Anesthesiology Crosswalk

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirement Language
Int.A.	***Definition of Graduate Medical Education*** ***Graduate medical education is the crucial step of professional development between medical school and autonomous clinical practice. It is in this vital phase of the continuum of medical education that residents learn to provide optimal patient care under the supervision of faculty members who not only instruct, but serve as role models of excellence, compassion, cultural sensitivity, professionalism, and scholarship.*** ***Graduate medical education transforms medical students into physician scholars who care for the patient, patient's family, and a diverse community; create and integrate new knowledge into practice; and educate future generations of physicians to serve the public. Practice patterns established during graduate medical education persist many years later.***	[None]	**Definition of Graduate Medical Education** ***Graduate medical education is the crucial step of professional development between medical school and autonomous clinical practice. It is in this vital phase of the continuum of medical education that residents learn to provide optimal patient care under the supervision of faculty members who not only instruct, but serve as role models of excellence, compassion, cultural sensitivity, professionalism, and scholarship.*** ***Graduate medical education transforms medical students into physician scholars who care for the patient, patient's family, and a diverse community; create and integrate new knowledge into practice; and educate future generations of physicians to serve the public. Practice patterns established during graduate medical education persist many years later.***
Int.A. (Continued)	***Graduate medical education has as a core tenet the graded authority and responsibility for patient care. The care of patients is undertaken with appropriate faculty supervision and conditional independence, allowing residents to attain the knowledge, skills, attitudes, judgment, and empathy required for autonomous practice. Graduate medical education develops physicians who focus on excellence in delivery of safe, equitable, affordable, quality care; and the health of the populations they serve. Graduate medical education values the strength that a diverse group of physicians brings to medical care, and the importance of inclusive and psychologically safe learning environments.*** ***Graduate medical education occurs in clinical settings that establish the foundation for practice-based and lifelong learning. The professional development of the physician, begun in medical school, continues through faculty modeling of the effacement of self-interest in a humanistic environment that emphasizes joy in curiosity, problem-solving, academic rigor, and discovery. This transformation is often physically, emotionally, and intellectually demanding and occurs in a variety of clinical learning environments committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.***	[None] - (Continued)	***Graduate medical education has as a core tenet the graded authority and responsibility for patient care. The care of patients is undertaken with appropriate faculty supervision and conditional independence, allowing residents to attain the knowledge, skills, attitudes, judgment, and empathy required for autonomous practice. Graduate medical education develops physicians who focus on excellence in delivery of safe, equitable, affordable, quality care; and the health of the populations they serve. Graduate medical education values the strength that a diverse group of physicians brings to medical care, and the importance of inclusive and psychologically safe learning environments.*** ***Graduate medical education occurs in clinical settings that establish the foundation for practice-based and lifelong learning. The professional development of the physician, begun in medical school, continues through faculty modeling of the effacement of self-interest in a humanistic environment that emphasizes joy in curiosity, problem-solving, academic rigor, and discovery. This transformation is often physically, emotionally, and intellectually demanding and occurs in a variety of clinical learning environments committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.***

Anesthesiology Crosswalk

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirement Language
Int.B.	**Definition of Specialty** Anesthesiology is the practice of medicine dealing with the peri-operative management of patients. This includes the peri-operative/peri-procedural management of patients during surgical and other therapeutic and diagnostic procedures. This management encompasses the pre-operative preparation of the patient and their peri-operative maintenance of normal physiology, as well as the post-operative relief and prevention of pain. An anesthesiologist is skilled in the management and diagnosis of critically-ill patients, including those experiencing cardiac arrest, and in the diagnosis and management of acute, chronic, and cancer-related pain. These goals are achieved through a thorough understanding of physiology and pharmacology, and the ability to conduct, interpret, and apply the results of medical research. Finally, the anesthesiologist is skilled in the leadership of health services delivery, prudent fiscal resource stewardship, and quality improvement, as well as the supervision, education, and evaluation of the performance of personnel, both medical and paramedical, involved in peri-operative and peri-procedural care.	**[None]**	**Definition of Specialty** *Anesthesiology is the practice of medicine dealing with the peri-operative management of patients. This includes the peri-operative/peri-procedural management of patients during surgical and other therapeutic and diagnostic procedures. This management encompasses the pre-operative preparation of the patient and their peri-operative maintenance of normal physiology, as well as the post-operative relief and prevention of pain. An anesthesiologist is skilled in the management and diagnosis of critically-ill patients, including those experiencing cardiac arrest, and in the diagnosis and management of acute, chronic, and cancer-related pain. These goals are achieved through a thorough understanding of physiology and pharmacology, and the ability to conduct, interpret, and apply the results of medical research. Finally, the anesthesiologist is skilled in the leadership of health services delivery, prudent fiscal resource stewardship, and quality improvement, as well as the supervision, education, and evaluation of the performance of personnel, both medical and paramedical, involved in peri-operative and peri-procedural care.*
Int.C.	**Length of Program** The educational programs in anesthesiology are configured in 36-month and 48-month formats. The latter includes 12 months of education in fundamental clinical skills of medicine, and both include 36 months of education in clinical anesthesia (CA-1, CA-2, and CA-3 years). (Core)	**4.1.**	**Length of Program** The educational programs in anesthesiology are configured in 36-month and 48-month formats. The latter includes 12 months of education in fundamental clinical skills of medicine, and both include 36 months of education in clinical anesthesia (CA-1, CA-2, and CA-3 years). (Core)
I.	**Oversight**	**Section 1**	**Section 1: Oversight**
I.A.	**Sponsoring Institution** ***The Sponsoring Institution is the organization or entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education, consistent with the ACGME Institutional Requirements.*** ***When the Sponsoring Institution is not a rotation site for the program, the most commonly utilized site of clinical activity for the program is the primary clinical site.***	**[None]**	**Sponsoring Institution** ***The Sponsoring Institution is the organization or entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education, consistent with the ACGME Institutional Requirements.*** ***When the Sponsoring Institution is not a rotation site for the program, the most commonly utilized site of clinical activity for the program is the primary clinical site.***
I.A.1.	**The program must be sponsored by one ACGME-accredited Sponsoring Institution.**	**1.1.**	**The program must be sponsored by one ACGME-accredited Sponsoring Institution.**
I.B.	**Participating Sites** ***A participating site is an organization providing educational experiences or educational assignments/rotations for residents.***	**[None]**	**Participating Sites** ***A participating site is an organization providing educational experiences or educational assignments/rotations for residents.***
I.B.1.	**The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)**	**1.2.**	**The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)**
I.B.1.a)	The Sponsoring Institution must also sponsor or be affiliated with ACGME-accredited residencies in at least the specialties of general surgery and internal medicine. (Core)	1.2.a.	The Sponsoring Institution must also sponsor or be affiliated with ACGME-accredited residencies in at least the specialties of general surgery and internal medicine. (Core)

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I.B.2.	**There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)**	**1.3.**	**There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)**
I.B.2.a)	**The PLA must:**	**[None]**	
I.B.2.a).(1)	**be renewed at least every 10 years; and, (Core)**	**1.3.a.**	**The PLA must be renewed at least every 10 years. (Core)**
I.B.2.a).(2)	**be approved by the designated institutional official (DIO). (Core)**	**1.3.b.**	**The PLA must be approved by the designated institutional official (DIO). (Core)**
I.B.3.	**The program must monitor the clinical learning and working environment at all participating sites. (Core)**	**1.4.**	**The program must monitor the clinical learning and working environment at all participating sites. (Core)**
I.B.3.a).	**At each participating site there must be one faculty member, designated by the program director as the site director, who is accountable for resident education at that site, in collaboration with the program director. (Core)**	**1.5.**	**At each participating site there must be one faculty member, designated by the program director as the site director, who is accountable for resident education at that site, in collaboration with the program director. (Core)**
I.B.4.	**The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the ACGME's Accreditation Data System (ADS). (Core)**	**1.6.**	**The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the ACGME's Accreditation Data System (ADS). (Core)**
I.B.5.	The majority of rotations for the anesthesiology program must occur at the primary clinical site. (Core)	1.6.a.	The majority of rotations for the anesthesiology program must occur at the primary clinical site. (Core)
I.B.5.a)	Participating sites must provide rotations that the Sponsoring Institution is unable to provide. (Core)	1.6.a.1.	Participating sites must provide rotations that the Sponsoring Institution is unable to provide. (Core)
I.B.5.a).(1)	Residents should not be required to rotate among multiple participating sites. (Detail)	1.6.a.1.a.	Residents should not be required to rotate among multiple participating sites. (Detail)
I.B.5.a).(2)	Assignments to a participating site should not exceed six months. (Detail)	1.6.a.1.b.	Assignments to a participating site should not exceed six months. (Detail)
I.C.	**Workforce Recruitment and Retention** **The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative GME staff members, and other relevant members of its academic community. (Core)**	**1.7.**	**Workforce Recruitment and Retention** **The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative GME staff members, and other relevant members of its academic community. (Core)**
I.D.	**Resources**	**1.8.**	**Resources** **The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education. (Core)**
I.D.1.	**The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education. (Core)**	**1.8.**	**Resources** **The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education. (Core)**
I.D.1.a)	There must be adequate space and equipment for the educational program, including meeting rooms, classrooms with visual and other educational aids, study areas for residents, office space for faculty members and residents, diagnostic and therapeutic facilities, laboratory facilities, computer support, and appropriate on-call facilities for male and female residents and faculty members. (Core)	1.8.a.	There must be adequate space and equipment for the educational program, including meeting rooms, classrooms with visual and other educational aids, study areas for residents, office space for faculty members and residents, diagnostic and therapeutic facilities, laboratory facilities, computer support, and appropriate on-call facilities for male and female residents and faculty members. (Core)

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I.D.2.	The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for:	1.9.	The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for:
I.D.2.a)	access to food while on duty; (Core)	1.9.a.	access to food while on duty; (Core)
I.D.2.b)	safe, quiet, clean, and private sleep/rest facilities available and accessible for residents with proximity appropriate for safe patient care; (Core)	1.9.b.	safe, quiet, clean, and private sleep/rest facilities available and accessible for residents with proximity appropriate for safe patient care; (Core)
I.D.2.c)	clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)	1.9.c.	clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)
I.D.2.d)	security and safety measures appropriate to the participating site; and, (Core)	1.9.d.	security and safety measures appropriate to the participating site; and, (Core)
I.D.2.e)	accommodations for residents with disabilities consistent with the Sponsoring Institution's policy. (Core)	1.9.e.	accommodations for residents with disabilities consistent with the Sponsoring Institution's policy. (Core)
I.D.3.	Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core)	1.10.	Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core)
I.E.	Other Learners and Health Care Personnel The presence of other learners and other health care personnel, including, but not limited to residents from other programs, subspecialty fellows, and advanced practice providers, must not negatively impact the appointed residents' education. (Core)	1.11.	Other Learners and Health Care Personnel The presence of other learners and other health care personnel, including, but not limited to residents from other programs, subspecialty fellows, and advanced practice providers, must not negatively impact the appointed residents' education. (Core)
II.	Personnel	Section 2	Section 2: Personnel
II.A.	Program Director	2.1.	Program Director There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core)
II.A.1.	There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core)	2.1.	Program Director There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core)
II.A.1.a)	The Sponsoring Institution's GMEC must approve a change in program director and must verify the program director's licensure and clinical appointment. (Core)	2.2.	The Sponsoring Institution's GMEC must approve a change in program director and must verify the program director's licensure and clinical appointment. (Core)
II.A.1.a).(1)	Final approval of the program director resides with the Review Committee. (Core)	2.2.a.	Final approval of the program director resides with the Review Committee. (Core)
II.A.1.b)	The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability. (Core)	2.3.	The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability. (Core)
II.A.2.	The program director and, as applicable, the program's leadership team, must be provided with support adequate for administration of the program based upon its size and configuration. (Core)	2.4.	The program director and, as applicable, the program's leadership team, must be provided with support adequate for administration of the program based upon its size and configuration. (Core)

