Program Director's Reference Guide to ACGME and Residency Review Committees

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OUR MISSION AND VISION

The mission of the ACGME is to improve the quality of health care in the United States...

Mission Statement

The mission of the ACGME is to improve the quality of health care in the United States by ensuring and improving the quality of graduate medical education experiences for physicians in training. The ACGME establishes national standards for graduate medical education by which it approves and continually assesses educational programs under its aegis. It uses the most effective methods available to evaluate the quality of graduate medical education programs. It strives to improve evaluation methods and processes that are valid, fair, open, and ethical.

In carrying out these activities the ACGME is responsive to change and innovation in education and current practice, promotes the use of effective measurement tools to assess resident physician competency, and encourages educational improvement.

Vision Statement

The ACGME will:

1. Be a source of inspiration, encouragement, support and assistance to all who strive for educational excellence;
2. Incorporate educational outcomes into accreditation decisions;
3. Be data and evidence driven;
4. Encourage the development of core competencies across all disciplines, including knowledge of quality improvement;
5. Explore a more comprehensive role in GME policy;
6. Become a world leader in accreditation efforts;
7. Maintain objectivity and independence while continuing it's interorganizational relationships;
8. Develop a consultative role and encourage innovation;
9. Be the spokesperson for GME.

FUNCTIONS OF THE RESIDENCY REVIEW COMMITTEES

*Included here is information about the accreditation process, accreditation standards, accreditation categories, including the new inactive category, and appeal process and procedures****. Any questions about the accreditation process may be directed to the RRC staff. A staff listing is included at the back of the manual. Any questions about the institutional review or appeals process may be directed to Cynthia Taradejna at*** *cat@acgme.org*

FUNCTIONS OF THE RESIDENCY REVIEW COMMITTEES

REVIEW RESIDENCY PROGRAMS

DETERMINE ACCREDITATION STATUS

PROPOSE PROGRAM REQUIREMENTS

The primary functions of an RRC are:

(1) To propose program requirements for the medical specialty and subsequently to propose revisions to those program requirements to improve the accreditation process.

(2) To review residency programs to determine whether they are in substantial compliance with the Institutional Requirements and with the program requirements for that specialty, and to determine an accreditation status for each program.

(3) To recommend to the ACGME improvements in accreditation policies and procedures.

ACCREDITATION PROCESS

The accreditation process essentially consists of four steps:

GATHERING PROGRAM INFORMATION

The director of a residency program prepares a comprehensive description of the program using program information forms (pifs) which are developed for this purpose by each Residency Review Committee (RRC). The completed forms may serve as an application for a new program, or for review of an existing program. Completed program information forms, program history, and pertinent interim correspondence are forwarded to the site visitor.

THE SITE VISITOR

Either a member of the field staff or a specialist conducts a site visit of the program. The site visitor's primary responsibility is to verify the accuracy and completeness of the information that has been provided by the program director. The site visitor conducts in-depth interviews with administrators, faculty, and residents to assess the various aspects of the educational program. It should be emphasized that the site visitor's report does not made accreditation recommendations and that the site visitor does not participate in the final accreditation decisions by the RRC.

REVIEW OF YOUR PROGRAM BY THE RESIDENCY REVIEW COMMITTEE

At its regularly scheduled meeting, the RRC reviews the program information forms and the site visitor's report, determines the program's compliance with the "Essentials of Accredited Residencies in Graduate Medical Education," and determines the accreditation status of the residency program. In determining whether the program is in substantial compliance with the "Essentials of Accredited Residencies in Graduate Medical Education," the RRC identifies specific areas of noncompliance.

ACCREDITATION STANDARDS

INSTITUTIONAL REQUIREMENTS

The Institutional Requirements, which apply to all sponsoring institutions, are developed by the Institutional Review Committee and are approved by the ACGME. The Institutional Requirements address the sponsoring institution's responsibility and support for all aspects of residency education. In addition, the Institutional Requirements serve to protect the residents in their working environment. Specific standards include the institution's organization and commitment to graduate medical education, institutional responsibilities for oversight of the residency programs, and the development of appropriate institutional policies and procedures that affect all residents while in training. (See *Graduate Medical Education Directory* or through the internet at www.acgme.org.)

The ACGME, through the Institutional Review Committee (IRC), evaluates institutions that sponsor graduate medical education for compliance with the Institutional Requirements. This process, known as the institutional review, is accomplished on a one-to-five-year cycle. The IRC's action taken on the institutional review is included as the last entry on the "history sheet" in the program file presented to an RRC for review. Since the ACGME does ***not*** accredit institutions, the actions are indicated by either a "favorable" or "unfavorable" status. At the time of the program's review, the RRC determines whether the areas of noncompliance identified in the institutional review have had an adverse impact on the program.

PROGRAM REQUIREMENTS

Program requirements for each medical specialty are prepared by the respective RRC. They are reviewed by the sponsoring organizations of the RRC, by the member organizations of the ACGME, by the program directors, and by the other RRCs. All program requirements are reviewed and approved by the ACGME. The program requirements are revised periodically to reflect the current educational practice of the specialty. For the RRC, the program requirements serve as the essential standards against which residency programs are evaluated and the quality of graduate medical education is enhanced. (See *Graduate Medical Education* Directory or through the internet at www.acgme.org.)

Evaluative comments about the program provided by the RRC for the program director must relate directly to specific standards in the Institutional Requirements and in the program requirements for that specialty.

ACCREDITATION CATEGORIES

Accredited:	**Non-Accredited:**
PROVISIONAL	***WITHHOLD***
FULL	***WITHDRAW***
PROBATION	***ADMINISTRATIVE WITHDRAWAL***

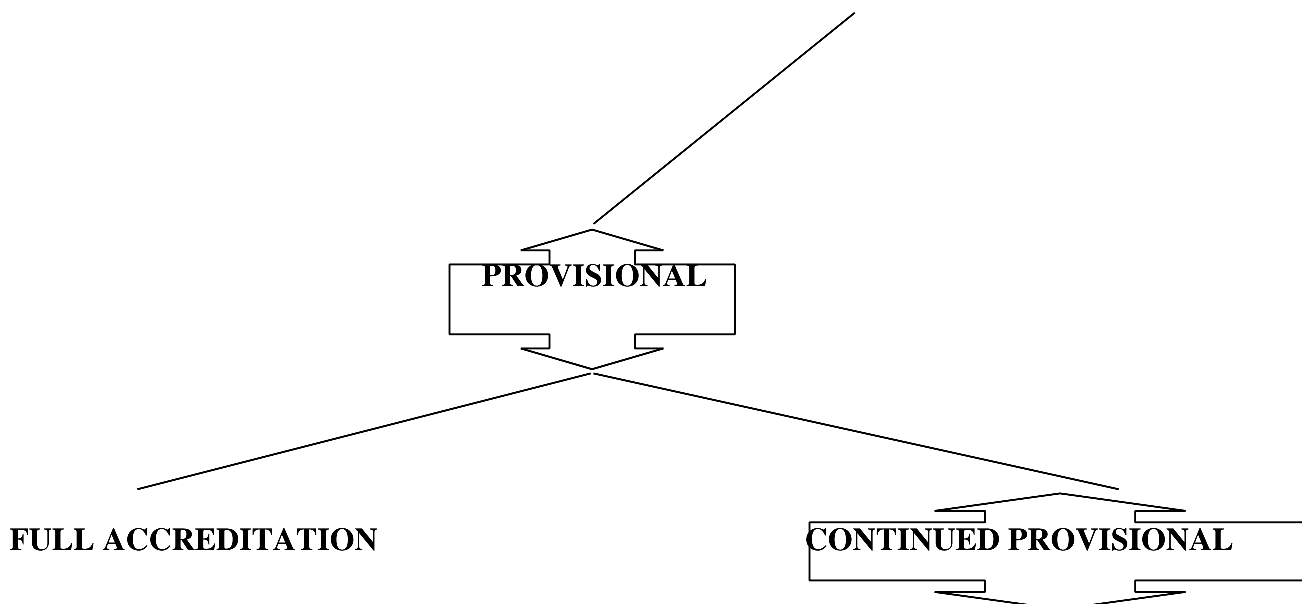
There are five basic accreditation categories. Three pertain to an accredited status and two are used to deny accreditation. In reviewing the description of each accreditation category, it is important to note that procedural stipulations for each dictate how and when they are used in the accreditation process. These rules determine the accreditation options open to an RRC in evaluating a residency program. Familiarity with each of the accreditation categories facilitates individual review of residency programs as well as committee action on the accreditation status of each program.

The accreditation categories are described on the following pages. Information is also provided on additional actions taken by the RRCs in accrediting residency programs.

PROVISIONAL ACCREDITATION

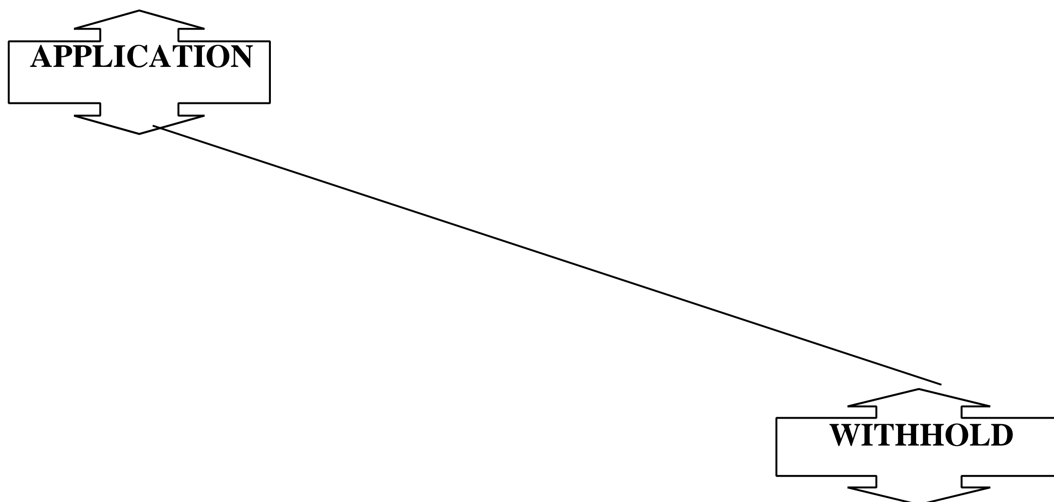
This category is granted for initial accreditation of a program or for a previously accredited program which had its accreditation withdrawn and has subsequently applied for reaccreditation. Provisional accreditation may also be used in the unusual circumstance in which a program has been so altered that, in the judgment of the RRC, it is the equivalent of a new program.

Following initial accreditation on a provisional basis, programs should undergo a site visit in approximately two years, but no more than three years in preparation for review by the RRC. In the course of monitoring a program's development, an RRC may continue provisional accreditation. Accreditation should not be withdrawn until the program has had notice of noncompliance with the "Essentials of Accredited Residencies" (See Warning Procedure). The total period of provisional accreditation should not exceed five years or the length of the program plus one year for programs of five years duration or longer. With the exception of special cases as determined by an RRC, if full accreditation is not granted within either of these time frames, accreditation of the program should be withdrawn.



WITHHOLD ACCREDITATION

This category is used when an RRC determines that the proposal for a new program is not in substantial compliance with the "Essentials of Accredited Residencies." The RRC will cite those standards with which the proposed program does not comply.



