



**Accreditation Council for
Graduate Medical Education**

ACGME Program Requirements for Graduate Medical Education in General Surgery

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Common Program Requirements are in BOLD

Where applicable, text in italics describes the underlying philosophy of the requirements in that section. These philosophic statements are not program requirements and are therefore not citable.

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. Definition and Scope of the Specialty

The practice of surgery encompasses the provision of comprehensive care to the patient with surgical disorders of the abdomen and its contents; the alimentary tract; skin, soft tissues, and breast; endocrine organs; and trauma. It provides the foundation for the surgical evaluation and management of patients with oncologic, vascular, pediatric, and intensive care disorders. Comprehensive care includes (but is not limited to) the evaluation, diagnosis, and treatment (both operative and non-operative) of surgical disorders, as well as the appropriate disposition and follow-up of the patients with those disorders. In order to provide optimal comprehensive care, the surgeon must effectively function in interprofessional and, often, multidisciplinary teams, frequently in a leadership role.

Int.B.1 The goal of a surgical residency program is to prepare the resident (1) to perform the role of a surgeon at the advanced level expected of a board-certified specialist, and (2) to direct interprofessional and multispecialty

teams necessary for the care of surgical patients. The education of surgeons in the performance of general surgery encompasses (1) didactic instruction in the basic and clinical sciences of surgical diseases and conditions; (2) education in procedural skills and operative techniques; and (3) preparation for the life-long provision of comprehensive care to surgical patients. The educational process must lead to the acquisition of an appropriate fund of knowledge and skills (including technical skills), the ability to integrate the acquired knowledge into the clinical situation, and the development of surgical judgment.

Int.C. Duration and Scope of Education

The length of a surgery residency program is five clinical years. ^{(Core)*}

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.
^(Core)

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. ^(Core)

I.A.1. An accredited surgery program must be conducted in an institution that can document a sufficient breadth of patient care. At a minimum, the institution must routinely care for patients with a broad spectrum of surgical diseases and conditions, including all of the essential content areas in surgical education. In addition, these institutions must include facilities and staff for a variety of other services that provide a critical role in the care of patients with surgical conditions, including radiology and pathology. ^(Detail)

I.A.2. The program director must be provided with a minimum of 30% protected time, which may take the form of direct or indirect salary support, such as release from clinical activities provided by the institution. ^(Core)

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. ^(Core)

The PLA should:

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

- I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;** ^(Detail)
- I.B.1.c) specify the duration and content of the educational experience; and,** ^(Detail)
- I.B.1.d) state the policies and procedures that will govern resident education during the assignment.** ^(Detail)
- 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).** ^(Core)
- I.B.3. Integrated and Non-Integrated Sites**
- An integrated or non-integrated site is defined as any site to which residents rotate for an assigned experience. There are two types of institutional relationships: integrated and non-integrated.
- I.B.3.a) An integrated site contributes substantially to the educational activities of the residency program.**
- I.B.3.a).(1) The program director must appoint the members of the teaching staff and the local program director at an integrated site.** ^(Detail)
- I.B.3.a).(2) The faculty at an integrated site must demonstrate a commitment to scholarly pursuits.** ^(Detail)
- I.B.3.a).(3) Clinical experiences in the essential content areas should be obtained in integrated sites. Exceptions will be considered on a case-by-case basis.** ^(Detail)
- I.B.3.a).(4) An integrated site should be in geographic proximity to allow all residents to attend core conferences. If the integrated site is geographically remote and joint conferences cannot be held, an equivalent educational program of lectures and conferences in the integrated site must occur and must be fully documented. Morbidity and mortality reviews must occur at each integrated site or at a combined central location.** ^(Detail)
- I.B.3.a).(5) Integration will not be approved between two sites if both have an accredited residency program in the same specialty.** ^(Detail)
- I.B.3.a).(6) Chief residents may be assigned only to participating integrated sites or to the primary clinical site/sponsoring**

institution. ^(Detail)

- I.B.3.b) A participating non-integrated site should supplement resident education by providing focused clinical experience not available at the primary clinical site or at the integrated site. ^(Detail)
- I.B.3.b).(1) Assignment to participating non-integrated sites must have a clear educational rationale. ^(Detail)
- I.B.3.b).(2) Advance approval of the Review Committee is required for resident assignment of six months or more at a participating non-integrated site. ^(Detail)
- I.B.3.b).(3) Advance approval of the Review Committee is not required for resident assignment of less than six months, but the educational rationale for such assignments will be evaluated at the time of each site-visit and accreditation review. ^(Detail)

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.** ^(Core)
- II.A.1.a) **The program director must submit this change to the ACGME via the ADS.** ^(Core)
- II.A.1.b) The Review Committee must approve the qualifications of the program director. ^(Core)
- 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.** ^(Detail)
- II.A.2.a) The program director's initial appointment should be for at least six years. ^(Core)
- 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;** ^(Core)
- II.A.3.b) **current certification in the specialty by the American Board of Surgery, or specialty qualifications that are acceptable to the Review Committee;** ^(Core)
- II.A.3.c) **current medical licensure and appropriate medical staff**

appointment; ^(Core)

II.A.3.d) unrestricted credentials at the primary clinical site/sponsoring institution, and license to practice medicine in the state where the sponsoring institution is located; and, ^(Detail)

II.A.3.e) scholarly activity in at least one of the areas of scholarly activity delineated in Section II.B.5 of this document. ^(Detail)

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. ^(Core)

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; ^(Core)

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

II.A.4.c) approve the selection of program faculty as appropriate; ^(Core)

