

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

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

5
6 Effective: January 1, 2008

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. Definition and Scope of the Specialty**

34
35 **The goal of a surgical residency program is to prepare the resident to function as**
36 **a qualified practitioner of surgery at the advanced level of performance expected**
37 **of a board-certified specialist. The education of surgeons in the practice of**
38 **general surgery encompasses both didactic instruction in the basic and clinical**
39 **sciences of surgical diseases and conditions, as well as education in procedural**
40 **skills and operative techniques. The educational process must lead to the**
41 **acquisition of an appropriate fund of knowledge and technical skills, the ability to**
42 **integrate the acquired knowledge into the clinical situation, and the development**
43 **of surgical judgment.**

44
45 **Int.C. Duration and Scope of Education**

46
47 **The length of a surgery residency program is five clinical years. Each resident**
48 **must be notified in writing of the length of the program prior to admission.**
49 **Programs must comply with the resident eligibility and admission prerequisites as**
50 **outlined in the Institutional Requirements.**
51

- 52 **I. Institutions**
- 53
- 54 **I.A. Sponsoring Institution**
- 55
- 56 **One sponsoring institution must assume ultimate responsibility for the**
- 57 **program, as described in the Institutional Requirements, and this**
- 58 **responsibility extends to resident assignments at all participating sites.**
- 59
- 60 **The sponsoring institution and the program must ensure that the program**
- 61 **director has sufficient protected time and financial support for his or her**
- 62 **educational and administrative responsibilities to the program.**
- 63
- 64 I.A.1. An accredited surgery program must be conducted in an institution that
- 65 can document a sufficient breadth of patient care. At a minimum, the
- 66 institution must routinely care for patients with a broad spectrum of
- 67 surgical diseases and conditions, including all of the essential content
- 68 areas in surgical education. In addition, these institutions must include
- 69 facilities and staff for a variety of other services that provide a critical role
- 70 in the care of patients with surgical conditions, including radiology and
- 71 pathology.
- 72
- 73 I.A.2. The program director must be provided with a minimum of 30% protected
- 74 time, which may take the form of direct or indirect salary support, such as
- 75 release from clinical activities provided by the institution.
- 76
- 77 **I.B. Participating Sites**
- 78
- 79 **I.B.1. There must be a program letter of agreement (PLA) between the**
- 80 **program and each participating site providing a required**
- 81 **assignment. The PLA must be renewed at least every five years.**
- 82
- 83 **The PLA should:**
- 84
- 85 **I.B.1.a) identify the faculty who will assume both educational and**
- 86 **supervisory responsibilities for residents;**
- 87
- 88 **I.B.1.b) specify their responsibilities for teaching, supervision, and**
- 89 **formal evaluation of residents, as specified later in this**
- 90 **document;**
- 91
- 92 **I.B.1.c) specify the duration and content of the educational**
- 93 **experience; and,**
- 94
- 95 **I.B.1.d) state the policies and procedures that will govern resident**
- 96 **education during the assignment.**
- 97
- 98 **I.B.2. The program director must submit any additions or deletions of**
- 99 **participating sites routinely providing an educational experience,**
- 100 **required for all residents, of one month full time equivalent (FTE) or**
- 101 **more through the Accreditation Council for Graduate Medical**
- 102 **Education (ACGME) Accreditation Data System (ADS).**

103		
104	I.B.3.	Integrated and Non-Integrated Sites
105		
106		An integrated or non-integrated site is defined as any site to which
107		residents rotate for an assigned experience. There are two types of
108		institutional relationships: integrated and non-integrated.
109		
110	I.B.3.a)	An integrated site contributes substantially to the educational
111		activities of the residency program.
112		
113	I.B.3.a).(1)	The program director must appoint the members of the
114		teaching staff and the local program director at an
115		integrated site.
116		
117	I.B.3.a).(2)	The faculty at an integrated site must demonstrate a
118		commitment to scholarly pursuits.
119		
120	I.B.3.a).(3)	Clinical experiences in the essential content areas should
121		be obtained in integrated sites. Exceptions will be
122		considered on a case-by-case basis.
123		
124	I.B.3.a).(4)	An integrated site should be in geographic proximity to
125		allow all residents to attend core conferences. If the
126		integrated site is geographically remote and joint
127		conferences cannot be held, an equivalent educational
128		program of lectures and conferences in the integrated site
129		must occur and must be fully documented. Morbidity and
130		mortality reviews must occur at each integrated site or at a
131		combined central location.
132		
133	I.B.3.a).(5)	Integration will not be approved between two sites if both
134		have an accredited residency program in the same
135		specialty.
136		
137	I.B.3.a).(6)	Chief residents may be assigned only to participating
138		integrated sites or to the primary clinical site/sponsoring
139		institution.
140		
141	I.B.3.b)	A participating non-integrated site should supplement resident
142		education by providing focused clinical experience not available at
143		the primary clinical site or at the integrated site.
144		
145	I.B.3.b).(1)	Assignment to participating non-integrated sites must have
146		a clear educational rationale.
147		
148	I.B.3.b).(2)	Advance approval of the Review Committee is required for
149		resident assignment of six months or more at a
150		participating non-integrated site.
151		
152	I.B.3.b).(3)	Advance approval of the Review Committee is not required
153		for resident assignment of less than six months, but the

154 educational rationale for such assignments will be
155 evaluated at the time of each site-visit and accreditation
156 review.
157

158 **II. Program Personnel and Resources**

159
160 **II.A. Program Director**

161
162 **II.A.1. There must be a single program director with authority and**
163 **accountability for the operation of the program. The sponsoring**
164 **institution's GMEC must approve a change in program director.**
165 **After approval, the program director must submit this change to the**
166 **ACGME via the ADS.**
167

168 **II.A.2. The program director should continue in his or her position for a**
169 **length of time adequate to maintain continuity of leadership and**
170 **program stability.**
171

172 **II.A.2.a) The program director's initial appointment should be for at least**
173 **the duration of the program six years.**
174

175 **II.A.3. Qualifications of the program director must include:**
176

177 **II.A.3.a) requisite specialty expertise and documented educational**
178 **and administrative experience acceptable to the Review**
179 **Committee;**
180