FULL ACCREDITATION

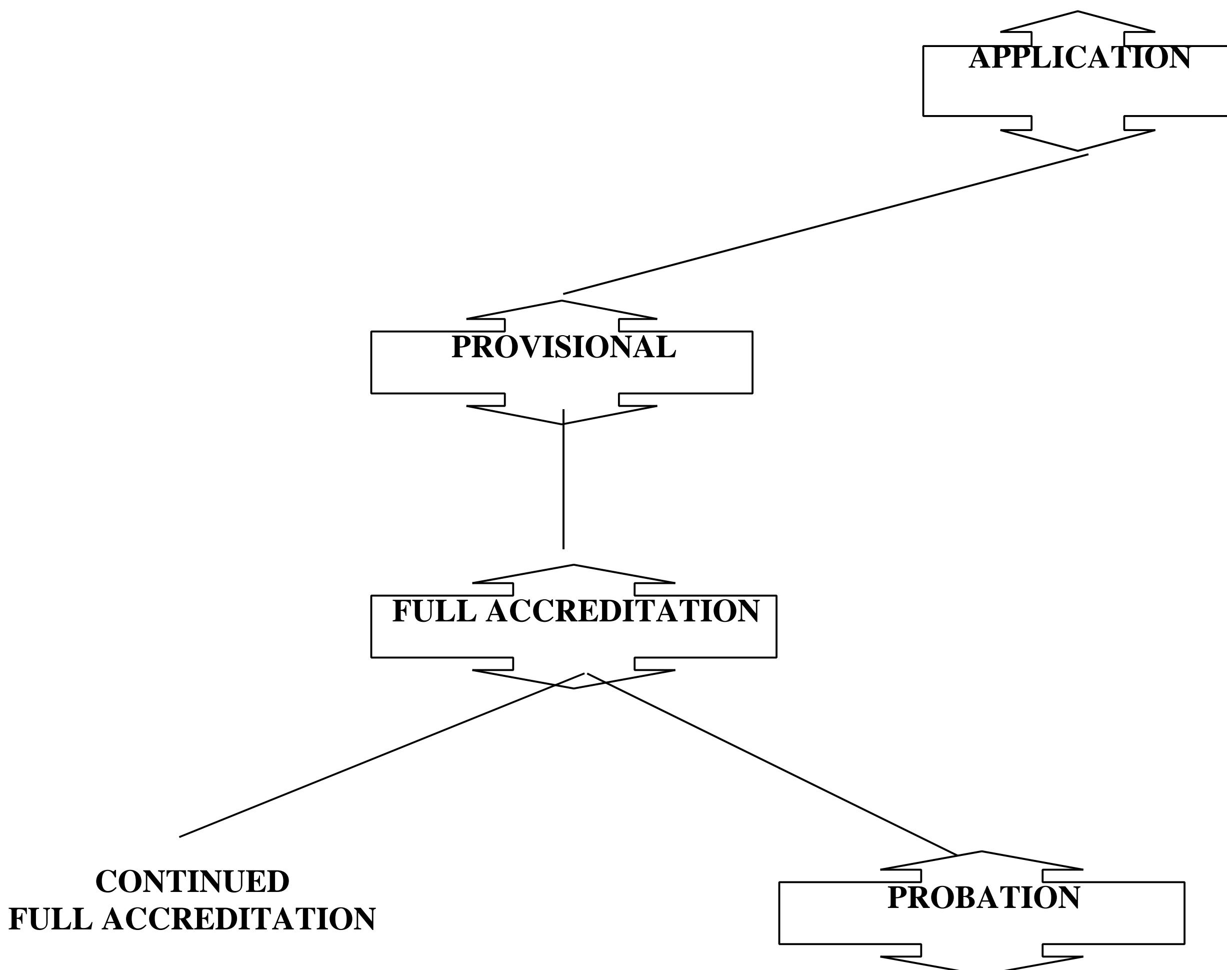
This category is used in three circumstances:

1. **For programs holding provisional accreditation which upon review have demonstrated that they are functioning in substantial compliance with the "Essentials of Accredited Residencies;"**

2. **For programs holding full accreditation which upon review have demonstrated that they continue to be in substantial compliance with the "Essentials of Accredited Residencies;"**

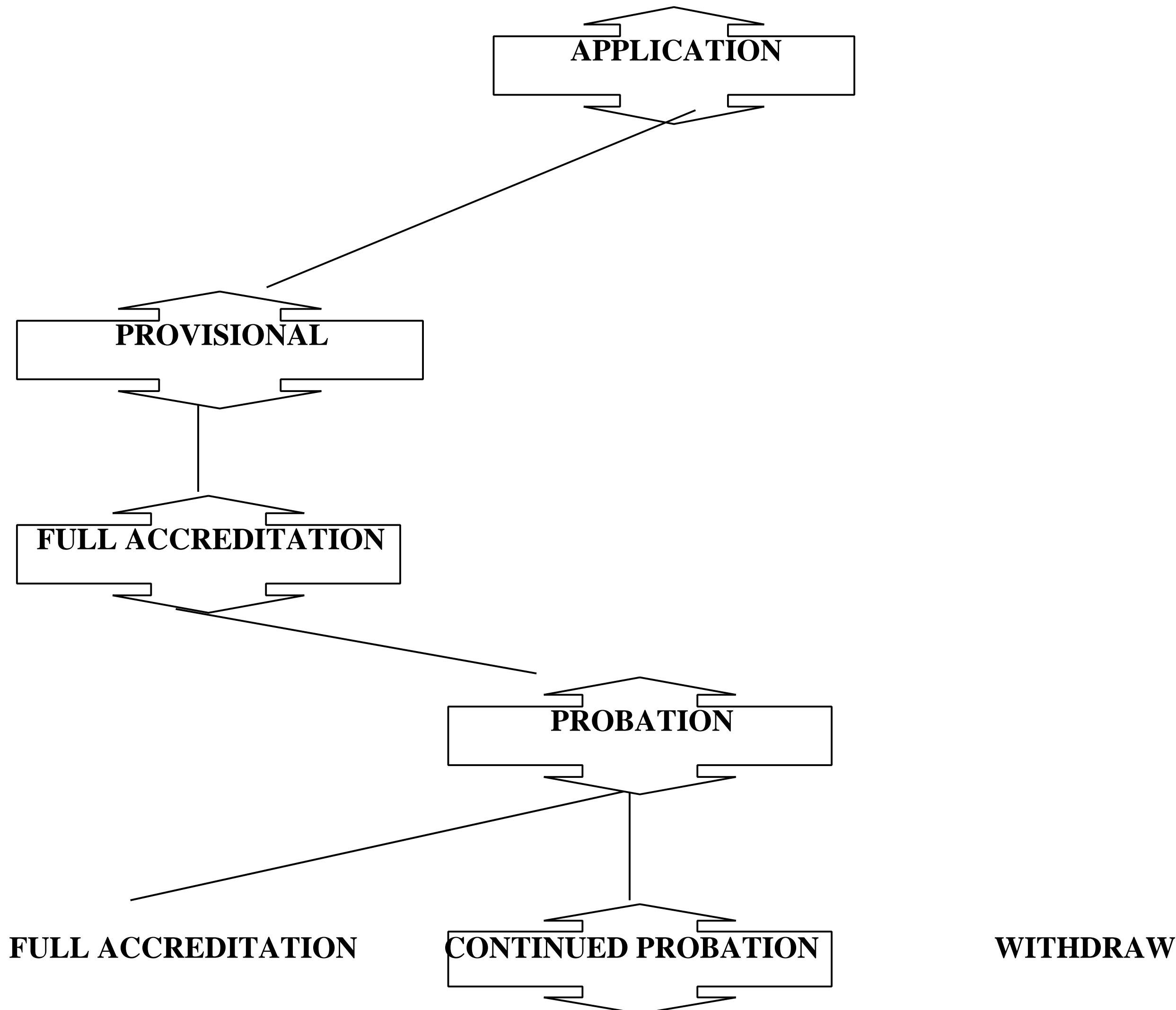
3. **For programs holding probationary accreditation which upon review have demonstrated that they are now in substantial compliance with the "Essentials of Accredited Residencies."**

The maximum interval between reviews of programs holding full accreditation is five years, however, an RRC may specify a shorter cycle.



PROBATIONARY ACCREDITATION

An RRC may grant probationary accreditation in the case of programs holding full accreditation, which upon review are no longer considered to be in substantial compliance with the " Essentials of Accredited Residencies." The normal interval for review of programs with probationary accreditation is two years, however, an RRC may specify a shorter cycle. In reviewing a residency program, which holds probationary accreditation, an RRC may exercise the following options:
grant full accreditation; withdraw accreditation; or, in special circumstances, continue probationary accreditation. A program should not hold probationary accreditation for more than four consecutive years until it is returned to full accreditation or the RRC acts to withdraw accreditation.



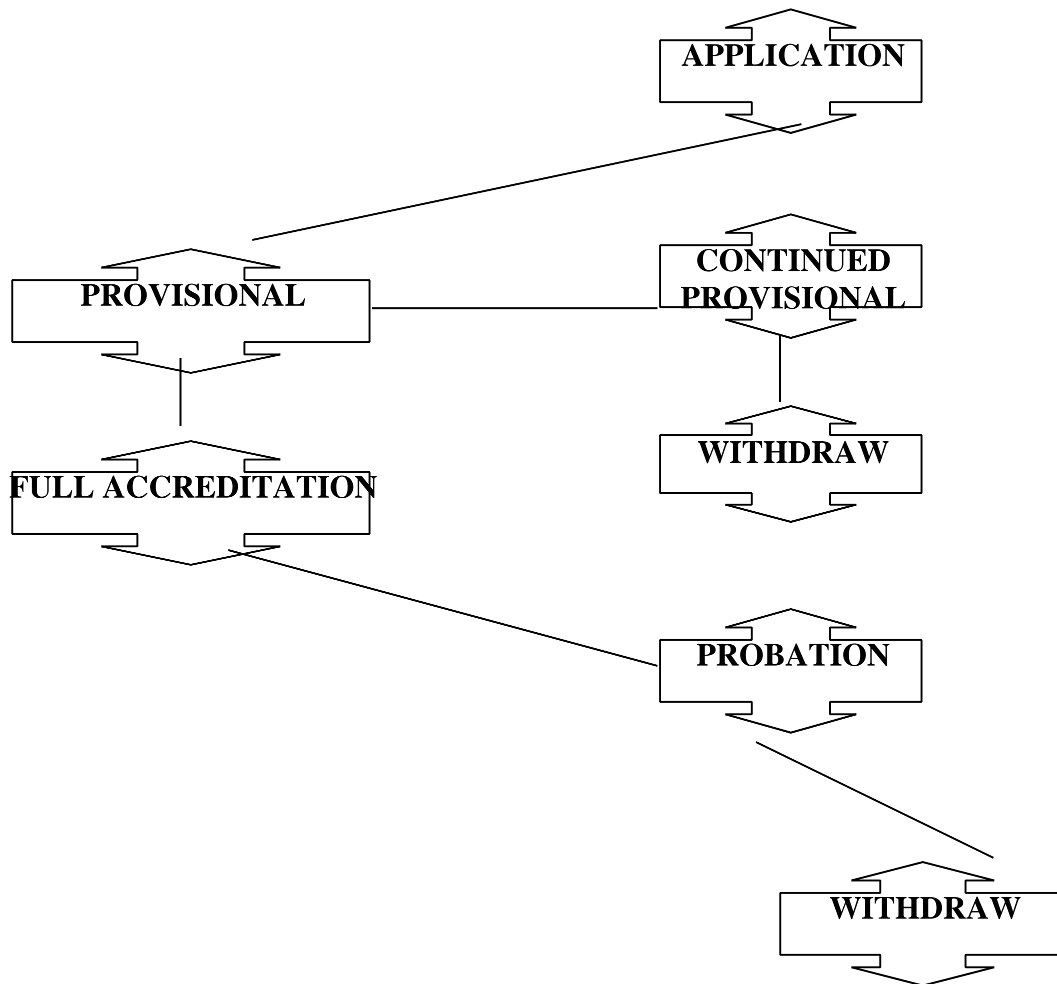
WITHDRAW

WITHDRAWAL OF ACCREDITATION

Accreditation may be withdrawn from a residency program holding either provisional accreditation or probationary accreditation which upon review is not considered to be in substantial compliance with the "Essentials of Accredited Residencies."

When accreditation is withdrawn, the effective date of withdrawal shall not be less than one year from the date of the final accreditation action. Also, the effective date of withdrawal shall permit the completion of the training year in which the action becomes effective. Once final action is taken to withdraw accreditation, residents may not be appointed to the program.

