ACGME Program Requirements for Graduate Medical Education in General Surgery

ACGME-approved focused revision: June 13, 2020; effective July 1, 2020

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 VI.C.1.d).(1).

I.D.2.d) **security and safety measures appropriate to the participating site; and,** (Core)

I.D.2.e) **accommodations for residents with disabilities consistent with the Sponsoring Institution's policy.** (Core)

I.D.3. **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)

I.D.4. **The program's educational and clinical resources must be adequate to support the number of residents appointed to the program.** (Core)

I.D.5. The institutional volume and variety of operative experience must be adequate to ensure a sufficient number and distribution of basic and complex cases (as determined by the Review Committee) for each resident in the program. (Core)

I.E. **The presence of other learners and other care providers, including, but not limited to, residents from other programs, subspecialty fellows, and advanced practice providers, must enrich the appointed residents' education.** (Core)

I.E.1. **The program must report circumstances when the presence of other learners has interfered with the residents' education to the DIO and Graduate Medical Education Committee (GMEC).** (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.

II. Personnel

II.A. Program Director

II.A.1. **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)

II.A.1.a) **The Sponsoring Institution's GMEC must approve a change in program director.** (Core)

II.A.1.b) **Final approval of the program director resides with the Review Committee.** (Core)

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 made responsible for the program. This individual will have dedicated time for the leadership of the residency, and it is this individual's responsibility to communicate with the residents, faculty members, DIO, GMEC, and the ACGME. The program director's nomination is reviewed and approved by the GMEC. Final approval of program directors resides with the Review Committee.

II.A.1.c) **The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability.** (Core)

II.A.1.c).(1) The program director's initial appointment should be for at least six years. (Detail)

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.

II.A.2. **At a minimum, the program director must be provided with the salary support required to devote** 30 percent **FTE of non-clinical time to the administration of the program.** (Core)

II.A.2.a) Associate program directors must be appointed and additional salary support for the associate program director(s) must be provided based on program size as follows: (Core)

Number of Approved Categorical and Preliminary Resident Positions	Minimum Number of Associate Program Directors	Minimum FTE per Associate Program Director(s)
0-20	0	0
21-50	1	0.1
51 or more	2	0.1

II.A.2.b) Program directors should devote their principal non-clinical effort to the program. (Detail)

II.A.2.b).(1) The associate program director's initial appointment should be for at least three years. (Detail)

Background and Intent: Thirty percent FTE is defined as one and one half days per week.

"Administrative time" is defined as non-clinical time spent meeting the responsibilities of the program director as detailed in requirements II.A.4.-II.A.4.a).(16).

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

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

II.A.3.a) must include 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 diverse 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.

II.A.3.b) must include current certification in the specialty for which they are the program director by the American Board of Surgery or by the American Osteopathic Board of Surgery, or specialty qualifications that are acceptable to the Review Committee; (Core)

Specialty-Specific Background and Intent: Sponsoring Institutions considering candidates for appointment as program director holding qualifications equivalent to those of the American Board of Surgery or the American Osteopathic Board of Surgery (e.g., Royal College of Physicians and Surgeons Canada) may submit a request for consideration and approval of qualifications to the executive director of the Review Committee. In accordance with Program Requirement II.A.4.a).(16) all requests must be co-signed by the DIO.

There may be situations in programs when a qualified program director cannot be immediately appointed or when a temporary absence of the permanent program director is anticipated. In situations where an interim program director is needed as a temporizing measure to provide stability to a program, a request should be entered into ADS, and

"interim" chosen as the term of appointment. Included in the submission of the request for approval, the institution/program will be required to submit an action plan outlining the support (e.g., institutional, division, department, and program) that will be provided to the interim program director, the plan for recruitment or placement of a qualified permanent program director, and the anticipated timeline until such placement. The program will be expected to submit a progress report six months following the request for approval of the interim program director if a qualified program director has not been appointed and approved by the Review Committee. Instructions for the submission of an interim program director may be found at: https://www.acgme.org/Specialties/Documents-and-Resources/pfcatid/24/Surgery.

II.A.3.c) **must include current medical licensure and appropriate medical staff appointment;** (Core)

II.A.3.d) **must include ongoing clinical activity; and,** (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.

II.A.3.e) must include scholarly activity in at least one of the areas of scholarly activity delineated in Section IV.D. of this document. (Detail)

Specialty-Specific Background and Intent: The Committee recommends that the program director's scholarly activities be reflective of the institution's and program's scholarly environment, and should align with the program's mission and aims.

