

ACGME Program Requirements for Graduate Medical Education in the Transitional Year

Common Program Requirements are in **BOLD**

Effective: July 1, 2007

Introduction

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

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

Int.B. Purpose of a Transitional Year

The objective of the transitional year is to provide a well-balanced program of graduate medical education in multiple clinical disciplines designed to facilitate the choice of and preparation for a specific specialty.

The transitional year must be designed to fulfill the educational needs of medical school graduates who:

Int.B.1. have chosen a career specialty for which the categorical program in graduate medical education has, as a prerequisite, one year of fundamental clinical education (this education may also contain certain specific experiences for development of desired skills);

Int.B.2. desire a broad-based year to assist them in making a career choice or specialty selection decision;

Int.B.3. are planning to serve in public health organizations or on active duty in the military as general medical officers or primary flight/undersea medicine physicians; or,

Int.B.4. desire or need to acquire at least one year of fundamental clinical education before entering administrative medicine or non-clinical research.

The sponsoring institution and the transitional year program must demonstrate substantial compliance with both the Institutional Requirements of the *Essentials of Accredited Residencies* and the Program Requirements that follow.

Int.C. Duration and Content of Program

The duration of the transitional year program must be one year.

I. Institutions

I.A. Sponsoring Institution

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

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

I.A.1. Service obligations of the sponsoring institution must be secondary to the transitional year educational objectives.

I.A.2. The transitional year program must be offered by an institution and its affiliate(s) conducting two or more residency programs accredited by and in good standing with the Accreditation Council for Graduate Medical Education (ACGME).

I.B. Participating Sites

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

The PLA should:

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

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

- I.B.1.c) specify the duration and content of the educational experience; and,**
- I.B.1.d) state the policies and procedures that will govern resident education during the assignment.**
- I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).**
- I.C. Sponsoring Programs**
- I.C.1. At least two ACGME-accredited programs must be designated as sponsoring programs of the transitional year program. One of these must be in a discipline that provides fundamental clinical skills training. Those disciplines considered to provide these experiences are emergency medicine, family medicine, internal medicine, obstetrics/gynecology, pediatrics, and general surgery.**
- I.C.2. A letter of commitment from each sponsoring program must be in place, and must specify responsibilities and arrangements.**
- I.C.3. If an adverse accreditation action is confirmed for a required sponsoring program, the program director must designate another sponsoring program in good standing within six months of notification.**
- I.C.4. Together the sponsoring programs must provide at least 25% of each resident's clinical experience.**
- I.C.5. The program director or a designee from each sponsoring program must participate in the organization of the didactic curriculum of the program.**
- I.D. Transitional Year Education Committee**
- The Transitional Year Education Committee (TYEC) must be appointed and have major responsibility for conducting and monitoring the activities of the transitional year program.**
- I.D.1. The TYEC may be constituted as a freestanding committee or a subcommittee of the Graduate Medical Education Committee (GMEC). The TYEC must be convened by the sponsoring institution at least four times in an academic year.**
- I.D.2. The membership of this committee should include:**
- I.D.2.a) the transitional year program director;**
- I.D.2.b) program directors (or designees) of the sponsoring programs;**

- I.D.2.c) program directors (or designees) of disciplines regularly included in the curriculum;
- I.D.2.d) the Chief Executive Officer (CEO) (or designee in hospital administration) of the sponsoring institution. The CEO or the designee must not be the transitional year program director; and,
- I.D.2.e) peer-selected residents, one of whom must be a current transitional year resident.
- I.D.3. The Transitional Year Education Committee must:
 - I.D.3.a) ensure adequate resources for the didactic and clinical curriculum prescribed. This includes monitoring the adequacy of the number of patients, variety of illnesses, educational materials, teaching/attending physicians, and financial support;
 - I.D.3.b) ensure that residents are educated in high-quality medical care based on scientific knowledge, evidence-based medicine, and sound teaching by qualified educators;
 - I.D.3.c) ensure educational opportunities are equivalent to those provided first-year residents in the categorical programs in which transitional year residents participate;
 - I.D.3.d) review at least twice a year the evaluations of transitional year residents' performance and the residents' assessment of, each rotation and the participating faculty;
 - I.D.3.e) review the curriculum each academic year to ensure that the educational program is current and relevant;
 - I.D.3.f) maintain a record of those in attendance and actions taken. Responsibilities (a-e) should be reviewed at least annually; and,
 - I.D.3.g) review ACGME letters of accreditation for sponsoring programs and to monitor areas of noncompliance.