II.A.4.d) evaluate program faculty; ^(Core)

II.A.4.e) approve the continued participation of program faculty based on evaluation; ^(Core)

II.A.4.f) monitor resident supervision at all participating sites; ^(Core)

II.A.4.g) prepare and submit all information required and requested by the ACGME. ^(Core)

II.A.4.g).(1) This includes but is not limited to the program application forms and annual program updates to the ADS, and ensure that the information submitted is accurate and complete. ^(Core)

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; ^(Detail)

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

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, ^(Core)

and, to that end, must:

- II.A.4.j).(1) **distribute these policies and procedures to the residents and faculty;** ^(Detail)
- II.A.4.j).(2) **monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;** ^(Core)
- II.A.4.j).(3) **adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,** ^(Detail)
- 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.** ^(Detail)
- 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;** ^(Detail)
- 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;** ^(Detail)
- 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;** ^(Detail)
- II.A.4.n) **obtain review and approval of the sponsoring institution's GMEC/DIO before submitting information or requests to the ACGME, including:** ^(Core)
 - II.A.4.n).(1) **all applications for ACGME accreditation of new programs;** ^(Detail)
 - II.A.4.n).(2) **changes in resident complement;** ^(Detail)
 - II.A.4.n).(3) **major changes in program structure or length of training;** ^(Detail)
 - II.A.4.n).(4) **progress reports requested by the Review Committee;** ^(Detail)
 - II.A.4.n).(5) **requests for increases or any change to resident duty hours;** ^(Detail)
 - II.A.4.n).(6) **voluntary withdrawals of ACGME-accredited programs;** ^(Detail)

- II.A.4.n).(7)** requests for appeal of an adverse action; and, ^(Detail)
- II.A.4.n).(8)** appeal presentations to a Board of Appeal or the ACGME. ^(Detail)
- II.A.4.o)** obtain DIO review and co-signature on all program application forms, as well as any correspondence or document submitted to the ACGME that addresses: ^(Detail)
- II.A.4.o).(1)** program citations, and/or, ^(Detail)
- II.A.4.o).(2)** request for changes in the program that would have significant impact, including financial, on the program or institution. ^(Detail)
- II.A.4.p) devote his or her principal effort to the program; ^(Detail)
- II.A.4.q) designate other well-qualified surgeons to assist in the supervision and education of the residents; ^(Detail)
- II.A.4.r) be responsible for all clinical assignments and input into the teaching staff appointments at all sites; ^(Core)
- II.A.4.s) along with the faculty, be responsible for the preparation and implementation of a comprehensive, effective, and well-organized educational curriculum; ^(Core)
- II.A.4.t) ensure that conferences be scheduled to permit resident attendance on a regular basis, and resident time must be protected from interruption by routine clinical duties. Documentation of attendance by 75% of residents at the core conferences must be achieved; ^(Detail)
- II.A.4.u) ensure that the following types of conferences exist within a program:
- II.A.4.u).(1)** a course or a structured series of lectures that ensures education in the basic and clinical sciences fundamental to surgery, including technological advances that relate to surgery and the care of patients with surgical diseases, as well as education in critical thinking, design of experiments and evaluation of data; ^(Detail)
- II.A.4.u).(2)** regular organized clinical teaching, such as grand rounds, ward rounds, and clinical conferences; ^(Detail)
- II.A.4.u).(3)** a weekly morbidity and mortality or quality improvement conference. ^(Core)
- II.A.4.u).(3).(a)** Sole reliance on textbook review is inadequate.

- II.A.4.v) along with the physician faculty, assess the technical competence of each resident; ^(Core)
- II.A.4.v).(1) The Review Committee requires that each resident perform a minimum number of certain cases for accreditation. Performance of this minimum number of cases by a resident must not be interpreted as an equivalent to competence achievement; ^(Detail)
- II.A.4.w) ensure that each resident has at least 750 major cases across the five years of training. This must include a minimum of 150 major cases in the resident's chief year; ^(Outcome)
- II.A.4.x) ensure that residents have required experience with a variety of endoscopic procedures, including esophogastro-duodenoscopy, colonoscopy and bronchoscopy as well as experience in advanced laparoscopy; ^(Core)
- II.A.4.y) ensure that residents have required experience with evolving diagnostic and therapeutic methods; ^(Core)
- II.A.4.z) along with the physician faculty members, ensure that residents have experiential learning in the provision of all elements of the comprehensive care of surgical patients; and, ^(Core)
- II.A.4.aa) appoint an associate program director for programs with more than 20 categorical residents. ^(Detail)

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.** ^(Core)

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;** ^(Core)
- II.B.1.b) **administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas; and,** ^(Core)
- II.B.1.c) for each approved chief resident position, consist of at least one full-time faculty member in addition to the program director (i.e., if there are three approved chief residents, there must be at least four fulltime faculty). The major function of these faculty is to support the program. These faculty must be appointed for a period sufficient to ensure continuity in the educational activities of the

residency program. ^(Core)

- II.B.2. The physician faculty must have current certification in the specialty by the American Board of Surgery, or possess qualifications judged acceptable to the Review Committee.** ^(Core)
- II.B.3. The physician faculty must possess current medical licensure and appropriate medical staff appointment.** ^(Core)
- II.B.4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.** ^(Core)
- II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.** ^(Core)
 - II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.** ^(Detail)
 - 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;** ^(Detail)
 - II.B.5.b).(2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;** ^(Detail)
 - 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,** ^(Detail)
 - II.B.5.b).(4) participation in national committees or educational organizations.** ^(Detail)
 - II.B.5.c) Faculty should encourage and support residents in scholarly activities.** ^(Core)
 - II.B.5.d) The faculty must collectively document active involvement in scholarly activity.** ^(Detail)
 - II.B.5.e) While not all members of the faculty can be investigators, clinical and/or basic science research must be:**
 - II.B.5.e).(1) ongoing in the residency program;** ^(Detail)
 - II.B.5.e).(2) based at the institution where residents spend the majority of their clinical time; and,** ^(Detail)
 - II.B.5.e).(3) performed by faculty with frequent, direct resident involvement.** ^(Detail)
 - II.B.5.f) Resident research is not a substitute for the involvement of the**

program director and faculty in research.

