

1 **ACGME Program Requirements for Graduate Medical Education**
2 **in Plastic Surgery**

3
4 **Common Program Requirements are in BOLD**

5
6 Effective: July 1, 2009

7
8 **Introduction**

9
10 **Int.A. Residency is an essential dimension of the transformation of the medical**
11 **student to the independent practitioner along the continuum of medical**
12 **education. It is physically, emotionally, and intellectually demanding, and**
13 **requires longitudinally-concentrated effort on the part of the resident.**

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

32
33 **Int.B. Plastic surgery residency programs educate physicians in the resection, repair,**
34 **replacement, and reconstruction of defects of form and function of the**
35 **integument and its underlying anatomic systems, including the craniofacial**
36 **structures, the oropharynx, the trunk, the extremities, the breast, and the**
37 **perineum. This includes aesthetic (cosmetic) surgery of structures with**
38 **undesirable form. Special knowledge and skill in the design and transfer of flaps,**
39 **in the transplantation of tissues, and in the replantation of structures are vital to**
40 **these ends, as is skill in excisional surgery, in management of complex wounds,**
41 **and in the use of alloplastic materials. Plastic surgery residency education trains**
42 **physicians broadly in the art and science of plastic and reconstructive surgery.**
43 **These residency programs develop a competent and responsible plastic surgeon**
44 **with high moral and ethical character, capable of functioning as an independent**
45 **surgeon. A variety of educational plans will produce the desired result.**

46
47 **Int.C. The Review Committee for Plastic Surgery will accredit *independent* plastic**
48 **surgery programs of three years duration and *integrated* programs of six years**
49 **duration. All prerequisite residency education must be taken within programs**
50 **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.

- 51
52
53
54 Int.C.1. Independent format: residents complete three years of concentrated
55 plastic surgery education, with 12 months of chief responsibility, after
56 successful completion of one of the following prerequisite curricula:
57
- 58 | Int.C.1.a) ~~At least three years of clinical education with progressive~~
59 ~~responsibility in a single ACGME or RCPSC accredited surgery~~
60 ~~residency program. A transitional year or rotating internships may~~
61 ~~not be used to fulfill this requirement;~~
62
- 63 | Int.C.1.ba) An ACGME-accredited surgery, neurological surgery, orthopaedic
64 surgery, otolaryngology, or urology residency; or,
65
- 66 | Int.C.1.eb) An educational program in oral and maxillofacial surgery approved
67 by the American Dental Association (ADA) is an alternate pathway
68 for prerequisite education prior to a plastic surgery residency. This
69 pathway is available only to those individuals holding the DMD/MD
70 or DDS/MD degree. This education also must include a minimum
71 of 24 months of progressive responsibility on surgical rotations
72 under the direction of the general surgery program director after
73 receipt of the MD degree. Rotations in general surgery during
74 medical school, prior to receiving the MD degree, will not be
75 considered as fulfilling any part of the 24-month minimum
76 requirement.
77
- 78 Int.C.2. Integrated format: residents complete six years of ACGME-accredited
79 plastic surgery education following receipt of an MD or DO degree from
80 an institution accredited by the Liaison Committee on Medical Education
81 (LCME) or the American Osteopathic Association (AOA). Graduates of
82 schools of medicine from countries other than the United States or
83 Canada must present evidence of final certification by the Education
84 Commission for Foreign Medical Graduates (ECFMG).
85
- 86 Int.C.2.a) The integrated curriculum must contain six years of clinical
87 surgical education under the authority and direction of the plastic
88 surgery program director.
89
- 90 Int.C.2.b) Of these years, 36 months must be concentrated plastic surgery
91 education with no less than 12 months of chief responsibility on
92 the clinical service of plastic surgery. Residents must complete the
93 last 36 months of their education in the same plastic surgery
94 program. See section IV.A.5.a) for specific plastic surgery
95 requirements.
96
- 97 Int.C.2.c) Clinical experiences appropriate to plastic surgery education
98 should be provided in alimentary tract surgery, abdominal surgery,
99 breast surgery, emergency medicine, pediatric surgery, surgical
100 critical care, surgical oncology, transplant, trauma management,

101 and vascular surgery. See section IV.A.5.a) for specific plastic
102 surgery requirements.

103
104 Int.C.3. Prior to entry into the program, each resident must be notified in writing of
105 the required program length.

106
107 **I. Institutions**

108
109 **I.A. Sponsoring Institution**

110
111 **One sponsoring institution must assume ultimate responsibility for the**
112 **program, as described in the Institutional Requirements, and this**
113 **responsibility extends to resident assignments at all participating sites.**

114
115 **The sponsoring institution and the program must ensure that the program**
116 **director has sufficient protected time and financial support for his or her**
117 **educational and administrative responsibilities to the program.**

118
119 I.A.1. The sponsoring institution must:

120
121 I.A.1.a) demonstrate commitment to education in plastic surgery education
122 in their support of the residency program;

123
124 I.A.1.b) provide the program director with a minimum of 15% protected
125 time, which may take the form of direct or indirect salary support,
126 such as release from clinical activities provided by the institution
127 for programs with one to six residents. Programs with more than
128 six residents shall provide the program director with a minimum of
129 25% protected time;

130
131 I.A.1.c) support and provide evidence of faculty development for the
132 program director and the faculty in education and teaching.

