy of Family Physicians. The same criteria were applied to extract evidence-based observations of problems in recruitment and retention for minority faculty.

RESULTS: Of the 548 studies identified and reviewed, 11 met inclusion criteria for this literature review. **This article presents the data from the reviewed papers that described or**

evaluated minority faculty development programs. **Faculty development programs in 15 different institutions showed mentoring and faculty development for minority faculty could increase retention, academic productivity, and promotion rates for this group.**

CONCLUSIONS: For medical schools to be successful in retention and recruitment of minority medical school faculty, specific programs need to be in place. Overall evidence is strong that faculty development programs and mentoring programs increase retention, productivity, and promotion for this group of medical faculty. This paper is a call to action for more faculty development and mentorship programs to reduce the disparities that exist between minority faculty and all other faculty members.

Beech BM, Calles-Escandon J, Hairston KG, Langdon SE, Latham-Sadler BA, Bell RA. Mentoring programs for underrepresented minority faculty in academic medical centers: a systematic review of the literature. Acad Med. 2013 Apr;88(4):541-9.

PURPOSE: Mentoring is critical for career advancement in academic medicine. However, underrepresented minority (URM) faculty often receive less mentoring than their nonminority peers. The authors conducted a comprehensive review of published mentoring programs designed for URM faculty to identify "promising practices."

METHOD: Databases (PubMed, PsycINFO, ERIC, PsychLit, Google Scholar, Dissertations Abstracts International, CINHAL, Sociological Abstracts) were searched for articles describing URM faculty mentoring programs. The RE-AIM framework (Reach, Effectiveness, Adoption, Implementation, and Maintenance) formed the model for analyzing programs.

RESULTS: The search identified 73 citations. **Abstract reviews led to retrieval of 38 full-text articles for assessment; 18 articles describing 13 programs were selected for review. The reach of these programs ranged from 7 to 128 participants. Most evaluated programs on the basis of the number of grant applications and manuscripts produced or satisfaction with program content. Programs offered a variety of training experiences, and adoption was relatively high, with minor changes made for implementing the intended content. Barriers included time-restricted funding, inadequate evaluation due to few participants, significant time commitments from mentors, and difficulty in addressing institutional challenges faced by URM faculty. Program sustainability was a concern because programs were supported through external funds, with minimal institutional support.**

CONCLUSIONS: Mentoring is an important part of academic medicine, particularly for URM faculty who often experience unique career challenges. Despite this need, relatively few publications exist to document mentoring programs for this population. Institutionally supported mentoring programs for URM faculty are needed, along with plans for program sustainability.

Racial/Ethnic Diversity in Medical Education

Raphael JL, Giardino AP, Harris T, Tran XG, Yoon J, Phillips JL. Perceptions Revisited: Pediatric Chief Resident views on Minority Housestaff Recruitment and Retention in Pediatric Residency Programs. J Natl Med Assoc. 2014 Summer;106(1):58-68.

PURPOSE: This study examined institutional strategies among pediatric residency programs for recruitment and retention of underrepresented minorities (URM) residents.

PROCEDURES: A questionnaire developed by the authors in a 1992 study was modified and then mailed to 185 pediatric chief residents at non-military pediatric training programs in the United States. Descriptive statistics (means and frequency) were calculated for each question. There were three rounds of mailings and a telephone follow-up.

MAIN FINDING: The response rate was 39% (n=73). **Thirty-eight percent reported that URM resident recruitment and retention was a priority for their program directors, 37% reported that it was a priority for themselves, 25% reported it was a priority for the hospital administration, and 36% reported that they were not sure about the priority of URM resident recruitment and retention within their organization. Sixty-seven percent stated that their resident selection committees do not have defined recruitment goals, 6% indicated that their committees have specifically defined recruitment goals, and 27% were not sure.**

CONCLUSIONS: Despite numerous initiatives from government agencies, medical institutions, and institutions of higher education, a critical gap remains among institutions in their recruitment efforts for URM at the level of residency training. The findings suggest that pediatric chief residents may not be adequately educated or primed regarding the importance of recruitment and retention of URM. As individuals involved with both medical training and hospital hierarchy, they are uniquely positioned to influence and carry out program goals and objectives.

Marrast L, Zallman L, Woolhandler S, Bor D, McCormick D. Minority physicians' role in the care of underserved patients: diversifying the physician workforce may be key in addressing health disparities. JAMA Internal Medicine. Feb 2014;174(2):289-291.

