



ACGME Program Requirements for Graduate Medical Education in Emergency Medicine including FAQs

Revision Information

ACGME-approved interim revision: September 28, 2026; effective July 1, 2027

Definitions

For more information, see the [ACGME Glossary of Terms](#).

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 with or applying for Osteopathic Recognition, the Osteopathic Recognition Requirements also apply (www.acgme.org/OsteopathicRecognition).

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ACGME Program Requirements for Graduate Medical Education in Emergency Medicine

Common Program Requirements (Residency) are in BOLD

Where applicable, italicized text is used to provide definitions or describe the underlying philosophy of the requirements in that section. These statements are not program requirements and are therefore not citable.

Introduction

Definition of Graduate Medical Education

Graduate medical education is the crucial step of professional development between medical school and 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, but serve as role models of excellence, compassion, cultural sensitivity, professionalism, and scholarship.

Graduate medical education transforms medical students into physician scholars who care for the patient, patient's family, and a heterogeneous community; create and integrate new knowledge into practice; and educate future generations of physicians to serve the public. Practice patterns established during graduate medical education persist many years later.

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, judgment, and empathy required for autonomous practice. Graduate medical education develops physicians who focus on excellence in delivery of safe, accessible, affordable, high-quality care for all, to improve the health of the populations they serve.

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 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.

Definition of Specialty

Residencies in emergency medicine prepare physicians for the practice of emergency medicine. These programs must teach the fundamental skills, knowledge, and humanistic qualities that constitute the foundations of emergency medicine practice. These programs provide progressive responsibility for and experience in these areas to enable effective management of clinical problems. Residents must have the opportunity, under the guidance and supervision of a qualified faculty member, to develop a satisfactory level of clinical maturity, judgment, and technical skill.

On completion of the program, residents should be capable of practicing emergency medicine, able to incorporate new skills and knowledge during their careers, and able to monitor their own physical and mental well-being.

Section 1: Oversight

Sponsoring Institution

The Sponsoring Institution is the organization or entity that assumes the ultimate financial and 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.

Background and Intent: Participating sites will reflect the health care needs of the community and the educational needs of the residents. A wide variety of organizations may provide a robust educational experience and, thus, Sponsoring Institutions and participating sites may encompass inpatient and outpatient settings including, but not limited to a university, a medical school, a teaching hospital, a nursing home, a school of public health, a health department, a public health agency, an organized health care delivery system, a medical examiner's office, an educational consortium, a teaching health center, a physician group practice, federally qualified health center, or an educational foundation.

- 1.1. The program must be sponsored by one ACGME-accredited Sponsoring Institution. (Core)**

Participating Sites

A participating site is an organization providing educational experiences or educational assignments/rotations for residents.

- 1.2. The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)**
- 1.3. There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)**
[See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix]
- 1.3.a. The PLA must be renewed at least every 10 years. (Core)**
[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 1.3.a has been suspended]
- 1.3.b. The PLA must be approved by the designated institutional official (DIO). (Core)**

Background and Intent: While all residency programs must be sponsored by a single ACGME-accredited Sponsoring Institution, many programs will utilize other clinical settings to provide required or elective training experiences. At times it is appropriate to utilize community sites that are not owned by or affiliated with the Sponsoring Institution. Some of these sites may be remote for geographic, transportation, or communication issues. When utilizing such sites, the program must ensure the quality of the educational experience.

Suggested elements to be considered in PLAs will be found in the Guide to the Common Program Requirements. These include:

- **Identifying the faculty members who will assume educational and supervisory responsibility for residents**
- **Specifying the responsibilities for teaching, supervision, and formal evaluation of residents**
- **Specifying the duration and content of the educational experience**
- **Stating the policies and procedures that will govern resident education during the assignment**

- 1.4. The program must monitor the clinical learning and working environment at all participating sites. (Core)**
- 1.5. At each participating site there must be one faculty member, designated by the program director as the site director, who is accountable for resident education at that site, in collaboration with the program director. (Core)**
- 1.6. 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 ACGME's Accreditation Data System (ADS). (Core)**
 - 1.6.a. The program should be based at the primary clinical site. (Core)**
 - 1.6.b. Programs using multiple participating sites must ensure the provision of a unified educational experience for the residents. (Core)**
[See FAQ in Appendix]
 - 1.6.c. Each participating site must offer significant educational opportunities to the overall program. (Core)**
 - 1.6.d. Required rotations to participating sites that are geographically distant from the sponsoring institution must offer educational opportunities unavailable locally that significantly augment residents' overall educational experience. (Core)**
[See FAQ in Appendix]

- 1.6.e. The program should ensure that residents are not unduly burdened by required rotations at geographically distant sites. (Core)

Specialty-Specific Background and Intent: The Review Committee for Emergency Medicine considers a participating site to be geographically distant if it requires extended travel (consistently more than half an hour each way) or if the distance between the site and the Sponsoring Institution exceeds 60 miles.

[See FAQ in Appendix]

1.7. Resources

The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education. (Core)

- 1.7.a. The program must demonstrate the availability of educational resources, including the presence of residents in other specialties, to enhance the training of the emergency medicine residents. (Core)

[See FAQ in Appendix] [See FAQ in Appendix]

- 1.7.b. At every site in which the emergency department provides resident education, the following must be provided: (Core)

[See FAQ in Appendix]

- 1.7.b.1. adequate space for patient care; (Core)

- 1.7.b.2. space for clinical support services; (Core)

- 1.7.b.3. diagnostic imaging completed and results available on a timely basis, especially those required on a STAT basis; (Core)

- 1.7.b.4. laboratory studies completed and results available on a timely basis, especially those required on a STAT basis; (Core)

- 1.7.b.5. office space for core physician faculty members, and residents; (Core)

- 1.7.b.6. instructional space; (Core)

- 1.7.b.7. information systems; and, (Core)

- 1.7.b.8. appropriate security services and systems to ensure a safe working environment. (Core)

- 1.7.c. Clinical support services must include nursing, clerical, intravenous, electrocardiogram (EKG), respiratory therapy, transporter, and phlebotomy, and must be available on a 24-hour basis so that residents are not burdened with these duties. (Core)

[See FAQ in Appendix]

- 1.7.d. Office space for program coordinators and additional support personnel must be provided at the primary clinical site. (Core)

[See FAQ in Appendix]

- 1.7.e. Each clinical site must provide timely consultation from services based on a patient's acuity. (Core)

[See FAQ in Appendix]

- 1.7.e.1. If any clinical services are not available for consultation or admission, each clinical site must have a written protocol for provision of these services elsewhere. (Core)

[See FAQ in Appendix]

- 1.7.e.2. Each clinical site must ensure timely consultation decisions by a provider from admitting and consulting services with decision making authority. (Core)

- 1.7.f. The patient population must include patients broadly representative of society and with a wide variety of clinical problems. (Core)

- 1.7.g. The primary clinical site to which residents rotate must have at least 30,000 emergency department visits annually. (Core)

- 1.7.g.1. The primary clinical site should have a significant number of critically-ill or critically injured patients constituting at least three percent or 1200 (whichever is greater) of the emergency department patients per year. (Core)

[See FAQ in Appendix]

- 1.7.g.2. All other emergency departments to which residents rotate for four months or longer should each have at least 30,000 emergency department visits annually. (Core)

- 1.7.h. Residents must be provided with prompt, reliable systems for communication and interaction with supervisory physicians. (Core)

- 1.8. 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:**

- 1.8.a. access to food while on duty; (Core)**

- 1.8.b. safe, quiet, clean, and private sleep/rest facilities available and accessible for residents with proximity appropriate for safe patient care; (Core)**

Background and Intent: Care of patients within a hospital or health system occurs continually through the day and night. Such care requires that residents function at their peak abilities, which requires the work environment to provide them with the ability to meet their basic needs within proximity of their clinical responsibilities. Access to food and rest are examples of these basic needs, which must be met while residents are working. Residents should have access to refrigeration where food may be stored. Food should be available when residents are required to be in the hospital overnight. Rest facilities are necessary, even when overnight call is not required, to accommodate the fatigued resident.

- 1.8.c.** clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)

Background and Intent: Sites must provide private and clean locations where residents may lactate and store the milk within a refrigerator. These locations should be in close proximity to clinical responsibilities. It would be helpful to have additional support within these locations that may assist the resident with the continued care of patients, such as a computer and a phone. While space is important, the time required for lactation is also critical for the well-being of the resident and the resident's family, as outlined in 6.13.c.1.

- 1.8.d.** security and safety measures appropriate to the participating site; and, (Core)

- 1.8.e.** accommodations for residents with disabilities consistent with the Sponsoring Institution's policy. (Core)

- 1.9.** Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core)

- 1.10.** **Other Learners and Health Care Personnel**
The presence of other learners and other health care personnel, including, but not limited to residents from other programs, subspecialty fellows, and advanced practice providers, must not negatively impact the appointed residents' education. (Core)

Background and Intent: The clinical learning environment has become increasingly complex and often includes care providers, students, and post-graduate residents and fellows from multiple disciplines. The presence of these practitioners and their learners enriches the learning environment. Programs have a responsibility to monitor the learning environment to ensure that residents' education is not compromised by the presence of other providers and learners.

Section 2: Personnel

2.1. Program Director

There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core)

2.2. The Sponsoring Institution's GMEC must approve a change in program director and must verify the program director's licensure and clinical appointment. (Core)

2.2.a. Final approval of the program director resides with the Review Committee. (Core)

[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 2.2.a has been suspended. It is noted that appointment of a program director who does not meet the Common Program Requirements and specialty specific requirements related to minimum qualifications of the program director may result in citation(s) for non-compliance with those requirements]

Background and Intent: While the ACGME recognizes the value of input from numerous individuals in the management of a residency, a single individual must be designated as program director and have overall responsibility for the program. The program director's nomination is reviewed and approved by the GMEC.

2.3. The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability. (Core)

Background and Intent: The success of residency programs is generally enhanced by continuity in the program director position. The professional activities required of a program director are unique and complex and take time to master. All programs are encouraged to undertake succession planning to facilitate program stability when there is necessary turnover in the program director position.

2.4. The program director and, as applicable, the program's leadership team, must be provided with support adequate for administration of the program based upon its size and configuration. (Core)

[See FAQ in Appendix]

2.4.a. The program leadership, in aggregate, must be provided with support equal to a dedicated minimum time specified below for administration of the program. This may be time spent by the program director only or divided between the program director and one or more associate (or assistant) program directors as follows: (Core)

Number of Approved Resident Positions	Minimum Support Required (FTE)	Minimum Number of Assistant or Associate Program Directors
18-20	0.6	1
21-25	0.7	1
26-30	0.8	1
31-35	0.85	1
36-40	1.0	2

Number of Approved Resident Positions	Minimum Support Required (FTE)	Minimum Number of Assistant or Associate Program Directors
41-45	1.10	2
46-50	1.20	2
51-53	1.20	2
54-55	1.30	3
56-60	1.40	3
61-65	1.50	3
66-70	1.55	3
71-75	1.55	3
76-80	1.55	3
81-85	1.55	3
86-90	1.55	3
91-95	1.55	3
96-100	1.55	3

[See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix]

- 2.4.b. From the support table listed above, program directors of programs approved for 18-35 residents must be provided no less than 35 percent support and program directors of programs approved for 36 or more residents must be provided no less than 50 percent support. ^(Core)

Background and Intent: To achieve successful graduate medical education, individuals serving as education and administrative leaders of residency programs, as well as those significantly engaged in the education, supervision, evaluation, and mentoring of residents, must have sufficient dedicated professional time to perform the vital activities required to sustain an accredited program.

The ultimate outcome of graduate medical education is excellence in resident education and patient care.

The program director and, as applicable, the program leadership team, devote a portion of their professional effort to the oversight and management of the residency program, as defined in 2.6. – 2.6.I. Both provision of support for the time required for the leadership effort and flexibility regarding how this support is provided are important. Programs, in partnership with their Sponsoring Institutions, may provide support for this time in a variety of ways. Examples of support may include, but are not limited to, salary support, supplemental compensation, educational value units, or relief of time from other professional duties.

Program directors and, as applicable, members of the program leadership team, who are new to the role may need to devote additional time to program oversight and management initially as they learn and become proficient in administering the program. It is suggested that during this initial period the support described above be increased as needed.

In addition, it is important to remember that the dedicated time and support requirement for ACGME activities is a *minimum*, recognizing that, depending on the unique needs of the program, additional support may be warranted. The need to ensure adequate resources, including adequate support and dedicated time for the program director, is also addressed in Institutional Requirement 2.2.a. The amount of support and dedicated time needed for individual programs will vary based on a number of factors and may exceed the minimum specified in the applicable specialty/subspecialty-specific Program Requirements. It is expected that the Sponsoring Institution, in partnership with its accredited programs, will ensure support for program directors to fulfill their program responsibilities effectively.

[See FAQ in Appendix] [See FAQ in Appendix]

2.5. Qualifications of the Program Director

The program director must possess specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee. (Core)

Background and Intent: Leading a program requires knowledge and skills that are established during residency and subsequently further developed. The time period from completion of residency until assuming the role of program director allows the individual to cultivate leadership abilities while becoming professionally established. The three-year period is intended for the individual's professional maturation.

The broad allowance for educational and/or administrative experience recognizes that strong leaders arise through a variety of pathways. These areas of expertise are important when identifying and appointing a program director. The choice of a program director should be informed by the mission of the program and the needs of the community.

In certain circumstances, the program and Sponsoring Institution may propose and the Review Committee may accept a candidate for program director who fulfills these goals but does not meet the three-year minimum.

Specialty-Specific Background and Intent: To ensure programs can maintain compliance with ACGME requirements, provide a stable learning environment, and provide residents with an optimal learning experience, it is essential that program director candidates have previous experience as a core faculty member in an ACGME-accredited or AOA-approved emergency medicine program. It is desirable that the core faculty experience occurred in the program the program director will lead.

[See FAQ in Appendix] [See FAQ in Appendix]

- 2.5.a. The program director must possess current certification in the specialty for which they are the program director by the American Board of Emergency Medicine (ABEM) or by the American Osteopathic Board of Emergency Medicine (AOBEM), or specialty qualifications that are acceptable to the Review Committee.**

[See FAQ in Appendix]

- 2.5.a.1. The Review Committee for Emergency Medicine will only consider ABMS and AOA board certification as acceptable program director certification qualifications. (Core)**

- 2.5.b. The program director must demonstrate ongoing clinical activity. (Core)**

Background and Intent: A program director is a role model for faculty members and residents. The program director must participate in clinical activity consistent with the specialty. This activity will allow the program director to role model the Core Competencies for the faculty members and residents.

[See FAQ in Appendix]

2.5.c. The program director must be a core physician faculty member. (Core)
[See FAQ in Appendix]

2.5.d. The program director must have demonstrated experience in a leadership role. (Core)

Specialty-Specific Background and Intent: Leadership experiences acceptable to the Review Committee when considering a new program director candidate include:

- experience as an assistant/associate program director or site director
- administrative program experience, such as serving on the program's Clinical Competency Committee (CCC), Program Evaluation Committee, or GMEC, or serving as a fellowship program director
- leadership role in the program, such as chair of the department, chair of the CCC, research director, etc.

[See FAQ in Appendix]

2.5.e. The program director must include evidence of ongoing involvement in scholarly activity, including peer-reviewed publications. (Core)

Specialty-Specific Background and Intent: Peer-reviewed publications may include scholarship of discovery or disseminated peer-reviewed teaching methods, or original contributions of knowledge published in journals indexed in PubMed or MEDLINE. Submissions to peer-reviewed online venues and MedEdPORTAL also count. This does not include abstracts, editorials, or letters to the editor submitted to peer-reviewed journals that have not undergone the rigorous, blinded, multiple peer-review process.

Non-peer-reviewed publications include all submissions to journals or online venues that do not fulfill peer-review criteria. This also includes abstracts, editorials, or letters to the editor submitted to peer-reviewed journals that have not undergone the rigorous, blinded, multiple peer-review process. This category also includes educational videos, social media posts, and podcasts.

[See FAQ in Appendix]

2.6. Program Director Responsibilities

The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care. (Core)

2.6.a. The program director must be a role model of professionalism. (Core)

Background and Intent: The program director, as the leader of the program, must serve as a role model to residents in addition to fulfilling the technical aspects of the role. As residents are expected to demonstrate compassion, integrity, and respect for others, they must be able to look to the program director as an exemplar. It is of utmost importance, therefore, that the program director model outstanding professionalism, high quality patient care, educational excellence, and a scholarly approach to work. The program director creates an environment where respectful discussion is welcome, with the goal of continued improvement of the educational experience.

2.6.b. The program director must design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program. (Core)

Background and Intent: The mission of institutions participating in graduate medical education is to improve the health of the public. Each community has health needs that vary based upon location and demographics. Programs must understand the social determinants of health of the populations they serve and incorporate them in the design and implementation of the program curriculum, with the ultimate goal of addressing these needs and eliminating health disparities.

2.6.c. The program director must administer and maintain a learning environment conducive to educating the residents in each of the ACGME Competency domains. (Core)

Background and Intent: The program director may establish a leadership team to assist in the accomplishment of program goals. Residency programs can be highly complex. In a complex organization, the leader typically has the ability to delegate authority to others, yet remains accountable. The leadership team may include physician and non-physician personnel with varying levels of education, training, and experience.