133
134 **I.B. Participating Sites**

135
136 **I.B.1. There must be a program letter of agreement (PLA) between the**
137 **program and each participating site providing a required**
138 **assignment. The PLA must be renewed at least every five years.**

139
140 **The PLA should:**

141
142 **I.B.1.a) identify the faculty who will assume both educational and**
143 **supervisory responsibilities for residents;**

144
145 **I.B.1.b) specify their responsibilities for teaching, supervision, and**
146 **formal evaluation of residents, as specified later in this**
147 **document;**

148
149 **I.B.1.c) specify the duration and content of the educational**
150 **experience; and,**

151

- 152 **I.B.1.d)** state the policies and procedures that will govern resident
153 education during the assignment.
154
- 155 **I.B.2.** The program director must submit any additions or deletions of
156 participating sites routinely providing an educational experience,
157 required for all residents, of one month full time equivalent (FTE) or
158 more through the Accreditation Council for Graduate Medical
159 Education (ACGME) Accreditation Data System (ADS).
160
- 161 **I.B.3.** The addition or deletion of participating sites providing three or more
162 months of a resident's required clinical education must be prior-approved
163 by the Review Committee
164
- 165 **II. Program Personnel and Resources**
166
- 167 **II.A. Program Director**
168
- 169 **II.A.1.** There must be a single program director with authority and
170 accountability for the operation of the program. The sponsoring
171 institution's GMEC must approve a change in program director.
172 After approval, the program director must submit this change to the
173 ACGME via the ADS.
174
- 175 **II.A.2.** The program director should continue in his or her position for a
176 length of time adequate to maintain continuity of leadership and
177 program stability.
178
- 179 **II.A.3.** Qualifications of the program director must include:
180
- 181 **II.A.3.a)** requisite specialty expertise and documented educational
182 and administrative experience acceptable to the Review
183 Committee;
184
- 185 **II.A.3.b)** current certification in the specialty by the American Board of
186 Plastic Surgery, or specialty qualifications that are acceptable
187 to the Review Committee; and,
188
- 189 **II.A.3.c)** current medical licensure and appropriate medical staff
190 appointment.
191
- 192 **II.A.4.** The program director must administer and maintain an educational
193 environment conducive to educating the residents in each of the
194 ACGME competency areas. The program director must:
195
- 196 **II.A.4.a)** oversee and ensure the quality of didactic and clinical
197 education in all sites that participate in the program;
198
- 199 **II.A.4.b)** approve a local director at each participating site who is
200 accountable for resident education;
201
- 202 **II.A.4.c)** approve the selection of program faculty as appropriate;

203		
204	II.A.4.d)	evaluate program faculty and approve the continued participation of program faculty based on evaluation;
205		
206		
207	II.A.4.e)	monitor resident supervision at all participating sites;
208		
209	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;
210		
211		
212		
213		
214		
215	II.A.4.g)	provide each resident with documented semiannual evaluation of performance with feedback;
216		
217		
218	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;
219		
220		
221		
222	II.A.4.i)	provide verification of residency education for all residents, including those who leave the program prior to completion;
223		
224		
225	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:
226		
227		
228		
229		
230	II.A.4.j).(1)	distribute these policies and procedures to the residents and faculty;
231		
232		
233	II.A.4.j).(2)	monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;
234		
235		
236		
237	II.A.4.j).(3)	adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,
238		
239		
240	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.
241		
242		
243		
244	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;
245		
246		
247		
248	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;
249		
250		
251		
252		
253	II.A.4.m)	be familiar with and comply with ACGME and Review

254 **Committee policies and procedures as outlined in the ACGME**
255 **Manual of Policies and Procedures;**
256
257 **II.A.4.n) obtain review and approval of the sponsoring institution’s**
258 **GMEC/DIO before submitting to the ACGME information or**
259 **requests for the following:**
260
261 **II.A.4.n).(1) all applications for ACGME accreditation of new**
262 **programs;**
263
264 **II.A.4.n).(2) changes in resident complement;**
265
266 **II.A.4.n).(3) major changes in program structure or length of**
267 **training;**
268
269 **II.A.4.n).(4) progress reports requested by the Review Committee;**
270
271 **II.A.4.n).(5) responses to all proposed adverse actions;**
272
273 **II.A.4.n).(6) requests for increases or any change to resident duty**
274 **hours;**
275
276 **II.A.4.n).(7) voluntary withdrawals of ACGME-accredited**
277 **programs;**
278
279 **II.A.4.n).(8) requests for appeal of an adverse action;**
280
281 **II.A.4.n).(9) appeal presentations to a Board of Appeal or the**
282 **ACGME; and,**
283
284 **II.A.4.n).(10) proposals to ACGME for approval of innovative**
285 **educational approaches.**
286
287 **II.A.4.o) obtain DIO review and co-signature on all program**
288 **information forms, as well as any correspondence or**
289 **document submitted to the ACGME that addresses:**
290
291 **II.A.4.o).(1) program citations, and/or**
292
293 **II.A.4.o).(2) request for changes in the program that would have**
294 **significant impact, including financial, on the program**
295 **or institution.**
296
297 **II.A.4.p) compile annually a comprehensive record of the number and type**
298 **of operative procedures performed by each resident completing**
299 **the program. This record must include all of the procedures in**
300 **which the plastic surgery resident was either surgeon or assistant**
301 **during the plastic surgery program. The operative log must be**
302 **provided as requested in the format and form specified by the**
303 **Review Committee and it must be signed by both the resident and**
304 **the program director as a statement of its accuracy. These**

