ACGME International Foundational Program Requirements for Graduate Medical Education

Reformatted: 1 April 2022
Revised: 1 February 2020
Reformatted: 31 March 2016
Revised: 14 March 2013
Initial Approval: 8 December 2009

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Graduate medical education is the crucial step of professional development leading to autonomous clinical practice. It is in this vital phase of the continuum of medical education that residents learn to provide optimal patient care under the supervision of faculty members who not only instruct and supervise, but also serve as role models of excellence, compassion, professionalism, and scholarship.

Graduate medical education has as a core tenet the graded authority and responsibility for patient care. The care of patients is undertaken with appropriate faculty supervision and conditional independence, allowing residents to attain the knowledge, skills, attitudes, and empathy required for autonomous practice.

Graduate medical education develops physicians who focus on excellence in delivery of safe, equitable, affordable, quality care; and the health of the populations they serve. Graduate medical education values the strength that a diverse group of physicians brings to medical care.

Graduate medical education occurs in clinical settings that establish the foundation for practice-based and lifelong learning. The professional development of the physician, begun in medical school, continues through faculty members' modeling of the effacement of self-interest in a humanistic environment that emphasizes joy in curiosity, problem-solving, academic rigor, and discovery. This transformation is often physically, emotionally, and intellectually demanding, and occurs in a variety of clinical learning environments committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.

I. Institution

I.A. Sponsoring Institution

Background and Intent: The Sponsoring Institution is the organization or entity that assumes the ultimate academic responsibility for a program of graduate medical education, consistent with the ACGME Institutional Requirements. When the Sponsoring Institution is not a rotation site for the program, the most commonly utilized site of clinical activity for the program is the primary clinical site.

I.A.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.

I.A.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.

I.A.3. The Sponsoring Institution must ensure there is a single program director with qualifications and appropriate authority.

I.B. Participating Sites

Background and Intent: A participating site is an organization providing educational experiences or educational assignments/rotations for residents. A participating site may be within the Sponsoring Institution's country or jurisdiction or can be an out-of-country posting.

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 approved by the designated institutional official (DIO) and renewed at least every five years.

The PLA should:

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

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

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

I.B.1.d) state the policies and procedures that will govern resident education during the assignment.

I.B.2. The program director must submit any additions or deletions of participating sites routinely providing required or elective educational experiences for the majority of residents through the Accreditation Data System (ADS).

I.B.3. Resident assignments away from the Sponsoring Institution should not prevent residents' regular participation in required didactics.

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.

II.A.1.a) The Sponsoring Institution's Graduate Medical Education Committee (GMEC) must approve a change in program director.

II.A.1.b) After approval, the program director must submit this change to the ACGME-I via ADS.

II.A.2. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME- I Competencies. The program director must:

II.A.2.a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;

II.A.2.b) monitor clinical and working environment at all participating sites;

II.A.2.c) provide a learning and working environment in which residents have the opportunity to raise concerns and provide feedback in a confidential manner as appropriate without fear of intimidation or retaliation;

II.A.2.d) dedicate no less than 50 percent (a minimum of 20 hours per week) of his/her professional effort to the administrative and educational activities of the program;

II.A.2.e) approve a director at each participating site who is accountable for resident education;

II.A.2.f) approve the selection of program faculty members as appropriate;

II.A.2.g) evaluate program faculty members and approve the continued participation of program faculty members based on evaluation;

II.A.2.h) monitor resident supervision at all participating sites;

II.A.2.i) in specialties where ACGME-I Case Logs are required, monitor resident Case Logs at least semi-annually and counsel residents or revise clinical experiences as needed;

II.A.2.j) prepare and submit all information required and requested by the ACGME-I, including program application forms and annual resident updates to ADS, and ensure the information submitted is accurate and complete;

II.A.2.k) meet with and review with each resident the documented semi-annual evaluation of performance, including progress on the specialty-specific Milestones;

II.A.2.l) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the Sponsoring Institution;

II.A.2.m) provide verification of residency education for all residents, including those who leave the program prior to completion;

II.A.2.n) implement policies and procedures consistent with the Institutional and Program Requirements for resident clinical work and education hours and the working environment and must:

II.A.2.n).(1) distribute these policies and procedures to the residents and members of the faculty;

II.A.2.n).(2) monitor resident work hours, according to institutional and program policies, with a frequency sufficient to ensure compliance with ACGME-I requirements;

II.A.2.n).(3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,

II.A.2.n).(4) monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.