When action has been taken by an RRC to withdraw accreditation of a residency program, and the program has entered into appeal procedures, an application for accreditation of a new program will not be considered until the appeal is concluded.



VOLUNTARY WITHDRAWAL OF ACCREDITATION

Voluntary withdrawal of accreditation is appropriate under the following circumstances:

(1) A program may request voluntary withdrawal of accreditation, without prejudice. It is expected that if a program is inactive for two years, the director will seek voluntary withdrawal of accreditation.

(2) Two or more programs may combine to form a single new program. If the RRC accredits the new program, it will take concurrent actions for withdrawal of accreditation, without prejudice, of the program(s) which no longer functions independently. The RRC will consider the expressed preference of the program director in establishing the effective date for withdrawal of accreditation of the program(s).

At an RRC meeting, voluntary withdrawal of accreditation is an uncontested decision, so the request is presented by the Executive Director rather than by a committee member.

INACTIVE STATUS
Effective July 1/2000

It is ACGME policy that a program may remain inactive for a total of no more than four consecutive years. The time is marked from the date the last resident left the program.

A program may be inactive for two years prior to requesting Inactive Status from the Residency Review Committee.

Request for Inactive Status

To request Inactive Status, submit a letter in which you include the following:

- A request for Inactive Status
- The date the last resident left the program
- Whether you will continue to recruit residents while inactive
- Date of last site visit and review by RRC

The request must be co-signed by the Chair of the GMEC of the sponsoring institution.

Send letter requesting the inactive status to the RRC Executive Director.

Request for Reactivation of Accreditation Status

Reactivation is not automatic. Submission of a complete program information form (PIF) may be required. It is suggested that you phone the Executive Director of the RRC to discuss your request before submitting the information listed below.

To request reactivation, send a letter that includes:

Effective Date of Inactive Status
Requested date of reactivation
Date of last review by RRC (date of Notification letter)
Whether a resident has already been appointed to begin training and, if so, on what date
A brief narrative in which you provide an update on the program, including:

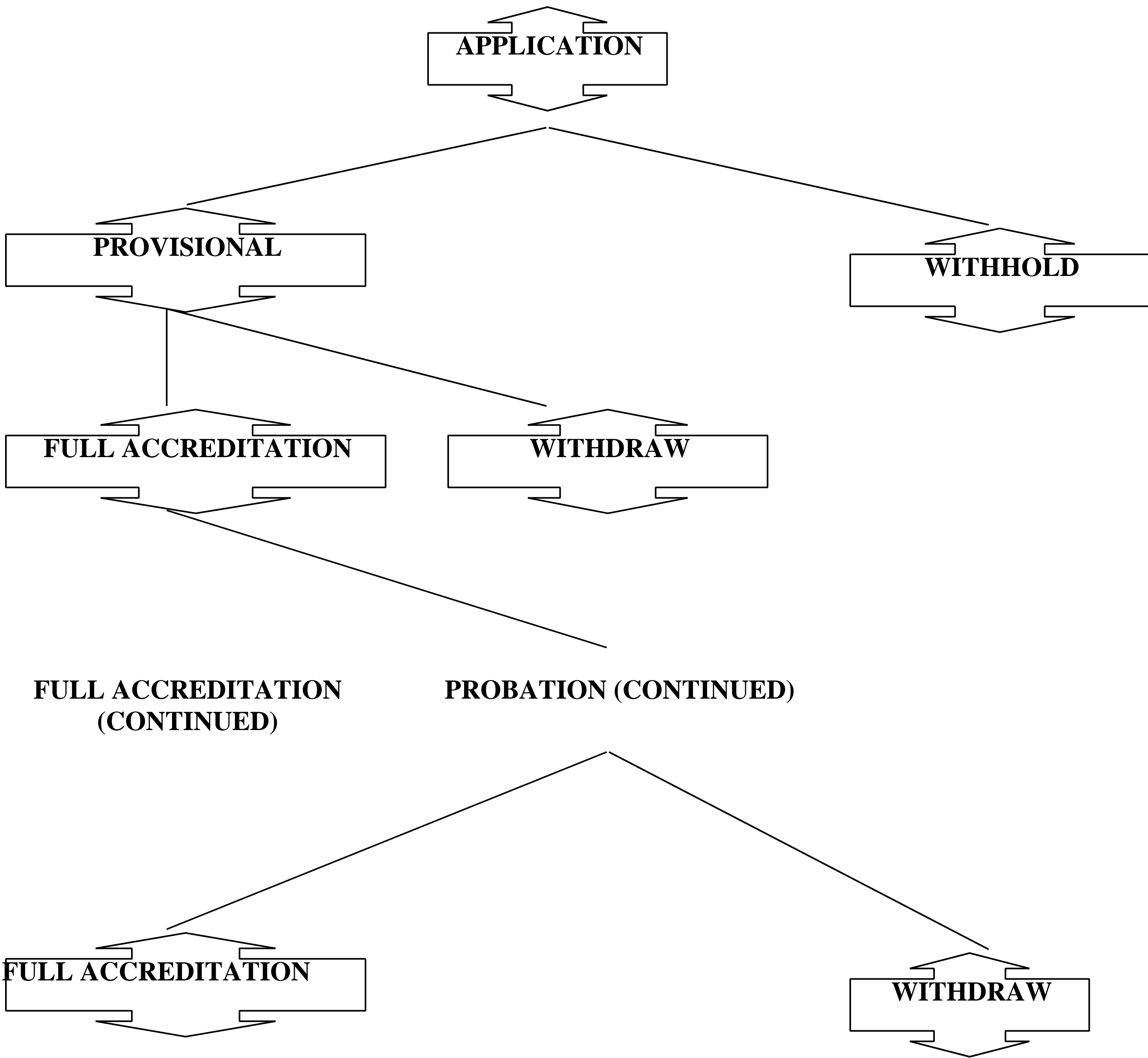
- Program director: Has there been a change since the request for Inactive Status? If so, provide the CV of the current program director
- Has there been a change in hospitals used for rotations? If so, provide the information requested in the PIF
- excerpt pages from the PIF on which you report the current data for inpatient and outpatient experience, and, if applicable, the most recent surgical and/or procedural log.
- a list of research projects currently underway by faculty, including topic, amount and source of outside funding .

The request must be co-signed by the Chair of the GEMC of the sponsoring institution.

"CONTINUATION" CATEGORIES OF ACCREDITATION

There exist indirectly three additional accreditation categories reflecting continuation of each of the three primary categories. Thus, programs may be granted "continued provisional accreditation," "continued full accreditation," and "continued probationary accreditation." Continued full accreditation is standard for programs which continue to meet minimum accreditation requirements.

ACCREDITATION OPTIONS



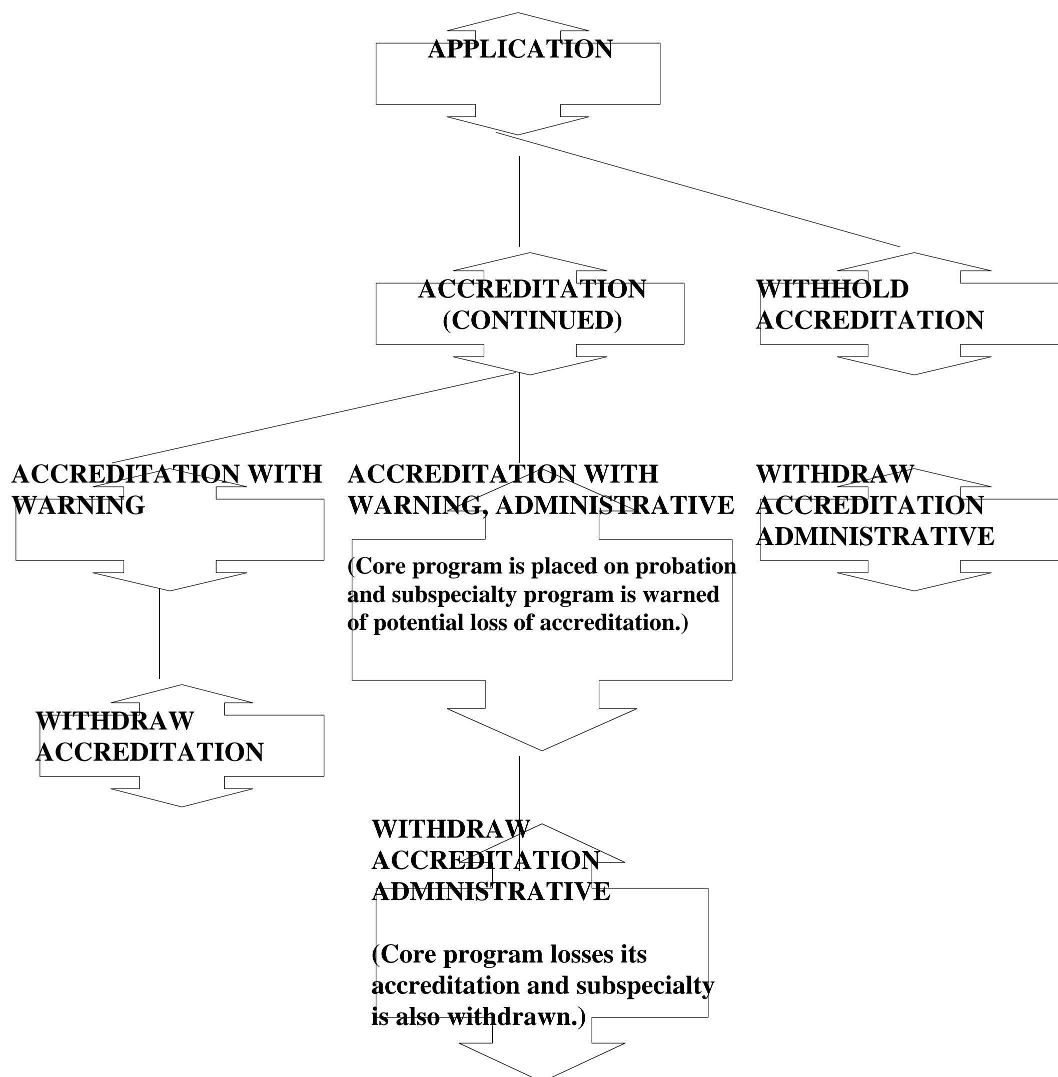
ACCREDITATION OF SUBSPECIALTY PROGRAMS

RRCs that accredit subspecialty programs develop special policies and procedures for the accreditation of these programs, which are published in the *Manual of Policies and Procedures for Graduate Medical Education Review Committees.*

Several RRCs accredit subspecialty or "fellowship" programs. There are two procedural models for the accreditation of these programs.

1. **When the accreditation status of the subspecialty programs is not directly related to or dependent upon the status of a specialty/parent program, the subspecialty programs are accredited in accordance with the same procedures used for general specialty programs as described earlier.**

2. **When the accreditation status of the subspecialty programs is directly related to or dependent upon the status of a general specialty/parent program, the following accreditation actions are used.**



WARNING PROCEDURE

An RRC may use a warning procedure to advise a program director that the program has serious areas of noncompliance with the "Essentials of Accredited Residencies in Graduate Medical Education" and that the program's future accreditation status may be in jeopardy. This procedure is not subject to appeal.

PROVISIONAL ACCREDITATION WITH WARNING

For a program holding provisional accreditation, an RRC may elect to continue provisional accreditation, but include in the letter of notification a statement that the program will be reviewed in approximately one year*, following a site visit. At that time, withdrawal of accreditation will be considered if the program has not achieved satisfactory development in establishing substantial compliance with the "Essentials of Accredited Residencies in Graduate Medical Education." Accreditation should not be withdrawn until the program has had such notice of noncompliance with the “Essentials of Accredited Residencies in Graduate Medical Education.”