- 305 records must be maintained by the program director using the
 306 ACGME Case Log System;
 307
 308 II.A.4.q) advise resident applicants of the prerequisite requirements of the
 309 American Board of Plastic Surgery;
 310
 311 II.A.4.r) ensure that the program has a well-organized, comprehensive,
 312 and effective educational curriculum necessary to ensure that all
 313 residents obtain experience in all the various areas of the
 314 specialty;
 315
 316 II.A.4.s) document periodic review of the morbidity and mortality
 317 experiences of the service;
 318
 319 II.A.4.t) ensure that faculty and resident attendance at conferences is
 320 documented; and,
 321
 322 II.A.4.u) demonstrate that residents have generally equivalent and
 323 adequate distribution of categories and cases.
 324

325 **II.B. Faculty**

326
 327 **II.B.1. At each participating site, there must be a sufficient number of**
 328 **faculty with documented qualifications to instruct and supervise all**
 329 **residents at that location.**

330
 331 **The faculty must:**

332
 333 **II.B.1.a) devote sufficient time to the educational program to fulfill**
 334 **their supervisory and teaching responsibilities; and to**
 335 **demonstrate a strong interest in the education of residents,**
 336 **and**

337
 338 **II.B.1.b) administer and maintain an educational environment**
 339 **conducive to educating residents in each of the ACGME**
 340 **competency areas.**

341
 342 **II.B.2. The physician faculty must have current certification in the specialty**
 343 **by the American Board of Plastic Surgery, or possess qualifications**
 344 **acceptable to the Review Committee.**

345
 346 **II.B.3. The physician faculty must possess current medical licensure and**
 347 **appropriate medical staff appointment.**

348
 349 **II.B.4. The nonphysician faculty must have appropriate qualifications in**
 350 **their field and hold appropriate institutional appointments.**

351
 352 **II.B.5. The faculty must establish and maintain an environment of inquiry**
 353 **and scholarship with an active research component.**

354
 355 **II.B.5.a) The faculty must regularly participate in organized clinical**

- 356 discussions, rounds, journal clubs, and conferences.
357
- 358 **II.B.5.b) Some members of the faculty should also demonstrate**
359 **scholarship by one or more of the following:**
360
- 361 **II.B.5.b).(1) peer-reviewed funding;**
362
- 363 **II.B.5.b).(2) publication of original research or review articles in**
364 **peer-reviewed journals, or chapters in textbooks;**
365
- 366 **II.B.5.b).(3) publication or presentation of case reports or clinical**
367 **series at local, regional, or national professional and**
368 **scientific society meetings; or,**
369
- 370 **II.B.5.b).(4) participation in national committees or educational**
371 **organizations.**
372
- 373 **II.B.5.c) Faculty should encourage and support residents in scholarly**
374 **activities.**
375
- 376 **II.B.5.d) The faculty should organize conferences to allow discussion of**
377 **topics that will broaden knowledge in the wide field of plastic**
378 **surgery and to evaluate current information.**
379
- 380 **II.C. Other Program Personnel**
381
- 382 **The institution and the program must jointly ensure the availability of all**
383 **necessary professional, technical, and clerical personnel for the effective**
384 **administration of the program.**
385
- 386 **II.C.1. There must be institutional support for a program coordinator, as follows:**
387
- 388 **II.C.1.a) 0.5 full-time equivalent for programs with up to six residents; and,**
389
- 390 **II.C.1.b) 1.0 full-time equivalent for programs with more than six residents.**
391
- 392 **II.D. Resources**
393
- 394 **The institution and the program must jointly ensure the availability of**
395 **adequate resources for resident education, as defined in the specialty**
396 **program requirements.**
397
- 398 **II.D.1. The sponsoring institutions and participating sites of the program must**
399 **have an adequate number and variety of adult and pediatric surgical**
400 **patients for resident education. Experience in all 12 categories of surgical**
401 **experience is important and must not be limited by excessive clinical**
402 **responsibility in any one or several categories or by excessive nonclinical**
403 **activities.**
404
- 405 **II.E. Medical Information Access**
406

407 Residents must have ready access to specialty-specific and other
408 appropriate reference material in print or electronic format. Electronic
409 medical literature databases with search capabilities should be available.
410

411 **III. Resident Appointments**

412
413 **III.A. Eligibility Criteria**

414
415 **The program director must comply with the criteria for resident eligibility**
416 **as specified in the Institutional Requirements.**
417

418 III.A.1. The program director must have documentation on file of the satisfactory
419 completion of prerequisite education before the candidate begins plastic
420 surgery residency education.
421

422 **III.B. Number of Residents**

423
424 **The program director may not appoint more residents than approved by the**
425 **Review Committee, unless otherwise stated in the specialty-specific**
426 **requirements. The program's educational resources must be adequate to**
427 **support the number of residents appointed to the program.**
428

429 III.B.1. Programs may not enroll more residents at any level or in total than the
430 number of residents approved by the Review Committee.
431

432 III.B.2. Any increase in resident complement, including a temporary increase,
433 must be approved in advance by the Review Committee. This also
434 includes a temporary increase in resident complement when a resident's
435 education must be extended for remedial reasons.
436

437 III.B.3. Vacant positions in either program format must be filled at the same level
438 as the vacancy. If the program director wishes to fill a vacancy with a
439 resident at another level, this request for a temporary increase in resident
440 complement also requires advance approval from the Review Committee.
441

