



**Accreditation Council for
Graduate Medical Education**

ACGME Program Requirements for Graduate Medical Education in Family Medicine

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Common Program Requirements are in BOLD

Introduction

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

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

Int.B. Family medicine is a primary care specialty which demonstrates high quality care within the context of a personal doctor-patient relationship and with an appreciation for the individual, family, and community connections. Continuity of comprehensive care for the diverse patient population family physicians serve is foundational to the specialty. Access, accountability, effectiveness, and efficiency are essential elements of the discipline. The coordination of patient care and leadership of advanced primary care practices and evolving health care systems are additional vital roles for family physicians. ^(Core)

Int.C. The educational program in family medicine must be 36 months in length. ^(Core)

I. Institutions

I.A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating sites. ^{(Core)*}

The sponsoring institution and the program must ensure that the program

director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program. ^(Core)

- I.A.1. Since family medicine programs are dependent in part on other specialties for the education of residents, the ability and commitment of the institution to fulfill these requirements must be documented. ^(Core)
- I.A.2. Instruction in the other specialties must be conducted by faculty members with appropriate expertise. ^(Core)
- I.A.3. There must be agreement with specialists in other areas/services regarding the requirement (II.D.2) that residents maintain concurrent commitment to their patients in the Family Medicine Practice (FMP) site during these rotations. ^(Core)
- I.A.4. The sponsoring institution and participating sites must:
 - I.A.4.a) provide at least 70 percent salary support (at least 28 hours per week) for the program director as protected time for administration, evaluation, teaching, resident precepting, and scholarship; and, ^(Core)
 - I.A.4.b) provide support for a full-time residency coordinator and other support personnel required for the operation of the program. ^(Detail)
- I.A.5. The sponsoring institution should provide access to an electronic health record system. ^(Detail)
 - I.A.5.a) In the absence of an existing electronic health record system, the sponsoring institution must demonstrate institutional commitment to its development, and progress towards its implementation. ^(Detail)

I.B. Participating Sites

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

The PLA should:

- I.B.1.a) **identify the faculty who will assume both educational and supervisory responsibilities for residents;** ^(Detail)
- I.B.1.b) **specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;** ^(Detail)
- I.B.1.c) **specify the duration and content of the educational experience; and,** ^(Detail)

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

I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS). ^(Core)

I.B.3. Participating sites should not be at such a distance from the primary clinical site that they require excessive travel time or otherwise fragment the educational experience for residents. ^(Detail)

II. Program Personnel and Resources

II.A. Program Director

II.A.1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. ^(Core)

II.A.1.a) The program director must submit this change to the ACGME via the ADS. ^(Core)

II.A.2. The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability. ^(Detail)

II.A.3. Qualifications of the program director must include:

II.A.3.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee; ^(Core)

II.A.3.b) current certification in the specialty by the American Board of Family Medicine, or specialty qualifications that are acceptable to the Review Committee; ^(Core)

II.A.3.b).(1) The Review Committee accepts no other qualifications. ^(Core)

II.A.3.c) current medical licensure and appropriate medical staff appointment; and, ^(Core)

II.A.3.d) a minimum of five years of clinical experience in family medicine, with two years as a core faculty member in an ACGME-accredited family medicine residency program. ^(Core)

II.A.4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. ^(Core)

The program director must:

- II.A.4.a)** oversee and ensure the quality of didactic and clinical education in all sites that participate in the program; ^(Core)
- II.A.4.b)** approve a local director at each participating site who is accountable for resident education; ^(Core)
- II.A.4.c)** approve the selection of program faculty as appropriate; ^(Core)
- II.A.4.d)** evaluate program faculty; ^(Core)
- II.A.4.e)** approve the continued participation of program faculty based on evaluation; ^(Core)
- II.A.4.f)** monitor resident supervision at all participating sites; ^(Core)
- II.A.4.g)** prepare and submit all information required and requested by the ACGME. ^(Core)
- II.A.4.g).(1)** This includes but is not limited to the program application forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete. ^(Core)
- II.A.4.h)** ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution; ^(Detail)
- II.A.4.i)** provide verification of residency education for all residents, including those who leave the program prior to completion; ^(Detail)
- II.A.4.j)** implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, ^(Core)

and, to that end, must:

- II.A.4.j).(1)** distribute these policies and procedures to the residents and faculty; ^(Detail)
- II.A.4.j).(2)** monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements; ^(Core)
- II.A.4.j).(3)** adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and, ^(Detail)