FULL ACCREDITATION WITH WARNING

For a program holding full accreditation, an RRC may determine that the program has areas of noncompliance with the "Essentials of Accredited Residencies in Graduate Medical Education" which, however, do not warrant probationary accreditation at the time. It may elect to continue full accreditation, but include in the letter of notification a statement that the program will be reviewed in approximately one year*, following a site visit, at which time probationary accreditation will be considered if the program is not in substantial compliance with the "Essentials of Accredited Residencies in Graduate Medical Education."

* RRCs may extend the interval to two years when it is deemed that the program will require additional time to address the issues cited.

DEFERRAL OF ACCREDITATION ACTION

An RRC may defer reaching an accreditation decision until its next scheduled meeting. The reason for deferral of accreditation action is lack of sufficient information about specific issues, the absence of which precludes an informed and reasonable decision. When the RRC defers accreditation action, the residency program retains its current accreditation status until a final decision is made.

ADVERSE ACCREDITATION ACTIONS

Withholding accreditation, withdrawing accreditation, and probationary accreditation are defined as adverse accreditation actions.

When an RRC determines that an adverse action is warranted, it will advise the program director of its intent in a letter that includes the citations which form the basis for the proposed adverse action. A copy of the site visitor's report will accompany this letter. The program director is given the opportunity to address each of the citations as well as the proposed accreditation action in a written response to the RRC. At a regularly scheduled meeting, the RRC will examine the program director's response and will complete its evaluation of the program. The RRC may confirm its proposed adverse action or modify its position and take a non-adverse action. In either case, a letter of notification will be sent to the program director setting forth the RRC's final action on the program.

APPEAL PROCEDURES

APPEALS PANEL

Adverse actions are subject to appeal procedures. If an RRC takes an adverse action, the program director may request a hearing before an Appeals Panel. The Appeals Panel is comprised of specialists in the field, experienced in graduate medical education, who have been appointed by the ACGME.

If the program director requests consideration by an Appeals Panel, a hearing is convened to review the program's rebuttal to the RRC's action. The Panel sends a recommendation to the ACGME either to sustain or to rescind the action of the RRC. The ACGME, after reviewing all the information made available leading up to the hearing, makes the final decision on the program's status. There is no provision for any further appeal.

II. ACGME PROCEDURES FOR APPEAL OF ADVERSE ACTIONS (Effective Date: June 10, 1997)

A. If a Residency Review Committee (RRC) takes an adverse action, the program may request a hearing before an appeals panel. [*Note:* Here and elsewhere in these *Procedures for Appeal of Adverse Actions*, reference to "Residency Review Committee" also includes the ACGME's Transitional Year Review Committee.] [*Note:* Here and elsewhere in these *Procedures for Appeal of Adverse Actions*, the word "action" reflects delegation of accreditation authority to an RRC. In the event of a decision by an RRC not holding delegated authority, read "recommendation of an RRC and action by the ACGME" throughout the procedures.] If a written request for such a hearing is not received by the executive director of the ACGME within 30 days following receipt of the letter of notification, the action of an RRC will be deemed final and not subject to further appeal.

   Requests for a hearing must be sent express mail to: Executive Director, Accreditation Council for Graduate Medical Education, 515 North State Street, Suite 2000, Chicago, Illinois 60610.

   If a hearing is requested, the appeals panel will be appointed according to the following procedures:

   1. The ACGME shall maintain a list of qualified persons in each specialty as potential appeals panel members.

   2. For a given hearing, the program shall receive a copy of the list of potential appeals panel members and shall have an opportunity to delete a maximum of one-third of the names from the list of potential appeals panel members. Within 15 days of receipt of the list, the program shall submit its revised list to the executive director of the ACGME.

   3. A three-member appeals panel will be constituted by the ACGME from among the remaining names on the list.

B. When a program requests a hearing before an appeals panel, the program reverts to its status prior to the appealed adverse action until the ACGME makes a final determination on the status of the program. Nonetheless, at this time residents and any applicants who have been invited to interview with the program must be informed in writing as to the confirmed adverse action by an RRC on the accreditation status. A copy of the written notice must be sent to the executive director of the RRC within 50 days of receipt of the RRC's letter of notification.

C. Hearings conducted in conformity with these procedures will be held at a time and place to be determined by the ACGME. At least 25 days prior to the hearing, the program shall be notified of the time and place of the hearing.

D. The program will be given the documentation of the RRC action in confirming its adverse action.

E. The documents comprising the program file, the record of the RRC's action, together with oral and written presentations to the appeals panel, shall be the basis for the recommendations of the appeals panel.

F. The appeals panel shall meet and review the written record, and receive the presentations. The appropriate RRC shall be notified of the hearing and a representative of the RRC may attend the hearing to be available to the appeals panel to provide clarification of the record.

Proceedings before an appeals panel are not of an adversary nature as typical in a court of law, but rather, provide an administrative mechanism for peer review of an accreditation decision about an educational program. The appeals panel shall not be bound by technical rules of evidence usually employed in legal proceedings.

The program may not amend the statistical or narrative descriptions on which the decision of the RRC was based. The appeals procedures limit the appeals panel's jurisdiction to clarification of information as of the time when the adverse action was proposed by the RRC. Information about the program subsequent to that time cannot be considered in the appeal. Furthermore, the appeals panel shall not consider any changes in the program or descriptions of the program which were not in the record at the time when the RRC reviewed the program and confirmed the adverse decision. [*Note:* Option: When there have been substantial changes in a program and/or correction of citations after the date of the proposed action by the RRC, a program may forego an appeal and request a new evaluation and accreditation decision. Such an evaluation will be done in accordance with the ACGME procedures, including an on-site survey of the program. The adverse status will remain in effect until a reevaluation and an accreditation decision have been made by the RRC.] Presentations shall be limited to clarifications of the record, arguments to address compliance by the program with the published standards for accreditation, and the review of the program in the context of the administrative procedures governing accreditation of programs. Presentations may include written and oral elements. The appellant may make oral arguments to the appeals panel, but the oral argument will be limited to two hours in duration.

The appellant shall communicate with the appeals panel only at the hearing or in writing through the executive director of the ACGME.

The appeals panel shall make recommendations to the ACGME whether there is substantial, credible and relevant evidence to support the action taken by the RRC in the matter that is being appealed. The appeals panel, in addition, will make recommendations as to whether there has been substantial compliance with the administrative procedures governing the process of accreditation of graduate medical education programs.

G. The program may submit additional written material within 15 days after the hearing. The intention to submit such material must be made known to the appeals panel at the hearing.

H. The appeals panel shall submit its recommendations to the ACGME within 20 days after receipt of additional written material. The ACGME shall act on the appeal at its next regularly scheduled meeting.

I. The decision of the ACGME in this matter shall be final. There is no provision for further appeal.

J. The executive director of the ACGME shall, within 15 days following the final ACGME decision, notify the program under appeal of the decision of the ACGME.

K. Expenses of the appeals panel members and the associated administrative costs shall be shared equally by the appellant and the ACGME.

PROGRAM REVIEW

Included here is information about program review and the results of the review, including a sample copy of a notification letter addressed to the program director. There is also a list of accredited specialties and subspecialties. ***Direct any questions to the RRC staff. A staff listing is included at the back of the manual.***

ACGME ACCREDITED SPECIALTIES AND SUBSPECIALTIES

Allergy/Immunology
- A&I-Clin Lab Immunology

Anesthesiology
- Pediatric
- Critical Care
- Pain Management

Colon & Rectal Surgery

Dermatology
- Dermatopathology
- Dermatologic Immuno/DLI

Emergency Medicine
- Pediatrics
- Sports Medicine
- Toxicology

Family Practice
- Geriatric Med
- Sports Medicine

Internal Medicine
- Cardiovascular Disease
- Clin Cardiac
- Electrophysiology
- Critical Care Med
- Endocrinology, Diabetes & Metab
- Gastroenterology
- Geriatric Medicine
- Hematology
- Hematology/Oncology
- Infectious Diseases
- Interventional Cardiology
- Medical Oncology
- Nephrology
- Pulmonary/Critical Care
- Pulmonary Disease
- Rheumatology
- Sports Medicine

Medical Genetics

Neurological Surgery
- Endovascular Surgical
- Neuroradiology

Neurology
- Pain Management
- Child Neurology
- Clinical Neurophysiology
- Neurodevelopment Disabilites
- Vascular Neurology

Molecular Genetic Pathology

Nuclear Medicine

Obstetrics/Gynecology

Ophthalmology

Orthopaedic Surgery
- Adult Reconstruction
- Foot & Ankle
- Hand Surgery
- Pediatric
- Rehabilitation
- Spinal Surgery
- Sports Medicine
- Trauma
- Musculoskeletal Oncology

Otolaryngology
- Otology/Neurotology
- Pediatric

Pathology
- Path-Selective
- Blood Banking
- Chemical
- Cytopathology
- Forensic
- Hematology
- Immunopathology
- Medical Microbiology
- Neuropathology
- Pediatric
- Radioisotopic

Pediatrics
- Adolescent Medicine
- Cardiology
- Critical Care
- Developmental-Behavioral
- Emergency Medicine
- Endocrinology
- Gastroentrology
- Hemato-Oncology
- Infectious Diseases
- Nephrology
- Neonatal-Perinatal
- Pulmonology
- Rheumatology
- Sports Medicine

Physical Medicine & Rehab
- Pain Management

Spinal Cord Injury Medicine
Plastic Surgery
Craniofacial Surgery
Hand Surgery
Preventive Medicine
Toxicology
Undersea and Hyperbaric Medicine
Psychiatry
Addiction
Child
Forensic
Geriatric
Pain Management
Radiology - Diagnostic
Abdominal
Cardiothoracic
Endovascular Surgical Neuroradiology
Musculoskeltal
Neuroradiology
Nuclear
Pediatric
Vascular/Interventional
Radiation Oncology
Surgery - General
Critical Care
Hand Surgery
Pediatric
Vascular
Thoracic Surgery
Urology
Pediatric
Transitional Program

PROGRAM REVIEW

Uniform procedures have been established for reviewing residency programs, establishing and maintaining records on each program, and informing the program director of the action taken by the RRC. Special forms have been devised within the computerized Program Accreditation System (PAS) to facilitate accomplishment of the phases of the review process. The following essential steps are included in this process:

(1) The ACGME staff prepares program materials for review and forwards them to one or more members of the RRC. Most RRCs use two reviewers for each program.

(2) The reviewer studies the program materials and prepares a written recommendation for presentation to the RRC. For most RRCs, the reviewer sheet is duplicated for use by each member of the RRC during the meeting.

(3) At the RRC meeting, the reviewer presents the program and recommends a course of action.

(4) Following deliberation, the RRC will adopt a course of action which may or may not agree with that recommended by the reviewer.

(5) The ACGME staff, on the basis of the discussion and decision, prepares a written statement of the action taken by the RRC on each program. This document (Review Committee Chair's Confirmation of Actions) is reviewed and signed by the RRC Chairman.

(6) The ACGME staff prepares a notification letter advising the program director of the action taken by the RRC.

The following pages provide a description as well as an example of the basic documents used in the review process.

RESIDENCY REVIEW COMMITTEE CHAIR'S CONFIRMATION OF ACTIONS

Following the RRC meeting, the ACGME staff records a formal statement of committee action for each program reviewed. The completed document is signed by the Chairman of the RRC. The ACGME staff uses the document to write the letter of notification.

LETTER OF NOTIFICATION

The letter of notification informs the program director of the action taken by the RRC. It includes the accreditation status, the number of approved resident positions, if applicable, and any areas of noncompliance with the Institutional or Program Requirements identified by the RRC. The letter may also include a request for a progress report, information pertaining to revision of the program listing based on addition or deletion of participating institutions, the approximate time of the next site visit of the program, and should the RRC have decided that a specialist should conduct the site visit, a notation to that effect.

The letter of notification is signed by the Executive Director. A copy of the letter is sent to the Designated Institutional Official (DIO). If a progress report is requested, it must be signed by the Chair of the institution's Graduate Medical Education Committee (GMEC).