2.6.d. The program director must have the authority to approve or remove physicians and non-physicians as faculty members at all participating sites, including the designation of core faculty members, and must develop and oversee a process to evaluate candidates prior to approval. (Core)

Background and Intent: The provision of optimal and safe patient care requires a team approach. The education of residents by non-physician educators may enable the resident to better manage patient care and provides valuable advancement of the residents' knowledge. Furthermore, other individuals contribute to the education of residents in the basic science of the specialty or in research methodology. If the program director determines that the contribution of a non-physician individual is significant to the education of the residents, the program director may designate the individual as a program faculty member or a program core faculty member.

- 2.6.e.** The program director must have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program. (Core)

Background and Intent: The program director has the responsibility to ensure that all who educate residents effectively role model the Core Competencies. Working with a resident is a privilege that is earned through effective teaching and professional role modeling. This privilege may be removed by the program director when the standards of the clinical learning environment are not met.

There may be faculty in a department who are not part of the educational program, and the program director controls who is teaching the residents.

- 2.6.f.** The program director must submit accurate and complete information required and requested by the DIO, GMEC, and ACGME. (Core)

Background and Intent: This includes providing information in the form and format requested by the ACGME and obtaining requisite sign-off by the DIO.

- 2.6.g.** The program director must provide a learning and working environment in which residents have the opportunity to raise concerns, report mistreatment, and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation. (Core)
- 2.6.h.** The program director must ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process, including when action is taken to suspend or dismiss, or not to promote or renew the appointment of a resident. (Core)

Background and Intent: A program does not operate independently of its Sponsoring Institution. It is expected that the program director will be aware of the Sponsoring Institution's policies and procedures, and will ensure they are followed by the program's leadership, faculty members, support personnel, and residents.

- 2.6.i. The program director must ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination. (Core)
- 2.6.j. The program director must document verification of education for all residents within 30 days of completion of or departure from the program. (Core)
- 2.6.k. The program director must provide verification of an individual resident's education upon the resident's request, within 30 days. (Core)

Background and Intent: Primary verification of graduate medical education is important to credentialing of physicians for further training and practice. Such verification must be accurate and timely. Sponsoring Institution and program policies for record retention are important to facilitate timely documentation of residents who have previously completed the program. Residents who leave the program prior to completion also require timely documentation of their summative evaluation.

- 2.6.l. The program director must provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s). (Core)

Faculty

Faculty members are a foundational element of graduate medical education – faculty members teach residents how to care for patients. Faculty members provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach and model exemplary behavior. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.

Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves.

Background and Intent: “Faculty” refers to the entire teaching force responsible for educating residents. The term “faculty,” including “core faculty,” does not imply or require an academic appointment.

- 2.7. There must be a sufficient number of faculty members with competence to instruct and supervise all residents. (Core)**

[See FAQ in Appendix]

2.8. Faculty Responsibilities

Faculty members must be role models of professionalism. (Core)

- 2.8.a. Faculty members must demonstrate commitment to the delivery of safe, high-quality, cost-effective, patient-centered care. (Core)**

Background and Intent: Patients have the right to expect quality, cost-effective care with patient safety at its core. The foundation for meeting this expectation is formed during residency and fellowship. Faculty members model these goals and continually strive for improvement in care and cost, embracing a commitment to the patient and the community they serve.

- 2.8.b. Faculty members must demonstrate a strong interest in the education of residents, including devoting sufficient time to the educational program to fulfill their supervisory and teaching responsibilities. (Core)**

- 2.8.c. Faculty members must administer and maintain an educational environment conducive to educating residents. (Core)**

[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 2.8.c. has been suspended]

- 2.8.d. Faculty members must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. (Core)**

- 2.8.e. Faculty members must pursue faculty development designed to enhance their skills at least annually: (Core)**

Background and Intent: Faculty development is intended to describe structured programming developed for the purpose of enhancing transfer-ence of knowledge, skill, and behavior from the educator to the learner. Faculty development may occur in a variety of configurations (lecture, workshop, etc.) using internal and/or external resources. Programming is typically needs-based (individual or group) and may be specific to the institution or the program. Faculty development programming is to be reported for the residency program faculty in the aggregate.

- 2.8.e.1. as educators and evaluators; (Detail)
- 2.8.e.2. in quality improvement, eliminating health care disparities, and patient safety; (Detail)
- 2.8.e.3. in fostering their own and their residents' well-being; and, (Detail)
- 2.8.e.4. in patient care based on their practice-based learning and improvement efforts. (Detail)

Background and Intent: Practice-based learning serves as the foundation for the practice of medicine. Through a systematic analysis of one's practice and review of the literature, one is able to make adjustments that improve patient outcomes and care. Thoughtful consideration to practice-based analysis improves quality of care, as well as patient safety. This allows faculty members to serve as role models for residents in practice-based learning.

- 2.8.f. Faculty members supervising emergency medicine residents in an adult emergency department must be emergency medicine physicians. (Core)
[See FAQ in Appendix]

2.9. Faculty Qualifications

Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)

- 2.9.a. Faculty members supervising emergency medicine residents on pediatric emergency medicine rotations where pediatric emergency medicine fellows are also present must be pediatricians, emergency medicine physicians, or pediatric emergency medicine physicians. (Core)
[See FAQ in Appendix]

2.10. Physician Faculty Members

Physician faculty members must have current certification in the specialty by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine, or possess qualifications judged acceptable to the Review Committee. (Core)

- 2.10.a. Any other specialty or subspecialty physician faculty members must have current certification in their specialty or subspecialty by the appropriate American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board, or possess qualifications judged acceptable to the Review Committee. (Core)**

Background and Intent: The ACGME expects that physician faculty members (especially core and other required faculty members) have current certification in the specialty or subspecialty by the relevant ABMS member board and/or AOA certifying board. However, in certain instances when a physician faculty member was never eligible for initial certification in the US by one of these entities, programs will be considered in compliance if all the following qualifications are met. The physician faculty member:

- 1. completed residency or fellowship in the relevant specialty or subspecialty;**
- 2. held board certification (if available) in the country where they trained or practiced, if outside the US;**
- 3. holds full and unrestricted licensure to practice medicine in the state where the program is located;**
- 4. has three years of experience in practice (after residency/fellowship) in the US, in the specialty or subspecialty for which they will serve as a physician faculty member;**
- 5. meets standards of professionalism;**
- 6. has demonstrated clinical qualifications and satisfactory patient out-comes; and,**
- 7. fulfills at least one of the following: a) demonstrated 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/fellowship.

2.11. Core Faculty

Core faculty members must have a significant role in the education and supervision of residents and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents. (Core)

Background and Intent: Core faculty members are critical to the success of resident education. They support the program leadership in develop-

ing, implementing, and assessing curriculum, mentoring residents, and assessing residents' progress toward achievement of competence in and the autonomous practice of the specialty. Core faculty members should be selected for their broad knowledge of and involvement in the program, permitting them to effectively evaluate the program. Core faculty members may also be selected for their specific expertise and unique contribution to the program. Core faculty members are engaged in a broad range of activities, which may vary across programs and specialties. Core faculty members provide clinical teaching and supervision of residents, and also participate in non-clinical activities related to resident education and program administration. Examples of these non-clinical activities include, but are not limited to, interviewing and selecting resident applicants, providing didactic instruction, mentoring residents, simulation exercises, completing the annual ACGME Faculty Survey, and participating on the program's Clinical Competency Committee, Program Evaluation Committee, and other GME committees.

- 2.11.a. Core faculty members must complete the annual ACGME Faculty Survey. (Core)**
- 2.11.b. There must be a minimum of one core physician faculty member for every three residents in the program. (Core)
[See FAQ in Appendix] [See FAQ in Appendix]
- 2.11.c. At a minimum, each required core faculty member, excluding program leadership, must be provided with support equal to a dedicated minimum of 10 percent FTE for educational and administrative responsibilities that do not involve direct patient care. (Core)
[See FAQ in Appendix]
- 2.11.d. Assistant or associate program directors must be clinically active in emergency medicine. (Core)
- 2.11.e. Assistant or associate program directors must be core faculty members. (Core)

2.12. Program Coordinator
There must be a program coordinator. (Core)

- 2.12.a. The program coordinator must be provided with dedicated time and support adequate for administration of the program based upon its size and configuration. (Core)**
[See FAQ in Appendix]
- 2.12.b. At a minimum, the program coordinator must be provided with the dedicated time and support specified below for administration of the program: (Core)

Number of Approved Resident Positions	Minimum Support Required (FTE)
18-20	0.9
21-25	1.0

26-30	1.10
31-35	1.20
36-40	1.30
41-45	1.40
46-50	1.50
51-55	1.60
56-60	1.70
61-65	1.80
66-70	1.90
71-75	2.0
76-80	2.10
81-85	2.20
86-90	2.30
91-95	2.40
96-100	2.50

Background and Intent: The requirement does not address the source of funding required to provide the specified salary support.

Each program requires a lead administrative person, frequently referred to as a program coordinator, administrator, or as otherwise titled by the institution. This person will frequently manage the day-to-day operations of the program and serve as an important liaison and facilitator between the learners, faculty and other staff members, and the ACGME. Individuals serving in this role are recognized as program coordinators by the ACGME.

The program coordinator is a key member of the leadership team and is critical to the success of the program. As such, the program coordinator must possess skills in leadership and personnel management appropriate to the complexity of the program. Program coordinators are expected to develop in-depth knowledge of the ACGME and Program Requirements, including policies and procedures. Program coordinators assist the program director in meeting accreditation requirements, educational programming, and support of residents.

Programs, in partnership with their Sponsoring Institutions, should encourage the professional development of their program coordinators and avail them of opportunities for both professional and personal growth. Programs with fewer residents may not require a full-time coordinator; one coordinator may support more than one program.

The minimum required dedicated time and support specified in 2.12.b. includes activities directly related to administration of the accredited program. It is understood that coordinators often have additional responsibilities, beyond those directly related to program

administration, including, but not limited to, departmental administrative responsibilities, medical school clerkships, planning lectures that are not solely intended for the accredited program, and mandatory reporting for entities other than the ACGME. Assignment of these other responsibilities will necessitate consideration of allocation of additional support so as not to preclude the coordinator from devoting the time specified above solely to administrative activities that support the accredited program.

In addition, it is important to remember that the dedicated time and support requirement for ACGME activities is a minimum, recognizing that, depending on the unique needs of the program, additional support may be warranted. The need to ensure adequate resources, including adequate support and dedicated time for the program coordinator, is also addressed in Institutional Requirement 2.2.d. The amount of support and dedicated time needed for individual programs will vary based on a number of factors and may exceed the minimum specified in the applicable specialty/subspecialty-specific Program Requirements. It is expected that the Sponsoring Institution, in partnership with its accredited programs, will ensure support for program coordinators to fulfill their program responsibilities effectively.

[See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix]

2.13. Other Program Personnel

The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective administration of the program. (Core)

Background and Intent: Multiple personnel may be required to effectively administer a program. These may include staff members with clerical skills, project managers, education experts, and staff members to maintain electronic communication for the program. These personnel may support more than one program in more than one discipline.

Section 3: Resident Appointments

3.1. Residents must not be required to sign a non-competition guarantee or restrictive covenant. (Core)

3.2. Eligibility Requirements

An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program: (Core)

- 3.2.a. graduation from a medical school in the United States, accredited by the Liaison Committee on Medical Education (LCME) or graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA); or, ^(Core)
- 3.2.b. graduation from a medical school outside of the United States, and meeting one of the following additional qualifications: ^(Core)
- holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, ^(Core)
 - holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. ^(Core)
- 3.3. 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, AOA-approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada, or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation. ^(Core)
- 3.3.a. Residency programs must receive verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation. ^(Core)

Background and Intent: Programs with ACGME-I Foundational Accreditation or from institutions with ACGME-I accreditation do not qualify unless the program has also achieved ACGME-I Advanced Specialty Accreditation. To ensure entrants into ACGME-accredited programs from ACGME-I programs have attained the prerequisite milestones for this training, they must be from programs that have ACGME-I Advanced Specialty Accreditation.

- 3.4. **Resident Complement**
The program director must not appoint more residents than approved by the Review Committee. ^(Core)

Background and Intent: Programs are required to request approval of all complement changes, whether temporary or permanent, by the Review Committee through ADS. Permanent increases require prior approval from the Review Committee and temporary increases may also require approval. Specialty-specific instructions for requesting a complement increase

are found in the “Documents and Resources” page of the applicable specialty section of the ACGME website.

[See FAQ in Appendix] [See FAQ in Appendix]

- 3.4.a. There should be a total of at least 18 residents in the program. (Core)

Specialty-Specific Background and Intent: A minimum of 18 residents is needed to foster a sense of both the program’s and the department’s identities. Additionally, 18 residents ensures a major impact in the emergency department to allow for meaningful attendance at emergency medicine conferences, provide progressive resident responsibility, and create an impact as resident teachers.

The Review Committee recognizes there may be unique instances in which a program may not fill all resident positions or may have a resident leave the program, causing the program to have fewer than 18 residents on duty per year.

The Review Committee also understands that new programs need time to ramp up until the program is fully staffed. Accordingly, the expectation is that new programs will build toward this total number by Year 3 in a three-year program and by Year 4 in a four-year program.

[See FAQ in Appendix] [See FAQ in Appendix]

3.5. Resident Transfers

The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring resident. (Core)

- 3.6. Prior to accepting a transfer resident, the program must obtain from the resident, and retain written confirmation that the resident understands the impact of the transfer on their eligibility for their intended specialty board’s initial certification. (Core)**

Section 4: Educational Program

The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.

The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.

It is recognized that programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-

specific goals for it and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from one focusing on community health.

4.1. Length of Program

Residency programs in emergency medicine are configured in 36-month and 48-month formats, and must include a minimum of 36 months of clinical education. (Core)

[See FAQ in Appendix]

- 4.1.a. Programs utilizing the 48-month format must ensure that all of the clinical, educational, and milestone elements contained in these Program Requirements are met, and must provide additional in-depth experience in areas related to emergency medicine, such as medical education, clinical- or laboratory-based research, or global health. An educational justification describing the additional educational goals and outcomes to be achieved by residents in the incremental 12 months of education must be submitted to the Review Committee prior to implementation, and at each subsequent accreditation review of residency programs of 48 months' duration. (Core)

4.2. Educational Components

The curriculum must contain the following educational components:

- 4.2.a. a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates, which must be made available to program applicants, residents, and faculty members; (Core)

[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 4.2.a. has been suspended]

- 4.2.b. competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice. These must be distributed, reviewed, and available to residents and faculty members; (Core)

Background and Intent: The trajectory to autonomous practice is documented by Milestones evaluations. Milestones are considered formative and should be used to identify learning needs. Milestones data may lead to focused or general curricular revision in any given program or to individualized learning plans for any specific resident.

[See FAQ in Appendix]

- 4.2.c. delineation of resident responsibilities for patient care, progressive responsibility for patient management, and graded supervision; (Core)

Background and Intent: These responsibilities may generally be described by PGY level and specifically by Milestones progress as

determined by the Clinical Competency Committee. This approach encourages the transition to competency-based education. An advanced learner may be granted more responsibility independent of PGY level and a learner needing more time to accomplish a certain task may do so in a focused rather than global manner.

- 4.2.d. a broad range of structured didactic activities; and, (Core)

Background and Intent: It is intended that residents will participate in structured didactic activities. It is recognized that there may be circumstances in which this is not possible. Programs should define core didactic activities for which time is protected and the circumstances in which residents may be excused from these didactic activities. Didactic activities may include, but are not limited to, lectures, conferences, courses, labs, asynchronous learning, simulations, drills, case discussions, grand rounds, didactic teaching, and education in critical appraisal of medical evidence.

- 4.2.e. formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)

[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 4.2.e. has been suspended]

ACGME Competencies

The Competencies provide a conceptual framework describing the required domains for a trusted physician to enter autonomous practice. These Competencies are core to the practice of all physicians, although the specifics are further defined by each specialty. The developmental trajectories in each of the Competencies are articulated through the Milestones for each specialty.

The program must integrate all ACGME Competencies into the curriculum.

4.3. ACGME Competencies – Professionalism

Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)

Residents must demonstrate competence in:

- 4.3.a. compassion, integrity, and respect for others; (Core)
- 4.3.b. responsiveness to patient needs that supersedes self-interest; (Core)
cultural awareness; (Core)
- 4.3.c. respect for patient privacy and autonomy; (Core)

- 4.3.d. **accountability to patients, society, and the profession;** (Core)
- 4.3.e. **respect and responsiveness to heterogeneous patient populations, including but not limited to gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation;** (Core)
- 4.3.f. **ability to recognize and develop a plan for one's own personal and professional well-being; and,** (Core)
- 4.3.g. **appropriately disclosing and addressing conflict or duality of interest.** (Core)

Background and Intent: This includes the recognition that under certain circumstances, the interests of the patient may be best served by transitioning care to another practitioner. Examples include fatigue, conflict or duality of interest, not connecting well with a patient, or when another physician would be better for the situation based on skill set or knowledge base.

- 4.4. **ACGME Competencies – Patient Care and Procedural Skills (Part A)**
Residents must be able to provide patient care that is patient- and family-centered, compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. (Core)

Background and Intent: Quality patient care is safe, effective, timely, efficient, patient-centered, fair, and designed to improve population health, while reducing per capita costs. In addition, there should be a focus on improving the clinician's well-being as a means to improve patient care and reduce burnout among residents, fellows, and practicing physicians.