- II.B.6. Faculty members, including the program director, must regularly participate in faculty development activities related to resident education, including evaluation, feedback, mentoring, supervision, or teaching. ^(Core)

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. ^(Core)

- II.C.1. There must be a full-time surgery program coordinator designated specifically for surgical education. ^(Core)
- II.C.1.a) Programs with more than 20 residents should be provided with additional administrative personnel. ^(Core)

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. ^(Core)

- II.D.1. These resources must include:
- II.D.1.a) a common office space for residents that includes a sufficient number of computers and adequate workspace at the primary clinical site; ^(Core)
- II.D.1.b) internet access to appropriate full-text journals and electronic medical reference resources for education and patient care at all participating sites; ^(Core)
- II.D.1.c) on-line radiographic and laboratory reporting systems at the primary clinical site and integrated sites; and, ^(Core)
- II.D.1.d) software resources for production of presentations, manuscripts, and portfolios. ^(Core)
- II.D.2. Resources must include simulation and skills laboratories. These facilities must address acquisition and maintenance of skills with a competency-based method of evaluation. ^(Core)
- II.D.3. The institutional volume and variety of operative experience must be adequate to ensure a sufficient number and distribution of complex cases (as determined by the Review Committee) for each resident in the program. ^(Core)

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.
(Detail)

III. Resident Appointments

III.A. Eligibility Criteria

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

III.A.1. Eligibility Requirements – Residency Programs

III.A.1.a) All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, or in Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada. Residency programs must receive verification of each applicant’s level of competency in the required clinical field using ACGME or CanMEDS Milestones assessments from the prior training program. (Core)

III.A.1.b) A physician who has completed a residency program that was not accredited by ACGME, RCPSC, or CFPC may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director at the ACGME-accredited program may be advanced to the PGY-2 level based on ACGME Milestones assessments at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry. (Core)

III.A.1.c) A Review Committee may grant the exception to the eligibility requirements specified in Section III.A.2.b) for residency programs that require completion of a prerequisite residency program prior to admission. (Core)

III.A.1.d) Review Committees will grant no other exceptions to these eligibility requirements for residency education. (Core)

III.A.2. Eligibility Requirements – Fellowship Programs

All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, or in an RCPSC-accredited or CFPC- accredited residency program located in Canada. (Core)

III.A.2.a) Fellowship programs must receive verification of each entering fellow's level of competency in the required field using ACGME or CanMEDS Milestones assessments from the core residency program. ^(Core)

III.A.2.b) Fellow Eligibility Exception

A Review Committee may grant the following exception to the fellowship eligibility requirements:

An ACGME-accredited fellowship program may accept an exceptionally qualified applicant**, who does not satisfy the eligibility requirements listed in Sections III.A.2. and III.A.2.a), but who does meet all of the following additional qualifications and conditions: ^(Core)

III.A.2.b).(1) Assessment by the program director and fellowship selection committee of the applicant's suitability to enter the program, based on prior training and review of the summative evaluations of training in the core specialty; and ^(Core)

III.A.2.b).(2) Review and approval of the applicant's exceptional qualifications by the GMEC or a subcommittee of the GMEC; and ^(Core)

III.A.2.b).(3) Satisfactory completion of the United States Medical Licensing Examination (USMLE) Steps 1, 2, and, if the applicant is eligible, 3, and; ^(Core)

III.A.2.b).(4) For an international graduate, verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification; and, ^(Core)

III.A.2.b).(5) Applicants accepted by this exception must complete fellowship Milestones evaluation (for the purposes of establishment of baseline performance by the Clinical Competency Committee), conducted by the receiving fellowship program within six weeks of matriculation. This evaluation may be waived for an applicant who has completed an ACGME International-accredited residency based on the applicant's Milestones evaluation conducted at the conclusion of the residency program. ^(Core)

III.A.2.b).(5).(a) If the trainee does not meet the expected level of Milestones competency following entry into the fellowship program, the trainee must undergo a period of remediation, overseen by the Clinical Competency Committee and monitored by the GMEC or a subcommittee of

the GMEC. This period of remediation must not count toward time in fellowship training. ^(Core)

**** An exceptionally qualified applicant has (1) completed a non-ACGME-accredited residency program in the core specialty, and (2) demonstrated clinical excellence, in comparison to peers, throughout training. Additional evidence of exceptional qualifications is required, which may include one of the following: (a) participation in additional clinical or research training in the specialty or subspecialty; (b) demonstrated scholarship in the specialty or subspecialty; (c) demonstrated leadership during or after residency training; (d) completion of an ACGME-International-accredited residency program.**

III.B. Number of Residents

The program's educational resources must be adequate to support the number of residents appointed to the program. ^(Core)

III.B.1. The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. ^(Core)

III.B.2. All resident positions must be approved in advance by the Review Committee. ^(Core)