Disparities in access to care persist despite efforts to improve care for underserved patients: racial and ethnic minorities, the uninsured, the poor, Medicaid recipients, and non-English speakers. A shortage of physicians practicing in communities where disadvantaged patients live is a major contributor.

Minority and non–English-speaking populations in the United States have grown markedly during the past 2 decades, and minorities may be a majority by 2050. While the Patient Protection and Affordable Care Act will expand insurance coverage for low-income, uninsured individuals, concern remains about the supply of physicians to care for these newly insured populations. If nonwhite physicians care for a large proportion of the underserved, then increasing the racial and ethnic diversity of the physician workforce may help. A prior nationally representative study indicated that in 1987, nonwhite physicians disproportionately cared for underserved and sicker patients; to the authors' knowledge, these data have not been updated since. Given the demographic changes and impending implementation of the Patient Protection and Affordable Care Act, this question has renewed relevance.

Experience of Minority Individuals in Medical Education

Morrison E, Grbic D. Dimensions of Diversity and Perception of Having Learned From Individuals From Different Backgrounds: The Particular Importance of Racial Diversity. Acad Med. 2015 Jul;90(7):937-45.

PURPOSE: Selective higher education institutions that take race into account in admissions decisions must be able to demonstrate that their policy is justified by a compelling governmental interest, is narrowly tailored, and is the least restrictive means for achieving that interest. The authors thus investigate whether, among medical students, the association between racial diversity (as distinct from other forms of diversity) and learning from individuals from different backgrounds is unique.

METHOD: The authors examined six dimensions of diversity, including racial/ethnic diversity, among the 2010, 2011, and 2012 cohorts of fourth-year medical students in the United States. They also examined students' responses to two Medical Student Graduation Questionnaire items pertaining to learning from individuals from different backgrounds. They modeled the association between each of the school-level dimensions of diversity and the student-level responses to having learned from others with different backgrounds, and they assessed whether associations vary across different groups of students.

RESULTS: **Racial/ethnic diversity is unique in its very strong association with student perceptions of having learned from others who are different. The association between racial/ethnic diversity and student perceptions of having learned from others who are different is especially strong for members of historically underrepresented minority groups.**

CONCLUSIONS: Compared with other forms of diversity, racial/ethnic diversity has a unique association with students' perceptions of learning from others who are different. This association is of particular relevance to admissions and diversity policies in an era of strict scrutiny of these policies.

Rodríguez JE, Campbell KM, Pololi LH. Addressing disparities in academic medicine: what of the minority tax? BMC Med Educ. 2015 Feb 1;15:6.

BACKGROUND: The proportion of black, Latino, and Native American faculty in U.S. academic medical centers has remained almost unchanged over the last 20 years. Some authors credit the "minority tax"-the burden of extra responsibilities placed on minority faculty in the name of diversity. This tax is in reality very complex, and a major source of inequity in academic medicine.

DISCUSSION: **The "minority tax" is better described as an Underrepresented Minority in Medicine (URMM) faculty responsibility disparity. This disparity is evident in many areas: diversity efforts, racism, isolation, mentorship, clinical responsibilities, and promotion. The authors examine the components of the URMM responsibility disparity and use information from the medical literature and from human resources to suggest practical steps that can be taken by academic leaders and policymakers to move toward**

establishing faculty equity and thus increase the numbers of black, Latino, and Native American faculty in academic medicine.

Datta J, Miller BM. International students in United States' medical schools: does the medical community know they exist? Med Educ Online. 2012;17. Epub 2012 Jun 4.

BACKGROUND: Matriculation of international students to United States' (US) medical schools has not mirrored the remarkable influx of these students to other US institutions of higher education.

METHODS: While these students' numbers are on the rise, the visibility for their unique issues remains largely ignored in the medical literature.

RESULTS: These students are disadvantaged in the medical school admissions process due to financial and immigration-related concerns, and academic standards for admittance also continue to be significantly higher compared with their US-citizen peers. Furthermore, it is simply beyond the mission of many medical schools - both public and private - to support international students' education, especially since federal, state-allocated or institutional funds are limited and these institutions have a commitment to fulfill the healthcare education needs of qualified domestic candidates. In spite of these obstacles, a select group of international students do gain admission to US medical schools and, upon graduation, are credentialed equally as their US-citizen counterparts by the Accreditation Council for Graduate Medical Education (ACGME). However, owing to their foreign citizenship, these students have visa requirements for post-graduate training that may adversely impact their candidacy for residency placement.