- 4.4.a. Residents must demonstrate competence in synthesizing essential data necessary for the correct management of a patient with multiple chronic medical problems and, when appropriate, comparing with a prior medical record and identifying significant differences between the current presentation and past presentations. (Core)
- 4.4.b. Residents must demonstrate competence in generating an appropriate differential diagnosis. (Core)
- 4.4.c. Residents must demonstrate competence in applying the results of diagnostic testing based on the probability of disease and the likelihood of test results altering management. (Core)
- 4.4.d. Residents must demonstrate competence in narrowing and prioritizing the list of weighted differential diagnoses to determine appropriate management based on all of the available data. (Core)
- 4.4.e. Residents must demonstrate competence in implementing an effective patient man-

agement plan. (Core)

- 4.4.f. Residents must demonstrate competence in selecting and prescribing appropriate pharmaceutical agents based upon relevant considerations, such as: allergies; clinical guidelines; intended effect; financial considerations; institutional policies; mechanism of action; patient preferences; possible adverse effects; and potential drug-food and drug-drug interactions; and effectively combining agents and monitoring and intervening in the advent of adverse effects in the emergency department. (Core)
- 4.4.g. Residents must demonstrate competence in progressing along a continuum of managing a single patient, to managing multiple patients and resources within the emergency department. (Core)
- 4.4.h. Residents must demonstrate competence in providing health care services aimed at preventing health problems or maintaining health. (Core)
- 4.4.i. Residents must demonstrate competence in working with health care professionals to provide patient-focused care. (Core)
- 4.4.j. Residents must demonstrate competence in identifying life-threatening conditions and the most likely diagnosis, synthesizing acquired patient data, and identifying how and when to access current medical information. (Core)
- 4.4.k. Residents must demonstrate competence in establishing and implementing a comprehensive disposition plan that uses appropriate consultation resources, patient education regarding diagnosis, treatment plan, medications, and time and location specific disposition instructions. (Core)
- 4.4.l. Residents must demonstrate competence in re-evaluating patients undergoing emergency department observation (and monitoring) and using appropriate data and resources, and, determining the differential diagnosis, treatment plan, and disposition. (Core)

4.5. ACGME Competencies – Patient Care and Procedural Skills (Part B)
Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)

- 4.5.a. Residents must demonstrate competence in performing diagnostic and therapeutic procedures and emergency stabilization. (Core)
- 4.5.b. Residents must demonstrate competence in managing critically ill and injured patients who present to the emergency department, prioritizing critical initial stabilization action, mobilizing hospital support services in the resuscitation of critically-ill or injured patients and reassessing after a stabilizing intervention. (Core)
- 4.5.c. Residents must demonstrate competence in properly sequencing critical actions for patient care and generating a differential diagnosis for an undifferentiated patient. (Core)

- 4.5.d. Residents must demonstrate competence in mobilizing and managing necessary personnel and other hospital resources to meet critical needs of multiple patients. (Core)
- 4.5.e. Residents must demonstrate competence in performing invasive procedures, monitoring unstable patients, and directing major resuscitations of all types on all age groups. (Core)
[See FAQ in Appendix]
- 4.5.f. Residents must perform indicated procedures on all appropriate patients, including those who are uncooperative, at the extremes of age, hemodynamically unstable and who have multiple co-morbidities, poorly defined anatomy, high risk for pain or procedural complications, or require sedation, take steps to avoid potential complications; and recognize the outcome and/or complications resulting from the procedures. (Core)
- 4.5.g. Residents must demonstrate competence in performing the following key index procedures:
 - 4.5.g.1. adult medical resuscitation; (Core)
 - 4.5.g.2. adult trauma resuscitation; (Core)
 - 4.5.g.3. anesthesia and pain management; (Core)
 - 4.5.g.3.a. Residents must provide safe acute pain management, anesthesia, and procedural sedation to patients of all ages regardless of the clinical situation. (Core)
 - 4.5.g.4. cardiac pacing; (Core)
 - 4.5.g.5. chest tubes; (Core)
 - 4.5.g.6. cricothyrotomy; (Core)
 - 4.5.g.7. dislocation reduction; (Core)
 - 4.5.g.8. emergency department bedside ultrasound; (Core)
 - 4.5.g.8.a. Residents must use ultrasound for the bedside diagnostic evaluation of emergency medical conditions and diagnoses, resuscitation of the acutely ill or injured patient, and procedural guidance. (Core)
 - 4.5.g.9. intubations; (Core)
 - 4.5.g.9.a. Residents must perform airway management on all appropriate patients, including those who are uncooperative, at the extremes of age, hemodynamically unstable and who have multiple co-morbidities, poorly-defined anatomy

my, high risk for pain or procedural complications, or require sedation); take steps to avoid potential complications; and recognize the outcome and/or complications resulting from the procedures. (Core)

- 4.5.g.10. lumbar puncture; (Core)
- 4.5.g.11. pediatric medical resuscitation; (Core)
- 4.5.g.12. pediatric trauma resuscitation; (Core)
- 4.5.g.13. pericardiocentesis; (Core)
- 4.5.g.14. procedural sedation; (Core)
- 4.5.g.15. vaginal delivery; (Core)
- 4.5.g.16. vascular access; and, (Core)
- 4.5.g.16.a. Residents must successfully obtain vascular access in patients of all ages regardless of the clinical situation. (Core)
- 4.5.g.17. wound management. (Core)
- 4.5.g.17.a. Residents must assess and appropriately manage wounds in patients of all ages regardless of the clinical situation. (Core)

4.6. ACGME Competencies – Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, including scientific inquiry, as well as the application of this knowledge to patient care. (Core)

- 4.6.a. Residents must demonstrate appropriate medical knowledge in the care of emergency medicine patients. (Core)
- 4.6.b. Residents must demonstrate knowledge of the scientific method of problem solving, evidence-based decision making, a commitment to lifelong learning, and an attitude of caring derived from humanistic and professional values. (Core)

4.7. ACGME Competencies – 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. (Core)

- 4.7.a. Residents must demonstrate competence in identifying strengths, deficiencies, and limits in one's knowledge and expertise. (Core)

- 4.7.b. Residents must demonstrate competence in setting learning and improvement goals. (Core)
- 4.7.c. Residents must demonstrate competence in identifying and performing appropriate learning activities. (Core)
- 4.7.d. Residents must demonstrate competence in systematically analyzing practice using quality improvement methods, including activities aimed at reducing health care disparities, and implementing changes with the goal of practice improvement. (Core)
- 4.7.e. Residents must demonstrate competence in incorporating feedback and formative evaluation into daily practice. (Core)
- 4.7.f. Residents must demonstrate competence in locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems. (Core)
- 4.7.g. Residents must demonstrate competence in applying knowledge of study design and statistical methods to critically appraise the medical literature. (Core)
- 4.7.h. Residents must demonstrate competence in using information technology to improve patient care. (Core)
- 4.7.i. Residents must demonstrate competence in evaluating teaching effectiveness. (Core)
- 4.7.j. Residents must demonstrate competence in teaching different audiences using appropriate strategies based on targeted learning objectives. (Core)
- 4.8. **ACGME Competencies – 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. (Core)
 - 4.8.a. Residents must demonstrate competence in communicating effectively with patients and patients' families, as appropriate, across a broad range of socioeconomic circumstances, cultural backgrounds, and language capabilities, learning to engage interpretive services as required to provide appropriate care to each patient. (Core)
 - 4.8.b. Residents must demonstrate competence in communicating effectively with physicians, other health professionals, and health-related agencies. (Core)
 - 4.8.c. Residents must demonstrate competence in working effectively as a member or leader of a health care team or other professional group. (Core)
 - 4.8.d. Residents must demonstrate competence in educating patients, patients' families, students, other residents, and other health professionals. (Core)

- 4.8.e. Residents must demonstrate competence in acting in a consultative role to other physicians and health professionals. (Core)
- 4.8.f. Residents must demonstrate competence in maintaining comprehensive, timely, and legible health care records, if applicable. (Core)
- 4.8.g. Residents must learn to communicate with patients and patients' families to partner with them to assess their care goals, including, when appropriate, end-of-life goals. (Core)
- 4.8.h. Residents must demonstrate competence in communicating sensitive issues or unexpected outcomes, including: (Core)
 - 4.8.h.1. diagnostic findings; (Core)
 - 4.8.h.2. end-of-life issues and death; and, (Core)
 - 4.8.h.3. medical errors. (Core)
- 4.8.i. Residents must demonstrate competence in leading patient care teams, ensuring effective communication and mutual respect among team members. (Core)
- 4.9. **ACGME Competencies – Systems-Based Practice**
Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)

Background and Intent: Medical practice occurs in the context of an increasingly complex clinical care environment where optimal patient care requires attention to compliance with external and internal administrative and regulatory requirements.

- 4.9.a. Residents must demonstrate competence in working effectively in various health care delivery settings and systems relevant to their clinical specialty. (Core)
- 4.9.b. Residents must demonstrate competence in coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty. (Core)

Background and Intent: Every patient deserves to be treated as a whole person. Therefore it is recognized that any one component of the health care system does not meet the totality of the patient's needs. An appropriate transition plan requires coordination and forethought by an interdisciplinary team. The patient benefits from proper care and the system benefits from proper use of resources.

- 4.9.c. Residents must demonstrate competence in advocating for quality patient care and optimal patient care systems. (Core)
- 4.9.d. Residents must demonstrate competence in participating in identifying system errors and implementing potential systems solutions. (Core)
- 4.9.e. Residents must demonstrate competence in incorporating considerations of value, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate. (Core)
- 4.9.f. Residents must demonstrate competence in understanding health care finances and its impact on individual patients' health decisions. (Core)
- 4.9.g. Residents must demonstrate competence in using tools and techniques that promote patient safety and disclosure of patient safety events (real or simulated). (Detail)
- 4.9.h. Residents must learn to advocate for patients within the health care system to achieve the patient's and patient's family's care goals, including, when appropriate, end-of-life goals. (Core)
- 4.9.i. Residents must demonstrate competence in participation in performance improvement to optimize self-learning, emergency department function, and patient safety. (Core)
- 4.9.j. Residents must demonstrate competence in using technology to accomplish and document safe health care delivery. (Core)
- 4.9.k. Residents must demonstrate the ability to effectively screen for nutrition, lifestyle, and other social determinants of their patient's presenting health concerns and provide targeted, non-judgmental counseling, resources, and/or referrals that address them. (Core)

Curriculum Organization and Resident Experiences

4.10. Curriculum Structure

The curriculum must be structured to optimize resident educational experiences, the length of the experiences, and the supervisory continuity. These educational experiences include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events. (Core)

Background and Intent: In some specialties, frequent rotational transitions, inadequate continuity of faculty member supervision, and dispersed patient locations within the hospital have adversely affected optimal resident education and effective team-based care. The need for patient care continuity varies from specialty to specialty and by clinical situation, and may be addressed by the individual Review Committee.

- 4.10.a. Clinical experiences should be structured to facilitate learning in a manner that

allows the residents to function as part of an effective interprofessional team that works together toward the shared goals of patient safety and quality improvement.
(Detail)

- 4.10.b. The emergency medicine program director is responsible for determining the duration of the clinical experiences for the emergency medicine residents on all rotations.
(Core)

4.11. Didactic and Clinical Experiences

Residents must be provided with protected time to participate in core didactic activities. (Core)

- 4.11.a. Didactics
Didactic experiences must include administrative seminars, journal review, presentations based on the defined curriculum, morbidity and mortality conferences, and research seminars. (Core)

[See FAQ in Appendix]

- 4.11.a.1. These didactic experiences should include joint conferences co-sponsored with other disciplines. (Core)
- 4.11.a.2. Educational methods should include problem-based learning, evidence-based learning, and computer-based instruction. (Core)
- 4.11.a.3. The majority of didactic experiences must occur at the primary clinical site.
(Core)
[See FAQ in Appendix]
- 4.11.a.4. There must be an average of at least five hours per week of planned didactic experiences developed by the program's faculty members. (Core)
[See FAQ in Appendix]
- 4.11.a.5. Individualized interactive instruction must not exceed 20 percent of the planned didactic experiences. (Core)
[See FAQ in Appendix]
- 4.11.a.6. All planned didactic experiences must be supervised by core physician faculty members. (Core)
- 4.11.a.7. Each core physician faculty member must attend, on average per year, at least 20 percent of planned didactic experiences. (Core)
[See FAQ in Appendix]
- 4.11.a.8. Emergency medicine faculty members must present at least 50 percent of resident conferences. (Core)

- 4.11.a.9. Residents must actively participate, on average, in at least 70 percent of the planned didactic experiences offered. (Core)
[See FAQ in Appendix] [See FAQ in Appendix]
- 4.11.a.10. All planned didactic experiences must have an evaluative component to measure resident participation and educational effectiveness. (Core)
- 4.11.b. Curriculum
The curriculum must include four months of dedicated critical care experiences, including critical care of infants and children. (Core)

[See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix]
- 4.11.b.1. At least two months of these experiences must be at the PGY-2 level or above. (Core)
- 4.11.c. The curriculum must include five FTE months, or 20 percent of all emergency department encounters, dedicated to the care of pediatric patients less than 18 years of age in the pediatric emergency department or other pediatric settings. (Core)
[See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix]
- 4.11.c.1. At least 50 percent of the five months should be in an emergency setting. (Core)
- 4.11.c.2. This experience must include the critical care of infants and children. (Core)
- 4.11.d. The curriculum must include at least 10 low-risk normal spontaneous vaginal deliveries. (Core)
- 4.11.e. The curriculum must include at least 60 percent of each resident's clinical experience, including experiences dedicated to the care of pediatric patients less than 18 years of age in the pediatric emergency department, must take place in the emergency department under the supervision of emergency medicine faculty members. (Core)

[See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix]
- 4.11.e.1. Residents should treat a significant number of critically ill or critically injured patients at participating sites. (Core)
- 4.11.e.1.a. These patients should be those admitted to intensive care units, operative care, or the morgue following treatment in the emergency department. (Core)
- 4.11.f. Resident Experiences
Each resident must maintain, in an accurate and timely manner, a record of all major resuscitations and procedures performed throughout the entire educational program. (Core)
- 4.11.f.1. The record must document each procedure type, adult or pediatric patient, and circumstances of each procedure (live or simulation). (Core)

- 4.11.f.2. Only one resident must be credited with the direction of each resuscitation and the performance of each procedure. (Core)
- 4.11.f.3. Resident experiences with major resuscitations and procedures must at least meet the procedural minimums as defined by the Review Committee where indicated. (Core)
- 4.11.g. Residents must have experience in emergency medical services (EMS), emergency preparedness, and disaster management. (Core)
 - 4.11.g.1. EMS experiences must include ground unit runs and should include direct medical oversight. (Core)
 - 4.11.g.2. This should include participation in multi-casualty incident drills. (Core)
 - 4.11.g.3. If programs allow residents to ride in air ambulance units, the residents must be notified in writing of the associated risks prior to their first flight. (Core)
 - 4.11.g.3.a. Residents must be given the opportunity to opt out of riding in air ambulance units at any point in residency. (Core)

4.12. Pain Management

The program must provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of substance use disorder. (Core)

Scholarship

Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through resident participation in scholarly activities. Scholarly activities may include discovery, integration, application, and teaching.

The ACGME recognizes the variety of residencies and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.

4.13. Program Responsibilities

The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)

- 4.13.a. **The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly**

activities. (Core)

- 4.13.b. The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. (Core)

4.14. Faculty Scholarly Activity

Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core)

- Research in basic science, education, translational science, patient care, or population health
- Peer-reviewed grants
- Quality improvement and/or patient safety initiatives
- Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports
- Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials
- Contribution to professional committees, educational organizations, or editorial boards
- Innovations in education

[See FAQ in Appendix]

- 4.14.a. The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:

- faculty 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; (Outcome)
- peer-reviewed publication. (Outcome)

Background and Intent: For the purposes of education, metrics of scholarly activity represent one of the surrogates for the program's effectiveness in the creation of an environment of inquiry that advances the residents' scholarly approach to patient care. The Review Committee will evaluate the dissemination of scholarship for the program as a whole, not for individual faculty members, for a five-year interval, for both core and non-core faculty members, with the goal of assessing the effectiveness of the creation of such an environment. The ACGME recognizes that there may be differences in scholarship requirements between different specialties and between residencies and fellowships in the same specialty.

Specialty-Specific Background and Intent: The Review Committee will evaluate the faculty scholarly activity based on scholarly output by the faculty as a whole averaged over five years. It is the Review Committee's expectation that the

program demonstrate scholarly activity that is not limited to the efforts of one or two prolific researchers with multiple scholarly works and publications.

[See FAQ in Appendix]

4.15. Resident Scholarly Activity

Residents must participate in scholarship. (Core)

- 4.15.a. The curriculum must advance the residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. (Core)
- 4.15.b. At the time of graduation, each resident should demonstrate:
- active participation in a research project, or formulation and implementation of an original research project, including funded and non-funded basic science or clinical outcomes research, as well as active participation in an emergency department quality improvement project; or, (Outcome)
 - presentation of grand rounds, posters, workshops, quality improvement presentations, podium presentations, webinars; or, (Core)
 - grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; or, (Outcome)

Section 5: Evaluation

Specialty-Specific Background and Intent: Examples of scholarly activity categories:

1. Peer Review – This refers to resident participation in the dissemination of knowledge through the preparation of a scholarly paper published in a journal indexed in PubMed, and original contributions of knowledge published in journals indexed in other formally recognized peer-reviewed databases. Abstracts, editorials, or letters to the editor do not qualify. Submissions to online venues, with the exception of MedEdPORTAL, do not qualify.
2. Non-Peer Review – This includes all submissions to journals or online venues that do not fulfill the peer-review criteria. This also includes abstracts, editorials, collective review, case reports, letters to the editor of peer-reviewed journals, educational videos, DVDs, and podcasts.
3. Textbooks/Chapters – This includes resident participation in the writing and submission of such works where the faculty mentor served as the chapter author.
4. Conference Presentations – This refers to presentations at local, regional, or national organizational meetings, including the presentation of abstracts and posters, panel discussions, and serving as forum leader.