III.B.3. Residency positions must be allocated to one of two groups: categorical or preliminary positions. ^(Detail)

III.B.3.a) Categorical (C) residents are accepted into the residency program with the expectation of completing the surgery program, assuming satisfactory performance. ^(Core)

III.B.3.a).(1) At the PG1, PG2, PG3, and PG4 levels, the number of categorical residents must not exceed the number of approved chief residency positions. ^(Detail)

III.B.3.b) Preliminary (P) residents are accepted into the program for one or two years before continuing their education. ^(Core)

III.B.3.b).(1) The number of preliminary positions in the PG1 and PG2 years combined must not exceed 300% of the number of approved categorical chief resident positions. ^(Detail)

III.B.3.b).(2) Documentation of continuation in graduate medical education for the preliminary residents must be provided at the time of each site visit. ^(Detail)

III.B.3.b).(3) It is the responsibility of the program director to counsel and assist preliminary residents in obtaining future

positions. ^(Detail)

III.B.4. Increases in resident complement:

III.B.4.a) Both temporary and permanent increases in resident complement must be approved in advance by the Review Committee. ^(Core)

III.B.4.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. ^(Detail)

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.** ^(Detail)

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. ^(Core)

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

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. ^(Core)

III.D.1. **The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.** ^(Detail)

III.D.2. All trainees in both ACGME-accredited and non-accredited programs in the sponsoring and integrated sites that may impact the educational experience of the surgery residents must be identified and their relationship to the surgery residents must be detailed. ^(Detail)

III.D.3. A chief resident and a fellow (whether the fellow is in an ACGME-accredited position or not) must not have primary responsibility for the same patient except that general surgeon and surgical critical care fellows may co-manage the non-operative care of the same patient. ^(Core)

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 make available to residents and faculty; ^(Core)

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty at least annually, in either written or electronic form; ^(Core)

IV.A.3. Regularly scheduled didactic sessions; ^(Core)

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, ^(Core)

IV.A.5. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum: ^(Core)

IV.A.5.a) Patient Care and Procedural Skills

IV.A.5.a).(1) 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. ^(Outcome)

IV.A.5.a).(2) Residents must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. Residents: ^(Outcome)

IV.A.5.a).(2).(a) must demonstrate competence in manual dexterity appropriate for their level; and, ^(Outcome)

IV.A.5.a).(2).(b) must develop competence in and execute comprehensive patient care plans appropriate for the resident's level, including management of pain. ^(Outcome)

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: ^(Outcome)

IV.A.5.b).(1) must demonstrate competence in the critical evaluation and demonstration of knowledge of pertinent scientific

information; (Outcome)

IV.A.5.b).(2) must demonstrate knowledge of the fundamentals of basic science as applied to clinical surgery; and, (Outcome)

IV.A.5.b).(2).(a) Residents must participate in an educational program that includes: applied surgical anatomy and surgical pathology; the elements of wound healing; homeostasis, shock and circulatory physiology; hematologic disorders; immunobiology and transplantation; oncology; surgical endocrinology; surgical nutrition, fluid and electrolyte balance; and the metabolic response to injury, including burns. (Core)

IV.A.5.b).(3) must demonstrate knowledge of the principles of immunology, immunosuppression, and the management of general surgical conditions arising in transplant patients. (Outcome)

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.
(Outcome)

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; (Outcome)

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

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

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

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

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

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

(Outcome)

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

IV.A.5.c).(9) participate in mortality and morbidity conferences that evaluate and analyze patient care outcomes; and, (Outcome)

IV.A.5.c).(10) utilize an evidence-based approach to patient care. (Outcome)

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. (Outcome)

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;** (Outcome)

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

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

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

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

IV.A.5.d).(6) counsel and educate patients and families; and, (Outcome)

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

IV.A.5.e)

Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. (Outcome)

Residents are expected to demonstrate:

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

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

- interest;** (Outcome)
- IV.A.5.e).(3)** **respect for patient privacy and autonomy;** (Outcome)
- IV.A.5.e).(4)** **accountability to patients, society and the profession;** (Outcome)
- 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;** (Outcome)
- IV.A.5.e).(6)** high standards of ethical behavior; and, (Outcome)
- IV.A.5.e).(7)** a commitment to continuity of comprehensive patient care. (Outcome)

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. (Outcome)

Residents are expected to:

- IV.A.5.f).(1)** **work effectively in various health care delivery settings and systems relevant to their clinical specialty;** (Outcome)
- IV.A.5.f).(2)** **coordinate patient care within the health care system relevant to their clinical specialty;** (Outcome)
- IV.A.5.f).(3)** **incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;** (Outcome)
- IV.A.5.f).(4)** **advocate for quality patient care and optimal patient care systems;** (Outcome)
- IV.A.5.f).(5)** **work in interprofessional teams to enhance patient safety and improve patient care quality;** (Outcome)
- IV.A.5.f).(6)** **participate in identifying system errors and implementing potential systems solutions** (Outcome)
- IV.A.5.f).(7)** practice high quality, cost effective patient care; (Outcome)
- IV.A.5.f).(8)** demonstrate knowledge of risk-benefit analysis; and, (Outcome)