- II.A.4.j).(4)** if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue. ^(Detail)
- II.A.4.k)** monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged; ^(Detail)
- II.A.4.l)** comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents; ^(Detail)
- II.A.4.m)** be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures; ^(Detail)
- II.A.4.n)** obtain review and approval of the sponsoring institution's GMEC/DIO before submitting information or requests to the ACGME, including: ^(Core)
- II.A.4.n).(1)** all applications for ACGME accreditation of new programs; ^(Detail)
- II.A.4.n).(2)** changes in resident complement; ^(Detail)
- II.A.4.n).(3)** major changes in program structure or length of training; ^(Detail)
- II.A.4.n).(4)** progress reports requested by the Review Committee; ^(Detail)
- II.A.4.n).(5)** responses to all proposed adverse actions; ^(Detail)
- II.A.4.n).(6)** requests for increases or any change to resident duty hours; ^(Detail)
- II.A.4.n).(7)** voluntary withdrawals of ACGME-accredited programs; ^(Detail)
- II.A.4.n).(8)** requests for appeal of an adverse action; ^(Detail)
- II.A.4.n).(9)** appeal presentations to a Board of Appeal or the ACGME; ^(Detail)
- II.A.4.n).(10)** proposals to ACGME for approval of innovative educational approaches; and, ^(Detail)
- II.A.4.n).(11)** proposals for new or significantly remodeled FMPs. ^(Detail)

- II.A.4.n).(11).(a) Prior approval of the Review Committee must be obtained before residents may rotate to these sites. (Detail)
- II.A.4.o) **obtain DIO review and co-signature on all program application forms, as well as any correspondence or document submitted to the ACGME that addresses:** (Detail)
- II.A.4.o).(1) **program citations, and/or,** (Detail)
- II.A.4.o).(2) **request for changes in the program that would have significant impact, including financial, on the program or institution.** (Detail)
- II.A.4.p) dedicate at least 70 percent of his or her time, (at least 28 hours per week or 1400 hours per year) to program administration, evaluation, teaching, resident precepting, and scholarship; and, (Core)
- II.A.4.p).(1) Time spent in direct patient care without the presence of residents must not be included in the 1400 hours per year total. (Detail)
- II.A.4.q) maintain clinical skills by providing direct patient care. (Detail)

II.B. Faculty

- II.B.1. **At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location.** (Core)
- The faculty must:
- II.B.1.a) **devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents; and,** (Core)
- II.B.1.b) **administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.** (Core)
- II.B.2. **The physician faculty must have current certification in the specialty by the American Board of Family Medicine, or possess qualifications judged acceptable to the Review Committee.** (Core)
- II.B.2.a) Family medicine physician faculty members who are not certified by the American Board of Family Medicine (ABFM) must demonstrate ongoing learning activities equivalent to the ABFM Maintenance of Certification process, including demonstration of professionalism, cognitive expertise, self-assessment and life-long

learning, and assessment of performance in practice. ^(Core)

II.B.2.b) Physician faculty members from other specialties must have current certification in their specialties by a member board of the American Board of Medical Specialties, or possess qualifications acceptable to the Review Committee. ^(Core)

II.B.3. The physician faculty must possess current medical licensure and appropriate medical staff appointment. ^(Core)

II.B.3.a) All family medicine physician faculty members must maintain clinical skills by providing direct patient care. ^(Core)

II.B.3.b) Some family medicine physician faculty members must have admitting privileges in the hospital(s) where FMP patients are hospitalized. ^(Core)

II.B.4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments. ^(Core)

II.B.4.a) Faculty members in other professional disciplines should possess certification as appropriate for their disciplines. ^(Detail)

II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component. ^(Core)

II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. ^(Detail)

II.B.5.b) Some members of the faculty should also demonstrate scholarship by one or more of the following:

II.B.5.b).(1) peer-reviewed funding; ^(Detail)

II.B.5.b).(2) publication of original research or review articles in peer reviewed journals, or chapters in textbooks; ^(Detail)

II.B.5.b).(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or, ^(Detail)

II.B.5.b).(4) participation in national committees or educational organizations. ^(Detail)

II.B.5.c) Faculty should encourage and support residents in scholarly activities. ^(Core)

II.B.6. There must be at least one core family medicine physician faculty member, in addition to the program director, for every six residents in the program. ^(Core)