CONCLUSION: By raising such issues, this article aims to increase the awareness of considerations pertinent to this unique population of medical students. **The argument is also made to support continued recruitment of international students to US medical schools in spite of these impediments. These students are not only qualified to tackle the rigors of a US medical education, but also enrich the cultural diversity of the medical student body. Moreover, these graduates could effectively complement the efforts to augment US physician workforce diversity while contributing to healthcare disparity eradication, minority health issues, and service in medically underserved areas.**

Ku MC, Li YE, Prober C, Valantine H, Girod SC. Decisions, decisions: how program diversity influences residency program choice. J Am Coll Surg. 2011 Aug;213(2):294-305. Epub 2011 Jun 8.

BACKGROUND: Recent studies suggest that students' feelings of fit with a residency program substantially influence students' ranking of the program. As diversity issues become increasingly focal concerns, the authors investigate how perception of gender and racial diversity of a program influences students' rankings of the program. They focus on students pursuing surgical specialties and ask whether diversity concerns are more prominent among applicants to surgical programs than among applicants to nonsurgical programs.

STUDY DESIGN: The authors invited all interviewees at all residency programs at the Stanford University School of Medicine to participate in the study in the spring of 2009. Nineteen residency programs, amounting to 1,657 residency interviewees, participated. Sixty-eight percent (n = 1,132) responded to the survey.

RESULTS: **Women and under-represented minority applicants differ in their assessments from male and non-under-represented minority applicants because women applying to surgical programs and under-represented minority students are less likely than others to perceive their prospective programs as diverse. However, perceived program diversity is an important factor that positively influences the program ranking decision for women and minorities pursuing surgical training.**

CONCLUSIONS: Surgical training programs that promote gender and racial diversity will likely be more successful in attracting women and minority students because women and minorities are especially sensitive to program diversity in both their perceptions and rankings of programs. Promoting women and minorities within programs and connecting women and minority applicants to outreach programs and mentors is pertinent to the recruitment of these traditionally under-represented groups to surgical programs.

Dyrbye LN, Power DV, Massie FS, Eacker A, Harper W, Thomas MR, Szydlo DW, Sloan JA, Shanafelt TD. Factors associated with resilience to and recovery from burnout: a prospective, multi-institutional study of US medical students. Med Educ. 2010 Oct;44(10):1016-26.

CONTEXT: Burnout is prevalent among medical students and is a predictor of subsequent serious consideration of dropping out of medical school and suicide ideation. Understanding of the factors that protect against burnout is needed to guide student wellness programs.

METHODS: A total of 1321 medical students attending five institutions were studied longitudinally (2006-2007). The surveys included standardized instruments to evaluate burnout, quality of life, fatigue and stress. Additional items explored social support, learning climate, life events, employment status and demographics. Students who did not have burnout at either time-point (resilient students) were compared with those who indicated burnout at one or both time-points (vulnerable students) using a Wilcoxon-Mann-Whitney test or Fisher's exact test. Similarly, the differences between those who recovered and those who were chronically burned out were also compared in students with burnout at the first time-point. Logistic regression modelling was employed to evaluate associations between the independent variables and resiliency to and recovery from burnout.

RESULTS: Overall, 792 (60.0%) students completed the burnout inventory at both time-points. No differences in demographic characteristics were observed between resilient (290/792 [36.6%]) and vulnerable (502/792 [63.4%]) students. **Resilient students were less likely to experience depression, had a higher quality of life, were less likely to be employed, had experienced fewer stressful life events, reported higher levels of social support, perceived their learning climate more positively and experienced less stress and fatigue (all p < 0.05) than vulnerable students. On multivariable analysis, perceiving student education as a priority for faculty staff, experiencing less stress, not being employed and being a minority were factors independently associated with recovery from burnout.**

CONCLUSIONS: Modifiable individual factors and learning climate characteristics including employment status, stress level and perceptions of the prioritizing of student education by faculty members relate to medical students' vulnerability to burnout.

Dyrbye LN, Thomas MR, Eacker A, Harper W, Massie FS Jr, Power DV, Huschka M, Novotny PJ, Sloan JA, Shanafelt TD. Race, ethnicity, and medical student well-being in the United States. Arch Intern Med. 2007 Oct 22;167(19):2103-9.

