

1 Common Program Requirements

2  
3 Introduction

4  
5 Residency is an essential dimension of the transformation of the medical student to the  
6 independent practitioner along the continuum of medical education. It is physically,  
7 emotionally, and intellectually demanding, and requires longitudinally-concentrated effort  
8 on the part of the resident.

9  
10 The specialty education of physicians to practice independently is experiential, and  
11 necessarily occurs within the context of the health care delivery system. Developing the  
12 skills, knowledge, and attitudes leading to proficiency in all the domains of clinical  
13 competency requires the resident physician to assume personal responsibility for the  
14 care of individual patients. For the resident, the essential learning activity is interaction  
15 with patients under the guidance and supervision of faculty who give value, context, and  
16 meaning to those interactions. As residents gain experience and demonstrate growth in  
17 their ability to care for patients, they assume roles that permit them to exercise those  
18 skills with greater independence. This concept--graded and progressive responsibility--is  
19 one of the core tenets of American graduate medical education. Supervision in the  
20 setting of graduate medical education has the goals of assuring the provision of safe and  
21 effective care to the individual patient; assuring the development of the skills,  
22 knowledge, and attitudes in the resident required to enter the unsupervised practice of  
23 medicine; and establishing a foundation for continued professional growth.

24  
25 I. Institutions

26  
27 I.A. Sponsoring Institution

28  
29 One sponsoring institution must assume ultimate responsibility for the program,  
30 as described in the Institutional Requirements, and this responsibility extends to  
31 resident assignments at all participating sites.

32  
33 The sponsoring institution and the program must ensure that the program  
34 director has sufficient protected time and financial support for his or her  
35 educational and administrative responsibilities to the program.

36  
37 I.B. Participating Sites

38  
39 I.B.1. There must be a program letter of agreement (PLA) between the program  
40 and each participating site providing a required assignment. The PLA  
41 must be renewed at least every five years.

42  
43 The PLA should:

44  
45 I.B.1.a) identify the faculty who will assume both educational and  
46 supervisory responsibilities for residents;

47  
48 I.B.1.b) specify their responsibilities for teaching, supervision, and formal  
49 evaluation of residents, as specified later in this document;

50  
51 I.B.1.c) specify the duration and content of the educational experience;

- 52 and,  
53  
54 I.B.1.d) state the policies and procedures that will govern resident  
55 education during the assignment.  
56  
57 I.B.2. The program director must submit any additions or deletions of  
58 participating sites routinely providing an educational experience, required  
59 for all residents, of one month full time equivalent (FTE) or more through  
60 the Accreditation Council for Graduate Medical Education (ACGME)  
61 Accreditation Data System (ADS).  
62  
63 [As further specified by the Review Committee]  
64  
65 II. Program Personnel and Resources  
66  
67 II.A. Program Director  
68  
69 II.A.1. There must be a single program director with authority and accountability  
70 for the operation of the program. The sponsoring institution's GMEC must  
71 approve a change in program director. After approval, the program  
72 director must submit this change to the ACGME via the ADS.  
73  
74 [As further specified by the Review Committee]  
75  
76 II.A.2. The program director should continue in his or her position for a length of  
77 time adequate to maintain continuity of leadership and program stability.  
78  
79 II.A.3. Qualifications of the program director must include:  
80  
81 II.A.3.a) requisite specialty expertise and documented educational and  
82 administrative experience acceptable to the Review Committee;  
83  
84 II.A.3.b) current certification in the specialty by the American Board of  
85 \_\_\_\_\_, or specialty qualifications that are acceptable to the  
86 Review Committee; and,  
87  
88 II.A.3.c) current medical licensure and appropriate medical staff  
89 appointment.  
90  
91 [As further specified by the Review Committee]  
92  
93 II.A.4. The program director must administer and maintain an educational  
94 environment conducive to educating the residents in each of the ACGME  
95 competency areas. The program director must:  
96  
97 II.A.4.a) oversee and ensure the quality of didactic and clinical education in  
98 all sites that participate in the program;  
99  
100 II.A.4.b) approve a local director at each participating site who is  
101 accountable for resident education;  
102

