

ACGME International Foundational Program Requirements for Graduate Medical Education

I. Institutions

A. Sponsoring Institution

1. 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.
2. The sponsoring institution and the program must ensure the program director has sufficient protected time and financial support for his/her educational and administrative responsibilities to the program.
3. The sponsoring institution must ensure there is a single program director with qualifications and appropriate authority.

B. Participating Sites

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:
 - a) identify the faculty who will assume both educational and supervisory responsibilities for residents;
 - b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;
 - c) specify the duration and content of the educational experience; and,
 - d) state the policies and procedures that will govern resident education during the assignment.
2. The program director must submit any additions or deletions of participating sites routinely providing required or elective educational experiences for the majority of residents through the ACGME-I Accreditation Data System (ADS).
3. Resident assignments away from the sponsoring institution should not prevent residents' regular participation in required didactics.

II. Program Personnel and Resources

A. Program Director

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-I via the ADS.
2. The program director should continue in his/her position for a length of time adequate to maintain continuity of leadership and program stability.
3. Qualifications of the program director should include:
 - a) A minimum of three years documented experience as a clinician, administrator, and educator in the program specialty;
 - b) current American Board of Medical Specialties (ABMS) certification in the program specialty or specialty qualifications that are deemed equivalent or acceptable to the ACGME-I Review

Committee; and,

- c) current medical licensure to practice in the sponsoring institution's host country and appropriate medical staff appointment.
4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME-I competency areas. The program director must:
- a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;
 - b) must dedicate no less than 50% (a minimum of 20 hours per week) of his/her professional effort to the administrative and educational activities of the educational program;
 - c) approve a local director at each participating site who is accountable for resident education;
 - d) approve the selection of program faculty as appropriate;
 - e) evaluate program faculty and approve the continued participation of program faculty based on evaluation;
 - f) monitor resident supervision at all participating sites;
 - g) prepare and submit all information required and requested by the ACGME-I, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure the information submitted is accurate and complete;
 - h) provide each resident with documented semi-annual evaluation of performance with feedback;
 - i) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;
 - j) provide verification of residency education for all residents, including those who leave the program prior to completion;
 - k) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment and must:
 - (1) distribute these policies and procedures to the residents and faculty;
 - (2) monitor resident duty hours, according to institutional and program policies, with a frequency sufficient to ensure compliance with ACGME-I requirements;
 - (3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,
 - (4) monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue, if applicable.
 - l) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;
 - m) 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 resident supervision;
 - n) obtain review and approval from the sponsoring institution's GMEC/DIO before submitting to the ACGME-I information or

requests for the following:

- (1) all applications for ACGME-I accreditation of new programs;
 - (2) changes in resident complement;
 - (3) major changes in program structure or length of training;
 - (4) progress reports requested by the ACGME-I Review Committee;
 - (5) responses to all proposed adverse actions;
 - (6) voluntary withdrawals of ACGME-I accredited programs;
 - (7) requests for appeal of an adverse action;
 - (8) appeal presentations to ACGME-I Review Committee
- o) obtain DIO review and co-sign off on all program information forms as well as any correspondence or document submitted to the ACGME-I that addresses:
- (1) program citations, and/or
 - (2) request for changes in the program that would have significant impact, including financial, on the program or institution.

B. The Faculty

1. There must be a sufficient number of (physician and non-physician) faculty with documented qualifications to instruct and supervise all residents for the program.
2. A portion of the faculty must be core physician faculty who:
 - a) are expert evaluators of the competency domains
 - b) work closely with and support the program director
 - c) assist in developing and implementing evaluation systems,
 - d) teach and advise residents
 - e) devote a minimum of 15 hours per week to resident education and administration
3. All faculty must:
 - a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities and demonstrate a strong interest in resident education;
 - b) administer and maintain an educational environment conducive to educating residents in each of the ACGME-I competency areas;
 - c) participate in faculty development programs designed to enhance the effectiveness of their teaching and to promote scholarly activity;
 - d) establish and maintain an environment of inquiry and scholarship with an active research component.
 - (1) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.
 - (2) Core faculty must demonstrate at least 1 piece of scholarly activity per year, averaged over 5 years by one or more of the following:
 - (a) peer-reviewed funding;
 - (b) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;
 - (c) publication or presentation of case reports or peer-reviewed educational seminars, or clinical series at

- (d) local, regional, national, or international professional and scientific society meetings; or, participation in national or international committees or educational organizations.

(3) Faculty should encourage and support residents in pursuing scholarly activities.

4. All physician faculty must:
 - a) have current ABMS certification in the program specialty or possess qualifications acceptable to the ACGME-I Review Committee; and
 - b) possess current medical licensure and appropriate medical staff appointment.
5. Physician Faculty to Resident Ratio
 - a) In addition to the program director, the core physician faculty to resident ratio must be no less than 1:6.
 - b) The ratio of all physician faculty to residents, which includes all core faculty and the program director, should be 1:1.
6. The non-physician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.

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.

D. Resources

1. The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements.
2. There must be sufficient patient population of different ages and gender, with a variety of ethnic, racial, sociocultural and economical backgrounds, having a range of clinical problems to meet the program's educational goals. Insufficient patient experience does not meet educational needs, and excessive patient load suggests an inappropriate reliance on residents for service obligations, which may jeopardize their educational experience.
3. Residents must have software resources to produce presentations, manuscripts, etc.