II. Program Personnel and Resources

II.A. Program Director

- II.A.1. **There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.**
 - II.A.1.a) The process by which the program director of the transitional year program is appointed must be consistent with the policies for the appointment of other program directors in the sponsoring

institution.

- II.A.2. The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.**
- II.A.2.a) The minimum length of the program director's appointment should be three years.
- II.A.3. Qualifications of the program director must include:**
- II.A.3.a) **requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;**
- II.A.3.b) **current certification in the specialty by the American Board of Medical Specialties, or specialty qualifications that are acceptable to the Review Committee; and,**
- II.A.3.c) **current medical licensure and appropriate medical staff appointment.**
- II.A.4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:**
- II.A.4.a) **oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;**
- II.A.4.b) **approve a local director at each participating site who is accountable for resident education;**
- II.A.4.c) **approve the selection of program faculty as appropriate;**
- II.A.4.d) **evaluate program faculty and approve the continued participation of program faculty based on evaluation;**
- II.A.4.e) **monitor resident supervision at all participating sites;**
- II.A.4.f) **prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;**
- II.A.4.f).(1) notify the executive director of the Review Committee when there is any change of accreditation status for the sponsoring program(s).
- II.A.4.g) **provide each resident with documented semiannual evaluation of performance with feedback;**

- II.A.4.h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;**
- II.A.4.i) provide verification of residency education for all residents, including those who leave the program prior to completion;**
- II.A.4.j) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:**
 - II.A.4.j).(1) distribute these policies and procedures to the residents and faculty;**
 - II.A.4.j).(2) monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;**
 - II.A.4.j).(3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,**
 - II.A.4.j).(4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.**
- II.A.4.k) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;**
- II.A.4.l) comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;**
- II.A.4.m) be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;**
- II.A.4.n) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:**
 - II.A.4.n).(1) all applications for ACGME accreditation of new programs;**
 - II.A.4.n).(2) changes in resident complement;**
 - II.A.4.n).(3) major changes in program structure or length of training;**

- II.A.4.n).(4) **progress reports requested by the Review Committee;**
- II.A.4.n).(5) **responses to all proposed adverse actions;**
- II.A.4.n).(6) **requests for increases or any change to resident duty hours;**
- II.A.4.n).(7) **voluntary withdrawals of ACGME-accredited programs;**
- II.A.4.n).(8) **requests for appeal of an adverse action;**
- II.A.4.n).(9) **appeal presentations to a Board of Appeal or the ACGME; and,**
- II.A.4.n).(10) **proposals to ACGME for approval of innovative educational approaches.**

- II.A.4.o) **obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:**
 - II.A.4.o).(1) **program citations, and/or**
 - II.A.4.o).(2) **request for changes in the program that would have significant impact, including financial, on the program or institution.**

- II.A.4.p) maintain permanent records of each resident's:
 - II.A.4.p).(1) appointment to the transitional year program;
 - II.A.4.p).(2) individual curriculum including elective and required rotation schedules;
 - II.A.4.p).(3) performance evaluations; and,
 - II.A.4.p).(4) professional activities. Written documentation of periodic evaluations for each resident must be maintained and available for review by the site-visitor.

- II.A.4.q) forward performance evaluations of those residents accepted into a residency following completion of the transitional year to the specialty program director at least twice a year, or as specified in the specialty requirements;

- II.A.4.r) ensure that rotations taken away from the sponsoring institution and its affiliates have educational justification and that the following policies are met:

- II.A.4.r).(1) No more than eight weeks of transitional year rotations may be taken away from the institution and its affiliates;
- II.A.4.r).(2) Outside required rotations must be taken in an ACGME-accredited program;
- II.A.4.r).(3) Outside rotations not part of ACGME-accredited programs must be designated as electives. The program director must provide a complete description of the experience to include curriculum objectives, resident responsibilities, and the faculty assigned for supervision;
- II.A.4.r).(4) Outside rotations must be evaluated by the residents, and the performance of each resident must be evaluated by the respective faculty. Evaluations are to be reviewed and kept on file by the program director; and,
- II.A.4.r).(5) The program director must give consideration to the resident's liability coverage and state licensing requirements prior to approving the rotation.
- II.A.4.s) ensure that transitional year residents accepted in a categorical program with specified curricular components for the PG-1 year have a curriculum which conforms to the respective specialty requirements.