February 19, 1996

Samuel F. Pilgrim, M.D.
Thoracic Surgery Division
Jasper University Hospital
1440 W. 39th Street
Metropolis, IL 60606

Dear Doctor Pilgrim:

The Residency Review Committee for Thoracic Surgery, which is composed of representatives of the American Board of Thoracic Surgery, the American College of Surgeons and the AMA Council on Medical Education, has reviewed the information submitted concerning the following residency:

Thoracic Surgery

Jasper University Program
University Hospital
County Hospital
St. Mary's Hospital
Veterans Affairs Medical Center
Metropolis, IL

Program Number : 1234567890

Based on all of the information available to it at the time of its recent meeting, the Residency Review Committee judged that the following adverse accreditation action may be warranted:

Status: Proposed Probationary Accreditation
Length of Training: 2 years
Maximum Number of Residents: 4
Residents per level: 2

The proposal to take an adverse accreditation action is based on failure of the program to demonstrate substantial compliance with the Essentials of Accredited Residencies.

Before final action is taken, you have the opportunity to respond to the following citations by submitting written information to the office of the Executive Director of the Residency Review Committee. In order to be considered by the Residency Review Committee, your response or notice of your decision not to respond must be received, in triplicate, by May 1, 1996. If you choose not to respond, the

proposed decision will be confirmed by the Residency Review Committee. For guidelines on Samuel F. Pilgrim, M.D.
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responding to this proposed adverse action, please see the enclosed document entitled "Procedures for Proposed Adverse Actions". Also included with this correspondence is a copy of the Site Visitor's Report.

The Committee proposed to accredit the program on a probationary basis and cited the following areas of noncompliance with the Institutional Requirements and with the Program Requirements:

1. On the basis of the operative experience reports submitted, the Committee concluded that the program is not able to provide the satisfactory volume and distribution of clinical procedures as specified in the Program Requirements for appropriate training of the residents. The Program Requirements set forth a guideline which specifies that a resident's annual operative experience should average 125 major thoracic operations from those listed in the program information forms. Thus, a minimum of 500 surgical procedures should be available for resident training each year. The operative experience report for the total program for the period July 1, 1993 to June 30, 1994 indicates that only 406 procedures were performed by residents during that period although 826 such cases were performed throughout the four participating institutions. For the two-year period July 1, 1992 to June 30, 1994, Doctor Smith performed 195 major operations versus 250 recommended and Doctor Jones performed 218 major operations versus 250 recommended; and for the period July 1, 1993 to June 30, 1994, Doctor Wall performed 116 major operations versus 125 recommended and Doctor Dean performed 120 major operations versus 125 recommended. (Program Requirements, V.A.1; Operative Experience Report, Program Information Forms, pp. 5-13.)

2. Procedures have not been established by the program director to ensure that all residents are properly supervised during their operative and clinical training. It is the Committee's understanding that senior residents frequently perform surgery without direct faculty supervision at the Veterans Affairs Medical Center and at the County Hospital and that supervision of residents providing patient care in the offices of attendings is sporadic throughout the participating institutions. (Program Requirements V.B; Site Visitor Report, pp. 6, 10.)

3. The program does not provide a well-coordinated schedule of teaching conferences in which both the thoracic surgery faculty and the residents participate. It is the Committee's understanding that there is only one structured thoracic surgery conference (the cardiac mortality and morbidity conference) and that faculty members attend approximately fifty percent of the session. (Program Requirements V.E; Site Visitor Report, pp. 7, 10; Program Information Forms, p. 14.)

Samuel F. Pilgrim, M.D.
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4. The sponsoring institution has not implemented the established institutional procedures for conducting a periodic analysis of the thoracic surgery program by representatives of
the concerned departments, the residents, and the administration. According to the institutional schedule for conducting such reviews, the thoracic surgery program should have been reviewed in the fall of 1995, but the program has not been reviewed since 1990. (Institutional Requirements I.B.3.c; Site Visitor Report, p. 12.)

5. As noted when the program was last reviewed, the curriculum does not include an organized written plan for rotation of residents among the various services and institutions in the program so that continuity in the care of patients is properly achieved as an educational experience. Residents are often reassigned among the four participating institutions to meet service obligations or operative experience requirements. (Program Requirements V.C.1; Site Visitor Report, pp. 5-6; Program Information Forms, p. 14.)

6. The Committee acknowledged that renovation of the County Hospital was underway; however, at this time, there has been no improvement in the facilities used by the thoracic surgery division since the program was accredited in 1986. In each review of the program, the Committee has noted that insufficient and poorly maintained space for patient care and for resident education has impacted negatively upon the educational environment and the training experience of the residents. (Program Requirements III.B.2; Site Visitor Report, pp. 9-10.)

The Committee noted that as of the time of the site visit (July 15, 1995), the sponsoring institution had failed to identify someone who would accept a permanent assignment as program director. Dr. Pilgrim, a member of the University Hospital Faculty, has accepted the position on a temporary basis.

The next review of the program will occur in approximately one year.

When corresponding with this office, please identify the program by number and name as indicated above.

Sincerely yours,

Jack T. Boberg, Ph.D.
Executive Director, Residency Review Committee
for Thoracic Surgery
(312) 464-4647

cc: Designated Institutional Official

PREPARING FOR A SITE VISIT

Included here is information on how to prepare for a site visit by knowing what to expect and what is expected. Also included are some helpful suggestions, i.e. common program information form (pif) errors. ***Direct questions about the site visit to Ingrid Philibert at iphilibert@acgme.org or Jerry Vasillias at jvasillias@acgme.org. Questions about the program information forms may be directed to the RRC staff. A staff listing is located at the back of the manual.***

PREPARING FOR A SITE VISIT - ACCREDITED PROGRAMS

Accreditation/Record File

A notification letter from the RRC following evaluation of the program at a regular meeting will either state the time of the next review and/or will request a progress report. When a report is reviewed at a subsequent meeting, some RRCs will determine the time of the next review at that time. These letters should be kept on file so that information on the citations and on the time of the next review is available.

A permanent file that includes all information pertaining to accreditation of the residency and correspondence with the RRC office should be maintained. **This file should be separate from a personal file on the residency that might be kept by the program director. It must remain in the residency if/when a director leaves the program**. It should also contain the current requirements.

1. Keep tickler file for reports due time of next survey.

2. Start preparation for the survey at least 1 year in advance (Notice of the survey date is usually not mailed until 3 months in advance of the date of the visit).

3. Check with RRC office to learn if any revisions to the requirements or PIF are underway.

Purpose of Review

It helps to keep the purpose of the periodic review in mind.

RRC: to determine the program’s degree of compliance with the requirements as evidenced in the written file

Program: to demonstrate compliance with requirements; seek approval for major changes.

Preparation of the Program Information Form (PIF) for A Site Visit

Assemble these materials:

1. The Program Requirements in effect on the date of the site visit and revised requirements due to go into effect within the year, if applicable (available on ACGME Website: www.acgme.org) .

2. The current Program Information Form (available on ACGME Website: www.acgme.org) .

   The Help Desk number is 312-464-5393.

3. The completed Program Information Form (PIF) that was submitted for the last review .

4. The notification letter from the last full RRC review of the program and any subsequent notification letters.

The person coordinating the preparation of the PIF should be responsible for these materials and should know whether the same forms and requirements are in effect now as at the time of the last visit. The materials should be reproduced and distributed as needed but one copy should be kept in a central location that is accessible to those involved in the preparation.

Identify a PIF Preparation Team

For many reasons several of the teaching faculty should be involved in preparing the information. Assemble a team and:

1. Appoint a coordinator who will direct this project and be responsible for collating all parts of the form, putting them into the same format/style, checking for accuracy and completeness, etc.

2. Include a variety of faculty to whom parts of the PIF/curriculum will be assigned and identify back-up participants who can step in as needed.

3. Involve residents

4. Establish a realistic timetable for accomplishing steps along the way and for periodic team meetings and post or distribute this schedule.

5. Acquaint all who are involved in the residency with the project and enlist their cooperation.

Recommended Steps

Assuming that the program is in substantial compliance with the requirements, the major task confronting you and your team is describing the program in a way which demonstrates this compliance clearly to those who are reading the information. To do this, you must be well acquainted with the requirements and with the history of this program. Special effort should be given to showing that previous citations have been corrected or are being addressed.

Preparation of the PIF is the most important input provided by the program director. Since the RRC's action must be based on written documentation in the program file, it is essential that the program director provide an accurate and complete description of the educational program and resident experiences. That written description, i.e., the PIF, is the primary document in the review, both at the time of the site visit and during the RRC''s evaluation.

The information submitted should demonstrate specifically how the requirements are met in the program. Therefore, familiarity with the requirements by those completing the forms is crucial. Anything the director wants the RRC to know should be provided in the PIF. **Do not rely on the site visitor to be the conduit of information between you and the RRC.**

These steps are suggested:

1. Assign each residency component to a member of the team and provide the PIF and program requirements.

2. Review with the team how to identify, in each of those two documents, all statements/sections pertaining to each component and how to prepare a description that explicitly demonstrates compliance with the requirements.

3. Review each previous citation and refer the issue to the person responsible for that component. S/he should review the requirements and the previous PIF to try to pinpoint the problem, i.e., whether it was a true deficiency in the program or a problem with the description. Address the issue directly (demonstrate compliance) in the material submitted for this site visit.

4. At the periodic meetings of the preparation team, review the work that has been done. There may be someone who developed a good outline that can be used by others for their curricular components. By discussing what is being presented for each component the group can fill in aspects that are missing, indicate areas of ambiguity, etc. Keep the reader (site visitor and RRC) in mind.

5. The program director is responsible for reviewing the finished product for thoroughness, accuracy, adequacy and should be able to demonstrate familiarity with the document during the site visit. Be prepared to answer a question about where the information came from, how the figures were arrived at, what rotations were changed since last year, etc.

6. Proofread the final version and ask someone outside the program to read the PIF and comment on unclear descriptions, vague or contradictory statements, etc.

7. **SEND THE WORK COPY TO THE SITE VISITOR BY THE DATE REQUESTED (at least 10 days in advance of the site visit).** This should be a final and accurate copy. Discuss with him/her the details of the visit. Follow the instructions in the letter announcing the site visit regarding selection of residents for the interview and verify the arrangements with the site visitor. If there is an IM/PEDS training arrangement, include residents from that group.

Day of Site Visit

To facilitate the activities of the site visitor:

1. Make sure all are alerted to the fact that this is the day of the visit and know the schedule.

2. Be sure those who are scheduled for interviews with the site visitor have been reminded, know his/her name, and will be present on time. Have someone monitor how the day is flowing so that busy people can be notified if their interview will take place later than scheduled.

3. Arrange to have someone meet the site visitor at the door of the hospital. Pre-arrange parking if necessary.

4. Make an office or other suitable space available for use by the site visitor for interviews, jotting down notes, reviewing materials.

5. Have available for review by the site visitor all affiliation agreements, a sample resident contract, residency and institutional policies and procedures, the document of residency goals and objectives, sample evaluation forms, records of surgical and/or procedural documentation, any similar item mentioned in the requirements and anything else the site visitor may request in advance. Be prepared to pull sample patient records, a resident''s permanent file, etc.

