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Numerals	Requirement Language	Requirement Number	Requiremen
	Definition of Graduate Medical Education 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, cultural sensitivity, professionalism, and scholarship.		Definition of Graduate Medical Education Graduate medical education is the crucia between medical school and autonomou of the continuum of medical education th patient care under the supervision of fac serve as role models of excellence, comp professionalism, and scholarship.
Int.A.	Graduate medical education transforms medical students into physician scholars who care for the patient, patient's 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.	[None]	who care for the patient, patient's family, integrate new knowledge into practice; an physicians to serve the public. Practice p medical education persist many years lat
	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, judgment, 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, and the importance of inclusive and psychologically safe learning environments.		Graduate medical education has as a cor responsibility for patient care. The care of appropriate faculty supervision and cond to attain the knowledge, skills, attitudes, autonomous practice. Graduate medical focus on excellence in delivery of safe, ea the health of the populations they serve. strength that a diverse group of physicial importance of inclusive and psychologica
Int.A. (Continued)	Graduate medical education occurs in clinical settings that establish the foundation for practice-based and lifelong learning. The professional development of the physician, begun in medical school, continues through faculty modeling of the effacement of self-interest in a humanistic environment that emphasizes joy in curiosity, problem-solving, academic rigor, and discovery. This transformation is often physically, emotionally, and intellectually demanding and occurs in a variety of clinical learning environments committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.	[None] - (Continued)	Graduate medical education occurs in cli foundation for practice-based and lifelon development of the physician, begun in n faculty modeling of the effacement of sel that emphasizes joy in curiosity, problem This transformation is often physically, e and occurs in a variety of clinical learning medical education and the well-being of p members, students, and all members of t

on

cial step of professional development bus clinical practice. It is in this vital phase that residents learn to provide optimal aculty members who not only instruct, but mpassion, cultural sensitivity,

s medical students into physician scholars ly, and a diverse community; create and and educate future generations of patterns established during graduate later.

ore tenet the graded authority and of patients is undertaken with nditional independence, allowing residents s, judgment, and empathy required for al education develops physicians who equitable, affordable, quality care; and e. Graduate medical education values the ians brings to medical care, and the ically safe learning environments.

clinical settings that establish the ong learning. The professional o medical school, continues through self-interest in a humanistic environment em-solving, academic rigor, and discovery. emotionally, and intellectually demanding ing environments committed to graduate of patients, residents, fellows, faculty f the health care team.

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
Int.B.	Definition of Specialty Anesthesiology is the practice of medicine dealing with the peri-operative management of patients. This includes the peri-operative/peri-procedural management of patients during surgical and other therapeutic and diagnostic procedures. This management encompasses the pre-operative preparation of the patient and their peri-operative maintenance of normal physiology, as well as the post-operative relief and prevention of pain. An anesthesiologist is skilled in the management and diagnosis of critically-ill patients, including those experiencing cardiac arrest, and in the diagnosis and management of acute, chronic, and cancer-related pain. These goals are achieved through a thorough understanding of physiology and pharmacology, and the ability to conduct, interpret, and apply the results of medical research. Finally, the anesthesiologist is skilled in the leadership of health services delivery, prudent fiscal resource stewardship, and quality improvement, as well as the supervision, education, and evaluation of the performance of personnel, both medical and paramedical, involved in peri-operative and peri-procedural care.	[None]	Definition of Specialty Anesthesiology is the practice of medici management of patients. This includes is management of patients during surgical procedures. This management encompo- the patient and their peri-operative main as the post-operative relief and prevents in the management and diagnosis of cri- experiencing cardiac arrest, and in the operation chronic, and cancer-related pain. These understanding of physiology and pharm interpret, and apply the results of medic anesthesiologist is skilled in the leaders fiscal resource stewardship, and quality supervision, education, and evaluation of medical and paramedical, involved in period
Int.C.	Length of Program The educational programs in anesthesiology are configured in 36-month and 48- month formats. The latter includes 12 months of education in fundamental clinical skills of medicine, and both include 36 months of education in clinical anesthesia (CA-1, CA-2, and CA-3 years). (Core)		Length of Program The educational programs in anesthesion month formats. The latter includes 12 m clinical skills of medicine, and both inclu anesthesia (CA-1, CA-2, and CA-3 year
I.	Oversight	Section 1	Section 1: Oversight
	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.		Sponsoring Institution The Sponsoring Institution is the org ultimate financial and academic resp medical education, consistent with th Requirements.
I.A.	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.	[None]	When the Sponsoring Institution is n most commonly utilized site of clinic primary clinical site.
I.A.1.	The program must be sponsored by one ACGME-accredited Sponsoring Institution.	1.1.	The program must be sponsored by o Institution.
I.B.	Participating Sites A participating site is an organization providing educational experiences or educational assignments/rotations for residents.	[None]	Participating Sites A participating site is an organization or educational assignments/rotations
I.B.1.	The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)	1.2.	The program, with approval of its Spe primary clinical site. (Core)
I.B.1.a)	The Sponsoring Institution must also sponsor or be affiliated with ACGME- accredited residencies in at least the specialties of general surgery and internal medicine. (Core)	1.2.a.	The Sponsoring Institution must also sp accredited residencies in at least the sp medicine. (Core)

icine dealing with the peri-operative s the peri-operative/peri-procedural cal and other therapeutic and diagnostic inpasses the pre-operative preparation of aintenance of normal physiology, as well ntion of pain. An anesthesiologist is skilled critically-ill patients, including those e diagnosis and management of acute, se goals are achieved through a thorough macology, and the ability to conduct, lical research. Finally, the orship of health services delivery, prudent ity improvement, as well as the n of the performance of personnel, both peri-operative and peri-procedural care.

siology are configured in 36-month and 48months of education in fundamental clude 36 months of education in clinical ars). (Core)

rganization or entity that assumes the sponsibility for a program of graduate the ACGME Institutional

not a rotation site for the program, the ical activity for the program is the

one ACGME-accredited Sponsoring

on providing educational experiences ns for residents.

ponsoring Institution, must designate a

sponsor or be affiliated with ACGMEspecialties of general surgery and internal

Requirement Number - Roman		Reformatted	
Numerals	Requirement Language	Requirement Number	Requiremen
I.B.2. I.B.2.a)	There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core) The PLA must:	1.3. [None]	There must be a program letter of age and each participating site that gover program and the participating site pr
,	be renewed at least every 10 years; and, (Core)	1.3.a.	
I.B.2.a).(1)	be renewed at least every 10 years, and, (Core)	1.3.d.	The PLA must be renewed at least ev The PLA must be approved by the de
I.B.2.a).(2)	be approved by the designated institutional official (DIO). (Core)	1.3.b.	(Core)
I.B.3.	The program must monitor the clinical learning and working environment at all participating sites. (Core)	1.4.	The program must monitor the clinica 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)	1.5.	At each participating site there must by the program director as the site di resident education at that site, in coll (Core)
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)	1.6.	The program director must submit an participating sites routinely providing for all residents, of one month full tim the ACGME's Accreditation Data Sys
I.B.5.	The majority of rotations for the anesthesiology program must occur at the primary clinical site. (Core)	1.6.a.	The majority of rotations for the anesthe primary clinical site. (Core)
I.B.5.a)	Participating sites must provide rotations that the Sponsoring Institution is unable to provide. (Core)	1.6.a.1.	Participating sites must provide rotations unable to provide. (Core)
I.B.5.a).(1)	Residents should not be required to rotate among multiple participating sites. (Detail)	1.6.a.1.a.	Residents should not be required to rota (Detail)
I.B.5.a).(2)	Assignments to a participating site should not exceed six months. (Detail)	1.6.a.1.b.	Assignments to a participating site shou
I.C.	Workforce Recruitment and Retention 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 GME staff members, and other relevant members of its academic community. (Core)	1.7.	Workforce Recruitment and Retention The program, in partnership with its s in practices that focus on mission-dr and retention of a diverse and inclusi present), faculty members, senior add other relevant members of its academ
I.D.	Resources	1.8.	Resources The program, in partnership with its s the availability of adequate resources
I.D.1.	The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education. (Core)	1.8.	Resources The program, in partnership with its s the availability of adequate resources
I.D.1.a)	There must be adequate space and equipment for the educational program, including meeting rooms, classrooms with visual and other educational aids, study areas for residents, office space for faculty members and residents, diagnostic and therapeutic facilities, laboratory facilities, computer support, and appropriate on-call facilities for male and female residents and faculty members. (Core)	1.8.a.	There must be adequate space and equincluding meeting rooms, classrooms wistudy areas for residents, office space for diagnostic and therapeutic facilities, laborappropriate on-call facilities for male and (Core)

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greement (PLA) between the program verns the relationship between the providing a required assignment. (Core)

every 10 years. ^(Core) designated institutional official (DIO).

ical learning and working environment

st be one faculty member, designated director, who is accountable for ollaboration with the program director.

any additions or deletions of ng an educational experience, required ime equivalent (FTE) or more through /stem (ADS). (Core)

hesiology program must occur at the

ons that the Sponsoring Institution is

otate among multiple participating sites.

ould not exceed six months. (Detail)

ion

s Sponsoring Institution, must engage driven, ongoing, systematic recruitment isive workforce of residents, fellows (if idministrative GME staff members, and emic community. (Core)

s Sponsoring Institution, must ensure es for resident education. (Core)

s Sponsoring Institution, must ensure es for resident education. (Core)

quipment for the educational program, with visual and other educational aids, of faculty members and residents, aboratory facilities, computer support, and and female residents and faculty members.

Requirement		Deferment to d	
Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirement
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:	1.9.	The program, in partnership with its S healthy and safe learning and working resident well-being and provide for:
I.D.2.a)	access to food while on duty; (Core)	1.9.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)	1.9.b.	safe, quiet, clean, and private sleep/re for residents with proximity appropria
I.D.2.c)	clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)	1.9.c.	clean and private facilities for lactatio with proximity appropriate for safe pa
I.D.2.d)	security and safety measures appropriate to the participating site; and, (Core)	1.9.d.	security and safety measures approp (Core)
I.D.2.e)	accommodations for residents with disabilities consistent with the Sponsoring Institution's policy. (Core)	1.9.e.	accommodations for residents with d Sponsoring Institution's policy. (Core
I.D.3.	Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core)	1.10.	Residents must have ready access to appropriate reference material in prin include access to electronic medical capabilities. (Core)
I.E.	Other Learners and Health Care Personnel The presence of other learners and other health care personnel, including, but not limited to residents from other programs, subspecialty fellows, and advanced practice providers, must not negatively impact the appointed residents' education. (Core)	1.11.	Other Learners and Health Care Perso The presence of other learners and of but not limited to residents from othe and advanced practice providers, mus appointed residents' education. (Core
II.	Personnel	Section 2	Section 2: Personnel
II.A.	Program Director	2.1.	Program Director There must be one faculty member ap authority and accountability for the ov with all applicable program requireme
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)	2.1.	Program Director There must be one faculty member an authority and accountability for the ov with all applicable program requireme
II.A.1.a)	The Sponsoring Institution's GMEC must approve a change in program director and must verify the program director's licensure and clinical appointment. (Core)	2.2.	The Sponsoring Institution's GMEC m director and must verify the program appointment. (Core)
II.A.1.a).(1)	Final approval of the program director resides with the Review Committee. (Core)	2.2.a.	Final approval of the program directo (Core)
II.A.1.b)	The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability. (Core)	2.3.	The program must demonstrate reten length of time adequate to maintain c stability. (Core)
II.A.2.	The program director and, as applicable, the program's leadership team, must be provided with support adequate for administration of the program based upon its size and configuration. (Core)	2.4.	The program director and, as applical must be provided with support adequ based upon its size and configuration

Sponsoring Institution, must ensure ng environments that promote

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rest facilities available and accessible riate for safe patient care; (Core)

ion that have refrigeration capabilities, patient care; (Core)

priate to the participating site; and,

disabilities consistent with the re)

to specialty-specific and other int or electronic format. This must al literature databases with full text

rsonnel

other health care personnel, including, ner programs, subspecialty fellows, nust not negatively impact the pre)

appointed as program director with overall program, including compliance nents. (Core)

appointed as program director with overall program, including compliance nents. (Core)

must approve a change in program m director's licensure and clinical

tor resides with the Review Committee.

ention of the program director for a continuity of leadership and program

able, the program's leadership team, quate for administration of the program on. (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirement
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	At a minimum, the program director must be provided with the dedicated time and support specified below for administration of the program. Additional support for program leadership must be provided as specified below. This additional support may be for the program director only or divided among the program director and one or more associate (or assistant) program directors. (Core)		At a minimum, the program director mus and support specified below for administ support for program leadership must be additional support may be for the progra program director and one or more assoc (Core)
	Number of Approved Resident Positions:1-20 Minimum Support Required (FTE) for the Program Director: 0.2 Minimum Additional Support Required (FTE) for Program Leadership: 0.2 Total Minimum Program Leadership Support: 0.4		Number of Approved Resident Positions (FTE) for the Program Director: 0.2 Min (FTE) for Program Leadership: 0.2 Tota Support: 0.4
	Number of Approved Resident Positions:21-30 Minimum Support Required (FTE) for the Program Director: 0.4 Minimum Additional Support Required (FTE) for Program Leadership: 0.2 Total Minimum Program Leadership Support: 0.6		Number of Approved Resident Positions (FTE) for the Program Director: 0.4 Mir (FTE) for Program Leadership: 0.2 Tota Support: 0.6
	Number of Approved Resident Positions:31-40 Minimum Support Required (FTE) for the Program Director: 0.4 Minimum Additional Support Required (FTE) for Program Leadership: 0.3 Total Minimum Program Leadership Support: 0.7		Number of Approved Resident Positions (FTE) for the Program Director: 0.4 Min (FTE) for Program Leadership: 0.3 Tota Support: 0.7
	Number of Approved Resident Positions:41-50 Minimum Support Required (FTE) for the Program Director: 0.4 Minimum Additional Support Required (FTE) for Program Leadership: 0.4 Total Minimum Program Leadership Support: 0.8		Number of Approved Resident Positions (FTE) for the Program Director: 0.4 Min (FTE) for Program Leadership: 0.4 Tota Support: 0.8
I.A.2.a)		2.4.a.	

ust be provided with the dedicated time istration of the program. Additional be provided as specified below. This ram director only or divided among the ociate (or assistant) program directors.

ns:1-20 | Minimum Support Required Iinimum Additional Support Required otal Minimum Program Leadership

ns:21-30 | Minimum Support Required Iinimum Additional Support Required otal Minimum Program Leadership

ns:31-40 | Minimum Support Required Iinimum Additional Support Required otal Minimum Program Leadership

ns:41-50 | Minimum Support Required Iinimum Additional Support Required otal Minimum Program Leadership