BACKGROUND: Little is known about the training experience of minority medical students. The authors explore differences in the prevalence of burnout, depressive symptoms, and quality of life (QOL) among minority and nonminority medical students as well as the role race/ethnicity plays in students' experiences.

METHODS: Medical students (N = 3080) at 5 medical schools were surveyed in 2006 using validated instruments to assess burnout, depression, and QOL. Students were also asked about the impact of race/ethnicity on their training experience.

RESULTS: The response rate was 55%. Nearly half of students reported burnout (47%) and depressive symptoms (49%). Mental QOL scores were lower among students than among the age-matched general population (43.1 vs 47.2; P < .001). **Prevalence of depressive symptoms was similar regardless of minority status, but more nonminority students had burnout (39% vs 33%; P < .03). Minority students were more likely to report that their race/ethnicity had adversely affected their medical school experience (11% vs 2%; P < .001) and cited racial discrimination, racial prejudice, feelings of isolation, and different cultural expectations as causes. Minority students reporting such experiences were more likely to have burnout, depressive symptoms, and low mental QOL scores than were minority students without such experiences (all P < .05).**

CONCLUSIONS: Symptoms of distress are prevalent among medical students. While minorities appear to be at lower risk for burnout than nonminority students, race does contribute to the distress minority students do experience. Additional studies are needed to define the causes of these perceptions and to improve the learning climate for all students.

Dyrbye LN, Thomas MR, Huschka MM, Lawson KL, Novotny PJ, Sloan JA, Shanafelt TD. A multicenter study of burnout, depression, and quality of life in minority and nonminority US medical students. Mayo Clin Proc. 2006 Nov;81(11):1435-42.

OBJECTIVE: To determine the well-being of minority medical students in a multicenter sample of US medical students.

PARTICIPANTS AND METHODS: All 1098 medical students at 3 medical schools in Minnesota were surveyed in April 2004. Validated instruments were used to assess burnout, depression, and quality of life (QOL). Students were also asked about the prevalence of significant personal life events in the previous 12 months and strategies used to cope with stress.

RESULTS: **Although symptoms of depression and overall burnout were similar among minority and nonminority students, minority students were more likely to have a low sense of personal accomplishment (P=.02) and lower QOL In a number of domains (all P<**

or =.05). These differences persisted on multivariate analysis that controlled for demographic characteristics and recent life events. Minority students were also more likely to have a child (P=.01), originate from outside Minnesota (P<.001), and experience a major personal Illness in the last 12 months (P=.03).

CONCLUSION: As a group, the minority medical students in this survey had a lower sense of personal accomplishment and QOL than nonminority students. Additional studies are needed to provide insight regarding the causes of these inequities and the unique challenges faced by minority medical students. Efforts to improve minority students' well-being, QOL, and learning experience may help prevent attrition among minority medical students and promote diversification in the physician workforce.

Work Experiences/Career Progression for Women and Minorities in Medicine

Nunez-Smith M, Pilgrim N, Wynia M, Desai MM, Bright C, Krumholz HM, Bradley EH. Health care workplace discrimination and physician turnover. J Natl Med Assoc. 2009 Dec;101(12):1274-82.

OBJECTIVE: The authors examined the association between physician race/ ethnicity, workplace discrimination, and physician job turnover.

METHODS: Cross-sectional, national survey conducted in 2006-2007 of practicing physicians (n = 529) randomly identified via the American Medical Association Masterfile and the National Medical Association membership roster. The authors assessed the relationships between career racial/ethnic discrimination at work and several career-related dependent variables, including 2 measures of physician turnover, career satisfaction, and contemplation of career change. They used standard frequency analyses, odds ratios and chi2 statistics, and multivariate logistic regression modeling to evaluate these associations.

RESULTS: **Physicians who self-identified as nonmajority were significantly more likely to have left at least 1 job because of workplace discrimination (black, 29%; Asian, 24%; other race, 21%; Hispanic/Latino, 20%; white, 9%). In multivariate models, having experienced racial/ethnic discrimination at work was associated with high job turnover (adjusted odds ratio, 2.7; 95% CI, 1.4-4.9). Among physicians who experienced workplace discrimination, only 45% of physicians were satisfied with their careers (vs 88% among those who had not experienced workplace discrimination, p value < .01), and 40% were contemplating a career change (vs 10% among those who had not experienced workplace discrimination, p value < .001).**

CONCLUSION: Workplace discrimination is associated with physician job turnover, career dissatisfaction, and contemplation of career change. These findings underscore the importance of monitoring for workplace discrimination and responding when opportunities for intervention and retention still exist.