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II.A.2.a)	At a minimum, the program director must be provided with the dedicated time and support specified below for administration of the program. Additional support for program leadership must be provided as specified below. This additional support may be for the program director only or divided among the program director and one or more associate (or assistant) program directors. (Core) Number of Approved Resident Positions:1-20 | Minimum Support Required (FTE) for the Program Director: 0.2 | Minimum Additional Support Required (FTE) for Program Leadership: 0.2 | Total Minimum Program Leadership Support: 0.4 Number of Approved Resident Positions:21-30 | Minimum Support Required (FTE) for the Program Director: 0.4 | Minimum Additional Support Required (FTE) for Program Leadership: 0.2 | Total Minimum Program Leadership Support: 0.6 Number of Approved Resident Positions:31-40 | Minimum Support Required (FTE) for the Program Director: 0.4 | Minimum Additional Support Required (FTE) for Program Leadership: 0.3 | Total Minimum Program Leadership Support: 0.7 Number of Approved Resident Positions:41-50 | Minimum Support Required (FTE) for the Program Director: 0.4 | Minimum Additional Support Required (FTE) for Program Leadership: 0.4 | Total Minimum Program Leadership Support: 0.8	2.4.a.	At a minimum, the program director must be provided with the dedicated time and support specified below for administration of the program. Additional support for program leadership must be provided as specified below. This additional support may be for the program director only or divided among the program director and one or more associate (or assistant) program directors. (Core) Number of Approved Resident Positions:1-20 | Minimum Support Required (FTE) for the Program Director: 0.2 | Minimum Additional Support Required (FTE) for Program Leadership: 0.2 | Total Minimum Program Leadership Support: 0.4 Number of Approved Resident Positions:21-30 | Minimum Support Required (FTE) for the Program Director: 0.4 | Minimum Additional Support Required (FTE) for Program Leadership: 0.2 | Total Minimum Program Leadership Support: 0.6 Number of Approved Resident Positions:31-40 | Minimum Support Required (FTE) for the Program Director: 0.4 | Minimum Additional Support Required (FTE) for Program Leadership: 0.3 | Total Minimum Program Leadership Support: 0.7 Number of Approved Resident Positions:41-50 | Minimum Support Required (FTE) for the Program Director: 0.4 | Minimum Additional Support Required (FTE) for Program Leadership: 0.4 | Total Minimum Program Leadership Support: 0.8

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirement Language
II.A.2.a) - (Continued)	Number of Approved Resident Positions:51-60 | Minimum Support Required (FTE) for the Program Director: 0.4 | Minimum Additional Support Required (FTE) for Program Leadership: 0.5 | Total Minimum Program Leadership Support: 0.9 Number of Approved Resident Positions:61-70 | Minimum Support Required (FTE) for the Program Director: 0.4 | Minimum Additional Support Required (FTE) for Program Leadership: 0.6 | Total Minimum Program Leadership Support: 1.0 Number of Approved Resident Positions:71-80 | Minimum Support Required (FTE) for the Program Director: 0.4 | Minimum Additional Support Required (FTE) for Program Leadership: 0.7 | Total Minimum Program Leadership Support: 1.1 Number of Approved Resident Positions:Over 80 | Minimum Support Required (FTE) for the Program Director: 0.4 | Minimum Additional Support Required (FTE) for Program Leadership: 0.8 | Total Minimum Program Leadership Support: 1.2	2.4.a. - (Continued)	Number of Approved Resident Positions:51-60 | Minimum Support Required (FTE) for the Program Director: 0.4 | Minimum Additional Support Required (FTE) for Program Leadership: 0.5 | Total Minimum Program Leadership Support: 0.9 Number of Approved Resident Positions:61-70 | Minimum Support Required (FTE) for the Program Director: 0.4 | Minimum Additional Support Required (FTE) for Program Leadership: 0.6 | Total Minimum Program Leadership Support: 1.0 Number of Approved Resident Positions:71-80 | Minimum Support Required (FTE) for the Program Director: 0.4 | Minimum Additional Support Required (FTE) for Program Leadership: 0.7 | Total Minimum Program Leadership Support: 1.1 Number of Approved Resident Positions:Over 80 | Minimum Support Required (FTE) for the Program Director: 0.4 | Minimum Additional Support Required (FTE) for Program Leadership: 0.8 | Total Minimum Program Leadership Support: 1.2
II.A.3.	**Qualifications of the program director:**	**2.5.**	**Qualifications of the Program Director** **The program director must possess specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee. (Core)**
II.A.3.a)	**must include specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee; (Core)**	**2.5.**	**Qualifications of the Program Director** **The program director must possess specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee. (Core)**
II.A.3.b)	**must include current certification in the specialty for which they are the program director by the American Board of** Anesthesiology **or by the American Osteopathic Board of** Anesthesiology **or specialty qualifications that are acceptable to the Review Committee; and, (Core)**	**2.5.a.**	**The program director must possess current certification in the specialty for which they are the program director by the American Board of** Anesthesiology **or by the American Osteopathic Board of** Anesthesiology **or specialty qualifications that are acceptable to the Review Committee. (Core)**
II.A.3.c)	**must include ongoing clinical activity. (Core)**	**2.5.b.**	**The program director must demonstrate ongoing clinical activity. (Core)**
II.A.3.d)	must demonstrate ongoing academic achievements in anesthesiology, including publications, the development of educational programs, or the conduct of research. (Core)	2.5.c.	The program director must demonstrate ongoing academic achievements in anesthesiology, including publications, the development of educational programs, or the conduct of research. (Core)

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II.A.4.	Program Director Responsibilities The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care. (Core)	2.6.	Program Director Responsibilities The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care. (Core)
II.A.4.a)	The program director must:	[None]	
II.A.4.a).(1)	be a role model of professionalism; (Core)	2.6.a.	The program director must be a role model of professionalism. (Core)
II.A.4.a).(2)	design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program; (Core)	2.6.b.	The program director must design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program. (Core)
II.A.4.a).(3)	administer and maintain a learning environment conducive to educating the residents in each of the ACGME Competency domains; (Core)	2.6.c.	The program director must administer and maintain a learning environment conducive to educating the residents in each of the ACGME Competency domains. (Core)
II.A.4.a).(4)	have the authority to approve or remove physicians and non-physicians as faculty members at all participating sites, including the designation of core faculty members, and must develop and oversee a process to evaluate candidates prior to approval; (Core)	2.6.d.	The program director must have the authority to approve or remove physicians and non-physicians as faculty members at all participating sites, including the designation of core faculty members, and must develop and oversee a process to evaluate candidates prior to approval. (Core)
II.A.4.a).(5)	have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program; (Core)	2.6.e.	The program director must have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program. (Core)
II.A.4.a).(6)	submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; (Core)	2.6.f.	The program director must submit accurate and complete information required and requested by the DIO, GMEC, and ACGME. (Core)
II.A.4.a).(7)	provide a learning and working environment in which residents have the opportunity to raise concerns, report mistreatment, and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; (Core)	2.6.g.	The program director must provide a learning and working environment in which residents have the opportunity to raise concerns, report mistreatment, and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation. (Core)
II.A.4.a).(8)	ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process, including when action is taken to suspend or dismiss, or not to promote or renew the appointment of a resident; (Core)	2.6.h.	The program director must ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process, including when action is taken to suspend or dismiss, or not to promote or renew the appointment of a resident. (Core)
II.A.4.a).(9)	ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; (Core)	2.6.i.	The program director must ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination. (Core)
II.A.4.a).(9).(a)	Residents must not be required to sign a non-competition guarantee or restrictive covenant. (Core)	3.1.	Residents must not be required to sign a non-competition guarantee or restrictive covenant. (Core)
II.A.4.a).(10)	document verification of education for all residents within 30 days of completion of or departure from the program; and, (Core)	2.6.j.	The program director must document verification of education for all residents within 30 days of completion of or departure from the program. (Core)

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II.A.4.a).(11)	**provide verification of an individual resident's education upon the resident's request, within 30 days; and (Core)**	**2.6.k.**	**The program director must provide verification of an individual resident's education upon the resident's request, within 30 days. (Core)**
II.A.4.a).(12)	**provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s). (Core)**	**2.6.l.**	**The program director must provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s). (Core)**
II.B.	**Faculty** ***Faculty members are a foundational element of graduate medical education – faculty members teach residents how to care for patients. Faculty members provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach and model exemplary behavior. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.*** ***Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves.***	**[None]**	**Faculty** ***Faculty members are a foundational element of graduate medical education – faculty members teach residents how to care for patients. Faculty members provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach and model exemplary behavior. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.*** ***Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves.***
II.B.1.	**There must be a sufficient number of faculty members with competence to instruct and supervise all residents. (Core)**	**2.7.**	**There must be a sufficient number of faculty members with competence to instruct and supervise all residents. (Core)**
II.B.1.a)	The members of the faculty must have varying interests, capabilities, and backgrounds, and include individuals who have specialized expertise in the subspecialties of anesthesiology, including critical care, obstetric anesthesia, pediatric anesthesia, neuroanesthesia, cardiothoracic anesthesia, and pain medicine, and also in research. (Core)	2.7.a.	The members of the faculty must have varying interests, capabilities, and backgrounds, and include individuals who have specialized expertise in the subspecialties of anesthesiology, including critical care, obstetric anesthesia, pediatric anesthesia, neuroanesthesia, cardiothoracic anesthesia, and pain medicine, and also in research. (Core)
II.B.1.b)	Didactic and clinical teaching should be provided by faculty members with documented interests and expertise in the subspecialty involved. (Detail)	2.7.b.	Didactic and clinical teaching should be provided by faculty members with documented interests and expertise in the subspecialty involved. (Detail)
II.B.1.c)	The number of faculty members must be sufficient to provide each resident with adequate supervision, which shall not vary substantially with the time of day or the day of the week. (Core)	2.7.c.	The number of faculty members must be sufficient to provide each resident with adequate supervision, which shall not vary substantially with the time of day or the day of the week. (Core)
II.B.1.d)	Designated faculty members must be readily and consistently available for consultation and teaching. (Core)	2.7.d.	Designated faculty members must be readily and consistently available for consultation and teaching. (Core)
II.B.2.	**Faculty members must:**	**[None]**	
II.B.2.a)	**be role models of professionalism; (Core)**	**2.8.**	**Faculty Responsibilities** **Faculty members must be role models of professionalism. (Core)**