II.B. Faculty

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

The faculty must:

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

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

II.B.1.c) The teaching and supervision of transitional year residents must be the same as that provided residents in the participating categorical programs.

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

- II.B.3.** The physician faculty must possess current medical licensure and appropriate medical staff appointment.
- II.B.4.** The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.
- II.B.5.** The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.
- II.B.5.a)** The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.
- II.B.5.b)** Some members of the faculty should also demonstrate scholarship by one or more of the following:
- II.B.5.b).(1)** peer-reviewed funding;
- II.B.5.b).(2)** publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;
- II.B.5.b).(3)** publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,
- II.B.5.b).(4)** participation in national committees or educational organizations.
- II.B.5.c)** Faculty should encourage and support residents in scholarly activities.
- II.C.** **Other Program Personnel**
- The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program.
- II.D.** **Resources**
- The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements.
- II.D.1.** Pathology, radiology, and nuclear medicine facilities must exist in the sponsoring institution and participating sites. These facilities must be directed by qualified physicians who are committed to medical education and to providing competent instruction to the transitional year residents when patients require these diagnostic and/or therapeutic modalities.
- II.E.** **Medical Information Access**
- Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic

medical literature databases with search capabilities should be available.

III. Resident Appointments

III.A. Eligibility Criteria

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

III.B. Number of Residents

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

III.B.1. A program must have at least four residents in training to provide appropriate peer interaction during all phases of the transitional year program.

III.B.2. Any proposed change in the number of transitional year residents must receive prior approval by the Transitional year Review Committee. Programs that consistently fail to fill the designated number of approved positions may be asked to reduce the number offered, but to no fewer than four residents.

III.B.3. Residents who have successfully completed 12 months of transitional year training are not eligible to receive additional credit for subsequent rotations taken.

III.C. Resident Transfers

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

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

III.D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' education. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.

IV. Educational Program

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

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

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

IV.A.3. Regularly scheduled didactic sessions;

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

IV.A.5. ACGME Competencies

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

IV.A.5.a) Patient Care

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

IV.A.5.a).(1) must be given responsibility for patient care commensurate with their ability. Residents must be given the responsibility for decision-making and for direct patient care in all settings, subject to review and approval by senior residents and attending physicians, to include the planning of care, and the writing of orders, progress notes, and relevant records;

IV.A.5.a).(2) should develop the following competencies:

IV.A.5.a).(2).(a) obtain a comprehensive medical history;

IV.A.5.a).(2).(b) perform a comprehensive physical examination;

IV.A.5.a).(2).(c) assess a patient's problems;

IV.A.5.a).(2).(d) make appropriate use of diagnostic studies and tests;

IV.A.5.a).(2).(e) integrate information to develop a differential diagnosis; and,

- IV.A.5.a).(2).(f) implement a treatment plan.
- IV.A.5.a).(3) should have rotations offering fundamental clinical skills that are at least four continuous weeks in duration to ensure reasonable continuity of education and patient care;
- IV.A.5.a).(4) must have at least a four week rotation (minimum of 140 hours) in emergency medicine under the supervision of qualified teaching staff within the sponsoring institution or an affiliated site;
- IV.A.5.a).(5) must have the opportunity to participate in the evaluation and management of the care of all types and acuity levels of patients who present to an institution's emergency department. The transitional year residents must have first-contact responsibility for these patients;
- IV.A.5.a).(6) must have at least 140 hours of documented experience in ambulatory care to further develop fundamental clinical skills. This experience may consist of a four week block, or be divided into lesser periods of time, no shorter than half-day sessions, to ensure a total of 140 hours. During the ambulatory clinic sessions, arrangements should be made to minimize interruptions of the residents' experience by duties with inpatient services;
- IV.A.5.a).(7) must have outpatient experience from ambulatory settings provided by family medicine or primary care internal medicine, obstetrics/gynecology, pediatrics, and general surgery at the sponsoring institution or participating sites. Continuity clinics, faculty physicians' offices, walk-in/urgent care clinics, and neighborhood health clinics may be used for these experiences; and,
- IV.A.5.a).(8) must have at least 24 weeks of their curriculum be provided by a discipline or disciplines that offer fundamental clinical skills in the primary specialties of emergency medicine, family medicine, internal medicine, obstetrics/gynecology, pediatrics, or general surgery. Subspecialty experiences, with the exception of critical care unit experiences, do not meet fundamental clinical skills curriculum requirements. These rotations must be taken in ACGME accredited categorical residencies;
- IV.A.5.a).(9) must have at least eight weeks of electives, which may not include vacation time. Elective rotations should be determined by the educational needs of the individual resident;