6. Provide site visitor with the three additional copies of the PIF that were requested in the letter announcing the site visit, unless other instructions have been received. Make any necessary revisions during the site visit and give the final copies to the site visitor. Do not send revised pages of the PIF later. **Please note this does not apply to Internal Medicine programs.**

7. Have secretarial help available on stand-by in case they are needed. (See #6)

COMMON PIF ERRORS

1. Correct Program Name (Use name listed in GME Directory and Web Accreditation Data System)

2. Omission of Program Number

3. Missing Signatures

4. Missing Letters of Agreement

5. Information Omitted - Questions Unanswered

6. Inconsistent Data

7. Common Rotations Not Indicated on the Block Diagram for Programs with Multiple Tracks

8. Incorrect Pagination

9. Extraneous information that was not requested (i.e. handbooks, brochures, manuals, etc.)

WEB ACCREDITATION DATA SYSTEM (ADS)

Learn about our new internet based Web Accreditation Data System (ADS) and how to update program director information and program data electronically. Visit our website and see the current accreditation status of your program and when the next site visit will occur. A listing of documents currently available on the web site is included. ***Direct your questions about the Web Accreditation Data System to Rebecca Miller at rmiller@acgme.org.*** **Web site questions may be directed to the Web Master, Beverly Bowers at bbowers@acgme.org.**

WEB ACCREDITATION DATA SYSTEM (ADS)

Background

Accreditation of GME programs is accomplished through a peer review process and is based upon established standards and guidelines. Currently, ACGME accreditation activities depend to a great extent on a site visit and the Program Information Form (PIF). The site visit serves to clarify and verify information and measures the extent to which the PIF reflects reality. The ACGME operational support for data analysis and other support activities related to accreditation continue to move toward ongoing data collection and analysis rather than data collection just occurring at the time of the site visit. All programs will be profiled annually and concise reports will be provided to the Residency Review Committees (RRCs) for interpretation. This shift will offer many efficiencies for the program director, the sponsoring institution, and the Residency Review Committee (RRC).

The first phase of the transition from dependency on the PIF form and site visit to ongoing communication with all accredited residency programs and the sponsoring institutions involves moving a portion of the paper-based PIF to a user-friendly web-based system. The data elements critical for accreditation and common to all disciplines have been defined and these elements generally constitute the 'institutional and program demographic' section of the PIF.

Specifically, the Web Accreditation Data System (ADS) is an Internet based data collection system that contains the current data on file with ACGME for all sponsoring institutions and programs. Sponsors and accredited programs are required to verify and update general information annually in a secured environment. In addition, programs will be required to verify the accredited training of all residents and to communicate organizational changes as they occur (https://www.acgme.org/ADS).

Overtime, the PIFs for all specialties will be rewritten to exclude these common elements collected annually and prior to a site visit the program will print the web information and attach it to the specialty specific portion of the PIF. However, if you have a site visit scheduled during 2001, you will need to use the existing PIF for your specialty available on the ACGME website (www.acgme.org). Until the web accreditation system is fully functional and we have data for all accredited programs we will not change the current process. You will be notified when the method for submitting PIFs changes. Over the next several years, more specialty specific information from the PIF will be made available over the web.

Data Collaboration with Other Professional GME Organizations

There are an increasing number of entrepreneurial GME data collection systems available. Some of these are tailored for a single discipline and others are quite broad. Because licensing data from an existing system would require post-collection primary source verification and due to the fact that many existing systems exceed the data needed for accreditation and may offer the data commercially, the ACGME will continue to collect and own the data needed for

accreditation decisions.

List of All Accredited Programs

To view basic information on ACGME-accredited programs select the *Accredited Programs* link from the ACGME homepage (www.acgme.org). This information on all programs is available to everyone, including potential residents, other programs, and the general public. This section has been revised to reflect data maintained and updated from the Accreditation Data System (ADS).

Access to the Application

The Accreditation Council for Graduate Medical Education (ACGME) has provided each sponsoring institution with a User Identifier and Password to access the data system. The Designated Institutional Officials (DIOs) were contacted and asked to log on and verify their data prior to their programs making annual updates. In addition, the application was made available to most core specialty programs during 2000-2001 and will be made available to all specialties and subspecialties during 2001-2002.

Access to the system is available through most commonly used Internet Browsers and providers, such as Microsoft Internet Explorer 5.1 and Netscape 4.75. No specific software is required and no software will be sent or needs to be downloaded to operate the web accreditation data system.

Security

The accreditation data may be entered from any PC connected to the World Wide Web, and the site is secured by a 128 bit SSL encryption certificate obtained through the Verisign Corporation. The data you provide will be used by ACGME for accreditation, will be maintained confidentially, and will not be distributed for commercial use.

Help-Contact ACGME

As you use this application, do not hesitate to call your assigned ADS Representative or e-mail WebADS@acgme.org. Additionally, you may contact the ACGME support center (312-464-5393) and someone will direct you to the proper ADS staff. The Center is staffed from 8:00 am to 5:00 pm Central Time Monday through Friday. Voicemail is used when staff are busy on other calls.

CURRENT LINKS AND DOCUMENTS ON WEBSITE

www.acgme.org

- About the ACGME
  - Contact ACGME
  - Staff
  - Directors
  - Member Organizations
  - Annual Report
  - Federal Government Report
  - ACGME at a Glance
- Accredited Programs
  - Accredited Programs
  - Sponsoring Institutions
- Accreditation Data System
  - Login
  - General Competencies Assessment Addendum Demo
  - Reports
    - List of Programs by Specialty
    - List of Programs by Sponsor
    - Number of all programs for a specific academic year (including combined programs)
    - Number of all accredited programs for a specific academic eyar (excluding combined programs)
    - Number of new program directors
    - Glossary of Terms
    - Link to Accreditation Data System
- Bulletin
  - Archives
- GME Useful Information
  - GME Accreditation
  - Preface (Essentials)

- Institutional Requirements
- Glossary of GME Terms
- Policy Manual
- Complaint Procedures
- Number of Programs
- Program Closure

▼ HR Job Opportunities

▼ Institutional Review
- Members
- Institutional Requirements
- Download IRD
- Review & Comment
- Competencies

▼ News Room
- ACGME at at Glance
- Media Relations Contact
- News Releases

▼ Meetings
- RRC Meetings
- Physician-Patient Communication
- Workshops

▼ Competencies & Outcome Assessment

▼ Parker J. Palmer Award
- Award Program
- Nomination Form
- Award Recipients 2003
- Award Recipients 2002
- Awards Dinner

▼ Program Directors

▼ Program Information Forms (PIFs)
- Caar

▼ Program Requirements
- Common Program Requirements

▼ Residency Review Committees

▼ Resident Data Collection System
- Login
- User Manuals
- GSOL

- ◆CPT Codes
- ◆Software Policy

▼ Resident Duty Hours

▼ Resident Information

- ◆ Complaint Procedures
- ◆ Duty Hours-Standards
- ◆ Duty Hours-Citations
- ◆ Egregious Violations
- ◆ Gold Foundation Awards
- ◆ Moonlighting Policy
- ◆ Number of Programs
- ◆ Program Closure

▼ Review & Comment

- ◆ Institutional Requirements
- ◆ Program Requirements
- ◆ Archive

▼ Site Visit

- ◆ Field Staff
- ◆ ACGME Staff
- ◆ FAQ
- ◆ Evaluation

ACGME OUTCOME PROJECT: GENERAL COMPETENCIES

The Outcome Project is a long-term initiative through which the ACGME is increasing emphasis on educational outcomes in the accreditation of residency programs. Two major activities of the Project involve: 1) the development and use of general and specialty-specific competencies and related learning objectives; and, 2) the identification and development of useful and sound methods of assessing the achievement of these competency-based learning objectivies. Defining practical evaluation systems using such tools should lead to an expanded role for continuous improvement processes within residency programs and throughout graduate medical education. Both the ACGME and the American Board of Medical Specialties (ABMS) have endorsed six general competencies. As of July 1, 2001, the Residency Review Committees have included the competencies in their respective Program Requirements.

A wealth of information regarding the competencies can be found on the ACGME's web site, including a slide presentation/introduction, reference lists and assessment tools for the competencies, and a "Toolbox of Assessment Methods" that describes a number of various tools that can be used in the development of an evaluation system. The following section includes the complete ACGME version of these competencies and the Timeline for the ACGME Outcome Project. Direct any questions about the Outcome Project to Susan Swing, PhD, at srs@acgme.org or Patricia Surdyk, at psurdyk@acgme.org.

ACGME OUTCOME PROJECT: GENERAL COMPETENCIES

At its February 1999 meeting, the ACGME endorsed general competencies for residents in the areas of :

patient care,

medical knowledge,

practice-based learning and improvement, and

interpersonal and communication skills,

professionalism,

systems-based practice.

Identification of general competencies is the first step in a long-term effort designed to emphasize educational outcome assessment in residency programs and in the accreditation process. The following statements have formed the basis for language regarding the competencies as appears in the Program Requirements for each specialty.

ACGME GENERAL COMPETENCIES Vers. 1.3

(9.28.99)

The residency program must require its residents to develop the competencies in the 6 areas below to the level expected of a new practitioner. Toward this end, programs must define the specific knowledge, skills, and attitudes required and provide educational experiences as needed in order for their residents to demonstrate the competencies.

PATIENT CARE

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 are expected to:

- communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families gather essential and accurate information about their patients make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment
- develop and carry out patient management plans
- counsel and educate patients and their families
- use information technology to support patient care decisions and patient education
- perform competently all medical and invasive procedures considered essential for the area of practice
- provide health care services aimed at preventing health problems or maintaining health
- work with health care professionals, including those from other disciplines, to provide patient-focused care

-

MEDICAL KNOWLEDGE

Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Residents are expected to:

- demonstrate an investigatory and analytic thinking approach to clinical situations
- know and apply the basic and clinically supportive sciences which are appropriate to their discipline

PRACTICE-BASED LEARNING AND IMPROVEMENT

Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents are expected to:

- analyze practice experience and perform practice-based improvement activities using a systematic methodology

- locate, appraise, and assimilate evidence from scientific studies related to their patients'' health problems
- obtain and use information about their own population of patients and the larger population from which their patients are drawn
- apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
- use information technology to manage information, access on-line medical information; and support their own education
- facilitate the learning of students and other health care professionals

INTERPERSONAL AND COMMUNICATION SKILLS

Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates. Residents are expected to:

- create and sustain a therapeutic and ethically sound relationship with patients
- use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills
- work effectively with others as a member or leader of a health care team or other professional group

PROFESSIONALISM

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to:

- demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supercedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development
- demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
- demonstrate sensitivity and responsiveness to patients'' culture, age, gender, and disabilities

SYSTEMS-BASED PRACTICE

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. Residents are expected to:

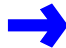
- understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice

- know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources
- practice cost-effective health care and resource allocation that does not compromise quality of care
- advocate for quality patient care and assist patients in dealing with system complexities
- know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance

Contact outcomes@acgme.org with any questions or concerns.

Outcomes project

TIME LINE



Forming an initial RESPONSE to changes in Requirements.

PHASE 1 - July 2001-June 2002

During this time, the ACGME expects that each RRC will define the competencies and adopt an evaluation approach to fit its specialty. Many of the competencies are already included in existing Program Requirements, although possibly not in the exact wording of the Minimum Language adopted by the ACGME. Programs will not be held responsible for NEW requirements related to the competencies until July 2002. However, programs should begin planning and/or piloting integration of the competencies and implementation of new and/or improved assessment tools during this time. Also, individual RRCs may choose to offer constructive citations related to the competencies and assessment during the period from July 1, 2001 to June 30, 2002.

ACGME OUTCOME PROJECT WORKING GUIDELINES

PHASE 1 - 7/01-6/02

Forming an initial RESPONSE to changes in Requirements

Programs

- Define specific objectives for residents to demonstrate learning in the competencies
- Review current approaches to evaluation of resident learning
- Begin integrating the teaching and learning of competencies into residents' didactic and clinical educational experiences as needed to ensure learning opportunities

RRCs

- Develop operational definitions of "substantial compliance" relevant to the competencies based on experience of field and judgments formed by available information
- Provide constructive citations and recommendations with no consequences

PHASE 2 - 7/02-6/06

Sharpening the FOCUS and definition of the competencies and assessment tools

Programs

- Provide evidence of learning in all six competencies
- Use progressively more dependable measurement tools
- Provide evidence of initial efforts to use evaluation data in assessing effectiveness in resident learning in all competencies

RRCs

- Review learning and assessment of all six competencies in programs under consideration
- Review assessment methods that emerge from field
- Provide citations with consequences based on expectations
- Revise Requirements to reflect new or changed expectations

PHASE 3 - 7/061-6/11

Full INTEGRATION of the competencies and their assessment with learning and clinical care

Programs

- Provide evidence of learning and assessment of all six competencies
- Use assessments to improve the program that include stakeholders beyond residents (i.e., employers, graduates, etc.)
- Begin to link clinical quality indicators and patient surveys with educational outcomes

RRCs

- Provide more specific guidance to programs
- Seek evidence that programs are using assessments for improvement
- Share experiences with other RRCs to identify best assessment tools for their respective disciplines

PHASE 4 - 7/11 AND BEYOND

EXPANSION of the competencies and their assessment to develop models of excellence.