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	- Requiremen
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	Number of Approved Resident Positions:51-60 Minimum Support Required (FTE) for the Program Director: 0.4 Minimum Additional Support Required (FTE) for Program Leadership: 0.5 Total Minimum Program Leadership Support: 0.9		Number of Approved Resident Positions (FTE) for the Program Director: 0.4 Min (FTE) for Program Leadership: 0.5 Tot Support: 0.9
	Number of Approved Resident Positions:61-70 Minimum Support Required (FTE) for the Program Director: 0.4 Minimum Additional Support Required (FTE) for Program Leadership: 0.6 Total Minimum Program Leadership Support: 1.0		Number of Approved Resident Positions (FTE) for the Program Director: 0.4 Mir (FTE) for Program Leadership: 0.6 Tot Support: 1.0
	Number of Approved Resident Positions:71-80 Minimum Support Required (FTE) for the Program Director: 0.4 Minimum Additional Support Required (FTE) for Program Leadership: 0.7 Total Minimum Program Leadership Support: 1.1		Number of Approved Resident Positions (FTE) for the Program Director: 0.4 Mir (FTE) for Program Leadership: 0.7 Tota Support: 1.1
II.A.2.a) - (Continued)	Number of Approved Resident Positions:Over 80 Minimum Support Required (FTE) for the Program Director: 0.4 Minimum Additional Support Required (FTE) for Program Leadership: 0.8 Total Minimum Program Leadership Support: 1.2	2.4.a (Continued)	Number of Approved Resident Positions (FTE) for the Program Director: 0.4 Mir (FTE) for Program Leadership: 0.8 Tota Support: 1.2
II.A.3.	Qualifications of the program director:	2.5.	Qualifications of the Program Directo The program director must possess s years of documented educational and qualifications acceptable to the Revie
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)	2.5.	Qualifications of the Program Directo The program director must possess s years of documented educational and qualifications acceptable to the Revie
II.A.3.b)	must include current certification in the specialty for which they are the program director by the American Board of Anesthesiology or by the American Osteopathic Board of Anesthesiology or specialty qualifications that are acceptable to the Review Committee; and, (Core)	2.5.a.	The program director must possess of for which they are the program direct Anesthesiology or by the American Os specialty qualifications that are accept (Core)
II.A.3.c)	must include ongoing clinical activity. (Core)	2.5.b.	The program director must demonstr
II.A.3.d)	must demonstrate ongoing academic achievements in anesthesiology, including publications, the development of educational programs, or the conduct of research. (Core)		The program director must demonstrate anesthesiology, including publications, t programs, or the conduct of research. (C

ns:51-60 | Minimum Support Required linimum Additional Support Required otal Minimum Program Leadership

ns:61-70 | Minimum Support Required linimum Additional Support Required otal Minimum Program Leadership

ns:71-80 | Minimum Support Required Iinimum Additional Support Required otal Minimum Program Leadership

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s specialty expertise and at least three nd/or administrative experience, or view Committee. (Core)

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s specialty expertise and at least three nd/or administrative experience, or view Committee. (Core)

current certification in the specialty ctor by the American Board of Osteopathic Board of Anesthesiology or eptable to the Review Committee.

trate ongoing clinical activity. (Core)

te ongoing academic achievements in , the development of educational (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremer
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)	2.6.	Program Director Responsibilities The program director must have resp accountability for: administration and activity; resident recruitment and sel residents, and disciplinary action; su education in the context of patient ca
II.A.4.a)	The program director must:	[None]	
II.A.4.a).(1)	be a role model of professionalism; (Core)	2.6.a.	The program director must be a role
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)	2.6.b.	The program director must design an consistent with the needs of the com Sponsoring Institution, and the missi
II.A.4.a).(3)	administer and maintain a learning environment conducive to educating the residents in each of the ACGME Competency domains; (Core)	2.6.c.	The program director must administe environment conducive to educating Competency domains. (Core)
II.A.4.a).(4)	have the authority to approve or remove physicians and non-physicians as faculty members at all participating sites, including the designation of core faculty members, and must develop and oversee a process to evaluate candidates prior to approval; (Core)	2.6.d.	The program director must have the a physicians and non-physicians as fac sites, including the designation of co develop and oversee a process to eva (Core)
II.A.4.a).(5)	have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program; (Core)	2.6.e.	The program director must have the a supervising interactions and/or learn the standards of the program. (Core)
II.A.4.a).(6)	submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; (Core)	2.6.f.	The program director must submit ac required and requested by the DIO, G
II.A.4.a).(7)	provide a learning and working environment in which residents have the opportunity to raise concerns, report mistreatment, and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; (Core)	2.6.g.	The program director must provide a which residents have the opportunity mistreatment, and provide feedback i appropriate, without fear of intimidati
II.A.4.a).(8)	ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process, including when action is taken to suspend or dismiss, or not to promote or renew the appointment of a resident; (Core)	2.6.h.	The program director must ensure th Sponsoring Institution's policies and and due process, including when act not to promote or renew the appointm
II.A.4.a).(9)	ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; (Core)	2.6.i.	The program director must ensure th Sponsoring Institution's policies and discrimination. (Core)
II.A.4.a).(9).(a)	Residents must not be required to sign a non-competition guarantee or restrictive covenant. (Core)	3.1.	Residents must not be required to sig restrictive covenant. (Core)
II.A.4.a).(10)	document verification of education for all residents within 30 days of completion of or departure from the program; and, (Core)	2.6.j.	The program director must document residents within 30 days of completic (Core)

sponsibility, authority, and nd operations; teaching and scholarly election, evaluation, and promotion of supervision of residents; and resident care. (Core)

e model of professionalism. (Core)

and conduct the program in a fashion ommunity, the mission(s) of the ssion(s) of the program. (Core)

ster and maintain a learning ig the residents in each of the ACGME

e authority to approve or remove faculty members at all participating core faculty members, and must evaluate candidates prior to approval.

e authority to remove residents from rning environments that do not meet e)

accurate and complete information GMEC, and ACGME. (Core)

a learning and working environment in ity to raise concerns, report k in a confidential manner as ation or retaliation. (Core)

the program's compliance with the nd procedures related to grievances ction is taken to suspend or dismiss, or ntment of a resident. (Core)

the program's compliance with the nd procedures on employment and non-

sign a non-competition guarantee or

ent verification of education for all tion of or departure from the program.

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Numerals	Requirement Language	Requirement Number	Requiremen
II.A.4.a).(11)	provide verification of an individual resident's education upon the resident's request, within 30 days; and (Core)	2.6.k.	The program director must provide v education upon the resident's reques
II.A.4.a).(12)	provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s). (Core)	2.6.1.	The program director must provide a interview with information related to relevant specialty board examination
	 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 and model exemplary behavior. 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 		Faculty Faculty members are a foundational of education – faculty members teach re Faculty members provide an importa- and become practice-ready, ensuring quality of care. They are role models by demonstrating compassion, comm patient care, professionalism, and a of Faculty members experience the priod development of future colleagues. The the opportunity to teach and model en- scholarly approach to patient care, fa- graduate medical education system, and the population. Faculty members ensure that patients from a specialist in the field. They rea- the patients, residents, community, a
	provide appropriate levels of supervision to promote patient safety.		provide appropriate levels of supervi
	Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and		Faculty members create an effective professional manner and attending to
II.B.	themselves.	[None]	themselves.
II.B.1.	There must be a sufficient number of faculty members with competence to instruct and supervise all residents. (Core)	2.7.	There must be a sufficient number of instruct and supervise all residents. (
II.B.1.a)	The members of the faculty must have varying interests, capabilities, and backgrounds, and include individuals who have specialized expertise in the subspecialties of anesthesiology, including critical care, obstetric anesthesia, pediatric anesthesia, neuroanesthesia, cardiothoracic anesthesia, and pain medicine, and also in research. (Core)	2.7.a.	The members of the faculty must have w backgrounds, and include individuals wh subspecialties of anesthesiology, includi pediatric anesthesia, neuroanesthesia, o medicine, and also in research. (Core)
II.B.1.b)	Didactic and clinical teaching should be provided by faculty members with documented interests and expertise in the subspecialty involved. (Detail)	2.7.b.	Didactic and clinical teaching should be documented interests and expertise in t
II.B.1.c)	The number of faculty members must be sufficient to provide each resident with adequate supervision, which shall not vary substantially with the time of day or the day of the week. (Core)	2.7.c.	The number of faculty members must be adequate supervision, which shall not va the day of the week. (Core)
II.B.1.d)	Designated faculty members must be readily and consistently available for consultation and teaching. (Core)	2.7.d.	Designated faculty members must be re consultation and teaching. (Core)
II.B.2.	Faculty members must:	[None]	
II.B.2.a)	be role models of professionalism; (Core)	2.8.	Faculty Responsibilities Faculty members must be role model

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verification of an individual resident's est, within 30 days. (Core)

applicants who are offered an o the applicant's eligibility for the on(s). (Core)

al element of graduate medical residents how to care for patients. tant bridge allowing residents to grow ng that patients receive the highest Is for future generations of physicians mmitment to excellence in teaching and a dedication to lifelong learning. ride and joy of fostering the growth and The care they provide is enhanced by I exemplary behavior. By employing a faculty members, through the n, improve the health of the individual

nts receive the level of care expected recognize and respond to the needs of , and institution. Faculty members rvision to promote patient safety. re learning environment by acting in a to the well-being of the residents and

of faculty members with competence to c. (Core)

e varying interests, capabilities, and who have specialized expertise in the uding critical care, obstetric anesthesia, , cardiothoracic anesthesia, and pain

be provided by faculty members with in the subspecialty involved. (Detail)

be sufficient to provide each resident with vary substantially with the time of day or

readily and consistently available for

lels of professionalism. (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
II.B.2.b)	demonstrate commitment to the delivery of safe, equitable, high-quality, cost-effective, patient-centered care; (Core)	2.8.a.	Faculty members must demonstrate equitable, high-quality, cost-effective
	demonstrate a strong interest in the education of residents, including devoting sufficient time to the educational program to fulfill their		Faculty members must demonstrate a residents, including devoting sufficie
II.B.2.c)	supervisory and teaching responsibilities; (Core)	2.8.b.	fulfill their supervisory and teaching i
II.B.2.d)	administer and maintain an educational environment conducive to educating residents; (Core)	2.8.c.	Faculty members must administer an environment conducive to educating
II.B.2.e)	regularly participate in organized clinical discussions, rounds, journal clubs, and conferences; and, (Core)	2.8.d.	Faculty members must regularly parti discussions, rounds, journal clubs, a
II.B.2.f)	pursue faculty development designed to enhance their skills at least annually: (Core)	2.8.e.	Faculty members must pursue faculty their skills at least annually: (Core)
II.B.2.f).(1)	as educators and evaluators; (Detail)	2.8.e.1.	as educators and evaluators; (Detail)
II.B.2.f).(2)	in quality improvement, eliminating health inequities, and patient safety; (Detail)	2.8.e.2.	in quality improvement, eliminating h (Detail)
II.B.2.f).(3)	in fostering their own and their residents' well-being; and, (Detail)	2.8.e.3.	in fostering their own and their reside
II.B.2.f).(4)	in patient care based on their practice-based learning and improvement efforts. (Detail)	2.8.e.4.	in patient care based on their practice efforts. (Detail)
			Faculty Qualifications Faculty members must have appropri
II.B.3.	Faculty Qualifications	2.9.	hold appropriate institutional appoint
II.B.3.a)	Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)	2.9.	Faculty Qualifications Faculty members must have appropri hold appropriate institutional appoint
II.B.3.b)	Physician faculty members must:	[None]	
II.B.3.b).(1)	have current certification in the specialty by the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology, or possess qualifications judged acceptable to the Review Committee. (Core)		Physician faculty members must have by the American Board of Anesthesiolo Board of Anesthesiology, or possess the Review Committee. (Core)
	Core Faculty		
II.B.4.	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)	2.11.	Core Faculty Core faculty members must have a si supervision of residents and must de entire effort to resident education and component of their activities, teach, e feedback to residents. (Core)
II.B.4.a)	Core faculty members must complete the annual ACGME Faculty Survey. (Core)	2.11.a.	Core faculty members must complete (Core)
II.B.4.b)	There must be at least six core physician faculty members, not including the program director. (Core)	2.11.b.	There must be at least six core physicial program director. (Core)
II.C.	Program Coordinator	2.12.	Program Coordinator There must be a program coordinator
II.C.1.	There must be a program coordinator. (Core)	2.12.	Program Coordinator There must be a program coordinator

e commitment to the delivery of safe, /e, patient-centered care. (Core)

e a strong interest in the education of cient time to the educational program to g responsibilities. (Core)

and maintain an educational

ng residents. (Core)

rticipate in organized clinical

and conferences. (Core)

Ity development designed to enhance

I)

health inequities, and patient safety;

dents' well-being; and, (Detail) ice-based learning and improvement

priate qualifications in their field and intments. (Core)

priate qualifications in their field and ntments. (Core)

ave current certification in the specialty iology or the American Osteopathic is qualifications judged acceptable to

significant role in the education and devote a significant portion of their and/or administration, and must, as a a, evaluate, and provide formative

ete the annual ACGME Faculty Survey.

cian faculty members, not including the

tor. (Core)

tor. (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremer
II.C.2.	The program coordinator must be provided with dedicated time and support adequate for administration of the program based upon its size and configuration. (Core)	2.12.a.	The program coordinator must be pr support adequate for administration and configuration. (Core)
	At a minimum, the program coordinator must be provided with the dedicated time and support specified below for administration of the program: (Core)		At a minimum, the program coordinator time and support specified below for add
	Number of Approved Resident Positions:9-10 Minimum Support Required (FTE):0.7		Number of Approved Resident Positions (FTE):0.7
	Number of Approved Resident Positions:11-15 Minimum Support Required (FTE):0.8		Number of Approved Resident Positions (FTE):0.8
	Number of Approved Resident Positions:16-20 Minimum Support Required (FTE):0.9		Number of Approved Resident Positions (FTE):0.9
	Number of Approved Resident Positions:21-25 Minimum Support Required (FTE):1		Number of Approved Resident Positions (FTE):1
	Number of Approved Resident Positions:26-30 Minimum Support Required (FTE):1.1		Number of Approved Resident Positions (FTE):1.1
	Number of Approved Resident Positions:31-35 Minimum Support Required (FTE):1.2		Number of Approved Resident Positions (FTE):1.2
	Number of Approved Resident Positions:36-40 Minimum Support Required (FTE):1.3		Number of Approved Resident Positions (FTE):1.3
	Number of Approved Resident Positions:41-45 Minimum Support Required (FTE):1.4		Number of Approved Resident Positions (FTE):1.4
	Number of Approved Resident Positions:46-50 Minimum Support Required (FTE):1.5		Number of Approved Resident Positions (FTE):1.5
II.C.2.a)	Number of Approved Resident Positions:51-55 Minimum Support Required (FTE):1.6	2.12.b.	Number of Approved Resident Positions (FTE):1.6

provided with dedicated time and n of the program based upon its size

or must be provided with the dedicated administration of the program: (Core) ons:9-10|Minimum Support Required ons:11-15|Minimum Support Required ons:16-20|Minimum Support Required ons:21-25|Minimum Support Required ons:26-30|Minimum Support Required ons:31-35|Minimum Support Required ons:41-45|Minimum Support Required ons:46-50|Minimum Support Required

