ACGME Program Requirements for Graduate Medical Education in Plastic Surgery

One-year Common Program Requirements are in BOLD

Effective: July 1, 2009

Introduction

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

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

Int.B. Plastic surgery residency programs educate physicians in the resection, repair, replacement, and reconstruction of defects of form and function of the integument and its underlying anatomic systems, including the craniofacial structures, the oropharynx, the trunk, the extremities, the breast, and the perineum. This includes aesthetic (cosmetic) surgery of structures with undesirable form. Special knowledge and skill in the design and transfer of flaps, in the transplantation of tissues, and in the replantation of structures are vital to these ends, as is skill in excisional surgery, in management of complex wounds, and in the use of alloplastic materials. Plastic surgery residency education trains physicians broadly in the art and science of plastic and reconstructive surgery. These residency programs develop a competent and responsible plastic surgeon with high moral and ethical character, capable of functioning as an independent surgeon. A variety of educational plans will produce the desired result.

Int.C. The Review Committee for Plastic Surgery will accredit *independent* plastic surgery programs of three years duration and *integrated* programs of six years duration. All prerequisite residency education must be taken within programs accredited by the Accreditation Council of Graduate Medical Education

(ACGME), the Royal College of Physicians and Surgeons of Canada (RCPSC), or the American Dental Association.

Int.C.1. Independent format: residents complete three years of concentrated plastic surgery education, with 12 months of chief responsibility, after successful completion of one of the following prerequisite curricula:

Int.C.1.a) an ACGME-accredited surgery, neurological surgery, orthopaedic surgery, otolaryngology, or urology residency; or,

Int.C.1.b) an educational program in oral and maxillofacial surgery approved by the American Dental Association (ADA) is an alternate pathway for prerequisite education prior to a plastic surgery residency. This pathway is available only to those individuals holding the DMD/MD or DDS/MD degree. This education also must include a minimum of 24 months of progressive responsibility on surgical rotations under the direction of the general surgery program director after receipt of the MD degree. Rotations in general surgery during medical school, prior to receiving the MD degree, will not be considered as fulfilling any part of the 24-month minimum requirement.

Int.C.2. Integrated format: residents complete six years of ACGME-accredited plastic surgery education following receipt of an MD or DO degree from an institution accredited by the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association (AOA). Graduates of schools of medicine from countries other than the United States or Canada must present evidence of final certification by the Education Commission for Foreign Medical Graduates (ECFMG).

Int.C.2.a) The integrated curriculum must contain six years of clinical surgical education under the authority and direction of the plastic surgery program director.

Int.C.2.b) Of these years, 36 months must be concentrated plastic surgery education with no less than 12 months of chief responsibility on the clinical service of plastic surgery. Residents must complete the last 36 months of their education in the same plastic surgery program. See section IV.A.5.a) for specific plastic surgery requirements.

Int.C.2.c) Clinical experiences appropriate to plastic surgery education should be provided in alimentary tract surgery, abdominal surgery, breast surgery, emergency medicine, pediatric surgery, surgical critical care, surgical oncology, transplant, trauma management, and vascular surgery. See section IV.A.5.a) for specific plastic surgery requirements.

Int.C.3. Prior to entry into the program, each resident must be notified in writing of the required program length.

I. Institutions

I.A. Sponsoring Institution

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

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

I.A.1. The sponsoring institution must:

I.A.1.a) demonstrate commitment to education in plastic surgery education in their support of the residency program;

I.A.1.b) provide the program director with a minimum of 15% protected time, which may take the form of direct or indirect salary support, such as release from clinical activities provided by the institution for programs with one to six residents. Programs with more than six residents shall provide the program director with a minimum of 25% protected time;

I.A.1.c) support and provide evidence of faculty development for the program director and the faculty in education and teaching.

I.B. Participating Sites

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

The PLA should:

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

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

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

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

I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or

more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).

I.B.3. The addition or deletion of participating sites providing three or more months of a resident's required clinical education must be prior-approved by the Review Committee

II. Program Personnel and Resources

II.A. Program Director

II.A.1. **There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.**

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

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

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

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

II.A.3.c) **current medical licensure and appropriate medical staff appointment.**

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

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

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

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

II.A.4.d) **evaluate program faculty and approve the continued participation of program faculty based on evaluation;**

II.A.4.e) **monitor resident supervision at all participating sites;**

II.A.4.f) prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;

II.A.4.g) provide each resident with documented semiannual evaluation of performance with feedback;

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

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

II.A.4.j) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:

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

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

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

II.A.4.j).(4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.