- Identify benchmark programs
- Adapt and adopt generalizable information about emerging models of excellence
- Involve community in building knowledge about good GME

USEFUL INFORMATION

Included here you will find information on mergers, and instructions for submitting requests for changes in participating institutions, and resident complement. Direct any questions to the RRC staff. A staff listing is included at the back of the manual with email addresses and phone numbers.

MERGERS

When two programs propose to merge, it usually involves one of these scenarios:

Two separate residencies combine to form a third entity that is a new program.

In this case the new program, if approved, will be accredited on a provisional basis and each of the two previously accredited programs will submit a request for voluntary withdrawal of accreditation. They will stipulate whether the effective date should be immediate or when the current residents complete their training in these programs. A full PIF, describing the new program, will be required. Some RRCs may require a site visit. Check with the Executive Director of the RRC on policy.

ACGME requires that one sponsoring entity be identified for each program and that each program have one program director.

One program absorbs the other.

The program that will remain proposes to add rotations to the other institution and demonstrates how all residents will participate in common training. This is presented as a major change in that program and will mostly likely NOT result in a change in the program's accreditation status. That is, it may remain fully accredited. The RRC will decide whether the proposed change is so extensive that it constitutes virtually a new program. In that case, the status would be changed to provisional. Some RRCs may require a site visit. Check with the Executive Director of the RRC on policy.

The program that is closing and being absorbed will submit a request for voluntary withdrawal of accreditation with the proposed effective date.

Contact the RRC office to discuss what information will be required.

It is possible for the RRC to review a proposal for a merger without a previous site visit. This will depend on the extent of the changes being proposed, the current accreditation status of the programs involved, and when they were last reviewed by the RRC. Prior to submitting a proposal to merge, contact the RRC office to discuss it and to learn what information will be required and the deadline for submission of the proposal.

REQUESTS FOR CHANGES IN PARTICIPATING INSTITUTIONS

A. The addition to the program of a new institution with rotations of six months or more for a core specialty (i.e. General Surgery) and three months or more for a subspecialty (i.e. Surgical Critical Care) requires prior approval and should be submitted to the Residency Review Committee (RRC). Please note: Internal Medicine is different. They use what is called the "2-rule"; that is, the length of training (years) times two (2) defines the total number of months for a program's significant/major participating training sites and for which prior approval must be sought. For example, in a three-year program you need approval for rotations of six months; for a two-year program, it's 4 months, and for a one-year program, it's 2 months. In addition, the RRC for Internal Medicine requests notification of any rotation changes that impacts the training program. Some other specialities may also follow this rule. It is a good idea to check with the RRCs Executive Director to find out the policy.

The request must include:

1. **An affiliation or integration agreement between the sponsoring institution and the new participating institution.**

2. **An affiliation or integration agreement, with appropriate educational justification, between the program and the relevant department of the new participating institution if this is not adequately covered in the institutional agreement.**

3. **The CV of the program director in charge of the residents on rotation at the affiliated or integrated institution, as well as, for the integrated institution, the CV's of all the principal teaching staff.**

4. **A block diagram of resident rotations in the current program.**

5. **A block diagram of resident assignments as they would be organized if the participating institution is approved.**

6. **Documentation and commentary on the resources (teaching staff, funding, institutional support, volume and variety of the patient population, etc.) available in the participating institution. The institutional procedural data should reflect those services to which the residents will rotate.**

7. If any issues were raised at the time of the last review, describe how the program has addressed them.

B. Programs requesting substantial changes in participating institutions are advised to make the request in conjunction with a full site visit and review, if the site visit is scheduled approximately in one year.

C. The best way to present the requested information and documentation is to use the appropriate sections of the Program Information Forms. They are available from the ACGME website at www.acgme.org.

D. Any request for a change in participating institutions must be received in the Office of the Executive Director at least six weeks prior to an RRC meeting in order to be reviewed at that meeting. Any requests that are not received by that time will be deferred until the next meeting.

INCREASES IN RESIDENT COMPLEMENT

Each RRC has different policies about the degree of control the RRC exerts over resident complement, both permanent and temporary increases. Some RRC's evaluate the quality and sufficiency of resources, at the time of the site visit (i.e. Allergy & Immunology and Pediatrics) and if resources are sufficient, approve the resident complement. Other RRC's control resident complement in total and by level, requiring prior approval by the RRC before any change is permitted. Still others have modified policies based on these extremes. Check with RRC staff about their policies and before submitting any documentation. In requesting increases in resident complement, other than at the time of the site visit, some RRCs (i.e. General Surgery, Thoracic Surgery, Ophthalmology, Orthopedic Surgery, Diagnostic Radiology, etc.) may request the following information:

A. Written requests for permanent increases in the number of resident positions should be submitted to the Residency Review Committee (RRC). That request must include:

1. **A summary of the proposed increase, including the number and the level of training of positions requested as well as the schedule and manner in which the increase would be phased in.**

2. **Educational justification for the proposed increase.**

3. **Explanation of how the increase will improve the educational experience of all the residents.**

4. **A block diagram of resident rotations in the current program.**

5. **A block diagram of resident assignments as they would be organized if the increase were approved.**

6. **Comment on the resources (teaching staff, funding, institutional support, volume and variety of the patient population, etc.) available to support the increase.**

7. **If any issues were raised at the time of the last review, describe how the program has addressed them.**

B. The RRC will approve an increase in complement only when the increase would be educationally sound. Any change should improve the overall educational quality of the program.

C. Programs requesting substantial changes in resident complement are advised to make the request in conjunction with a full site visit and review, if the site visit is scheduled approximately in one year. RRCs vary and not all may require a site visit. It is recommended that you check with the RRC staff about this.

D. The best way to present the requested information and documentation is to use the appropriate sections of the Program Information Forms. They can be down loaded from our website at www.acgme.org

E. Any request for a permanent change must be received in the Office of the Executive Director at least six weeks prior to an RRC meeting in order to be reviewed at that meeting. Any requests that are not received by that time will be deferred until the next meeting.

Note: For temporary increases in resident complement contact the RRC staff.

ACGME POLICIES

Included are some of the most asked about ACGME policies. You may also find these on our website at www.acgme.org or in the Manual of Policies and Procedures for Graduate Medical Education Review Committees, also available on the website. To review or download the manual, look for "GME Useful Information" in the index and then click on "Policy Manual." Direct any policy questions to Jeanne Heard, M.D. at jheard@acgme.org. Questions about residency complaints may be directed to Marsha Miller at mmiller@acgme.org.

FOR INSERTION INTO THE COMMON PROGRAM REQUIREMENTS

FOR ALL CORE AND SUBSPECIALTY PROGRAMS BY JULY 1, 2003

D. Resident Duty Hours and the Working Environment

Providing residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energies. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

1. Supervision of Residents

a. All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of residents at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty.

b. Faculty schedules must be structured to provide residents with continuous supervision and consultation.

c. Faculty and residents must be educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects.

2. Duty Hours

a. Duty hours are defined as all clinical and academic activities related to the residency program, ie, patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled

academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

b. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

c. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.

d. Adequate time for rest and personal activities must be provided. This should consist of a 10 hour time period provided between all daily duty periods and after in-house call.

3. On-Call Activities

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal work day when residents are required to be immediately available in the assigned institution.

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

b. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care as defined in Specialty and Subspecialty Program Requirements.

c. No new patients, as defined in Specialty and Subspecialty Program Requirements, may be accepted after 24 hours of continuous duty.

d. At-home call (pager call) is defined as call taken from outside the assigned institution.

1.) The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.

2.) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

3.) The program director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

4. Moonlighting

a. Because residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

b. The program director must comply with the sponsoring institution's written policies and procedures regarding moonlighting, in compliance with the Institutional Requirements III. D.1.k.

c. Moonlighting that occurs within the residency program and/or the sponsoring institution or the non-hospital sponsor's primary clinical site(s), ie, internal moonlighting, must be counted toward the 80-hour weekly limit on duty hours.

5. Oversight

a. Each program must have written policies and procedures consistent with the Institutional and Program Requirements

for resident duty hours and the working environment. These policies must be distributed to the residents and the faculty. Monitoring of duty hours is required with frequency sufficient to ensure an appropriate balance between education and service.

b. Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.

6. Duty Hours Exception

An RRC may grant exceptions for up to 10 % of the 80-hour limit, to individual programs based on a sound educational rationale. However, prior permission of the institution's GMEC is required.

ACGME POLICY ON "MOONLIGHTING" BY GME RESIDENT

Characteristically the physician in the United States accepts the responsibility for his or her patients regardless of time or calendar. If the physician may be unavailable, arrangements are made for appropriate coverage. It is in this philosophical context that graduate medical education (GME) carries the same connotation of total engagement of the resident for the care of his or her patients and the attendant dedication to the learning of the skills, knowledge and professional behaviors of the educational program. Obviously, finite limits of the work schedule must be observed to provide for study, assimilation of knowledge and appropriate rest and recreation for good mental and physical health. Further, recognizing that the physician with a well-balanced life style may well provide more for his or her patients, these elements must be incorporated as well.

All of this suggests that while the physician resident may be totally dedicated to the care of his/her patients and to the learning opportunity, there are realistic limits that must be observed. Thus the Residency Review Committees have attempted in different ways to recognize prudent limits on work requirements so that the learning objectives are not compromised.

In recent years, an additional burden has been placed on some residents. The high cost of education in general and medical education in particular has forced many medical school graduates to borrow large sums of money to complete their undergraduate and MD degree programs. Increasingly, the available loan programs do not defer payments after medical school and those that do add even more burdensome interest. Resident stipends are often not sufficient to cover the cost of living and loan repayments. Thus, residents may seek opportunities to earn additional money during residency to assist in educational loan repayments.

The circumstance of working as a physician outside of one's authorized training program is called "moonlighting". Moonlighting has been discouraged in the past for several reasons. First, it clearly competes with the opportunity to achieve the full measure of the educational objectives of the residency. Not only does the added time burden take away from study; it reduces rest and the ability for a more balanced lifestyle. Nevertheless, many residents find the need for money to be

compelling, and wish to use their time away from their training program to meet financial obligations.

First and foremost, the moonlighting workload must not interfere with the ability of the resident to achieve the goals and objectives of their GME program. The program director should monitor resident performance to assure that factors such as resident fatigue are not contributing to diminished learning or performance, or detracting from patient safety. The program director may also choose to monitor the number of hours and the nature of the workload of residents engaging in moonlighting experiences.

Residents must not be required to engage in "moonlighting."

All residents engaged in moonlighting must be licensed for unsupervised medical practice in the state where the moonlighting occurs. It is the responsibility of the institution hiring the resident to moonlight to determine whether such licensure is in place, adequate liability coverage is provided, and whether the resident has the appropriate training and skills to carry out assigned duties.

The program director should acknowledge in writing that s/he is aware that the resident is moonlighting, and this information should be part of the residents folder.

ACGME Approved Procedure

June 27, 2000

ACGME PROCEDURES FOR DEALING WITH COMPLAINTS AGAINST RESIDENCY PROGRAMS

EFFECTIVE 2/9/99

A. General Considerations

ACGME Review Committees (Residency Review, Transitional Year Review, and Institutional) are responsible for monitoring compliance with the Institutional and Program Requirements (Essentials of Accredited Residencies).

The purpose of the procedures outlined here is to provide a formal mechanism for processing complaints specifically related to alleged non-compliance of sponsoring institutions, residency programs or Transitional Year Programs with the published Institutional and Program Requirements. The procedures may be used for complaints by anyone associated with a residency program, e.g., a resident or a staff member, or by anyone who has knowledge of the residency program. Those intending to submit a complaint alleging non-compliance with requirements should be acquainted with the requirements that pertain and should identify the specific requirement(s) with which there is alleged non-compliance. The requirements are available on the ACGME Web site (www.acgme.org) and through the ACGME automated Fax System (312-245-9174).