- II.B.6.a) Core physician faculty members must: ^(Core)
- II.B.6.a).(1) dedicate at least 60 percent time (at least 24 hours per week, or 1200 hours per year), to the program, exclusive of patient care without residents; and, ^(Detail)
- II.B.6.a).(2) devote the majority of their professional effort to teaching, administration, scholarly activity, and patient care within the program. ^(Detail)
- II.B.7. All programs must have family medicine physician faculty members providing and teaching care for each of the following: maternity care, including deliveries; inpatient adults; and inpatient children. ^(Core)
- II.B.8. Family medicine physician faculty members should have a specific time commitment to patient care. ^(Detail)
- II.B.9. Some family medicine physician faculty members must see patients in each of the FMPs used by the program. ^(Detail)
- II.B.10. There must be faculty members dedicated to the integration of behavioral health into the educational program. ^(Detail)
- II.B.11. There must be a structured program of faculty development that involves regularly scheduled faculty development activities designed to enhance the effectiveness of teaching, administration, leadership, scholarship, clinical, and behavioral components of faculty members' performance. ^(Detail)

II.C. Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program. ^(Core)

- II.C.1. The program must have a program coordinator. ^(Core)

II.D. Resources

The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements. ^(Core)

- II.D.1. Patient Population
- II.D.1.a) The patient population must include a volume and variety of clinical problems and diseases sufficient to enable all residents to learn and demonstrate competence for all required patient care outcomes. ^(Core)
- II.D.1.b) The patient population must include a sufficient number of patients

of both genders, with a broad range of ages, from newborns to the aged. ^(Core)

- II.D.2. There must be at least one FMP site to serve as the foundation for educating residents and to provide family medicine physician role models. ^(Core)
- II.D.2.a) This space must support continuous, comprehensive, convenient, accessible, and coordinated patient care. ^(Detail)
- II.D.2.b) If multiple FMP sites are used for resident education, each must meet the criteria for the primary practice and be approved by the Review Committee prior to use. ^(Detail)
- II.D.2.c) Each FMP must have a mission statement describing dedication to education and the care of patients within the practice as it relates to the greater community and the community served by the residency program. ^(Detail)
- II.D.2.d) Each FMP site must provide contiguous space for residents' clinical work and education. ^(Detail)
- II.D.2.e) Each FMP site should provide space for meetings, group visits, or small group counseling. ^(Detail)
- II.D.2.f) Each FMP site should use an electronic health record. ^(Detail)
- II.D.2.g) There must be a ratio of residents-to-faculty preceptors in the FMP not to exceed 4:1. ^(Detail)
- II.D.2.g).(1) If only one resident is seeing patients in the FMP, a single faculty member must devote at least 50 percent of his or her time to teaching and supervising that resident. ^(Detail)
- II.D.2.h) Each FMP site should provide, on average, two examination rooms for each faculty member and resident when they are providing patient care. ^(Detail)
- II.D.2.i) The FMP site must be sufficiently staffed to ensure efficiency of operation and adequate support for patient care and fulfillment of educational requirements. ^(Detail)
- II.D.2.j) Other physician specialists should not see patients in the FMP site unless their presence enhances the experiences and learning of the residents. ^(Detail)
- II.D.2.k) Each FMP site must involve all members of the practice in ongoing performance improvement, and must demonstrate use of outcomes in improving clinical quality, patient satisfaction, patient safety, and financial performance. ^(Detail)

II.D.3. The inpatient facilities must have occupied teaching beds to ensure a patient load and variety of problems sufficient to support the education of the number of residents and other learners on the services. ^(Core)

II.D.4. Inpatient facilities must also provide physical, human, and educational resources for education in family medicine. ^(Core)

II.E. Medical Information Access

Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available.
^(Detail)

III. Resident Appointments

III.A. Eligibility Criteria

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

III.B. Number of Residents

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

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

III.B.2. The program must offer at least four resident positions at each educational level. ^(Detail)

III.B.3. The program should have at least 12 on-duty residents. ^(Detail)

III.C. Resident Transfers

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

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

III.D. Appointment of Fellows and Other Learners

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

practitioners) in the program must not interfere with the appointed residents' education. ^(Core)

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

IV. Educational Program

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

IV.A.1. Overall educational goals for the program, which the program must make available to residents and faculty; ^(Core)

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

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

IV.A.3.a) The program must provide a regularly scheduled forum for residents to explore and analyze evidence pertinent to the practice of family medicine. ^(Core)

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

IV.A.5. ACGME Competencies

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

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

IV.A.5.a).(1) Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents: ^(Outcome)

IV.A.5.a).(1).(a) must demonstrate competence to independently: ^(Outcome)

IV.A.5.a).(1).(a).(i) diagnose, manage, and integrate the care of patients of all ages in various outpatient settings, including the FMP site and home environment; ^(Outcome)