II.A.2.o) monitor the need for and ensure the provision of back-up support systems when patient care responsibilities are unusually difficult or prolonged;

II.A.2.p) 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;

II.A.2.q) obtain review and approval from the Sponsoring Institution's GMEC/DIO before submitting to the ACGME-I information or requests for the following:

II.A.2.q).(1) all applications for ACGME-I accreditation of new programs;

II.A.2.q).(2) changes in resident complement;

II.A.2.q).(3) major changes in program structure or length of the educational program;

II.A.2.q).(4) progress reports requested by the Review Committee-International;

II.A.2.q).(5) responses to all proposed adverse actions;

II.A.2.q).(6) voluntary withdrawals of ACGME-I-accredited programs;

II.A.2.q).(7) requests for appeal of an adverse action; and,

II.A.2.q).(8) appeal presentations to the Review Committee-International.

II.A.2.r) obtain DIO review and co-sign-off on all program application forms, as well as on any correspondence or document submitted to the ACGME-I that addresses:

II.A.2.r).(1) program citations; and/or,

II.A.2.r).(2) requests for changes in the program that would have significant impact, including financial, on the program or institution.

II.A.3. The program director should continue in his/her position for a length of time adequate to maintain continuity of leadership and program stability.

II.A.4. Qualifications of the program director should include:

II.A.4.a) a minimum of three years of documented experience as a clinician, administrator, and educator in the specialty;

II.A.4.b) current American Board of Medical Specialties (ABMS) certification or equivalent in the specialty, or specialty qualifications that are ~~deemed equivalent or~~acceptable to the Review Committee-International; and,

II.A.4.c) current medical licensure to practice in the Sponsoring Institution's host country and appropriate medical staff appointment.

II.B. Faculty

II.B.1. There must be a sufficient number of physician and non-physician faculty members with documented qualifications to instruct and supervise all residents in the program.

II.B.2. A portion of the faculty must be designated as core physician faculty members who:

II.B.2.a) are expert evaluators of the Competency domains;

II.B.2.b) work closely with and support the program director;

II.B.2.c) assist in developing and implementing evaluation systems;

II.B.2.d) teach and advise residents; and,

II.B.2.e) devote a minimum of 15 hours per week to resident education and program administration.

II.B.3. All faculty members must:

II.B.3.a) be role models of professionalism;

II.B.3.b) demonstrate commitment to the delivery of safe, quality, cost-effective, patient-centered care;

II.B.3.c) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities and demonstrate a strong interest in resident education;

II.B.3.d) administer and maintain an educational environment conducive to educating residents in each of the ACGME-I Competency areas;

II.B.3.e) participate in faculty development programs designed to enhance the effectiveness of their teaching and to promote scholarly activity; and,

II.B.3.f) establish and maintain an environment of inquiry and scholarship.

II.B.3.f).(1) The members of the faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.

II.B.3.f).(2) Faculty members should encourage and support residents in pursuing scholarly activities.

II.B.4. All physician faculty members must:

II.B.4.a) have current ABMS certification in the specialty or possess qualifications that meet all criteria for appointment as a faculty member at the program's Sponsoring Institution; and,

II.B.4.b) possess current medical licensure and appropriate medical staff appointment.

II.B.5. ~~Physician Faculty to Resident Ratio~~ In addition to the program director, the core physician faculty member-to-resident ratio must be no less than 1:6.