E. Medical Information Access

1. 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

A. Eligibility Criteria

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

B. Number of Residents

The program director may not appoint more residents than approved by the ACGME-I 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. There should be at least three residents in each year of the program unless otherwise specified by the specialty.

C. Resident Transfers

1. Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences including their summative competency-based performance evaluation.
2. A program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion.

D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, 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

A. The curriculum must contain the following educational components:

1. Overall educational goals for the program must be distributed to residents and faculty annually in either written or electronic form;
2. Competency-based goals and objectives for each assignment at each educational level that must be distributed to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation;
3. The core curriculum must include a didactic program based upon the core knowledge content and areas defined as resident outcomes in the specialty. Regularly scheduled didactic sessions, including but not limited to:
 - a) multidisciplinary conferences;
 - b) morbidity and mortality conferences;
 - c) journal or evidence-based reviews;
 - d) case-based planned didactic experiences;
 - e) seminars and workshops to meet specific competencies;
 - f) computer-aided instruction; and
 - g) grand rounds.
4. Delineation of educational experiences ensuring the program continues to provide each resident with increased responsibility in patient care and management, leadership, supervision, teaching, and administration.

B. Residents' Scholarly Activities

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.

2. Residents should participate in scholarly activity.
3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.

V. Evaluation

A. The program director must appoint the Clinical Competency Committee and the Program Evaluation Committee.

1. The Clinical Competency Committee should:
 - a) be composed of members of the residency faculty;
 - b) have a written description of its responsibilities including its responsibility to the sponsoring institutions and to the program director; and
 - c) participate actively in:
 - (1) reviewing all resident evaluations by all evaluators; and,
 - (2) making recommendations to the program director for resident progress, including promotion, remediation, and dismissal.
2. The Program Evaluation Committee should:
 - a) be composed of members of the residency faculty and include representation from the residents;
 - b) have a written description of its responsibilities including its responsibility to the sponsoring institution and to the program director; and
 - c) participate actively in:
 - (1) planning, developing, implementing, and evaluating all significant activities of the residency program,
 - (2) developing competency-based curriculum goals and objectives;
 - (3) reviewing annually the program as noted in Section V.D below;
reviewing the GMCC internal review of the residency program with recommended action plans.; and,
 - (4) assuring that areas of non-compliance with ACGME-I standards are corrected.

B. Resident Evaluation

1. Formative Evaluation
 - 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.
 - b) The program must:
 - (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;
 - (2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);
 - (3) document progressive resident performance improvement appropriate to educational level; and,

- (4) provide each resident with a documented semi-annual evaluation of performance with feedback.
 - c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.
 - d) Assessment must include a review of case volume, and breadth and complexity of patient cases.
 - e) Assessment should specifically monitor resident knowledge by use of formal in-service cognitive exams.
 - 2. Summative Evaluation
 - 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.
 - b) The evaluation must:
 - (1) document the resident's performance during the final period of education, and
 - (2) verify the resident has demonstrated sufficient competence to enter practice without direct supervision.
- C. Faculty Evaluation
- 1. The program must evaluate faculty performance as it relates to the educational program at least once per year.
 - 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.
 - 3. The evaluation must include the confidential evaluations written by the residents each year.
- D. Program Evaluation and Improvement
- 1. The program must document formal, systematic evaluation of the curriculum at least once per year. The program must monitor and track each of the following areas:
 - a) resident performance;
 - b) faculty development;
 - c) graduate performance, including performance of program graduates taking the certification examination; and,
 - d) program quality. Specifically:
 - (1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at a minimum of once per year, and
 - (2) The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.
 - 2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the above listed areas. 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

- A. Principles
1. The program must be committed to and be responsible for promoting patient safety and resident well-being and to providing a supportive educational environment.
 2. The learning objectives of the program must not be compromised by excessive reliance on residents to fulfill service obligations.
 3. Didactic and clinical education must have priority in the allotment of residents' time and energy.
 4. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.
- B. Supervision of Residents
- The program must ensure that qualified faculty provides appropriate supervision of residents in patient care activities. All residents must have supervision commensurate to their level of training. Although senior residents require less direction than junior residents, even the most senior residents must be supervised by teaching faculty.
- C. Fatigue
- Faculty and residents must be educated to recognize the signs of fatigue and sleep deprivation and must adopt and apply policies to prevent and counteract its potential negative effects on patient care and learning.
- D. Duty Hours (the terms in this section are defined in the ACGME-I Glossary and apply to all programs).
- Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do *not* include reading and preparation time spent away from the duty site.
1. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
 2. Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of in-house call.
 3. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.
- E. On-call Activities
1. In-house call must occur no more frequently than every third night, averaged over a four-week period.
 2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.
 3. No new patients may be accepted after 24 hours of continuous duty.
 4. At-home call (or pager call)
 - a) The frequency of at-home call is not subject to the every-third-night, or 24+6 limitation. However at-home call must not be so

frequent as to preclude rest and reasonable personal time for each resident.

- b) Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.
- c) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

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Updated: 110211