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
	Number of Approved Resident Positions:56-60 Minimum Support Required (FTE):1.7		Number of Approved Resident Positions (FTE):1.7
	Number of Approved Resident Positions:61-65 Minimum Support Required (FTE):1.8		Number of Approved Resident Positions (FTE):1.8
	Number of Approved Resident Positions:66-70 Minimum Support Required (FTE):1.9		Number of Approved Resident Positions (FTE):1.9
	Number of Approved Resident Positions:71-75 Minimum Support Required (FTE):2		Number of Approved Resident Positions (FTE):2
	Number of Approved Resident Positions:76-80 Minimum Support Required (FTE):2.1		Number of Approved Resident Positions (FTE):2.1
	Number of Approved Resident Positions:81-85 Minimum Support Required (FTE):2.2		Number of Approved Resident Positions (FTE):2.2
	Number of Approved Resident Positions:86-90 Minimum Support Required (FTE):2.3		Number of Approved Resident Positions (FTE):2.3
	Number of Approved Resident Positions:91-95 Minimum Support Required (FTE):2.4		Number of Approved Resident Positions (FTE):2.4
	Number of Approved Resident Positions:96-100 Minimum Support Required (FTE):2.5		Number of Approved Resident Positions Required (FTE):2.5
	Number of Approved Resident Positions:101-105 Minimum Support Required (FTE):2.6		Number of Approved Resident Positions Required (FTE):2.6
	Number of Approved Resident Positions:106-110 Minimum Support Required (FTE):2.7		Number of Approved Resident Positions Required (FTE):2.7
	Number of Approved Resident Positions:111-115 Minimum Support Required (FTE):2.8		Number of Approved Resident Positions Required (FTE):2.8
	Number of Approved Resident Positions:116-120 Minimum Support Required (FTE):2.9		Number of Approved Resident Positions Required (FTE):2.9
II.C.2.a) - (Continued)	Number of Approved Resident Positions:Over 120 Minimum Support Required (FTE):3	2.12.b (Continued)	Number of Approved Resident Positions Required (FTE):3
	Other Program Personnel		Other Program Personnel
	The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective		The program, in partnership with its s ensure the availability of necessary p
II.D.	administration of the program. (Core)	2.13. Section 3	administration of the program. (Core)
III. 	Resident Appointments		Section 3: Resident Appointments Eligibility Requirements
II.A.	Eligibility Requirements	3.2.	An applicant must meet one of the fo for appointment to an ACGME-accred
III.A.1.	An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program: (Core)	3.2.	Eligibility Requirements An applicant must meet one of the fo for appointment to an ACGME-accred
	graduation from a medical school in the United States, accredited by the Liaison Committee on Medical Education (LCME) or graduation from a		graduation from a medical school in t Liaison Committee on Medical Educa
	college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College	2.2.0	college of osteopathic medicine in th American Osteopathic Association C
III.A.1.a)	Accreditation (AOACOCA); or, (Core)	3.2.a.	Accreditation (AOACOCA); or, (Core)

ons:56-60|Minimum Support Required ons:61-65|Minimum Support Required ons:66-70|Minimum Support Required ons:71-75|Minimum Support Required ons:76-80|Minimum Support Required ons:81-85|Minimum Support Required ons:86-90|Minimum Support Required ons:91-95|Minimum Support Required ons:96-100|Minimum Support ons:106-110|Minimum Support ons:116-120|Minimum Support ons:116-120|Minimum Support

s Sponsoring Institution, must jointly v personnel for the effective re)

following qualifications to be eligible redited program: (Core)

following qualifications to be eligible edited program: (Core)

n the United States, accredited by the cation (LCME) or graduation from a the United States, accredited by the Commission on Osteopathic College re)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
			graduation from a medical school ou meeting one of the following additior
			 holding a currently valid certificate Foreign Medical Graduates (ECFMG)
III.A.1.b)	graduation from a medical school outside of the United States, and meeting one of the following additional qualifications: (Core)	3.2.b.	 holding a full and unrestricted licen: States licensing jurisdiction in which located. (Core)
			graduation from a medical school ou meeting one of the following addition
			 holding a currently valid certificate f Foreign Medical Graduates (ECFMG)
III.A.1.b).(1)	holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core)	3.2.b.	 holding a full and unrestricted licens States licensing jurisdiction in which located. (Core)
			graduation from a medical school ou meeting one of the following addition
			 holding a currently valid certificate f Foreign Medical Graduates (ECFMG)
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)	3.2.b.	 holding a full and unrestricted licens States licensing jurisdiction in which 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)	3.3.	All prerequisite post-graduate clinica or transfer into ACGME-accredited re completed in ACGME-accredited residency programs, Royal College of (RCPSC)-accredited or College of Far accredited residency programs locate programs with ACGME International (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)	3.3.a.	Residency programs must receive ve competency in the required clinical fi ACGME-I Milestones evaluations fron matriculation. (Core)

- outside of the United States, and onal qualifications: (Core)
- e from the Educational Commission for G) prior to appointment; or, (Core)
- ense to practice medicine in the United checked by the ACGME-accredited program is
- outside of the United States, and onal qualifications: (Core)
- e from the Educational Commission for G) prior to appointment; or, (Core)
- ense to practice medicine in the United checked by the ACGME-accredited program is
- outside of the United States, and onal qualifications: (Core)
- e from the Educational Commission for G) prior to appointment; or, (Core)
- ense to practice medicine in the United checked by the ACGME-accredited program is
- cal education required for initial entry residency programs must be sidency programs, AOA-approved of Physicians and Surgeons of Canada family Physicians of Canada (CFPC)ated in Canada, or in residency al (ACGME-I) Advanced Specialty
- verification of each resident's level of field using ACGME, CanMEDS, or om the prior training program upon

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremer
III.A.2.a).(1)	Residents entering a 36-month anesthesiology program that does not include education in fundamental clinical skills of medicine must have successfully completed 12 months of education in fundamental clinical skills of medicine in a program that satisfies the requirements in III.A.2. (Core)	3.3.a.1.	Residents entering a 36-month anesthe education in fundamental clinical skills completed 12 months of education in fu program that satisfies the requirements
III.A.2.a).(1).(a)	If such residents have also been accepted into an anesthesiology program, then in order to be accepted into the CA-1 year, they must demonstrate satisfactory abilities on written performance evaluations in fundamental clinical skills of medicine prior to starting their education. (Core)	3.3.a.1.a.	If such residents have also been accep then in order to be accepted into the CA satisfactory abilities on written performa skills of medicine prior to starting their e
III.A.2.a).(1).(b)	When residents complete education in fundamental clinical skills of medicine in another accredited program, the anesthesiology program director must ensure they receive their written performance evaluations. (Core)	3.3.a.1.b.	When residents complete education in a another accredited program, the anesthe they receive their written performance e
III.B.	Resident Complement The program director must not appoint more residents than approved by the Review Committee. (Core)	3.4.	Resident Complement The program director must not appo the Review Committee. (Core)
III.B.1.	There must be a minimum of nine residents with, on average, three appointed in each of the CA-1, CA-2, and CA-3 years. (Core)	3.4.a.	There must be a minimum of nine resid each of the CA-1, CA-2, and CA-3 year
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)	3.5.	Resident Transfers The program must obtain verificatior and a summative competency-based acceptance of a transferring resident matriculation. (Core)
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. It is recognized 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.	Section 4	Section 4: Educational Program The ACGME accreditation system is and innovation in graduate medical e organizational affiliation, size, or loca The educational program must suppor knowledgeable, skillful physicians w It is recognized programs may place leadership, public health, etc. It is ex reflect the nuanced program-specific example, it is expected that a program scientists will have a different curricul community health.
IV.A.	Educational Components The curriculum must contain the following educational components:	4.2.	Educational Components The curriculum must contain the foll

ent Language

hesiology program that does not include s of medicine must have successfully fundamental clinical skills of medicine in a ts in 3.3. (Core)

epted into an anesthesiology program, CA-1 year, they must demonstrate nance evaluations in fundamental clinical r education. (Core)

n fundamental clinical skills of medicine in thesiology program director must ensure e evaluations. (Core)

oint more residents than approved by

idents with, on average, three appointed in ars. (Core)

on of previous educational experiences ed performance evaluation prior to nt, and Milestones evaluations upon

is designed to encourage excellence I education regardless of the ocation of the program.

port the development of who provide compassionate care.

e different emphasis on research, expected that the program aims will fic goals for it and its graduates; for ram aiming to prepare physicianiculum from one focusing on

llowing educational components:

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Numerals	Requirement Language	Requirement Number	Requiremen
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, which must be made available to program applicants, residents, and faculty members; (Core)	4.2.a.	a set of program aims consistent with mission, the needs of the community capabilities of its graduates, which m applicants, residents, and faculty me
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)	4.2.b.	competency-based goals and objectiv designed to promote progress on a tr These must be distributed, reviewed, faculty members; (Core)
IV.A.3. IV.A.4.	delineation of resident responsibilities for patient care, progressive responsibility for patient management, and graded supervision; (Core) a broad range of structured didactic activities; and, (Core)	4.2.c.	delineation of resident responsibilitie responsibility for patient managemen
IV.A.4.	a broad range of structured didactic activities; and, (Core)	4.2.d.	a broad range of structured didactic a Curriculum Organization and Resider
IV.A.4.a)	Residents must be provided with protected time to participate in core didactic activities. (Core)	4.11.	Experiences Residents must be provided with prot didactic activities. (Core)
IV.A.5.	formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)	4.2.e.	formal educational activities that pror tools, and techniques. (Core)
IV.B.	ACGME Competencies	[None]	ACGME Competencies The Competencies provide a concept required domains for a trusted physic These Competencies are core to the p the specifics are further defined by ea trajectories in each of the Competence Milestones for each specialty.
IV.B.1.	The program must integrate the following ACGME Competencies into the curriculum:	[None]	The program must integrate all ACGN
	Professionalism Residents must demonstrate a commitment to professionalism and an		ACGME Competencies – Professiona Residents must demonstrate a comm adherence to ethical principles. (Core
IV.B.1.a)	adherence to ethical principles. (Core)	4.3.	Residents must demonstrate competer
			ACGME Competencies – Professiona Residents must demonstrate a comm adherence to ethical principles. (Core
IV.B.1.a).(1)	Residents must demonstrate competence in:	4.3.	Residents must demonstrate competer
IV.B.1.a).(1).(a)	compassion, integrity, and respect for others; (Core)	4.3.a.	compassion, integrity, and respect fo
IV.B.1.a).(1).(b)	responsiveness to patient needs that supersedes self-interest; (Core)	4.3.b.	responsiveness to patient needs that
IV.B.1.a).(1).(c)	cultural humility; (Core)	4.3.c.	cultural humility; (Core)
IV.B.1.a).(1).(d)	respect for patient privacy and autonomy; (Core) accountability to patients, society, and the profession; (Core)	4.3.d.	respect for patient privacy and autono
IV.B.1.a).(1).(e)	accountability to patients, society, and the profession; (Core)	4.3.e.	accountability to patients, society, an

ith the Sponsoring Institution's ity it serves, and the desired distinctive must be made available to program nembers; (Core)

ctives for each educational experience a trajectory to autonomous practice. d, and available to residents and

ies for patient care, progressive ent, and graded supervision; (Core) c activities; and, (Core)

lent Experiences – Didactic and Clinical

rotected time to participate in core

romote patient safety-related goals,

eptual framework describing the sician to enter autonomous practice. e practice of all physicians, although each specialty. The developmental prices are articulated through the

GME Competencies into the curriculum.

nalism nmitment to professionalism and an pre)

etence in:

nalism nmitment to professionalism and an pre)

etence in: for others; (Core)

at supersedes self-interest; (Core)

onomy; (Core) and the profession; (Core)

Requirement Number - Roman		Reformatted	
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		•	
	respect and responsiveness to diverse patient populations, including but		respect and responsiveness to diver
	not limited to diversity in gender, age, culture, race, religion, disabilities,		not limited to diversity in gender, age
IV.B.1.a).(1).(f)	national origin, socioeconomic status, and sexual orientation; (Core)	4.3.f.	national origin, socioeconomic statu
	ability to recognize and develop a plan for one's own personal and		ability to recognize and develop a pla
IV.B.1.a).(1).(g)	professional well-being; and, (Core)	4.3.g.	professional well-being; and, (Core)
	appropriately disclosing and addressing conflict or duality of interest.		appropriately disclosing and address
IV.B.1.a).(1).(h)	(Core)	4.3.h.	(Core)
IV.B.1.b)	Patient Care and Procedural Skills	[None]	
	Residents must be able to provide patient care that is patient- and family- centered, compassionate, equitable, appropriate, and effective for the treatment of health problems and the promotion of health. (Core)	4.4.	ACGME Competencies – Patient Care Residents must be able to provide pa centered, compassionate, equitable, treatment of health problems and the
	Residents must demonstrate competence in fundamental clinical skills of		Residents must demonstrate competend
, (, (,	medicine, including:	4.4.a.	medicine, including:
, , , , , , ,	obtaining a comprehensive medical history; (Core)	4.4.a.1.	obtaining a comprehensive medical hist
IV.B.1.b).(1).(a).(ii)	performing a comprehensive physical examination; (Core)	4.4.a.2.	performing a comprehensive physical ex
IV.B.1.b).(1).(a).(iii)	assessing a patient's medical conditions; (Core)	4.4.a.3.	assessing a patient's medical conditions
IV.B.1.b).(1).(a).(iv)	making appropriate use of diagnostic studies and tests; (Core)	4.4.a.4.	making appropriate use of diagnostic st
IV.B.1.b).(1).(a).(v)	integrating information to develop a differential diagnosis; and, (Core)	4.4.a.5.	integrating information to develop a diffe
IV.B.1.b).(1).(a).(vi)	implementing a treatment plan. (Core)	4.4.a.6.	implementing a treatment plan. (Core)
	Residents must demonstrate competence in anesthetic management, including care for:	4.4.b.	Residents must demonstrate competend care for:
	patients younger than 12 years of age undergoing surgery or other procedures requiring anesthetics; (Core)	4.4.b.1.	patients younger than 12 years of age u requiring anesthetics; (Core)
IV.B.1.b).(1).(b).(i).(a)	This experience must involve care for 100 patients younger than 12 years of age. (Core)	4.4.b.1.a.	This experience must involve care for 10 age. (Core)
	Within this patient group, 20 children must be younger than three years of age, including five younger than three months of age. (Core)	4.4.b.1.b.	Within this patient group, 20 children muincluding five younger than three month
	patients who are evaluated for management of acute, chronic, or cancer-related pain disorders; (Core)	4.4.b.2.	patients who are evaluated for manager pain disorders; (Core)
	This experience must involve care for 20 patients presenting for initial evaluation		This experience must involve care for 20
IV.B.1.b).(1).(b).(ii).(a)	of pain. (Core)	4.4.b.2.a.	evaluation of pain. (Core)
	Residents must be familiar with the breadth of pain management, including clinical experience with interventional pain procedures. (Core)	4.4.b.2.b.	Residents must be familiar with the breaction of the brea
IV.B.1.b).(1).(b).(iii)	patients scheduled for evaluation prior to elective surgical procedures; (Core)	4.4.b.3.	patients scheduled for evaluation prior t
	patients immediately after anesthesia, including direct care of patients in the post-anesthesia-care unit, and responsibilities for management of pain, hemodynamic changes, and emergencies related to the post-anesthesia care unit; and, (Core)	4.4.b.4.	patients immediately after anesthesia, ir post-anesthesia-care unit, and responsi hemodynamic changes, and emergenci- unit; and, (Core)
, , , , , , ,	critically-ill patients. (Core)	4.4.b.5.	critically-ill patients. (Core)
, , , , , , , ,	Residents must achieve competence in the delivery of anesthetic care to:	4.4.c.	Residents must achieve competence in
	patients undergoing vaginal delivery; (Core)	4.4.c.1.	patients undergoing vaginal delivery; (C

ent Language

erse patient populations, including but ge, culture, race, religion, disabilities, tus, and sexual orientation; (Core) blan for one's own personal and

ssing conflict or duality of interest.