II.A.4.k) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;

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

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

II.A.4.n) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:

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

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

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

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

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

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

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

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

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

II.A.4.n).(10) **proposals to ACGME for approval of innovative educational approaches.**

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

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

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

II.A.4.p) compile annually a comprehensive record of the number and type of operative procedures performed by each resident completing the program. This record must include all of the procedures in which the plastic surgery resident was either surgeon or assistant during the plastic surgery program. The operative log must be provided as requested in the format and form specified by the Review Committee and it must be signed by both the resident and the program director as a statement of its accuracy. These records must be maintained by the program director using the ACGME Case Log System;

II.A.4.q) advise resident applicants of the prerequisite requirements of the American Board of Plastic Surgery;

II.A.4.r) ensure that the program has a well-organized, comprehensive, and effective educational curriculum necessary to ensure that all residents obtain experience in all the various areas of the specialty;

II.A.4.s) document periodic review of the morbidity and mortality experiences of the service;

II.A.4.t) ensure that faculty and resident attendance at conferences is documented; and,

II.A.4.u) demonstrate that residents have generally equivalent and adequate distribution of categories and cases.

II.B. Faculty

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

The faculty must:

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

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

II.B.2. The physician faculty must have current certification in the specialty by the American Board of Plastic Surgery**, or possess qualifications acceptable to the Review Committee.**

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

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

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

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

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

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

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

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

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

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

II.B.5.d) The faculty should organize conferences to allow discussion of topics that will broaden knowledge in the wide field of plastic surgery and to evaluate current information.

II.C. Other Program Personnel

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

II.C.1. There must be institutional support for a program coordinator, as follows:

II.C.1.a) 0.5 full-time equivalent for programs with up to six residents; and,

II.C.1.b) 1.0 full-time equivalent for programs with more than six residents.

II.D. Resources

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

II.D.1. The sponsoring institutions and participating sites of the program must have an adequate number and variety of adult and pediatric surgical patients for resident education. Experience in all 12 categories of surgical experience is important and must not be limited by excessive clinical responsibility in any one or several categories or by excessive nonclinical activities.

II.E. Medical Information Access

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

III. Resident Appointments

III.A. Eligibility Criteria

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

III.A.1. The program director must have documentation on file of the satisfactory completion of prerequisite education before the candidate begins plastic surgery residency education.

III.B. Number of Residents

The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program's educational resources must be adequate to support the number of residents appointed to the program.

III.B.1. Programs may not enroll more residents at any level or in total than the number of residents approved by the Review Committee.

III.B.2. Any increase in resident complement, including a temporary increase, must be approved in advance by the Review Committee. This also includes a temporary increase in resident complement when a resident's education must be extended for remedial reasons.

III.B.3. Vacant positions in either program format must be filled at the same level as the vacancy. If the program director wishes to fill a vacancy with a resident at another level, this request for a temporary increase in resident complement also requires advance approval from the Review Committee.

III.C. Resident Transfers

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

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

III.C.3. Although residents may transfer from one program to another, they may not change from one format education to another, e.g., integrated to independent format or vice versa, without advance approval of the Review Committee.

III.D. Appointment of Fellows and Other Learners

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

residents' education. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.

III.D.1. The addition of fellows or other students requires a clear statement of the areas of education, clinical responsibilities, duration of the education, and the impact of these fellows/other students on the education of the plastic surgery residents.

IV. Educational Program

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

IV.A.1. Overall educational goals for the program, which the program must distribute to residents and faculty annually;

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation;

IV.A.3. Regularly scheduled didactic sessions;

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

IV.A.5. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum:

IV.A.5.a) Patient Care

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents:

IV.A.5.a).(1) should have specific clinical experience in the following areas:

IV.A.5.a).(1).(a) congenital defects of the head and neck, including clefts of the lip and palate, and craniofacial surgery;

IV.A.5.a).(1).(b) neoplasms of the head and neck surgery, including neoplasms of the head and neck, and the oropharynx;

IV.A.5.a).(1).(c) craniomaxillofacial trauma, including fractures;

IV.A.5.a).(1).(d) aesthetic (cosmetic) surgery of the head and neck, trunk, and extremities;

IV.A.5.a).(1).(e) plastic surgery of the breast;

IV.A.5.a).(1).(f) surgery of the hand/upper extremities;

IV.A.5.a).(1).(g) plastic surgery of the lower extremities;

IV.A.5.a).(1).(h) plastic surgery of the trunk and genitalia;

IV.A.5.a).(1).(i) burn reconstruction;

IV.A.5.a).(1).(j) microsurgical techniques applicable to plastic surgery;

IV.A.5.a).(1).(k) reconstruction by tissue transfer, including flaps and grafts; and,

IV.A.5.a).(1).(l) surgery of benign and malignant lesions of the skin and soft tissues.