IV.A.5.a).(1).(a).(ii) diagnose, manage, and integrate the care of patients of all ages in various inpatient

	settings, including hospitals, long-term care facilities, and rehabilitation facilities; ^(Outcome)
IV.A.5.a).(1).(a).(iii)	diagnose, manage, and coordinate care for common mental illness and behavioral issues in patients of all ages; ^(Outcome)
IV.A.5.a).(1).(a).(iv)	assess community, environmental, and family influences on the health of patients; ^(Outcome)
IV.A.5.a).(1).(a).(v)	use multiple information sources to develop a patient care plan based on current medical evidence; and, ^(Outcome)
IV.A.5.a).(1).(a).(vi)	provide end-of-life care. ^(Outcome)
IV.A.5.a).(1).(b)	must demonstrate proficiency in their ability to: ^(Outcome)
IV.A.5.a).(1).(b).(i)	evaluate patients of all ages with undiagnosed and undifferentiated presentations; ^(Outcome)
IV.A.5.a).(1).(b).(ii)	treat medical conditions commonly managed by family physicians; ^(Outcome)
IV.A.5.a).(1).(b).(iii)	provide preventive care; ^(Outcome)
IV.A.5.a).(1).(b).(iv)	interpret basic clinical tests and images; ^(Outcome)
IV.A.5.a).(1).(b).(v)	recognize and provide initial management of emergency medical problems; and, ^(Outcome)
IV.A.5.a).(1).(b).(vi)	use pharmacotherapy. ^(Outcome)
IV.A.5.a).(1).(c)	must demonstrate competence in their ability to provide maternity care, including: ^(Outcome)
IV.A.5.a).(1).(c).(i)	distinguishing abnormal and normal pregnancies; ^(Outcome)
IV.A.5.a).(1).(c).(ii)	caring for common medical problems arising from pregnancy or coexisting with pregnancy; ^(Outcome)
IV.A.5.a).(1).(c).(iii)	performing a spontaneous vaginal delivery; and, ^(Outcome)
IV.A.5.a).(1).(c).(iv)	demonstrating basic skills in managing

obstetrical emergencies. (Outcome)

IV.A.5.a).(1).(d) should demonstrate competence in providing basic pre- and post-operative care, recognizing patients requiring acute surgical intervention, diagnosing surgical problems, and using sterile technique. (Outcome)

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

IV.A.5.a).(2).(a) must appropriately use and perform diagnostic and therapeutic procedures. (Outcome)

IV.A.5.b) Medical Knowledge

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

IV.A.5.b).(1) must demonstrate proficiency in their knowledge of the broad spectrum of clinical disorders seen in the practice of family medicine; and, (Outcome)

IV.A.5.b).(2) must demonstrate proficiency in their ability to evaluate evolving medical knowledge and incorporate it into meaningful clinical practice. (Outcome)

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

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. (Outcome)

Residents are expected to develop skills and habits to be able to meet the following goals:

IV.A.5.c).(1) identify strengths, deficiencies, and limits in one's knowledge and expertise; (Outcome)

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

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

IV.A.5.c).(4) systematically analyze practice using quality

improvement methods, and implement changes with the goal of practice improvement; ^(Outcome)

IV.A.5.c).(5)

incorporate formative evaluation feedback into daily practice; ^(Outcome)

IV.A.5.c).(6)

locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems; ^(Outcome)

IV.A.5.c).(7)

use information technology to optimize learning; and, ^(Outcome)

IV.A.5.c).(8)

participate in the education of patients, families, students, residents and other health professionals. ^(Outcome)

IV.A.5.d)

Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. ^(Outcome)

Residents are expected to:

IV.A.5.d).(1)

communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; ^(Outcome)

IV.A.5.d).(2)

communicate effectively with physicians, other health professionals, and health related agencies; ^(Outcome)

IV.A.5.d).(3)

work effectively as a member or leader of a health care team or other professional group; ^(Outcome)

IV.A.5.d).(4)

act in a consultative role to other physicians and health professionals; and, ^(Outcome)

IV.A.5.d).(5)

maintain comprehensive, timely, and legible medical records, if applicable. ^(Outcome)

IV.A.5.e)

Professionalism

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

Residents are expected to demonstrate:

IV.A.5.e).(1)

compassion, integrity, and respect for others; ^(Outcome)

- IV.A.5.e).(2) **responsiveness to patient needs that supersedes self-interest;** ^(Outcome)
- IV.A.5.e).(3) **respect for patient privacy and autonomy;** ^(Outcome)
- IV.A.5.e).(4) **accountability to patients, society and the profession;** ^(Outcome)
- IV.A.5.e).(5) **sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation; and,** ^(Outcome)
- IV.A.5.e).(6) adherence to the sponsoring institution's professionalism standards and code of conduct, and to citizenship and other responsibilities. ^(Outcome)