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II.B.2.b)	**demonstrate commitment to the delivery of safe, equitable, high-quality, cost-effective, patient-centered care; (Core)**	**2.8.a.**	**Faculty members must demonstrate commitment to the delivery of safe, equitable, high-quality, cost-effective, patient-centered care. (Core)**
II.B.2.c)	**demonstrate a strong interest in the education of residents, including devoting sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; (Core)**	**2.8.b.**	**Faculty members must demonstrate a strong interest in the education of residents, including devoting sufficient time to the educational program to fulfill their supervisory and teaching responsibilities. (Core)**
II.B.2.d)	**administer and maintain an educational environment conducive to educating residents; (Core)**	**2.8.c.**	**Faculty members must administer and maintain an educational environment conducive to educating residents. (Core)**
II.B.2.e)	**regularly participate in organized clinical discussions, rounds, journal clubs, and conferences; and, (Core)**	**2.8.d.**	**Faculty members must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. (Core)**
II.B.2.f)	**pursue faculty development designed to enhance their skills at least annually: (Core)**	**2.8.e.**	**Faculty members must pursue faculty development designed to enhance their skills at least annually: (Core)**
II.B.2.f).(1)	**as educators and evaluators; (Detail)**	**2.8.e.1.**	**as educators and evaluators; (Detail)**
II.B.2.f).(2)	**in quality improvement, eliminating health inequities, and patient safety; (Detail)**	**2.8.e.2.**	**in quality improvement, eliminating health inequities, and patient safety; (Detail)**
II.B.2.f).(3)	**in fostering their own and their residents' well-being; and, (Detail)**	**2.8.e.3.**	**in fostering their own and their residents' well-being; and, (Detail)**
II.B.2.f).(4)	**in patient care based on their practice-based learning and improvement efforts. (Detail)**	**2.8.e.4.**	**in patient care based on their practice-based learning and improvement efforts. (Detail)**
II.B.3.	**Faculty Qualifications**	**2.9.**	**Faculty Qualifications** **Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)**
II.B.3.a)	**Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)**	**2.9.**	**Faculty Qualifications** **Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)**
II.B.3.b)	**Physician faculty members must:**	**[None]**	
II.B.3.b).(1)	**have current certification in the specialty by the American Board of** Anesthesiology **or the American Osteopathic Board of** Anesthesiology**, or possess qualifications judged acceptable to the Review Committee. (Core)**	**2.10.**	**Physician faculty members must have current certification in the specialty by the American Board of** Anesthesiology **or the American Osteopathic Board of** Anesthesiology**, or possess qualifications judged acceptable to the Review Committee. (Core)**
II.B.4.	**Core Faculty** **Core faculty members must have a significant role in the education and supervision of residents and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents. (Core)**	**2.11.**	**Core Faculty** **Core faculty members must have a significant role in the education and supervision of residents and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents. (Core)**
II.B.4.a)	**Core faculty members must complete the annual ACGME Faculty Survey. (Core)**	**2.11.a.**	**Core faculty members must complete the annual ACGME Faculty Survey. (Core)**
II.B.4.b)	There must be at least six core physician faculty members, not including the program director. (Core)	2.11.b.	There must be at least six core physician faculty members, not including the program director. (Core)
II.C.	**Program Coordinator**	**2.12.**	**Program Coordinator** **There must be a program coordinator. (Core)**
II.C.1.	**There must be a program coordinator. (Core)**	**2.12.**	**Program Coordinator** **There must be a program coordinator. (Core)**

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II.C.2.	**The program coordinator must be provided with dedicated time and support adequate for administration of the program based upon its size and configuration. (Core)**	**2.12.a.**	**The program coordinator must be provided with dedicated time and support adequate for administration of the program based upon its size and configuration. (Core)**
II.C.2.a)	At a minimum, the program coordinator must be provided with the dedicated time and support specified below for administration of the program: (Core) Number of Approved Resident Positions:9-10|Minimum Support Required (FTE):0.7 Number of Approved Resident Positions:11-15|Minimum Support Required (FTE):0.8 Number of Approved Resident Positions:16-20|Minimum Support Required (FTE):0.9 Number of Approved Resident Positions:21-25|Minimum Support Required (FTE):1 Number of Approved Resident Positions:26-30|Minimum Support Required (FTE):1.1 Number of Approved Resident Positions:31-35|Minimum Support Required (FTE):1.2 Number of Approved Resident Positions:36-40|Minimum Support Required (FTE):1.3 Number of Approved Resident Positions:41-45|Minimum Support Required (FTE):1.4 Number of Approved Resident Positions:46-50|Minimum Support Required (FTE):1.5 Number of Approved Resident Positions:51-55|Minimum Support Required (FTE):1.6	2.12.b.	At a minimum, the program coordinator must be provided with the dedicated time and support specified below for administration of the program: (Core) Number of Approved Resident Positions:9-10|Minimum Support Required (FTE):0.7 Number of Approved Resident Positions:11-15|Minimum Support Required (FTE):0.8 Number of Approved Resident Positions:16-20|Minimum Support Required (FTE):0.9 Number of Approved Resident Positions:21-25|Minimum Support Required (FTE):1 Number of Approved Resident Positions:26-30|Minimum Support Required (FTE):1.1 Number of Approved Resident Positions:31-35|Minimum Support Required (FTE):1.2 Number of Approved Resident Positions:36-40|Minimum Support Required (FTE):1.3 Number of Approved Resident Positions:41-45|Minimum Support Required (FTE):1.4 Number of Approved Resident Positions:46-50|Minimum Support Required (FTE):1.5 Number of Approved Resident Positions:51-55|Minimum Support Required (FTE):1.6

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II.C.2.a) - (Continued)	Number of Approved Resident Positions:56-60|Minimum Support Required (FTE):1.7 Number of Approved Resident Positions:61-65|Minimum Support Required (FTE):1.8 Number of Approved Resident Positions:66-70|Minimum Support Required (FTE):1.9 Number of Approved Resident Positions:71-75|Minimum Support Required (FTE):2 Number of Approved Resident Positions:76-80|Minimum Support Required (FTE):2.1 Number of Approved Resident Positions:81-85|Minimum Support Required (FTE):2.2 Number of Approved Resident Positions:86-90|Minimum Support Required (FTE):2.3 Number of Approved Resident Positions:91-95|Minimum Support Required (FTE):2.4 Number of Approved Resident Positions:96-100|Minimum Support Required (FTE):2.5 Number of Approved Resident Positions:101-105|Minimum Support Required (FTE):2.6 Number of Approved Resident Positions:106-110|Minimum Support Required (FTE):2.7 Number of Approved Resident Positions:111-115|Minimum Support Required (FTE):2.8 Number of Approved Resident Positions:116-120|Minimum Support Required (FTE):2.9 Number of Approved Resident Positions:Over 120|Minimum Support Required (FTE):3	2.12.b. - (Continued)	Number of Approved Resident Positions:56-60|Minimum Support Required (FTE):1.7 Number of Approved Resident Positions:61-65|Minimum Support Required (FTE):1.8 Number of Approved Resident Positions:66-70|Minimum Support Required (FTE):1.9 Number of Approved Resident Positions:71-75|Minimum Support Required (FTE):2 Number of Approved Resident Positions:76-80|Minimum Support Required (FTE):2.1 Number of Approved Resident Positions:81-85|Minimum Support Required (FTE):2.2 Number of Approved Resident Positions:86-90|Minimum Support Required (FTE):2.3 Number of Approved Resident Positions:91-95|Minimum Support Required (FTE):2.4 Number of Approved Resident Positions:96-100|Minimum Support Required (FTE):2.5 Number of Approved Resident Positions:101-105|Minimum Support Required (FTE):2.6 Number of Approved Resident Positions:106-110|Minimum Support Required (FTE):2.7 Number of Approved Resident Positions:111-115|Minimum Support Required (FTE):2.8 Number of Approved Resident Positions:116-120|Minimum Support Required (FTE):2.9 Number of Approved Resident Positions:Over 120|Minimum Support Required (FTE):3
II.D.	**Other Program Personnel** **The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective administration of the program. (Core)**	**2.13.**	**Other Program Personnel** **The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective administration of the program. (Core)**
III.	**Resident Appointments**	**Section 3**	**Section 3: Resident Appointments**
II.A.	**Eligibility Requirements**	**3.2.**	**Eligibility Requirements** **An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program: (Core)**
III.A.1.	**An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program: (Core)**	**3.2.**	**Eligibility Requirements** **An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program: (Core)**
III.A.1.a)	**graduation from a medical school in the United States, accredited by the Liaison Committee on Medical Education (LCME) or graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA); or, (Core)**	**3.2.a.**	**graduation from a medical school in the United States, accredited by the Liaison Committee on Medical Education (LCME) or graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA); or, (Core)**

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III.A.1.b)	graduation from a medical school outside of the United States, and meeting one of the following additional qualifications: (Core)	3.2.b.	graduation from a medical school outside of the United States, and meeting one of the following additional qualifications: (Core) • holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core) • holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core)
III.A.1.b).(1)	holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core)	3.2.b.	graduation from a medical school outside of the United States, and meeting one of the following additional qualifications: (Core) • holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core) • holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core)
III.A.1.b).(2)	holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core)	3.2.b.	graduation from a medical school outside of the United States, and meeting one of the following additional qualifications: (Core) • holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core) • holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core)
III.A.2.	All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, AOA-approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada, or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation. (Core)	3.3.	All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, AOA-approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada, or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation. (Core)
III.A.2.a)	Residency programs must receive verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation. (Core)	3.3.a.	Residency programs must receive verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation. (Core)

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III.A.2.a).(1)	Residents entering a 36-month anesthesiology program that does not include education in fundamental clinical skills of medicine must have successfully completed 12 months of education in fundamental clinical skills of medicine in a program that satisfies the requirements in III.A.2. (Core)	**3.3.a.1.**	Residents entering a 36-month anesthesiology program that does not include education in fundamental clinical skills of medicine must have successfully completed 12 months of education in fundamental clinical skills of medicine in a program that satisfies the requirements in 3.3. (Core)
III.A.2.a).(1).(a)	If such residents have also been accepted into an anesthesiology program, then in order to be accepted into the CA-1 year, they must demonstrate satisfactory abilities on written performance evaluations in fundamental clinical skills of medicine prior to starting their education. (Core)	**3.3.a.1.a.**	If such residents have also been accepted into an anesthesiology program, then in order to be accepted into the CA-1 year, they must demonstrate satisfactory abilities on written performance evaluations in fundamental clinical skills of medicine prior to starting their education. (Core)
III.A.2.a).(1).(b)	When residents complete education in fundamental clinical skills of medicine in another accredited program, the anesthesiology program director must ensure they receive their written performance evaluations. (Core)	**3.3.a.1.b.**	When residents complete education in fundamental clinical skills of medicine in another accredited program, the anesthesiology program director must ensure they receive their written performance evaluations. (Core)
III.B.	**Resident Complement** **The program director must not appoint more residents than approved by the Review Committee. (Core)**	**3.4.**	**Resident Complement** **The program director must not appoint more residents than approved by the Review Committee. (Core)**
III.B.1.	There must be a minimum of nine residents with, on average, three appointed in each of the CA-1, CA-2, and CA-3 years. (Core)	3.4.a.	There must be a minimum of nine residents with, on average, three appointed in each of the CA-1, CA-2, and CA-3 years. (Core)
III.C.	**Resident Transfers** **The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring resident, and Milestones evaluations upon matriculation. (Core)**	**3.5.**	**Resident Transfers** **The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring resident, and Milestones evaluations upon matriculation. (Core)**
IV.	**Educational Program** ***The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.*** ***The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.*** ***It is recognized programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-specific goals for it and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from one focusing on community health.***	**Section 4**	**Section 4: Educational Program** ***The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.*** ***The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.*** ***It is recognized programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-specific goals for it and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from one focusing on community health.***
IV.A.	**Educational Components** **The curriculum must contain the following educational components:**	**4.2.**	**Educational Components** **The curriculum must contain the following educational components:**

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IV.A.1.	a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates, which must be made available to program applicants, residents, and faculty members; (Core)	4.2.a.	a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates, which must be made available to program applicants, residents, and faculty members; (Core)
IV.A.2.	competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice. These must be distributed, reviewed, and available to residents and faculty members; (Core)	4.2.b.	competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice. These must be distributed, reviewed, and available to residents and faculty members; (Core)
IV.A.3.	delineation of resident responsibilities for patient care, progressive responsibility for patient management, and graded supervision; (Core)	4.2.c.	delineation of resident responsibilities for patient care, progressive responsibility for patient management, and graded supervision; (Core)
IV.A.4.	a broad range of structured didactic activities; and, (Core)	4.2.d.	a broad range of structured didactic activities; and, (Core)
IV.A.4.a)	Residents must be provided with protected time to participate in core didactic activities. (Core)	4.11.	Curriculum Organization and Resident Experiences – Didactic and Clinical Experiences Residents must be provided with protected time to participate in core didactic activities. (Core)
IV.A.5.	formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)	4.2.e.	formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)
IV.B.	ACGME Competencies	[None]	<u>ACGME Competencies</u> ***The Competencies provide a conceptual framework describing the required domains for a trusted physician to enter autonomous practice. These Competencies are core to the practice of all physicians, although the specifics are further defined by each specialty. The developmental trajectories in each of the Competencies are articulated through the Milestones for each specialty.***
IV.B.1.	The program must integrate the following ACGME Competencies into the curriculum:	[None]	The program must integrate all ACGME Competencies into the curriculum.
IV.B.1.a)	Professionalism Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)	4.3.	ACGME Competencies – Professionalism Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core) Residents must demonstrate competence in:
IV.B.1.a).(1)	Residents must demonstrate competence in:	4.3.	ACGME Competencies – Professionalism Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core) Residents must demonstrate competence in:
IV.B.1.a).(1).(a)	compassion, integrity, and respect for others; (Core)	4.3.a.	compassion, integrity, and respect for others; (Core)
IV.B.1.a).(1).(b)	responsiveness to patient needs that supersedes self-interest; (Core)	4.3.b.	responsiveness to patient needs that supersedes self-interest; (Core)
IV.B.1.a).(1).(c)	cultural humility; (Core)	4.3.c.	cultural humility; (Core)
IV.B.1.a).(1).(d)	respect for patient privacy and autonomy; (Core)	4.3.d.	respect for patient privacy and autonomy; (Core)
IV.B.1.a).(1).(e)	accountability to patients, society, and the profession; (Core)	4.3.e.	accountability to patients, society, and the profession; (Core)