It should be clearly understood that the ACGME and its Review Committees will not adjudicate individual disputes between persons and residency programs. Residents who are involved in disputes with a program regarding promotion, non-renewal of contract or dismissal, sexual harassment, or discrimination should utilize their institution's formal grievance procedures and familiarize themselves with the ACGME Institutional Requirements. If the sponsoring institution lacks grievance procedures described in the Institutional Requirements, use of these ACGME complaint procedures may be appropriate.

Residents may also choose to contact any of the national resident physician organizations, including those of the American Medical Association, the Association of the American Medical Colleges, the Council of Medical Specialty Societies, the National Medical Association, the Bureau of Health Professions (Consortium of Resident Specialty Groups), or their specialty for advice. If appropriate, they may choose to seek legal counsel.

Persons having evidence of non-compliance with requirements should be aware of the options available to them for expressing concern, either as an individual or as a member of a group. These options are listed below in the recommended order in which they should be utilized depending on the complainant's relationship to the program:

1. contact the program director to try to resolve the issue;

2. inform the Graduate Medical Education Committee of the sponsoring organization or similar oversight body;

3. for residents, contact the resident organization of the institution, if one exists, or the appropriate institutional forum or individual appointed to address resident concerns, as outlined in the Institutional Requirements;

4. send a signed, written communication to the Executive Director of the appropriate Review Committee as listed on the ACGME Web site.

B. Procedures for Submitting a Complaint

All communications to the ACGME regarding alleged non-compliance with ACGME Institutional and/or Program Requirements must be signed by the complainant and be addressed to the Executive Director of the appropriate Review Committee at 515 N. State Street, Suite 2000, Chicago, Illinois 60610.

Anonymous complaints will not be considered by the ACGME. If the concern is serious enough to warrant investigation by the ACGME, the complainant must provide his/her name and mailing address with the expectation of confidentiality solely as described below in section C.

The failure of the program or institution to comply with ACGME Institutional and/or Program Requirements must be documented and specific details provided. This must include the following:

- reference to the Program and/or the Institutional Requirements allegedly being violated and documentation supporting the complaint; and

- a statement of the steps that were taken in an attempt to resolve the issues within the institution, as described above in section A.1-3, and the results of those efforts.

C. Confidentiality

At the discretion of the Executive Director, a complaint may be brought to the attention of a Review Committee, the program director and/or others outside the ACGME without revealing the name of the complainant. If the Executive Director deems confidentiality appropriate, in all such communication, the Executive Director will summarize the complaint without revealing the name of the complainant.

If the Executive Director decides that the issues or incidents involved require the disclosure of the name of the complainant to a Review Committee, a program director and/or others outside the ACGME, s/he will be so informed and written authorization to use his/her name will be requested. A complainant's name will not be disclosed to any party without written consent.

D. Processing of Complaints

The Executive Director will notify the complainant of whether the complaint falls within the scope of these procedures, as described above in section A and, if so, how it will be processed. If the criticisms are vague as to the situation that constitutes alleged non-compliance, the Executive Director will ask the complainant to provide more specific information. If the complaint does not fall within the scope of these procedures, the complainant will be so informed and no further action will be taken.

If the complaint is considered potentially valid, the issues of non-compliance outlined in it may be dealt with as part of the next scheduled review of the program/institution or be brought to the attention of a Review Committee at one of its regular meetings. This determination will be made by the Executive Director in consultation with the Chair of the Review Committee, as appropriate.

If it is determined that the complaint should be brought to the attention of the Review Committee prior to the next scheduled survey of the program, the Executive Director will inform the program director and/or the designated institutional official for graduate medical education of the complaint and request a written response. This response must be co-signed by the CEO of the sponsoring institution and by the designated institutional official.

E. Action on Complaints

After receiving the written response of the program director and/or the designated institutional official, the Executive Director will forward the case to the Review Committee.

The following options may be exercised by a Review Committee:

1. **The Review Committee may conclude that no action on the complaint is warranted. The complainant, program director and/or the designated institutional official will be so advised.**

2. **The Review Committee may decide to investigate the issues raised in the complaint through a site visit that will be scheduled immediately or during the next regularly scheduled site visit and review. The complainant, program director and/or the designated institutional official will be informed of the decision.**

   When the program is reviewed following the site visit, the Review Committee will indicate its

findings on the complaint to the program director and/or the designated institutional official in the regular notification letter.

3. **A Residency Review Committee or the Transitional Year Review Committee that has handled a complaint against a particular program may notify the ACGME Institutional Review Committee for further investigation at the institutional level. The complaint will be processed as per section D and acted upon as per section E of these procedures.**

ACGME PROCEDURE FOR RAPID RESPONSE TO ALLEGED EGREGIOUS ACCREDITATION VIOLATIONS OR CATASTROPHIC INSTITUTIONAL EVENTS

The occurrence of an alleged egregious accreditation violation or a catastrophic institutional event which, because of its urgency, must be addressed outside of the established processes of the ACGME should be reported promptly to the Executive Director of the ACGME. Any component of the ACGME accreditation process having knowledge of such an occurrence, including residents in training or member organizations, has a responsibility to report the matter promptly and directly to the ACGME Executive Director who will initiate an investigation to determine credibility and degree of urgency of the matter. Whenever the ACGME Executive Director determines that the matter disclosed is of sufficient importance and urgency to require expedited action, the following process will be initiated:

1. **The ACGME Executive Director will consult with an ad-hoc advisory committee composed of the ACGME Executive Director, the Chair of the Institutional Review Committee, and the Chair of the Residency Review Committee Council provided said individuals do not exhibit or declare a conflict of interest. This committee may request a formal and prompt response from the appropriate responsible individual(s) or decide that an immediate on-site survey should occur.**

2. **If the committee decides that an immediate on-site survey should occur, a focused survey will be conducted by one or more members of the ACGME field staff or other knowledgeable individuals appointed by the ad-hoc advisory committee. The ACGME Executive Director will inform the appropriate responsible individual(s) at the institution of the focused site visit and the stated reasons(s).**

3. **The site visitor(s) will conduct a focused survey of the residency program or institution considering all matters related to the alleged egregious or catastrophic accreditation violation. At the conclusion of the survey, the site visitor(s) will submit a written report to the ACGME Executive Director. The ACGME Executive Director will forward the report to the Institutional Committee or the relevant Residency Review Committee for consideration at the next regular meeting and may share the report with the responsible individual(s) at the institution.**

ACGME APPROVED PROCEDURE

9/25/00

A GLOSSARY OF SELECTED TERMS USED IN GME ACCREDITATION

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A GLOSSARY OF SELECTED TERMS USED IN GME ACCREDITATION

Affiliated Institution: **Institutions may be affiliated with the parent institution through an Affiliation Agreement and conjoint responsibilities to provide complementary facilities, teaching staff and teaching sessions. Affiliated institutions must promote the educational goals of the program rather than simply enlarge the program and must not be added primarily for the purpose of meeting service needs.**

Applicant**: Persons invited to come for an interview for a GME program.**

Consortium**: Two or more organizations or institutions that have come together to pursue common objectives (e.g., GME). A consortium may serve as a "sponsoring institution" for GME programs if it is formally established as an ongoing institutional entity with a documented commitment to GME.**

Desirable**: A term, along with it companion "highly desirable," used to designate aspects of an educational program that are not mandatory but are considered to be very important. A program may be cited for failing to do something that is desirable or highly desirable.**

Essential**: (See "Must".)**

Fellow**: A physician in a program of graduate medical education accredited by the ACGME that is beyond the requirements for eligibility for first board certification in the discipline. Such physicians may also be termed as "resident" as well. Other uses of the term "fellow" require modifiers for precision and clarity, e.g., "research fellow."**

Institution**: An organization having the primary purpose of providing educational and/or health care services (e.g., a university, a medical school, a hospital, a school of public health, a health department, a public health agency, an organized health care delivery system, a medical examiner's office, a consortium, an educational foundation).**

A. ***Major participating Institution*****: An institution to which residents rotate for a required experience and/or those that require explicit approval by the appropriate RRC prior to utilization. Major participating institutions are listed as part of an accredited program in the *Graduate Medical Education Directory*.**

B. ***Participating Institution*****: An institution that provides specific learning experiences within a multi-institutional program of GME. Subsections of institutions, such as a department, clinic, or unit of a hospital, do not qualify as participating institutions.**

C. ***Sponsoring Institution*****: The institution that assumes the ultimate responsibility for a GME**

program.

***Institutional Review*: The process undertaken by the ACGME to judge whether a sponsoring institution offering GME programs is in substantial compliance with the Institutional Requirements.**

***Integrated Institution:* Institutions may be integrated with the parent institution through an Integration Agreement that must specify that the program director of the parent institution (1) appoint the members of the teaching staff at the integrated institution, (2) appoint the chief or director f the teaching service in the integrated institution, (3) appoint all residents in the program, and (4) determine all rotations and assignments of both residents and members of the teaching staff.**

***Intern*: Historically, "intern" was used to designate individuals in the first year of GME; less commonly it designated individuals in the first year of any residency program. Since 1975 the *Graduate Medical Education Directory* and the ACGME have not used the term, instead referring to individuals in their first year of GME as residents.**

***Internal Review*: The formal process undertaken by a sponsoring institution of its individual ACGME-accredited programs in conformity with Section I.B.3.c. of the Institutional Requirements to evaluate the sponsored programs.**

***Moonlighting*: A term used to describe the activity of a resident working as a physician outside his/her authorized training program. The term does not connote with or without compensation. For further detail see " IX. ACGME Policy on 'Moonlighting' by GME Resident", Manual of Policies and Procedures for Graduate Medical Edducation Review Committees., September 26,2000. P 84.**

***Must (Shall, Essential)*: Terms used to indicate that something is required, mandatory, or done without fail. These terms indicate absolute requirements.**

***Program*: The unit of specialty education, comprising a series of graduated learning experiences in GME, designed to conform to the Program Requirements of a particular specialty.**

***Program listing:* The notification letter lists the title of the program, followed by the names of the sponsoring institution and clinical sites of major rotations requiring Residency Review Committee (RRC) approval. Institutions used for short rotations are not included in the program listing. The program listing is also found in the AMA's Graduate Medical Education Directory and on the ACGME's web site under Accredited Programs.**

Program identification number: **The notification letter specifies a 10-digit identification number used by the ACGME to track the program. Refer to this number when writing or calling about the program.**

Resident**: A physician in a program of graduate medical education accredited by the ACGME. Other uses of the term "resident" require modifiers.**

Scholarly Activity**: Educational experiences that include active participation of the teaching staff in clinical discussions, rounds, and conferences in a manner that promotes a spirit of inquiry and scholarship; active participation in journal clubs, research conferences, regional or national professional and scientific societies, particularly through presentations at the organizations' meetings and publications in their journals; participation in research, particularly in projects that are funded following peer review and/or result in publications or presentations at regional and national scientific meetings; offering of guidance and technical support, e.g., research design, statistical analysis, for residents involved in research; and provision of support for resident participation as appropriate in scholarly activities. May be defined in more detail in specific Program Requirements.**

Shall: (See "must.")

Should**: A term used to designate requirements that are so important that their absence must be justified. The accreditation status of a program or institution is at risk if it is not in compliance with a "should."**

Substantial Compliance**: The determination of substantial compliance results from a judgment based on all available information as to the degree that the entity being evaluated meets accreditation standards.**

Suggested**: A term, along with it companion "strongly suggested," used to indicate that something is distinctly urged rather than required. An institution or a program will not be cited for failing to do something that is suggested or strongly suggested.**

ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION
STAFF ASSIGNMENTS AND TELEPHONE NUMBERS

Please visit our web site at www.acgme.org for a current listing of ACGME/RRC staff by department with email addresses and phone numbers.