181 **II.A.3.b) current certification in the specialty by the American Board of**
182 **Surgery, or specialty qualifications that are acceptable to the**
183 **Review Committee; and,**
184

185 **II.A.3.c) current medical licensure and appropriate medical staff**
186 **appointment.**
187

188 **II.A.3.d) unrestricted credentials at the primary clinical site/sponsoring**
189 **institution, and license to practice medicine in the state where the**
190 **sponsoring institution is located.**
191

192 **II.A.3.e) scholarly activity in at least one of the areas of scholarly activity**
193 **delineated in Section II.B.5 of this document.**
194

195 **II.A.4. The program director must administer and maintain an educational**
196 **environment conducive to educating the residents in each of the**
197 **ACGME competency areas. The program director must:**
198

199 **II.A.4.a) oversee and ensure the quality of didactic and clinical**
200 **education in all sites that participate in the program;**
201

202 **II.A.4.b) approve a local director at each participating site who is**
203 **accountable for resident education;**
204

- 205 **II.A.4.c)** approve the selection of program faculty as appropriate;
206
- 207 **II.A.4.d)** evaluate program faculty and approve the continued
208 participation of program faculty based on evaluation;
209
- 210 **II.A.4.e)** monitor resident supervision at all participating sites;
211
- 212 **II.A.4.f)** prepare and submit all information required and requested by
213 the ACGME, including but not limited to the program
214 information forms and annual program resident updates to
215 the ADS, and ensure that the information submitted is
216 accurate and complete;
217
- 218 **II.A.4.g)** provide each resident with documented semiannual
219 evaluation of performance with feedback;
220
- 221 **II.A.4.h)** ensure compliance with grievance and due process
222 procedures as set forth in the Institutional Requirements and
223 implemented by the sponsoring institution;
224
- 225 **II.A.4.i)** provide verification of residency education for all residents,
226 including those who leave the program prior to completion;
227
- 228 **II.A.4.j)** implement policies and procedures consistent with the
229 institutional and program requirements for resident duty
230 hours and the working environment, including moonlighting,
231 and, to that end, must:
232
- 233 **II.A.4.j).(1)** distribute these policies and procedures to the
234 residents and faculty;
235
- 236 **II.A.4.j).(2)** monitor resident duty hours, according to sponsoring
237 institutional policies, with a frequency sufficient to
238 ensure compliance with ACGME requirements;
239
- 240 **II.A.4.j).(3)** adjust schedules as necessary to mitigate excessive
241 service demands and/or fatigue; and,
242
- 243 **II.A.4.j).(4)** if applicable, monitor the demands of at-home call and
244 adjust schedules as necessary to mitigate excessive
245 service demands and/or fatigue.
246
- 247 **II.A.4.k)** monitor the need for and ensure the provision of back up
248 support systems when patient care responsibilities are
249 unusually difficult or prolonged;
250
- 251 **II.A.4.l)** comply with the sponsoring institution's written policies and
252 procedures, including those specified in the Institutional
253 Requirements, for selection, evaluation and promotion of
254 residents, disciplinary action, and supervision of residents;
255

256	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;
257		
258		
259		
260	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:
261		
262		
263		
264	II.A.4.n).(1)	all applications for ACGME accreditation of new programs;
265		
266		
267	II.A.4.n).(2)	changes in resident complement;
268		
269	II.A.4.n).(3)	major changes in program structure or length of training;
270		
271		
272	II.A.4.n).(4)	progress reports requested by the Review Committee;
273		
274	II.A.4.n).(5)	responses to all proposed adverse actions;
275		
276	II.A.4.n).(6)	requests for increases or any change to resident duty hours;
277		
278		
279	II.A.4.n).(7)	voluntary withdrawals of ACGME-accredited programs;
280		
281		
282	II.A.4.n).(8)	requests for appeal of an adverse action;
283		
284	II.A.4.n).(9)	appeal presentations to a Board of Appeal or the ACGME; and,
285		
286		
287	II.A.4.n).(10)	proposals to ACGME for approval of innovative educational approaches.
288		
289		
290	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:
291		
292		
293		
294	II.A.4.o).(1)	program citations, and/or
295		
296	II.A.4.o).(2)	request for changes in the program that would have significant impact, including financial, on the program or institution.
297		
298		
299		
300	II.A.4.p)	devote his or her principal effort to the program.
301		
302	II.A.4.q)	designate other well-qualified surgeons to assist in the supervision and education of the residents;
303		
304		
305	II.A.4.r)	be responsible for all clinical assignments and input into the teaching staff appointments at all sites;
306		

307		
308	II.A.4.s)	along with the faculty, be responsible for the preparation and
309		implementation of a comprehensive, effective, and well-organized
310		educational curriculum;
311		
312	II.A.4.t)	ensure that conferences should be scheduled to permit resident
313		attendance on a regular basis, and resident time must be
314		protected from interruption by routine clinical duties.
315		Documentation of attendance by 75% of residents at the core
316		conferences must be achieved; and,
317		
318	II.A.4.u)	ensure that the following types of conferences must exist within a
319		program:
320		
321	II.A.4.u).(1)	a course or a structured series of lectures that ensures
322		education in the basic and clinical sciences fundamental to
323		surgery, including technological advances that relate to
324		surgery and the care of patients with surgical diseases, as
325		well as education in critical thinking, design of experiments
326		and evaluation of data;
327		
328	II.A.4.u).(2)	regular organized clinical teaching, such as grand rounds,
329		ward rounds, and clinical conferences;
330		
331	II.A.4.u).(3)	a weekly morbidity and mortality or quality improvement
332		conference.
333		
334	II.A.4.u).(3).(a)	Sole reliance on textbook review is inadequate;
335		
336	II.A.4.v)	along with the physician faculty, assess the technical competence
337		of each resident. The Review Committee requires that each
338		resident perform a minimum number of certain cases for
339		accreditation. Performance of this minimum number of cases by a
340		resident must not be interpreted as an equivalent to competence
341		achievement;
342		
343	II.A.4.w)	ensure that each resident has at least 750 major cases across the
344		five years of training. This must include a minimum of 150 major
345		cases in the resident's chief year;
346		
347	II.A.4.x)	ensure that residents have required experience with a variety of
348		endoscopic procedures, including esophogastro-duodenoscopy,
349		colonoscopy and bronchoscopy as well as experience in
350		advanced laparoscopy; and,
351		
352	II.A.4.y)	ensure that residents have required experience with evolving
353		diagnostic and therapeutic methods.
354		
355	II.B.	Faculty
356		
357	II.B.1.	At each participating institution, there must be a sufficient number

358 of faculty with documented qualifications to instruct and supervise
359 all residents at that location.