II.A.4. **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)

II.A.4.a) **The program director must:**

II.A.4.a).(1) **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.

II.A.4.a).(2) 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 health disparities.

II.A.4.a).(3) 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.

II.A.4.a).(4) develop and oversee a process to evaluate candidates prior to approval as program faculty members for participation in the residency program education and at least annually thereafter, as outlined in V.B.; (Core)

II.A.4.a).(5) have the authority to approve program faculty members for participation in the residency program education at all sites; (Core)

II.A.4.a).(6) have the authority to remove program faculty members from participation in the residency program education at all sites; (Core)

II.A.4.a).(7) 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.

II.A.4.a).(8) submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; (Core)

II.A.4.a).(9) provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s); (Core)

II.A.4.a).(10) provide a learning and working environment in which residents have the opportunity to raise concerns and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; (Core)

II.A.4.a).(11) ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process; (Core)

II.A.4.a).(12) ensure the program's compliance with the Sponsoring Institution's policies and procedures for due process when action is taken to suspend or dismiss, not to promote, or not to 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.

II.A.4.a).(13) ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; (Core)

II.A.4.a).(13).(a) Residents must not be required to sign a non-competition guarantee or restrictive covenant. (Core)

II.A.4.a).(14) document verification of program completion for all graduating residents within 30 days; (Core)

II.A.4.a).(15) provide verification of an individual resident's completion upon the resident's request, within 30 days; and, (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.

II.A.4.a).(16) obtain review and approval of the Sponsoring Institution's DIO before submitting information or requests to the ACGME, as required in the Institutional Requirements and outlined in the ACGME Program Director's Guide to the Common Program Requirements. (Core)

II.B. 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. 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 or salary support.

II.B.1. At each participating site, there must be a sufficient number of faculty members with competence to instruct and supervise all residents at that location. (Core)

II.B.2. Faculty members must:

II.B.2.a) be role models of professionalism; (Core)

II.B.2.b) demonstrate commitment to the delivery of safe, 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.

II.B.2.c) demonstrate a strong interest in the education of residents; (Core)

II.B.2.d) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; (Core)

II.B.2.e) administer and maintain an educational environment conducive to educating residents; (Core)

II.B.2.f) regularly participate in organized clinical discussions, rounds, journal clubs, and conferences; and, (Core)

II.B.2.g) 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 transference 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.

II.B.2.g).(1) as educators; (Core)

II.B.2.g).(2) in quality improvement and patient safety; (Core)

II.B.2.g).(3) in fostering their own and their residents' well-being; and, (Core)

II.B.2.g).(4) in patient care based on their practice-based learning and improvement efforts. (Core)

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.

II.B.3. Faculty Qualifications

II.B.3.a) Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)

II.B.3.b) Physician faculty members must:

II.B.3.b).(1) have current certification in the specialty by the American Board of Surgery or the American Osteopathic Board of Surgery, or possess

qualifications judged acceptable to the Review Committee; and, (Core)

II.B.3.b).(2) have current certification in their designated specialty or subspecialty if they are not surgical faculty members, or possess qualifications judged acceptable to the Review Committee. (Core)

Specialty-Specific Background and Intent: Programs need to submit a request to the executive director of the Review Committee for consideration and approval of qualifications of any faculty member who is not currently certified by the American Board of Surgery, another ABMS member board, or the American Osteopathic Association. In accordance with Program Requirement II.A.4.a).(16), all requests must be co-signed by the DIO.

II.B.3.c) **Any non-physician faculty members who participate in residency program education must be approved by the program director.** (Core)

Background and Intent: The provision of optimal and safe patient care requires a team approach. The education of residents by non-physician educators enables the resident to better manage patient care and provides valuable advancement of the residents' knowledge. Furthermore, other individuals contribute to the education of the resident 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.

II.B.4. **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 developing, implementing, and assessing curriculum and in assessing residents' progress toward achievement of competence in 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, including completion of the annual ACGME Faculty Survey.

II.B.4.a) **Core faculty members must be designated by the program director.** (Core)

II.B.4.b) **Core faculty members must complete the annual ACGME Faculty Survey.** (Core)

II.B.4.c) For each approved chief resident position there must be at least one core faculty member with current board certification in surgery