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

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

Residents are expected to:

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

IV.A.6. Curriculum Organization and Resident Experiences

- IV.A.6.a) Each resident must be assigned to a primary FMP site. ^(Outcome)

- IV.A.6.a).(1) Residents must be scheduled to see patients in the FMP site for a minimum of 40 weeks during each year of the program. ^(Detail)
- IV.A.6.a).(1).(a) Residents' other assignments must not interrupt continuity for more than eight weeks at any given time or in any one year. ^(Detail)
- IV.A.6.a).(1).(b) The periods between interruptions in continuity must be at least four weeks in length. ^(Detail)
- IV.A.6.a).(2) Experiences in the FMP must include acute care, chronic care, and wellness care for patients of all ages. ^(Core)
- IV.A.6.a).(3) Residents must be primarily responsible for a panel of continuity patients, integrating each patient's care across all settings, including the home, long-term care facilities, the FMP site, specialty care facilities, and inpatient care facilities. ^(Core)
- IV.A.6.a).(3).(a) Long-term care experiences must occur over a minimum of 24 months. ^(Detail)
- IV.A.6.a).(4) Residents should participate in and assume progressive leadership of appropriate care teams to coordinate and optimize care for a panel of continuity patients. ^(Detail)
- IV.A.6.a).(5) Residents must provide care for a minimum of 1650 in-person patient encounters in the FMP site. ^(Core)
- IV.A.6.a).(5).(a) The majority of these visits must occur in the resident's primary FMP site. ^(Detail)
- IV.A.6.a).(5).(b) One hundred sixty-five of the FMP site patient encounters must be with patients younger than 10 years of age. ^(Detail)
- IV.A.6.a).(5).(c) One hundred sixty-five of the FMP site patient encounters must be with patients 60 years of age or older. ^(Detail)
- IV.A.6.a).(6) Residents' patient encounters should include telephone visits, e-visits, group visits, and patient-peer education sessions. ^(Detail)
- IV.A.6.b) Residents must have at least 600 hours (or six months) and 750 patient encounters dedicated to the care of hospitalized adult patients with a broad range of ages and medical conditions. ^(Core)
- IV.A.6.b).(1) Residents must have at least 100 hours (or one month) or

- 15 encounters dedicated to the care of ICU patients. ^(Detail)
- IV.A.6.b).(2) Residents must provide care to hospitalized adults during all years of the program. ^(Detail)
- IV.A.6.c) Residents must have emergency department experience. ^(Core)
- IV.A.6.c).(1) Residents must have at least 200 hours (or two months) or 250 patient encounters dedicated to the care of acutely ill or injured adults in an emergency department setting. ^(Detail)
- IV.A.6.d) Residents must have at least 100 hours (or one month) or 125 patient encounters dedicated to the care of the older patient. ^(Core)
- IV.A.6.d).(1) The experience must include functional assessment, disease prevention and health promotion, and management of patients with multiple chronic diseases. ^(Detail)
- IV.A.6.d).(2) The experience should incorporate care of older patients across a continuum of sites. ^(Detail)
- IV.A.6.e) Residents must have at least 200 hours (or two months) and 250 patient encounters dedicated to the care of ill child patients in the hospital and/or emergency setting. ^(Core)
- IV.A.6.e).(1) This experience should include a minimum of 75 inpatient encounters with children. ^(Detail)
- IV.A.6.e).(2) This experience should include a minimum of 75 emergency department patient encounters with children. ^(Detail)
- IV.A.6.f) Residents must have at least 200 hours (or two months) or 250 patient encounters dedicated to the care of children and adolescents in an ambulatory setting. ^(Core)
- IV.A.6.f).(1) This care must include well-child care, acute care, and chronic care. ^(Detail)
- IV.A.6.g) Residents must have at least 40 newborn patient encounters, including well and ill newborns. ^(Core)
- IV.A.6.h) Residents must have at least 100 hours (or one month) dedicated to the care of surgical patients, including hospitalized surgical patients. ^(Core)
- IV.A.6.h).(1) This experience must include operating room experience. ^(Detail)
- IV.A.6.i) Residents must have at least 200 hours (or two months) dedicated

to the care of patients with a breadth of musculoskeletal problems.
(Core)