360
361 The faculty must:

362
363 **II.B.1.a) devote sufficient time to the educational program to fulfill**
364 **their supervisory and teaching responsibilities; and to**
365 **demonstrate a strong interest in the education of residents,**
366 **and**

367
368 **II.B.1.b) administer and maintain an educational environment**
369 **conducive to educating residents in each of the ACGME**
370 **competency areas.**

371
372 **II.B.1.c)** for each approved chief resident position, consist of at least one
373 full-time faculty member in addition to the program director (i.e., if
374 there are three approved chief residents, there must be at least
375 four fulltime faculty). The major function of these faculty is to
376 support the program. These faculty must be appointed for a period
377 sufficient to ensure continuity in the educational activities of the
378 residency program and, (N.B.: moved from III. A. 4f)

379
380 **II.B.1.d)** appoint an associate program director for programs with more
381 than 20 categorical residents.

382
383 **II.B.2. The physician faculty must have current certification in the specialty**
384 **by the American Board of Surgery, or possess qualifications**
385 **acceptable to the Review Committee.**

386
387 **II.B.3. The physician faculty must possess current medical licensure and**
388 **appropriate medical staff appointment.**

389
390 **II.B.4. The nonphysician faculty must have appropriate qualifications in**
391 **their field and hold appropriate institutional appointments.**

392
393 **II.B.5. The faculty must establish and maintain an environment of inquiry**
394 **and scholarship with an active research component.**

395
396 **II.B.5.a) The faculty must regularly participate in organized clinical**
397 **discussions, rounds, journal clubs, and conferences.**

398
399 **II.B.5.b) Some members of the faculty should also demonstrate**
400 **scholarship by one or more of the following:**

401
402 **II.B.5.b).(1) peer-reviewed funding;**

403
404 **II.B.5.b).(2) publication of original research or review articles in**
405 **peer-reviewed journals, or chapters in textbooks;**

406
407 **II.B.5.b).(3) publication or presentation of case reports or clinical**
408 **series at local, regional, or national professional and**

460 and portfolios.

461

462 | II.D.2. Resources ~~should~~must include simulation and skills laboratories. These

463 | facilities must address acquisition and maintenance of skills with a

464 | competency-based method of evaluation.

465

466 | II.D.3. There must be a full-time surgery program coordinator designated

467 | specifically for surgical education. Programs with more than 20

468 | categorical residents should be provided with additional administrative

469 | personnel.

470

471 | II.D.4. The institutional volume and variety of operative experience must be

472 | adequate to ensure a sufficient number and distribution of complex cases

473 | (as determined by the Review Committee) for each resident in the

474 | program.

475

476 | **II.E. Medical Information Access**

477

478 | **Residents must have ready access to specialty-specific and other**

479 | **appropriate reference material in print or electronic format. Electronic**

480 | **medical literature databases with search capabilities should be available.**

481

482 | **III. Resident Appointments**

483

484 | **III.A. Eligibility Criteria**

485

486 | **The program director must comply with the criteria for resident eligibility**

487 | **as specified in the Institutional Requirements.**

488

489 | **III.B. Number of Residents**

490

491 | **The program director may not appoint more residents than approved by the**

492 | **Review Committee, unless otherwise stated in the specialty-specific**

493 | **requirements. The program’s educational resources must be adequate to**

494 | **support the number of residents appointed to the program.**

495

496 | All resident positions must be approved in advance by the Review Committee.

497

498 | III.B.1. Residency positions must be allocated to one of ~~these three~~two groups:

499 | categorical, ~~designated preliminary,~~ or ~~nondesignated~~ preliminary

500 | positions.

501

502 | III.B.1.a) Categorical (C) residents are accepted into the residency program

503 | with the expectation of completing the surgery program, assuming

504 | satisfactory performance. At the PG1, PG2, PG3, and PG4 levels,

505 | the number of categorical residents must not exceed the number

506 | of approved chief residency positions.

507

508 | ~~III.B.1.b) Designated preliminary (DP) residents are accepted for one, two,~~

509 | ~~or three years before continuing education in another ACGME-~~

510 | ~~accredited surgical or nonsurgical specialty or in an ACGME~~

511		subspecialty program.
512		
513	III.B.1.b).(1)	On admission to the program, a letter of commitment to continue education must be on file for each resident in a designated preliminary position.
514		
515		
516		
517	III.B.1.b).(2)	The number of designated preliminary positions will not be limited, as long as the total number of these residents does not exceed the educational capacity of the residency program.
518		
519		
520		
521		
522	III.B.1.c) III.B.1.b)	Nondesignated p reliminary (NDP) residents are accepted into the program for one or two years before continuing their education. At the time of recruitment these residents will not have obtained a position for further residency education.
523		
524		
525		
526		
527	III.B.1.c).(1) III.B.1.b).(1)	The number of nondesignated preliminary positions in the PG1 and PG2 years combined must not exceed 200 300% of the number of approved categorical chief resident positions.
528		
529		
530		
531		
532	III.B.1.c).(2) III.B.1.b).(2)	Documentation of continuation in graduate medical education for the NDP residents must be provided at the time of each site visit.
533		
534		
535		
536	III.B.1.c).(3) III.B.1.b).(3)	It is the responsibility of the program director to counsel and assist nondesignated preliminary residents in obtaining future positions.
537		
538		
539		
540	III.B.2.	Increases in resident complement:
541		
542	III.B.2.a)	Both temporary and permanent increases in resident complement must be approved in advance by the Review Committee.
543		
544		
545	III.B.2.b)	A sound educational rationale for an increase in complement must be submitted. Documentation of adequate clinical material and complex operative cases, as well as documentation of a quality didactic education, must also be submitted. A clearly outlined block diagram must accompany the request to illustrate the proposed clinical assignments.
546		
547		
548		
549		
550		
551		
552	III.C.	Resident Transfers
553		
554	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.
555		
556		
557		
558		
559		
560	III.C.1.a)	The final two years of residency education (i.e., the PG 4 and PG 5 [chief] years) must be spent in the same program.
561		