~~II.B.5.b) The ratio of all physician faculty members to residents, which includes all core faculty members and the program director, should be 1:1.~~

II.B.6. Non-physician faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments.

II.C. Other Program Personnel

II.C.1. The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program.

II.C.2. There must be a program coordinator who must be supported for at least 20 hours a week for administrative time.

II.D. Resources

II.D.1. The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for:

II.D.1.b) access to food while on duty;

II.D.1.c) safe, quiet, clean, and private sleep/rest facilities available and accessible for residents with proximity appropriate for safe patient care; and,

II.D.1.d) clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care.

II.D.2. The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty-specific Program Requirements.

II.D.3. There must be a sufficient population of patients of different ages and genders, with a variety of ethnic, racial, sociocultural, and economic backgrounds, having a range of clinical problems to meet the program's educational goals and provide a breadth and depth of experience in the specialty.

II.D.4. Residents must have software resources to produce presentations, manuscripts, etc.

II.D.5. Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format.

II.D.5.b) Electronic medical literature databases with search capabilities must be available.

III. Resident Appointments

III.C. Eligibility Criteria

III.C.1. The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements.

III.D. Number of Residents

III.D.1. The program director may not appoint more residents than approved by the Review Committee-International.

III.D.2. The program's educational resources must be adequate to support the number of residents appointed to the program.

III.D.3. ~~There should be at least three residents in each year of the~~ The number of available positions in the program must be at least one per year unless otherwise specified in the specialty-specific Program Requirements ~~or approved by the Review Committee-International~~.

III.E. Resident Transfers

III.E.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 the resident's summative competency- based performance evaluation.

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

III.F. Appointment of Fellows and Other Learners

III.F.1. The presence of other learners (including 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

IV.C. ACGME-I Competencies

IV.C.1. The program must integrate the following ACGME-I Competencies into the curriculum, and structure the curriculum to support resident attainment of each.

IV.C.1.b) Professionalism
Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.

IV.C.1.c) Patient Care and Procedural Skills
Residents must provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

IV.C.1.d) Medical Knowledge
Residents must demonstrate knowledge of established and evolving biomedical clinical, epidemiological, and social-behavioral sciences, as well at the application of this knowledge to patient care.

IV.C.1.e) 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 lifelong learning.

IV.C.1.f) 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.

IV.C.1.g) Systems-based Practice
Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinates of health, as well as the ability to call effectively on other resources in the system to provide optimal patient care.

IV.D. Regularly Scheduled Educational Activities

IV.D.1. Residents must be provided with protected time to participate in regularly scheduled educational activities.

IV.D.2. The core curriculum must include a didactic program based upon the core knowledge content and areas defined as resident outcomes in the specialty.

IV.D.3. Educational activities should include:

IV.D.3.b) multidisciplinary conferences;

IV.D.3.c) morbidity and mortality conferences;

IV.D.3.d) journal clubs or evidence-based reviews;

IV.D.3.e) case-based planned didactic experiences;

IV.D.3.f) seminars and workshops to meet ACGME-I Competencies, including professionalism;

IV.D.3.g) computer-aided instruction;

IV.D.3.h) simulation; and,

IV.D.3.i) grand rounds.

IV.E. Clinical Experiences

IV.E.1. The curriculum must contain the following educational components:

IV.E.1.b) a set of program aims, consistent with the Sponsoring Institution's mission, the needs of the country or jurisdiction that the program serves, and the desired distinctive capabilities of its graduates;

IV.E.1.c) overall educational goals for the program that must be distributed to residents and faculty members annually in either written or electronic form; and,

IV.E.1.d) competency-based goals and objectives for each assignment at each educational level that must be distributed to residents and faculty members annually, in either written or electronic form, and these should be reviewed by the residents at the start of each rotation.

IV.E.2. Educational experiences must be structured to ensure the program provides each resident with increased responsibility in patient care and management, leadership, supervision, teaching, and administration.

IV.F. Scholarly Activity

IV.F.1. Resident Scholarly Activity

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

IV.F.1.c) Residents should participate in scholarly activity.