- IV.A.6.i).(1) This experience must include a structured sports medicine experience. (Detail)
- IV.A.6.j) Residents must have at least 100 hours (or one month) or 125 patient encounters dedicated to the care of women with gynecologic issues, including well-woman care, family planning, contraception, and options counseling for unintended pregnancy.
(Core)
- IV.A.6.k) Residents must document 200 hours (or two months) dedicated to participating in deliveries and providing prenatal and post-partum care.
(Core)
- IV.A.6.k).(1) This experience must include a structured curriculum in prenatal, intra-partum, and post-partum care. (Core)
- IV.A.6.l) Programs should provide an experience in prenatal care, labor management, and delivery management. (Detail)
- IV.A.6.l).(1) Some of the maternity experience should include the prenatal, intra-partum, and post-partum care of the same patient in a continuity care relationship. (Detail)
- IV.A.6.m) Residents must have experience in diagnosing and managing common dermatologic conditions. (Core)
- IV.A.6.n) The curriculum must be structured so behavioral health is integrated into the residents' total educational experience, to include the physical aspects of patient care. (Detail)
- IV.A.6.o) There must be a structured curriculum in which residents are educated in the diagnosis and management of common mental illnesses. (Detail)
- IV.A.6.p) There must be a structured curriculum in which residents address population health, including the evaluation of health problems of the community. (Detail)
- IV.A.6.q) There must be specific subspecialty curricula to address the breadth of patients seen in family medicine. (Core)
- IV.A.6.q).(1) The program must ensure that every resident has exposure to a variety of medical and surgical subspecialties throughout the educational program. (Detail)
- IV.A.6.r) Residents must receive training to perform clinical procedures required for their future practices in ambulatory and hospital environments. (Core)

- IV.A.6.r).(1) The program director and family medicine faculty should develop a list of procedural competencies required for completion by all residents in the program prior to graduation. ^(Core)
- IV.A.6.r).(1).(a) This list must be based on the anticipated practice needs of all family medicine residents. ^(Core)
- IV.A.6.r).(1).(b) In creating this list, the faculty should consider the current practices of program graduates, national data regarding procedural care in family medicine, and the needs of the community to be served. ^(Core)
- IV.A.6.s) Residents must have at least 100 hours (or one month) dedicated to health system management experiences. ^(Core)
- IV.A.6.s).(1) This curriculum should prepare residents to be active participants and leaders in their practices, their communities, and the profession of medicine. ^(Detail)
- IV.A.6.s).(2) Each resident should be a member of a health system or professional group committee. ^(Detail)
- IV.A.6.s).(3) Residents must receive regular reports of individual and practice productivity, financial performance, and clinical quality, as well as the training needed to analyze these reports. ^(Detail)
- IV.A.6.s).(4) Residents must attend regular FMP business meetings with staff and faculty members to discuss practice-related policies and procedures, business and service goals, and practice efficiency and quality. ^(Detail)
- IV.A.6.t) The curriculum should include diagnostic imaging interpretation and nuclear medicine therapy pertinent to family medicine. ^(Detail)
- IV.A.6.u) Residents must have at least 300 hours (or three months) dedicated to elective experiences. ^(Core)

IV.B. Residents' Scholarly Activities

- IV.B.1. The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. ^(Core)**
- IV.B.2. Residents should participate in scholarly activity. ^(Core)**
- IV.B.2.a) Residents should complete two scholarly activities, at least one of which should be a quality improvement project. ^(Outcome)

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

V. Evaluation

V.A. Resident Evaluation

V.A.1. The program director must appoint the Clinical Competency Committee. ^(Core)

V.A.1.a) At a minimum the Clinical Competency Committee must be composed of three members of the program faculty. ^(Core)

V.A.1.a).(1) Others eligible for appointment to the committee include faculty from other programs and non-physician members of the health care team. ^(Detail)

V.A.1.b) There must be a written description of the responsibilities of the Clinical Competency Committee. ^(Core)

V.A.1.b).(1) The Clinical Competency Committee should:

V.A.1.b).(1).(a) review all resident evaluations semi-annually; ^(Core)

V.A.1.b).(1).(b) prepare and assure the reporting of Milestones evaluations of each resident semi-annually to ACGME; and, ^(Core)

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

V.A.2. Formative Evaluation

V.A.2.a) The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment. ^(Core)