- IV.A.5.f).(9) demonstrate an understanding of the role of different specialists and other health care professionals in overall patient management, and actively participate in interprofessional and multispecialty teams. ^(Outcome)
- IV.A.6. Curriculum Organization and Resident Experiences
- IV.A.6.a) Residents will participate in a program that must document a clinical curriculum that is sequential, comprehensive, and organized from basic to complex. ^(Core)
- IV.A.6.a).(1) The clinical assignments should be carefully structured to ensure that graded levels of responsibility, continuity in patient care, a balance between education and service, and progressive clinical experiences are achieved for each resident. ^(Core)
- IV.A.6.a).(2) The 60-month clinical program should be organized as follows: ^(Core)
- IV.A.6.a).(2).(a) At least 54 months of the 60-month program must be spent on clinical assignments in surgery, with documented experience in emergency care and surgical critical care in order to enable residents to manage patients with severe and complex illnesses and with major injuries. ^(Core)
- IV.A.6.a).(2).(b) 42 months of these 54 months must be spent on clinical assignments in the essential content areas of surgery. ^(Core)
- IV.A.6.a).(2).(b).(i) The essential content areas are: the abdomen and its contents; the alimentary tract; skin, soft tissues, and breast; endocrine surgery; head and neck surgery; pediatric surgery; surgical critical care; surgical oncology; trauma and non-operative trauma (burn experience that includes patient management may be counted toward non-operative trauma); and the vascular system. ^(Core)
- IV.A.6.a).(2).(c) A formal rotation in burn care, gynecology, neurological surgery, orthopaedic surgery, cardiac surgery, and urology is not required. Clearly documented goals and objectives must be presented if these components are included as rotations. ^(Detail)
- IV.A.6.a).(2).(c).(i) Knowledge of burn physiology and initial

	burn management is required. ^(Core)
IV.A.6.a).(2).(d)	A formal transplant experience is required. It must include patient management. ^(Core)
IV.A.6.a).(2).(d).(i)	Clearly documented goals and objectives must be presented for this experience. ^(Detail)
IV.A.6.a).(2).(e)	No more than six months total may be allocated to research or to non-surgical disciplines such as anesthesiology, internal medicine, pediatrics, or surgical pathology. ^(Core)
IV.A.6.a).(2).(e).(i)	Gastroenterology is exempt from this limit if this rotation provides endoscopic experiences. ^(Detail)
IV.A.6.a).(2).(f)	No more than 12 months may be devoted to surgical discipline other than the principal components of surgery. ^(Core)
IV.A.6.a).(2).(g)	The Chief Year
IV.A.6.a).(2).(g).(i)	Clinical assignments at the chief resident level should be scheduled in the final (5 th) year of the program. ^(Core)
IV.A.6.a).(2).(g).(i).(a)	To take advantage of a unique educational opportunity in a program, up to 6 months of the chief year may be served in the next to the last year (4 th). ^(Detail)
IV.A.6.a).(2).(g).(ii)	This experience must not occur any earlier than the 4 th clinical year. Any special Program of this type must be approved in advance by the Review Committee. Operative cases counted as the chief cases must be performed during the 12 months designated as the chief year. ^(Detail)
IV.A.6.a).(2).(g).(iii)	The clinical assignments during the chief year must be scheduled at the primary clinical site or at participating integrated site(s). ^(Core)
IV.A.6.a).(2).(g).(iv)	Clinical assignments during the chief year must be in the essential content areas of general surgery. No more than six months of the chief year may be devoted exclusively to only one essential content area. ^(Core)

IV.A.6.a).(2).(g).(v) Noncardiac thoracic surgery and transplantation rotations may be considered an acceptable chief resident assignment as long as the chief resident performs an appropriate number of complex cases with documented participation in pre and post-operative care (program director may use the flexibility outlined in Program Requirement IV.A.6.a).(2).(g).(i).(a)). ^(Detail)

IV.A.6.b) Operative Experience

IV.A.6.b).(1) The program must document that residents are performing a sufficient breadth of complex procedures to graduate qualified surgeons. ^(Core)

IV.A.6.b).(2) All residents (categorical and preliminary residents in ACGME-accredited positions) must enter their operative experience concurrently during each year of the residency in the ACGME case log system. ^(Core)

IV.A.6.b).(3) 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. ^(Core)

IV.A.6.b).(4) When justified by experience, a PG 4 or 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. ^(Detail)

IV.A.6.b).(5) Each program is required to provide residents with an outpatient experience to evaluate patients both pre-operatively, including initial evaluation, and post-operatively. ^(Core)

IV.A.6.b).(6) 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). ^(Detail)

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.** ^(Core)
- IV.B.2. **Residents should participate in scholarly activity.** ^(Core)
 - IV.B.2.a) The participation of residents in clinical and/or laboratory research is encouraged. ^(Detail)
- IV.B.3. **The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.** ^(Detail)

V. Evaluation

V.A. Resident Evaluation

- V.A.1. **The program director must appoint the Clinical Competency Committee.** ^(Core)
 - V.A.1.a) **At a minimum the Clinical Competency Committee must be composed of three members of the program faculty.** ^(Core)
 - V.A.1.a).(1) **The program director may appoint additional members of the Clinical Competency Committee.**
 - V.A.1.a).(1).(a) **These additional members must be physician faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents in patient care and other health care settings.** ^(Core)
 - V.A.1.a).(1).(b) **Chief residents who have completed core residency programs in their specialty and are eligible for specialty board certification may be members of the Clinical Competency Committee.** ^(Core)
 - V.A.1.b) **There must be a written description of the responsibilities of the Clinical Competency Committee.** ^(Core)
 - V.A.1.b).(1) **The Clinical Competency Committee should:**
 - V.A.1.b).(1).(a) **review all resident evaluations semi-annually;** ^(Core)
 - V.A.1.b).(1).(b) **prepare and ensure the reporting of Milestones evaluations of each resident semi-annually to ACGME; and,** ^(Core)