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IV.B.1.a).(1).(f)	**respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation; (Core)**	**4.3.f.**	**respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation; (Core)**
IV.B.1.a).(1).(g)	**ability to recognize and develop a plan for one's own personal and professional well-being; and, (Core)**	**4.3.g.**	**ability to recognize and develop a plan for one's own personal and professional well-being; and, (Core)**
IV.B.1.a).(1).(h)	**appropriately disclosing and addressing conflict or duality of interest. (Core)**	**4.3.h.**	**appropriately disclosing and addressing conflict or duality of interest. (Core)**
IV.B.1.b)	**Patient Care and Procedural Skills**	**[None]**	
IV.B.1.b).(1)	**Residents must be able to provide patient care that is patient- and family-centered, compassionate, equitable, appropriate, and effective for the treatment of health problems and the promotion of health. (Core)**	**4.4.**	**ACGME Competencies – Patient Care** **Residents must be able to provide patient care that is patient- and family-centered, compassionate, equitable, appropriate, and effective for the treatment of health problems and the promotion of health. (Core)**
IV.B.1.b).(1).(a)	Residents must demonstrate competence in fundamental clinical skills of medicine, including:	4.4.a.	Residents must demonstrate competence in fundamental clinical skills of medicine, including:
IV.B.1.b).(1).(a).(i)	obtaining a comprehensive medical history; (Core)	4.4.a.1.	obtaining a comprehensive medical history; (Core)
IV.B.1.b).(1).(a).(ii)	performing a comprehensive physical examination; (Core)	4.4.a.2.	performing a comprehensive physical examination; (Core)
IV.B.1.b).(1).(a).(iii)	assessing a patient's medical conditions; (Core)	4.4.a.3.	assessing a patient's medical conditions; (Core)
IV.B.1.b).(1).(a).(iv)	making appropriate use of diagnostic studies and tests; (Core)	4.4.a.4.	making appropriate use of diagnostic studies and tests; (Core)
IV.B.1.b).(1).(a).(v)	integrating information to develop a differential diagnosis; and, (Core)	4.4.a.5.	integrating information to develop a differential diagnosis; and, (Core)
IV.B.1.b).(1).(a).(vi)	implementing a treatment plan. (Core)	4.4.a.6.	implementing a treatment plan. (Core)
IV.B.1.b).(1).(b)	Residents must demonstrate competence in anesthetic management, including care for:	4.4.b.	Residents must demonstrate competence in anesthetic management, including care for:
IV.B.1.b).(1).(b).(i)	patients younger than 12 years of age undergoing surgery or other procedures requiring anesthetics; (Core)	4.4.b.1.	patients younger than 12 years of age undergoing surgery or other procedures requiring anesthetics; (Core)
IV.B.1.b).(1).(b).(i).(a)	This experience must involve care for 100 patients younger than 12 years of age. (Core)	4.4.b.1.a.	This experience must involve care for 100 patients younger than 12 years of age. (Core)
IV.B.1.b).(1).(b).(i).(b)	Within this patient group, 20 children must be younger than three years of age, including five younger than three months of age. (Core)	4.4.b.1.b.	Within this patient group, 20 children must be younger than three years of age, including five younger than three months of age. (Core)
IV.B.1.b).(1).(b).(ii)	patients who are evaluated for management of acute, chronic, or cancer-related pain disorders; (Core)	4.4.b.2.	patients who are evaluated for management of acute, chronic, or cancer-related pain disorders; (Core)
IV.B.1.b).(1).(b).(ii).(a)	This experience must involve care for 20 patients presenting for initial evaluation of pain. (Core)	4.4.b.2.a.	This experience must involve care for 20 patients presenting for initial evaluation of pain. (Core)
IV.B.1.b).(1).(b).(ii).(b)	Residents must be familiar with the breadth of pain management, including clinical experience with interventional pain procedures. (Core)	4.4.b.2.b.	Residents must be familiar with the breadth of pain management, including clinical experience with interventional pain procedures. (Core)
IV.B.1.b).(1).(b).(iii)	patients scheduled for evaluation prior to elective surgical procedures; (Core)	4.4.b.3.	patients scheduled for evaluation prior to elective surgical procedures; (Core)
IV.B.1.b).(1).(b).(iv)	patients immediately after anesthesia, including direct care of patients in the post-anesthesia-care unit, and responsibilities for management of pain, hemodynamic changes, and emergencies related to the post-anesthesia care unit; and, (Core)	4.4.b.4.	patients immediately after anesthesia, including direct care of patients in the post-anesthesia-care unit, and responsibilities for management of pain, hemodynamic changes, and emergencies related to the post-anesthesia care unit; and, (Core)
IV.B.1.b).(1).(b).(v)	critically-ill patients. (Core)	4.4.b.5.	critically-ill patients. (Core)
IV.B.1.b).(1).(c)	Residents must achieve competence in the delivery of anesthetic care to:	4.4.c.	Residents must achieve competence in the delivery of anesthetic care to:
IV.B.1.b).(1).(c).(i)	patients undergoing vaginal delivery; (Core)	4.4.c.1.	patients undergoing vaginal delivery; (Core)
IV.B.1.b).(1).(c).(i).(a)	This experience must involve care for 40 patients. (Core)	4.4.c.1.a.	This experience must involve care for 40 patients. (Core)

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IV.B.1.b).(1).(c).(ii)	patients undergoing cesarean sections; (Core)	4.4.c.2.	patients undergoing cesarean sections; (Core)
IV.B.1.b).(1).(c).(ii).(a)	This experience must involve care for 20 patients. (Core)	4.4.c.2.a.	This experience must involve care for 20 patients. (Core)
IV.B.1.b).(1).(c).(iii)	patients undergoing cardiac surgery; (Core)	4.4.c.3.	patients undergoing cardiac surgery; (Core)
IV.B.1.b).(1).(c).(iii).(a)	This experience must involve care for 20 patients. (Core)	4.4.c.3.a.	This experience must involve care for 20 patients. (Core)
IV.B.1.b).(1).(c).(iii).(b)	The care provided to 10 of these patients must involve the use of cardiopulmonary bypass. (Core)	4.4.c.3.b.	The care provided to 10 of these patients must involve the use of cardiopulmonary bypass. (Core)
IV.B.1.b).(1).(c).(iv)	patients undergoing open or endovascular procedures on major vessels, including carotid surgery, intrathoracic vascular surgery, intra-abdominal vascular surgery, or peripheral vascular surgery; (Core)	4.4.c.4.	patients undergoing open or endovascular procedures on major vessels, including carotid surgery, intrathoracic vascular surgery, intra-abdominal vascular surgery, or peripheral vascular surgery; (Core)
IV.B.1.b).(1).(c).(iv).(a)	This experience must involve care for 20 patients, not including surgery for vascular access or repair of vascular access. (Core)	4.4.c.4.a.	This experience must involve care for 20 patients, not including surgery for vascular access or repair of vascular access. (Core)
IV.B.1.b).(1).(c).(v)	patients undergoing non-cardiac intrathoracic surgery, including pulmonary surgery and surgery of the great vessels, esophagus, and the mediastinum and its structures; (Core)	4.4.c.5.	patients undergoing non-cardiac intrathoracic surgery, including pulmonary surgery and surgery of the great vessels, esophagus, and the mediastinum and its structures; (Core)
IV.B.1.b).(1).(c).(v).(a)	This experience must involve care for 20 patients. (Core)	4.4.c.5.a.	This experience must involve care for 20 patients. (Core)
IV.B.1.b).(1).(c).(vi)	patients undergoing intracerebral procedures, including those undergoing intracerebral endovascular procedures; (Core)	4.4.c.6.	patients undergoing intracerebral procedures, including those undergoing intracerebral endovascular procedures; (Core)
IV.B.1.b).(1).(c).(vi).(a)	This experience must involve care for 20 patients, the majority of which must involve an open cranium. (Core)	4.4.c.6.a.	This experience must involve care for 20 patients, the majority of which must involve an open cranium. (Core)
IV.B.1.b).(1).(c).(vii)	patients for whom epidural anesthetics are used as part of the anesthetic technique or epidural catheters are placed for peri-operative analgesia; (Core)	4.4.c.7.	patients for whom epidural anesthetics are used as part of the anesthetic technique or epidural catheters are placed for peri-operative analgesia; (Core)
)	This experience must involve care for 40 patients. (Core)	4.4.c.7.a.	This experience must involve care for 40 patients. (Core)
IV.B.1.b).(1).(c).(viii)	patients undergoing procedures for complex, immediate life-threatening pathology; (Core)	4.4.c.8.	patients undergoing procedures for complex, immediate life-threatening pathology; (Core)
)	This experience must involve care for 20 patients. (Core)	4.4.c.8.a.	This experience must involve care for 20 patients. (Core)
IV.B.1.b).(1).(c).(ix)	patients undergoing surgical procedures, including cesarean sections, with spinal anesthetics; (Core)	4.4.c.9.	patients undergoing surgical procedures, including cesarean sections, with spinal anesthetics; (Core)
IV.B.1.b).(1).(c).(ix).(a)	This experience must involve care for 40 patients. (Core)	4.4.c.9.a.	This experience must involve care for 40 patients. (Core)
IV.B.1.b).(1).(c).(x)	patients undergoing surgical procedures in whom peripheral nerve blocks are used as part of the anesthetic technique or peri-operative analgesic management; (Core)	4.4.c.10.	patients undergoing surgical procedures in whom peripheral nerve blocks are used as part of the anesthetic technique or peri-operative analgesic management; (Core)
IV.B.1.b).(1).(c).(x).(a)	This experience must involve care for 40 patients. (Core)	4.4.c.10.a.	This experience must involve care for 40 patients. (Core)
IV.B.1.b).(1).(c).(xi)	patients with acute post-operative pain, including those with patient-controlled intravenous techniques, neuraxial blockade, and other pain-control modalities; (Core)	4.4.c.11.	patients with acute post-operative pain, including those with patient-controlled intravenous techniques, neuraxial blockade, and other pain-control modalities; (Core)
IV.B.1.b).(1).(c).(xii)	patients whose peri-operative care requires specialized techniques, including: (Core)	4.4.c.12.	patients whose peri-operative care requires specialized techniques, including: (Core)
IV.B.1.b).(1).(c).(xii).(a)	a broad spectrum of airway management techniques, to include laryngeal masks, fiberoptic intubation, and lung isolation techniques, such as double lumen endotracheal tube placement and endobronchial blockers; (Core)	4.4.c.12.a.	a broad spectrum of airway management techniques, to include laryngeal masks, fiberoptic intubation, and lung isolation techniques, such as double lumen endotracheal tube placement and endobronchial blockers; (Core)
IV.B.1.b).(1).(c).(xii).(b)	central vein and pulmonary artery catheter placement, and the use of transesophageal echocardiography and evoked potentials; and, (Core)	4.4.c.12.b.	central vein and pulmonary artery catheter placement, and the use of transesophageal echocardiography and evoked potentials; and, (Core)