- 562
563 **III.C.2. A program director must provide timely verification of residency**
564 **education and summative performance evaluations for residents**
565 **who leave the program prior to completion.**
566
- 567 **III.D. Appointment of Fellows and Other Learners**
568
569 **The presence of other learners (including, but not limited to, residents from**
570 **other specialties, subspecialty fellows, PhD students, and nurse**
571 **practitioners) in the program must not interfere with the appointed**
572 **residents' education. The program director must report the presence of**
573 **other learners to the DIO and GMEC in accordance with sponsoring**
574 **institution guidelines.**
575
- 576 **III.D.1. All trainees in both ACGME-accredited and non-accredited programs in**
577 **the sponsoring and integrated sites that may impact the educational**
578 **experience of the surgery residents must be identified and their**
579 **relationship to the surgery residents must be detailed.**
580
- 581 **III.D.2. A chief resident and a fellow (whether the fellow is in an ACGME-**
582 **accredited position or not) must not have primary responsibility for the**
583 **same patient except that general surgeon and surgical critical care**
584 **fellows may co-manage the non-operative care of the same patient.**
585
- 586 **IV. Educational Program**
587
- 588 **IV.A. The curriculum must contain the following educational components:**
589
- 590 **IV.A.1. Overall educational goals for the program, which the program must**
591 **distribute to residents and faculty annually;**
592
- 593 **IV.A.2. Competency-based goals and objectives for each assignment at**
594 **each educational level, which the program must distribute to**
595 **residents and faculty annually, in either written or electronic form.**
596 **These should be reviewed by the resident at the start of each**
597 **rotation;**
598
- 599 **IV.A.3. Regularly scheduled didactic sessions;**
600
- 601 **IV.A.4. Delineation of resident responsibilities for patient care, progressive**
602 **responsibility for patient management, and supervision of residents**
603 **over the continuum of the program; and,**
604
- 605 **IV.A.5. ACGME Competencies**
606
607 **The program must integrate the following ACGME competencies**
608 **into the curriculum:**
609
- 610 **IV.A.5.a) Patient Care**
611
612 **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:

- 613
614
615
616 IV.A.5.a).(1) will demonstrate manual dexterity appropriate for their
617 level;
618
619 IV.A.5.a).(2) will develop and execute patient care plans appropriate for
620 the resident's level, including management of pain;
621
622 IV.A.5.a).(3) will participate in a program that must document a clinical
623 curriculum that is sequential, comprehensive, and
624 organized from basic to complex. The clinical assignments
625 should be carefully structured to ensure that graded levels
626 of responsibility, continuity in patient care, a balance
627 between education and service, and progressive clinical
628 experiences are achieved for each resident;
629
630 The 60-month clinical program should be organized as
631 follows:
632
633 IV.A.5.a).(3).(a) At least 54 months of the 60-month program must
634 be spent on clinical assignments in surgery, with
635 documented experience in emergency care and
636 surgical critical care in order to enable residents to
637 manage patients with severe and complex illnesses
638 and with major injuries;
639
640 IV.A.5.a).(3).(b) 42 months of these 54 months must be spent on
641 clinical assignments in the essential content areas
642 of surgery. The essential content areas are: the
643 abdomen and its contents; the alimentary tract;
644 skin, soft tissues, and breast; endocrine surgery;
645 head and neck surgery; pediatric surgery; surgical
646 critical care; surgical oncology; trauma and non-
647 operative trauma (burn experience that includes
648 patient management may be counted toward non-
649 operative trauma); and the vascular system;
650
651 IV.A.5.a).(3).(c) A formal rotation in burn care, gynecology,
652 neurological surgery, orthopaedic surgery, cardiac
653 surgery, and urology is not required. Clearly
654 documented goals and objectives must be
655 presented if these components are included as
656 rotations;
657
658 IV.A.5.a).(3).(c).(i) Knowledge of burn physiology and initial
659 burn management is required;
660
661 | IV.A.5.a).(3).(d) A formal transplant ~~rotation~~ experience is required.
662 It must include patient management and cover
663 knowledge of the principles of immunology,

664		immunosuppression, and the management of
665		general surgical conditions arising in transplant
666		patients. Clearly documented goals and objectives
667		must be presented for this experience;
668		
669	IV.A.5.a).(3).(e)	No more than six months total may be allocated to
670		research or to non- surgical disciplines such as
671		anesthesiology, internal medicine, pediatrics, or
672		surgical pathology. (Gastroenterology is exempt
673		from this limit if this rotation provides endoscopic
674		experiences.)
675		
676		No more than 12 months may be devoted to
677		surgical discipline other than the principal
678		components of surgery;
679		
680	IV.A.5.a).(3).(f)	The Chief Year
681		
682	IV.A.5.a).(3).(f).(i)	Clinical assignments at the chief resident
683		level should be scheduled in the final (5 th)
684		year of the program;
685		
686	IV.A.5.a).(3).(f).(ii)	To take advantage of a unique educational
687		opportunity in a program, up to 6 months of
688		the chief year may be served in the next to
689		the last year (4 th). This experience must not
690		occur any earlier than the 4 th clinical year.
691		Any special Program of this type must be
692		approved in advance by the Review
693		Committee. Operative cases counted as the
694		chief cases must be performed during the
695		12 months designated as the chief year;
696		
697	IV.A.5.a).(3).(f).(iii)	The clinical assignments during the chief
698		year must be scheduled at the primary
699		clinical site or at participating integrated
700		site(s);
701		
702	IV.A.5.a).(3).(f).(iv)	Clinical assignments during the chief year
703		must be in the essential content areas of
704		general surgery. No more than four <u>six</u>
705		months of the chief year may be devoted
706		exclusively to any <u>only</u> one essential
707		content area;
708		
709	IV.A.5.a).(3).(f).(v)	Noncardiac thoracic surgery and
710		transplantation rotations may be considered
711		an acceptable chief resident assignment as
712		long as the chief resident performs an
713		appropriate number of complex cases with
714		documented participation in pre and post-