Nunez-Smith M, Curry LA, Berg D, Krumholz HM, Bradley EH. Healthcare workplace conversations on race and the perspectives of physicians of African descent. J Gen Intern Med. 2008 Sep;23(9):1471-6. Epub 2008 Jul 10.

BACKGROUND: Although experts recommend that healthcare organizations create forums for honest dialogue about race, there is little insight into the physician perspectives that may influence these conversations across the healthcare workforce.

OBJECTIVE: To identify the range of perspectives that might contribute to workplace silence on race and affect participation in race-related conversations within healthcare settings.

DESIGN: In-person, in-depth, racially concordant qualitative interviews.

PARTICIPANTS: Twenty-five physicians of African descent practicing in the 6 New England states.

APPROACH: Line-by-line independent coding and group negotiated consensus to develop codes structure using constant comparative method.

MAIN RESULTS**: Five themes characterize perspectives of participating physicians of African descent that potentially influence race-related conversations at work: 1) Perceived race-related healthcare experiences shape how participating physicians view healthcare organizations and their professional identities prior to any formal medical training; 2) Protecting racial/ethnic minority patients from healthcare discrimination is a top priority for participating physicians;   3) Participating physicians often rely on external support systems for race-related issues, rather than support systems inside the organization; 4) Participating physicians perceive differences between their interpretations of potentially offensive race-related work experiences and their non-minority colleagues' interpretations of the same experiences; and 5) Participating physicians are uncomfortable voicing race-related concerns at work.**

CONCLUSIONS: Creating a healthcare work environment that successfully supports diversity is as important as recruiting diversity across the workforce. Developing constructive ways to discuss race and race relations among colleagues in the workplace is a key step towards creating a supportive environment for employees and patients from all backgrounds.

Nunez-Smith M, Curry LA, Bigby J, Berg D, Krumholz HM, Bradley EH. Impact of race on the professional lives of physicians of African descent. Ann Intern Med. 2007 Jan 2;146(1):45-51.

BACKGROUND: Increasing the racial and ethnic diversity of the physician workforce is a national priority. However, insight into the professional experiences of minority physicians is limited. This knowledge is fundamental to developing effective strategies to recruit, retain, and support a diverse physician workforce.

OBJECTIVE: To characterize how physicians of African descent experience race in the workplace.

DESIGN: Qualitative study based on in-person and in-depth racially concordant interviews using a standard discussion guide.

SETTING: The 6 New England states in the United States.

PARTICIPANTS: 25 practicing physicians of African descent representing a diverse range of primary practice settings, specialties, and ages.

MEASUREMENTS: Professional experiences of physicians of African descent.

RESULTS: **1) Awareness of race permeates the experience of physicians of African descent in the health care workplace; 2) race-related experiences shape interpersonal interactions and define the institutional climate; 3) responses to perceived racism at work vary along a spectrum from minimization to confrontation; 4) the health care workplace is often silent on issues of race; and 5) collective race-related experiences can result in "racial fatigue," with personal and professional consequences for physicians.**

Examples included:

- Participants reported constant awareness of their racial minority status in the workplace.
- Physicians described negative patient care experiences – "Patients rejecting my care is… fairly overt."
- All physicians described feeling invisible at work or routinely being mistaken for maintenance, housekeeping, and food service employees (not just by patients but also by coworkers).
- In addition, physicians of African descent reported that they were held to higher performance standards than nonminority peers.
- Feeling undervalued
- Not being in leadership positions or tracks leading to those positions.
- Mentors presumed that they wanted to work directly in underserved communities of color rather than pursue academic careers or leadership positions.
- Involuntarily "cast" into race-based roles: minority physician recruitment, serving on diversity committees, intervening in difficult situations with minority colleagues or trainees (sometimes physicians were pleased to contribute, others viewed this as offensive and isolating)
- "At work… whenever they want to diversify something, they call me. When they don't need that, when they would need someone purely for individual intellectual capacity, I am not the first person they think of."
- Racial fatigue – "It is a burden to carry this burden. My burden is to deal with the pressure of whatever stereotypes people may have about race… and it is a daily stress at work. It's exhausting."
- Racial fatigue contributed to professional dissatisfaction and unexpected changes in career trajectory. Participants changed residency programs, specialties, geographic location, etc. in search of more supportive work environments.
- The relevance of race is generally not acknowledged, and informal and formal structures to discuss race in the workplace are typically nonexistent.