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IV.B.1.b).(1).(c).(xii).(c)	use of electroencephalography (EEG) or processed EEG monitoring as part of the procedure, or adequate didactic instruction to ensure familiarity with EEG use and interpretation. (Core)	4.4.c.12.c.	use of electroencephalography (EEG) or processed EEG monitoring as part of the procedure, or adequate didactic instruction to ensure familiarity with EEG use and interpretation. (Core)
IV.B.1.b).(1).(c).(xiii)	patients undergoing a variety of diagnostic or therapeutic procedures outside the surgical suite. (Core) This must include competency in:	4.4.c.13.	patients undergoing a variety of diagnostic or therapeutic procedures outside the surgical suite. (Core) This must include competency in:
IV.B.1.b).(1).(c).(xiii).(a)	using surface ultrasound and transesophageal and transthoracic echocardiography to guide the performance of invasive procedures and to evaluate organ function and pathology as related to anesthesia, critical care, and resuscitation; (Core)	4.4.c.13.a.	using surface ultrasound and transesophageal and transthoracic echocardiography to guide the performance of invasive procedures and to evaluate organ function and pathology as related to anesthesia, critical care, and resuscitation; (Core)
IV.B.1.b).(1).(c).(xiii).(b)	understanding the principles of ultrasound, including the physics of ultrasound transmission, ultrasound transducer construction, and transducer selection for specific applications, to include being able to obtain images with an understanding of limitations and artifacts; (Core)	4.4.c.13.b.	understanding the principles of ultrasound, including the physics of ultrasound transmission, ultrasound transducer construction, and transducer selection for specific applications, to include being able to obtain images with an understanding of limitations and artifacts; (Core)
IV.B.1.b).(1).(c).(xiii).(c)	obtaining standard views of the heart and inferior vena cava with transthoracic echocardiography allowing the evaluation of myocardial function, estimation of central venous pressure, and gross pericardial/cardiac pathology (e.g., large pericardial effusion); (Core)	4.4.c.13.c.	obtaining standard views of the heart and inferior vena cava with transthoracic echocardiography allowing the evaluation of myocardial function, estimation of central venous pressure, and gross pericardial/cardiac pathology (e.g., large pericardial effusion); (Core)
IV.B.1.b).(1).(c).(xiii).(d)	obtaining standard views of the heart with transesophageal echocardiography allowing the evaluation of myocardial function and gross pericardial/cardiac pathology (e.g., large pericardial effusion); (Core)	4.4.c.13.d.	obtaining standard views of the heart with transesophageal echocardiography allowing the evaluation of myocardial function and gross pericardial/cardiac pathology (e.g., large pericardial effusion); (Core)
IV.B.1.b).(1).(c).(xiii).(e)	using transthoracic ultrasound for the detection of pneumothorax and pleural effusion; (Core)	4.4.c.13.e.	using transthoracic ultrasound for the detection of pneumothorax and pleural effusion; (Core)
IV.B.1.b).(1).(c).(xiii).(f)	using surface ultrasound to guide vascular access (both central and peripheral) and to guide regional anesthesia procedures; and, (Core)	4.4.c.13.f.	using surface ultrasound to guide vascular access (both central and peripheral) and to guide regional anesthesia procedures; and, (Core)
)	describing techniques, views, and findings in standard language. (Core)	4.4.c.13.g.	describing techniques, views, and findings in standard language. (Core)
IV.B.1.b).(2)	**Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)**	**4.5.**	**ACGME Competencies – Procedural Skills: Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)**
IV.B.1.c)	**Medical Knowledge** **Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, including scientific inquiry, as well as the application of this knowledge to patient care. (Core)**	**4.6.**	**ACGME Competencies – Medical Knowledge** **Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, including scientific inquiry, as well as the application of this knowledge to patient care. (Core)**
IV.B.1.c).(1)	Residents must demonstrate appropriate medical knowledge in the topics related to the anesthetic care of patients, including:	4.6.a.	Residents must demonstrate appropriate medical knowledge in the topics related to the anesthetic care of patients, including:
IV.B.1.c).(1).(a)	practice management to address issues such as: (Core)	4.6.a.1.	practice management to address issues such as: (Core)
IV.B.1.c).(1).(a).(i)	operating room management; (Core)	4.6.a.1.a.	operating room management; (Core)
IV.B.1.c).(1).(a).(ii)	evaluation of types of practice; (Core)	4.6.a.1.b.	evaluation of types of practice; (Core)
IV.B.1.c).(1).(a).(iii)	contract negotiations; (Core)	4.6.a.1.c.	contract negotiations; (Core)
IV.B.1.c).(1).(a).(iv)	billing arrangements; (Core)	4.6.a.1.d.	billing arrangements; (Core)
IV.B.1.c).(1).(a).(v)	professional liability; (Core)	4.6.a.1.e.	professional liability; (Core)
IV.B.1.c).(1).(a).(vi)	health care finance, legislative, and regulatory issues; and, (Core)	4.6.a.1.f.	health care finance, legislative, and regulatory issues; and, (Core)
IV.B.1.c).(1).(a).(vii)	fiscal stewardship of health services delivery. (Core)	4.6.a.1.g.	fiscal stewardship of health services delivery. (Core)

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IV.B.1.c).(1).(b)	management skills, to include basic knowledge of organizational culture, decision making, change management, conflict resolution, and negotiation and advocacy; (Core)	4.6.a.2.	management skills, to include basic knowledge of organizational culture, decision making, change management, conflict resolution, and negotiation and advocacy; (Core)
IV.B.1.c).(1).(c)	care of the patient in the continuum of the peri-operative period, to include collaboration with medical and surgical colleagues to:	4.6.a.3.	care of the patient in the continuum of the peri-operative period, to include collaboration with medical and surgical colleagues to:
IV.B.1.c).(1).(c).(i)	optimize preoperative patient condition; and, (Core)	4.6.a.3.a.	optimize preoperative patient condition; and, (Core)
IV.B.1.c).(1).(c).(ii)	optimize recovery; (Core)	4.6.a.3.b.	optimize recovery; (Core)
IV.B.1.c).(1).(d)	management of the specific needs of patients undergoing diagnostic or therapeutic procedures outside of the surgical suite. (Core)	4.6.a.4.	management of the specific needs of patients undergoing diagnostic or therapeutic procedures outside of the surgical suite. (Core)
IV.B.1.d)	**Practice-based Learning and Improvement** **Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning; (Core)**	**4.7.**	**ACGME Competencies – Practice-Based Learning and Improvement** **Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning. (Core)**
IV.B.1.d).(1)	**Residents must demonstrate competence in:**	**[None]**	
IV.B.1.d).(1).(a)	**identifying strengths, deficiencies, and limits in one's knowledge and expertise; (Core)**	**4.7.a.**	**Residents must demonstrate competence in identifying strengths, deficiencies, and limits in one's knowledge and expertise. (Core)**
IV.B.1.d).(1).(b)	**setting learning and improvement goals; (Core)**	**4.7.b.**	**Residents must demonstrate competence in setting learning and improvement goals. (Core)**
IV.B.1.d).(1).(c)	**identifying and performing appropriate learning activities; (Core)**	**4.7.c.**	**Residents must demonstrate competence in identifying and performing appropriate learning activities. (Core)**
IV.B.1.d).(1).(d)	**systematically analyzing practice using quality improvement methods, including activities aimed at reducing health care disparities, and implementing changes with the goal of practice improvement; (Core)**	**4.7.d.**	**Residents must demonstrate competence in systematically analyzing practice using quality improvement methods, including activities aimed at reducing health care disparities, and implementing changes with the goal of practice improvement. (Core)**
IV.B.1.d).(1).(e)	**incorporating feedback and formative evaluation into daily practice; and, (Core)**	**4.7.e.**	**Residents must demonstrate competence in incorporating feedback and formative evaluation into daily practice. (Core)**
IV.B.1.d).(1).(f)	**locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems. (Core)**	**4.7.f.**	**Residents must demonstrate competence in locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems. (Core)**
IV.B.1.e)	**Interpersonal and Communication Skills** **Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Core)**	**4.8.**	**ACGME Competencies – Interpersonal and Communication Skills** **Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Core)**
IV.B.1.e).(1)	**Residents must demonstrate competence in**	**[None]**	
IV.B.1.e).(1).(a)	**communicating effectively with patients and patients' families, as appropriate, across a broad range of socioeconomic circumstances, cultural backgrounds, and language capabilities, learning to engage interpretive services as required to provide appropriate care to each patient; (Core)**	**4.8.a.**	**Residents must demonstrate competence in communicating effectively with patients and patients' families, as appropriate, across a broad range of socioeconomic circumstances, cultural backgrounds, and language capabilities, learning to engage interpretive services as required to provide appropriate care to each patient. (Core)**
IV.B.1.e).(1).(b)	**communicating effectively with physicians, other health professionals, and health-related agencies; (Core)**	**4.8.b.**	**Residents must demonstrate competence in communicating effectively with physicians, other health professionals, and health-related agencies. (Core)**

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IV.B.1.e).(1).(c)	**working effectively as a member or leader of a health care team or other professional group; (Core)**	**4.8.c.**	**Residents must demonstrate competence in working effectively as a member or leader of a health care team or other professional group. (Core)**
IV.B.1.e).(1).(d)	**educating patients, patients' families, students, other residents, and other health professionals; (Core)**	**4.8.d.**	**Residents must demonstrate competence in educating patients, patients' families, students, other residents, and other health professionals. (Core)**
IV.B.1.e).(1).(e)	**acting in a consultative role to other physicians and health professionals; (Core)**	**4.8.e.**	**Residents must demonstrate competence in acting in a consultative role to other physicians and health professionals. (Core)**
IV.B.1.e).(1).(f)	**maintaining comprehensive, timely, and legible health care records, if applicable. (Core)**	**4.8.f.**	**Residents must demonstrate competence in maintaining comprehensive, timely, and legible health care records, if applicable. (Core)**
IV.B.1.e).(1).(g)	maintaining a comprehensive anesthesia record for each patient, including evidence of pre- and post-operative anesthesia assessment, the drugs administered, the monitoring employed, the techniques used, the physiologic variations observed, the therapy provided, and the fluids administered; and, (Core)	4.8.h.	Residents must demonstrate competence in maintaining a comprehensive anesthesia record for each patient, including evidence of pre- and post-operative anesthesia assessment, the drugs administered, the monitoring employed, the techniques used, the physiologic variations observed, the therapy provided, and the fluids administered. (Core)
IV.B.1.e).(1).(h)	creating and sustaining a therapeutic relationship with patients, engaging in active listening, providing information using appropriate language, asking clear questions, and providing an opportunity for comments and questions. (Core)	4.8.i.	Residents must demonstrate competence in creating and sustaining a therapeutic relationship with patients, engaging in active listening, providing information using appropriate language, asking clear questions, and providing an opportunity for comments and questions. (Core)
IV.B.1.e).(2)	**Residents must learn to communicate with patients and patients' families to partner with them to assess their care goals, including, when appropriate, end-of-life goals. (Core)**	**4.8.g.**	**Residents must learn to communicate with patients and patients' families to partner with them to assess their care goals, including, when appropriate, end-of-life goals. (Core)**
IV.B.1.f).	**Systems-based Practice** **Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the structural and social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)**	**4.9.**	**ACGME Competencies - Systems-Based Practice** **Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the structural and social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)**
IV.B.1.f).(1)	**Residents must demonstrate competence in:**	**[None]**	
IV.B.1.f).(1).(a)	**working effectively in various health care delivery settings and systems relevant to their clinical specialty; (Core)**	**4.9.a.**	**Residents must demonstrate competence in working effectively in various health care delivery settings and systems relevant to their clinical specialty. (Core)**
IV.B.1.f).(1).(b)	**coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty; (Core)**	**4.9.b.**	**Residents must demonstrate competence in coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty. (Core)**
IV.B.1.f).(1).(c)	**advocating for quality patient care and optimal patient care systems; (Core)**	**4.9.c.**	**Residents must demonstrate competence in advocating for quality patient care and optimal patient care systems. (Core)**
IV.B.1.f).(1).(d)	**participating in identifying system errors and implementing potential systems solutions; (Core)**	**4.9.d.**	**Residents must demonstrate competence in participating in identifying system errors and implementing potential systems solutions. (Core)**
IV.B.1.f).(1).(e)	**incorporating considerations of value, equity, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate;(Core)**	**4.9.e.**	**Residents must demonstrate competence in incorporating considerations of value, equity, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate. (Core)**