715		operative care (program director may use the flexibility outlined in IV.A.5.a.3.d.ii.);
716		
717		
718	IV.A.5.a).(3).(g)	Operative Experience
719		
720	IV.A.5.a).(3).(g).(i)	The program must document that residents are performing a sufficient breadth of complex procedures to graduate qualified surgeons;
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722		
723		
724		
725	IV.A.5.a).(3).(g).(ii)	All residents (categorical, designated preliminary, and nondesigned preliminary residents in ACGME-accredited positions) must enter their operative experience concurrently during each year of the residency in the ACGME case log system;
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732	IV.A.5.a).(3).(g).(iii)	A resident may be considered the surgeon only when he or she can document a significant role in the following aspects of management: determination or confirmation of the diagnosis, provision of preoperative care, selection, and accomplishment of the appropriate operative procedure, and direction of the postoperative care;
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741	IV.A.5.a).(3).(g).(iv)	When justified by experience, a PG 5 (chief) resident may act as a teaching assistant (TA) to a more junior resident with appropriate faculty supervision. Up to 50 cases listed by the chief resident as TA will be credited for the total requirement of 750 cases. TA cases may not count towards the 150 minimum cases needed to fulfill the operative requirements for the chief resident year. The junior resident performing the case will also be credited as surgeon for these cases; and,
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754	IV.A.5.a).(3).(g).(v)	Each program is required to provide residents with an outpatient experience to evaluate patients both pre-operatively, including initial evaluation, and post-operatively. At least 75% of the assignments in the essential content areas must include an outpatient experience of 1/2 day per week. (An outpatient experience is not required for assignments in the secondary components of surgery or surgical critical care).
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766	IV.A.5.b)	Medical Knowledge
767		
768		Residents must demonstrate knowledge of established and
769		evolving biomedical, clinical, epidemiological and social-
770		behavioral sciences, as well as the application of this
771		knowledge to patient care. Residents:
772		
773	IV.A.5.b).(1)	will critically evaluate and demonstrate knowledge of
774		pertinent scientific information and,
775		
776	IV.A.5.b).(2)	will participate in an educational program that should
777		include the fundamentals of basic science as applied to
778		clinical surgery, including: applied surgical anatomy and
779		surgical pathology; the elements of wound healing;
780		homeostasis, shock and circulatory physiology;
781		hematologic disorders; immunobiology and transplantation;
782		oncology; surgical endocrinology; surgical nutrition, fluid
783		and electrolyte balance; and the metabolic response to
784		injury, including burns.
785		
786	IV.A.5.c)	Practice-based Learning and Improvement
787		
788		Residents must demonstrate the ability to investigate and
789		evaluate their care of patients, to appraise and assimilate
790		scientific evidence, and to continuously improve patient care
791		based on constant self-evaluation and life-long learning.
792		Residents are expected to develop skills and habits to be able
793		to meet the following goals:
794		
795	IV.A.5.c).(1)	identify strengths, deficiencies, and limits in one's
796		knowledge and expertise;
797		
798	IV.A.5.c).(2)	set learning and improvement goals;
799		
800	IV.A.5.c).(3)	identify and perform appropriate learning activities;
801		
802	IV.A.5.c).(4)	systematically analyze practice using quality
803		improvement methods, and implement changes with
804		the goal of practice improvement;
805		
806	IV.A.5.c).(5)	incorporate formative evaluation feedback into daily
807		practice;
808		
809	IV.A.5.c).(6)	locate, appraise, and assimilate evidence from
810		scientific studies related to their patients' health
811		problems;
812		
813	IV.A.5.c).(7)	use information technology to optimize learning; and,
814		
815	IV.A.5.c).(8)	participate in the education of patients, families,
816		students, residents and other health professionals.

817
818 IV.A.5.c).(9) participate in mortality and morbidity conferences that
819 evaluate and analyze patient care outcomes, and
820
821 IV.A.5.c).(10) utilize an evidence-based approach to patient care
822

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

824
825 **Residents must demonstrate interpersonal and**
826 **communication skills that result in the effective exchange of**
827 **information and collaboration with patients, their families,**
828 **and health professionals. Residents are expected to:**
829

830 **IV.A.5.d).(1) communicate effectively with patients, families, and**
831 **the public, as appropriate, across a broad range of**
832 **socioeconomic and cultural backgrounds;**
833

834 **IV.A.5.d).(2) communicate effectively with physicians, other health**
835 **professionals, and health related agencies;**
836

837 **IV.A.5.d).(3) work effectively as a member or leader of a health care**
838 **team or other professional group;**
839

840 **IV.A.5.d).(4) act in a consultative role to other physicians and**
841 **health professionals; and,**
842

843 **IV.A.5.d).(5) maintain comprehensive, timely, and legible medical**
844 **records, if applicable.**
845

846 IV.A.5.d).(6) counsel and educate patients and families; and
847

848 IV.A.5.d).(7) effectively document practice activities.
849

850 **IV.A.5.e) Professionalism**

851
852 **Residents must demonstrate a commitment to carrying out**
853 **professional responsibilities and an adherence to ethical**
854 **principles. Residents are expected to demonstrate:**
855

856 **IV.A.5.e).(1) compassion, integrity, and respect for others;**
857

858 **IV.A.5.e).(2) responsiveness to patient needs that supersedes self-**
859 **interest;**
860

861 **IV.A.5.e).(3) respect for patient privacy and autonomy;**
862

863 **IV.A.5.e).(4) accountability to patients, society and the profession;**
864 **and,**
865

866 **IV.A.5.e).(5) sensitivity and responsiveness to a diverse patient**
867 **population, including but not limited to diversity in**