re

patient care that is patient- and familye, appropriate, and effective for the he promotion of health. (Core)

ence in fundamental clinical skills of

istory; (Core)

examination; (Core)

ons; (Core)

studies and tests; (Core)

fferential diagnosis; and, (Core)

ence in anesthetic management, including

undergoing surgery or other procedures

100 patients younger than 12 years of

must be younger than three years of age, ths of age. (Core)

ement of acute, chronic, or cancer-related

20 patients presenting for initial

eadth of pain management, including pain procedures. (Core)

to elective surgical procedures; (Core)

, including direct care of patients in the sibilities for management of pain, icies related to the post-anesthesia care

in the delivery of anesthetic care to: (Core)

40 patients. (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	. Requirement Language
IV.B.1.b).(1).(c).(ii)	patients undergoing cesarean sections; (Core)	4.4.c.2.	patients undergoing cesarean sections; (Core)
, , , , , , ,	This experience must involve care for 20 patients. (Core)	4.4.c.2.a.	This experience must involve care for 20 patients. (Core)
, , , , , , , , , , ,	patients undergoing cardiac surgery; (Core)	4.4.c.3.	patients undergoing cardiac surgery; (Core)
	This experience must involve care for 20 patients. (Core)	4.4.c.3.a.	This experience must involve care for 20 patients. (Core)
11.D.1.D).(1).(0).(11).(0)	The care provided to 10 of these patients must involve the use of	1.1.0.0.0.	The care provided to 10 of these patients must involve the use of
IV.B.1.b).(1).(c).(iii).(b)	cardiopulmonary bypass. (Core)	4.4.c.3.b.	cardiopulmonary bypass. (Core)
IV.B.1.b).(1).(c).(iv)	patients undergoing open or endovascular procedures on major vessels, including carotid surgery, intrathoracic vascular surgery, intra-abdominal vascular surgery, or peripheral vascular surgery; (Core)	4.4.c.4.	patients undergoing open or endovascular procedures on major vessels, including carotid surgery, intrathoracic vascular surgery, intra-abdominal vascular surgery, or peripheral vascular surgery; (Core)
IV.B.1.b).(1).(c).(iv).(a)	This experience must involve care for 20 patients, not including surgery for vascular access or repair of vascular access. (Core)	4.4.c.4.a.	This experience must involve care for 20 patients, not including surgery for vascular access or repair of vascular access. (Core)
IV.B.1.b).(1).(c).(v)	patients undergoing non-cardiac intrathoracic surgery, including pulmonary surgery and surgery of the great vessels, esophagus, and the mediastinum and its structures; (Core)	4.4.c.5.	patients undergoing non-cardiac intrathoracic surgery, including pulmonary surgery and surgery of the great vessels, esophagus, and the mediastinum and its structures; (Core)
IV.B.1.b).(1).(c).(v).(a)	This experience must involve care for 20 patients. (Core)	4.4.c.5.a.	This experience must involve care for 20 patients. (Core)
IV.B.1.b).(1).(c).(vi)	patients undergoing intracerebral procedures, including those undergoing intracerebral endovascular procedures; (Core)	4.4.c.6.	patients undergoing intracerebral procedures, including those undergoing intracerebral endovascular procedures; (Core)
IV.B.1.b).(1).(c).(vi).(a)	This experience must involve care for 20 patients, the majority of which must involve an open cranium. (Core)	4.4.c.6.a.	This experience must involve care for 20 patients, the majority of which must involve an open cranium. (Core)
IV.B.1.b).(1).(c).(vii))	patients for whom epidural anesthetics are used as part of the anesthetic technique or epidural catheters are placed for peri-operative analgesia; (Core) This experience must involve care for 40 patients. (Core)	4.4.c.7. 4.4.c.7.a.	patients for whom epidural anesthetics are used as part of the anesthetic technique or epidural catheters are placed for peri-operative analgesia; (Core) This experience must involve care for 40 patients. (Core)
IV.B.1.b).(1).(c).(viii)	patients undergoing procedures for complex, immediate life-threatening pathology; (Core)	4.4.c.8.	patients undergoing procedures for complex, immediate life-threatening pathology; (Core)
)	This experience must involve care for 20 patients. (Core)	4.4.c.8.a.	This experience must involve care for 20 patients. (Core)
IV.B.1.b).(1).(c).(ix)	patients undergoing surgical procedures, including cesarean sections, with spinal anesthetics; (Core)	4.4.c.9.	patients undergoing surgical procedures, including cesarean sections, with spinal anesthetics; (Core)
	This experience must involve care for 40 patients. (Core)	4.4.c.9.a.	This experience must involve care for 40 patients. (Core)
	patients undergoing surgical procedures in whom peripheral nerve blocks are used as part of the anesthetic technique or peri-operative analgesic management; (Core)	4.4.c.10.	patients undergoing surgical procedures in whom peripheral nerve blocks are used as part of the anesthetic technique or peri-operative analgesic management; (Core)
	This experience must involve care for 40 patients. (Core)	4.4.c.10.a.	This experience must involve care for 40 patients. (Core)
	patients with acute post-operative pain, including those with patient-controlled intravenous techniques, neuraxial blockade, and other pain-control modalities;	4.4.c.11.	patients with acute post-operative pain, including those with patient-controlled intravenous techniques, neuraxial blockade, and other pain-control modalities; (Core)
IV.B.1.b).(1).(c).(xii)	patients whose peri-operative care requires specialized techniques, including: (Core)	4.4.c.12.	patients whose peri-operative care requires specialized techniques, including: (Core)
	a broad spectrum of airway management techniques, to include laryngeal masks, fiberoptic intubation, and lung isolation techniques, such as double lumen endotracheal tube placement and endobronchial blockers; (Core)	4.4.c.12.a.	a broad spectrum of airway management techniques, to include laryngeal masks, fiberoptic intubation, and lung isolation techniques, such as double lumen endotracheal tube placement and endobronchial blockers; (Core)
IV.B.1.b).(1).(c).(xii).(b)	central vein and pulmonary artery catheter placement, and the use of transesophageal echocardiography and evoked potentials; and, (Core)	4.4.c.12.b.	central vein and pulmonary artery catheter placement, and the use of transesophageal echocardiography and evoked potentials; and, (Core)

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	use of electroencephalography (EEG) or processed EEG monitoring as part of the procedure, or adequate didactic instruction to ensure familiarity with EEG use and interpretation. (Core)	4.4.c.12.c.	use of electroencephalography (EEG) of the procedure, or adequate didactic inst use and interpretation. (Core)
	patients undergoing a variety of diagnostic or therapeutic procedures outside the surgical suite. (Core)		patients undergoing a variety of diagnos the surgical suite. (Core)
IV.B.1.b).(1).(c).(xiii)	This must include competency in:	4.4.c.13.	This must include competency in:
IV.B.1.b).(1).(c).(xiii).(a	using surface ultrasound and transesophageal and transthoracic echocardiography to guide the performance of invasive procedures and to evaluate organ function and pathology as related to anesthesia, critical care, and resuscitation; (Core)	4.4.c.13.a.	using surface ultrasound and transesop echocardiography to guide the performa evaluate organ function and pathology a and resuscitation; (Core)
IV.B.1.b).(1).(c).(xiii).(b	understanding the principles of ultrasound, including the physics of ultrasound transmission, ultrasound transducer construction, and transducer selection for specific applications, to include being able to obtain images with an understanding of limitations and artifacts; (Core)	4.4.c.13.b.	understanding the principles of ultrasou transmission, ultrasound transducer cor specific applications, to include being al understanding of limitations and artifact
IV.B.1.b).(1).(c).(xiii).(c	obtaining standard views of the heart and inferior vena cava with transthoracic echocardiography allowing the evaluation of myocardial function, estimation of central venous pressure, and gross pericardial/cardiac pathology (e.g., large pericardial effusion); (Core)	4.4.c.13.c.	obtaining standard views of the heart ar echocardiography allowing the evaluation central venous pressure, and gross peri pericardial effusion); (Core)
	obtaining standard views of the heart with transesophageal echocardiography allowing the evaluation of myocardial function and gross pericardial/cardiac pathology (e.g., large pericardial effusion); (Core)	4.4.c.13.d.	obtaining standard views of the heart wi allowing the evaluation of myocardial fu pathology (e.g., large pericardial effusio
, , , , , , , , ,	using transthoracic ultrasound for the detection of pneumothorax and pleural effusion; (Core)	4.4.c.13.e.	using transthoracic ultrasound for the de effusion; (Core)
IV.B.1.b).(1).(c).(xiii).(f)	using surface ultrasound to guide vascular access (both central and peripheral) and to guide regional anesthesia procedures; and, (Core)	4.4.c.13.f. 4.4.c.13.g.	using surface ultrasound to guide vascu and to guide regional anesthesia procec describing techniques, views, and findin
, , ,	describing techniques, views, and findings in standard language. (Core) Residents must be able to perform all medical, diagnostic, and surgical		ACGME Competencies – Procedural perform all medical, diagnostic, and s
IV.B.1.b).(2) IV.B.1.c)	procedures considered essential for the area of practice. (Core) Medical Knowledge Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, including scientific inquiry, as well as the application of this knowledge to patient care. (Core)	4.5.	essential for the area of practice. (Co ACGME Competencies – Medical Kno Residents must demonstrate knowled biomedical, clinical, epidemiological, including scientific inquiry, as well as patient care. (Core)
IV.B.1.c).(1)	Residents must demonstrate appropriate medical knowledge in the topics related to the anesthetic care of patients, including:	4.6.a.	Residents must demonstrate appropriat related to the anesthetic care of patients
IV.B.1.c).(1).(a)	practice management to address issues such as: (Core)	4.6.a.1.	practice management to address issues
IV.B.1.c).(1).(a).(i)	operating room management; (Core)	4.6.a.1.a.	operating room management; (Core)
IV.B.1.c).(1).(a).(ii)	evaluation of types of practice; (Core)	4.6.a.1.b.	evaluation of types of practice; (Core)
IV.B.1.c).(1).(a).(iii)	contract negotiations; (Core)	4.6.a.1.c.	contract negotiations; (Core)
IV.B.1.c).(1).(a).(iv) IV.B.1.c).(1).(a).(v)	billing arrangements; (Core) professional liability; (Core)	4.6.a.1.d. 4.6.a.1.e.	billing arrangements; (Core) professional liability; (Core)
·v. D. 1.0).(1).(a).(V)			
IV.B.1.c).(1).(a).(vi)	health care finance, legislative, and regulatory issues; and, (Core)	4.6.a.1.f.	health care finance, legislative, and regi

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or processed EEG monitoring as part of struction to ensure familiarity with EEG

ostic or therapeutic procedures outside

ophageal and transthoracic nance of invasive procedures and to y as related to anesthesia, critical care,

ound, including the physics of ultrasound construction, and transducer selection for able to obtain images with an cts; (Core)

and inferior vena cava with transthoracic ation of myocardial function, estimation of ericardial/cardiac pathology (e.g., large

with transesophageal echocardiography function and gross pericardial/cardiac ion); (Core)

detection of pneumothorax and pleural

cular access (both central and peripheral) ædures; and, (Core)

lings in standard language. (Core)

al Skills: Residents must be able to d surgical procedures considered Core)

nowledge

ledge of established and evolving al, and social-behavioral sciences, as the application of this knowledge to

iate medical knowledge in the topics nts, including:

es such as: (Core)

egulatory issues; and, (Core) lelivery. (Core)

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	management skills, to include basic knowledge of organizational culture,		management skills, to include basic kno
	decision making, change management, conflict resolution, and negotiation and		decision making, change management,
IV.B.1.c).(1).(b)	advocacy; (Core)	4.6.a.2.	advocacy; (Core)
	care of the patient in the continuum of the peri-operative period, to include		care of the patient in the continuum of th
IV.B.1.c).(1).(c)	collaboration with medical and surgical colleagues to:	4.6.a.3.	collaboration with medical and surgical of
IV.B.1.c).(1).(c).(i)	optimize preoperative patient condition; and, (Core)	4.6.a.3.a.	optimize preoperative patient condition;
IV.B.1.c).(1).(c).(ii)	optimize recovery; (Core)	4.6.a.3.b.	optimize recovery; (Core)
	management of the specific needs of patients undergoing diagnostic or		management of the specific needs of pa
IV.B.1.c).(1).(d)	therapeutic procedures outside of the surgical suite. (Core)	4.6.a.4.	therapeutic procedures outside of the su
	Practice-based Learning and Improvement		ACGME Competencies – Practice-Bas
IV.B.1.d)	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)	4.7.	Residents must demonstrate the abili care of patients, to appraise and assi continuously improve patient care ba lifelong learning. (Core)
IV.B.1.d).(1)	Residents must demonstrate competence in:	[None]	
	identifying strengths, deficiencies, and limits in one's knowledge and		Residents must demonstrate compete
IV.B.1.d).(1).(a)	expertise; (Core)	4.7.a.	deficiencies, and limits in one's know
			Residents must demonstrate compete
IV.B.1.d).(1).(b)	setting learning and improvement goals; (Core)	4.7.b.	improvement goals. (Core)
IV.B.1.d).(1).(c)	identifying and performing appropriate learning activities; (Core)	4.7.c.	Residents must demonstrate competer appropriate learning activities. (Core)
IV.B.1.d).(1).(d)	systematically analyzing practice using quality improvement methods, including activities aimed at reducing health care disparities, and implementing changes with the goal of practice improvement; (Core)	4.7.d.	Residents must demonstrate competer practice using quality improvement n reducing health care disparities, and of practice improvement. (Core)
	incorporating feedback and formative evaluation into daily practice; and,		Residents must demonstrate compete
IV.B.1.d).(1).(e)	(Core)	4.7.e.	formative evaluation into daily practic
IV.B.1.d).(1).(f)	locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems. (Core)	4.7.f.	Residents must demonstrate competer assimilating evidence from scientific health problems. (Core)
	Interpersonal and Communication Skills		
IV.B.1.e)	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)	4.8.	ACGME Competencies – Interpersona Residents must demonstrate interper result in the effective exchange of inf patients, their families, and health pro
IV.B.1.e).(1)	Residents must demonstrate competence in	[None]	
IV.B.1.e).(1).(a)	communicating effectively with patients and patients' families, as appropriate, across a broad range of socioeconomic circumstances, cultural backgrounds, and language capabilities, learning to engage interpretive services as required to provide appropriate care to each patient; (Core)	4.8.a.	Residents must demonstrate competer with patients and patients' families, a of socioeconomic circumstances, cul capabilities, learning to engage interp provide appropriate care to each patie
IV.B.1.e).(1).(b)	communicating effectively with physicians, other health professionals, and health-related agencies; (Core)	4.8.b.	Residents must demonstrate competer with physicians, other health profess (Core)

nowledge of organizational culture, t, conflict resolution, and negotiation and

f the peri-operative period, to include al colleagues to: n; and, (Core)

patients undergoing diagnostic or surgical suite. (Core)

Based Learning and Improvement

bility to investigate and evaluate their similate scientific evidence, and to based on constant self-evaluation and

etence in identifying strengths, owledge and expertise. (Core) etence in setting learning and

etence in identifying and performing re)

etence in systematically analyzing t methods, including activities aimed at id implementing changes with the goal

etence in incorporating feedback and stice. (Core)

etence in locating, appraising, and ic studies related to their patients'

onal and Communication Skills personal and communication skills that nformation and collaboration with professionals. (Core)

etence in communicating effectively , as appropriate, across a broad range cultural backgrounds, and language erpretive services as required to atient. ^(Core)

etence in communicating effectively ssionals, and health-related agencies.