103	II.A.4.c)	approve the selection of program faculty as appropriate;
104		
105	II.A.4.d)	evaluate program faculty and approve the continued participation
106		of program faculty based on evaluation;
107		
108	II.A.4.e)	monitor resident supervision at all participating sites;
109		
110	II.A.4.f)	prepare and submit all information required and requested by the
111		ACGME, including but not limited to the program information
112		forms and annual program resident updates to the ADS, and
113		ensure that the information submitted is accurate and complete;
114		
115	II.A.4.g)	provide each resident with documented semiannual evaluation of
116		performance with feedback;
117		
118	II.A.4.h)	ensure compliance with grievance and due process procedures as
119		set forth in the Institutional Requirements and implemented by the
120		sponsoring institution;
121		
122	II.A.4.i)	provide verification of residency education for all residents,
123		including those who leave the program prior to completion;
124		
125	II.A.4.j)	implement policies and procedures consistent with the institutional
126		and program requirements for resident duty hours and the working
127		environment, including moonlighting, and, to that end, must:
128		
129	II.A.4.j).(1)	distribute these policies and procedures to the residents
130		and faculty;
131		
132	II.A.4.j).(2)	monitor resident duty hours, according to sponsoring
133		institutional policies, with a frequency sufficient to ensure
134		compliance with ACGME requirements;
135		
136	II.A.4.j).(3)	adjust schedules as necessary to mitigate excessive
137		service demands and/or fatigue; and,
138		
139	II.A.4.j).(4)	if applicable, monitor the demands of at-home call and
140		adjust schedules as necessary to mitigate excessive
141		service demands and/or fatigue.
142		
143	II.A.4.k)	monitor the need for and ensure the provision of back up support
144		systems when patient care responsibilities are unusually difficult
145		or prolonged;
146		
147	II.A.4.l)	comply with the sponsoring institution's written policies and
148		procedures, including those specified in the Institutional
149		Requirements, for selection, evaluation and promotion of
150		residents, disciplinary action, and supervision of residents;
151		
152	II.A.4.m)	be familiar with and comply with ACGME and Review Committee
153		policies and procedures as outlined in the ACGME Manual of

154 Policies and Procedures;

155

156 II.A.4.n) obtain review and approval of the sponsoring institution's

157 GMEC/DIO before submitting to the ACGME information or

158 requests for the following:

159

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

161

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

163

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

165

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

167

168 II.A.4.n).(5) responses to all proposed adverse actions;

169

170 II.A.4.n).(6) requests for increases or any change to resident duty

171 hours;

172

173 II.A.4.n).(7) voluntary withdrawals of ACGME-accredited programs;

174

175 II.A.4.n).(8) requests for appeal of an adverse action;

176

177 II.A.4.n).(9) appeal presentations to a Board of Appeal or the ACGME;

178 and,

179

180 II.A.4.n).(10) proposals to ACGME for approval of innovative

181 educational approaches.

182

183 II.A.4.o) obtain DIO review and co-signature on all program information

184 forms, as well as any correspondence or document submitted to

185 the ACGME that addresses:

186

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

188

189 II.A.4.o).(2) request for changes in the program that would have

190 significant impact, including financial, on the program or

191 institution.

192

193 [As further specified by the Review Committee].

194

195 II.B. Faculty

196

197 II.B.1. At each participating site, there must be a sufficient number of faculty with

198 documented qualifications to instruct and supervise all residents at that

199 location.

200

201 The faculty must:

202

203 II.B.1.a) devote sufficient time to the educational program to fulfill their

204 supervisory and teaching responsibilities; and to demonstrate a

205 strong interest in the education of residents, and  
206  
207 II.B.1.b) administer and maintain an educational environment conducive to  
208 educating residents in each of the ACGME competency areas.  
209  
210 II.B.2. The physician faculty must have current certification in the specialty by  
211 the American Board of \_\_\_\_\_, or possess qualifications acceptable to  
212 the Review Committee.  
213  
214 [As further specified by the Review Committee]  
215  
216 II.B.3. The physician faculty must possess current medical licensure and  
217 appropriate medical staff appointment.  
218  
219 II.B.4. The nonphysician faculty must have appropriate qualifications in their field  
220 and hold appropriate institutional appointments.  
221  
222 II.B.5. The faculty must establish and maintain an environment of inquiry and  
223 scholarship with an active research component.  
224  
225 II.B.5.a) The faculty must regularly participate in organized clinical  
226 discussions, rounds, journal clubs, and conferences.  
227  
228 II.B.5.b) Some members of the faculty should also demonstrate  
229 scholarship by one or more of the following:  
230  
231 II.B.5.b).(1) peer-reviewed funding;  
232  
233 II.B.5.b).(2) publication of original research or review articles in peer-  
234 reviewed journals, or chapters in textbooks;  
235  
236 II.B.5.b).(3) publication or presentation of case reports or clinical series  
237 at local, regional, or national professional and scientific  
238 society meetings; or,  
239  
240 II.B.5.b).(4) participation in national committees or educational  
241 organizations.  
242  
243 II.B.5.c) Faculty should encourage and support residents in scholarly  
244 activities.  
245  
246 [As further specified by the Review Committee]  
247  
248 II.C. Other Program Personnel  
249  
250 The institution and the program must jointly ensure the availability of all  
251 necessary professional, technical, and clerical personnel for the effective  
252 administration of the program.  
253  
254 [As further specified by the Review Committee]  
255

256 II.D. Resources  
257  
258 The institution and the program must jointly ensure the availability of adequate  
259 resources for resident education, as defined in the specialty program  
260 requirements.  
261  
262 [As further specified by the Review Committee]  
263