5.1. Resident Evaluation: Feedback and Evaluation

Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)

Background and Intent: Feedback is ongoing information provided regarding aspects of one's performance, knowledge, or understanding. The faculty empower residents to provide much of that feedback themselves in a spirit of continuous learning and self-reflection. Feedback from faculty members in the context of routine clinical care should be frequent, and need not always be formally documented.

Formative and summative evaluation have distinct definitions. Formative evaluation is *monitoring resident learning* and providing ongoing feedback that can be used by residents to improve their learning in the context of provision of patient care or other educational opportunities. More specifically, formative evaluations help:

- residents identify their strengths and weaknesses and target areas that need work
- program directors and faculty members recognize where residents are struggling and address problems immediately

Summative evaluation is *evaluating a resident's learning* by comparing the residents against the goals and objectives of the rotation and program, respectively. Summative evaluation is utilized to make decisions about promotion to the next level of training, or program completion.

End-of-rotation and end-of-year evaluations have both summative and formative components. Information from a summative evaluation can be used formatively when residents or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the residency program.

Feedback, formative evaluation, and summative evaluation compare intentions with accomplishments, enabling the transformation of a neophyte physician to one with growing expertise.

Background and Intent: Faculty members should provide feedback frequently throughout the course of each rotation. Residents require feedback from faculty members to reinforce well-performed duties and tasks, as well as to correct deficiencies. This feedback will allow for the development of the learner as they strive to achieve the Milestones. More frequent feedback is strongly encouraged for residents who have deficiencies that may result in a poor final rotation evaluation.

- 5.1.a. Evaluation must be documented at the completion of the assignment. (Core)
- 5.1.a.1. For block rotations of greater than three months in duration, evaluation must be documented at least every three months. (Core)
- 5.1.a.2. Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion. (Core)
- 5.1.b. The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones. (Core)
- 5.1.b.1. The program must use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members). (Core)
- 5.1.b.2. The program must provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. (Core)
- 5.1.c. The program director or their designee, with input from the Clinical Competency Committee, must meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones. (Core)
- 5.1.c.1. The program director must verify each resident's records of major resuscitations and procedures as part of the semiannual evaluation. (Core)
- 5.1.d. The program director or their designee, with input from the Clinical Competency Committee, must assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth. (Core)
- 5.1.e. The program director or their designee, with input from the Clinical Competency Committee, must develop plans for residents failing to progress, following institutional policies and procedures. (Core)
- 5.1.e.1. A plan to remedy deficiencies must be in writing and on file. (Core)
[See FAQ in Appendix]
- 5.1.e.1.a. Progress and improvement must be monitored at a minimum of every three months if a resident has been identified as needing a remediation plan. (Core)

Background and Intent: Learning is an active process that requires effort from the teacher and the learner. Faculty members evaluate a resident's performance at least at the end of each rotation. The program director or their designee will review those evaluations, including their progress on the Milestones, at a minimum of every six months. Residents should be encouraged to reflect upon the evaluation, using the information to

reinforce well-performed tasks or knowledge or to modify deficiencies in knowledge or practice. Working together with the faculty members, residents should develop an individualized learning plan.

Residents who are experiencing difficulties with achieving progress along the Milestones may require intervention to address specific deficiencies. Such intervention, documented in an individual remediation plan developed by the program director or a faculty mentor and the resident, will take a variety of forms based on the specific learning needs of the resident. However, the ACGME recognizes that there are situations which require more significant intervention that may alter the time course of resident progression. To ensure due process, it is essential that the program director follow institutional policies and procedures.

- 5.1.f. At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable. (Core)**
- 5.1.f.1. At least annually, each resident's competency in procedures and resuscitations must be formally evaluated by the program director. (Core)**
- 5.1.g. The evaluations of a resident's performance must be accessible for review by the resident. (Core)**
- 5.2. Resident Evaluation: Final Evaluation**
The program director must provide a final evaluation for each resident upon completion of the program. (Core)
- 5.2.a. The specialty-specific Milestones, and when applicable the specialty-specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program. (Core)**
- 5.2.b. The final 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. (Core)**
- 5.2.c. The final evaluation must verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice. (Core)**
[See FAQ in Appendix]
- 5.2.d. The final evaluation must be shared with the resident upon completion of the program. (Core)**
- 5.3. Clinical Competency Committee**
A Clinical Competency Committee must be appointed by the program director. (Core)
[See FAQ in Appendix] [See FAQ in Appendix]

- 5.3.a. At a minimum, the Clinical Competency Committee must include three members of the program faculty, at least one of whom is a core faculty member. (Core)**

[See FAQ in Appendix] [See FAQ in Appendix]

- 5.3.b. Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents. (Core)**

Background and Intent: The requirements regarding the Clinical Competency Committee do not preclude or limit a program director's participation on the Clinical Competency Committee. The intent is to leave flexibility for each program to decide the best structure for its own circumstances, but a program should consider: its program director's other roles as resident advocate, advisor, and confidante; the impact of the program director's presence on the other Clinical Competency Committee members' discussions and decisions; the size of the program faculty; and other program-relevant factors. The program director has final responsibility for resident evaluation and promotion decisions.

Program faculty may include more than the physician faculty members, such as other physicians and non-physicians who teach and evaluate the program's residents. There may be additional members of the Clinical Competency Committee. Chief residents who have completed core residency programs in their specialty may be members of the Clinical Competency Committee.

[See FAQ in Appendix]

- 5.3.c. The Clinical Competency Committee must review all resident evaluations at least semi-annually. (Core)**

- 5.3.d. The Clinical Competency Committee must determine each resident's progress on achievement of the specialty-specific Milestones. (Core)**

- 5.3.e. The Clinical Competency Committee must meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress. (Core)**

5.4. Faculty Evaluation

The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)

Background and Intent: The program director is responsible for the educational program and all educators. While the term “faculty” may be applied to physicians within a given institution for other reasons, it is applied to residency program faculty members only through approval by a program director. The development of the faculty improves the education, clinical, and research aspects of a program. Faculty members have a strong commitment to the resident and desire to provide optimal education and work opportunities. Faculty members must be provided feedback on their contribution to the mission of the program. All faculty members who interact with residents desire feedback on their education, clinical care, and research. If a faculty member does not interact with residents, feedback is not required. With regard to the varied operating environments and configurations, the residency program director may need to work with others to determine the effectiveness of the program’s faculty performance with regard to their role in the educational program. All teaching faculty members should have their educational efforts evaluated by the residents in a confidential and anonymous manner. Other aspects for the feedback may include research or clinical productivity, review of patient outcomes, or peer review of scholarly activity. The process should reflect the local environment and identify the necessary information. The feedback from the various sources should be summarized and provided to the faculty on an annual basis by a member of the leadership team of the program.

Specialty-Specific Background and Intent: The Review Committee believes that other important aspects for faculty evaluations may include the faculty member’s administrative and interpersonal skills, quality of feedback and mentoring for residents, and participation in and contributions to resident conferences.

- 5.4.a.** This evaluation must include a review of the faculty member’s clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities. (Core)
- 5.4.b.** This evaluation must include written, anonymous, and confidential evaluations by the residents. (Core)
[See FAQ in Appendix]
- 5.4.c.** Faculty members must receive feedback on their evaluations at least annually. (Core)
- 5.4.d.** Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)

Background and Intent: The quality of the faculty’s teaching and clinical care is a determinant of the quality of the program and the quality of

the residents' future clinical care. Therefore, the program has the responsibility to evaluate and improve the program faculty members' teaching, scholarship, professionalism, and quality care. This section mandates annual review of the program's faculty members for this purpose, and can be used as input into the Annual Program Evaluation.

5.5. Program Evaluation and Improvement

The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)

- 5.5.a. The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident. (Core)**
[See FAQ in Appendix]

- 5.5.b. Program Evaluation Committee responsibilities must include review of the program's self-determined goals and progress toward meeting them. (Core)**

- 5.5.c. Program Evaluation Committee responsibilities must include guiding ongoing program improvement, including development of new goals, based upon outcomes. (Core)**

- 5.5.d. Program Evaluation Committee responsibilities must include review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core)**

Background and Intent: To achieve its mission and educate and train quality physicians, a program must evaluate its performance and plan for improvement in the Annual Program Evaluation. Performance of residents and faculty members is a reflection of program quality, and can use metrics that reflect the goals that a program has set for itself. The Program Evaluation Committee utilizes outcome parameters and other data to assess the program's progress toward achievement of its goals and aims. The Program Evaluation Committee advises the program director through program oversight.

- 5.5.e. The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate resident and faculty written evaluations of the program, and other relevant data in its assessment of the program. (Core)**

Background and Intent: Other data to be considered for assessment include:

- Curriculum

- ACGME letters of notification, including citations, Areas for Improvement, and comments
- Quality and safety of patient care
- Aggregate resident and faculty well-being; recruitment and retention; engagement in quality improvement and patient safety; and scholarly activity
- ACGME Resident and Faculty Survey results
- Aggregate resident Milestones evaluations, and achievement on in-training examinations (where applicable), board pass and certification rates, and graduate performance.
- Aggregate faculty evaluation and professional development

5.5.f. The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. *(Core)*

[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 5.5.f. has been suspended]

5.5.g. The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the residents and the members of the teaching faculty, and be submitted to the DIO. *(Core)*

5.5.h. The program must complete a Self-Study and submit it to the DIO. *(Core)*

[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 5.5.h. has been suspended]

Board Certification

One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.

The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.

5.6. Board Certification

For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. *(Outcome)*

5.6.a. For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. *(Outcome)*

- 5.6.b.** For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)
- 5.6.c.** For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)
- 5.6.d.** For each of the exams referenced in 5.6.a.-c., any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty. (Outcome)

Background and Intent: Setting a single standard for pass rate that works across specialties is not supportable based on the heterogeneity of the psychometrics of different examinations. By using a percentile rank, the performance of the lower five percent (fifth percentile) of programs can be identified and set on a path to curricular and test preparation reform.

There are specialties where there is a very high board pass rate that could leave successful programs in the bottom five percent (fifth percentile) despite admirable performance. These high-performing programs should not be cited, and 5.6.d. is designed to address this.

- 5.6.e.** Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years earlier. (Core)

Background and Intent: It is essential that residency programs demonstrate knowledge and skill transfer to their residents. One measure of that is the qualifying or initial certification exam pass rate. Another important parameter of the success of the program is the ultimate board certification rate of its graduates. Graduates are eligible for up to seven years from residency graduation for initial certification. The ACGME will calculate a rolling three-year average of the ultimate board certification rate at seven years post-graduation, and the Review Committees will monitor it.

The Review Committees will track the rolling seven-year certification rate as an indicator of program quality. Programs are encouraged to monitor their graduates' performance on board certification examinations.

In the future, the ACGME may establish parameters related to ultimate board certification rates.

Section 6: The Learning and Working Environment

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*
- *Appreciation for the privilege of caring for patients*
- *Commitment to the well-being of the students, residents, faculty members, and all members of the health care team*

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.

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

Patient Safety Events

Reporting, investigation, and follow-up of safety 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.

- 6.2. Residents, fellows, faculty members, and other clinical staff members must know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report such events. (Core)
- 6.2.a. Residents, fellows, faculty members, and other clinical staff members must be provided with summary information of their institution's patient safety reports. (Core)
- 6.3. Residents must participate as team members in real and/or simulated interprofessional clinical patient safety and quality improvement activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)

Quality Metrics

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

- 6.4. Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. ^(Core)

[See FAQ in Appendix]

Supervision and Accountability

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.

- 6.5. Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. This information must be available to residents, faculty members, other members of the health care team, and patients. ^(Core)

Background and Intent: Each patient will 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.

- 6.6. 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)

Background and Intent: Appropriate supervision is essential for patient safety and high-quality teaching. Supervision is also contextual. There is tremendous variability of resident-patient interactions, training locations, and resident skills and abilities, even at the same level of the educational program. The degree of supervision for a resident is expected to evolve progressively as the resident gains more experience, even with the same patient condition or procedure. The level of supervision for each resident is commensurate with that resident's level of independence in practice; this level of supervision may be enhanced based on factors such as patient safety, complexity, acuity, urgency, risk of serious safety events, or other pertinent variables.

[See FAQ in Appendix] [See FAQ in Appendix]

Levels of Supervision

To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision.

6.7. Direct Supervision

The supervising physician is physically present with the resident during the key portions of the patient interaction.

The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.

[See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix]

6.7.a. PGY-1 residents must initially be supervised directly, only as described in the above definition. (Core)

[See FAQ in Appendix]

Indirect Supervision

The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.

Oversight

The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

6.8. The program must define when physical presence of a supervising physician is required. (Core)

[See FAQ in Appendix] [See FAQ in Appendix]

6.9. 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)

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

6.9.b. 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)

6.9.c. 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)

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

[See FAQ in Appendix]

6.10.a. 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)

Background and Intent: The ACGME Glossary of Terms defines conditional independence as: Graded, progressive responsibility for patient care with defined oversight.

6.11. 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)

6.12. Professionalism

Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional and ethical responsibilities of physicians, including but not limited to their obligation to be appropriately rested and fit to provide the care required by their patients. (Core)

Background and Intent: This requirement emphasizes the professional responsibility of residents and faculty members to arrive for work adequately rested and ready to care for patients. It is also the responsibility of residents, faculty members, and other members of the care team to be observant, to intervene, and/or to escalate their concern about resident and faculty member fitness for work, depending on the situation, and in accordance with institutional policies. This includes recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team, and 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 practitioner.

6.12.a. The learning objectives of the program must be accomplished without excessive reliance on residents to fulfill non-physician obligations. (Core)

Background and Intent: Routine reliance on residents to fulfill non-physician obligations increases work compression for residents and does not provide an optimal educational experience. Non-physician obligations are those duties which in most institutions are performed by nursing and allied health professionals, transport services, or clerical staff. Examples of such obligations include transport of patients from the wards or units for procedures elsewhere in the hospital; routine blood drawing for laboratory tests; routine monitoring of patients when off the ward; and clerical duties, such as scheduling. While it is understood that residents may be expected to do any of these things on occasion when the need arises, these activities should not be performed by residents routinely and must be kept to a minimum to optimize resident education.

6.12.b. The learning objectives of the program must ensure manageable patient care

responsibilities. (Core)

Background and Intent: The Common Program Requirements do not define “manageable patient care responsibilities” as this is variable by specialty and PGY level. Review Committees will provide further detail regarding patient care responsibilities in the applicable specialty-specific Program Requirements and accompanying FAQs. However, all programs, regardless of specialty, should carefully assess how the assignment of patient care responsibilities can affect work compression, especially at the PGY-1 level.

- 6.12.c.** The learning objectives of the program must include efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, providing administrative support, promoting progressive independence and flexibility, and enhancing professional relationships. (Core)
- 6.12.d.** The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)

Background and Intent: The accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data are the responsibility of the program leadership, residents, and faculty.

[See FAQ in Appendix]

- 6.12.e.** Residents and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events. (Core)
[See FAQ in Appendix]
- 6.12.f.** Programs, in partnership with their Sponsoring Institutions, must provide a professional, respectful, and civil environment that is psychologically safe and that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff. (Core)

Background and Intent: Psychological safety is defined as an environment of trust and respect that allows individuals to feel able to ask for help, admit mistakes, raise concerns, suggest ideas, and challenge ways of working and the ideas of others on the team, including the ideas of those in authority, without fear of humiliation, and the knowledge that mistakes will be handled justly and fairly.

The ACGME is unable to adjudicate disputes between individuals, including residents, faculty members, and staff members. However, information that suggests a pattern of behavior that violates the requirement above

will trigger a careful review and, if deemed appropriate, action by the Review Committee and/or ACGME, in accordance with ACGME Policies and Procedures.

- 6.12.g. 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)

Well-Being

Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of residency training.

Residents and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. A positive culture in a clinical learning environment models constructive behaviors, and prepares residents with the skills and attitudes needed to thrive throughout their careers.

- 6.13. The responsibility of the program, in partnership with the Sponsoring Institution, must include:
- 6.13.a. attention to scheduling, work intensity, and work compression that impacts resident well-being; (Core)
- 6.13.b. evaluating workplace safety data and addressing the safety of residents and faculty members; (Core)

Background and Intent: This requirement emphasizes the responsibility shared by the Sponsoring Institution and its programs to gather information and utilize systems that monitor and enhance resident and faculty member safety, including physical safety. Issues to be addressed include, but are not limited to, monitoring of workplace injuries, physical or emotional violence, vehicle collisions, and emotional well-being after safety events.

- 6.13.c. policies and programs that encourage optimal resident and faculty member well-being; and, (Core)

Background and Intent: Well-being includes having time away from work to engage with family and friends, as well as to attend to personal needs and to one's own health, including adequate rest, healthy diet, and regular exercise. The intent of this requirement is to ensure that residents have the opportunity to access medical and dental care, including mental health care, at times that are appropriate to their individual circumstances. Residents must be provided with time away from the program as needed to access care, including appointments scheduled during their working hours.