IV.A.5.a).(2) are strongly suggested to have specific clinical experience in the following areas:

IV.A.5.a).(2).(a) acute burn management;

IV.A.5.a).(2).(b) anesthesia;

IV.A.5.a).(2).(c) oral & maxillofacial surgery;

IV.A.5.a).(2).(d) dermatology;

IV.A.5.a).(2).(e) oculoplastic surgery or ophthalmology;

IV.A.5.a).(2).(f) orthopedic surgery;

IV.A.5.a).(2).(f).(i) These additional strongly suggested clinical experiences may occur during training prior to plastic surgery, if verified and documented by the program director.

IV.A.5.a).(3) must have a well-organized and -supervised outpatient clinic experience operating in relation to an inpatient service used in the program. This experience must include:

IV.A.5.a).(3).(a) the opportunity to see patients, establish provisional diagnoses, and initiate preliminary plans prior to the patients' treatment;

IV.A.5.a).(3).(b) an opportunity for follow-up care so that the results of surgical care may be evaluated by the responsible residents; and,

IV.A.5.a).(3).(c) appropriate faculty supervision.

IV.A.5.a).(4) who participate in patient care in a private office setting must function with an appropriate degree of responsibility and adequate supervision, with program director oversight.

IV.A.5.b) Medical Knowledge

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

IV.A.5.b).(1) must have conferences that include the pertinent basic science subjects, such as anatomy, physiology, pathology, embryology, radiation biology, genetics, microbiology, pharmacology, as well as practice management, ethics, and medico-legal topics;

IV.A.5.b).(2) must participate and present educational material at conferences. Adequate time for preparation should be permitted, both to maximize the educational experience for the residents and to emphasize the importance of the experience; and,

IV.A.5.b).(3) must be exposed to surgical design, surgical diagnosis, embryology, surgical and artistic anatomy, surgical physiology and pharmacology, wound healing, surgical pathology and microbiology, adjunctive oncological therapy, biomechanics, rehabilitation, and surgical instrumentation are fundamental to the specialty. Residents must have sound judgment and technical capabilities to achieve satisfactory surgical results.

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

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:

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

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

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

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

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

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

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

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

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

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:

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

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

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

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

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

IV.A.5.e) Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:

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

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

interest;

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

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

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

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

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

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

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

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

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

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

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

IV.B. **Residents' Scholarly Activities**

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

IV.B.2. **Residents should participate in scholarly activity.**

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

V. Evaluation

V.A. Resident Evaluation

V.A.1. Formative Evaluation

V.A.1.a) The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.

V.A.1.b) The program must:

V.A.1.b).(1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;

V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);

V.A.1.b).(3) document progressive resident performance improvement appropriate to educational level; and,

V.A.1.b).(4) provide each resident with documented semiannual evaluation of performance with feedback.

V.A.1.c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.

V.A.1.d) A policy for a resident's annual advancement must be developed and implemented.

V.A.2. Summative Evaluation

The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. This evaluation must:

V.A.2.a) document the resident's performance during the final period of education, and

V.A.2.b) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.

V.B. Faculty Evaluation

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

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

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

V.C. **Program Evaluation and Improvement**

V.C.1. **The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:**

V.C.1.a) **resident performance;**

V.C.1.b) **faculty development;**

V.C.1.c) **graduate performance, including performance of program graduates on the certification examination; and,**

V.C.1.d) **program quality. Specifically:**

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

V.C.1.d).(2) **The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.**

V.C.2. **If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.**

VI. **Resident Duty Hours in the Learning and Working Environment**

VI.A. **Professionalism, Personal Responsibility, and Patient Safety**

VI.A.1. **Programs and sponsoring institutions must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.**

VI.A.2. **The program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational**

environment.

VI.A.3. **The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.**

VI.A.4. **The learning objectives of the program must:**

VI.A.4.a) **be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,**

VI.A.4.b) **not be compromised by excessive reliance on residents to fulfill non-physician service obligations.**

VI.A.5. **The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following:**

VI.A.5.a) **assurance of the safety and welfare of patients entrusted to their care;**

VI.A.5.b) **provision of patient- and family-centered care;**

VI.A.5.c) **assurance of their fitness for duty;**

VI.A.5.d) **management of their time before, during, and after clinical assignments;**

VI.A.5.e) **recognition of impairment, including illness and fatigue, in themselves and in their peers;**

VI.A.5.f) **attention to lifelong learning;**

VI.A.5.g) **the monitoring of their patient care performance improvement indicators; and,**

VI.A.5.h) **honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.**

VI.A.6. **All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient’s care to another qualified and rested provider.**

VI.B. **Transitions of Care**

VI.B.1. **Programs must design clinical assignments to minimize the number**

of transitions in patient care.