264 II.E. Medical Information Access  
265  
266 Residents must have ready access to specialty-specific and other appropriate  
267 reference material in print or electronic format. Electronic medical literature  
268 databases with search capabilities should be available.  
269

270 III. Resident Appointments  
271

272 III.A. Eligibility Criteria  
273  
274 The program director must comply with the criteria for resident eligibility as  
275 specified in the Institutional Requirements.  
276  
277 [As further specified by the Review Committee]  
278

279 III.B. Number of Residents  
280  
281 The program director may not appoint more residents than approved by the  
282 Review Committee, unless otherwise stated in the specialty-specific  
283 requirements. The program’s educational resources must be adequate to support  
284 the number of residents appointed to the program.  
285  
286 [As further specified by the Review Committee]  
287

288 III.C. Resident Transfers  
289

290 III.C.1. Before accepting a resident who is transferring from another program, the  
291 program director must obtain written or electronic verification of previous  
292 educational experiences and a summative competency-based  
293 performance evaluation of the transferring resident.  
294

295 III.C.2. A program director must provide timely verification of residency education  
296 and summative performance evaluations for residents who leave the  
297 program prior to completion.  
298

299 III.D. Appointment of Fellows and Other Learners  
300  
301 The presence of other learners (including, but not limited to, residents from other  
302 specialties, subspecialty fellows, PhD students, and nurse practitioners) in the  
303 program must not interfere with the appointed residents’ education. The program  
304 director must report the presence of other learners to the DIO and GMEC in  
305 accordance with sponsoring institution guidelines.  
306

307 [As further specified by the Review Committee]  
308  
309 IV. Educational Program  
310  
311 IV.A. The curriculum must contain the following educational components:  
312  
313 IV.A.1. Overall educational goals for the program, which the program must  
314 distribute to residents and faculty annually;  
315  
316 IV.A.2. Competency-based goals and objectives for each assignment at each  
317 educational level, which the program must distribute to residents and  
318 faculty annually, in either written or electronic form. These should be  
319 reviewed by the resident at the start of each rotation;  
320  
321 IV.A.3. Regularly scheduled didactic sessions;  
322  
323 IV.A.4. Delineation of resident responsibilities for patient care, progressive  
324 responsibility for patient management, and supervision of residents over  
325 the continuum of the program; and,  
326  
327 IV.A.5. ACGME Competencies  
328  
329 The program must integrate the following ACGME competencies into the  
330 curriculum:  
331  
332 IV.A.5.a) Patient Care  
333  
334 Residents must be able to provide patient care that is  
335 compassionate, appropriate, and effective for the treatment of  
336 health problems and the promotion of health. Residents:  
337  
338 [As further specified by the Review Committee]  
339  
340 IV.A.5.b) Medical Knowledge  
341  
342 Residents must demonstrate knowledge of established and  
343 evolving biomedical, clinical, epidemiological and social-  
344 behavioral sciences, as well as the application of this knowledge  
345 to patient care. Residents:  
346  
347 [As further specified by the Review Committee]  
348  
349 IV.A.5.c) Practice-based Learning and Improvement  
350  
351 Residents must demonstrate the ability to investigate and evaluate  
352 their care of patients, to appraise and assimilate scientific  
353 evidence, and to continuously improve patient care based on  
354 constant self-evaluation and life-long learning. Residents are  
355 expected to develop skills and habits to be able to meet the  
356 following goals:  
357

- 358 IV.A.5.c).(1) identify strengths, deficiencies, and limits in one's  
 359 knowledge and expertise;  
 360  
 361 IV.A.5.c).(2) set learning and improvement goals;  
 362  
 363 IV.A.5.c).(3) identify and perform appropriate learning activities;  
 364  
 365 IV.A.5.c).(4) systematically analyze practice using quality improvement  
 366 methods, and implement changes with the goal of practice  
 367 improvement;  
 368  
 369 IV.A.5.c).(5) incorporate formative evaluation feedback into daily  
 370 practice;  
 371  
 372 IV.A.5.c).(6) locate, appraise, and assimilate evidence from scientific  
 373 studies related to their patients' health problems;  
 374  
 375 IV.A.5.c).(7) use information technology to optimize learning; and,  
 376  
 377 IV.A.5.c).(8) participate in the education of patients, families, students,  
 378 residents and other health professionals.  
 379

[As further specified by the Review Committee]

- 380  
 381  
 382 IV.A.5.d) Interpersonal and Communication Skills  
 383  
 384 Residents must demonstrate interpersonal and communication  
 385 skills that result in the effective exchange of information and  
 386 collaboration with patients, their families, and health professionals.  
 387 Residents are expected to:  
 388  
 389 IV.A.5.d).(1) communicate effectively with patients, families, and the  
 390 public, as appropriate, across a broad range of  
 391 socioeconomic and cultural backgrounds;  
 392  
 393 IV.A.5.d).(2) communicate effectively with physicians, other health  
 394 professionals, and health related agencies;  
 395  
 396 IV.A.5.d).(3) work effectively as a member or leader of a health care  
 397 team or other professional group;  
 398  
 399 IV.A.5.d).(4) act in a consultative role to other physicians and health  
 400 professionals; and,  
 401  
 402 IV.A.5.d).(5) maintain comprehensive, timely, and legible medical  
 403 records, if applicable.  
 404