V.A.1.b).(1).(c) **advise the program director regarding resident progress, including promotion, remediation, and dismissal.** ^(Detail)

V.A.2. Formative Evaluation

V.A.2.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.** ^(Core)

V.A.2.b) **The program must:**

V.A.2.b).(1) **provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones;** ^(Core)

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

V.A.2.b).(3) **document progressive resident performance improvement appropriate to educational level; and,** ^(Core)

V.A.2.b).(4) **provide each resident with documented semiannual evaluation of performance with feedback.** ^(Core)

V.A.2.c) **The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.** ^(Detail)

V.A.2.d) **Semiannual assessment must include a review of case volume, breadth, and complexity, and must ensure that residents are entering cases concurrently.** ^(Core)

V.A.2.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.** ^(Core)

V.A.3. Summative Evaluation

V.A.3.a) **The specialty-specific Milestones must be used as one of the tools to ensure residents are able to practice core professional activities without supervision upon completion**

of the program. ^(Core)

V.A.3.b) The program director must provide a summative evaluation for each resident upon completion of the program. ^(Core)

This evaluation must:

V.A.3.b).(1) 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; ^(Detail)

V.A.3.b).(2) document the resident's performance during the final period of education; and, ^(Detail)

V.A.3.b).(3) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision. ^(Detail)

V.B. Faculty Evaluation

V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program. ^(Core)

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. ^(Detail)

V.B.3. This evaluation must include at least annual written confidential evaluations by the residents. ^(Detail)

V.C. Program Evaluation and Improvement

V.C.1. The program director must appoint the Program Evaluation Committee (PEC). ^(Core)

V.C.1.a) The Program Evaluation Committee:

V.C.1.a).(1) must be composed of at least two program faculty members and should include at least one resident; ^(Core)

V.C.1.a).(2) must have a written description of its responsibilities; and, ^(Core)

V.C.1.a).(3) should participate actively in:

V.C.1.a).(3).(a) planning, developing, implementing, and evaluating educational activities of the program; ^(Detail)

- V.C.1.a).(3).(b)** reviewing and making recommendations for revision of competency-based curriculum goals and objectives; ^(Detail)
- V.C.1.a).(3).(c)** addressing areas of non-compliance with ACGME standards; and, ^(Detail)
- V.C.1.a).(3).(d)** reviewing the program annually using evaluations of faculty, residents, and others, as specified below. ^(Detail)
- V.C.2.** The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written, annual program evaluation. ^(Core)
- The program must monitor and track each of the following areas:
- V.C.2.a)** resident performance; ^(Core)
- V.C.2.b)** faculty development; ^(Core)
- V.C.2.b).(1)** The program must provide documentation of faculty member participation in annual faculty development activities relating to resident evaluation and teaching. ^(Core)
- V.C.2.c)** graduate performance, including performance of program graduates on the certification examination; ^(Core)
- V.C.2.c).(1)** The performance of program residents and graduates on the certification examination should be used as one measure of evaluating program effectiveness. ^(Outcome)
- V.C.2.c).(1).(a)** For programs with residents and graduates taking the American Board of Surgery examinations:
- V.C.2.c).(1).(a).(i)** a minimum of 65 percent of residents or graduates who have taken the General Surgery Qualifying Examination during the most recent five-year period must have passed on the first attempt; and, ^(Outcome)
- V.C.2.c).(1).(a).(ii)** a minimum of 65 percent of residents or graduates who have taken the General Surgery Certifying Examination during the most recent five-year period must have passed on the first attempt. ^(Outcome)
- V.C.2.c).(1).(b)** For programs with residents and graduates taking the American Osteopathic Board of Surgery – Surgery examinations:

- V.C.2.c).(1).(b).(i) a minimum of 65 percent of residents and graduates who have taken the Qualifying Examination during the most recent five-year period must have passed on the first attempt; and, ^(Outcome)
- V.C.2.c).(1).(b).(ii) a minimum of 65 percent of residents and graduates who have taken the Certifying Examination on the first attempt during the most recent five-year period must have passed on the first attempt. ^(Outcome)
- V.C.2.d) program quality; and, ^(Core)**
- V.C.2.d).(1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and ^(Detail)**
- V.C.2.d).(2) The program must use the results of residents' and faculty members' assessments of the program together with other program evaluation results to improve the program. ^(Detail)**
- V.C.2.e) progress on the previous year's action plan(s). ^(Core)**
- V.C.3. The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section V.C.2., as well as delineate how they will be measured and monitored. ^(Core)**
- V.C.3.a) The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes. ^(Detail)**

VI. The Learning and Working Environment

Residency education must occur in the context of a learning and working environment that emphasizes the following principles:

- ***Excellence in the safety and quality of care rendered to patients by residents today***
- ***Excellence in the safety and quality of care rendered to patients by today's residents in their future practice***
- ***Excellence in professionalism through faculty modeling of:***
 - ***the effacement of self-interest in a humanistic environment that supports the professional development of physicians***
 - ***the joy of curiosity, problem-solving, intellectual rigor, and discovery***

- **Commitment to the well-being of the students, residents, faculty members, and all members of the health care team**

VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability

VI.A.1. Patient Safety and Quality Improvement

All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Graduate medical education must prepare residents to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by residents who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.

Residents must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating residents will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

It is necessary for residents and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.

VI.A.1.a) Patient Safety

VI.A.1.a).(1) Culture of Safety

A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.