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Humorulo			Kequitemen
IV.B.1.e).(1).(c)	working effectively as a member or leader of a health care team or other professional group; (Core)	4.8.c.	Residents must demonstrate compet member or leader of a health care tea
IV.B.1.e).(1).(d)	educating patients, patients' families, students, other residents, and other health professionals; (Core)	4.8.d.	Residents must demonstrate compet families, students, other residents, an
IV.B.1.e).(1).(e)	acting in a consultative role to other physicians and health professionals; (Core)	4.8.e.	Residents must demonstrate compet to other physicians and health profes
IV.B.1.e).(1).(f)	maintaining comprehensive, timely, and legible health care records, if applicable. (Core)	4.8.f.	Residents must demonstrate competitimely, and legible health care record
IV.B.1.e).(1).(g)	maintaining a comprehensive anesthesia record for each patient, including evidence of pre- and post-operative anesthesia assessment, the drugs administered, the monitoring employed, the techniques used, the physiologic variations observed, the therapy provided, and the fluids administered; and, (Core)	4.8.h.	Residents must demonstrate competend anesthesia record for each patient, inclu operative anesthesia assessment, the d employed, the techniques used, the phy therapy provided, and the fluids adminis
IV.B.1.e).(1).(h)	creating and sustaining a therapeutic relationship with patients, engaging in active listening, providing information using appropriate language, asking clear questions, and providing an opportunity for comments and questions. (Core)	4.8.i.	Residents must demonstrate competend therapeutic relationship with patients, er information using appropriate language, an opportunity for comments and questi
IV.B.1.e).(2)	Residents must learn to communicate with patients and patients' families to partner with them to assess their care goals, including, when appropriate, end-of-life goals. (Core)	4.8.g.	Residents must learn to communicate to partner with them to assess their c appropriate, end-of-life goals. (Core)
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 structural and social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)	4.9.	ACGME Competencies - Systems-Bas Residents must demonstrate an awar larger context and system of health c social determinants of health, as well other resources to provide optimal he
IV.B.1.f).(1)	Residents must demonstrate competence in:	[None]	
IV.B.1.f).(1).(a)	working effectively in various health care delivery settings and systems relevant to their clinical specialty; (Core)	4.9.a.	Residents must demonstrate competends in the second system of the second
IV.B.1.f).(1).(b)	coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty; (Core)	4.9.b.	Residents must demonstrate competence across the health care continuum and specialty. ^(Core)
IV.B.1.f).(1).(c)	advocating for quality patient care and optimal patient care systems; (Core)	4.9.c.	Residents must demonstrate competer care and optimal patient care systems
IV.B.1.f).(1).(d)	participating in identifying system errors and implementing potential systems solutions; (Core)	4.9.d.	Residents must demonstrate competers system errors and implementing pote
IV.B.1.f).(1).(e)	incorporating considerations of value, equity, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate;(Core)	4.9.e.	Residents must demonstrate compete of value, equity, cost awareness, deli- analysis in patient and/or population-

ent Language

etence in working effectively as a eam or other professional group. (Core)

etence in educating patients, patients' and other health professionals. (Core) etence in acting in a consultative role essionals. (Core)

etence in maintaining comprehensive, rds, if applicable. (Core)

nce in maintaining a comprehensive cluding evidence of pre- and postdrugs administered, the monitoring hysiologic variations observed, the histered. (Core)

ence in creating and sustaining a engaging in active listening, providing le, asking clear questions, and providing stions. (Core)

ate with patients and patients' families care goals, including, when

Based Practice

vareness of and responsiveness to the a care, including the structural and ell as the ability to call effectively on health care. (Core)

etence in working effectively in various stems relevant to their clinical

etence in coordinating patient care and beyond as relevant to their clinical

etence in advocating for quality patient ms. (Core)

etence in participating in identifying otential systems solutions. (Core)

etence in incorporating considerations elivery and payment, and risk-benefit on-based care as appropriate. (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
IV.B.1.f).(1).(f)	understanding health care finances and its impact on individual patients' health decisions; and, (Core)	4.9.f.	Residents must demonstrate compet finances and its impact on individual
IV.B.1.f).(1).(g)	using tools and techniques that promote patient safety and disclosure of patient safety events (real or simulated). (Detail)	4.9.g.	Residents must demonstrate compet that promote patient safety and discle simulated). (Detail)
IV.B.1.f).(2)	Residents must learn to advocate for patients within the health care system to achieve the patient's and patient's family's care goals, including, when appropriate, end-of-life goals. (Core)	4.9.h.	Residents must learn to advocate for system to achieve the patient's and p including, when appropriate, end-of-l
			 4.10. Curriculum Organization and Restructure The curriculum must be structured to experiences, the length of the experience continuity. These educational experiences upervised patient care responsibilitie educational events. (Core) 4.11. Curriculum Organization and Restructure Clinical Experiences Residents must be provided with prodidactic activities. (Core) 4.12. Curriculum Organization and Restructure and restruction of the program must provide instruction management if applicable for the spesigns of substance use disorder. (Core)
	Curriculum Organization and Resident Experiences The curriculum must be structured to optimize resident educational experiences, the length of the experiences, and the supervisory continuity. These educational experiences include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational		Curriculum Organization and Resider Structure The curriculum must be structured to experiences, the length of the experie continuity. These educational experie supervised patient care responsibiliti
IV.C.1. IV.C.1.a)	events. (Core)Assignment of rotations must be of sufficient length to provide a quality educational experience, defined by continuity of patient care, ongoing supervision, longitudinal relationships with faculty members, and meaningful assessment and feedback, or as otherwise specified in the specialty-specific Program Requirements. (Core)	4.10. 4.10.a.	educational events. (Core) Assignment of rotations must be of suffic educational experience, defined by cont supervision, longitudinal relationships wi assessment and feedback, or as otherw Program Requirements. (Core)
IV.C.1.b)	Clinical experiences should be structured to facilitate learning in a manner that allows residents to function as part of an effective interprofessional team that works together longitudinally with shared goals of patient safety and quality improvement. (Core)	4.10.b.	Clinical experiences should be structure allows residents to function as part of an works together longitudinally with shared improvement. (Core)

etence in understanding health care al patients' health decisions. (Core)

etence in using tools and techniques closure of patient safety events (real or

or patients within the health care patient's family's care goals, f-life goals. (Core)

Resident Experiences – Curriculum

to optimize resident educational riences, and the supervisory riences include an appropriate blend of lities, clinical teaching, and didactic

Resident Experiences – Didactic and

rotected time to participate in core

Resident Experiences – Pain

ion and experience in pain pecialty, including recognition of the Core)

lent Experiences – Curriculum

to optimize resident educational riences, and the supervisory riences include an appropriate blend of lities, clinical teaching, and didactic

fficient length to provide a quality ontinuity of patient care, ongoing with faculty members, and meaningful rwise specified in the specialty-specific

red to facilitate learning in a manner that an effective interprofessional team that red goals of patient safety and quality

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
IV.C.2.	The program must provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of substance use disorder. (Core)	4.12.	Curriculum Organization and Reside The program must provide instructio management if applicable for the spe signs of substance use disorder. (Co
IV.C.2.a)	The program must have a written policy and an educational program regarding substance use disorders as related to physician well-being that specifically addresses the needs of anesthesiology. (Core)	4.11.a.	The program must have a written policy substance use disorders as related to p addresses the needs of anesthesiology
IV.C.3.	Twelve months of the resident's educational program must provide broad education in fundamental clinical skills of medicine relevant to the practice of anesthesiology. (Core)	4.11.b.	Twelve months of the resident's educati education in fundamental clinical skills of anesthesiology. (Core)
IV.C.3.a)	Fundamental clinical skills of medicine education completed as part of an anesthesiology residency need not be contiguous, but must be completed before starting the final year of the program. (Core)	4.11.b.1.	Fundamental clinical skills of medicine e anesthesiology residency need not be c before starting the final year of the prog
IV.C.3.b)	At least six months of fundamental clinical skills of medicine education must include experience in caring for inpatients in family medicine, internal medicine, neurology, obstetrics and gynecology, pediatrics, surgery or any of the surgical specialties, or any combination of these. (Core)	4.11.b.2.	At least six months of fundamental clinic include experience in caring for inpatien neurology, obstetrics and gynecology, p specialties, or any combination of these
IV.C.3.c)	The program director must maintain oversight of resident education in fundamental clinical skills of medicine. (Core)	4.11.b.3.	The program director must maintain ove fundamental clinical skills of medicine. (
IV.C.4.	During the first 12 months of the program, there must be at least one month, but not more than two month(s) each of critical care and emergency medicine. (Core)	4.11.c.	During the first 12 months of the program not more than two month(s) each of criti (Core)
IV.C.5.	Thirty-six months of education must be in peri-operative medicine. (Core)	4.11.d.	Thirty-six months of education must be
IV.C.5.a)	This must include experience with a wide spectrum of disease processes and surgical procedures available within the CA-1 through CA-3 years to provide each resident with broad exposure to different types of anesthetic management. (Core)	4.11.d.1.	This must include experience with a wid surgical procedures available within the each resident with broad exposure to dir (Core)
IV.C.5.b)	The program must ensure that the rotations for residents beginning the peri- operative medicine component of the residency be in surgical anesthesia, critical care medicine, and pain medicine. (Core)	4.11.d.2.	The program must ensure that the rotati operative medicine component of the re critical care medicine, and pain medicine
IV.C.5.c)	Residents must receive training in the complex technology and equipment associated with the practice of anesthesiology. (Core)	4.11.d.3.	Residents must receive training in the co associated with the practice of anesthes
IV.C.5.d)	Clinical experience in surgical anesthesia, pain medicine, and critical care medicine must be distributed throughout the curriculum in order to provide progressive responsibility in the later stages of the program. (Core)	4.11.d.4.	Clinical experience in surgical anesthesi medicine must be distributed throughout progressive responsibility in the later sta
IV.C.6.	Residents must have a rotation of at least two weeks in pre-operative medicine. (Core)	4.11.e.	Residents must have a rotation of at lea (Core)
IV.C.7.	Residents must have a rotation of at least two weeks in post-anesthesia care. (Core)	4.11.f.	Residents must have a rotation of at lea (Core)
IV.C.7.a)	Resident clinical responsibilities in the post-operative care unit must be limited to the care of post-operative patients, with the exception of providing emergency response capability for cardiac arrests and rapid response situations within the facility. (Core)		Resident clinical responsibilities in the p to the care of post-operative patients, w response capability for cardiac arrests a facility. (Core)
, IV.C.8.	Resident education must include a minimum of four one-month rotations in	4.11.g.	Resident education must include a minir critical care medicine. (Core)

lent Experiences – Pain Management: ion and experience in pain pecialty, including recognition of the Core)

cy and an educational program regarding physician well-being that specifically gy. (Core)

ational program must provide broad of medicine relevant to the practice of

e education completed as part of an contiguous, but must be completed ogram. (Core)

nical skills of medicine education must ents in family medicine, internal medicine, pediatrics, surgery or any of the surgical se. (Core)

versight of resident education in (Core)

am, there must be at least one month, but itical care and emergency medicine.

e in peri-operative medicine. (Core)

vide spectrum of disease processes and ne CA-1 through CA-3 years to provide different types of anesthetic management.

ations for residents beginning the periresidency be in surgical anesthesia, ine. (Core)

complex technology and equipment esiology. (Core)

esia, pain medicine, and critical care but the curriculum in order to provide stages of the program. (Core)

east two weeks in pre-operative medicine.

east two weeks in post-anesthesia care.

e post-operative care unit must be limited with the exception of providing emergency and rapid response situations within the

nimum of four one-month rotations in

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	. Requiremen
IV.C.8.a)	No more than two months of this experience should occur prior to the CA-1 year. (Core)	4.11.g.1.	No more than two months of this experie year. (Core)
IV.C.8.b)	Each critical care medicine rotation must be at least one month in duration, with progressive patient care responsibility in advanced rotations. (Core)	4.11.g.2.	Each critical care medicine rotation mus progressive patient care responsibility in
IV.C.8.c)	Training must take place in units, providing care for both men and women, in which the majority of patients have multisystem disease. (Core)	4.11.g.3.	Training must take place in units, provid which the majority of patients have multi
IV.C.8.d)	Residents must actively participate in all patient care activities as fully integrated members of the critical care team. (Core)	4.11.g.4.	Residents must actively participate in all members of the critical care team. (Core
IV.C.8.e)	During at least two of the required four months of critical care medicine, faculty anesthesiologists experienced in the practice and teaching of critical care must be actively involved in the care of the critically-ill patients seen by residents, and in the educational activities of the residents. (Core)	4.11.g.5.	During at least two of the required four n anesthesiologists experienced in the pra be actively involved in the care of the cri in the educational activities of the reside
IV.C.9.	Resident education must include a minimum of two one-month rotations each in obstetric anesthesia, pediatric anesthesia, neuroanesthesia, and cardiothoracic anesthesia. (Core)	4.11.h.	Resident education must include a minir obstetric anesthesia, pediatric anesthesi anesthesia. (Core)
IV.C.9.a)	Additional subspecialty and research rotations are encouraged, but resident rotations in a single anesthesia subspecialty must not exceed six months. (Detail)	4.11.h.1.	Additional subspecialty and research rot rotations in a single anesthesia subspec (Detail)
IV.C.9.b)	Advanced subspecialty rotations must not compromise the learning opportunities for residents participating in their initial subspecialty rotations. (Core)	4.11.h.2.	Advanced subspecialty rotations must no opportunities for residents participating i (Core)
IV.C.10.	Resident education must include a minimum of three months in pain medicine, including: (Core)	4.11.i.	Resident education must include a minir including: (Core)
IV.C.10.a)	one month in an acute peri-operative pain management rotation; (Core)	4.11.i.1.	one month in an acute peri-operative pa
IV.C.10.b)	one month in a rotation for the assessment and treatment of inpatients and outpatients with chronic pain; and, (Core)	4.11.i.2.	one month in a rotation for the assessme outpatients with chronic pain; and, (Core
IV.C.10.c)	one month of a regional analgesia experience rotation. (Core)	4.11.i.3.	one month of a regional analgesia exper
IV.C.11.	Residents must have at least two weeks of experience managing the anesthetic care of patients undergoing diagnostic or therapeutic procedures outside of the surgical suite. (Core)	4.11.j.	Residents must have at least two weeks care of patients undergoing diagnostic o surgical suite. (Core)
IV.C.12.	In the clinical anesthesia setting, faculty members must not direct anesthesia at more than two anesthetizing locations simultaneously when supervising residents. (Core)	4.11.k.	In the clinical anesthesia setting, faculty more than two anesthetizing locations si residents. (Core)
IV.C.12.a)	Clinical instruction of residents by non-physician personnel should be limited to not more than 10 percent of total instruction, and should use such personnel only when access to their specific expertise will enhance the educational experience of residents. (Detail)	4.11.k.1.	Clinical instruction of residents by non-p not more than 10 percent of total instruc only when access to their specific exper- experience of residents. (Detail)
IV.C.13.	All residents must obtain advanced cardiac life support (ACLS) certification at least once during the program. (Core)	4.11.l.	All residents must obtain advanced card least once during the program. (Core)
IV.C.14.	Residents must participate in at least one simulated clinical experience each year. (Core)	4.11.m.	Residents must participate in at least on year. (Core)

rience should occur prior to the CA-1

ust be at least one month in duration, with in advanced rotations. (Core)

iding care for both men and women, in Itisystem disease. (Core)

all patient care activities as fully integrated ore)

months of critical care medicine, faculty ractice and teaching of critical care must critically-ill patients seen by residents, and dents. (Core)

nimum of two one-month rotations each in esia, neuroanesthesia, and cardiothoracic

rotations are encouraged, but resident ecialty must not exceed six months.