[As further specified by the Review Committee]

- 405  
 406  
 407 IV.A.5.e) Professionalism  
 408

409 Residents must demonstrate a commitment to carrying out  
 410 professional responsibilities and an adherence to ethical  
 411 principles. Residents are expected to demonstrate:  
 412  
 413 IV.A.5.e).(1) compassion, integrity, and respect for others;  
 414  
 415 IV.A.5.e).(2) responsiveness to patient needs that supersedes self-  
 416 interest;  
 417  
 418 IV.A.5.e).(3) respect for patient privacy and autonomy;  
 419  
 420 IV.A.5.e).(4) accountability to patients, society and the profession; and,  
 421  
 422 IV.A.5.e).(5) sensitivity and responsiveness to a diverse patient  
 423 population, including but not limited to diversity in gender,  
 424 age, culture, race, religion, disabilities, and sexual  
 425 orientation.  
 426

[As further specified by the Review Committee]

427  
 428  
 429 IV.A.5.f) Systems-based Practice

430 Residents must demonstrate an awareness of and  
 431 responsiveness to the larger context and system of health care, as  
 432 well as the ability to call effectively on other resources in the  
 433 system to provide optimal health care. Residents are expected to:  
 434  
 435

436 IV.A.5.f).(1) work effectively in various health care delivery settings and  
 437 systems relevant to their clinical specialty;  
 438  
 439 IV.A.5.f).(2) coordinate patient care within the health care system  
 440 relevant to their clinical specialty;  
 441  
 442 IV.A.5.f).(3) incorporate considerations of cost awareness and risk-  
 443 benefit analysis in patient and/or population-based care as  
 444 appropriate;  
 445  
 446 IV.A.5.f).(4) advocate for quality patient care and optimal patient care  
 447 systems;  
 448  
 449 IV.A.5.f).(5) work in interprofessional teams to enhance patient safety  
 450 and improve patient care quality; and,  
 451  
 452 IV.A.5.f).(6) participate in identifying system errors and implementing  
 453 potential systems solutions.  
 454

[As further specified by the Review Committee]

455  
 456 IV.B. Residents' Scholarly Activities

457  
 458  
 459 IV.B.1. The curriculum must advance residents' knowledge of the basic principles

460 of research, including how research is conducted, evaluated, explained to  
461 patients, and applied to patient care.  
462  
463 IV.B.2. Residents should participate in scholarly activity.  
464  
465 [As further specified by the Review Committee]  
466  
467 IV.B.3. The sponsoring institution and program should allocate adequate  
468 educational resources to facilitate resident involvement in scholarly  
469 activities.  
470  
471 [As further specified by the Review Committee]  
472  
473 V. Evaluation  
474  
475 V.A. Resident Evaluation  
476  
477 V.A.1. Formative Evaluation  
478  
479 V.A.1.a) The faculty must evaluate resident performance in a timely  
480 manner during each rotation or similar educational assignment,  
481 and document this evaluation at completion of the assignment.  
482  
483 V.A.1.b) The program must:  
484  
485 V.A.1.b).(1) provide objective assessments of competence in patient  
486 care, medical knowledge, practice-based learning and  
487 improvement, interpersonal and communication skills,  
488 professionalism, and systems-based practice;  
489  
490 V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self,  
491 and other professional staff);  
492  
493 V.A.1.b).(3) document progressive resident performance improvement  
494 appropriate to educational level; and,  
495  
496 V.A.1.b).(4) provide each resident with documented semiannual  
497 evaluation of performance with feedback.  
498  
499 V.A.1.c) The evaluations of resident performance must be accessible for  
500 review by the resident, in accordance with institutional policy.  
501  
502 V.A.2. Summative Evaluation  
503  
504 The program director must provide a summative evaluation for each  
505 resident upon completion of the program. This evaluation must become  
506 part of the resident's permanent record maintained by the institution, and  
507 must be accessible for review by the resident in accordance with  
508 institutional policy. This evaluation must:  
509  
510 V.A.2.a) document the resident's performance during the final period of