- 6.13.c.1.** Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core)
- 6.13.d.** education of residents and faculty members in:
- 6.13.d.1.** identification of the symptoms of burnout, depression, and substance use disorders, suicidal ideation, or potential for violence, including means to assist those who experience these conditions; (Core)
[See FAQ in Appendix]
- 6.13.d.2.** recognition of these symptoms in themselves and how to seek appropriate care; and, (Core)
- 6.13.d.3.** access to appropriate tools for self-screening. (Core)

Background and Intent: Programs and Sponsoring Institutions are encouraged to review materials to create systems for identification of burnout, depression, and substance use disorders. Materials and more information are available in Learn at ACGME (<https://dl.acgme.org/pages/well-being-tools-resources>).

Individuals experiencing burnout, depression, a substance use disorder, and/or suicidal ideation are often reluctant to reach out for help due to the stigma associated with these conditions and may be concerned that seeking help may have a negative impact on their career. Recognizing that physicians are at increased risk in these areas, it is essential that residents and faculty members are able to report their concerns when another resident or faculty member displays signs of any of these conditions, so that the program director or other designated personnel, such as the department chair, may assess the situation and intervene as necessary to facilitate access to appropriate care. Residents and faculty members must know which personnel, in addition to the program director, have been designated with this responsibility; those personnel and the program director should be familiar with the institution's impaired physician policy and any employee health, employee assistance, and/or wellness/well-be-

ing programs within the institution. In cases of physician impairment, the program director or designated personnel should follow the policies of their institution for reporting.

- 6.13.e. providing 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)

Background and Intent: The intent of this requirement is to ensure that residents have immediate access at all times to a mental health professional (psychiatrist, psychologist, Licensed Clinical Social Worker, Primary Mental Health Nurse Practitioner, or Licensed Professional Counselor) for urgent or emergent mental health issues. In-person, telemedicine, or telephonic means may be utilized to satisfy this requirement. Care in the Emergency Department may be necessary in some cases, but not as the primary or sole means to meet the requirement.

The reference to affordable counseling is intended to require that financial cost not be a barrier to obtaining care.

- 6.14. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and medical, parental, or caregiver leave. Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities. (Core)
- 6.14.a. The program must have policies and procedures in place to ensure coverage of patient care and ensure continuity of patient care. (Core)
- 6.14.b. These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work. (Core)

Background and Intent: Residents may need to extend their length of training depending on length of absence and specialty board eligibility requirements. Teammates should assist colleagues in need and fairly reintegrate them upon return.

- 6.15. **Fatigue Mitigation**
Programs must educate all residents and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes. (Detail)

Background and Intent: Providing medical care to patients is physically and mentally demanding. Night shifts, even for those who have had enough rest, cause fatigue. Experiencing fatigue in a supervised environment during training prepares residents for managing fatigue in practice.

It is expected that programs adopt fatigue mitigation processes and ensure that there are no negative consequences and/or stigma for using fatigue mitigation strategies.

Strategies that may be used include but are not limited to strategic napping; the judicious use of caffeine; availability of other caregivers; time management to maximize sleep off-duty; learning to recognize the signs of fatigue, and self-monitoring performance and/or asking others to monitor performance; remaining active to promote alertness; maintaining a healthy diet; using relaxation techniques to fall asleep; maintaining a consistent sleep routine; exercising regularly; increasing sleep time before and after call; and ensuring sufficient sleep recovery periods.

- 6.16. 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)**

[See FAQ in Appendix]

6.17. 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)

Background and Intent: The changing clinical care environment of medicine has meant that work compression due to high complexity has increased stress on residents. Faculty members and program directors need to make sure residents function in an environment that has safe patient care and a sense of resident well-being. It is an essential responsibility of the program director to monitor resident workload. Workload should be distributed among the resident team and interdisciplinary teams to minimize work compression.

[See FAQ in Appendix]

- 6.17.a. When emergency medicine residents are on emergency medicine rotations, the following standards apply: (Core)**
- 6.17.a.1. While on duty in the emergency department, residents may not work longer than 12 continuous scheduled hours. (Core)**
[See FAQ in Appendix]
- 6.17.a.2. There must be at least one equivalent period of continuous time off between scheduled work period. (Core)**
[See FAQ in Appendix]
- 6.17.a.3. A resident must not work more than 60 scheduled hours per week seeing patients in the emergency department, and no more than 72 total hours per week. (Core)**

[See FAQ in Appendix]

- 6.17.a.4. Emergency medicine residents must have a minimum of one day (24-hour period) free per each seven-day period. This cannot be averaged over a four-week period. (Core)

6.18. Teamwork

Residents must care for patients in an environment that maximizes communication and promotes safe, interprofessional, team-based care in the specialty and larger health system. (Core)

Background and Intent: Effective programs will have a structure that promotes safe, interprofessional, team-based care. Optimal patient safety occurs in the setting of a coordinated interprofessional learning and working environment.

- 6.18.a. Interprofessional teams should be used to ensure effective and efficient communication for appropriate patient care for emergency medicine department admissions, transfers, and discharges. (Detail)

Specialty-Specific Background and Intent: Examples of professional personnel who may be part of interprofessional teams, all members of which must participate in the education of residents, include advanced practice providers, case managers, child-life specialists, emergency medical technicians, nurses, pain management specialists, pastoral care specialists, pharmacists, physician assistants, physicians, psychiatrists, psychologists, rehabilitative therapists, respiratory therapists, and social workers.

[See FAQ in Appendix]

6.19. Transitions of Care

Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)

[See FAQ in Appendix]

- 6.19.a. **Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety. (Core)**
- 6.19.b. **Programs must ensure that residents are competent in communicating with team members in the hand-off process. (Outcome)**

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.

Background and Intent: The terms “clinical experience and education,” “clinical and educational work,” and “clinical and educational work hours” replace the terms “duty hours,” “duty periods,” and “duty.” These terms are used in response to concerns that the previous use of the term “duty” in reference to number of hours worked may have led some to conclude that residents’ duty to “clock out” on time superseded their duty to their patients.

6.20. 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, including all in-house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)

Background and Intent: Programs and residents have a shared responsibility to ensure that the 80-hour maximum weekly limit is not exceeded. While the requirement has been written with the intent of allowing residents to remain beyond their scheduled work periods to care for a patient or participate in an educational activity, these additional hours must be accounted for in the allocated 80 hours when averaged over four weeks.

Work from Home

While the requirement specifies that clinical work done from home must be counted toward the 80-hour maximum weekly limit, the expectation remains that scheduling be structured so that residents are able to complete most work on site during scheduled clinical work hours without requiring them to take work home. The requirements acknowledge the changing landscape of medicine, including electronic health records, and the resulting increase in the amount of work residents choose to do from home. The requirement provides flexibility for residents to do this while ensuring that the time spent by residents completing clinical work from home is accomplished within the 80-hour weekly maximum. Types of work from home that must be counted include using an electronic health record and taking calls from home. Reading done in preparation for the following day’s cases, studying, and research done from home do not count toward the 80 hours. Resident decisions to leave the hospital before their clinical work has been completed and to finish that work later from home should be made in consultation with the resident’s supervisor. In such circumstances, residents should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality.

Residents are to track the time they spend on clinical work from home and to report that time to the program. Decisions regarding whether to report infrequent phone calls of very short duration will be left to the

individual resident. Programs will need to factor in time residents are spending on clinical work at home when schedules are developed to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks. There is no requirement that programs assume responsibility for documenting this time. Rather, the program's responsibility is ensuring that residents report their time from home and that schedules are structured to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks.

[See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix]

6.21. Mandatory Time Free of Clinical Work and Education

Residents should have eight hours off between scheduled clinical work and education periods. (Detail)

Background and Intent: 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 occurs within the context of the 80-hour and the one-day-off-in-seven requirements. While it is expected that resident schedules will be structured to ensure that residents are provided with a minimum of eight hours off between scheduled work periods, it is recognized that residents may choose to remain beyond their scheduled time, or return to the clinical site during this time-off period, to care for a patient. The requirement preserves the flexibility for residents to make those choices. It is also noted that the 80-hour weekly limit (averaged over four weeks) is a deterrent for scheduling fewer than eight hours off between clinical and education work periods, as it would be difficult for a program to design a schedule that provides fewer than eight hours off without violating the 80-hour rule.

6.21.a. Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)

Background and Intent: Residents have a responsibility to return to work rested, and thus are expected to use this time away from work to get adequate rest. In support of this goal, residents are encouraged to prioritize sleep over other discretionary activities.

[See FAQ in Appendix]

6.21.b. 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)

Background and Intent: The requirement provides flexibility for programs to distribute days off in a manner that meets program and resident needs. It is strongly recommended that residents' preference regarding how their days off are distributed be considered as schedules are developed. It is desirable that days off be distributed throughout the month, but some residents may prefer to group their days off to have a "golden weekend," meaning a consecutive Saturday and Sunday free from work. The requirement for one free day in seven should not be interpreted as precluding a golden weekend. Where feasible, schedules may be designed to provide residents with a weekend, or two consecutive days, free of work. The applicable Review Committee will evaluate the number of consecutive days of work and determine whether they meet educational objectives. Programs are encouraged to distribute days off in a fashion that optimizes resident well-being, and educational and personal goals. It is noted that a day off is defined in the ACGME Glossary of Terms as "one (1) continuous 24-hour period free from all administrative, clinical, and educational activities."

[See FAQ in Appendix]

6.22. Maximum Clinical Work and Education Period Length

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

- 6.22.a.** 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. Additional patient care responsibilities must not be assigned to a resident during this time. ^(Core)

Background and Intent: The additional time referenced in 6.22.a. should not be used for the care of new patients. It is essential that the resident continue to function as a member of the team in an environment where other members of the team can assess resident fatigue, and that supervision for post-call residents is provided. This 24 hours and up to an additional four hours must occur within the context of 80-hour weekly limit, averaged over four weeks.

[See FAQ in Appendix]

6.23. Clinical and Educational Work Hour Exceptions

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: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events. ^(Detail)

- 6.23.a.** These additional hours of care or education must be counted toward the

80-hour weekly limit. (Detail)

Background and Intent: This requirement is intended to provide residents with some control over their schedules by providing the flexibility to voluntarily remain beyond the scheduled responsibilities under the circumstances described above. It is important to note that a resident may remain to attend a conference, or return for a conference later in the day, only if the decision is made voluntarily. Residents must not be required to stay. Programs allowing residents to remain or return beyond the scheduled work and clinical education period must ensure that the decision to remain is initiated by the resident and that residents are not coerced. This additional time must be counted toward the 80-hour maximum weekly limit.

- 6.24. 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 Emergency Medicine will not consider requests for exceptions to the 80-hour limit to the residents' work week.

[Pending the outcome of the major revision of the Common Program Requirements, enforcement of Common Program Requirement 6.24. has been suspended]

6.25. Moonlighting

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)

- 6.25.a. 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)**

[See FAQ in Appendix]

- 6.25.b. PGY-1 residents are not permitted to moonlight. (Core)**

[See FAQ in Appendix]

6.26. In-House Night Float

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

6.27. 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)

6.28. At-Home Call

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)

[See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix] [See FAQ in Appendix]

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

Background and Intent: As noted in 6.20., clinical work done from home when a resident is taking at-home call must count toward the 80-hour maximum weekly limit. This acknowledges the often significant amount of time residents devote to clinical activities when taking at-home call, and ensures that taking at-home call does not result in residents routinely working more than 80 hours per week. At-home call activities that must be counted include responding to phone calls and other forms of communication, as well as documentation, such as entering notes in an electronic health record. Activities such as reading about the next day's case, studying, or research activities do not count toward the 80-hour weekly limit.

In their evaluation of residency/fellowship programs, Review Committees will look at the overall impact of at-home call on resident/fellow rest and personal time.

[See FAQ in Appendix]

7. Frequently Asked Questions: Emergency Medicine

FAQs related to Emergency Medicine Program Requirements

Last updated July 2026

Review Committee for Emergency Medicine

Section 1: Oversight

Questions concerning *"There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)" (1.3)*

Q: What is the purpose of program letters of agreement (PLAs)?

A: PLAs provide details on faculty members, supervision, evaluation, educational content, length of assignment, and policies and procedures for each required assignment that occurs outside of an accredited program's Sponsoring Institution. These documents are intended to protect the program's residents/fellows by ensuring an appropriate educational experience under adequate supervision.

Questions concerning *"There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)" (1.3)*

ing site providing a required assignment. (Core)" (1.3)

Q: Under what circumstances are PLAs required?

A: There must be PLAs between an accredited program and all participating sites to which residents/fellows rotate for required education or assignments. PLAs are not required for participating sites under the same governance as the program's Sponsoring Institution. PLAs are not required for elective rotations for individual residents and fellows, but programs and Sponsoring Institutions may determine if there are local expectations for a PLA or similar agreement.

Questions concerning *"There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)" (1.3)*

Q: Are PLAs necessary for "courses," such as the Armed Forces Institute of Pathology course or the Bellevue Hospital Toxicology Course?

A: These types of courses are not examples of participating sites, and therefore do not require PLAs.

Questions concerning *"There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)" (1.3)*

Q: Who should sign the PLAs?

A: It is the responsibility of the designated institutional official (DIO), in collaboration with the Graduate Medical Education Committee (GMEC) of the Sponsoring Institution, to establish and administer the local policies and procedures regarding PLAs and determine the individuals authorized to sign the PLAs.

Questions concerning *"Programs using multiple participating sites must ensure the provision of a unified educational experience for the residents. (Core)" (1.6.b)*

Q: If a program uses a multi-hospital system that includes separate emergency departments located at separate sites, but references these separate sites under one hospital name, how should the program represent this configuration?

A: Each emergency department location is considered an additional participating site, and programs should list and describe each emergency department separately.

Additionally, the annual patient volumes and critical care volumes at each site cannot be aggregated under one hospital name and should also be listed separately with their respective site.

Questions concerning *"Required rotations to participating sites that are geographically distant from the sponsoring institution must offer educational opportunities unavailable locally that significantly augment residents' overall educational experience. (Core)" (1.6.d)*, *"The program should ensure that residents are not unduly burdened by required rotations at geographically distant sites. (Core)" (1.6.e)*

Q: If a program wants to establish a rotation at a site that is not in close geographic proximity to the Sponsoring Institution, what accommodations should be made?

- A:** If a program establishes an affiliation with a site which is geographically distant from the Sponsoring Institution due to special resources provided at the site:
1. The program should provide a rationale for why this site has been designated for the rotation.
 2. The program should consider the social impacts of resident removal from family, life, and the day-to-day community of the residency program. The program should ensure that major burdens residents may experience in traveling to and from the site are addressed. If the site is of such distance that daily travel between the site and the Sponsoring Institution is burdensome or not feasible, the program may need to provide transportation options and/or housing arrangements for residents while on rotation there. It is recommended that the financial impacts to residents are addressed.

Questions concerning *"The program must demonstrate the availability of educational resources, including the presence of residents in other specialties, to enhance the training of the emergency medicine residents. (Core)" (1.7.a)*

- Q:** What other services should be present at the Sponsoring Institution to demonstrate the availability of educational resources that includes the presence of residents in other specialties?
- A:** Residents' educational experience will be enhanced by exposure to other specialties, particularly as related to faculty education and supervision, and through promotion of collaboration and team building among specialties. The Review Committee does not require that any specific specialty be present at the Sponsoring Institution.

Questions concerning *"The program must demonstrate the availability of educational resources, including the presence of residents in other specialties, to enhance the training of the emergency medicine residents. (Core)" (1.7.a)* , *"At every site in which the emergency department provides resident education, the following must be provided: (Core)" (1.7.b)* , *"Clinical support services must include nursing, clerical, intravenous, electrocardiogram (EKG), respiratory therapy, transporter, and phlebotomy, and must be available on a 24-hour basis so that residents are not burdened with these duties. (Core)" (1.7.c)* , *"Office space for program coordinators and additional support personnel must be provided at the primary clinical site. (Core)" (1.7.d)* , *"Each clinical site must provide timely consultation from services based on a patient's acuity. (Core)" (1.7.e)*

- Q:** Does every participating site need to have all resource amenities listed?
- A:** The Review Committee expects most participating sites in the Accreditation Data System (ADS) to demonstrate all site resources listed in the requirements to ensure healthy and safe learning and working environments that promote resident well-being. However, if the site is a non-clinical rotation outside of a university or hospital setting (e.g., high school, sports training facility, wilderness, firehouse), the Review Committee will not expect all areas delineated in the requirements to be static on site (e.g., lactation facilities, refrigeration for human milk storage, sleep/rest facilities), but there should be a provision that accommodations will be made if/when needed.

Questions concerning *"If any clinical services are not available for consultation or admission, each clinical site must have a written protocol for provision of these services elsewhere. (Core)" (1.7.e.1)*

Q: What should a written consultation protocol include?

A: Such a protocol should include written agreements for the transfer of patients to a designated hospital that provides the needed clinical services.

Questions concerning *"The primary clinical site should have a significant number of critically-ill or critically injured patients constituting at least three percent or 1200 (whichever is greater) of the emergency department patients per year. (Core)" (1.7.g.1)*

Q: How can programs calculate their critical care numbers?