IV.F.1.d) The Sponsoring Institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.

IV.F.2. Faculty Scholarly Activity

IV.F.2.b) Among their scholarly activity, programs must demonstrate faculty members' accomplishments in at least three of the following domains:

IV.D.2.a).(1) research in basic science, education, translational science, patient care, or population health;

IV.D.2.a).(2) peer-reviewed grants;

IV.D.2.a).(3) quality improvement and/or patient safety initiatives;

IV.D.2.a).(4) systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports;

IV.D.2.a).(5) creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials;

IV.D.2.a).(6) active membership in national or international committees or leadership in educational organizations; and,

IV.D.2.a).(7) innovations in education.

IV.F.2.c) The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:

IV.D.2.b).(1) faculty member participation in grand rounds; posters; workshops; quality improvement presentations; podium presentations; grant leadership; non-peer-reviewed print/electronic resources; articles or publications; book chapters; textbooks; webinars; service on professional committees; or serving as a journal reviewer, journal editorial board member, or editor; and,

IV.D.2.b).(2) peer-reviewed publication.

V. Evaluation

V.C. Resident Evaluation

V.C.1. Formative Evaluation

V.C.1.b) The members of the faculty must directly observe, evaluate, and provide feedback on resident performance in a timely manner during each rotation or similar educational assignment and document this evaluation at completion of the assignment.

V.C.1.c) The program must:

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

V.A.1.b).(2) use multiple evaluators including faculty members, peers, patients, self, and other professional staff members;

V.A.1.b).(3) document progressive resident performance improvement appropriate to educational level in each of the milestones; and,

V.A.1.b).(4) provide each resident with a documented semi-annual evaluation of performance with feedback aimed at assisting residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth.

V.C.1.d) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.

V.C.1.e) Assessment must include a review of case volume, and breadth and complexity of both inpatient and outpatient cases.

V.C.1.f) Assessment should specifically monitor resident knowledge by use of formal in-service cognitive exams.

V.C.2. Summative Evaluation

V.C.2.b) The program director must provide a summative evaluation for each resident upon completion of the program, which 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.

V.C.2.c) The evaluation must:

V.A.2.b).(1) document the resident's performance during the final period of education; and,

V.A.2.b).(2) verify the resident has demonstrated sufficient competence to enter practice without direct supervision.

V.D. Clinical Competency Committee

V.D.1. Programs must provide residents' objective performance evaluations based on the ACGME-I Competencies and regular evaluation of the Milestones.

V.D.2. The program director must appoint a Clinical Competency Committee (CCC) to review performance evaluations for each resident.

V.D.3. The CCC must:

V.D.3.b) be composed of at least three program faculty members, at least one of whom is a core faculty member;

V.D.3.c) have a written description of its responsibilities, including its responsibility to the Sponsoring Institution and to the program director; and,

V.D.3.d) participate actively in:

V.B.3.c).(1) reviewing all resident evaluations by all evaluators, Case Logs, the Milestones, incident reports, and other data semi- annually; and,

V.B.3.c).(2) making recommendations to the program director for resident progress, including promotion, remediation, corrective actions, or dismissal.

V.D.3.e) The findings of the CCC and program director must be shared with each resident on at least a semi-annual basis.

V.E. Faculty Evaluation

V.E.1. The program must evaluate faculty member performance as it relates to the educational program at least once per year.

V.E.2. These evaluations should include a review of each faculty member's clinical teaching abilities, commitment to the educational program, participation in faculty development related to the individual's skills as an educator, clinical knowledge, professionalism, and scholarly activities.

Background and Intent: Faculty development is structured programming developed to enhance transference of knowledge, skill, and behavior from the educator to the learner. Faculty development may use a variety of methods, such as a lecture, workshop, or video conference, and can use internal or external resources. Programming is based on the needs of the faculty member(s) (individual or group) and may be specific to the institution or the program. Faculty development programming is reported for the program faculty in aggregate.