511 education, and  
512  
513 V.A.2.b) verify that the resident has demonstrated sufficient competence to  
514 enter practice without direct supervision.  
515  
516 V.B. Faculty Evaluation  
517  
518 V.B.1. At least annually, the program must evaluate faculty performance as it  
519 relates to the educational program.  
520  
521 V.B.2. These evaluations should include a review of the faculty's clinical  
522 teaching abilities, commitment to the educational program, clinical  
523 knowledge, professionalism, and scholarly activities.  
524  
525 V.B.3. This evaluation must include at least annual written confidential  
526 evaluations by the residents.  
527  
528 V.C. Program Evaluation and Improvement  
529  
530 V.C.1. The program must document formal, systematic evaluation of the  
531 curriculum at least annually. The program must monitor and track each of  
532 the following areas:  
533  
534 V.C.1.a) resident performance;  
535  
536 V.C.1.b) faculty development;  
537  
538 V.C.1.c) graduate performance, including performance of program  
539 graduates on the certification examination; and,  
540  
541 V.C.1.d) program quality. Specifically:  
542  
543 V.C.1.d).(1) Residents and faculty must have the opportunity to  
544 evaluate the program confidentially and in writing at least  
545 annually, and  
546  
547 V.C.1.d).(2) The program must use the results of residents'  
548 assessments of the program together with other program  
549 evaluation results to improve the program.  
550  
551 V.C.2. If deficiencies are found, the program should prepare a written plan of  
552 action to document initiatives to improve performance in the areas listed  
553 in section V.C.1. The action plan should be reviewed and approved by the  
554 teaching faculty and documented in meeting minutes.  
555  
556 VI. Resident Duty Hours in the Learning and Working Environment  
557  
558 VI.A. Principles  
559  
560 VI.A.1. ~~The program must be committed to and be responsible for promoting~~  
561 ~~patient safety and resident well-being and to providing a supportive~~

- 562 educational environment.
- 563
- 564 VI.A.2. ~~The learning objectives of the program must not be compromised by~~  
565 ~~excessive reliance on residents to fulfill service obligations.~~
- 566
- 567 VI.A.3. ~~Didactic and clinical education must have priority in the allotment of~~  
568 ~~residents' time and energy.~~
- 569
- 570 VI.A.1. ~~Duty hour assignments must recognize that faculty and residents~~  
571 ~~collectively have responsibility for the safety and welfare of patients.~~
- 572
- 573 VI.A. Professionalism, Personal Responsibility, and Patient Safety
- 574
- 575 VI.A.1. Programs and sponsoring institutions must educate residents and faculty  
576 members concerning the professional responsibilities of physicians to  
577 appear for duty appropriately rested and fit to provide the services  
578 required by their patients.
- 579
- 580 VI.A.2. The program must be committed to and be responsible for promoting  
581 patient safety and resident well-being in a supportive educational  
582 environment.
- 583
- 584 VI.A.3. The program director must ensure that residents are integrated and  
585 actively participate in interdisciplinary clinical quality improvement and  
586 patient safety programs.
- 587
- 588 VI.A.4. The learning objectives of the program must:
- 589
- 590 VI.A.4.a) be accomplished through an appropriate blend of supervised  
591 patient care responsibilities, clinical teaching, and didactic  
592 educational events; and,
- 593
- 594 VI.A.4.b) not be compromised by excessive reliance on residents to fulfill  
595 non-physician service obligations.
- 596
- 597 VI.A.5. The program director and institution must ensure a culture of  
598 professionalism that supports patient safety and personal responsibility.  
599 Residents and faculty members must demonstrate:
- 600
- 601 VI.A.5.a) assurance of the safety and welfare of patients entrusted to their  
602 care;
- 603
- 604 VI.A.5.b) provision of patient- and family-centered care;
- 605
- 606 VI.A.5.c) assurance of their fitness for duty;
- 607
- 608 VI.A.5.d) management of their time before, during, and after clinical  
609 assignments;
- 610
- 611 VI.A.5.e) recognition of impairment, including illness and fatigue, in  
612 themselves and in their peers;

- 613
- 614 VI.A.5.f) attention to lifelong learning;
- 615
- 616 VI.A.5.g) the monitoring of their patient care performance improvement
- 617 indicators; and,
- 618
- 619 VI.A.5.h) honest and accurate reporting of duty hours, patient outcomes,
- 620 and clinical experience data.
- 621
- 622 VI.A.6. All residents and faculty members must demonstrate responsiveness to
- 623 patient needs that supersede self-interest. Physicians must recognize that
- 624 under certain circumstances, the best interests of the patient may be
- 625 served by transitioning that patient's care to another qualified and rested
- 626 provider.
- 627
- 628 VI.B. Transitions of Care
- 629
- 630 VI.B.1. Programs must design clinical assignments to minimize the number of
- 631 transitions in patient care.
- 632
- 633 VI.B.2. Institutions and programs must ensure and monitor effective, structured
- 634 hand-over processes to facilitate both continuity of care and patient
- 635 safety.
- 636
- 637 VI.B.3. Programs must ensure that residents are competent in communicating
- 638 with team members in the hand-over process.
- 639
- 640 VI.B.4. Institutions must ensure the availability of schedules that inform all
- 641 members of the health care team of faculty members and residents
- 642 currently responsible for each patient's care.
- 643
- 644 VI.C. Alertness Management
- 645
- 646 VI.C.1. The program must:
- 647
- 648 VI.C.1.a) educate all faculty members and residents to recognize the signs
- 649 of fatigue and sleep deprivation;
- 650
- 651 VI.C.1.b) educate all faculty members and residents in fatigue mitigation
- 652 processes; and,
- 653
- 654 VI.C.1.c) adopt fatigue mitigation processes to manage the potential
- 655 negative effects of fatigue on patient care and learning, including
- 656 naps and back-up call schedules.
- 657
- 658 VI.C.2. Each program must have a process to ensure continuity of patient care in
- 659 the event that a resident may be unable to perform his/her patient care
- 660 duties.
- 661
- 662 VI.C.3. The sponsoring institution must provide adequate sleep facilities and/or
- 663 safe transportation options for residents who may be too fatigued to