A: As programs determine their critical care patient volume at the primary site, resources can include: Emergency Department billing and coding numbers for critical care, admission data to step down unit, intensive care unit (ICU), operating room, or morgue.

Section 2: Personnel

Questions concerning *"The program director and, as applicable, the program's leadership team, must be provided with support adequate for administration of the program based upon its size and configuration. (Core)" (2.4)* , *"The program leadership, in aggregate, must be provided with support equal to a dedicated minimum time specified below for administration of the program. This may be time spent by the program director only or divided between the program director and one or more associate (or assistant) program directors as follows: (Core) " (2.4.a)* , *"The program coordinator must be provided with dedicated time and support adequate for administration of the program based upon its size and configuration. (Core)" (2.12.a)* , *"At a minimum, the program coordinator must be provided with the dedicated time and support specified below for administration of the program: (Core)" (2.12.b)*

Q: Are there circumstances in which a Sponsoring Institution, in partnership with its programs, is required to provide support and dedicated time that exceeds the minimum specified in the requirements?

A: The dedicated time and support requirements for ACGME activities specified in 2.4. and 2.4.a. for program leadership, 2.12.a. and 2.12.b. for program coordinators, and section 2.11. for those specialties that specify a minimum level of support for core faculty members, are minimum requirements, recognizing that, depending on the unique needs of the program, additional support may be warranted. The need to ensure adequate resources, including adequate support and dedicated time for the program director, is also addressed in Institutional Requirements 2.2.-2.2.d. The amount of support and dedicated time needed for individual programs will vary based on a number of factors and may exceed the minimum specified in the applicable specialty-/subspecialty-specific Program Requirements. It is expected that the Sponsoring Institution, in partnership with its accredited programs, will ensure support for program directors, core faculty members, and program coordinators to fulfill their program responsibilities effectively. If the Institutional Review Committee determines that support and dedicated time for one or more programs within a Sponsoring Institution is inadequate, it may issue a citation even if the minimum specified in the applicable specialty-/subspecialty-specific Program Requirements has been met.

Note that Review Committees may choose to specify minimum time and support for the program director only, or may specify minimum time and support that may be divided among the program director and one or more associate or assistant program directors. Questions regarding the requirements for a specific specialty should be directed to the Review Committee Executive Director.

Questions concerning *"The program leadership, in aggregate, must be provided with support equal to a dedicated minimum time specified below for administration of the program. This may be time spent by the program director only or divided between the program director and one or more associate (or assistant) program directors as follows: (Core) " (2.4.a) , "At a minimum, the program coordinator must be provided with the dedicated time and support specified below for administration of the program: (Core)" (2.12.b)*

Q: How can a program identify and demonstrate adequate associate program director and program coordinator support for the number of residents in the program?

A: When reviewing a program, the Review Committee would expect to see the required program coordinator and support personnel FTE for the number of approved residents in the program as indicated under "Program Leadership" in ADS.

If the size of the program requires support personnel in addition to the required 1.0 FTE program coordinator, the Review Committee would expect to see at least two program coordinator names listed in ADS. To add support personnel in ADS, click on "+ add personnel" in the "Program Profile, Program Leadership" section.

To identify the required associate program director(s) for the program, add this title under "Program Specific Title" in their faculty profile to reflect it on the Faculty Roster.

Questions concerning *"The program leadership, in aggregate, must be provided with support equal to a dedicated minimum time specified below for administration of the program. This may be time spent by the program director only or divided between the program director and one or more associate (or assistant) program directors as follows: (Core) " (2.4.a) , "From the support table listed above, program directors of programs approved for 18-35 residents must be provided no less than 35 percent support and program directors of programs approved for 36 or more residents must be provided no less than 50 percent support. (Core)" (2.4.b)*

Q: What salary support is the institution/department expected to provide for the program director's non-clinical time for administration of the program ?

A: The program director must receive no less than 35 percent support if their program is approved for 18-35 residents and no less than 50 percent support if their program is approved for 36 or more residents. This does not mean 35 or 50 percent of the **aggregate** support delineated in the support table in requirement 2.4.a., but rather a pure 0.35 or 0.5 FTE support.

Questions concerning *"The program leadership, in aggregate, must be provided with support equal to a dedicated minimum time specified below for administration of the program. This may be time spent by the program director only or divided between the program director and one or more associate (or assistant) program directors as follows: (Core) " (2.4.a) , "At a minimum, each required core faculty member, excluding program leadership, must be provided with support equal to a dedicated minimum of 10 percent FTE for educational and administrative responsibilities that do not involve direct patient care. (Core) " (2.11.c) , "At a minimum, the program coordinator must be provided with the dedicated time and support specified below for administration of the program: (Core)" (2.12.b)*

Q: What faculty and coordinator support is a new program applying for initial accreditation

expected to have in place at the time of the application?

- A:** When the Review Committee reviews a new program application, it would expect to see a program director in place with the required protected support (a minimum of either 0.35 or 0.50 depending on program size), core faculty in a 1:3 ratio with the number of residents for at least the initial cohort of first-year residents being requested, and the required program coordinator FTE for the number of approved resident positions in the program.

If the size of the program requires support personnel in addition to the required 1.0 FTE program coordinator, the Review Committee would expect to see additional program coordinator names listed in ADS.

Programs applying for initial accreditation may identify an interim program coordinator on the application, but the Review Committee will expect the program to fully meet the requirement by having a permanent program coordinator in place by matriculation of the inaugural class on June 30.

Support personnel whose time is divided across several programs (such as emergency medical services, toxicology, and the core emergency medicine program) must have the time devoted to each program as described in each of the respective sets of Program Requirements.

Example: If a Sponsoring Institution has an emergency medicine program approved for 24 residents, requiring a 1.0 FTE program coordinator, and also has a fellowship program in emergency medical services, requiring at least 0.2 FTE program coordinator time for the fellowship program, both programs must meet the requirements. Therefore, the EMS fellowship program cannot use the 1.0 FTE emergency medicine program coordinator to provide support to the fellowship.

Example: For a new emergency medicine program requesting 30 residents (10 per year for a three-year format), the program would be expected to have at least 10 core faculty members (nine plus the program director) in place at the time of the application. The Review Committee would expect there to be one program director (minimum 0.35 FTE) and one associate program director (minimum 0.25 FTE) designated.

Questions concerning *"The program leadership, in aggregate, must be provided with support equal to a dedicated minimum time specified below for administration of the program. This may be time spent by the program director only or divided between the program director and one or more associate (or assistant) program directors as follows: (Core) " (2.4.a) , "From the support table listed above, program directors of programs approved for 18-35 residents must be provided no less than 35 percent support and program directors of programs approved for 36 or more residents must be provided no less than 50 percent support. (Core)" (2.4.b) , "There must be a minimum of one core physician faculty member for every three residents in the program. (Core) " (2.11.b) , "At a minimum, the program coordinator must be provided with the dedicated time and support specified below for administration of the program: (Core)" (2.12.b)*

- Q:** When a program requests a permanent increase in resident complement, what is the timeline for demonstrating a parallel increase in the required program resources to match the increased program size?
- A:** If a program requests a complement increase that will require an increase in program

resources (i.e., program director support, number of associate program directors, program coordinator support, and the number of core faculty members), the Review Committee would expect the program to outline a detailed plan for increasing the program's resources accordingly once the extra work of having the additional residents begins.

Example: If a Sponsoring Institution has an emergency medicine program currently approved for 24 residents and requests to increase to 36 residents, the program will need to increase resources to add one additional associate program director, increase the program director support to at least 0.50 FTE, increase the number of core faculty members from eight to 12, and increase program coordinator support from 1.0 FTE to 1.30 FTE. The Review Committee will need to see a commitment and plan to increase the resources in the educational rationale.

Questions concerning *"Qualifications of the Program Director"* (2.5)

- Q:** Why must a program director have at least three years' experience as a core faculty member in an ACGME-accredited emergency medicine program?
- A:** The administration of a program is so complex that experience with and understanding of program operations are necessary for program director candidates. This is why the Review Committee believes that to ensure that programs can maintain compliance with ACGME requirements, provide a stable learning environment, and provide residents an optimal learning experience, the program director should have a minimum of three years' experience as a core faculty member in an ACGME-accredited emergency medicine program or a former American Osteopathic Association (AOA)-approved program.

Questions concerning *"Qualifications of the Program Director"* (2.5) , *"The program director must possess current certification in the specialty for which they are the program director by the American Board of Emergency Medicine (ABEM) or by the American Osteopathic Board of Emergency Medicine (AOBEM), or specialty qualifications that are acceptable to the Review Committee."* (2.5.a) , *"The program director must demonstrate ongoing clinical activity. (Core)"* (2.5.b) , *"The program director must be a core physician faculty member. (Core) "* (2.5.c) , *"The program director must have demonstrated experience in a leadership role. (Core) "* (2.5.d) , *"The program director must include evidence of ongoing involvement in scholarly activity, including peer-reviewed publications. (Core)"* (2.5.e)

- Q:** What does the Review Committee consider to be satisfactory educational and administrative experience?
- A:** 2.5. and 2.5.e. Educational and administrative experience(s) acceptable to the Review Committee: While many types of leadership experience may qualify, the Review Committee expects this experience to be recently acquired and preferably within the three years preceding a proposed appointment.

2.5.b. Ongoing clinical activity: The candidate's prior clinical activity should involve working with residents.

2.5.e. Scholarly activity, including peer-reviewed publications: The program director must demonstrate evidence of ongoing involvement in scholarly activity, including peer-reviewed publication. In assessing compliance with this requirement, the Committee will look for publications within the most recent five-year period.

Questions concerning *"There must be a sufficient number of faculty members with competence to instruct and supervise all residents. (Core)" (2.7)*

Q: Which faculty members should be included in the ADS Faculty Roster?

A: At a minimum, the program must list the following core faculty members: program director, associate/assistant program director(s) (if applicable), and all other core physician faculty members who are trained in emergency medicine residency, in order to demonstrate the 1:3 ratio of one core faculty member for every three resident positions (2.11.b.).

ADS will not display the core faculty indicator for the program director. The Review Committee is aware of this functionality and will manually count this role as a core faculty member toward the 1:3 ratio.

Additional core faculty and non-core faculty members may be added to the Faculty Roster at the discretion of the program.

Questions concerning *"Faculty members supervising emergency medicine residents in an adult emergency department must be emergency medicine physicians. (Core)" (2.8.f)*

Q: Who can supervise emergency medicine residents in urgent care/fast track settings?

A: If an emergency medicine resident is assigned to an area of any emergency department where undifferentiated and less urgent patients are seen (e.g., fast track, quick care, urgent care) and the experience is counted toward the 60 percent required emergency medicine rotations, the emergency medicine resident must be supervised by emergency medicine-certified physician faculty.

If an emergency medicine resident is assigned to a freestanding facility geographically distinct from any acute care hospital that treats undifferentiated "urgent care" patients and would not thus qualify as a full freestanding emergency department, the emergency medicine resident can be supervised by any credentialed provider in this site, but this experience cannot count toward the 60 percent required emergency medicine rotations.

Questions concerning *"Faculty members supervising emergency medicine residents on pediatric emergency medicine rotations where pediatric emergency medicine fellows are also present must be pediatricians, emergency medicine physicians, or pediatric emergency medicine physicians. (Core)" (2.9.a)*

Q: Are there any other qualification requirements specific to faculty members providing supervision in an emergency department (either adult or pediatric)?

A: Faculty members providing supervision to emergency medicine residents on emergency medicine rotations must have appropriate qualifications relative to the patient population for which they are providing the supervision.

For example, a faculty member certified in pediatrics and pediatric emergency medicine or meeting the other qualification criteria in 2.10.a. would be qualified to supervise emergency medicine residents on pediatric cases, but not adult cases.

Emergency medicine residents rotating in a pediatric emergency department where there are also pediatric emergency medicine fellows in an ACGME-accredited program are subject to the pediatric emergency medicine requirements related to faculty qualifications and

supervision.

In all other instances, faculty members board-certified solely in pediatrics may not supervise emergency medicine residents in the emergency department.

Questions concerning *"There must be a minimum of one core physician faculty member for every three residents in the program. (Core) "* (2.11.b)

Q: Which physician faculty members are included in the required core faculty- to-resident ratio of 1:3?

A: Only core faculty members who meet the qualifications in 2.10. and 2.10.a. will be considered toward the required 1:3 faculty-to-resident ratio.

ADS will not display the core faculty indicator for the program director. The Review Committee is aware of this functionality and will manually count this role as a core faculty member toward the 1:3 ratio.

Section 3: Resident Appointments

Questions concerning *"Resident Complement"* (3.4)

Q: Why does the Review Committee review resident attrition?

A: Resident attrition may impact residents' work and learning environment, and may serve as an indicator for an unstable educational environment.

Questions concerning *"Resident Complement"* (3.4)

Q: How long does it take for the Review Committee to communicate its decisions regarding complement change requests?

A: Complement change requests are reviewed in an ad hoc fashion. Typically, the Committee is able to provide a response to a complement change request in approximately two to four weeks. Occasionally, responses to a request may take longer if it is determined that the request will need to be reviewed at the time of the Committee's next meeting.

Complement increase requests will not be reviewed between the agenda closing date for an upcoming Committee meeting and the last date of that meeting. In order to be reviewed within two to four weeks of submission, all complement increase requests must be submitted through ADS prior to the agenda closing dates posted on the [Emergency Medicine](#) section of the ACGME website. Information on how to submit a request for a complement change in ADS is outlined in the "Requests for Changes in Resident Complement" document posted on the [Documents and Resources](#) page of the Emergency Medicine section of the ACGME website.

Questions concerning *"There should be a total of at least 18 residents in the program. (Core) "* (3.4.a)

Q: Why is there a minimum of 18 approved resident positions in a program?

A: A minimum of 18 residents is needed to foster a sense of identity within the program and the department. Additionally, 18 residents ensures a major impact in the emergency department to allow for meaningful attendance at emergency medicine conferences, to provide for progressive resident responsibility, and impact as resident teachers.

The Review Committee recognizes there may be unique instances in which a program may not fill all resident positions or may have a resident leave the program, causing the program to have fewer than 18 residents on duty per year.

Questions concerning *"There should be a total of at least 18 residents in the program. (Core) "* (3.4.a)

Q: How can a new program meet the requirement for a minimum of 18 residents?

A: The Review Committee understands that new programs need time to ramp up until the program is fully staffed. Accordingly, the expectation is that new programs will build toward this total number by the end of the first graduating class, both for three-year and four-year formats.

Section 4: Educational Program

Questions concerning *"Length of Program"* (4.1)

Q: What should be included in the educational rationale for programs seeking a 48-month program format?

A: The educational rationale for a 48-month program format should describe:

1. A more in-depth curriculum in areas related to emergency medicine, not just additional clinical rotations
 - Examples: focused experiences in ultrasound, emergency medical services (EMS), health administration, research, toxicology, critical care, etc.
2. The expected skillset/outcome residents will obtain by completing the additional 12 months of the program
 - Examples: ultrasound certification, global health, increased scholarly activity, including work toward a Master of Public Health or Master of Education degree, etc.
3. Graduated responsibilities for fourth-year residents
 - Example: Supervision of junior residents by fourth-year emergency medicine residents on critical care rotations

Questions concerning *" competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice. These must be distributed, reviewed, and available to residents and faculty members; (Core) "* (4.2.b)

- Q:** Can programs use the Emergency Medicine Milestones as goals and objectives or as a primary evaluation tool?
- A:** The required goals and objectives are not the Milestones. The Milestones are a competency assessment tool and should not be the only measure or primary evaluation tool used in conducting resident evaluations, as the Milestones do not cover every aspect of education and training. The program's 360-degree evaluation tools are used by the program director and the Clinical Competency Committee to map the resident's longitudinal progress on the Milestones. Program evaluation tools can be Milestones-based, but the Milestones themselves do not meet the criteria for goals and objectives.

Questions concerning *"Residents must demonstrate competence in performing invasive procedures, monitoring unstable patients, and directing major resuscitations of all types on all age groups. (Core) "* (4.5.e)

- Q:** How does the Review Committee define a major resuscitation?
- A:** A major resuscitation is patient care for which prolonged physician attention is needed at the bedside, and interventions—such as defibrillation, cardiac pacing, treatment of shock, including emergent transfusion of blood products, intravenous use of drugs (e.g., thrombolytics, vasopressors, antiarrhythmics), or invasive procedures (e.g., central line insertion, tube thoracostomy, endotracheal intubations)—are necessary for stabilization and treatment.

Each resident is provided the opportunity to make admission recommendations and direct resuscitations. Patients may experience a "major resuscitation" but may improve before disposition to a critical care area occurs. Programs are encouraged to measure the resident's resuscitation experience rather than focusing on the patient's disposition location.

Questions concerning *"Didactics"* (4.11.a)

- Q:** What types of experiences *do not* qualify as didactic experiences?
- A:** Daily experiences, such as morning report or change of shift teaching, which are informal and at which not all residents are consistently present, do not meet the requirements for didactic experiences.

Questions concerning *"The majority of didactic experiences must occur at the primary clinical site. (Core) "* (4.11.a.3)

- Q:** Can residents attend conferences at the site where their rotation is located or must they return to the home institution for conferences?
- A:** The requirements for the didactic experiences allow for joint conferences co-sponsored with other disciplines, so if residents joined the participating site's conferences, this could count toward requirement 4.11.a.3. However, attendance at the participating site's conferences cannot count toward the five hours per week of planned didactic experiences since these must be developed by and supervised by the program's core faculty (4.11.a.4. and 4.11.a.6). The program could also consider video conferencing while rotating at the participating site to allow those residents to participate in the home institution's conferences synchronously.