LIMITATIONS: The study was restricted to New England and may not reflect the experiences of physicians in other geographic regions. The findings are meant to be hypothesis-generating and require additional follow-up studies.

CONCLUSIONS: The issue of race remains a pervasive influence in the work lives of physicians of African descent. Without sufficient attention to the specific ways in which race shapes

physicians' work experiences, health care organizations are unlikely to create environments that successfully foster and sustain a diverse physician workforce.

Programs to Promote Diversity in Medical Education

Tunson J, Boatright D, Oberfoell S, Bakes K, Angerhofer C, Lowenstein S, Zane R, King R, Druck J. Increasing Resident Diversity in an Emergency Medicine Residency Program: A Pilot Intervention With Three Principal Strategies. Acad Med. 2016 Jul;91(7):958-61.

PROBLEM: Much work remains to be done to align the diversity of the health care workforce with the changing racial and ethnic backgrounds of patients, especially in the field of emergency medicine.

APPROACH: In academic year (AY) 2012-2013, to increase the number of underrepresented minority (URM) candidates who were interviewed and matched, the Denver Health Residency in Emergency Medicine program (DHREM) initiated a focused pilot intervention with three principal strategies: (1) a scholarship-based externship program, (2) a funded second-look event, and (3) increased involvement and visibility of URM faculty in the interview and recruitment process.

OUTCOMES: One year after implementation of the pilot intervention, the percentage of URMs among all applicants invited to interview at the DHREM doubled (7.1% [20/282] in AY 2011-2012, 7.0% [24/344] in AY 2012-2013, and 14.8% [58/393] in AY 2013-2014) (95% confidence interval [CI] = 5-10, 4-11, and 11-19, respectively). **Of all DHREM interviewees in AY 2013-2014, 17.6% (49/279) (95% CI = 12-23) were URMs, nearly a threefold increase from AY 2012-2013 (6.2% [14/226], 95% CI = 3-10). In AY 2013-2014, 23.5% (4/17) (95% CI = 7-50) of all new DHREM residents were URMs, compared with 5.9% (1/17) in AY 2011-2012 and 5.6% (1/18) in AY 2012-2013 (95% CI = 0-29 and 0-27, respectively).**

NEXT STEPS: Additional studies are needed to determine whether these results are sustainable and generalizable to other residency programs in emergency medicine and other specialties.

Lin SY, Francis HW, Minor LB, Eisele DW. Faculty diversity and inclusion program outcomes at an academic otolaryngology department. Laryngoscope. 2016 Feb;126(2): 352-6. Epub 2015 Jul 7.

OBJECTIVES/HYPOTHESIS: To describe a 10-year diversity initiative to increase the number of women and underrepresented minorities in an academic department of otolaryngology-head and neck surgery.

STUDY DESIGN: Retrospective review.

METHODS: A multifaceted approach was undertaken to recruit and retain women and underrepresented minority (URM) faculty: creation of a climate of diversity, aggressive recruitment, achievement of parity of salary at rank regardless of gender or minority status, provision of mentorship to women and URM faculty, and increasing the pipeline of qualified

candidates. Primary outcomes measures included number of women and URM faculty, academic rank, and salary.

RESULTS: From 2004 to 2014, the percentage of women clinical faculty increased from 5.8% to 23.7%; women basic science faculty increased from 11.1% to 37.5%. The number of women at associate professor rank increased from 0 to eight. During this period, underrepresented minority faculty increased in number from two to four; URM full professors increased in number from 0 to 1. In 2004, women earned 4% to 12% less than their male counterparts; there were no salary differences for URM. In 2014, salary was equal by rank and subspecialty training independent of gender or minority status.

CONCLUSION: **A comprehensive diversity and inclusion initiative has increased representation of women and URM faculty in an academic department of otolaryngology-head and neck surgery. However, there continue to be opportunities to further increase diversity.**

Pachter LM, Kodjo C. New Century Scholars: A Mentorship Program to Increase Workforce Diversity in Academic Pediatrics. Acad Med. 2015 Jul;90(7):881-7.