IV.A.5.b)

Medical Knowledge

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

- IV.A.5.b).(1) must participate in educational experiences that are designed to help them achieve competence in the six defined areas;
- IV.A.5.b).(2) should, on those rotations designated as providing fundamental clinical skills, have planned educational experiences that complement and enhance the clinical experience. The planned educational experiences may be part of the curriculum for categorical residents, as long as the content is applicable to the transitional year residents' learning needs;
- IV.A.5.b).(3) must, on those rotations not providing fundamental clinical skills (e.g. electives, internal medicine and surgery subspecialties), participate in planned educational experiences that correspond to the clinical experience;
- IV.A.5.b).(4) must have planned educational experiences which occur on each block rotation throughout the academic year, and in which all didactic curriculum disciplines must participate;
- IV.A.5.b).(5) may have planned educational experiences that include:
 - IV.A.5.b).(5).(a) multidisciplinary conferences;
 - IV.A.5.b).(5).(b) morbidity and mortality conferences;
 - IV.A.5.b).(5).(c) journal or evidence-based reviews;
 - IV.A.5.b).(5).(d) case-based planned didactic experiences;
 - IV.A.5.b).(5).(e) seminars and workshops to meet specific competencies;
 - IV.A.5.b).(5).(f) computer-aided instruction; and,
 - IV.A.5.b).(5).(g) grand rounds.

Attendance must be monitored and documented.

- IV.A.5.b).(6) must have no more than eight weeks of training be designated for nonclinical patient care experience; e.g., research, administration, and computer science.

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

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

- IV.A.5.c).(1) identify strengths, deficiencies, and limits in one's knowledge and expertise;**
- IV.A.5.c).(2) set learning and improvement goals;**
- IV.A.5.c).(3) identify and perform appropriate learning activities;**
- IV.A.5.c).(4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;**
- IV.A.5.c).(5) incorporate formative evaluation feedback into daily practice;**
- IV.A.5.c).(6) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;**
- IV.A.5.c).(7) use information technology to optimize learning; and,**
- IV.A.5.c).(8) participate in the education of patients, families, students, residents and other health professionals.**

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

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

- IV.A.5.d).(1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;**
- IV.A.5.d).(2) communicate effectively with physicians, other health professionals, and health related agencies;**
- IV.A.5.d).(3) work effectively as a member or leader of a health care team or other professional group;**
- IV.A.5.d).(4) act in a consultative role to other physicians and health professionals; and,**

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

IV.A.5.e) Professionalism

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

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

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

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

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

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

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

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

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

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

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

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

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

IV.A.5.f).(6) participate in identifying system errors and

implementing potential systems solutions.

IV.B. Residents' Scholarly Activities

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

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

IV.B.2.a) This participation may include resident interaction with faculty members who:

IV.B.2.a).(1) participate in research conferences that emphasize the presentation of original research;

IV.B.2.a).(2) participate in research or scholarly activity that leads to publication or presentations at regional or national scientific meetings; and,

IV.B.2.a).(3) offer guidance and technical support such as research design and statistical analysis to residents involved in research or scholarly activity.

IV.B.2.b) Participation may also include residents' presentation of a case report or a presentation to colleagues on a subject of interest, and/or development of a research project.

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

V. Evaluation

V.A. Resident Evaluation

V.A.1. Formative Evaluation

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

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

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

- V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);
- V.A.1.b).(3) document progressive resident performance improvement appropriate to educational level; and,
- V.A.1.b).(4) provide each resident with documented semiannual evaluation of performance with feedback.
- V.A.1.c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.
- V.A.2. **Summative Evaluation**
- V.A.2.a) The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. This evaluation must:
- V.A.2.b) document the resident's performance during the final period of education, and
- V.A.2.c) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.
- V.A.3. The Transitional Year Review Committee does not require that the summative evaluation include verification that the resident has demonstrated sufficient competence to enter practice without direct supervision. For transitional year residents, the summative evaluation must verify that the resident has demonstrated sufficient competence and has successfully completed the transitional year residency.
- V.B. **Faculty Evaluation**
- V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program.
- V.B.2. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.
- V.B.3. This evaluation must include at least annual written confidential evaluations by the residents.
- V.C. **Program Evaluation and Improvement**
- V.C.1. The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track

each of the following areas:

- V.C.1.a) resident performance;**
- V.C.1.b) faculty development;**
- V.C.1.c) graduate performance, including performance of program graduates on the certification examination; and,**
- V.C.1.d) program quality. Specifically:**
 - V.C.1.d).(1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and**
 - V.C.1.d).(2) The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.**
- V.C.2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.**

VI. Resident Duty Hours in the Learning and Working Environment

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

- VI.A.1. Programs and sponsoring institutions must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.**
- VI.A.2. The program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment.**
- VI.A.3. The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.**
- VI.A.4. The learning objectives of the program must:**
 - VI.A.4.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,**
 - VI.A.4.b) not be compromised by excessive reliance on residents to fulfill non-physician service obligations.**

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

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

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

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

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

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

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

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

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

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

VI.B. Transitions of Care

VI.B.1. Programs must design clinical assignments to minimize the number of transitions in patient care.

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

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

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

VI.C. Alertness Management/Fatigue Mitigation

- VI.C.1. The program must:**
- VI.C.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;**
 - VI.C.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; and,**
 - VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.**
- VI.C.2. Each program must have a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties.**
- VI.C.3. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home.**
- VI.D. Supervision of Residents**
- VI.D.1. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.**
 - VI.D.1.a) This information should be available to residents, faculty members, and patients.**
 - VI.D.1.b) Residents and faculty members should inform patients of their respective roles in each patient's care.**
 - VI.D.2. The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.**

Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care.
 - VI.D.3. Levels of Supervision**

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

- VI.D.3.a) **Direct Supervision – the supervising physician is physically present with the resident and patient.**
- VI.D.3.b) **Indirect Supervision:**
 - VI.D.3.b).(1) **with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.**
 - VI.D.3.b).(2) **with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.**
- VI.D.3.c) **Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.**
- VI.D.4. **The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.**
 - VI.D.4.a) **The program director must evaluate each resident’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.**
 - VI.D.4.b) **Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.**
 - VI.D.4.c) **Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.**
- VI.D.5. **Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.**
 - VI.D.5.a) **Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.**

- VI.D.5.a).(1)** In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.
- VI.D.6.** Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.
- VI.E. Clinical Responsibilities**
- The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services.
- VI.F. Teamwork**
- Residents must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty.
- VI.G. Resident Duty Hours**
- VI.G.1. Maximum Hours of Work per Week**
- Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.
- VI.G.1.a) Duty Hour Exceptions**
- A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.
- The Transitional Year Review Committee will not consider requests for exceptions to the 80-hour limit to the residents' work week.
- VI.G.1.a).(1)** In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.
- VI.G.1.a).(2)** Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.
- VI.G.2. Moonlighting**

- VI.G.2.a) Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.**
- VI.G.2.b) Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.**
- VI.G.2.c) PGY-1 residents are not permitted to moonlight.**
- VI.G.3. Mandatory Time Free of Duty**
- Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.**
- VI.G.4. Maximum Duty Period Length**
- VI.G.4.a) Duty periods of PGY-1 residents must not exceed 16 hours in duration.**
- VI.G.4.b) Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.**
- VI.G.4.b).(1) It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.**
- VI.G.4.b).(2) Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.**
- VI.G.4.b).(3) In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.**
- VI.G.4.b).(3).(a) Under those circumstances, the resident must:**
- VI.G.4.b).(3).(a).(i) appropriately hand over the care of all**

- other patients to the team responsible for their continuing care; and,
- VI.G.4.b).(3).(a).(ii)** document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.
- VI.G.4.b).(3).(b)** The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.
- VI.G.5. Minimum Time Off between Scheduled Duty Periods**
- VI.G.5.a)** PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.
- VI.G.5.b)** Intermediate-level residents should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.
- 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.
- VI.G.5.c).(1)** This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.
- VI.G.5.c).(1).(a)** Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.
- VI.G.6. Maximum Frequency of In-House Night Float**
- Residents must not be scheduled for more than six consecutive nights of night float.
- VI.G.7. Maximum In-House On-Call Frequency**
- PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-

week period).

VI.G.8. At-Home Call

VI.G.8.a) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.

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

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

VII. Innovative Projects

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

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