not compromise the learning g in their initial subspecialty rotations.

nimum of three months in pain medicine,

pain management rotation; (Core)

ment and treatment of inpatients and pre)

erience rotation. (Core)

ks of experience managing the anesthetic or therapeutic procedures outside of the

ty members must not direct anesthesia at simultaneously when supervising

-physician personnel should be limited to uction, and should use such personnel ertise will enhance the educational

rdiac life support (ACLS) certification at

one simulated clinical experience each

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
IV.C.15.	The program director must ensure regular review of the residents' clinical experience logs and verify their accuracy and completeness when they are transmitted to the Review Committee. (Core)	4.11.n.	The program director must ensure regule experience logs and verify their accurace transmitted to the Review Committee. (0
IV.C.15.a)	The program director must ensure that experience logs are submitted annually to the Review Committee in accordance with the format and the due date specified by the Committee. (Core)	4.11.n.1.	The program director must ensure that e to the Review Committee in accordance specified by the Committee. (Core)
IV.C.16.	The program director must determine sequencing of rotations. (Detail)	4.11.o.	The program director must determine se
IV.C.17.	The program director must monitor the appropriate distribution of cases among the residents. (Core)	4.11.p.	The program director must monitor the a the residents. (Core)
IV.C.18.	The program director must ensure that service commitments do not compromise the achievement of educational goals and objectives. (Core)	4.11.q.	The program director must ensure that s compromise the achievement of educati
IV.C.19.	The curriculum must contain didactic instruction through a variety of learning opportunities occurring in conference, in the clinical setting or online that encompasses clinical anesthesiology and related areas of basic science. (Core)	4.11.r.	The curriculum must contain didactic ins opportunities occurring in conference, in encompasses clinical anesthesiology an
IV.C.20.	Other topics from internal medicine that are important for the pre-operative preparation of the patient, from surgery as to the nature of the surgical procedure affecting anesthetic care, and from obstetrics that impacts anesthetic management of the patient, should be included. (Core)	4.11.s.	Other topics from internal medicine that preparation of the patient, from surgery procedure affecting anesthetic care, and management of the patient, should be in
IV.C.20.a)	The material covered in the didactic program must demonstrate appropriate continuity and sequencing to ensure that residents are ultimately exposed to all subjects at regularly held learning exercises. (Core)	4.11.s.1.	The material covered in the didactic pro- continuity and sequencing to ensure tha subjects at regularly held learning exerc
IV.C.20.a).(1)	There should be evidence of regular faculty member participation in didactic sessions. (Detail)	4.11.s.1.a.	There should be evidence of regular fac sessions. (Detail)
IV.C.20.a).(2)	The program director and faculty members from other disciplines and other institutions should conduct these sessions. (Detail)	4.11.s.1.b.	The program director and faculty member institutions should conduct these sessio
IV.C.21.	When 12 months of education in fundamental clinical skills of medicine is approved as part of the accredited program, the program director must maintain oversight for all rotations, and must approve the rotations for individual residents. (Core)	4.11.t.	When 12 months of education in fundan approved as part of the accredited progr oversight for all rotations, and must appr residents. (Core)
IV.C.22.	The program director must review written resident performance evaluations from each clinical service on which each resident rotates on a quarterly basis. (Core)		The program director must review writte from each clinical service on which each (Core)
IV.C.23.	The education must culminate in sufficiently independent responsibility for clinical decision-making and patient care, so that the graduating resident exhibits sound clinical judgment in a wide variety of clinical situations and can function as a leader of peri-operative care teams. (Core)	4.11.v.	The education must culminate in sufficient clinical decision-making and patient care exhibits sound clinical judgment in a wide function as a leader of peri-operative care
IV.C.24.	As the resident advances through the program, goals and objectives must reflect the opportunity to learn to plan and administer anesthesia care for patients with more severe and complicated diseases, as well as for patients who undergo more complex surgical procedures. (Core)	4.11.w.	As the resident advances through the pr reflect the opportunity to learn to plan ar patients with more severe and complica undergo more complex surgical procedu
IV.C.25.	International rotations should be limited to the final year of training and should be limited to three months or less. (Detail)	4.11.x.	International rotations should be limited be limited to three months or less. (Deta

ular review of the residents' clinical acy and completeness when they are (Core)

t experience logs are submitted annually ce with the format and the due date

sequencing of rotations. (Detail) appropriate distribution of cases among

t service commitments do not ational goals and objectives. (Core)

instruction through a variety of learning in the clinical setting or online that and related areas of basic science. (Core)

at are important for the pre-operative ry as to the nature of the surgical and from obstetrics that impacts anesthetic included. (Core)

rogram must demonstrate appropriate nat residents are ultimately exposed to all rcises. (Core)

aculty member participation in didactic

bers from other disciplines and other ions. (Detail)

amental clinical skills of medicine is ogram, the program director must maintain oprove the rotations for individual

tten resident performance evaluations ach resident rotates on a quarterly basis.

ciently independent responsibility for are, so that the graduating resident vide variety of clinical situations and can care teams. (Core)

program, goals and objectives must and administer anesthesia care for cated diseases, as well as for patients who dures. (Core)

ed to the final year of training and should etail)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremer
IV.C.25.a)	International rotations must be approved by the Review Committee through a written request submitted by the program director. (Detail)	4.11.x.1.	International rotations must be approve written request submitted by the progra
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.	[None]	Scholarship Medicine is both an art and a science scientist who cares for patients. This evaluate the literature, appropriately practice lifelong learning. The progra environment that fosters the acquisit participation in scholarly activities. S discovery, integration, application, at The ACGME recognizes the diversity programs prepare physicians for a va scientists, and educators. It is expect will reflect its mission(s) and aims, at serves. For example, some programs activity on quality improvement, pop other programs might choose to utilit research as the focus for scholarship
			Program Responsibilities The program must demonstrate evide
IV.D.1.	Program Responsibilities	4.13.	with its mission(s) and aims. (Core)
IV.D.1.a)	The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)	4.13.	Program Responsibilities The program must demonstrate evide 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)	4.13.a.	The program, in partnership with its adequate resources to facilitate resic 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)	4.13.b.	The program must advance residents scholarly approach to evidence-base

ved by the Review Committee through a ram director. (Detail)

ce. The physician is a humanistic his requires the ability to think critically, ly assimilate new knowledge, and ram and faculty must create an sition of such skills through resident . Scholarly activities may include and teaching.

ty of residencies and anticipates that variety of roles, including clinicians, ected that the program's scholarship and the needs of the community it ms may concentrate their scholarly opulation health, and/or teaching, while tilize more classic forms of biomedical hip.

idence of scholarly activities consistent

idence of scholarly activities consistent

ts Sponsoring Institution, must allocate sident and faculty involvement in

nts' knowledge and practice of the sed patient care. (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
			Faculty Scholarly Activity Among their scholarly activity, progra accomplishments in at least three of t
			 Research in basic science, educatio or population health Peer-reviewed grants Quality improvement and/or patient = Systematic reviews, meta-analyses, textbooks, or case reports Creation of curricula, evaluation too electronic educational materials Contribution to professional commit editorial boards
IV.D.2.	Faculty Scholarly Activity	4.14.	 Innovations in education
	Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core)		Faculty Scholarly Activity Among their scholarly activity, progra accomplishments in at least three of t
IV.D.2.a)	 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 	4.14.	 Research in basic science, educatio or population health Peer-reviewed grants Quality improvement and/or patient Systematic reviews, meta-analyses, textbooks, or case reports Creation of curricula, evaluation too electronic educational materials Contribution to professional commit editorial boards Innovations in education
	The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:		The program must demonstrate disse and external to the program by the fol • faculty participation in grand rounds improvement presentations, podium p peer-reviewed print/electronic resourc chapters, textbooks, webinars, servic serving as a journal reviewer, journal (Outcome)
IV.D.2.b)		4.14.a.	 peer-reviewed publication. (Outcom

- rams must demonstrate f the following domains: (Core)
- ion, translational science, patient care,
- nt safety initiatives s, review articles, chapters in medical
- ools, didactic educational activities, or
- nittees, educational organizations, or
- rams must demonstrate f the following domains: (Core)
- ion, translational science, patient care,
- nt safety initiatives s, review articles, chapters in medical
- ools, didactic educational activities, or
- nittees, educational organizations, or
- semination of scholarly activity within following methods:
- nds, posters, workshops, quality n presentations, grant leadership, nonurces, articles or publications, book ice on professional committees, or al editorial board member, or editor;

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Requirement Number - Roman		Reformatted	
Numerals	Requirement Language	Requirement Number	Requiremer
			The program must demonstrate diss and external to the program by the fo
	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;		improvement presentations, podium peer-reviewed print/electronic resour chapters, textbooks, webinars, servio serving as a journal reviewer, journal (Outcome)
IV.D.2.b).(1)	(Outcome)	4.14.a.	peer-reviewed publication. (Outcon
			The program must demonstrate disse and external to the program by the fo
			 faculty participation in grand round improvement presentations, podium peer-reviewed print/electronic resour chapters, textbooks, webinars, servio serving as a journal reviewer, journal (Outcome)
IV.D.2.b).(2)	peer-reviewed publication. (Outcome)	4.14.a.	peer-reviewed publication. (Outcor
IV.D.3.	Resident Scholarly Activity	4.15.	Resident Scholarly Activity Residents must participate in schola
IV.D.3.a)	Residents must participate in scholarship. (Core)	4.15.	Resident Scholarly Activity Residents must participate in schola
IV.D.3.b)	Each resident must complete, under faculty member supervision, an academic assignment. (Core)	4.15.a.	Each resident must complete, under fac assignment. (Core)
IV.D.3.b).(1)	Academic assignments should include grand rounds presentations; preparation and publication of review articles, book chapters, manuals for teaching or clinical practice; or development, performance, or participation in one or more clinical or laboratory investigations. (Detail)	4.15.a.1.	Academic assignments should include g and publication of review articles, book clinical practice; or development, perfor clinical or laboratory investigations. (De
IV.D.3.b).(1).(a)	The outcome of resident investigations should be suitable for presentation at local, regional, or national scientific meetings, and/or result in peer-reviewed abstracts or manuscripts. (Detail)	4.15.a.1.a.	The outcome of resident investigations local, regional, or national scientific mee abstracts or manuscripts. (Detail)
V.	Evaluation	Section 5	Section 5: Evaluation
V 4			Resident Evaluation: Feedback and E Faculty members must directly obser feedback on resident performance du
V.A.	Resident Evaluation	5.1.	educational assignment. (Core) Resident Evaluation: Feedback and E Faculty members must directly obser feedback on resident performance du
V.A.1.	Feedback and Evaluation	5.1.	educational assignment. (Core)

semination of scholarly activity within following methods:

nds, posters, workshops, quality m presentations, grant leadership, nonurces, articles or publications, book vice on professional committees, or nal editorial board member, or editor;

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larship. (Core)

aculty member supervision, an academic

e grand rounds presentations; preparation ok chapters, manuals for teaching or ormance, or participation in one or more Detail)

s should be suitable for presentation at eetings, and/or result in peer-reviewed

I Evaluation

serve, evaluate, and frequently provide during each rotation or similar

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Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
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)	5.1.	Resident Evaluation: Feedback and E Faculty members must directly obser feedback on resident performance du educational assignment. (Core)
V.A.1.b)	Evaluation must be documented at the completion of the assignment. (Core)	5.1.a.	Evaluation must be documented at th (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)	5.1.a.1.	For block rotations of greater than the must be documented at least every the
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)	5.1.a.2.	Longitudinal experiences, such as co clinical responsibilities, must be eval 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)	5.1.b.	The program must provide an objection the Competencies and the specialty-s
V.A.1.c).(1)	use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, (Core)	5.1.b.1.	The program must use multiple evalu patients, self, and other professional
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)	5.1.b.2.	The program must provide that inform Committee for its synthesis of progre improvement toward unsupervised p
V.A.1.d)	The program director or their designee, with input from the Clinical Competency Committee, must:	[None]	
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)	5.1.c.	The program director or their designe Competency Committee, must meet v their documented semi-annual evalua progress along the specialty-specific
V.A.1.d).(2)	assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and, (Core)	5.1.d.	The program director or their designer Competency Committee, must assist individualized learning plans to capita areas for growth. (Core)
V.A.1.d).(3)	develop plans for residents failing to progress, following institutional policies and procedures. (Core)	5.1.e.	The program director or their designe Competency Committee, must develo progress, following institutional polic
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)	5.1.f.	At least annually, there must be a sur that includes their readiness to progr applicable. (Core)
V.A.1.f).	The evaluations of a resident's performance must be accessible for review by the resident. (Core)	5.1.g.	The evaluations of a resident's perfor by the resident. (Core)
			Resident Evaluation: Final Evaluation
V.A.2.	Final Evaluation	5.2.	The program director must provide a upon completion of the program. (Co
V.A.2.a)	The program director must provide a final evaluation for each resident upon completion of the program. (Core)	5.2.	Resident Evaluation: Final Evaluation The program director must provide a upon completion of the program. (Co

l Evaluation erve, evaluate, and frequently provide during each rotation or similar

the completion of the assignment.

three months in duration, evaluation three months. (Core)

continuity clinic in the context of other valuated at least every three months

ctive performance evaluation based on y-specific Milestones. ^(Core)

luators (e.g., faculty members, peers, al staff members). (Core)

prmation to the Clinical Competency pressive resident performance and practice. (Core)

nee, with input from the Clinical t with and review with each resident uation of performance, including ic Milestones. (Core)

nee, with input from the Clinical st residents in developing vitalize on their strengths and identify

nee, with input from the Clinical elop plans for residents failing to licies and procedures. (Core)

ummative evaluation of each resident gress to the next year of the program, if

formance must be accessible for review

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a final evaluation for each resident Core)

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a final evaluation for each resident Core)