442 **III.C. Resident Transfers**

443
444 **III.C.1. Before accepting a resident who is transferring from another**
445 **program, the program director must obtain written or electronic**
446 **verification of previous educational experiences and a summative**
447 **competency-based performance evaluation of the transferring**
448 **resident.**
449

450 **III.C.2. A program director must provide timely verification of residency**
451 **education and summative performance evaluations for residents**
452 **who leave the program prior to completion.**
453

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

458
459 **III.D. Appointment of Fellows and Other Learners**
460
461 **The presence of other learners (including, but not limited to, residents from**
462 **other specialties, subspecialty fellows, PhD students, and nurse**
463 **practitioners) in the program must not interfere with the appointed**
464 **residents' education. The program director must report the presence of**
465 **other learners to the DIO and GMEC in accordance with sponsoring**
466 **institution guidelines.**
467
468 III.D.1. The addition of fellows or other students requires a clear statement of the
469 areas of education, clinical responsibilities, duration of the education, and
470 the impact of these fellows/other students on the education of the plastic
471 surgery residents.
472
473 **IV. Educational Program**
474
475 **IV.A. The curriculum must contain the following educational components:**
476
477 **IV.A.1. Overall educational goals for the program, which the program must**
478 **distribute to residents and faculty annually;**
479
480 **IV.A.2. Competency-based goals and objectives for each assignment at**
481 **each educational level, which the program must distribute to**
482 **residents and faculty annually, in either written or electronic form.**
483 **These should be reviewed by the resident at the start of each**
484 **rotation;**
485
486 **IV.A.3. Regularly scheduled didactic sessions;**
487
488 **IV.A.4. Delineation of resident responsibilities for patient care, progressive**
489 **responsibility for patient management, and supervision of residents**
490 **over the continuum of the program; and,**
491
492 **IV.A.5. ACGME Competencies**
493
494 **The program must integrate the following ACGME competencies**
495 **into the curriculum:**
496
497 **IV.A.5.a) Patient Care**
498
499 **Residents must be able to provide patient care that is**
500 **compassionate, appropriate, and effective for the treatment of**
501 **health problems and the promotion of health. Residents:**
502
503 IV.A.5.a).(1) should have specific clinical experience in the following
504 areas:
505
506 IV.A.5.a).(1).(a) congenital defects of the head and neck, including
507 clefts of the lip and palate, and craniofacial surgery;
508

509	IV.A.5.a).(1).(b)	neoplasms of the head and neck surgery, including
510		neoplasms of the head and neck, and the
511		oropharynx;
512		
513	IV.A.5.a).(1).(c)	craniomaxillofacial trauma, including fractures;
514		
515	IV.A.5.a).(1).(d)	aesthetic (cosmetic) surgery of the head and neck,
516		trunk, and extremities;
517		
518	IV.A.5.a).(1).(e)	plastic surgery of the breast;
519		
520	IV.A.5.a).(1).(f)	surgery of the hand/upper extremities;
521		
522	IV.A.5.a).(1).(g)	plastic surgery of the lower extremities;
523		
524	IV.A.5.a).(1).(h)	plastic surgery of the trunk and genitalia;
525		
526	IV.A.5.a).(1).(i)	burn reconstruction;
527		
528	IV.A.5.a).(1).(j)	microsurgical techniques applicable to plastic
529		surgery;
530		
531	IV.A.5.a).(1).(k)	reconstruction by tissue transfer, including flaps
532		and grafts; and,
533		
534	IV.A.5.a).(1).(l)	surgery of benign and malignant lesions of the skin
535		and soft tissues.
536		
537	IV.A.5.a).(2)	are strongly suggested to have specific clinical experience
538		in the following areas:
539		
540	IV.A.5.a).(2).(a)	acute burn management;
541		
542	IV.A.5.a).(2).(b)	anesthesia;
543		
544	IV.A.5.a).(2).(c)	oral & maxillofacial surgery;
545		
546	IV.A.5.a).(2).(d)	dermatology;
547		
548	IV.A.5.a).(2).(e)	oculoplastic surgery or ophthalmology;
549		
550	IV.A.5.a).(2).(f)	orthopedic surgery;
551		
552	IV.A.5.a).(2).(f).(i)	These additional strongly suggested clinical
553		experiences may occur during training prior
554		to plastic surgery, if verified and
555		documented by the program director.
556		
557	IV.A.5.a).(3)	must have a well-organized and -supervised outpatient
558		clinic experience operating in relation to an inpatient
559		service used in the program. This experience must include:

- 560
561 IV.A.5.a).(3).(a) the opportunity to see patients, establish
562 provisional diagnoses, and initiate preliminary plans
563 prior to the patients' treatment;
564
565 IV.A.5.a).(3).(b) an opportunity for follow-up care so that the results
566 of surgical care may be evaluated by the
567 responsible residents; and,
568
569 IV.A.5.a).(3).(c) appropriate faculty supervision.
570
571 IV.A.5.a).(4) who participate in patient care in a private office setting
572 must function with an appropriate degree of responsibility
573 and adequate supervision, with program director oversight.
574

575 **IV.A.5.b)**

Medical Knowledge

576
577 **Residents must demonstrate knowledge of established and**
578 **evolving biomedical, clinical, epidemiological and social-**
579 **behavioral sciences, as well as the application of this**
580 **knowledge to patient care. Residents:**