This article describes a program aimed to increase workforce diversity and underrepresented minority (URM) representation in academic pediatric medicine. The New Century Scholars (NCScholars) program is a core program in the Academic Pediatric Association, the largest national organization for academic pediatric generalists. The program selects URM pediatric (or medicine-pediatrics) residents who are interested in academic careers and provides each NCScholar with a junior and senior mentor, as well as travel grants to the Pediatric Academic Societies annual meeting where activities specific to the program are held, and provides ongoing mentorship and career counseling support. **The authors discuss the origination, operation, and changes to the program over the first 10 years of its existence, as well as outcome data for the participants in the program. To date, 60 of the 63 NCScholars have finished residency and/or have made postresidency plans, and 38 of these URM pediatricians (63%) have entered academic careers.** The authors suggest that this type of mentorship program for URM pediatric trainees can be used as a model for other specialties and medical organizations.

Faculty Development and Mentoring for Women and Minority Faculty

Palermo AG, Soto-Greene ML, Taylor VS, Cornbill R, Johnson J, Mindt MR, Byrd D, Butts GC, Herbert-Carter J, Fry-Johnson YW, Smith QT, Rust G, Strelnick AH. Diversity in academic medicine no. 5 successful programs in minority faculty development: overview. Mt Sinai J Med. 2008 Dec 1;75(6):523-32.

Despite recent drastic cutbacks in federal funding for programs to diversify academic medicine, many such programs survive and continue to set examples for others of how to successfully increase the participation of minorities underrepresented in the healthcare professions and, in particular, how to increase physician and nonphysician minority medical faculty. This article

provides an overview of such programs, including those in historically black colleges and universities, minority-serving institutions, research-intensive private and public medical schools, and more primary care-oriented public medical schools. Although the models for faculty development developed by these successful schools overlap, each has unique features worthy of consideration by other schools seeking to develop programs of their own. **The ingredients of success are discussed in detail in another article in this theme issue of the Mount Sinai Journal of Medicine, "Successful Programs in Minority Faculty Development: Ingredients of Success."**

Cultural Competency, Sensitivity and Humility

Marshall JK, Cooper LA, Green AR, Bertram A, Wright L, Matusko N, McCullough W, Sisson SD. Residents' Attitude, Knowledge, and Perceived Preparedness Toward Caring for Patients from Diverse Sociocultural Backgrounds. Health Equity. 2017 Feb 1;1(1):43-49.

Purpose: Training residents to deliver care to increasingly diverse patients in the United States is an important strategy to help alleviate racial and ethnic disparities in health outcomes. Cross-cultural care training of residents continues to present challenges. This study sought to explore the associations among residents' cross-cultural attitudes, preparedness, and knowledge about disparities to better elucidate possible training needs.

Methods: This cross-sectional study used web-based questionnaires from 2013 to 2014. Eighty-four internal medicine residency programs with 954 residents across the United States participated. The main outcome was perceived preparedness to care for sociocultural diverse patients.

Results: Regression analysis showed attitude toward cross-cultural care (beta coefficient [β]=0.57, 95% confidence interval [CI]: 0.49-0.64, p<0.001) and report of serving a large number of racial/ethnic minorities (β=0.90, 95% CI: 0.56-1.24, p<0.001), and low-socioeconomic status patients (β=0.74, 95% CI: 0.37-1.10, p<0.001) were positively associated with preparedness. Knowledge of disparities was poor and did not differ significantly across postgraduate year (PGY)-1, PGY-2, and PGY-3 residents (mean scores: 56%, 58%, and 55%, respectively; p=0.08).

Conclusion: **Residents' knowledge of health and healthcare disparities is poor and does not improve during training. Residents' preparedness to provide cross-cultural care is directly associated with their attitude toward cross-cultural care and their level of exposure to patients from diverse sociocultural backgrounds.** Future studies should examine the role of residents' cross-cultural care-related attitudes on their ability to care for diverse patients.

Ambrose AJ, Lin SY, Chun MB. Cultural competency training requirements in graduate medical education. J Grad Med Educ. 2013 Jun;5(2):227-31.

BACKGROUND: Cultural competency is an important skill that prepares physicians to care for patients from diverse backgrounds.