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IV.B.1.f).(1).(f)	**understanding health care finances and its impact on individual patients' health decisions; and, (Core)**	**4.9.f.**	**Residents must demonstrate competence in understanding health care finances and its impact on individual patients' health decisions. (Core)**
IV.B.1.f).(1).(g)	**using tools and techniques that promote patient safety and disclosure of patient safety events (real or simulated). (Detail)**	**4.9.g.**	**Residents must demonstrate competence in using tools and techniques that promote patient safety and disclosure of patient safety events (real or simulated). (Detail)**
IV.B.1.f).(2)	**Residents must learn to advocate for patients within the health care system to achieve the patient's and patient's family's care goals, including, when appropriate, end-of-life goals. (Core)**	**4.9.h.**	**Residents must learn to advocate for patients within the health care system to achieve the patient's and patient's family's care goals, including, when appropriate, end-of-life goals. (Core)**
IV.C.	**Curriculum Organization and Resident Experiences**	**4.10. - 4.12.**	**4.10. Curriculum Organization and Resident Experiences – Curriculum Structure** **The curriculum must be structured to optimize resident educational experiences, the length of the experiences, and the supervisory continuity. These educational experiences include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events. (Core)** **4.11. Curriculum Organization and Resident Experiences – Didactic and Clinical Experiences** **Residents must be provided with protected time to participate in core didactic activities. (Core)** **4.12. Curriculum Organization and Resident Experiences – Pain Management** **The program must provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of substance use disorder. (Core)**
IV.C.1.	**The curriculum must be structured to optimize resident educational experiences, the length of the experiences, and the supervisory continuity. These educational experiences include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events. (Core)**	**4.10.**	**Curriculum Organization and Resident Experiences – Curriculum Structure** **The curriculum must be structured to optimize resident educational experiences, the length of the experiences, and the supervisory continuity. These educational experiences include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events. (Core)**
IV.C.1.a)	Assignment of rotations must be of sufficient length to provide a quality educational experience, defined by continuity of patient care, ongoing supervision, longitudinal relationships with faculty members, and meaningful assessment and feedback, or as otherwise specified in the specialty-specific Program Requirements. (Core)	4.10.a.	Assignment of rotations must be of sufficient length to provide a quality educational experience, defined by continuity of patient care, ongoing supervision, longitudinal relationships with faculty members, and meaningful assessment and feedback, or as otherwise specified in the specialty-specific Program Requirements. (Core)
IV.C.1.b)	Clinical experiences should be structured to facilitate learning in a manner that allows residents to function as part of an effective interprofessional team that works together longitudinally with shared goals of patient safety and quality improvement. (Core)	4.10.b.	Clinical experiences should be structured to facilitate learning in a manner that allows residents to function as part of an effective interprofessional team that works together longitudinally with shared goals of patient safety and quality improvement. (Core)

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IV.C.2.	**The program must provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of substance use disorder. (Core)**	**4.12.**	**Curriculum Organization and Resident Experiences – Pain Management: The program must provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of substance use disorder. (Core)**
IV.C.2.a)	The program must have a written policy and an educational program regarding substance use disorders as related to physician well-being that specifically addresses the needs of anesthesiology. (Core)	4.11.a.	The program must have a written policy and an educational program regarding substance use disorders as related to physician well-being that specifically addresses the needs of anesthesiology. (Core)
IV.C.3.	Twelve months of the resident's educational program must provide broad education in fundamental clinical skills of medicine relevant to the practice of anesthesiology. (Core)	4.11.b.	Twelve months of the resident's educational program must provide broad education in fundamental clinical skills of medicine relevant to the practice of anesthesiology. (Core)
IV.C.3.a)	Fundamental clinical skills of medicine education completed as part of an anesthesiology residency need not be contiguous, but must be completed before starting the final year of the program. (Core)	4.11.b.1.	Fundamental clinical skills of medicine education completed as part of an anesthesiology residency need not be contiguous, but must be completed before starting the final year of the program. (Core)
IV.C.3.b)	At least six months of fundamental clinical skills of medicine education must include experience in caring for inpatients in family medicine, internal medicine, neurology, obstetrics and gynecology, pediatrics, surgery or any of the surgical specialties, or any combination of these. (Core)	4.11.b.2.	At least six months of fundamental clinical skills of medicine education must include experience in caring for inpatients in family medicine, internal medicine, neurology, obstetrics and gynecology, pediatrics, surgery or any of the surgical specialties, or any combination of these. (Core)
IV.C.3.c)	The program director must maintain oversight of resident education in fundamental clinical skills of medicine. (Core)	4.11.b.3.	The program director must maintain oversight of resident education in fundamental clinical skills of medicine. (Core)
IV.C.4.	During the first 12 months of the program, there must be at least one month, but not more than two month(s) each of critical care and emergency medicine. (Core)	4.11.c.	During the first 12 months of the program, there must be at least one month, but not more than two month(s) each of critical care and emergency medicine. (Core)
IV.C.5.	Thirty-six months of education must be in peri-operative medicine. (Core)	4.11.d.	Thirty-six months of education must be in peri-operative medicine. (Core)
IV.C.5.a)	This must include experience with a wide spectrum of disease processes and surgical procedures available within the CA-1 through CA-3 years to provide each resident with broad exposure to different types of anesthetic management. (Core)	4.11.d.1.	This must include experience with a wide spectrum of disease processes and surgical procedures available within the CA-1 through CA-3 years to provide each resident with broad exposure to different types of anesthetic management. (Core)
IV.C.5.b)	The program must ensure that the rotations for residents beginning the peri-operative medicine component of the residency be in surgical anesthesia, critical care medicine, and pain medicine. (Core)	4.11.d.2.	The program must ensure that the rotations for residents beginning the peri-operative medicine component of the residency be in surgical anesthesia, critical care medicine, and pain medicine. (Core)
IV.C.5.c)	Residents must receive training in the complex technology and equipment associated with the practice of anesthesiology. (Core)	4.11.d.3.	Residents must receive training in the complex technology and equipment associated with the practice of anesthesiology. (Core)
IV.C.5.d)	Clinical experience in surgical anesthesia, pain medicine, and critical care medicine must be distributed throughout the curriculum in order to provide progressive responsibility in the later stages of the program. (Core)	4.11.d.4.	Clinical experience in surgical anesthesia, pain medicine, and critical care medicine must be distributed throughout the curriculum in order to provide progressive responsibility in the later stages of the program. (Core)
IV.C.6.	Residents must have a rotation of at least two weeks in pre-operative medicine. (Core)	4.11.e.	Residents must have a rotation of at least two weeks in pre-operative medicine. (Core)
IV.C.7.	Residents must have a rotation of at least two weeks in post-anesthesia care. (Core)	4.11.f.	Residents must have a rotation of at least two weeks in post-anesthesia care. (Core)
IV.C.7.a)	Resident clinical responsibilities in the post-operative care unit must be limited to the care of post-operative patients, with the exception of providing emergency response capability for cardiac arrests and rapid response situations within the facility. (Core)	4.11.f.1.	Resident clinical responsibilities in the post-operative care unit must be limited to the care of post-operative patients, with the exception of providing emergency response capability for cardiac arrests and rapid response situations within the facility. (Core)
IV.C.8.	Resident education must include a minimum of four one-month rotations in critical care medicine. (Core)	4.11.g.	Resident education must include a minimum of four one-month rotations in critical care medicine. (Core)

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IV.C.8.a)	No more than two months of this experience should occur prior to the CA-1 year. (Core)	4.11.g.1.	No more than two months of this experience should occur prior to the CA-1 year. (Core)
IV.C.8.b)	Each critical care medicine rotation must be at least one month in duration, with progressive patient care responsibility in advanced rotations. (Core)	4.11.g.2.	Each critical care medicine rotation must be at least one month in duration, with progressive patient care responsibility in advanced rotations. (Core)
IV.C.8.c)	Training must take place in units, providing care for both men and women, in which the majority of patients have multisystem disease. (Core)	4.11.g.3.	Training must take place in units, providing care for both men and women, in which the majority of patients have multisystem disease. (Core)
IV.C.8.d)	Residents must actively participate in all patient care activities as fully integrated members of the critical care team. (Core)	4.11.g.4.	Residents must actively participate in all patient care activities as fully integrated members of the critical care team. (Core)
IV.C.8.e)	During at least two of the required four months of critical care medicine, faculty anesthesiologists experienced in the practice and teaching of critical care must be actively involved in the care of the critically-ill patients seen by residents, and in the educational activities of the residents. (Core)	4.11.g.5.	During at least two of the required four months of critical care medicine, faculty anesthesiologists experienced in the practice and teaching of critical care must be actively involved in the care of the critically-ill patients seen by residents, and in the educational activities of the residents. (Core)
IV.C.9.	Resident education must include a minimum of two one-month rotations each in obstetric anesthesia, pediatric anesthesia, neuroanesthesia, and cardiothoracic anesthesia. (Core)	4.11.h.	Resident education must include a minimum of two one-month rotations each in obstetric anesthesia, pediatric anesthesia, neuroanesthesia, and cardiothoracic anesthesia. (Core)
IV.C.9.a)	Additional subspecialty and research rotations are encouraged, but resident rotations in a single anesthesia subspecialty must not exceed six months. (Detail)	4.11.h.1.	Additional subspecialty and research rotations are encouraged, but resident rotations in a single anesthesia subspecialty must not exceed six months. (Detail)
IV.C.9.b)	Advanced subspecialty rotations must not compromise the learning opportunities for residents participating in their initial subspecialty rotations. (Core)	4.11.h.2.	Advanced subspecialty rotations must not compromise the learning opportunities for residents participating in their initial subspecialty rotations. (Core)
IV.C.10.	Resident education must include a minimum of three months in pain medicine, including: (Core)	4.11.i.	Resident education must include a minimum of three months in pain medicine, including: (Core)
IV.C.10.a)	one month in an acute peri-operative pain management rotation; (Core)	4.11.i.1.	one month in an acute peri-operative pain management rotation; (Core)
IV.C.10.b)	one month in a rotation for the assessment and treatment of inpatients and outpatients with chronic pain; and, (Core)	4.11.i.2.	one month in a rotation for the assessment and treatment of inpatients and outpatients with chronic pain; and, (Core)
IV.C.10.c)	one month of a regional analgesia experience rotation. (Core)	4.11.i.3.	one month of a regional analgesia experience rotation. (Core)
IV.C.11.	Residents must have at least two weeks of experience managing the anesthetic care of patients undergoing diagnostic or therapeutic procedures outside of the surgical suite. (Core)	4.11.j.	Residents must have at least two weeks of experience managing the anesthetic care of patients undergoing diagnostic or therapeutic procedures outside of the surgical suite. (Core)
IV.C.12.	In the clinical anesthesia setting, faculty members must not direct anesthesia at more than two anesthetizing locations simultaneously when supervising residents. (Core)	4.11.k.	In the clinical anesthesia setting, faculty members must not direct anesthesia at more than two anesthetizing locations simultaneously when supervising residents. (Core)
IV.C.12.a)	Clinical instruction of residents by non-physician personnel should be limited to not more than 10 percent of total instruction, and should use such personnel only when access to their specific expertise will enhance the educational experience of residents. (Detail)	4.11.k.1.	Clinical instruction of residents by non-physician personnel should be limited to not more than 10 percent of total instruction, and should use such personnel only when access to their specific expertise will enhance the educational experience of residents. (Detail)
IV.C.13.	All residents must obtain advanced cardiac life support (ACLS) certification at least once during the program. (Core)	4.11.l.	All residents must obtain advanced cardiac life support (ACLS) certification at least once during the program. (Core)
IV.C.14.	Residents must participate in at least one simulated clinical experience each year. (Core)	4.11.m.	Residents must participate in at least one simulated clinical experience each year. (Core)