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

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

V.A.2.b).(1).(a) This assessment must involve direct observation of

- resident-patient encounters. ^(Detail)
- V.A.2.b).(1).(b) Each resident should be assessed in each of the six competency areas on entrance into the program. ^(Detail)
- V.A.2.b).(1).(c) Interpersonal and communication skills assessment must include both direct observation and multi-source evaluation (including at least patients, peers, and non-physician team members). ^(Detail)
- V.A.2.b).(1).(d) Each resident must be assessed in data gathering, clinical reasoning, patient management, and procedures in both the inpatient and outpatient settings. ^(Detail)
- V.A.2.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);** ^(Detail)
- V.A.2.b).(3) document progressive resident performance improvement appropriate to educational level; and,** ^(Core)
- V.A.2.b).(3).(a) The program must use an objective validated formative assessment method (e.g., in-training examination, chart stimulated recall). ^(Detail)
- V.A.2.b).(3).(a).(i) The same objective formative assessment method must be administered at least annually. ^(Detail)
- V.A.2.b).(4) provide each resident with documented semiannual evaluation of performance with feedback.** ^(Core)
- V.A.2.c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.** ^(Detail)
- V.A.3. Summative Evaluation**
- V.A.3.a) The specialty-specific Milestones must be used as one of the tools to ensure residents are able to practice core professional activities without supervision upon completion of the program.** ^(Core)
- V.A.3.b) The program director must provide a summative evaluation for each resident upon completion of the program.** ^(Core)
- This evaluation must:**
- V.A.3.b).(1) become part of the resident's permanent record**

maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy; ^(Detail)

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

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

V.B. Faculty Evaluation

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

V.B.2. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities. ^(Detail)

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

V.C. Program Evaluation and Improvement

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

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

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

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

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

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

V.C.1.a).(3).(b) reviewing and making recommendations for revision of competency-based curriculum goals and objectives; ^(Detail)

V.C.1.a).(3).(c) addressing areas of non-compliance with ACGME standards; and, ^(Detail)

V.C.1.a).(3).(d) reviewing the program annually using

evaluations of faculty, residents, and others, as specified below. ^(Detail)

V.C.2. The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written and Annual Program Evaluation (APE). ^(Core)

The program must monitor and track each of the following areas:

V.C.2.a) resident performance; ^(Core)

V.C.2.b) faculty development; ^(Core)

V.C.2.c) graduate performance, including performance of program graduates on the certification examination; ^(Core)

V.C.2.d) program quality; and, ^(Core)

V.C.2.d).(1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and ^(Detail)

V.C.2.d).(2) The program must use the results of residents' and faculty members' assessments of the program together with other program evaluation results to improve the program. ^(Detail)

V.C.2.e) progress on the previous year's action plan(s). ^(Core)

V.C.3. The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section V.C.2., as well as delineate how they will be measured and monitored. ^(Core)

V.C.3.a) The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes. ^(Detail)

V.C.4. At least 95 percent of a program's eligible graduates from the preceding five years must have taken the American Board of Family Medicine (ABFM) certifying examination for family medicine. ^(Outcome)

V.C.5. At least 90 percent of a program's graduates from the preceding five years who take the ABFM certifying examination for family medicine for the first time must pass. ^(Outcome)

V.C.6. Program graduates should be surveyed at least every five years, and the results should be used in the annual program evaluation. ^(Detail)

V.C.7. Program evaluation must include factors such as resident attrition and the presence of a critical mass of residents. ^(Detail)

V.C.7.a) Over a five-year period, program attrition should not exceed 15 percent. ^(Detail)

VI. Resident Duty Hours in the Learning and Working Environment

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

VI.A.1. Programs and sponsoring institutions must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients. ^(Core)

VI.A.2. The program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment. ^(Core)

VI.A.3. The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs. ^(Core)

VI.A.4. The learning objectives of the program must:

VI.A.4.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and, ^(Core)

VI.A.4.b) not be compromised by excessive reliance on residents to fulfill non-physician service obligations. ^(Core)

VI.A.5. The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. ^(Core)

VI.A.6. Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following:

VI.A.6.a) assurance of the safety and welfare of patients entrusted to their care; ^(Outcome)

VI.A.6.b) provision of patient- and family-centered care; ^(Outcome)

VI.A.6.c) assurance of their fitness for duty; ^(Outcome)

VI.A.6.d) management of their time before, during, and after clinical assignments; ^(Outcome)

VI.A.6.e) recognition of impairment, including illness and fatigue, in themselves and in their peers; ^(Outcome)

VI.A.6.f) attention to lifelong learning; ^(Outcome)

- VI.A.6.g) the monitoring of their patient care performance improvement indicators; and, ^(Outcome)
- VI.A.6.h) honest and accurate reporting of duty hours, patient outcomes, and clinical experience data. ^(Outcome)
- VI.A.7. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. They must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider. ^(Outcome)
- VI.B. Transitions of Care
- VI.B.1. Programs must design clinical assignments to minimize the number of transitions in patient care. ^(Core)
- VI.B.2. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. ^(Core)
- VI.B.3. Programs must ensure that residents are competent in communicating with team members in the hand-over process. ^(Outcome)
- VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care. ^(Detail)
- VI.C. Alertness Management/Fatigue Mitigation
- VI.C.1. The program must:
- VI.C.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation; ^(Core)
- VI.C.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; and, ^(Core)
- VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules. ^(Detail)
- VI.C.2. Each program must have a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties. ^(Core)
- VI.C.3. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home. ^(Core)