V.E.3. The evaluation of faculty members must include the confidential evaluations written by the residents each year.

V.F. Program Evaluation and Improvement

V.F.1. The program must document formal, systematic evaluation of the curriculum at least once per year that is based on the program's stated mission and aims and that monitors and tracks each of the following areas:

V.F.1.b) resident performance, including Milestones evaluations;

V.F.1.c) faculty development;

V.F.1.d) graduate performance, including performance of program graduates taking the certification examination;

V.F.1.e) program quality;

V.D.1.d).(1) Residents and faculty members must have the opportunity to evaluate the program confidentially and in writing at least once per year.

V.D.1.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.

V.F.1.f) measures of resident and faculty member well-being;

V.F.1.g) engagement in quality improvement and patient safety efforts, and;

V.F.1.h) scholarly activity of residents and faculty members.

V.F.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 members of the teaching faculty and documented in meeting minutes.

V.F.3. Programs that are reviewed annually as part of the Next Accreditation System-International, must complete a Self-Study prior to the program's accreditation site visit.

V.F.3.b) The Self-Study must include a longitudinal evaluation of the program and its learning environment using data from the following:

V.D.3.a).(1) the annual reviews of the program; and,

V.D.3.a).(2) an analysis of the program's strengths and self-identified areas for improvement.

V.F.3.c) A summary of the Self-Study must be submitted to the DIO.

V.G. Program Evaluation Committee

V.G.1. The program director must appoint a Program Evaluation Committee (PEC) to evaluate the overall program.

V.G.2. The PEC must:

V.G.2.b) be composed of at least two program faculty members, at least one of whom is a core faculty member, and must include resident representatives from different years of the educational program;

V.G.2.c) have a written description of its responsibilities, including its responsibility to the Sponsoring Institution and to the program director; and,

V.G.2.d) participate actively in:

V.E.2.c).(1) planning, developing, implementing, and evaluating all significant activities of the program;

V.E.2.c).(2) developing competency-based curriculum goals and objectives;

V.E.2.c).(3) annually reviewing the program using evaluations from faculty members, residents, and others;

V.E.2.c).(4) creating the Annual Program Evaluation document;

V.E.2.c).(5) reviewing the GMEC internal review of the program with recommended action plans; and,

V.E.2.c).(6) ensuring that areas of non-compliance with ACGME-I requirements are corrected.

VI. The Learning and Working Environment

VI.C. Principles

VI.C.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.

VI.C.2. The learning objectives of the program must not be compromised by excessive reliance on residents to fulfill service obligations.

VI.C.3. Didactic and clinical education must have priority in the allotment of residents' time and energy.

VI.C.4. Work hour assignments must recognize that faculty members and residents collectively have responsibility for the safety and welfare of patients.

VI.D. Patient Safety

VI.D.1. The program and its faculty members, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety.

VI.D.2. The program must have a structure that promotes safe, interprofessional, team-based care.

VI.D.3. Education on Patient Safety

VI.D.3.b) Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques.

VI.D.3.c) Residents, fellows, faculty members, and other clinical staff members must:

VI.B.3.b).(1) know their responsibilities in reporting patient safety events at the clinical site; and,

VI.B.3.b).(2) know how to report patient safety events, including near misses, at the clinical site.

VI.E. Quality Improvement

VI.E.1. Residents must receive training and experience and participate in quality improvement processes, including an understanding of health care disparities.

VI.E.2. Residents must have the opportunity to participate in interprofessional quality improvement activities.

VI.F. Supervision and Accountability

VI.F.1. The program must ensure that qualified faculty members provide appropriate supervision of residents in patient care activities.

VI.F.2. All residents must have supervision commensurate to their level of education.

VI.F.2.b) Although senior residents require less direction than junior residents, even the most senior residents must be supervised by teaching faculty members.

VI.F.3. To promote oversight of resident supervision while providing residents with graded authority and responsibility, the program must have a supervision policy that includes the following classifications of supervision:

VI.F.3.b) Direct Supervision: The supervising physician is physically present with the resident and patient.