Requirement			
Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
Ramoralo			Kequitemer
	The specialty-specific Milestones, and when applicable the specialty-		The specialty-specific Milestones, an
	specific Case Logs, must be used as tools to ensure residents are able to		specific Case Logs, must be used as
V.A.2.a).(1)	engage in autonomous practice upon completion of the program. (Core)	5.2.a.	engage in autonomous practice upor
V.A.2.a).(2)	The final evaluation must:	[None]	
	become part of the resident's permanent record maintained by the		The final evaluation must become pa
	institution, and must be accessible for review by the resident in		maintained by the institution, and mu
V.A.2.a).(2).(a)	accordance with institutional policy; (Core)	5.2.b.	resident in accordance with institution
			The final evaluation must verify that
	verify that the resident has demonstrated the knowledge, skills, and		knowledge, skills, and behaviors nec
V.A.2.a).(2).(b)	behaviors necessary to enter autonomous practice; and, (Core)	5.2.c.	(Core)
			The final evaluation must be shared
V.A.2.a).(2).(c)	be shared with the resident upon completion of the program. (Core)	5.2.d.	the program. (Core)
	A Clinical Competency Consultant must be any stated by the sures		Clinical Competency Committee
V.A.3.	A Clinical Competency Committee must be appointed by the program	5.3.	A Clinical Competency Committee m
V.A.J.	director. (Core)	5.3.	director. (Core)
	At a minimum, the Clinical Competency Committee must include three members of the program faculty, at least one of whom is a core faculty		At a minimum, the Clinical Competen members of the program faculty, at le
V.A.3.a)	members of the program faculty, at least one of whom is a core faculty member. (Core)	5.3.a.	member. (Core)
•		0.0.0.	
	Additional members must be faculty members from the same program or		Additional members must be faculty
	other programs, or other health professionals who have extensive contact		other programs, or other health profe
V.A.3.a).(1)	and experience with the program's residents. (Core)	5.3.b.	and experience with the program's re
V.A.3.b)	The Clinical Competency Committee must:	[None]	
,			The Clinical Competency Committee
V.A.3.b).(1)	review all resident evaluations at least semi-annually; (Core)	5.3.c.	at least semi-annually. (Core)
	determine each resident's progress on achievement of the specialty-		The Clinical Competency Committee
V.A.3.b).(2)	specific Milestones; and, (Core)	5.3.d.	progress on achievement of the spec
			The Clinical Competency Committee
	meet prior to the residents' semi-annual evaluations and advise the		semi-annual evaluations and advise t
V.A.3.b).(3)	program director regarding each resident's progress. (Core)	5.3.e.	resident's progress. (Core)
			Faculty Evaluation
			The program must have a process to
			performance as it relates to the educ
V.B.	Faculty Evaluation	5.4.	(Core)
			Faculty Evaluation
	The program must have a process to evaluate each faculty member's		The program must have a process to
V.B.1.	performance as it relates to the educational program at least annually.	5.4.	performance as it relates to the education (Core)
V.D.I.	(Core)	5.4.	
	This evolution must include a review of the feaulty memberie clinical		This evolution must include a review
	This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation		This evaluation must include a review teaching abilities, engagement with t
	in faculty development related to their skills as an educator, clinical		in faculty development related to the
	performance, professionalism, and scholarly activities. (Core)	5.4.a.	performance, professionalism, and s
V.B.1.a)			
V.B.1.a)	This evaluation must include written, anonymous, and confidential		This evaluation must include written,

ent Language

and when applicable the specialtyas tools to ensure residents are able to on completion of the program. (Core)

part of the resident's permanent record nust be accessible for review by the tional policy. (Core)

t the resident has demonstrated the ecessary to enter autonomous practice.

with the resident upon completion of

must be appointed by the program

ency Committee must include three least one of whom is a core faculty

y members from the same program or ofessionals who have extensive contact residents. (Core)

e must review all resident evaluations

ee must determine each resident's ecialty-specific Milestones. (Core)

e must meet prior to the residents' e the program director regarding each

to evaluate each faculty member's ucational program at least annually.

to evaluate each faculty member's ucational program at least annually.

ew of the faculty member's clinical n the educational program, participation neir skills as an educator, clinical scholarly activities. (Core) en, anonymous, and confidential

Requirement Number - Roman		Reformatted	
Numerals	Requirement Language	Requirement Number	Requirement
V.B.2.	Faculty members must receive feedback on their evaluations at least annually. (Core)	5.4.c.	Faculty members must receive feedba annually. (Core)
V.B.3.	Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)	5.4.d.	Results of the faculty educational eva program-wide faculty development pl
V.C.	Program Evaluation and Improvement	5.5.	Program Evaluation and Improvement The program director must appoint th conduct and document the Annual Pro program's continuous improvement p
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)	5.5.	Program Evaluation and Improvement The program director must appoint th conduct and document the Annual Pr program's continuous improvement p
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)	5.5.a.	The Program Evaluation Committee m program faculty members, at least on and at least one resident. (Core)
V.C.1.b)	Program Evaluation Committee responsibilities must include:	[None]	
V.C.1.b).(1)	review of the program's self-determined goals and progress toward meeting them; (Core)	5.5.b.	Program Evaluation Committee respo program's self-determined goals and
V.C.1.b).(2)	guiding ongoing program improvement, including development of new goals, based upon outcomes; and, (Core)	5.5.c.	Program Evaluation Committee respo ongoing program improvement, inclue based upon outcomes. (Core)
V.C.1.b).(3)	review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core)	5.5.d.	Program Evaluation Committee respo current operating environment to ider opportunities, and threats as related t (Core)
V.C.1.c)	The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate resident and faculty written evaluations of the program, and other relevant data in its assessment of the program. (Core)	5.5.e.	The Program Evaluation Committee s prior Annual Program Evaluation(s), a evaluations of the program, and other the program. (Core)
V.C.1.d)	The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)	5.5.f.	The Program Evaluation Committee m and aims, strengths, areas for improv
V.C.1.e)	The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the residents and the members of the teaching faculty, and be submitted to the DIO. (Core)	5.5.g.	The Annual Program Evaluation, inclu distributed to and discussed with the teaching faculty, and be submitted to
V.C.2.	The program must complete a Self-Study and submit it to the DIO. (Core)	5.5.h.	The program must complete a Self-St

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back on their evaluations at least

valuations should be incorporated into plans. (Core)

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the Program Evaluation Committee to Program Evaluation as part of the t process. (Core)

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the Program Evaluation Committee to Program Evaluation as part of the t process. (Core)

must be composed of at least two one of whom is a core faculty member,

ponsibilities must include review of the d progress toward meeting them. ^(Core)

ponsibilities must include guiding luding development of new goals,

oonsibilities must include review of the entify strengths, challenges, d to the program's mission and aims.

should consider the outcomes from , aggregate resident and faculty written er relevant data in its assessment of

must evaluate the program's mission ovement, and threats. (Core)

cluding the action plan, must be ne residents and the members of the to the DIO. (Core)

Study and submit it to the DIO. (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirement
	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.	•	Board Certification One goal of ACGME-accredited educa seek and achieve board certification. the educational program is the ultimat
V.C.3.	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.	[None]	The program director should encourage take the certifying examination offered of Medical Specialties (ABMS) member 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)	5.6.	Board Certification For specialties in which the ABMS me board offer(s) an annual written exam program's aggregate pass rate of thos time must be higher than the bottom f 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)	5.6.a.	For specialties in which the ABMS me board offer(s) a biennial written exam, program's aggregate pass rate of thos time must be higher than the bottom f 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)	5.6.b.	For specialties in which the ABMS me board offer(s) an annual oral exam, in program's aggregate pass rate of thos time must be higher than the bottom f 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)	5.6.c.	For specialties in which the ABMS me board offer(s) a biennial oral exam, in program's aggregate pass rate of thos time must be higher than the bottom f 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)	5.6.d.	For each of the exams referenced in 5 graduates over the time period specifi an 80 percent pass rate will have met percentile rank of the program for pas
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)	5.6.e.	Programs must report, in ADS, board cohort of board-eligible residents that

cation is to educate physicians who n. One measure of the effectiveness of nate pass rate.

rage all eligible program graduates to red by the applicable American Board ber board or American Osteopathic

nember board and/or AOA certifying m, in the preceding three years, the lose taking the examination for the first n fifth percentile of programs in that

nember board and/or AOA certifying m, in the preceding six years, the lose taking the examination for the first n fifth percentile of programs in that

nember board and/or AOA certifying in the preceding three years, the lose taking the examination for the first n fifth percentile of programs in that

nember board and/or AOA certifying in the preceding six years, the lose taking the examination for the first n fifth percentile of programs in that

n 5.6.a.-c., any program whose cified in the requirement have achieved et this requirement, no matter the ass rate in that specialty. ^(Outcome)

rd certification status annually for the nat graduated seven years earlier. ^(Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
			Section 6: The Learning and Working
	The Learning and Working Environment		The Learning and Working Environme
	Residency education must occur in the context of a learning and working environment that emphasizes the following principles:		Residency education must occur in the environment that emphasizes the foll
	 Excellence in the safety and quality of care rendered to patients by residents today 		• Excellence in the safety and quality residents today
	 Excellence in the safety and quality of care rendered to patients by today's residents in their future practice 		• Excellence in the safety and quality today's residents in their future pract
	• Excellence in professionalism		• Excellence in professionalism
	 Appreciation for the privilege of caring for patients 		• Appreciation for the privilege of car
VI	 Commitment to the well-being of the students, residents, faculty members, and all members of the health care team 	Section 6	• Commitment to the well-being of the members, and all members of the heat
VI.A.	Patient Safety, Quality Improvement, Supervision, and Accountability	[None]	
VI.A.1.	Patient Safety and Quality Improvement	[None]	
VI.A.1.a)	Patient Safety	[None]	
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.	[None]	Culture of Safety A culture of safety requires continuou and a willingness to transparently de organization has formal mechanisms attitudes of its personnel toward safe 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)	6.1.	The program, its faculty, residents, an patient safety systems and contribute
VI.A.1.a).(2)	Patient Safety Events Reporting, investigation, and follow-up of safety 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.	[None]	Patient Safety Events Reporting, investigation, and follow-u unsafe conditions are pivotal mechar and are essential for the success of a and experiential learning are essentia the ability to identify causes and inst changes to ameliorate patient safety
VI.A.1.a).(2).(a)	Residents, fellows, faculty members, and other clinical staff members must:	[None]	

ng Environment

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n the context of a learning and working ollowing principles:

ty of care rendered to patients by

ity of care rendered to patients by actice

aring for patients

the students, residents, faculty realth care team

ous identification of vulnerabilities deal with them. An effective ns to assess the knowledge, skills, and afety in order to identify areas for

and fellows must actively participate in ute to a culture of safety. (Core)

y-up of safety events, near misses, and panisms for improving patient safety, f any patient safety program. Feedback tial to developing true competence in stitute sustainable systems-based ty vulnerabilities.

Requirement Number - Roman	Demoissance	Reformatted	
Numerals	Requirement Language	Requirement Number	Requiremen Residents, fellows, faculty members,
	know their responsibilities in reporting patient safety events and unsafe		must know their responsibilities in re
	conditions at the clinical site, including how to report such events; and,		unsafe conditions at the clinical site,
VI.A.1.a).(2).(a).(i)	(Core)	6.2.	(Core)
l			Residents, fellows, faculty members,
	be provided with summary information of their institution's patient safety		must be provided with summary info
VI.A.1.a).(2).(a).(ii)	reports. (Core)	6.2.a.	safety reports. ^(Core)
	Residents must participate as team members in real and/or simulated		Residents must participate as team n
	interprofessional clinical patient safety and quality improvement activities,		interprofessional clinical patient safe
	such as root cause analyses or other activities that include analysis, as		such as root cause analyses or other
VI.A.1.a).(2).(b)	well as formulation and implementation of actions. (Core)	6.3.	well as formulation and implementati
	Quality Metrics		
			Quality Metrics
	Access to data is essential to prioritizing activities for care improvement		Access to data is essential to prioritize
VI.A.1.a).(3)	and evaluating success of improvement efforts.	[None]	and evaluating success of improvem
	Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)	6.4.	Residents and faculty members must benchmarks related to their patient p
VI.A.1.a).(3).(a)	benchmarks related to their patient populations. (Core)	0.4.	benchmarks related to their patient p
VI.A.2.	Supervision and Accountability	[None]	Supervision and Accountability Although the attending physician is u the patient, every physician shares in accountability for their efforts in the programs, in partnership with their S communicate, and monitor a structur accountability as it relates to the sup Supervision in the setting of graduate and effective care to patients; ensure skills, knowledge, and attitudes requi practice of medicine; and establishes professional growth.
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.		Supervision and Accountability Although the attending physician is u the patient, every physician shares in accountability for their efforts in the programs, in partnership with their S communicate, and monitor a structur accountability as it relates to the sup Supervision in the setting of graduate and effective care to patients; ensure skills, knowledge, and attitudes requi practice of medicine; and establishes professional growth.

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s, and other clinical staff members reporting patient safety events and e, including how to report such events.

s, and other clinical staff members formation of their institution's patient

n members in real and/or simulated afety and quality improvement activities, ar activities that include analysis, as ation of actions. (Core)

itizing activities for care improvement ment efforts.

ist receive data on quality metrics and populations. (Core)

s ultimately responsible for the care of in the responsibility and e provision of care. Effective Sponsoring Institutions, define, widely tured chain of responsibility and upervision of all patient care.

ate medical education provides safe ares each resident's development of the quired to enter the unsupervised ares a foundation for continued

s ultimately responsible for the care of in the responsibility and e provision of care. Effective Sponsoring Institutions, define, widely tured chain of responsibility and upervision of all patient care.

ate medical education provides safe res each resident's development of the juired to enter the unsupervised es a foundation for continued

Requirement Number - Roman	Demoinement Lemmune	Reformatted	
Numerals	Requirement Language	Requirement Number	Requiremen
VI.A.2.a).(1)	Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. (Core)	6.5.	Residents and faculty members must respective roles in that patient's care This information must be available to members of the health care team, and
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)	6.5.	Residents and faculty members must respective roles in that patient's care This information must be available to members of the health care team, and
VI.A.2.a).(2)	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)	6.6.	The program must demonstrate that t place for all residents is based on eac ability, as well as patient complexity a exercised through a variety of method (Core)
VI.A.2.b)	Levels of Supervision To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:	[None]	Levels of Supervision To promote appropriate resident supe authority and responsibility, the prog classification of supervision.
VI.A.2.b).(1)	Direct Supervision	6.7.	Direct Supervision The supervising physician is physical the key portions of the patient interac The supervising physician and/or pat the resident and the supervising physician patient care through appropriate teled
VI.A.2.b).(1).(a)	the supervising physician is physically present with the resident during the key portions of the patient interaction; or,	6.7.	Direct Supervision The supervising physician is physical the key portions of the patient interac The supervising physician and/or pat the resident and the supervising physician patient care through appropriate telec
	PGY-1 residents must initially be supervised directly, only as described in		PGY-1 residents must initially be supe
VI.A.2.b).(1).(a).(i) VI.A.2.b).(1).(b)	VI.A.2.b).(1).(a). (Core) the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.	6.7.a. 6.7.	the above definition. (Core) Direct Supervision The supervising physician is physical the key portions of the patient interac The supervising physician and/or pat the resident and the supervising physic patient care through appropriate teled

st inform each patient of their re when providing direct patient care. to residents, faculty members, other nd patients. (Core)

st inform each patient of their re when providing direct patient care. to residents, faculty members, other nd patients. (Core)

t the appropriate level of supervision in ach resident's level of training and y and acuity. Supervision may be ods, as appropriate to the situation.

pervision while providing for graded ogram must use the following

cally present with the resident during action.

atient is not physically present with ysician is concurrently monitoring the lecommunication technology.

cally present with the resident during action.

atient is not physically present with ysician is concurrently monitoring the lecommunication technology.

pervised directly, only as described in

cally present with the resident during action.

atient is not physically present with ysician is concurrently monitoring the lecommunication technology.