868		gender, age, culture, race, religion, disabilities, and
869		sexual orientation.
870		
871	IV.A.5.e).(6)	high standards of ethical behavior, and
872		
873	IV.A.5.e).(7)	a commitment to continuity of patient care.
874		
875	IV.A.5.f)	Systems-based Practice
876		
877		Residents must demonstrate an awareness of and
878		responsiveness to the larger context and system of health
879		care, as well as the ability to call effectively on other
880		resources in the system to provide optimal health care.
881		Residents are expected to:
882		
883	IV.A.5.f).(1)	work effectively in various health care delivery
884		settings and systems relevant to their clinical
885		specialty;
886		
887	IV.A.5.f).(2)	coordinate patient care within the health care system
888		relevant to their clinical specialty;
889		
890	IV.A.5.f).(3)	incorporate considerations of cost awareness and
891		risk-benefit analysis in patient and/or population-
892		based care as appropriate;
893		
894	IV.A.5.f).(4)	advocate for quality patient care and optimal patient
895		care systems;
896		
897	IV.A.5.f).(5)	work in interprofessional teams to enhance patient
898		safety and improve patient care quality; and,
899		
900	IV.A.5.f).(6)	participate in identifying system errors and
901		implementing potential systems solutions.
902		
903	IV.A.5.f).(7)	practice high quality, cost effective patient care;
904		
905	IV.A.5.f).(8)	demonstrate knowledge of risk-benefit analysis; and,
906		
907	IV.A.5.f).(9)	demonstrate an understanding of the role of different
908		specialists and other health care professionals in overall
909		patient management.
910		
911	IV.B.	Residents' Scholarly Activities
912		
913	IV.B.1.	The curriculum must advance residents' knowledge of the basic
914		principles of research, including how research is conducted,
915		evaluated, explained to patients, and applied to patient care.
916		
917	IV.B.2.	Residents should participate in scholarly activity.
918		

919	IV.B.2.a)	The participation of residents in clinical and/or laboratory research is encouraged.
920		
921		
922	IV.B.3.	The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.
923		
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926	V. Evaluation	
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928	V.A. Resident Evaluation	
929		
930	V.A.1. Formative Evaluation	
931		
932	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.
933		
934		
935		
936		
937	V.A.1.b)	The program must:
938		
939	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;
940		
941		
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943		
944		
945	V.A.1.b).(2)	use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);
946		
947		
948	V.A.1.b).(3)	document progressive resident performance improvement appropriate to educational level; and,
949		
950		
951	V.A.1.b).(4)	provide each resident with documented semiannual evaluation of performance with feedback.
952		
953		
954	V.A.1.c)	The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.
955		
956		
957		
958	V.A.1.d)	Biannual assessment must include a review of case volume, breadth, and complexity, and must ensure that residents are entering cases concurrently.
959		
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961		
962	V.A.1.e)	Assessment should specifically monitor the resident's knowledge by use of a formal exam such as the American Board of Surgery In Training Examination (ABSITE) or other cognitive exams. Test results should not be the sole criterion of resident knowledge, and should not be used as the sole criterion for promotion to a subsequent PG level.
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969	V.A.2. Summative Evaluation	

- 970
971 The program director must provide a summative evaluation for each
972 resident upon completion of the program. This evaluation must
973 become part of the resident's permanent record maintained by the
974 institution, and must be accessible for review by the resident in
975 accordance with institutional policy. This evaluation must:
976
- 977 V.A.2.a) document the resident's performance during the final period
978 of education, and
- 979
- 980 V.A.2.b) verify that the resident has demonstrated sufficient
981 competence to enter practice without direct supervision.
982
- 983 V.B. Faculty Evaluation
- 984
- 985 V.B.1. At least annually, the program must evaluate faculty performance as
986 it relates to the educational program.
987
- 988 V.B.2. These evaluations should include a review of the faculty's clinical
989 teaching abilities, commitment to the educational program, clinical
990 knowledge, professionalism, and scholarly activities.
991
- 992 V.B.3. This evaluation must include at least annual written confidential
993 evaluations by the residents.
994
- 995 V.C. Program Evaluation and Improvement
- 996
- 997 V.C.1. The program must document formal, systematic evaluation of the
998 curriculum at least annually. The program must monitor and track
999 each of the following areas:
- 1000
- 1001 V.C.1.a) resident performance;
- 1002
- 1003 V.C.1.b) faculty development;
- 1004
- 1005 V.C.1.c) graduate performance, including performance of program
1006 graduates on the certification examination; and,
- 1007
- 1008 V.C.1.d) program quality. Specifically:
- 1009
- 1010 V.C.1.d).(1) Residents and faculty must have the opportunity to
1011 evaluate the program confidentially and in writing at
1012 least annually, and
- 1013
- 1014 V.C.1.d).(2) The program must use the results of residents'
1015 assessments of the program together with other
1016 program evaluation results to improve the program.
1017
- 1018 V.C.2. If deficiencies are found, the program should prepare a written plan
1019 of action to document initiatives to improve performance in the
1020 areas listed in section V.C.1. The action plan should be reviewed

1021		and approved by the teaching faculty and documented in meeting
1022		minutes.
1023		
1024	V.C.3.	The performance of program graduates on the certification examination
1025		should be used as one measure of evaluating program effectiveness. At
1026		minimum, for the most recent five-year period, 65% of the graduates must
1027		pass each of the qualifying and certifying examinations on the first
1028		attempt.
1029		
1030	VI.	Resident Duty Hours in the Learning and Working Environment
1031		
1032	VI.A.	Professionalism, Personal Responsibility, and Patient Safety
1033		
1034	VI.A.1.	Programs and sponsoring institutions must educate residents and
1035		faculty members concerning the professional responsibilities of
1036		physicians to appear for duty appropriately rested and fit to provide
1037		the services required by their patients.
1038		
1039	VI.A.2.	The program must be committed to and responsible for promoting
1040		patient safety and resident well-being in a supportive educational
1041		environment.
1042		
1043	VI.A.3.	The program director must ensure that residents are integrated and
1044		actively participate in interdisciplinary clinical quality improvement
1045		and patient safety programs.
1046		
1047	VI.A.4.	The learning objectives of the program must:
1048		
1049	VI.A.4.a)	be accomplished through an appropriate blend of supervised
1050		patient care responsibilities, clinical teaching, and didactic
1051		educational events; and,
1052		
1053	VI.A.4.b)	not be compromised by excessive reliance on residents to
1054		fulfill non-physician service obligations.
1055		
1056	VI.A.5.	The program director and institution must ensure a culture of
1057		professionalism that supports patient safety and personal
1058		responsibility. Residents and faculty members must demonstrate an
1059		understanding and acceptance of their personal role in the
1060		following:
1061		
1062	VI.A.5.a)	assurance of the safety and welfare of patients entrusted to
1063		their care;
1064		
1065	VI.A.5.b)	provision of patient- and family-centered care;
1066		
1067	VI.A.5.c)	assurance of their fitness for duty;
1068		
1069	VI.A.5.d)	management of their time before, during, and after clinical
1070		assignments;
1071		