664 safely return home.

665

666 VI.D. Supervision of Residents

667

668 ~~The program must ensure that qualified faculty provide appropriate supervision of~~

669 ~~residents in patient care activities.~~

670

671 Supervision may be exercised through a variety of methods. Some activities

672 require the physical presence of the supervising faculty member. For many

673 aspects of patient care, the supervising physician may be a more advanced

674 resident. Other portions of care provided by the resident can be adequately

675 supervised by the immediate availability of the supervising faculty member or

676 resident physician, either in the institution, or by means of telephonic and/or

677 electronic modalities. In some circumstances, supervision may include post-hoc

678 review of resident-delivered care with feedback as to the appropriateness of that

679 care.

680

681 VI.D.1. In the clinical learning environment, each patient must have an

682 identifiable, appropriately-credentialed and privileged, supervising faculty

683 member who is ultimately responsible for that patient's care.

684

685 VI.D.1.a) This information should be available to residents, faculty

686 members, and patients.

687

688 VI.D.1.b) Residents and faculty members should inform patients of their

689 respective roles in each patient's care.

690

691 VI.D.2. The program must demonstrate that the appropriate level of supervision

692 is in place for all patients cared for by all residents.

693

694 VI.D.3. Levels of Supervision.

695

696 To ensure oversight of resident supervision and graded authority and

697 responsibility, the program must use the following classification of

698 supervision:

699

700 VI.D.3.a) Direct Supervision – The supervising physician is physically

701 present with the resident and patient.

702

703 VI.D.3.b) Indirect Supervision:

704

705 VI.D.3.b).(1) with direct supervision immediately available – The

706 supervising physician is physically within the confines of

707 the site of patient care, and is immediately available to

708 provide Direct Supervision.

709

710 VI.D.3.b).(2) with direct supervision available – The supervising

711 physician is not physically present within the confines of

712 the site of patient care, but is immediately available via

713 phone, and is available to provide Direct Supervision.

714

- 715 VI.D.3.c) Oversight – The supervising physician is available to provide  
716 review of procedures/encounters with feedback provided after  
717 care is delivered.  
718
- 719 VI.D.4. The privilege of progressive responsibility, authority and a supervisory  
720 role in patient care delegated to each resident must be assigned by the  
721 program director and faculty members.  
722
- 723 VI.D.4.a) The program director must evaluate each resident’s abilities  
724 based on specific criteria. When available, evaluation should be  
725 guided by specific national standards-based criteria.  
726
- 727 VI.D.4.b) Faculty members functioning as supervising physicians should  
728 delegate portions of care to residents, based on the needs of the  
729 patient and the skills of the residents.  
730
- 731 VI.D.4.c) Senior residents or fellows should serve in a supervisory role of  
732 junior residents in recognition of their progress toward  
733 independence, based on the needs of each patient and the skills  
734 of the individual resident or fellow.  
735
- 736 VI.D.5. Programs must set guidelines for circumstances and events in which  
737 residents must communicate with appropriate supervising faculty  
738 members, such as the transfer of a patient to an intensive care unit, or  
739 end-of-life decisions.  
740
- 741 VI.D.5.a) Each resident is responsible for knowing the limits of his/her  
742 scope of authority, and the circumstances under which he/she is  
743 permitted to act with conditional independence.  
744
- 745 VI.D.5.a).(1) In particular, during PGY-1, residents must be supervised  
746 either directly or indirectly, with direct supervision  
747 immediately available.  
748
- 749 VI.D.6. Faculty supervision assignments should be of sufficient duration to  
750 assess the knowledge and skills of each resident and delegate to him/her  
751 the appropriate level of patient care authority and responsibility.  
752
- 753 VI.E. ~~\_\_\_\_\_~~ **Fatigue**  
754  
755 ~~Faculty and residents must be educated to recognize the signs of fatigue and~~  
756 ~~sleep deprivation and must adopt and apply policies to prevent and counteract its~~  
757 ~~potential negative effects on patient care and learning.~~  
758
- 759 VI.E. Clinical Responsibilities  
760  
761 The clinical responsibilities for each resident must be based on the PGY-level,  
762 patient safety, resident education, severity and complexity of patient  
763 illness/condition and available support services.  
764  
765 [As further specified by the Review Committee]