- 581
582 IV.A.5.b).(1) must have conferences that include the pertinent basic
583 science subjects, such as anatomy, physiology, pathology,
584 embryology, radiation biology, genetics, microbiology,
585 pharmacology, as well as practice management, ethics,
586 and medico-legal topics;
587
588 IV.A.5.b).(2) must participate and present educational material at
589 conferences. Adequate time for preparation should be
590 permitted, both to maximize the educational experience for
591 the residents and to emphasize the importance of the
592 experience; and,
593
594 IV.A.5.b).(3) must be exposed to surgical design, surgical diagnosis,
595 embryology, surgical and artistic anatomy, surgical
596 physiology and pharmacology, wound healing, surgical
597 pathology and microbiology, adjunctive oncological
598 therapy, biomechanics, rehabilitation, and surgical
599 instrumentation are fundamental to the specialty.
600 Residents must have sound judgment and technical
601 capabilities to achieve satisfactory surgical results.
602

603 **IV.A.5.c)**

Practice-based Learning and Improvement

604
605 **Residents must demonstrate the ability to investigate and**
606 **evaluate their care of patients, to appraise and assimilate**
607 **scientific evidence, and to continuously improve patient care**
608 **based on constant self-evaluation and life-long learning.**
609 **Residents are expected to develop skills and habits to be able**
610 **to meet the following goals:**

611		
612	IV.A.5.c).(1)	identify strengths, deficiencies, and limits in one’s knowledge and expertise;
613		
614		
615	IV.A.5.c).(2)	set learning and improvement goals;
616		
617	IV.A.5.c).(3)	identify and perform appropriate learning activities;
618		
619	IV.A.5.c).(4)	systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
620		
621		
622		
623	IV.A.5.c).(5)	incorporate formative evaluation feedback into daily practice;
624		
625		
626	IV.A.5.c).(6)	locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems;
627		
628		
629		
630	IV.A.5.c).(7)	use information technology to optimize learning; and,
631		
632	IV.A.5.c).(8)	participate in the education of patients, families, students, residents and other health professionals.
633		
634		
635	IV.A.5.d)	Interpersonal and Communication Skills
636		
637		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:
638		
639		
640		
641		
642	IV.A.5.d).(1)	communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
643		
644		
645		
646	IV.A.5.d).(2)	communicate effectively with physicians, other health professionals, and health related agencies;
647		
648		
649	IV.A.5.d).(3)	work effectively as a member or leader of a health care team or other professional group;
650		
651		
652	IV.A.5.d).(4)	act in a consultative role to other physicians and health professionals; and,
653		
654		
655	IV.A.5.d).(5)	maintain comprehensive, timely, and legible medical records, if applicable.
656		
657		
658	IV.A.5.e)	Professionalism
659		
660		Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical
661		

662		principles. Residents are expected to demonstrate:
663		
664	IV.A.5.e).(1)	compassion, integrity, and respect for others;
665		
666	IV.A.5.e).(2)	responsiveness to patient needs that supersedes self-
667		interest;
668		
669	IV.A.5.e).(3)	respect for patient privacy and autonomy;
670		
671	IV.A.5.e).(4)	accountability to patients, society and the profession;
672		and,
673		
674	IV.A.5.e).(5)	sensitivity and responsiveness to a diverse patient
675		population, including but not limited to diversity in
676		gender, age, culture, race, religion, disabilities, and
677		sexual orientation.
678		
679	IV.A.5.f)	Systems-based Practice
680		
681		Residents must demonstrate an awareness of and
682		responsiveness to the larger context and system of health
683		care, as well as the ability to call effectively on other
684		resources in the system to provide optimal health care.
685		Residents are expected to:
686		
687	IV.A.5.f).(1)	work effectively in various health care delivery
688		settings and systems relevant to their clinical
689		specialty;
690		
691	IV.A.5.f).(2)	coordinate patient care within the health care system
692		relevant to their clinical specialty;
693		
694	IV.A.5.f).(3)	incorporate considerations of cost awareness and
695		risk-benefit analysis in patient and/or population-
696		based care as appropriate;
697		
698	IV.A.5.f).(4)	advocate for quality patient care and optimal patient
699		care systems;
700		
701	IV.A.5.f).(5)	work in interprofessional teams to enhance patient
702		safety and improve patient care quality; and,
703		
704	IV.A.5.f).(6)	participate in identifying system errors and
705		implementing potential systems solutions.
706		
707	IV.B.	Residents' Scholarly Activities
708		
709	IV.B.1.	The curriculum must advance residents' knowledge of the basic
710		principles of research, including how research is conducted,
711		evaluated, explained to patients, and applied to patient care.
712		

713	IV.B.2.	Residents should participate in scholarly activity.
714		
715	IV.B.3.	The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.
716		
717		
718		
719	V. Evaluation	
720		
721	V.A. Resident Evaluation	
722		
723	V.A.1. Formative Evaluation	
724		
725	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.
726		
727		
728		
729		
730	V.A.1.b)	The program must:
731		
732	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;
733		
734		
735		
736		
737		
738	V.A.1.b).(2)	use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);
739		
740		
741	V.A.1.b).(3)	document progressive resident performance improvement appropriate to educational level; and,
742		
743		
744	V.A.1.b).(4)	provide each resident with documented semiannual evaluation of performance with feedback.
745		
746		
747	V.A.1.c)	The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.
748		
749		
750		
751	V.A.1.d)	A policy for a resident's annual advancement must be developed and implemented.
752		
753		
754	V.A.2. Summative Evaluation	
755		
756		
757		
758		
759		
760		
761		
762	V.A.2.a)	document the resident's performance during the final period of education, and
763		