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IV.C.15.	The program director must ensure regular review of the residents' clinical experience logs and verify their accuracy and completeness when they are transmitted to the Review Committee. (Core)	4.11.n.	The program director must ensure regular review of the residents' clinical experience logs and verify their accuracy and completeness when they are transmitted to the Review Committee. (Core)
IV.C.15.a)	The program director must ensure that experience logs are submitted annually to the Review Committee in accordance with the format and the due date specified by the Committee. (Core)	4.11.n.1.	The program director must ensure that experience logs are submitted annually to the Review Committee in accordance with the format and the due date specified by the Committee. (Core)
IV.C.16.	The program director must determine sequencing of rotations. (Detail)	4.11.o.	The program director must determine sequencing of rotations. (Detail)
IV.C.17.	The program director must monitor the appropriate distribution of cases among the residents. (Core)	4.11.p.	The program director must monitor the appropriate distribution of cases among the residents. (Core)
IV.C.18.	The program director must ensure that service commitments do not compromise the achievement of educational goals and objectives. (Core)	4.11.q.	The program director must ensure that service commitments do not compromise the achievement of educational goals and objectives. (Core)
IV.C.19.	The curriculum must contain didactic instruction through a variety of learning opportunities occurring in conference, in the clinical setting or online that encompasses clinical anesthesiology and related areas of basic science. (Core)	4.11.r.	The curriculum must contain didactic instruction through a variety of learning opportunities occurring in conference, in the clinical setting or online that encompasses clinical anesthesiology and related areas of basic science. (Core)
IV.C.20.	Other topics from internal medicine that are important for the pre-operative preparation of the patient, from surgery as to the nature of the surgical procedure affecting anesthetic care, and from obstetrics that impacts anesthetic management of the patient, should be included. (Core)	4.11.s.	Other topics from internal medicine that are important for the pre-operative preparation of the patient, from surgery as to the nature of the surgical procedure affecting anesthetic care, and from obstetrics that impacts anesthetic management of the patient, should be included. (Core)
IV.C.20.a)	The material covered in the didactic program must demonstrate appropriate continuity and sequencing to ensure that residents are ultimately exposed to all subjects at regularly held learning exercises. (Core)	4.11.s.1.	The material covered in the didactic program must demonstrate appropriate continuity and sequencing to ensure that residents are ultimately exposed to all subjects at regularly held learning exercises. (Core)
IV.C.20.a).(1)	There should be evidence of regular faculty member participation in didactic sessions. (Detail)	4.11.s.1.a.	There should be evidence of regular faculty member participation in didactic sessions. (Detail)
IV.C.20.a).(2)	The program director and faculty members from other disciplines and other institutions should conduct these sessions. (Detail)	4.11.s.1.b.	The program director and faculty members from other disciplines and other institutions should conduct these sessions. (Detail)
IV.C.21.	When 12 months of education in fundamental clinical skills of medicine is approved as part of the accredited program, the program director must maintain oversight for all rotations, and must approve the rotations for individual residents. (Core)	4.11.t.	When 12 months of education in fundamental clinical skills of medicine is approved as part of the accredited program, the program director must maintain oversight for all rotations, and must approve the rotations for individual residents. (Core)
IV.C.22.	The program director must review written resident performance evaluations from each clinical service on which each resident rotates on a quarterly basis. (Core)	4.11.u.	The program director must review written resident performance evaluations from each clinical service on which each resident rotates on a quarterly basis. (Core)
IV.C.23.	The education must culminate in sufficiently independent responsibility for clinical decision-making and patient care, so that the graduating resident exhibits sound clinical judgment in a wide variety of clinical situations and can function as a leader of peri-operative care teams. (Core)	4.11.v.	The education must culminate in sufficiently independent responsibility for clinical decision-making and patient care, so that the graduating resident exhibits sound clinical judgment in a wide variety of clinical situations and can function as a leader of peri-operative care teams. (Core)
IV.C.24.	As the resident advances through the program, goals and objectives must reflect the opportunity to learn to plan and administer anesthesia care for patients with more severe and complicated diseases, as well as for patients who undergo more complex surgical procedures. (Core)	4.11.w.	As the resident advances through the program, goals and objectives must reflect the opportunity to learn to plan and administer anesthesia care for patients with more severe and complicated diseases, as well as for patients who undergo more complex surgical procedures. (Core)
IV.C.25.	International rotations should be limited to the final year of training and should be limited to three months or less. (Detail)	4.11.x.	International rotations should be limited to the final year of training and should be limited to three months or less. (Detail)

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IV.C.25.a)	International rotations must be approved by the Review Committee through a written request submitted by the program director. (Detail)	4.11.x.1.	International rotations must be approved by the Review Committee through a written request submitted by the program director. (Detail)
IV.D.	**Scholarship** ***Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through resident participation in scholarly activities. Scholarly activities may include discovery, integration, application, and teaching.*** ***The ACGME recognizes the diversity of residencies and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.***	**[None]**	**Scholarship** ***Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through resident participation in scholarly activities. Scholarly activities may include discovery, integration, application, and teaching.*** ***The ACGME recognizes the diversity of residencies and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.***
IV.D.1.	**Program Responsibilities**	**4.13.**	**Program Responsibilities** **The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)**
IV.D.1.a)	**The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)**	**4.13.**	**Program Responsibilities** **The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)**
IV.D.1.b)	**The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities. (Core)**	**4.13.a.**	**The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities. (Core)**
IV.D.1.c)	**The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. (Core)**	**4.13.b.**	**The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. (Core)**

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IV.D.2.	Faculty Scholarly Activity	4.14.	Faculty Scholarly Activity Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core) • Research in basic science, education, translational science, patient care, or population health • Peer-reviewed grants • Quality improvement and/or patient safety initiatives • Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports • Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials • Contribution to professional committees, educational organizations, or editorial boards • Innovations in education
IV.D.2.a)	Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core) • Research in basic science, education, translational science, patient care, or population health • Peer-reviewed grants • Quality improvement and/or patient safety initiatives • Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports • Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials • Contribution to professional committees, educational organizations, or editorial boards • Innovations in education	4.14.	Faculty Scholarly Activity Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core) • Research in basic science, education, translational science, patient care, or population health • Peer-reviewed grants • Quality improvement and/or patient safety initiatives • Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports • Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials • Contribution to professional committees, educational organizations, or editorial boards • Innovations in education
IV.D.2.b)	The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:	4.14.a.	The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods: • faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; (Outcome) • peer-reviewed publication. (Outcome)

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IV.D.2.b).(1)	**faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; (Outcome)**	**4.14.a.**	**The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:** **• faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; (Outcome)** **• peer-reviewed publication. (Outcome)**
IV.D.2.b).(2)	**peer-reviewed publication. (Outcome)**	**4.14.a.**	**The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:** **• faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; (Outcome)** **• peer-reviewed publication. (Outcome)**
IV.D.3.	**Resident Scholarly Activity**	**4.15.**	**Resident Scholarly Activity** **Residents must participate in scholarship. (Core)**
IV.D.3.a)	**Residents must participate in scholarship. (Core)**	**4.15.**	**Resident Scholarly Activity** **Residents must participate in scholarship. (Core)**
IV.D.3.b)	Each resident must complete, under faculty member supervision, an academic assignment. (Core)	4.15.a.	Each resident must complete, under faculty member supervision, an academic assignment. (Core)
IV.D.3.b).(1)	Academic assignments should include grand rounds presentations; preparation and publication of review articles, book chapters, manuals for teaching or clinical practice; or development, performance, or participation in one or more clinical or laboratory investigations. (Detail)	4.15.a.1.	Academic assignments should include grand rounds presentations; preparation and publication of review articles, book chapters, manuals for teaching or clinical practice; or development, performance, or participation in one or more clinical or laboratory investigations. (Detail)
IV.D.3.b).(1).(a)	The outcome of resident investigations should be suitable for presentation at local, regional, or national scientific meetings, and/or result in peer-reviewed abstracts or manuscripts. (Detail)	4.15.a.1.a.	The outcome of resident investigations should be suitable for presentation at local, regional, or national scientific meetings, and/or result in peer-reviewed abstracts or manuscripts. (Detail)
V.	**Evaluation**	**Section 5**	**Section 5: Evaluation**
V.A.	**Resident Evaluation**	**5.1.**	**Resident Evaluation: Feedback and Evaluation** **Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)**
V.A.1.	**Feedback and Evaluation**	**5.1.**	**Resident Evaluation: Feedback and Evaluation** **Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)**

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V.A.1.a)	Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)	5.1.	Resident Evaluation: Feedback and Evaluation Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)
V.A.1.b)	Evaluation must be documented at the completion of the assignment. (Core)	5.1.a.	Evaluation must be documented at the completion of the assignment. (Core)
V.A.1.b).(1)	For block rotations of greater than three months in duration, evaluation must be documented at least every three months. (Core)	5.1.a.1.	For block rotations of greater than three months in duration, evaluation must be documented at least every three months. (Core)
V.A.1.b).(2)	Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion. (Core)	5.1.a.2.	Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion. (Core)
V.A.1.c)	The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones, and must: (Core)	5.1.b.	The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones. (Core)
V.A.1.c).(1)	use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, (Core)	5.1.b.1.	The program must use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members). (Core)
V.A.1.c).(2)	provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. (Core)	5.1.b.2.	The program must provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. (Core)
V.A.1.d)	The program director or their designee, with input from the Clinical Competency Committee, must:	[None]	
V.A.1.d).(1)	meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones; (Core)	5.1.c.	The program director or their designee, with input from the Clinical Competency Committee, must meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones. (Core)
V.A.1.d).(2)	assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and, (Core)	5.1.d.	The program director or their designee, with input from the Clinical Competency Committee, must assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth. (Core)
V.A.1.d).(3)	develop plans for residents failing to progress, following institutional policies and procedures. (Core)	5.1.e.	The program director or their designee, with input from the Clinical Competency Committee, must develop plans for residents failing to progress, following institutional policies and procedures. (Core)
V.A.1.e)	At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable. (Core)	5.1.f.	At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable. (Core)
V.A.1.f).	The evaluations of a resident's performance must be accessible for review by the resident. (Core)	5.1.g.	The evaluations of a resident's performance must be accessible for review by the resident. (Core)
V.A.2.	Final Evaluation	5.2.	Resident Evaluation: Final Evaluation The program director must provide a final evaluation for each resident upon completion of the program. (Core)
V.A.2.a)	The program director must provide a final evaluation for each resident upon completion of the program. (Core)	5.2.	Resident Evaluation: Final Evaluation The program director must provide a final evaluation for each resident upon completion of the program. (Core)