766  
767 VI.F. Teamwork  
768  
769 Residents must care for patients in an environment that maximizes effective  
770 communication. This must include the opportunity to work as a member of  
771 effective interdisciplinary teams that are appropriate to the delivery of care in the  
772 specialty.  
773  
774 VI.G. ~~Duty Hours (the terms in this section are defined in the ACGME Glossary and~~  
775 ~~apply to all programs)~~  
776  
777 ~~Duty hours are defined as all clinical and academic activities related to the~~  
778 ~~program; i.e., patient care (both inpatient and outpatient), administrative duties~~  
779 ~~relative to patient care, the provision for transfer of patient care, time spent in-~~  
780 ~~house during call activities, and scheduled activities, such as conferences. Duty~~  
781 ~~hours do not include reading and preparation time spent away from the duty site.~~  
782  
783 VI.G.1. ~~Duty hours must be limited to 80 hours per week, averaged over a four-~~  
784 ~~week period, inclusive of all in-house call activities.~~  
785  
786 VI.G.2. ~~Residents must be provided with one day in seven free from all~~  
787 ~~educational and clinical responsibilities, averaged over a four-week~~  
788 ~~period, inclusive of call.~~  
789  
790 VI.G.3. ~~Adequate time for rest and personal activities must be provided. This~~  
791 ~~should consist of a 10-hour time period provided between all daily duty~~  
792 ~~periods and after in-house call.~~  
793  
794 VI.H. On-call Activities  
795  
796 VI.H.1. ~~In-house call must occur no more frequently than every third night,~~  
797 ~~averaged over a four-week period.~~  
798  
799 VI.H.2. ~~Continuous on-site duty, including in-house call, must not exceed 24~~  
800 ~~consecutive hours. Residents may remain on duty for up to six additional~~  
801 ~~hours to participate in didactic activities, transfer care of patients, conduct~~  
802 ~~outpatient clinics, and maintain continuity of medical and surgical care.~~  
803  
804 VI.H.3. ~~No new patients may be accepted after 24 hours of continuous duty.~~  
805  
806 VI.H.4. At home call (or pager call)  
807  
808 VI.H.1.a) ~~The frequency of at home call is not subject to the every third-~~  
809 ~~night, or 24+6 limitation. However at home call must not be so~~  
810 ~~frequent as to preclude rest and reasonable personal time for~~  
811 ~~each resident.~~  
812  
813 VI.H.1.b) ~~Residents taking at home call must be provided with one day in~~  
814 ~~seven completely free from all educational and clinical~~  
815 ~~responsibilities, averaged over a four-week period.~~  
816

817 ~~VI.H.1.c) When residents are called into the hospital from home, the hours~~  
818 ~~residents spend in house are counted toward the 80-hour limit.~~  
819  
820 VI.I. ~~Moonlighting~~  
821  
822 ~~VI.I.1. Moonlighting must not interfere with the ability of the resident to achieve~~  
823 ~~the goals and objectives of the educational program.~~  
824  
825 ~~VI.I.2. Internal moonlighting must be considered part of the 80-hour weekly limit~~  
826 ~~on duty hours.~~  
827  
828 VI.G. Resident Duty Hours  
829  
830 VI.G.1. Maximum Hours of Work per Week  
831  
832 Duty hours must be limited to 80 hours per week, averaged over a four-  
833 week period, inclusive of all in-house call activities and all moonlighting.  
834  
835 VI.G.1.a) Duty Hour Exceptions  
836  
837 A Review Committee may grant exceptions for up to 10% or a  
838 maximum of 88 hours to individual programs based on a sound  
839 educational rationale.  
840  
841 VI.G.1.a).(1) In preparing a request for an exception the program  
842 director must follow the duty hour exception policy from the  
843 ACGME Manual on Policies and Procedures.  
844  
845 VI.G.1.a).(2) Prior to submitting the request to the Review Committee,  
846 the program director must obtain approval of the  
847 institution's GMEC and DIO.  
848  
849 VI.G.2. Moonlighting  
850  
851 VI.G.2.a) Time spent by residents in Internal and External Moonlighting (as  
852 defined in the ACGME Glossary of Terms) must be counted  
853 towards the 80-hour Maximum Weekly Hour Limit.  
854  
855 VI.G.2.b) PGY-1 residents are not permitted to moonlight.  
856  
857 VI.G.3. Mandatory Time Free of Duty  
858  
859 Residents must be scheduled for a minimum of one day free of duty every  
860 week (when averaged over four weeks). At-home call cannot be assigned  
861 on these free days.  
862  
863 VI.G.4. Maximum Duty Period Length  
864  
865 VI.G.4.a) Duty periods of PGY-1 residents must not exceed 16 hours in  
866 duration.