764		
765	V.A.2.b)	verify that the resident has demonstrated sufficient
766		competence to enter practice without direct supervision.
767		
768	V.B.	Faculty Evaluation
769		
770	V.B.1.	At least annually, the program must evaluate faculty performance as
771		it relates to the educational program.
772		
773	V.B.2.	These evaluations should include a review of the faculty’s clinical
774		teaching abilities, commitment to the educational program, clinical
775		knowledge, professionalism, and scholarly activities.
776		
777	V.B.3.	This evaluation must include at least annual written confidential
778		evaluations by the residents.
779		
780	V.C.	Program Evaluation and Improvement
781		
782	V.C.1.	The program must document formal, systematic evaluation of the
783		curriculum at least annually. The program must monitor and track
784		each of the following areas:
785		
786	V.C.1.a)	resident performance;
787		
788	V.C.1.b)	faculty development;
789		
790	V.C.1.c)	graduate performance, including performance of program
791		graduates on the certification examination; and,
792		
793	V.C.1.d)	program quality. Specifically:
794		
795	V.C.1.d).(1)	Residents and faculty must have the opportunity to
796		evaluate the program confidentially and in writing at
797		least annually, and
798		
799	V.C.1.d).(2)	The program must use the results of residents’
800		assessments of the program together with other
801		program evaluation results to improve the program.
802		
803	V.C.2.	If deficiencies are found, the program should prepare a written plan
804		of action to document initiatives to improve performance in the
805		areas listed in section V.C.1. The action plan should be reviewed
806		and approved by the teaching faculty and documented in meeting
807		minutes.
808		
809	VI.	Resident Duty Hours in the Learning and Working Environment
810		
811	VI.A.	Professionalism, Personal Responsibility, and Patient Safety
812		
813	VI.A.1.	Programs and sponsoring institutions must educate residents and
814		faculty members concerning the professional responsibilities of

815 physicians to appear for duty appropriately rested and fit to provide
816 the services required by their patients.
817

818 **VI.A.2.** The program must be committed to and responsible for promoting
819 patient safety and resident well-being in a supportive educational
820 environment.
821

822 **VI.A.3.** The program director must ensure that residents are integrated and
823 actively participate in interdisciplinary clinical quality improvement
824 and patient safety programs.
825

826 **VI.A.4.** The learning objectives of the program must:
827

828 **VI.A.4.a)** be accomplished through an appropriate blend of supervised
829 patient care responsibilities, clinical teaching, and didactic
830 educational events; and,
831

832 **VI.A.4.b)** not be compromised by excessive reliance on residents to
833 fulfill non-physician service obligations.
834

835 **VI.A.5.** The program director and institution must ensure a culture of
836 professionalism that supports patient safety and personal
837 responsibility. Residents and faculty members must demonstrate an
838 understanding and acceptance of their personal role in the
839 following:
840

841 **VI.A.5.a)** assurance of the safety and welfare of patients entrusted to
842 their care;
843

844 **VI.A.5.b)** provision of patient- and family-centered care;
845

846 **VI.A.5.c)** assurance of their fitness for duty;
847

848 **VI.A.5.d)** management of their time before, during, and after clinical
849 assignments;
850

851 **VI.A.5.e)** recognition of impairment, including illness and fatigue, in
852 themselves and in their peers;
853

854 **VI.A.5.f)** attention to lifelong learning;
855

856 **VI.A.5.g)** the monitoring of their patient care performance improvement
857 indicators; and,
858

859 **VI.A.5.h)** honest and accurate reporting of duty hours, patient
860 outcomes, and clinical experience data.
861

862 **VI.A.6.** All residents and faculty members must demonstrate
863 responsiveness to patient needs that supersedes self-interest.
864 Physicians must recognize that under certain circumstances, the
865 best interests of the patient may be served by transitioning that

- 866 patient's care to another qualified and rested provider.
867
- 868 **VI.B. Transitions of Care**
869
- 870 **VI.B.1. Programs must design clinical assignments to minimize the number**
871 **of transitions in patient care.**
872
- 873 **VI.B.2. Sponsoring institutions and programs must ensure and monitor**
874 **effective, structured hand-over processes to facilitate both**
875 **continuity of care and patient safety.**
876
- 877 **VI.B.3. Programs must ensure that residents are competent in**
878 **communicating with team members in the hand-over process.**
879
- 880 **VI.B.4. The sponsoring institution must ensure the availability of schedules**
881 **that inform all members of the health care team of attending**
882 **physicians and residents currently responsible for each patient's**
883 **care.**
884
- 885 **VI.C. Alertness Management/Fatigue Mitigation**
886
- 887 **VI.C.1. The program must:**
888
- 889 **VI.C.1.a) educate all faculty members and residents to recognize the**
890 **signs of fatigue and sleep deprivation;**
891
- 892 **VI.C.1.b) educate all faculty members and residents in alertness**
893 **management and fatigue mitigation processes; and,**
894
- 895 **VI.C.1.c) adopt fatigue mitigation processes to manage the potential**
896 **negative effects of fatigue on patient care and learning, such**
897 **as naps or back-up call schedules.**
898
- 899 **VI.C.2. Each program must have a process to ensure continuity of patient**
900 **care in the event that a resident may be unable to perform his/her**
901 **patient care duties.**
902
- 903 **VI.C.3. The sponsoring institution must provide adequate sleep facilities**
904 **and/or safe transportation options for residents who may be too**
905 **fatigued to safely return home.**
906
- 907 **VI.D. Supervision of Residents**
908
- 909 **VI.D.1. In the clinical learning environment, each patient must have an**
910 **identifiable, appropriately-credentialed and privileged attending**
911 **physician (or licensed independent practitioner as approved by each**
912 **Review Committee) who is ultimately responsible for that patient's**
913 **care.**
914
- 915 **VI.D.1.a) This information should be available to residents, faculty**
916 **members, and patients.**