VI.A.1.a).(1).(a) The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)

VI.A.1.a).(1).(b) The program must have a structure that promotes safe, interprofessional, team-based care. (Core)

VI.A.1.a).(2) Education on Patient Safety

Programs must provide formal educational activities that promote patient safety-related goals, tools, and

techniques. ^(Core)

VI.A.1.a).(3)

Patient Safety Events

Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.

VI.A.1.a).(3).(a)

Residents, fellows, faculty members, and other clinical staff members must:

VI.A.1.a).(3).(a).(i)

know their responsibilities in reporting patient safety events at the clinical site;
^(Core)

VI.A.1.a).(3).(a).(ii)

know how to report patient safety events, including near misses, at the clinical site; and, ^(Core)

VI.A.1.a).(3).(a).(iii)

be provided with summary information of their institution's patient safety reports. ^(Core)

VI.A.1.a).(3).(b)

Residents must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. ^(Core)

VI.A.1.a).(4)

Resident Education and Experience in Disclosure of Adverse Events

Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for residents to develop and apply.

VI.A.1.a).(4).(a)

All residents must receive training in how to disclose adverse events to patients and families. ^(Core)

VI.A.1.a).(4).(b)

Residents should have the opportunity to participate in the disclosure of patient safety

events, real or simulated. ^(Detail)

VI.A.1.b) **Quality Improvement**

VI.A.1.b).(1) **Education in Quality Improvement**

A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.

VI.A.1.b).(1).(a) Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities. ^(Core)

VI.A.1.b).(2) **Quality Metrics**

Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.

VI.A.1.b).(2).(a) Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. ^(Core)

VI.A.1.b).(3) **Engagement in Quality Improvement Activities**

Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.

VI.A.1.b).(3).(a) Residents must have the opportunity to participate in interprofessional quality improvement activities. ^(Core)

VI.A.1.b).(3).(a).(i) This should include activities aimed at reducing health care disparities. ^(Detail)

VI.A.2. **Supervision and Accountability**

VI.A.2.a) *Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.*

Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each

resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

- VI.A.2.a).(1) Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care. (Core)
- VI.A.2.a).(1).(a) This information must be available to residents, faculty members, other members of the health care team, and patients. (Core)
- VI.A.2.a).(1).(b) Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. (Core)
- VI.A.2.b) *Supervision may be exercised through a variety of methods. 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, fellow, or senior resident physician, either on site or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.*
- VI.A.2.b).(1) The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)
- VI.A.2.c) **Levels of Supervision**
- To promote oversight of resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision: (Core)
- VI.A.2.c).(1) **Direct Supervision – the supervising physician is physically present with the resident and patient.** (Core)
- VI.A.2.c).(2) **Indirect Supervision:**
- VI.A.2.c).(2).(a) **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. ^(Core)

VI.A.2.c).(2).(b)

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. ^(Core)

VI.A.2.c).(3)

Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. ^(Core)

VI.A.2.d)

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. ^(Core)

VI.A.2.d).(1)

The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones. ^(Core)

VI.A.2.d).(2)

Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. ^(Core)

VI.A.2.d).(3)

Senior residents or fellows should serve in a supervisory role to 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. ^(Detail)

VI.A.2.e)

Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). ^(Core)

VI.A.2.e).(1)

Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. ^(Outcome)

VI.A.2.e).(1).(a)

Initially, PGY-1 residents must be supervised either directly, or indirectly with direct supervision immediately available. ^(Core)

VI.A.2.e).(1).(a).(i)

The program must define those physician tasks for which PGY-1 residents may be

supervised indirectly, with direct supervision available, and must define “direct supervision” in the context of the program.
(Detail)

VI.A.2.e).(1).(a).(ii)

The program must define those physician tasks for which PGY-1 residents must be supervised directly until they have demonstrated competence as defined by the program director, and must maintain records of such demonstrations of competence.
(Detail)

VI.A.2.e).(1).(a).(iii)

The program should use the template of definitions provided in the FAQ or a variation of the template to develop these definitions.
(Detail)

VI.A.2.f)

Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. (Core)

VI.B. Professionalism

VI.B.1.

Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients. (Core)

VI.B.2.

The learning objectives of the program must:

VI.B.2.a)

be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; (Core)

VI.B.2.b)

be accomplished without excessive reliance on residents to fulfill non-physician obligations; and, (Core)

VI.B.2.c)

ensure manageable patient care responsibilities. (Core)

VI.B.3.

The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)

VI.B.4.

Residents and faculty members must demonstrate an understanding of their personal role in the:

VI.B.4.a)

provision of patient- and family-centered care; (Outcome)

- VI.B.4.b) safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; ^(Outcome)
- VI.B.4.c) assurance of their fitness for work, including: ^(Outcome)
- VI.B.4.c).(1) management of their time before, during, and after clinical assignments; and, ^(Outcome)
- VI.B.4.c).(2) recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team. ^(Outcome)
- VI.B.4.d) commitment to lifelong learning; ^(Outcome)
- VI.B.4.e) monitoring of their patient care performance improvement indicators; and, ^(Outcome)
- VI.B.4.f) accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data. ^(Outcome)
- VI.B.5. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition 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. ^(Outcome)
- VI.B.6. Programs must provide a professional, respectful, and civil environment that is free from mistreatment, abuse, or coercion of students, residents, faculty, and staff. Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. ^(Core)
- VI.C. Well-Being
- In the current health care environment, residents and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician. Self-care is an important component of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of residency training. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as they do to evaluate other aspects of resident competence.*
- VI.C.1. This responsibility must include:
- VI.C.1.a) efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations,

providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; ^(Core)