VI.D. Supervision of Residents

VI.D.1. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care. ^(Core)

VI.D.1.a) This information should be available to residents, faculty members, and patients. ^(Detail)

VI.D.1.b) Residents and faculty members should inform patients of their respective roles in each patient's care. ^(Detail)

VI.D.2. The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients. ^(Core)

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

VI.D.3. Levels of Supervision

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

VI.D.3.a) Direct Supervision – the supervising physician is physically present with the resident and patient. ^(Core)

VI.D.3.b) Indirect Supervision:

VI.D.3.b).(1) with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision. ^(Core)

VI.D.3.b).(2) with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision. ^(Core)

- VI.D.3.c) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. ^(Core)**
- VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. ^(Core)**
- VI.D.4.a) The program director must evaluate each resident’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria. ^(Core)**
- VI.D.4.b) Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents. ^(Detail)**
- VI.D.4.c) Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. ^(Detail)**
- VI.D.5. Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions. ^(Core)**
- VI.D.5.a) Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence. ^(Outcome)**
- VI.D.5.a).(1) In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available. ^(Core)**
- VI.D.6. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility. ^(Detail)**
- VI.E. Clinical Responsibilities**
- The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services. ^(Core)**
- VI.E.1. The program director must have the authority and responsibility to set appropriate clinical responsibilities (i.e., patient caps) for each resident based on that resident’s PGY level, patient safety, resident education, severity and complexity of patient illness/condition, and available support**

services. ^(Core)

VI.F. Teamwork

Residents must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty. ^(Core)

VI.G. Resident Duty Hours

VI.G.1. Maximum Hours of Work per Week

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting. ^(Core)

VI.G.1.a) Duty Hour Exceptions

A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale. ^(Detail)

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

VI.G.1.a).(1) In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures. ^(Detail)

VI.G.1.a).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO. ^(Detail)

VI.G.2. Moonlighting

VI.G.2.a) Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program. ^(Core)

VI.G.2.b) Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit. ^(Core)

VI.G.2.c) PGY-1 residents are not permitted to moonlight. ^(Core)

VI.G.3. Mandatory Time Free of Duty

Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days. ^(Core)

VI.G.4. Maximum Duty Period Length

VI.G.4.a) Duty periods of PGY-1 residents must not exceed 16 hours in duration. ^(Core)

VI.G.4.b) Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. ^(Core)

VI.G.4.b).(1) Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested. ^(Detail)

VI.G.4.b).(2) It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours. ^(Core)

VI.G.4.b).(3) Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty. ^(Core)

VI.G.4.b).(4) In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. ^(Detail)

VI.G.4.b).(4).(a) Under those circumstances, the resident must:

VI.G.4.b).(4).(a).(i) appropriately hand over the care of all other patients to the team responsible for their continuing care; and, ^(Detail)

VI.G.4.b).(4).(a).(ii) document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director. ^(Detail)

VI.G.4.b).(4).(b) The program director must review each

submission of additional service, and track both individual resident and program-wide episodes of additional duty. ^(Detail)

VI.G.5. Minimum Time Off between Scheduled Duty Periods

VI.G.5.a) PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods. ^(Core)

VI.G.5.b) Intermediate-level residents should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty. ^(Core)

PGY-2 residents are considered to be at the intermediate-level.

VI.G.5.c) Residents in the final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. ^(Outcome)

PGY-3 residents are considered to be in the final years of education.

VI.G.5.c).(1) This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. ^(Detail)

VI.G.5.c).(1).(a) Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director. ^(Detail)

VI.G.5.c).(1).(b) The Review Committee defines such circumstances, applicable to all residents, as: required continuity of care for a severely ill or unstable patient, or a complex patient, or a maternity care continuity delivery patient with whom the resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. ^(Detail)

VI.G.6. Maximum Frequency of In-House Night Float

Residents must not be scheduled for more than six consecutive

nights of night float. ^(Core)

VI.G.6.a) Night float experiences must not exceed 50 percent of a resident's inpatient experiences. ^(Core)

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

PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period). ^(Core)

VI.G.8. At-Home Call

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

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

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

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

Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs 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.