867  
868 VI.G.4.b) Duty periods of PGY-2 residents and above may be scheduled to  
869 a maximum of 24 hours of continuous duty in the hospital.  
870 Programs must encourage residents to use alertness  
871 management strategies in the context of patient care  
872 responsibilities. Strategic napping, especially after 16 hours of  
873 continuous duty and between the hours of 10:00 p.m. and 8:00  
874 a.m., is strongly suggested.  
875  
876 VI.G.4.b).(1) It is essential for patient safety and resident education that  
877 effective transitions in care occur. Residents may be  
878 allowed to remain on-site in order to accomplish these  
879 tasks; however, this period of time must be no longer than  
880 an additional four hours.  
881  
882 VI.G.4.b).(2) Residents must not attend continuity clinics after 24 hours  
883 of continuous in-house duty.  
884  
885 VI.G.4.b).(3) In unusual circumstances, residents, on their own initiative,  
886 may remain beyond their scheduled period of duty to  
887 continue to provide care to a single patient. Justifications  
888 for such extensions of duty are limited to reasons of  
889 required continuity for a severely ill or unstable patient,  
890 academic importance of the events transpiring, or  
891 humanistic attention to the needs of a patient or family.  
892  
893 VI.G.4.b).(3).(a) Under those circumstances, the resident must:  
894  
895 VI.G.4.b).(3).(a).(i) appropriately hand over the care of all other  
896 patients to the team responsible for their  
897 continuing care; and,  
898  
899 VI.G.4.b).(3).(a).(ii) document the reasons for remaining to care  
900 for the patient in question and submit that  
901 documentation in every circumstance to the  
902 program director.  
903  
904 VI.G.4.b).(3).(b) The program director must review each submission  
905 of additional service, and track both individual  
906 resident and program-wide episodes of additional  
907 duty.  
908  
909 VI.G.5. Minimum Time Off between Scheduled Duty Periods  
910  
911 VI.G.5.a) PGY-1 residents should have 10 hours, and must have eight  
912 hours, free of duty between scheduled duty periods.  
913  
914 VI.G.5.b) Intermediate-level residents [as defined by the Review Committee]  
915 should have 10 hours free of duty, and must have eight hours  
916 between scheduled duty periods. They must have at least 14  
917 hours free of duty after 24 hours of in-house duty.

918  
919 VI.G.5.c) Residents in the final years of education (as defined by the  
920 Review Committee) should have eight hours between scheduled  
921 duty periods. However, these residents must be prepared to enter  
922 the unsupervised practice of medicine and care for patients over  
923 irregular or extended periods. Under circumstances defined and  
924 approved by the Review Committee, residents in their final years  
925 of education (as determined by the Review Committee) may be  
926 permitted to return to duty with fewer than eight hours between in-  
927 hospital activities. This must occur only within the context of the  
928 80-hour and one-day-off-in-seven standards.

929  
930 VI.G.5.d) Circumstances of return-to-hospital activities with fewer than eight  
931 hours away from the hospital by residents in their final years of  
932 education must be monitored by the program director.

933  
934 VI.G.6. Maximum Frequency of In-House Night Float  
935  
936 Residents must not be scheduled for more than six consecutive nights of  
937 night float. (The *maximum number of consecutive weeks of night float,*  
938 *and maximum number of months of night float per year* may be further  
939 specified by the Review Committee.)

940  
941 VI.G.7. Maximum In-House On-Call Frequency  
942  
943 PGY-2 residents and above must be scheduled for in-house call no more  
944 frequently than every-third-night (no averaging).

945  
946 VI.G.8. At-Home Call  
947  
948 VI.G.8.a) Time spent in the hospital by residents on at-home call must count  
949 towards the 80-hour maximum weekly hour limit. The frequency of  
950 at-home call is not subject to the every-third-night limitation.

951  
952 VI.G.8.a).(1) At-home call must not be so frequent or taxing to preclude  
953 rest or reasonable personal time for each resident.

954  
955 VI.G.8.b) Residents are permitted to return to the hospital while on at-home  
956 call to care for new or established patients. Each episode of this  
957 type of care, while it must be included in the 80-hour weekly  
958 maximum, will not initiate a new “off-duty period.”

959  
960 VII. Experimentation and Innovation  
961  
962 Requests for experimentation or innovative projects that may deviate from the  
963 institutional, common and/or specialty specific program requirements must be approved  
964 in advance by the Review Committee. In preparing requests, the program director must  
965 follow Procedures for Approving Proposals for Experimentation or Innovative Projects  
966 located in the ACGME Manual on Policies and Procedures. Once a Review Committee  
967 approves a project, the sponsoring institution and program are jointly responsible for the  
968 quality of education offered to residents for the duration of such a project.

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