- 917
918 **VI.D.1.b)** Residents and faculty members should inform patients of
919 their respective roles in each patient’s care.
920
- 921 **VI.D.2.** The program must demonstrate that the appropriate level of
922 supervision is in place for all residents who care for patients.
923
924 Supervision may be exercised through a variety of methods. Some
925 activities require the physical presence of the supervising faculty
926 member. For many aspects of patient care, the supervising
927 physician may be a more advanced resident or fellow. Other
928 portions of care provided by the resident can be adequately
929 supervised by the immediate availability of the supervising faculty
930 member or resident physician, either in the institution, or by means
931 of telephonic and/or electronic modalities. In some circumstances,
932 supervision may include post-hoc review of resident-delivered care
933 with feedback as to the appropriateness of that care.
934
- 935 **VI.D.3.** Levels of Supervision
936
937 To ensure oversight of resident supervision and graded authority
938 and responsibility, the program must use the following classification
939 of supervision:
940
- 941 **VI.D.3.a)** Direct Supervision – the supervising physician is physically
942 present with the resident and patient.
943
- 944 **VI.D.3.b)** Indirect Supervision:
945
- 946 **VI.D.3.b).(1)** with direct supervision immediately available – the
947 supervising physician is physically within the hospital
948 or other site of patient care, and is immediately
949 available to provide Direct Supervision.
950
- 951 **VI.D.3.b).(2)** with direct supervision available – the supervising
952 physician is not physically present within the hospital
953 or other site of patient care, but is immediately
954 available by means of telephonic and/or electronic
955 modalities, and is available to provide Direct
956 Supervision.
957
- 958 **VI.D.3.c)** Oversight – the supervising physician is available to provide
959 review of procedures/encounters with feedback provided
960 after care is delivered.
961
- 962 **VI.D.4.** The privilege of progressive authority and responsibility, conditional
963 independence, and a supervisory role in patient care delegated to
964 each resident must be assigned by the program director and faculty
965 members.
966
- 967 **VI.D.4.a)** The program director must evaluate each resident’s abilities

968		based on specific criteria. When available, evaluation should
969		be guided by specific national standards-based criteria.
970		
971	VI.D.4.b)	Faculty members functioning as supervising physicians
972		should delegate portions of care to residents, based on the
973		needs of the patient and the skills of the residents.
974		
975	VI.D.4.c)	Senior residents or fellows should serve in a supervisory role
976		of junior residents in recognition of their progress toward
977		independence, based on the needs of each patient and the
978		skills of the individual resident or fellow.
979		
980	VI.D.5.	Programs must set guidelines for circumstances and events in
981		which residents must communicate with appropriate supervising
982		faculty members, such as the transfer of a patient to an intensive
983		care unit, or end-of-life decisions.
984		
985	VI.D.5.a)	Each resident must know the limits of his/her scope of
986		authority, and the circumstances under which he/she is
987		permitted to act with conditional independence.
988		
989	VI.D.5.a).(1)	In particular, PGY-1 residents should be supervised
990		either directly or indirectly with direct supervision
991		immediately available.
992		
993	VI.D.6.	Faculty supervision assignments should be of sufficient duration to
994		assess the knowledge and skills of each resident and delegate to
995		him/her the appropriate level of patient care authority and
996		responsibility.
997		
998	VI.E.	Clinical Responsibilities
999		
1000		The clinical responsibilities for each resident must be based on PGY-level,
1001		patient safety, resident education, severity and complexity of patient
1002		illness/condition and available support services.
1003		
1004	VI.F.	Teamwork
1005		
1006		Residents must care for patients in an environment that maximizes
1007		effective communication. This must include the opportunity to work as a
1008		member of effective interprofessional teams that are appropriate to the
1009		delivery of care in the specialty.
1010		
1011	VI.G.	Resident Duty Hours
1012		
1013	VI.G.1.	Maximum Hours of Work per Week
1014		
1015		Duty hours must be limited to 80 hours per week, averaged over a
1016		four-week period, inclusive of all in-house call activities and all
1017		moonlighting.
1018		