Questions concerning *"There must be an average of at least five hours per week of planned didactic experiences developed by the program's faculty members. (Core) "* (4.11.a.4) , *"Residents*

must actively participate, on average, in at least 70 percent of the planned didactic experiences offered. (Core) " (4.11.a.9)

Q: What considerations are taken when calculating the 70 percent resident conference attendance?

A: The expectation is that residents will attend at least 70 percent of the total planned didactic experiences per year. The program will determine the denominator for the number of "planned" didactic experiences per year.

The denominator should include all conferences offered and not a reduced amount by the number of conferences missed due to vacation, off-service rotations, etc. as the lowered 70 percent attendance requirement already takes these absences into account.

For example, if a program schedules five hours of weekly conference for 48 weeks, the total planned didactic experience per year is 240 hours. Each resident is expected to attend 168 hours of planned didactic experiences each academic year. The missed 72 hours can occur during vacation, illness, specific off-service rotation, or when work requirements preclude conference.

Finally, residents can attend conferences virtually, in an active, synchronous format using online platforms. Watching a recorded version of conference asynchronously does NOT count toward the 70 percent requirement.

Questions concerning *"Individualized interactive instruction must not exceed 20 percent of the planned didactic experiences. (Core) " (4.11.a.5)*

Q: How much individualized interactive instruction is acceptable and what qualifies?

A: Programs may utilize individualized interactive instruction, such as web-based learning, for up to 20 percent of the planned educational experiences or didactics (i.e., on average, one hour out of the five hours per week of planned educational activity).

The goal of individualized interactive instruction is to allow program directors to adjust curricular needs to the individual needs of each resident. It is important to note that simply reading or answering questions does not meet the requirements for planned educational activities. Watching pre-recorded conferences also does not count, given the activity is simply asynchronous, but not individualized for the learner.

Examples of individualized interactive instruction include:

- A resident prepares for and takes a quiz or test, and receives timely feedback about their performance from a faculty member.
- A resident spends additional time in the simulation lab or cadaver/animal lab because they need more practice with a certain procedure.
- Residents who are doing poorly on quizzes/tests participate in board review study sessions with colleagues or faculty members.

Attestation and completion pages are not acceptable to the Review Committee as evaluation. Use of audio, video, or podcasts alone constitutes passive learning and is not considered interactive learning unless an individualized study plan has been created with

the faculty, there is oversight, and there is an evaluative component. Proprietary systems that allow for real-time questions and answers qualify as active/interactive participation .

Questions concerning *"Each core physician faculty member must attend, on average per year, at least 20 percent of planned didactic experiences. (Core) "* (4.11.a.7)

Q: Why is there a requirement that each core faculty member attend, on average per year, at least 20 percent of planned didactic experiences?

A: Core faculty members' attendance at conferences and other resident didactics gives residents the opportunity to benefit from their perspective, experience, and discussion. It also demonstrates their commitment to the educational program.

Questions concerning *"Residents must actively participate, on average, in at least 70 percent of the planned didactic experiences offered. (Core) "* (4.11.a.9)

Q: How does the Review Committee verify resident attendance at 70 percent of the planned emergency medicine didactic experiences?

A: Programs are to report the resident conference attendance in the Emergency Medicine Specialty Data section of ADS by reviewing an eight-week conference block and averaging resident attendance for that eight-week period.

Questions concerning *"Curriculum"* (4.11.b)

Q: In meeting the requirement for four months of critical care, can programs consider experiences in step-down units, emergency department critical care units, critical care transport teams, or anesthesiology rotations?

A: No, experiences in step-down units, critical care/trauma units in the emergency department, critical care transport teams, and anesthesiology rotations do not count toward the critical care requirement. The intent of the requirement is for the resident to learn acute decision-making and resuscitative skills outside the emergency department that can be applied in future emergency department patient care.

Questions concerning *"Curriculum"* (4.11.b)

Q: How can a program ensure their critical care experiences meet the requirement for "including the critical care of infants and children?"

A: The Review Committee expects there to be a minimum of four weeks or one block of time dedicated to the care of infants AND children. This can be met with either:

- Four weeks or one block of pediatric intensive care unit (PICU)
- At least two weeks or a half-block of PICU, plus two weeks or a half-block of neonatal intensive care unit (NICU)

Given the lack of children in the NICU, time in the NICU alone does not satisfy this requirement. Rotation on pediatric transport teams outside of the PICU/NICU also does not meet this requirement.

Questions concerning *"Curriculum"* (4.11.b) , *"The curriculum must include five FTE months, or 20 percent of all emergency department encounters, dedicated to the care of pediatric patients less*

than 18 years of age in the pediatric emergency department or other pediatric settings. (Core) " (4.11.c)

Q: Can pediatric critical care months count toward the four months of required critical care?

A: Yes, months spent in the PICU or NICU setting count toward both the four-month critical care requirement and the five-month pediatric requirement.

Questions concerning *"Curriculum"* (4.11.b) , *"The curriculum must include five FTE months, or 20 percent of all emergency department encounters, dedicated to the care of pediatric patients less than 18 years of age in the pediatric emergency department or other pediatric settings. (Core) "* (4.11.c) , *"The curriculum must include at least 60 percent of each resident's clinical experience, including experiences dedicated to the care of pediatric patients less than 18 years of age in the pediatric emergency department, must take place in the emergency department under the supervision of emergency medicine faculty members. (Core) "* (4.11.e)

Q: Can residents take vacation time when assigned to emergency medicine, critical care, or pediatric rotations?

A: Yes, however, the expectation is that residents satisfy the minimum training time stipulated in the requirements for the designated experiences:

- 60 percent time in the emergency department
- Four months critical care
- Five months pediatrics

If vacation is taken during these rotations or if residents are pulled from these rotations to cover back-up call in the emergency department, it is up to the program director to ensure that the minimum time is met by the resident(s).

Questions concerning *"The curriculum must include five FTE months, or 20 percent of all emergency department encounters, dedicated to the care of pediatric patients less than 18 years of age in the pediatric emergency department or other pediatric settings. (Core) "* (4.11.c)

Q: How are longitudinal pediatric experiences calculated?

A: To calculate longitudinal pediatric patient encounters, multiply the number of general emergency department months or four-week blocks by the percent of pediatric patients from the annual patient volume of the emergency department where the rotation is located.

For example, if the annual patient volume of the emergency department includes 15 percent pediatric patients and the resident spends 20 months in the emergency department (i.e., 20 months x .15 = 3 or the equivalent of 3 months), the resident would need two additional months of dedicated pediatric experiences to meet the five-month minimum. This calculation should be completed for the primary site and all participating sites to which the residents rotate. Using this calculation assumes that pediatric patients are not periodically sequestered in a separate pediatric emergency department or pediatric treatment area.

Programs that have a separate "pediatric emergency department" or area configured in or near the main emergency department must clearly describe what portion of the resident's assignment to the emergency department is in this area.

Programs that split emergency department rotations between emergency departments must clearly describe the assigned fraction to each emergency department on the block diagram to facilitate the calculation of the pediatric experience.

Questions concerning *"The curriculum must include at least 60 percent of each resident's clinical experience, including experiences dedicated to the care of pediatric patients less than 18 years of age in the pediatric emergency department, must take place in the emergency department under the supervision of emergency medicine faculty members. (Core) "* (4.11.e)

- Q:** Can a rotation assignment in an observation unit or non-emergency department-based urgent care center satisfy the requirement that at least 60 percent of each resident's clinical experience must take place in the emergency department?
- A:** No. Resident assignments to an observation unit or non-emergency department-based urgent care center (e.g., for-profit locations such as Patient First) cannot be counted toward the requirement that 60 percent of the resident's clinical experience take place in the emergency department.

Experiences that can be counted toward the 60 percent requirement require residents to:

- Evaluate undifferentiated emergency department patients
- Perform an appropriate history and physical examination
- Order and interpret appropriate diagnostics tests
- Assist in determining the patient's disposition

While patients placed in observation units are often considered outpatients, not inpatients, and the observation unit may be under the control of the emergency medicine residency faculty, patients placed in observation status have already had a history and physical examination performed and sufficient diagnostic testing completed to determine that "observation status" is an appropriate disposition. Rotations in an observation unit should be represented on the block diagram as "Observation" and not as an emergency medicine rotation.

Questions concerning *"The curriculum must include at least 60 percent of each resident's clinical experience, including experiences dedicated to the care of pediatric patients less than 18 years of age in the pediatric emergency department, must take place in the emergency department under the supervision of emergency medicine faculty members. (Core) "* (4.11.e)

- Q:** Can an ultrasound rotation be counted toward the 60 percent emergency medicine requirement?
- A:** Yes, an emergency department-based ultrasound rotation can be counted toward the 60 percent emergency medicine requirement provided the rotation occurs in the emergency department and with emergency department patients. Rotations based in radiology would not satisfy this requirement.

Questions concerning *"Faculty Scholarly Activity" (4.14) , " The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods: "* (4.14.a)

- Q:** Are there any Review Committee considerations in meeting the faculty scholarly activity requirement?

- A:** The Review Committee expects the program's core faculty members to lead the scholarly efforts by demonstrating significant contributions in the form of accomplishments in at least three of the domains listed in the Program Requirements, including peer-reviewed publications related to the specialty or subspecialty areas of emergency medicine.

It is the Review Committee's expectation that this scholarly requirement be fulfilled by participation by multiple faculty members, specifically by at least half of the faculty (in particular the core faculty), and not by one or two prolific researchers/authors with multiple publications, grants, etc.

Section 5: Evaluation

Questions concerning *"A plan to remedy deficiencies must be in writing and on file. (Core) "* (5.1.e.1)

- Q:** How will resident advancement be affected if a resident needs remediation?
- A:** Deficiencies in specific areas do not necessarily mean a resident should be held back in progressing to the next year or level of education; however, plans must be in place to support such residents in achieving the required competencies.

Questions concerning *"The final evaluation must verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice. (Core)"* (5.2.c)

- Q:** Can the semi-annual resident evaluation be used to fulfill the requirement for a final evaluation?
- A:** Yes, as long as the form used to facilitate the final evaluation of the residents includes verification as stated in the requirements that:

"...the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice."

Questions concerning *"Clinical Competency Committee"* (5.3)

- Q:** What is the role of the program director on the Clinical Competency Committee (CCC)?
- A:** The requirements regarding the CCC do not preclude or limit a program director's participation on the committee, however, programs should consult with Review Committee staff for any specialty or subspecialty-specific guidance. The intent is to leave flexibility for each program to decide the best structure for its own circumstances. Still, a program should consider: its program director's other roles as resident/fellow advocate, advisor, and confidante; the impact of the program director's presence on the other CCC members' discussions and decisions; the size of the program faculty; and other program-relevant factors. The program director has final responsibility for the program's evaluation and promotion decisions.

Questions concerning *"Clinical Competency Committee"* (5.3)

- Q:** What is the role of the program coordinator on the CCC?
- A:** Program coordinators play a critical role in their programs and may, through the program's resident/fellow evaluation system, provide valuable insight on resident/fellow performance in areas such as interpersonal and communication skills, teamwork, and professionalism. Further, the program coordinator may, at the program director's discretion, attend CCC

meetings to support the activities of the CCC, such as collation of data on each resident/fellow, taking meeting minutes, recording decisions, and managing the submission of Milestones data to the ACGME. However, evaluation of resident/fellow competence related to the Milestones for patient care and medical knowledge is a vital responsibility of the CCC and these assessments should be made by individuals with background and experience in health care. Therefore, program coordinators, although they may administratively support the committee and take part in the 360 assessments of the residents/fellows, may not serve as voting members of the CCC.

Questions concerning *"At a minimum, the Clinical Competency Committee must include three members of the program faculty, at least one of whom is a core faculty member. (Core)"* (5.3.a)

Q: How can small programs have three program faculty members on the CCC?

A: The intent is to have enough members to broaden the input on each resident's/fellow's evaluation. Program faculty representation can include more than physician faculty members, such as other physicians and non-physicians who teach and evaluate the program's residents/fellows. For example, a fellowship may include faculty members from the affiliated residency program or from required rotations in other specialties.

Questions concerning *"At a minimum, the Clinical Competency Committee must include three members of the program faculty, at least one of whom is a core faculty member. (Core)"* (5.3.a)

Q: What role can program residents, including chief residents who have not completed the program, play on the CCC?

A: Program residents and chief residents in accredited years of the program may provide input to the CCC Chair and/or the program director, outside the context of CCC meetings, through the evaluation system. However, to ensure that residents' peers are not involved in promotion and graduation decisions, and that they are not involved in recommendations for remediation or disciplinary actions, these residents may not serve as CCC members or attend CCC meetings.

Questions concerning *"Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents. (Core)"* (5.3.b) , *"The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident. (Core)"* (5.5.a)

Q: Can the program coordinator and/or residents be members of the Program Evaluation Committee (PEC)?

A: The Program Evaluation Committee (PEC) must include at least one resident and can include the program coordinator.

Questions concerning *"This evaluation must include written, anonymous, and confidential evaluations by the residents. (Core)"* (5.4.b)

Q: How can a program demonstrate that resident evaluations of the faculty are anonymous?

A: The Review Committee recognizes that many programs use residency management systems to facilitate evaluations, and that the form may include a field for the evaluator name

even when the settings are set to not show the evaluator name in certain instances. Should the evaluation form template not accurately represent that the form is anonymous, the program can either:

- Print a copy and cross out the evaluator name to alert the committee that the program is aware of this requirement
- Complete a dummy evaluation and print it as an example to the committee of how the template looks when viewed

Section 6: The Learning and Working Environment

Questions concerning *"Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)"* (6.4)

- Q:** With regards to the requirement relating to provision of data to residents/fellows and faculty members on quality metrics and benchmarks related to their patient populations, is the expectation that individual data regarding clinical performance must be provided?
- A:** Providing individual, specialty-specific data is desirable, but not required. The requirement seeks to ensure that quality metrics used by the Sponsoring Institution are shared with residents/fellows and faculty members. Examples of metrics include, but are not limited to, those provided by the Hospital Consumer Assessment of Healthcare Providers and Systems, Centers for Medicaid and Medicare Services, Press Ganey, and National Surgical Quality Improvement Program.

Questions concerning *"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)"* (6.6)

- Q:** Who can supervise emergency medicine residents in urgent care/fast track settings?
- A:** If an emergency medicine resident is assigned to an area of any emergency department where undifferentiated and less urgent patients are seen (e.g., fast track, quick care, urgent care) and the experience is counted toward the 60 percent required emergency medicine rotations, the emergency medicine resident must be supervised by emergency medicine-certified physician faculty.

If an emergency medicine resident is assigned to a freestanding facility geographically distinct from any acute care hospital that treats undifferentiated "urgent care" patients and would not thus qualify as a full freestanding emergency department, the emergency medicine resident can be supervised by any credentialed provider in this site, but this experience cannot count toward the 60 percent required emergency medicine rotations.

Questions concerning *"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)"* (6.6) , *"Direct Supervision"* (6.7) , *"The program must define when physical presence of a supervising physician is required. (Core)"* (6.8)

- Q:** How should the appropriate level of supervision be determined for each resident or fellow?

- A:** The assignment of progressive responsibility for patient care to residents and fellows is an essential component of graduate medical education and is necessary to prepare residents and fellows to be independent practitioners. While decisions regarding the appropriate level of supervision are made by the program director in consultation with the CCC, the Common Program Requirements provide a framework for the progression from direct supervision to oversight. The program director determines the level of supervision required for an individual resident or fellow both by assessing the abilities and competence of the resident/fellow and the needs of the individual patient. Therefore, the level of supervision required for a resident or fellow may vary based on the circumstances.

Questions concerning *"Direct Supervision"* (6.7)

- Q:** Can residents be supervised by licensed independent practitioners?
- A:** The Review Review Committee will accept licensed or certified non-physicians on occasion to supervise residents in unique educational settings within the scope of their licensure or certification. Examples may include physician assistants, nurse practitioners, clinical psychologists, licensed clinical social workers, certified nurse midwives, certified registered nurse anesthetists, and doctors of pharmacy. Oversight by a physician faculty member during these situations is required.

Questions concerning *"Direct Supervision"* (6.7)

- Q:** Can residents from other specialties supervise emergency medicine residents?
- A:** Residents from other specialties cannot supervise emergency medicine residents on any rotation in the emergency department. Residents from other specialties can supervise emergency medicine residents on rotations in clinical areas related to their graduate medical education training and expertise, but the program director must monitor supervision on off-service rotations and ensure that the supervision is appropriate.

Questions concerning *"PGY-1 residents must initially be supervised directly, only as described in the above definition. (Core)"* (6.7.a)

- Q:** Can PGY-1 residents take at-home call, and if so, what are the work hour restrictions for this?
- A:** PGY-1 residents are not initially allowed to take at-home call because appropriate supervision (either direct supervision or indirect supervision with direct supervision immediately available) is not possible when a resident is on at-home call. However, a Review Committee may specify the circumstances and achieved competencies required for residents to progress to be supervised indirectly with direct supervision available at some point after the beginning and before the end of the PGY-1. Program directors should review the specialty-specific Program Requirements for further clarification.

Questions concerning *"The program must define when physical presence of a supervising physician is required. (Core)"* (6.8)

- Q:** Under what circumstances can a first-year resident be supervised indirectly with direct supervision immediately available?