VI.B.2. **Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.**

VI.B.3. **Programs must ensure that residents are competent in communicating with team members in the hand-over process.**

VI.B.4. **The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.**

VI.C. **Alertness Management/Fatigue Mitigation**

VI.C.1. **The program must:**

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

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

VI.C.1.c) **adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.**

VI.C.2. **Each program must have a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties.**

VI.C.3. **The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home.**

VI.D. **Supervision of Residents**

VI.D.1. **In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.**

VI.D.1.a) **This information should be available to residents, faculty members, and patients.**

VI.D.1.b) **Residents and faculty members should inform patients of their respective roles in each patient's care.**

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

supervision is in place for all residents who care for patients.

Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care.

VI.D.3. **Levels of Supervision**

To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:

VI.D.3.a) **Direct Supervision – the supervising physician is physically present with the resident and patient.**

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

VI.D.3.b).(1) **with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.**

VI.D.3.b).(2) **with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.**

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

VI.D.4. **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.**

VI.D.4.a) **The program director must evaluate each resident's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.**

VI.D.4.b) **Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the**

needs of the patient and the skills of the residents.

VI.D.4.c) **Senior residents or fellows should serve in a supervisory role of 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.**

VI.D.5. **Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.**

VI.D.5.a) **Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.**

VI.D.5.a).(1) **In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.**

VI.D.6. **Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.**

VI.E. Clinical Responsibilities

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

VI.F. Teamwork

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

VI.F.1. Effective surgical practices entail the involvement of interdisciplinary team members with a mix of complementary skills.

VI.F.2. Residents must collaborate with fellow surgical residents, and especially with faculty members, other physicians outside of the specialty, and non-physician health care providers, to best formulate treatment plans for an increasingly diverse patient population.

VI.F.3. Residents must assume personal responsibility to complete all tasks to which they are assigned (or which they voluntarily assume) in a timely fashion. These tasks must be completed in the hours assigned, or, if that is not possible, residents must learn and utilize the established methods for handing off remaining tasks to another member of the resident team

so that patient care is not compromised.

VI.F.4. Lines of authority should be defined by programs, and all residents must have a working knowledge of these expected reporting relationships to maximize quality care and patient safety.

VI.G. Resident Duty Hours

VI.G.1. Maximum Hours of Work per Week

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.

VI.G.1.a) Duty Hour Exceptions

A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.

VI.G.1.a).(1) In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.

VI.G.1.a).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.

VI.G.2. Moonlighting

VI.G.2.a) Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

VI.G.2.b) Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.

VI.G.2.c) PGY-1 residents are not permitted to moonlight.

VI.G.3. Mandatory Time Free of Duty

Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

VI.G.4. Maximum Duty Period Length

VI.G.4.a) Duty periods of PGY-1 residents must not exceed 16 hours in duration.

VI.G.4.b) **Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.**

VI.G.4.b).(1) **It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.**

VI.G.4.b).(2) **Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.**

VI.G.4.b).(3) **In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.**

VI.G.4.b).(3).(a) **Under those circumstances, the resident must:**

VI.G.4.b).(3).(a).(i) **appropriately hand over the care of all other patients to the team responsible for their continuing care; and,**

VI.G.4.b).(3).(a).(ii) **document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.**

VI.G.4.b).(3).(b) **The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.**

VI.G.5. **Minimum Time Off between Scheduled Duty Periods**

VI.G.5.a) **PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.**

VI.G.5.b) **Intermediate-level residents should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24**

hours of in-house duty.

For independent programs, Y-1, -2, and -3 residents are considered to be in the final years of education.

For integrated programs, Y-2 and -3 residents are considered to be at the intermediate level.

VI.G.5.c) Residents in the final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

For independent programs, Y-1, -2, and -3 residents are considered to be in the final years of education.

For integrated programs, Y-4, -5 and -6 residents are considered to be in the final years of education.

VI.G.5.c).(1) This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

VI.G.5.c).(1).(a) Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director

VI.G.5.c).(1).(b) The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.

VI.G.6. Maximum Frequency of In-House Night Float

Residents must not be scheduled for more than six consecutive nights of night float.

VI.G.6.a) Residents must not have more than four consecutive weeks of night float assignment, and night float cannot exceed one month per year.

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

PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

VI.G.8. At-Home Call

VI.G.8.a) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour 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 duty, when averaged over four weeks.

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

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

VII. Innovative Projects

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

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