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
VI.A.2.b).(1).(b).(i)	The use of telecommunication technology for direct supervision must not be used with invasive procedures, including the conduct of anesthesia; and, (Core)	6.7.b.	The use of telecommunication technolog used with invasive procedures, including
VI.A.2.b).(1).(b).(ii)	the supervising physician and the resident must interact with each other, and the patient, to solicit the key elements of the clinic visit and agree upon a management plan; and, (Core)	6.7.c.	The supervising physician and the resid the patient, to solicit the key elements or management plan. (Core)
VI.A.2.b).(1).(b).(iii)	must be limited to history-taking and patient examination, assessment, and counseling. (Core)	6.7.d.	The use of telecommunication technolog to history-taking and patient examination
VI.A.2.b).(2)	Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.	[None]	Indirect Supervision The supervising physician is not pro- or audio supervision but is immediate guidance and is available to provide a
VI.A.2.b).(3)	Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.	[None]	Oversight The supervising physician is availabl procedures/encounters with feedback
VI.A.2.c)	The program must define when physical presence of a supervising physician is required. (Core)	6.8.	The program must define when physi physician is required. (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)	6.9.	The privilege of progressive authority independence, and a supervisory role resident must be assigned by the pro (Core)
VI.A.2.d).(1)	The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones. (Core)	6.9.a.	The program director must evaluate e specific criteria, guided by the Mileste
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)	6.9.b.	Faculty members functioning as super portions of care to residents based of 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)	6.9.c.	Senior residents or fellows should se residents in recognition of their progr the needs of each patient and the skil (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)	6.10.	Programs must set guidelines for circ residents must communicate with the (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)	6.10.a.	Each resident must know the limits or circumstances under which the resid conditional independence. (Outcome)
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)	6.11.	Faculty supervision assignments mu the knowledge and skills of each resi the appropriate level of patient care a

ogy for direct supervision must not be ng the conduct of anesthesia. (Core)

ident must interact with each other, and of the clinic visit and agree upon a

ogy for direct supervision must be limited on, assessment, and counseling. (Core)

oviding physical or concurrent visual ately available to the resident for e appropriate direct supervision.

ble to provide review of ock provided after care is delivered. sical presence of a supervising

ity and responsibility, conditional ble in patient care delegated to each rogram director and faculty members.

e each resident's abilities based on stones. (Core)

pervising physicians must delegate on the needs of the patient and the

serve in a supervisory role to junior gress toward independence, based on kills of the individual resident or fellow.

ircumstances and events in which he supervising faculty member(s).

of their scope of authority, and the ident is permitted to act with ie)

ust be of sufficient duration to assess sident and to delegate to the resident authority and responsibility. (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirement
VI.B.	Professionalism	6.12.	Professionalism Programs, in partnership with their Sp residents and faculty members conce responsibilities of physicians, includi to be appropriately rested and fit to pr patients. (Core)
VI.B.1. VI.B.2.	Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional and ethical responsibilities of physicians, including but not limited to their obligation to be appropriately rested and fit to provide the care required by their patients. (Core) The learning objectives of the program must:	6.12. [None]	Professionalism Programs, in partnership with their Sp residents and faculty members conce responsibilities of physicians, includi to be appropriately rested and fit to pr patients. (Core)
VI.B.2.a)	be accomplished without excessive reliance on residents to fulfill non- physician obligations; (Core)	6.12.a.	The learning objectives of the programe excessive reliance on residents to full
VI.B.2.b)	ensure manageable patient care responsibilities; and, (Core)	6.12.b.	The learning objectives of the progran care responsibilities. (Core)
VI.B.2.c)	include efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, providing administrative support, promoting progressive independence and flexibility, and enhancing professional relationships. (Core)	6.12.c.	The learning objectives of the program the meaning that each resident finds in physician, including protecting time we administrative support, promoting pro- flexibility, and enhancing professiona
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)	6.12.d.	The program director, in partnership v provide a culture of professionalism t personal responsibility. (Core)
VI.B.4.	Residents and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events. (Core)	6.12.e.	Residents and faculty members must their personal role in the safety and w care, including the ability to report un (Core)
VI.B.5.	Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is psychologically safe and that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff. (Core)	6.12.f.	Programs, in partnership with their Sp a professional, equitable, respectful, a psychologically safe and that is free fi forms of harassment, mistreatment, a residents, faculty, and staff. (Core)
VI.B.6.	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)	6.12.g.	Programs, in partnership with their Sp process for education of residents an behavior and a confidential process fo addressing such concerns. (Core)

Sponsoring Institutions, must educate cerning the professional and ethical ding but not limited to their obligation provide the care required by their

Sponsoring Institutions, must educate cerning the professional and ethical ding but not limited to their obligation provide the care required by their

ram must be accomplished without fulfill non-physician obligations. ^(Core)

ram must ensure manageable patient

am must include efforts to enhance s in the experience of being a with patients, providing progressive independence and nal relationships. (Core)

o with the Sponsoring Institution, must I that supports patient safety and

st demonstrate an understanding of welfare of patients entrusted to their unsafe conditions and safety events.

Sponsoring Institutions, must provide l, and civil environment that is from discrimination, sexual and other abuse, or coercion of students,

Sponsoring Institutions, should have a and faculty regarding unprofessional for reporting, investigating, and

Requirement		Defermention	
Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
	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.		Well-Being Psychological, emotional, and physic development of the competent, caring proactive attention to life inside and o requires that physicians retain the joy own real-life stresses. Self-care and r members of the health care team are professionalism; they are also skills to nurtured in the context of other aspect
VI.C.	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. 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.	[None]	Residents and faculty members are a Programs, in partnership with their S same responsibility to address well-b competence. Physicians and all mem responsibility for the well-being of ea clinical learning environment models prepares residents with the skills and throughout their careers.
VI.C.1.	The responsibility of the program, in partnership with the Sponsoring Institution, must include:	6.13.	The responsibility of the program, in Institution, must include:
VI.C.1.a)	attention to scheduling, work intensity, and work compression that impacts resident well-being; (Core)	6.13.a.	attention to scheduling, work intensit impacts resident well-being; (Core)
VI.C.1.b)	evaluating workplace safety data and addressing the safety of residents and faculty members; (Core)	6.13.b.	evaluating workplace safety data and and faculty members; (Core)
VI.C.1.c)	policies and programs that encourage optimal resident and faculty member well-being; and, (Core)	6.13.c.	policies and programs that encourage member well-being; and, (Core)
VI.C.1.c).(1)	Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core)	6.13.c.1.	Residents must be given the opportu and dental care appointments, includ working hours. (Core)
VI.C.1.d)	education of residents and faculty members in:	6.13.d.	education of residents and faculty me
VI.C.1.d).(1)	identification of the symptoms of burnout, depression, and substance use disorders, suicidal ideation, or potential for violence, including means to assist those who experience these conditions; (Core)	6.13.d.1.	identification of the symptoms of bur disorders, suicidal ideation, or poten assist those who experience these co
VI.C.1.d).(2)	recognition of these symptoms in themselves and how to seek appropriate care; and, (Core)	6.13.d.2.	recognition of these symptoms in the appropriate care; and, (Core)
VI.C.1.d).(3)	access to appropriate tools for self-screening. (Core)	6.13.d.3.	access to appropriate tools for self-se
VI.C.1.e)	providing 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)	6.13.e.	providing access to confidential, affo counseling, and treatment, including 24 hours a day, seven days a week. (0

sical well-being are critical in the ing, and resilient physician and require d outside of medicine. Well-being joy in medicine while managing their d responsibility to support other re important components of 's that must be modeled, learned, and bects of residency training.

e at risk for burnout and depression. Sponsoring Institutions, have the I-being as other aspects of resident embers of the health care team share each other. A positive culture in a els constructive behaviors, and nd attitudes needed to thrive

n partnership with the Sponsoring

sity, and work compression that

nd addressing the safety of residents

age optimal resident and faculty

tunity to attend medical, mental health, uding those scheduled during their

members in:

urnout, depression, and substance use ential for violence, including means to conditions; (Core)

hemselves and how to seek

-screening. (Core)

fordable mental health assessment, ng access to urgent and emergent care . (Core)

Requirement Number - Roman		Defermetted	
Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
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 medical, parental, or caregiver leave. Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities. (Core)	· ·	There are circumstances in which res including but not limited to fatigue, ill medical, parental, or caregiver leave. appropriate length of absence for res care responsibilities. (Core)
VI.C.2.a)	The program must have policies and procedures in place to ensure coverage of patient care and ensure continuity of patient care. (Core)	6.14.a.	The program must have policies and coverage of patient care and ensure of
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)	6.14.b.	These policies must be implemented consequences for the resident who is work. (Core)
VI.D.	Fatigue Mitigation	6.15.	Fatigue Mitigation Programs must educate all residents of the signs of fatigue and sleep depr fatigue mitigation processes. (Detail)
VI.D.1.	Programs must educate all residents and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes. (Detail)	6.15.	Fatigue Mitigation Programs must educate all residents of the signs of fatigue and sleep depr fatigue mitigation processes. (Detail)
VI.D.2.	The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. (Core)	6.16.	The program, in partnership with its S adequate sleep facilities and safe trar may be too fatigued to safely return h
VI.E.	Clinical Responsibilities, Teamwork, and Transitions of Care	[None]	
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)	6.17.	Clinical Responsibilities The clinical responsibilities for each r patient safety, resident ability, severit illness/condition, and available suppo
VI.E.2.	Teamwork Residents must care for patients in an environment that maximizes communication and promotes safe, interprofessional, team-based care in the specialty and larger health system. (Core)	6.18.	Teamwork Residents must care for patients in ar communication and promotes safe, ir the specialty and larger health system Transitions of Care
VI.E.3.	Transitions of Care	6.19.	Programs must design clinical assign patient care, including their safety, free
VI.E.3.a)	Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)	6.19.	Transitions of Care Programs must design clinical assigr patient care, including their safety, fre
VI.E.3.b)	Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety. (Core)	6.19.a.	Programs, in partnership with their S and monitor effective, structured han continuity of care and patient safety.
VI.E.3.c)	Programs must ensure that residents are competent in communicating with team members in the hand-off process. (Outcome)	6.19.b.	Programs must ensure that residents with team members in the hand-off pr

esidents may be unable to attend work, illness, family emergencies, and e. Each program must allow an esidents unable to perform their patient

d procedures in place to ensure e continuity of patient care. (Core)

d without fear of negative is or was unable to provide the clinical

ts and faculty members in recognition privation, alertness management, and il)

ts and faculty members in recognition privation, alertness management, and il)

Sponsoring Institution, must ensure ansportation options for residents who home. (Core)

n resident must be based on PGY level, rity and complexity of patient port services. (Core)

an environment that maximizes interprofessional, team-based care in em. (Core)

gnments to optimize transitions in frequency, and structure. (Core)

gnments to optimize transitions in frequency, and structure. (Core)

Sponsoring Institutions, must ensure and-off processes to facilitate both y. (Core)

ts are competent in communicating process. (Outcome)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
			Kequitemen
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.	[None]	Clinical Experience and Education Programs, in partnership with their S an effective program structure that is educational and clinical experience of opportunities for rest and personal a
	Maximum Hours of Clinical and Educational Work per Week		
VI.F.1.	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)	6.20.	Maximum Hours of Clinical and Educ Clinical and educational work hours r hours per week, averaged over a four house clinical and educational activit and all moonlighting. (Core)
			Mandatory Time Free of Clinical Work
VI.F.2.	Mandatory Time Free of Clinical Work and Education	6.21.	Residents should have eight hours of and education periods. (Detail)
VI.F.2.a)	Residents should have eight hours off between scheduled clinical work and education periods. (Detail)	6.21.	Mandatory Time Free of Clinical Work Residents should have eight hours of and education periods. (Detail)
••••••••	Residents must have at least 14 hours free of clinical work and education		Residents must have at least 14 hour
VI.F.2.b)	after 24 hours of in-house call. (Core)	6.21.a.	after 24 hours of in-house call. (Core)
VI.F.2.c)	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)	6.21.b.	Residents must be scheduled for a m clinical work and required education home call cannot be assigned on the Maximum Clinical Work and Educatio
VI.F.3.	Maximum Clinical Work and Education Period Length	6.22.	Clinical and educational work periods hours of continuous scheduled clinic
VI.F.3.a)	Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core)	6.22.	Maximum Clinical Work and Educatio Clinical and educational work periods hours of continuous scheduled clinic
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. Additional patient care responsibilities must not be assigned to a resident during this time. (Core)	6.22.a.	Up to four hours of additional time ma patient safety, such as providing effe resident education. Additional patien assigned to a resident during this tim
VI.F.4.	Clinical and Educational Work Hour Exceptions	6.23.	Clinical and Educational Work Hour E In rare circumstances, after handing resident, on their own initiative, may clinical site in the following circumsta a single severely ill or unstable patien needs of a patient or patient's family; events. (Detail)

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Sponsoring Institutions, must design is configured to provide residents with opportunities, as well as reasonable activities.

ucational Work per Week s must be limited to no more than 80 ur-week period, inclusive of all invities, clinical work done from home,

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ork and Education off between scheduled clinical work

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minimum of one day in seven free of on (when averaged over four weeks). Atnese free days. (Core)

tion Period Length ods for residents must not exceed 24 nical assignments. (Core)

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may be used for activities related to fective transitions of care, and/or ent care responsibilities must not be ime. (Core)

Exceptions

g off all other responsibilities, a by elect to remain or return to the stances: to continue to provide care to ient; to give humanistic attention to the by; or to attend unique educational

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiremen
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: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events. (Detail)	6.23.	Clinical and Educational Work Hour E In rare circumstances, after handing or resident, on their own initiative, may or clinical site in the following circumsta a single severely ill or unstable patier needs of a patient or patient's family; events. (Detail)
VI.F.4.b)	These additional hours of care or education must be counted toward the 80-hour weekly limit. (Detail)	6.23.a.	These additional hours of care or edu 80-hour weekly limit. (Detail)
	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.		A Review Committee may grant rotati percent or a maximum of 88 clinical a individual programs based on a soun
VI.F.4.c)	The Review Committee for Anesthesiology will not consider requests for exceptions to the 80-hour limit to the residents' work week.	6.24.	The Review Committee for Anesthesiolo exceptions to the 80-hour limit to the res
VI.F.5.	Moonlighting	6.25.	Moonlighting Moonlighting must not interfere with t the goals and objectives of the educa interfere with the resident's fitness fo safety. (Core)
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)	6.25.	Moonlighting Moonlighting must not interfere with t the goals and objectives of the educa interfere with the resident's fitness fo 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)	6.25.a.	Time spent by residents in internal an in the ACGME Glossary of Terms) mu maximum weekly limit. (Core)
VI.F.5.c)	PGY-1 residents are not permitted to moonlight. (Core)	6.25.b.	PGY-1 residents are not permitted to I
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)	6.26.	In-House Night Float Night float must occur within the cont seven requirements. (Core)
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)	6.27.	Maximum In-House On-Call Frequency Residents must be scheduled for in-h every third night (when averaged over
VI.F.8.	At-Home Call	6.28.	At-Home Call Time spent on patient care activities b count toward the 80-hour maximum w home call is not subject to the every-t the requirement for one day in seven when averaged over four weeks. (Cor

Exceptions g off all other responsibilities, a y elect to remain or return to the stances: to continue to provide care to ent; to give humanistic attention to the y; or to attend unique educational

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ation-specific exceptions for up to 10 and educational work hours to and educational rationale.

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o moonlight. (Core)

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-house call no more frequently than /er a four-week period). (Core)

s by residents on at-home call must weekly limit. The frequency of aty-third-night limitation, but must satisfy n free of clinical work and education, ore)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirement
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)		At-Home Call Time spent on patient care activities b count toward the 80-hour maximum w home call is not subject to the every-t the requirement for one day in seven t 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)	6.28.a.	At-home call must not be so frequent reasonable personal time for each res

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s by residents on at-home call must weekly limit. The frequency of aty-third-night limitation, but must satisfy n free of clinical work and education, ore)

nt or taxing as to preclude rest or resident. (Core)