1072	VI.A.5.e)	recognition of impairment, including illness and fatigue, in themselves and in their peers;
1073		
1074		
1075	VI.A.5.f)	attention to lifelong learning;
1076		
1077	VI.A.5.g)	the monitoring of their patient care performance improvement indicators; and,
1078		
1079		
1080	VI.A.5.h)	honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.
1081		
1082		
1083	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.
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1089	VI.B.	Transitions of Care
1090		
1091	VI.B.1.	Programs must design clinical assignments to minimize the number of transitions in patient care.
1092		
1093		
1094	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.
1095		
1096		
1097		
1098	VI.B.3.	Programs must ensure that residents are competent in communicating with team members in the hand-over process.
1099		
1100		
1101	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.
1102		
1103		
1104		
1105		
1106	VI.C.	Alertness Management/Fatigue Mitigation
1107		
1108	VI.C.1.	The program must:
1109		
1110	VI.C.1.a)	educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;
1111		
1112		
1113	VI.C.1.b)	educate all faculty members and residents in alertness management and fatigue mitigation processes; and,
1114		
1115		
1116	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.
1117		
1118		
1119		
1120	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.
1121		
1122		

1123		
1124	VI.C.3.	The sponsoring institution must provide adequate sleep facilities
1125		and/or safe transportation options for residents who may be too
1126		fatigued to safely return home.
1127		
1128	VI.D.	Supervision of Residents
1129		
1130	VI.D.1.	In the clinical learning environment, each patient must have an
1131		identifiable, appropriately-credentialed and privileged attending
1132		physician (or licensed independent practitioner as approved by each
1133		Review Committee) who is ultimately responsible for that patient’s
1134		care.
1135		
1136	VI.D.1.a)	This information should be available to residents, faculty
1137		members, and patients.
1138		
1139	VI.D.1.b)	Residents and faculty members should inform patients of
1140		their respective roles in each patient’s care.
1141		
1142	VI.D.2.	The program must demonstrate that the appropriate level of
1143		supervision is in place for all residents who care for patients.
1144		
1145		Supervision may be exercised through a variety of methods. Some
1146		activities require the physical presence of the supervising faculty
1147		member. For many aspects of patient care, the supervising
1148		physician may be a more advanced resident or fellow. Other
1149		portions of care provided by the resident can be adequately
1150		supervised by the immediate availability of the supervising faculty
1151		member or resident physician, either in the institution, or by means
1152		of telephonic and/or electronic modalities. In some circumstances,
1153		supervision may include post-hoc review of resident-delivered care
1154		with feedback as to the appropriateness of that care.
1155		
1156	VI.D.3.	Levels of Supervision
1157		
1158		To ensure oversight of resident supervision and graded authority
1159		and responsibility, the program must use the following classification
1160		of supervision:
1161		
1162	VI.D.3.a)	Direct Supervision – the supervising physician is physically
1163		present with the resident and patient.
1164		
1165	VI.D.3.b)	Indirect Supervision:
1166		
1167	VI.D.3.b).(1)	with direct supervision immediately available – the
1168		supervising physician is physically within the hospital
1169		or other site of patient care, and is immediately
1170		available to provide Direct Supervision.
1171		
1172	VI.D.3.b).(2)	with direct supervision available – the supervising
1173		physician is not physically present within the hospital

1174		or other site of patient care, but is immediately
1175		available by means of telephonic and/or electronic
1176		modalities, and is available to provide Direct
1177		Supervision.
1178		
1179	VI.D.3.c)	Oversight – the supervising physician is available to provide
1180		review of procedures/encounters with feedback provided
1181		after care is delivered.
1182		
1183	VI.D.4.	The privilege of progressive authority and responsibility, conditional
1184		independence, and a supervisory role in patient care delegated to
1185		each resident must be assigned by the program director and faculty
1186		members.
1187		
1188	VI.D.4.a)	The program director must evaluate each resident’s abilities
1189		based on specific criteria. When available, evaluation should
1190		be guided by specific national standards-based criteria.
1191		
1192	VI.D.4.b)	Faculty members functioning as supervising physicians
1193		should delegate portions of care to residents, based on the
1194		needs of the patient and the skills of the residents.
1195		
1196	VI.D.4.c)	Senior residents or fellows should serve in a supervisory role
1197		of junior residents in recognition of their progress toward
1198		independence, based on the needs of each patient and the
1199		skills of the individual resident or fellow.
1200		
1201	VI.D.5.	Programs must set guidelines for circumstances and events in
1202		which residents must communicate with appropriate supervising
1203		faculty members, such as the transfer of a patient to an intensive
1204		care unit, or end-of-life decisions.
1205		
1206	VI.D.5.a)	Each resident must know the limits of his/her scope of
1207		authority, and the circumstances under which he/she is
1208		permitted to act with conditional independence.
1209		
1210	VI.D.5.a).(1)	In particular, PGY-1 residents should be supervised
1211		either directly or indirectly with direct supervision
1212		immediately available.
1213		
1214	VI.D.5.a).(1).(a)	The program must define those physician tasks for
1215		which PGY-1 residents may be supervised
1216		indirectly, with direct supervision available, and
1217		must define “direct supervision” in the context of the
1218		program.
1219		
1220	VI.D.5.a).(1).(b)	The program must define those physician tasks for
1221		which PGY-1 residents must be supervised directly
1222		until they have demonstrated competence as
1223		defined by the program director, and must maintain
1224		records of such demonstrations of competence.