- A:** Programs must assess the independence of each first-year resident based upon the six core competencies in order to progress to indirect supervision with direct supervision immediately available.

Various required experiences may necessitate different sets of skills. For example, if a resident is deemed to have progressed to indirect supervision with direct supervision immediately available while rotating in the emergency department, this may not be the case in a subsequent required experience if it is the resident's first experience for another rotation, such as medical intensive care unit (MICU) or trauma surgery.

Questions concerning *"Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). (Core)"* (6.10)

- Q:** What types of circumstances and events should be included in the supervision policy to demonstrate when residents should communicate with the supervising faculty members?
- A:** For clarity, the supervision policy should include examples of circumstances and events for when residents should communicate with their supervising attending. Such examples could include:
- Discussion of end-of-life/do not resuscitate (DNR) decisions
 - Change in patient clinical status
 - Patients wishing to leave against medical advice

Questions concerning *"The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)"* (6.12.d) , *"Residents and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events. (Core)"* (6.12.e)

- Q:** In addition to the 80-hour maximum weekly limit, do all other clinical and educational work hour rules apply to moonlighting (maximum clinical and educational work period length, minimum time off between shifts, etc.)?
- A:** The hours spent moonlighting are counted toward the total hours worked for the week. No other clinical and educational work hour requirements apply, but the following requirements do:
- 6.25 "Moonlighting must not interfere with the ability of the resident/fellow to achieve the goals and objectives of the educational program, and must not interfere with the resident's/fellow's fitness for work nor compromise patient safety."
 - 6.12.d.-6.12.e. "The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. Residents/Fellows and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events."

Questions concerning *"identification of the symptoms of burnout, depression, and substance use disorders, suicidal ideation, or potential for violence, including means to assist those who experience these conditions; (Core)"* (6.13.d.1)

Q: Can residents/fellows be required to use vacation or sick time when attending appointments during scheduled working hours?

A: The requirements do not specify whether residents/fellows will be required to use vacation or sick time for medical, dental, and mental health appointments. Programs should comply with their institution's policies regarding time off for such appointments.

The intent of this requirement is to ensure that residents and fellows are able to attend appointments as needed, and that their work schedule not prevent them from seeking care when they need it, including during scheduled call days.

Questions concerning *"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)"* (6.16)

Q: If a program wants to establish a rotation at a site that is not in close geographic proximity to the Sponsoring Institution, what accommodations should be made?

A: If a program establishes an affiliation with a site which is geographically distant from the Sponsoring Institution due to special resources provided at the site:

1. The program should provide a rationale for why this site has been designated for the rotation.
2. The program should consider the social impacts of resident removal from family, life, and the day-to-day community of the residency program. The program should ensure that major burdens residents may experience in traveling to and from the site are addressed. If the site is of such distance that daily travel between the site and the Sponsoring Institution is burdensome or not feasible, the program may need to provide transportation options and/or housing arrangements for residents while on rotation there. It is recommended that the financial impacts to residents are addressed.

Questions concerning *"Clinical Responsibilities"* (6.17)

Q: What does the Review Committee consider an optimal clinical workload?

A: A resident in the emergency department at the very beginning of the program should have a smaller workload than a resident at the same level in the same rotation at the end of that academic year. Each program must adhere to its graduated responsibility policy. This may vary by area of service, and is based upon each individual's level of achieved competence (knowledge, skills, and attitudes) and upon patient acuity. The Milestones must be used to assess each resident's competence.

Both insufficient patient experiences and excessive patient loads may jeopardize the quality of resident education.

Questions concerning *"While on duty in the emergency department, residents may not work longer than 12 continuous scheduled hours. (Core) "* (6.17.a.1) , *"There must be at least one equivalent period of continuous time off between scheduled work period. (Core) "* (6.17.a.2)

Q: How much time should a resident have off between emergency medicine shifts?

A: In emergency medicine, the scheduled clinical shift is the basis for the required time off and considers additional clinical time after the assigned shift is completed toward the total clinical and educational work hours each week (finishing documentation, transitions in care, etc.).

A resident must have at minimum a scheduled break equal to the scheduled length of the shift within the 24-hour period that includes the shift.

All time (clinical and educational) counts toward the total average time cap per week. Didactic and other educational experiences count toward weekly clinical and educational work hour limits but are not considered when calculating time off between clinical shifts.

Example:

If a resident works a 10-hour shift (9:00 p.m. to 7:00 a.m.) and then attends a conference until 11:00 a.m., they must have 10 hours off before returning to their next clinical shift (starting from the 11:00 a.m. end time of the conference, meaning that the resident should not return to clinical work until 9:00 p.m. If the resident chooses not to attend the conference, the 10-hour break begins at 7:00 a.m. when the clinical shift ends).

Conference time is added in the calculation of clinical and educational work hours for the week when the resident is present.

Clinical Shift in the Emergency Department Tuesday	Break Wednesday	Conferences Wednesday	Clinical Shift in the Emergency Department Wednesday
4:00 p.m.-12:00 a.m.	(8 hours)	8:00 a.m.-12:00 p.m.	4:00 p.m.-12:00 a.m.
9:00 p.m.-7:00 a.m.	(10 hours)	7:00 a.m.-11:00 a.m.	9:00 p.m.-7:00 a.m.

Example:

If a resident works from 4:00 p.m. to midnight, has a conference from 8:00 a.m. to 12:00 p.m., and then works again at 4:00 p.m., this is compliant, since there is a scheduled eight-hour break in a 24-hour period. There is no expectation for an additional eight-hour break after the conference.

The Review Committee does not have an expectation regarding time off between block didactic sessions followed by a clinical shift; however, programs must review the appropriateness of resident attendance at conferences following an evening or night shift based on the duration of the program's clinical shifts, didactic schedule, and resident fatigue. Residents should be provided the opportunity to adjust their individual attendance at didactic sessions scheduled between clinical shifts when necessary to mitigate excessive fatigue. The program should ensure the required time off between clinical shifts to allow adequate rest for each resident based on their individual schedule.

Questions concerning *"A resident must not work more than 60 scheduled hours per week seeing patients in the emergency department, and no more than 72 total hours per week. (Core) "* (6.17.a.3) , *"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)" (6.25.a) , "PGY-1 residents are not permitted to moonlight. (Core)" (6.25.b)

Q: Are residents permitted to moonlight?

A: Emergency medicine residents may moonlight. However, the hours spent moonlighting in the emergency department count toward the 72 total hours per week on emergency medicine rotations. Hours spent moonlighting outside of the emergency department count toward the 80-hour weekly limit. PGY-1 residents are not permitted to moonlight.

Questions concerning *"Interprofessional teams should be used to ensure effective and efficient communication for appropriate patient care for emergency medicine department admissions, transfers, and discharges. (Detail)" (6.18.a)*

Q: Who should be included in interprofessional teams?

A: Interprofessional team members must participate in the education of residents, and may include advanced practice providers, case managers, child-life specialists, emergency medical technicians, nurses, pain management specialists, pastoral care specialists, pharmacists, physician assistants, physicians, psychiatrists, psychologists, rehabilitative therapists, respiratory therapists, and social workers.

Questions concerning *"Transitions of Care" (6.19)*

Q: What are the ACGME's expectations regarding transitions of care, and how should programs and institutions monitor effective transitions of care and minimize the number of such transitions?

A: Transitions of care are critical elements in patient safety and must be organized such that complete and accurate clinical information on all involved patients is transmitted between the outgoing and incoming individuals and/or teams responsible for the specific patient or group of patients. Sponsoring Institutions and programs are expected to have a documented process in place for ensuring the effectiveness of transitions. Scheduling of on-call assignments should be optimized to ensure a minimal number of transitions, and there should be documentation of the process involved in arriving at the final schedule. Specific schedules will depend upon various factors, including the size of the program, the acuity and quantity of the workload, and the level of resident/fellow education.

Questions concerning *"Maximum Hours of Clinical and Educational Work per Week" (6.20)*

Q: What are the ACGME's expectations regarding monitoring of clinical and educational work hours for all accredited programs?

A: The ACGME requires that Sponsoring Institutions and programs monitor residents'/fellows' clinical and educational work hours, including work done from home (as applicable), to ensure they comply with the requirements, but does not specify how monitoring and tracking of clinical and educational work hours should be accomplished. The ACGME does not mandate a specific monitoring approach since the ideal approach should be tailored to each program and its Sponsoring Institution.

Questions concerning *"Maximum Hours of Clinical and Educational Work per Week" (6.20)*

Q: Do the ACGME Common Program Requirements related to clinical and educational work hours apply to research activities?

A: The clinical and educational work hour requirements pertain to all required hours in the program (the only exceptions are reading and self-learning). When research is a formal part of the residency/fellowship and occurs during the accredited years of the program, research hours or any combination of research and patient care activities must comply with the weekly limit on hours and other pertinent clinical and educational work hour requirements.

When programs offer an additional research year that is not part of the accredited years, or when residents/fellows conduct research on their own time, making these hours identical to other personal pursuits, these hours do not count toward the limit on clinical and educational work hours. The combined hours spent on self-directed research and program-required activities should meet the test for a reasonably rested and alert resident/fellow when the resident/fellow participates in patient care.

Questions concerning *"Maximum Hours of Clinical and Educational Work per Week"* (6.20)

Q: What is included in the definition of clinical and educational work hours under the requirement limiting them to 80 hours per week?

A: Clinical and educational work hours are defined as all clinical and academic activities related to the residency/fellowship program. This includes inpatient and outpatient clinical care, in-house call, short call, night float and day float, transfer of patient care, and administrative activities related to patient care, such as completing medical records, ordering and reviewing lab tests, and signing orders. For call from home, time devoted to clinical work done from home and time spent in the hospital after being called in to provide patient care count toward the 80-hour weekly limit. Types of work from home that must be counted include using an electronic health record and taking calls. Reading done in preparation for the following day's cases, studying, and research done from home do not count toward the 80 hours.

Hours spent on activities that are required in the accreditation requirements, such as membership on a hospital committee, or that are accepted practice in residency/fellowship programs, such as residents'/fellows' participation in interviewing residency/fellowship candidates, must be included in the count of clinical and educational work hours.

Time residents and fellows devote to military commitments counts toward the 80-hour limit only if that time is spent providing patient care.

Questions concerning *"Maximum Hours of Clinical and Educational Work per Week"* (6.20)

Q: If some of a program's residents/fellows attend a conference that requires travel, how should the hours be counted for clinical and educational work hour compliance?

A: If attendance at the conference is required by the program, or if the resident/fellow is a representative for the program (e.g., presenting a paper or poster), the hours should be included as clinical and educational work hours. Travel time and non-conference hours while away do not meet the definition of "clinical and educational work hours" in the ACGME requirements.

Questions concerning *"Maximum Hours of Clinical and Educational Work per Week"* (6.20)

- Q:** Why do the requirements specify that clinical work done from home must count toward the 80-hour weekly maximum, averaged over four weeks?
- A:** The requirements acknowledge the changes in medicine, including electronic health records, and the increase in the amount of work residents and fellows choose to do from home. Resident/Fellow decisions to complete work at home should be made in consultation with the resident's/fellow's supervisor. In such circumstances, residents/fellows should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality. The requirement provides flexibility for residents/fellows to do this while ensuring that the time spent completing clinical work from home is accomplished within the 80-hour weekly maximum.

Questions concerning *"Maximum Hours of Clinical and Educational Work per Week"* (6.20)

- Q:** How should the averaging of the clinical and educational work hour requirements (e.g., 80-hour weekly limit, one day free of clinical and educational work every week, and call no more frequently than every third night) be handled? For example, what should be done if a resident/fellow takes a vacation week?
- A:** Averaging must occur by rotation. This is done over one of the following: a four-week period; a one-month period (28-31 days); or the period of the rotation if it is shorter than four weeks. When rotations are shorter than four weeks in length, averaging must be made over these shorter assignments. This avoids heavy and light assignments being combined to achieve compliance.

If a resident/fellow takes vacation or other leave, the ACGME requires that vacation or leave days be omitted from the numerator and the denominator for calculating clinical and educational work hours, call frequency, or days off. The requirements do not permit a "rolling" average, because this may mask compliance problems by averaging across high and low clinical and educational work hour rotations. The rotation with the greatest hours and frequency of call must comply with the common clinical and educational work hour requirements.

Questions concerning *"Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)"* (6.21.a)

- Q:** If a post-call resident/fellow remains on site for up to four additional hours as described in the requirements, does the required 14-hour time-off period begin at the end of the scheduled 24-hour period, or when the resident/fellow leaves the hospital?
- A:** The 14-hour time-off period begins when the resident/fellow completes all required clinical and educational work, regardless of when the resident/fellow was scheduled to leave.

Questions concerning *"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)"* (6.21.b)

- Q:** Since the requirements state that residents/fellows must be provided with one day in seven free from all responsibilities, with one day defined as one continuous 24-hour period, how should programs interpret this requirement if the "day off" occurs after a resident's/fellow's on-call day?

- A:** The requirements specify a 24-hour day off. This day should ideally be a calendar day (i.e., the resident/fellow wakes up at home and has a whole day available). It is not permissible to have the day off regularly or frequently scheduled on a resident's/fellow's post-call day, but in smaller programs this may occasionally be necessary. Note that in this case, a resident/fellow would need to leave the hospital post-call early enough to allow for 24 hours off from clinical and educational work. Because call from home does not require a rest period, the day after home call may be used as a day off.

Questions concerning *"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. Additional patient care responsibilities must not be assigned to a resident during this time. (Core)"* (6.22.a)

- Q:** What activities are permitted during the four hours allowed for activities related to patient safety and/or resident/fellow education?
- A:** Residents/fellows who have completed a 24-hour clinical and educational work period may spend up to an additional four hours on site to ensure an appropriate, effective, and safe transition of care (including rounds), to maintain continuity of patient care, and to participate in educational activities such as conferences. During this four-hour period, residents/fellows must not be permitted to participate in the care of new patients in any patient care setting; must not be assigned to outpatient clinics, including continuity clinics; and must not be assigned to participate in a new procedure, such as an elective scheduled surgery. Residents/fellows who have satisfactorily completed the transition of care may attend an educational conference that occurs during this four-hour period.

Questions concerning *"At-Home Call"* (6.28)

- Q:** When determining the one-day-off in seven, how should at-home call be considered?
- A:** At-home call, including sick call or back-up call, should not be assigned during the required one day free from clinical experience and education every week.

Questions concerning *"At-Home Call"* (6.28)

- Q:** What are considered on-call hours and how should they be factored in when determining clinical and educational work hours?
- A:** On-call hours include scheduled sick call or back-up call. When determining clinical and educational work hours, only the hours spent in the hospital after being called in to provide patient care are considered. The clinical and educational work period begins at the time the resident reports for duty.

Questions concerning *"At-Home Call"* (6.28)

- Q:** Is it permissible for residents/fellows to take call from home for extended periods, such as a month?
- A:** No. The requirement for one day free every week prohibits being assigned home call for an entire month. Assignment of a partial month (more than six days but fewer than 28 days) is possible. However, keep in mind that call from home is appropriate if service intensity and frequency of being called is low. Program directors are expected to monitor the intensity and workload resulting from home call through periodic assessment of workload and intensity of in-house activities.

Questions concerning *"At-Home Call"* (6.28) , *"At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core)"* (6.28.a)

Q: Which requirements apply to time in the hospital after being called in from home call?

A: For call taken from home (home or pager call), the time a resident/fellow spends in the hospital after being called in counts toward the weekly clinical and educational work hour limit. The only other numeric clinical and educational work hour requirement that applies is the one day free of clinical and educational work every week that must be free of all patient care responsibilities, which includes at-home call. Program directors must monitor the intensity and workload resulting from at-home call through periodic assessment of the frequency of being called into the hospital, and the length and intensity of the in-house activities.

When residents/fellows assigned to at-home call return to the hospital to care for patients, a new time-off period is not initiated, and therefore the requirement for eight hours between shifts does not apply. The frequency and duration of clinical work done from home and time returning to the hospital must not preclude rest or reasonable personal time for residents/fellows.

Other

Q: Are emergency medicine residents required to obtain or maintain life support certification(s)?

A: No, the Review Committee believes residency education in emergency medicine establishes expertise in acute cardiac life support beyond that which is taught in an Advanced Cardiac Life Support, Advanced Trauma Life Support, Basic Life Support, or Pediatric Advanced Life Support certification course.

Q: Can the clinical and educational work hour requirements be relaxed over holidays or during other times when a hospital is short-staffed, during periods when some residents/fellows are ill or on leave, or when there is an unusually large patient census or demand for care?

A: The ACGME expects that clinical and educational work hours in any given four-week period comply with all applicable requirements. This includes months with holidays, during which institutions may have fewer staff members available. During the holiday period, scheduling for the rotation (generally four weeks or a month) must comply with the common and specialty-specific clinical and educational work hour requirements. Further, the schedule during the holidays themselves may not violate common clinical and educational work hour requirements (such as the requirement for adequate rest between clinical and educational work periods), or specialty-specific requirements.

Q: Where are the ACGME Resident/Fellow and Faculty Survey -Common Program Requirements Crosswalk documents located?

A: The crosswalk documents for the Resident/Fellow and Faculty Surveys can be found on the ACGME website [here](#). These resources help programs, residents, fellows, and faculty understand and interpret their ACGME Resident/Fellow and Faculty Survey results by mapping ACGME survey questions to the corresponding Common Program Requirements.