VI.F.3.c) Indirect Supervision with Direct Supervision Immediately Available: The supervising physician is physically within the site of patient care and available to provide direct supervision.

VI.F.3.d) Indirect Supervision with Direct Supervision Available: The supervising physician is available by phone or other means, and able to provide supervision, but is not physically present within the site of care.

VI.F.3.e) Oversight: The supervising physician is available to provide review and feedback of procedures or patient care encounters after care is delivered.

VI.G. Professionalism

VI.G.1. The program, in partnership with its Sponsoring Institution, 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.

VI.G.2. Residents and faculty members must demonstrate an understanding of their personal role in the:

VI.G.2.b) provision of patient- and family-centered care; and,

VI.G.2.c) safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events.

VI.G.3. The program must provide a culture of professionalism that supports patient safety and personal responsibility.

VI.G.4. The program must provide a professional, civil, and respectful environment that is free from mistreatment, abuse, or coercion of students, residents, and faculty members.

VI.G.5. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest, including 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.

VI.G.6. The program, in partnership with its Sponsoring Institution, should have a process for education of residents and faculty members regarding unprofessional behavior, as well as a confidential process for reporting, investigating, and addressing such concerns.

VI.H. Well-Being

VI.H.1. The program, in partnership with its Sponsoring Institution, must demonstrate a responsibility to address well-being of residents and faculty members, which includes policies and programs that encourage optimal well-being, access to health and personal care, and recognition of burnout, depression, and substance abuse.

VI.H.2. The responsibility of the program, in partnership with its Sponsoring Institution, to address well-being must include:

VI.H.2.b) attention to scheduling, work intensity, and work compression minimizing non-physician obligations and providing administrative support to impact resident well-being;

VI.H.2.c) evaluating workplace safety;

VI.H.2.d) providing the opportunity to attend medical, mental health, and dental care appointments; and,

VI.H.2.e) attention to resident and faculty member burnout, depression, and substance abuse.

VI.H.3. 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.

VI.H.3.b) The program, in partnership with its Sponsoring Institution, must: 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.

VI.H.4. When residents are unable to attend work due to circumstances such as fatigue, illness, family emergencies, or parental responsibilities, the program must allow an appropriate length of absence from patient care responsibilities.

VI.H.4.b) Residents must be permitted to take leave from patient care responsibilities without fear of negative consequences.

VI.I. Fatigue

VI.I.1. Faculty members 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.

VI.I.2. The program, in partnership with its Sponsoring Institution, must ensure adequate sleeping facilities and safe transportation options for residents who may be too fatigued to safely return home.

VI.J. Transitions of Care

VI.J.1. The program must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure.

VI.J.2. The program, in partnership with its Sponsoring Institution, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.

VI.J.3. Programs and clinical sites must maintain and communicate schedules of attending physicians and residents currently responsible for care.

VI.K. Clinical Experience and Education

VI.I.1. Residents must accurately report their clinical and educational work hours, patient outcomes, Case Logs, and other clinical experience data.

VI.I.2. Clinical and education work hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities and clinical work done at home.

VI.I.3. 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.

VI.I.4. Adequate time for rest and personal activities must be provided. This should consist of an eight-hour time period provided between all daily duty periods and 14-hour period after 24 hours of in-house call.

VI.L. On-Call Activities

VI.L.1. In-house call must occur no more frequently than every third night, averaged over a four-week period.

VI.L.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.

VI.L.3. No new patients may be accepted after 24 hours of continuous duty.

VI.L.4. At-home call (or pager call)

VI.L.4.b) The frequency of at-home call is not subject to the every-third-night, or 24+6 limitation.

VI.L.4.c) At-home call must not be so frequent as to preclude rest and reasonable personal time for each resident.

VI.L.4.d) 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.

VI.L.4.e) When residents are called into the hospital from home, the hours residents spend in-house must be counted toward the 80-hour limit.