1225		
1226	VI.D.5.a).(1).(c)	The program should use the template of definitions provided in the FAQ or a variation of the template to develop these definitions.
1227		
1228		
1229		
1230	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.
1231		
1232		
1233		
1234		
1235	VI.E.	Clinical Responsibilities
1236		
1237		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.
1238		
1239		
1240		
1241	VI.E.1.	The workload associated with optimal clinical care of surgical patients is a continuum from the moment of admission to the point of discharge.
1242		
1243		
1244	VI.E.2.	During the residency education process, surgical teams should be made up of attending surgeons, residents at various PG levels, medical students (when appropriate), and other health care providers.
1245		
1246		
1247		
1248	VI.E.3.	The work of the caregiver team should be assigned to team members based on each resident's level of education, experience, and competence.
1249		
1250		
1251		
1252	VI.F.	Teamwork
1253		
1254		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.
1255		
1256		
1257		
1258		
1259	VI.F.1.	Effective surgical practices entail the involvement of members with a mix of complementary skills and attributes (physicians, nurses, and other staff). Success requires both an unwavering mutual respect for those skills and contributions, and a shared commitment to the process of patient care.
1260		
1261		
1262		
1263		
1264		
1265	VI.F.2.	Residents must collaborate with fellow surgical residents, and especially with faculty, other physicians outside of their specialty, and non-traditional health care providers, to best formulate treatment plans for an increasingly diverse patient population.
1266		
1267		
1268		
1269		
1270	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.
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1277	VI.F.4.	Lines of authority should be defined by programs, and all residents must
1278		have a working knowledge of these expected reporting relationships to
1279		maximize quality care and patient safety.
1280		
1281	VI.G.	Resident Duty Hours
1282		
1283	VI.G.1.	Maximum Hours of Work per Week
1284		
1285		Duty hours must be limited to 80 hours per week, averaged over a
1286		four-week period, inclusive of all in-house call activities and all
1287		moonlighting.
1288		
1289	VI.G.1.a)	Duty Hour Exceptions
1290		
1291		A Review Committee may grant exceptions for up to 10% or a
1292		maximum of 88 hours to individual programs based on a
1293		sound educational rationale.
1294		
1295		The Review Committee for General Surgery will not consider
1296		requests for exceptions to the 80-hour limit to the residents' work
1297		week.
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1299	VI.G.1.a).(1)	In preparing a request for an exception the program
1300		director must follow the duty hour exception policy
1301		from the ACGME Manual on Policies and Procedures.
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1303	VI.G.1.a).(2)	Prior to submitting the request to the Review
1304		Committee, the program director must obtain approval
1305		of the institution's GMEC and DIO.
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1307	VI.G.2.	Moonlighting
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1309	VI.G.2.a)	Moonlighting must not interfere with the ability of the resident
1310		to achieve the goals and objectives of the educational
1311		program.
1312		
1313	VI.G.2.b)	Time spent by residents in Internal and External Moonlighting
1314		(as defined in the ACGME Glossary of Terms) must be
1315		counted towards the 80-hour Maximum Weekly Hour Limit.
1316		
1317	VI.G.2.c)	PGY-1 residents are not permitted to moonlight.
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1319	VI.G.3.	Mandatory Time Free of Duty
1320		
1321		Residents must be scheduled for a minimum of one day free of duty
1322		every week (when averaged over four weeks). At-home call cannot
1323		be assigned on these free days.
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1325	VI.G.4.	Maximum Duty Period Length
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1327	VI.G.4.a)	Duty periods of PGY-1 residents must not exceed 16 hours in duration.
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1330	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.
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1338	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.
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1344	VI.G.4.b).(2)	Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
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1348	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.
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1357	VI.G.4.b).(3).(a)	Under those circumstances, the resident must:
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1359	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,
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1363	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.
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1368	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.
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1373	VI.G.5.	Minimum Time Off between Scheduled Duty Periods
1374		
1375	VI.G.5.a)	PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.
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1378	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.
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1383		PGY-2 and PGY-3 residents are considered to be at the
1384		intermediate level.
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1386	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.
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1390		Residents at the PGY-4 level and beyond are considered to be in
1391		the final years of education.
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1393	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.
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1402	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.
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1408	VI.G.5.c).(1).(b)	The Review Committee defines such
1409		circumstances as: required continuity of care for a
1410		severely ill or unstable patient, or a complex patient
1411		with whom the resident has been involved; events
1412		of exceptional educational value; or, humanistic
1413		attention to the needs of a patient or family.
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1415	VI.G.6.	Maximum Frequency of In-House Night Float
1416		
1417		Residents must not be scheduled for more than six consecutive
1418		nights of night float.
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1420	VI.G.6.a)	Residents must not be scheduled for more than six consecutive
1421		nights of night float.
1422		
1423	VI.G.6.b)	Night float rotations must not exceed two months in duration, and
1424		there can be no more than three months of night float per year.
1425		
1426	VI.G.6.c)	Night float rotations must not exceed two months in duration, <u>four months</u>
1427		<u>of night float per PGY level, and 15 months for the entire program.</u>
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1429 **VI.G.7. Maximum In-House On-Call Frequency**
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1431 **PGY-2 residents and above must be scheduled for in-house call no**
1432 **more frequently than every-third-night (when averaged over a four-**
1433 **week period).**
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1435 **VI.G.8. At-Home Call**
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1437 **VI.G.8.a) Time spent in the hospital by residents on at-home call must**
1438 **count towards the 80-hour maximum weekly hour limit. The**
1439 **frequency of at-home call is not subject to the every-third-**
1440 **night limitation, but must satisfy the requirement for one-day-**
1441 **in-seven free of duty, when averaged over four weeks.**
1442
1443 **VI.G.8.a).(1) At-home call must not be so frequent or taxing as to**
1444 **preclude rest or reasonable personal time for each**
1445 **resident.**
1446
1447 **VI.G.8.b) Residents are permitted to return to the hospital while on at-**
1448 **home call to care for new or established patients. Each**
1449 **episode of this type of care, while it must be included in the**
1450 **80-hour weekly maximum, will not initiate a new “off-duty**
1451 **period”.**
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1453 **VII. Innovative Projects**
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1455 **Requests for innovative projects that may deviate from the institutional, common**
1456 **and/or specialty specific program requirements must be approved in advance by**
1457 **the Review Committee. In preparing requests, the program director must follow**
1458 **Procedures for Approving Proposals for Innovative Projects located in the**
1459 **ACGME Manual on Policies and Procedures. Once a Review Committee approves**
1460 **a project, the sponsoring institution and program are jointly responsible for the**
1461 **quality of education offered to residents for the duration of such a project.**
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1463 *******
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1465 **ACGME-approved: June 12, 2007 Effective: January 1, 2008**
1466 **Minor Revision Approved: June 10, 2008 Effective: August 10, 2008**
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1468 **Revised Common Program Requirements Effective: July 1, 2011**
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