1019	VI.G.1.a)	Duty Hour Exceptions
1020		
1021		A Review Committee may grant exceptions for up to 10% or a
1022		maximum of 88 hours to individual programs based on a
1023		sound educational rationale.
1024		
1025	VI.G.1.a).(1)	In preparing a request for an exception the program
1026		director must follow the duty hour exception policy
1027		from the ACGME Manual on Policies and Procedures.
1028		
1029	VI.G.1.a).(2)	Prior to submitting the request to the Review
1030		Committee, the program director must obtain approval
1031		of the institution's GMEC and DIO.
1032		
1033	VI.G.2.	Moonlighting
1034		
1035	VI.G.2.a)	Moonlighting must not interfere with the ability of the resident
1036		to achieve the goals and objectives of the educational
1037		program.
1038		
1039	VI.G.2.b)	Time spent by residents in Internal and External Moonlighting
1040		(as defined in the ACGME Glossary of Terms) must be
1041		counted towards the 80-hour Maximum Weekly Hour Limit.
1042		
1043	VI.G.2.c)	PGY-1 residents are not permitted to moonlight.
1044		
1045	VI.G.3.	Mandatory Time Free of Duty
1046		
1047		Residents must be scheduled for a minimum of one day free of duty
1048		every week (when averaged over four weeks). At-home call cannot
1049		be assigned on these free days.
1050		
1051	VI.G.4.	Maximum Duty Period Length
1052		
1053	VI.G.4.a)	Duty periods of PGY-1 residents must not exceed 16 hours in
1054		duration.
1055		
1056	VI.G.4.b)	Duty periods of PGY-2 residents and above may be
1057		scheduled to a maximum of 24 hours of continuous duty in
1058		the hospital. Programs must encourage residents to use
1059		alertness management strategies in the context of patient
1060		care responsibilities. Strategic napping, especially after 16
1061		hours of continuous duty and between the hours of 10:00
1062		p.m. and 8:00 a.m., is strongly suggested.
1063		
1064	VI.G.4.b).(1)	It is essential for patient safety and resident education
1065		that effective transitions in care occur. Residents may
1066		be allowed to remain on-site in order to accomplish
1067		these tasks; however, this period of time must be no
1068		longer than an additional four hours.
1069		

1070	VI.G.4.b).(2)	Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
1071		
1072		
1073		
1074	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.
1075		
1076		
1077		
1078		
1079		
1080		
1081		
1082		
1083	VI.G.4.b).(3).(a)	Under those circumstances, the resident must:
1084		
1085	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,
1086		
1087		
1088		
1089	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.
1090		
1091		
1092		
1093		
1094	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.
1095		
1096		
1097		
1098		
1099	VI.G.5.	Minimum Time Off between Scheduled Duty Periods
1100		
1101	VI.G.5.a)	PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.
1102		
1103		
1104	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.
1105		
1106		
1107		
1108		
1109		For independent programs, Y-1, -2, and -3 residents are considered to be in the final years of education.
1110		
1111		
1112		For integrated programs, Y-2 and -3 residents are considered to be at the intermediate level.
1113		
1114		
1115	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.
1116		
1117		
1118		
1119		For independent programs, Y-1, -2, and -3 residents are considered to be in the final years of education.
1120		

1121		
1122		For integrated programs, Y-4, -5 and -6 residents are considered
1123		to be in the final years of education.
1124		
1125	VI.G.5.c).(1)	This preparation must occur within the context of the
1126		80-hour, maximum duty period length, and one-day-
1127		off-in-seven standards. While it is desirable that
1128		residents in their final years of education have eight
1129		hours free of duty between scheduled duty periods,
1130		there may be circumstances when these residents
1131		must stay on duty to care for their patients or return to
1132		the hospital with fewer than eight hours free of duty.
1133		
1134	VI.G.5.c).(1).(a)	Circumstances of return-to-hospital activities
1135		with fewer than eight hours away from the
1136		hospital by residents in their final years of
1137		education must be monitored by the program
1138		director
1139		
1140	VI.G.5.c).(1).(b)	The Review Committee defines such
1141		circumstances as: required continuity of care for a
1142		severely ill or unstable patient, or a complex patient
1143		with whom the resident has been involved; events
1144		of exceptional educational value; or, humanistic
1145		attention to the needs of a patient or family.
1146		
1147	VI.G.6.	Maximum Frequency of In-House Night Float
1148		
1149		Residents must not be scheduled for more than six consecutive
1150		nights of night float.
1151		
1152	VI.G.6.a)	Residents must not have more than four consecutive weeks of
1153		night float assignment, and night float cannot exceed one month
1154		per year.
1155		
1156	VI.G.7.	Maximum In-House On-Call Frequency
1157		
1158		PGY-2 residents and above must be scheduled for in-house call no
1159		more frequently than every-third-night (when averaged over a four-
1160		week period).
1161		
1162	VI.G.8.	At-Home Call
1163		
1164	VI.G.8.a)	Time spent in the hospital by residents on at-home call must
1165		count towards the 80-hour maximum weekly hour limit. The
1166		frequency of at-home call is not subject to the every-third-
1167		night limitation, but must satisfy the requirement for one-day-
1168		in-seven free of duty, when averaged over four weeks.
1169		
1170	VI.G.8.a).(1)	At-home call must not be so frequent or taxing as to
1171		preclude rest or reasonable personal time for each

1172 resident.

1173

1174 **VI.G.8.b)** Residents are permitted to return to the hospital while on at-
1175 home call to care for new or established patients. Each
1176 episode of this type of care, while it must be included in the
1177 80-hour weekly maximum, will not initiate a new “off-duty
1178 period”.

1179

1180 **VII. Innovative Projects**

1181

1182 Requests for innovative projects that may deviate from the institutional, common
1183 and/or specialty specific program requirements must be approved in advance by
1184 the Review Committee. In preparing requests, the program director must follow
1185 Procedures for Approving Proposals for Innovative Projects located in the
1186 ACGME Manual on Policies and Procedures. Once a Review Committee approves
1187 a project, the sponsoring institution and program are jointly responsible for the
1188 quality of education offered to residents for the duration of such a project.

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1192 ACGME-approved: June 10, 2008; Effective: July 1, 2009

1193 Revised Common Program Requirements Effective: July 1, 2011

1194 ACGME-approved Focused Revision: October 1, 2011; Effective: July 1, 2012