- VI.C.1.b)** attention to scheduling, work intensity, and work compression that impacts resident well-being; ^(Core)
- VI.C.1.c)** evaluating workplace safety data and addressing the safety of residents and faculty members; ^(Core)
- VI.C.1.d)** policies and programs that encourage optimal resident and faculty member well-being; and, ^(Core)
- VI.C.1.d).(1)** Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. ^(Core)
- VI.C.1.e)** attention to resident and faculty member burnout, depression, and substance abuse. The program, in partnership with its Sponsoring Institution, must educate faculty members and residents in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must: ^(Core)
- VI.C.1.e).(1)** encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence; ^(Core)
- VI.C.1.e).(2)** provide access to appropriate tools for self-screening; and, ^(Core)
- VI.C.1.e).(3)** provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. ^(Core)
- VI.C.2.** There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. Each program must have policies and procedures in place that ensure coverage of patient care in the event that a resident may be unable to perform their patient care responsibilities. These policies must be implemented without fear of negative consequences for the resident who is unable to provide the clinical

work. ^(Core)

VI.D. Fatigue Mitigation

VI.D.1. Programs must:

VI.D.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation; ^(Core)

VI.D.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; and, ^(Core)

VI.D.1.c) encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. ^(Detail)

VI.D.2. Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue. ^(Core)

VI.D.3. The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. ^(Core)

VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care

VI.E.1. Clinical Responsibilities

The clinical responsibilities for each resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services. ^(Core)

VI.E.1.a) The provision of optimal care is a continuum from the initial encounter with the patient until follow-up appropriate to that patient's surgical disorder(s) is complete. ^(Detail)

VI.E.1.b) 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. ^(Detail)

VI.E.1.c) The work of the caregiver team should be assigned to team members based on each resident's level of education, experience, and competence. ^(Detail)

VI.E.2. Teamwork

Residents must care for patients in an environment that maximizes 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 and larger health system. (Core)

- VI.E.2.a) Care of the surgical patient requires the effective involvement of nurses, therapists, and other personnel, and often requires the involvement of physicians from other disciplines. Residents must demonstrate an unwavering respect for the skills and contributions of other members of the surgical care team, as well as commitment to the optimal comprehensive care of the patient. (Core)
- VI.E.2.b) Residents must collaborate with attending surgeons, other residents, and other members of interprofessional and multidisciplinary teams to formulate treatment plans for a diverse patient population. (Core)
- VI.E.2.c) 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. (Detail)
- VI.E.2.d) Lines of authority should be defined by programs, and all residents must have a working knowledge of these expected reporting relationships to maximize quality care and patient safety. (Detail)

VI.E.3. Transitions of Care

- VI.E.3.a) **Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure.** (Core)
- VI.E.3.b) **Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.** (Core)
- VI.E.3.c) **Programs must ensure that residents are competent in communicating with team members in the hand-over process.** (Outcome)
- VI.E.3.d) **Programs and clinical sites must maintain and communicate schedules of attending physicians and residents currently responsible for care.** (Core)
- VI.E.3.e) **Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency.** (Core)

VI.F. Clinical Experience and Education

Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.

VI.F.1. Maximum Hours of Clinical and Educational Work per Week

Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. ^(Core)

VI.F.2. Mandatory Time Free of Clinical Work and Education

VI.F.2.a) The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being. ^(Core)

VI.F.2.b) Residents should have eight hours off between scheduled clinical work and education periods. ^(Detail)

VI.F.2.b).(1) There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements. ^(Detail)

VI.F.2.c) Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. ^(Core)

VI.F.2.d) Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. ^(Core)

VI.F.3. Maximum Clinical Work and Education Period Length

VI.F.3.a) Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. ^(Core)

VI.F.3.a).(1) Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. ^(Core)

VI.F.3.a).(1).(a) Additional patient care responsibilities must not be assigned to a resident during this time. ^(Core)

VI.F.4. Clinical and Educational Work Hour Exceptions

VI.F.4.a) In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:

VI.F.4.a).(1) to continue to provide care to a single severely ill or unstable patient; ^(Detail)

VI.F.4.a).(2) humanistic attention to the needs of a patient or family; or, ^(Detail)

VI.F.4.a).(3) to attend unique educational events. ^(Detail)

VI.F.4.b) These additional hours of care or education will be counted toward the 80-hour weekly limit. ^(Detail)

VI.F.4.c) A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.

The Review Committee for General Surgery will not consider requests for exceptions to the 80-hour limit to the residents' work week.

VI.F.4.c).(1) In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the *ACGME Manual of Policies and Procedures*. ^(Core)

VI.F.4.c).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval from the Sponsoring Institution's GMEC and DIO. ^(Core)

VI.F.5. Moonlighting

VI.F.5.a) Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. ^(Core)

VI.F.5.b) Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. ^(Core)

VI.F.5.c) PGY-1 residents are not permitted to moonlight. ^(Core)

VI.F.6. In-House Night Float

Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. ^(Core)

VI.F.6.a) Night float rotations must not exceed two months in duration, four months of night float per PGY level, and 15 months for the entire program. ^(Core)

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

Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). ^(Core)

VI.F.8. At-Home Call

VI.F.8.a) **Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly 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 clinical work and education, when averaged over four weeks.** ^(Core)

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

VI.F.8.b) **Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit.** ^(Detail)

***Core Requirements:** Statements that define structure, resource, or process elements essential to every graduate medical educational program.

Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.

Osteopathic Recognition

For programs seeking Osteopathic Recognition for the entire program, or for a track within the program, the Osteopathic Recognition Requirements are also applicable.

(http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/Osteopathic_Recognition_Requirements.pdf)