OBJECTIVE: The authors reviewed Accreditation Council for Graduate Medical Education (ACGME) program requirements and relevant documents from the ACGME website to evaluate competency requirements across specialties.

METHODS: The program requirements for each specialty and its subspecialties were reviewed from December 2011 through February 2012. The review focused on the 3 competency domains relevant to culturally competent care: professionalism, interpersonal and communication skills, and patient care. Specialty and subspecialty requirements were assigned a score between 0 and 3 (from least specific to most specific). Given the lack of a standardized cultural competence rating system, the scoring was based on explicit mention of specific keywords.

RESULTS: A majority of program requirements fell into the low- or no-specificity score (1 or 0). This included 21 core specialties (leading to primary board certification) program requirements (78%) and 101 subspecialty program requirements (79%). For all specialties, cultural competency elements did not gravitate toward any particular competency domain. Four of 5 primary care program requirements (pediatrics, obstetrics-gynecology, family medicine, and psychiatry) acquired the high-specificity score of 3, in comparison to only 1 of 22 specialty care program requirements (physical medicine and rehabilitation).

CONCLUSIONS: **The degree of specificity, as judged by use of keywords in 3 competency domains, in ACGME requirements regarding cultural competency is highly variable across specialties and subspecialties. Greater specificity in requirements is expected to benefit the acquisition of cultural competency in residents, but this has not been empirically tested.**

Chun MB, Yamada AM, Huh J, Hew C, Tasaka S. Using the cross-cultural care survey to assess cultural competency in graduate medical education. J Grad Med Educ. 2010 Mar;2(1):96-101.

BACKGROUND: Cultural competency is an important part of medical policy and practice, yet the evidence base for the effectiveness of training in this area is weak. One reason is the lack of valid, reliable, and feasible tools to quantify measures of knowledge, skill, and attitudes before and/or after cultural training. Given that cultural competency is a critical aspect of "professionalism" and "interpersonal and communication skills," such a tool would aid in assessing the impact of such training in residency programs.

OBJECTIVES: The aim of this study is to enhance the feasibility and extend the validity of a tool to assess cultural competency in resident physicians. The work contributes to efforts to evaluate resident preparedness for working with diverse patient populations.

METHOD: Eighty-four residents (internal medicine, psychiatry, obstetrics-gynecology, and surgery) completed the Cross-Cultural Care Survey (CCCS) to assess their self-reported knowledge, skill, and attitudes regarding the provision of cross-cultural care. The study entailed descriptive analyses, factor analysis, internal consistency, and validity tests using bivariate correlations.

RESULTS: Feasibility of using the CCCS was demonstrated with reduced survey completion time and ease of administration, and the survey reliably measures knowledge, skill, and

attitudes for providing cross-cultural care. Resident characteristics and amount of postgraduate training relate differently to the 3 different subscales of the CCCS.

CONCLUSIONS**: The study confirmed that the CCCS is a reliable and valid tool to assess baseline attitudes of cultural competency across specialties in residency programs. Implications of the subscale scores for designing training programs are discussed.**

Bias in the Learning and Working Environment

Karani R, Varpio L, May W, Horsley T, Chenault J, Miller KH, O'Brien B. Commentary: Racism and Bias in Health Professions Education: How Educators, Faculty Developers, and Researchers Can Make a Difference. Acad Med. 2017 Nov;92(11S Association of American Medical Colleges Learn Serve Lead: Proceedings of the 56th Annual Research in Medical Education Sessions):S1-S6.

The Research in Medical Education (RIME) Program Planning Committee is committed to advancing scholarship in and promoting dialogue about the critical issues of racism and bias in health professions education (HPE). From the call for studies focused on underrepresented learners and faculty in medicine to the invited 2016 RIME plenary address by Dr. Camara Jones, the committee strongly believes that dismantling racism is critical to the future of HPE.The evidence is glaring: Dramatic racial and ethnic health disparities persist in the United States, people of color remain deeply underrepresented in medical school and academic health systems as faculty, learner experiences across the medical education continuum are fraught with bias, and current approaches to teaching perpetuate stereotypes and insufficiently challenge structural inequities. **To achieve racial justice in HPE, academic medicine must commit to leveraging positions of influence and contributing from these positions. In this Commentary, the authors consider three roles (educator, faculty developer, and researcher) represented by the community of scholars and pose potential research questions as well as suggestions for advancing educational research relevant to eliminating racism and bias in HPE.**