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V.A.2.a).(1)	The specialty-specific Milestones, and when applicable the specialty-specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program. (Core)	5.2.a.	The specialty-specific Milestones, and when applicable the specialty-specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program. (Core)
V.A.2.a).(2)	The final evaluation must:	[None]	
V.A.2.a).(2).(a)	become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy; (Core)	5.2.b.	The final evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. (Core)
V.A.2.a).(2).(b)	verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice; and, (Core)	5.2.c.	The final evaluation must verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice. (Core)
V.A.2.a).(2).(c)	be shared with the resident upon completion of the program. (Core)	5.2.d.	The final evaluation must be shared with the resident upon completion of the program. (Core)
V.A.3.	A Clinical Competency Committee must be appointed by the program director. (Core)	5.3.	Clinical Competency Committee A Clinical Competency Committee must be appointed by the program director. (Core)
V.A.3.a)	At a minimum, the Clinical Competency Committee must include three members of the program faculty, at least one of whom is a core faculty member. (Core)	5.3.a.	At a minimum, the Clinical Competency Committee must include three members of the program faculty, at least one of whom is a core faculty member. (Core)
V.A.3.a).(1)	Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents. (Core)	5.3.b.	Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents. (Core)
V.A.3.b)	The Clinical Competency Committee must:	[None]	
V.A.3.b).(1)	review all resident evaluations at least semi-annually; (Core)	5.3.c.	The Clinical Competency Committee must review all resident evaluations at least semi-annually. (Core)
V.A.3.b).(2)	determine each resident's progress on achievement of the specialty-specific Milestones; and, (Core)	5.3.d.	The Clinical Competency Committee must determine each resident's progress on achievement of the specialty-specific Milestones. (Core)
V.A.3.b).(3)	meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress. (Core)	5.3.e.	The Clinical Competency Committee must meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress. (Core)
V.B.	Faculty Evaluation	5.4.	Faculty Evaluation The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)
V.B.1.	The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)	5.4.	Faculty Evaluation The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)
V.B.1.a)	This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities. (Core)	5.4.a.	This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities. (Core)
V.B.1.b)	This evaluation must include written, anonymous, and confidential evaluations by the residents. (Core)	5.4.b.	This evaluation must include written, anonymous, and confidential evaluations by the residents. (Core)

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V.B.2.	Faculty members must receive feedback on their evaluations at least annually. (Core)	5.4.c.	Faculty members must receive feedback on their evaluations at least annually. (Core)
V.B.3.	Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)	5.4.d.	Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)
V.C.	Program Evaluation and Improvement	5.5.	Program Evaluation and Improvement The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)
V.C.1.	The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)	5.5.	Program Evaluation and Improvement The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)
V.C.1.a)	The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident. (Core)	5.5.a.	The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident. (Core)
V.C.1.b)	Program Evaluation Committee responsibilities must include:	[None]	
V.C.1.b).(1)	review of the program's self-determined goals and progress toward meeting them; (Core)	5.5.b.	Program Evaluation Committee responsibilities must include review of the program's self-determined goals and progress toward meeting them. (Core)
V.C.1.b).(2)	guiding ongoing program improvement, including development of new goals, based upon outcomes; and, (Core)	5.5.c.	Program Evaluation Committee responsibilities must include guiding ongoing program improvement, including development of new goals, based upon outcomes. (Core)
V.C.1.b).(3)	review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core)	5.5.d.	Program Evaluation Committee responsibilities must include review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core)
V.C.1.c)	The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate resident and faculty written evaluations of the program, and other relevant data in its assessment of the program. (Core)	5.5.e.	The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate resident and faculty written evaluations of the program, and other relevant data in its assessment of the program. (Core)
V.C.1.d)	The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)	5.5.f.	The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)
V.C.1.e)	The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the residents and the members of the teaching faculty, and be submitted to the DIO. (Core)	5.5.g.	The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the residents and the members of the teaching faculty, and be submitted to the DIO. (Core)
V.C.2.	The program must complete a Self-Study and submit it to the DIO. (Core)	5.5.h.	The program must complete a Self-Study and submit it to the DIO. (Core)

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V.C.3.	***One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.*** ***The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.***	[None]	**Board Certification** ***One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.*** ***The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.***
V.C.3.a)	**For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)**	5.6.	**Board Certification** **For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)**
V.C.3.b)	**For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)**	5.6.a.	**For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.** (Outcome)
V.C.3.c)	**For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)**	5.6.b.	**For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.** (Outcome)
V.C.3.d)	**For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)**	5.6.c.	**For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.** (Outcome)
V.C.3.e)	**For each of the exams referenced in V.C.3.a)-d), any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty. (Outcome)**	5.6.d.	**For each of the exams referenced in 5.6.a.-c., any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty.** (Outcome)
V.C.3.f)	**Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years earlier. (Core)**	5.6.e.	**Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years earlier.** (Core)

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VI	The Learning and Working Environment ***Residency education must occur in the context of a learning and working environment that emphasizes the following principles:*** ***• Excellence in the safety and quality of care rendered to patients by residents today*** ***• Excellence in the safety and quality of care rendered to patients by today's residents in their future practice*** ***• Excellence in professionalism*** ***• Appreciation for the privilege of caring for patients*** ***• Commitment to the well-being of the students, residents, faculty members, and all members of the health care team***	Section 6	Section 6: The Learning and Working Environment The Learning and Working Environment ***Residency education must occur in the context of a learning and working environment that emphasizes the following principles:*** ***• Excellence in the safety and quality of care rendered to patients by residents today*** ***• Excellence in the safety and quality of care rendered to patients by today's residents in their future practice*** ***• Excellence in professionalism*** ***• Appreciation for the privilege of caring for patients*** ***• Commitment to the well-being of the students, residents, faculty members, and all members of the health care team***
VI.A.	Patient Safety, Quality Improvement, Supervision, and Accountability	[None]	
VI.A.1.	Patient Safety and Quality Improvement	[None]	
VI.A.1.a)	Patient Safety	[None]	
VI.A.1.a).(1)	Culture of Safety ***A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.***	[None]	Culture of Safety ***A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.***
VI.A.1.a).(1).(a)	The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)	6.1.	The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)
VI.A.1.a).(2)	Patient Safety Events ***Reporting, investigation, and follow-up of safety events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.***	[None]	Patient Safety Events ***Reporting, investigation, and follow-up of safety events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.***
VI.A.1.a).(2).(a)	Residents, fellows, faculty members, and other clinical staff members must:	[None]	

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VI.A.1.a).(2).(a).(i)	know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report such events; and, (Core)	6.2.	Residents, fellows, faculty members, and other clinical staff members must know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report such events. (Core)
VI.A.1.a).(2).(a).(ii)	be provided with summary information of their institution's patient safety reports. (Core)	6.2.a.	Residents, fellows, faculty members, and other clinical staff members must be provided with summary information of their institution's patient safety reports. (Core)
VI.A.1.a).(2).(b)	Residents must participate as team members in real and/or simulated interprofessional clinical patient safety and quality improvement activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)	6.3.	Residents must participate as team members in real and/or simulated interprofessional clinical patient safety and quality improvement activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)
VI.A.1.a).(3)	Quality Metrics *Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.*	[None]	Quality Metrics *Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.*
VI.A.1.a).(3).(a)	Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)	6.4.	Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)
VI.A.2.	Supervision and Accountability	[None]	Supervision and Accountability *Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.* *Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.*
VI.A.2.a)	*Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.* *Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.*	[None]	Supervision and Accountability *Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.* *Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.*

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VI.A.2.a).(1)	Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. (Core)	6.5.	Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. This information must be available to residents, faculty members, other members of the health care team, and patients. (Core)
VI.A.2.a).(1).(a)	This information must be available to residents, faculty members, other members of the health care team, and patients. (Core)	6.5.	Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. This information must be available to residents, faculty members, other members of the health care team, and patients. (Core)
VI.A.2.a).(2)	The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)	6.6.	The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)
VI.A.2.b)	Levels of Supervision To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:	[None]	Levels of Supervision *To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision.*
VI.A.2.b).(1)	Direct Supervision	6.7.	Direct Supervision *The supervising physician is physically present with the resident during the key portions of the patient interaction.* *The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.*
VI.A.2.b).(1).(a)	the supervising physician is physically present with the resident during the key portions of the patient interaction; or,	6.7.	Direct Supervision *The supervising physician is physically present with the resident during the key portions of the patient interaction.* *The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.*
VI.A.2.b).(1).(a).(i)	PGY-1 residents must initially be supervised directly, only as described in VI.A.2.b).(1).(a). (Core)	6.7.a.	PGY-1 residents must initially be supervised directly, only as described in the above definition. (Core)
VI.A.2.b).(1).(b)	the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.	6.7.	Direct Supervision *The supervising physician is physically present with the resident during the key portions of the patient interaction.* *The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.*

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VI.A.2.b).(1).(b).(i)	The use of telecommunication technology for direct supervision must not be used with invasive procedures, including the conduct of anesthesia; and, (Core)	6.7.b.	The use of telecommunication technology for direct supervision must not be used with invasive procedures, including the conduct of anesthesia. (Core)
VI.A.2.b).(1).(b).(ii)	the supervising physician and the resident must interact with each other, and the patient, to solicit the key elements of the clinic visit and agree upon a management plan; and, (Core)	6.7.c.	The supervising physician and the resident must interact with each other, and the patient, to solicit the key elements of the clinic visit and agree upon a management plan. (Core)
VI.A.2.b).(1).(b).(iii)	must be limited to history-taking and patient examination, assessment, and counseling. (Core)	6.7.d.	The use of telecommunication technology for direct supervision must be limited to history-taking and patient examination, assessment, and counseling. (Core)
VI.A.2.b).(2)	**Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.**	**[None]**	**Indirect Supervision** ***The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.***
VI.A.2.b).(3)	**Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.**	**[None]**	**Oversight** ***The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.***
VI.A.2.c)	**The program must define when physical presence of a supervising physician is required. (Core)**	**6.8.**	**The program must define when physical presence of a supervising physician is required. (Core)**
VI.A.2.d)	**The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. (Core)**	**6.9.**	**The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. (Core)**
VI.A.2.d).(1)	**The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones. (Core)**	**6.9.a.**	**The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones. (Core)**
VI.A.2.d).(2)	**Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. (Core)**	**6.9.b.**	**Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. (Core)**
VI.A.2.d).(3)	**Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)**	**6.9.c.**	**Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)**
VI.A.2.e)	**Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). (Core)**	**6.10.**	**Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). (Core)**
VI.A.2.e).(1)	**Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. (Outcome)**	**6.10.a.**	**Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. (Outcome)**
VI.A.2.f)	**Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. (Core)**	**6.11.**	**Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. (Core)**

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VI.B.	Professionalism	6.12.	Professionalism Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional and ethical responsibilities of physicians, including but not limited to their obligation to be appropriately rested and fit to provide the care required by their patients. (Core)
VI.B.1.	Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional and ethical responsibilities of physicians, including but not limited to their obligation to be appropriately rested and fit to provide the care required by their patients. (Core)	6.12.	Professionalism Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional and ethical responsibilities of physicians, including but not limited to their obligation to be appropriately rested and fit to provide the care required by their patients. (Core)
VI.B.2.	The learning objectives of the program must:	[None]	
VI.B.2.a)	be accomplished without excessive reliance on residents to fulfill non-physician obligations; (Core)	6.12.a.	The learning objectives of the program must be accomplished without excessive reliance on residents to fulfill non-physician obligations. (Core)
VI.B.2.b)	ensure manageable patient care responsibilities; and, (Core)	6.12.b.	The learning objectives of the program must ensure manageable patient care responsibilities. (Core)
VI.B.2.c)	include efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, providing administrative support, promoting progressive independence and flexibility, and enhancing professional relationships. (Core)	6.12.c.	The learning objectives of the program must include efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, providing administrative support, promoting progressive independence and flexibility, and enhancing professional relationships. (Core)
VI.B.3.	The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)	6.12.d.	The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)
VI.B.4.	Residents and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events. (Core)	6.12.e.	Residents and faculty members must demonstrate an understanding of their personal role in the safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and safety events. (Core)
VI.B.5.	Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is psychologically safe and that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff. (Core)	6.12.f.	Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is psychologically safe and that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff. (Core)
VI.B.6.	Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)	6.12.g.	Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)

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VI.C.	**Well-Being** ***Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of residency training.*** ***Residents and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. A positive culture in a clinical learning environment models constructive behaviors, and prepares residents with the skills and attitudes needed to thrive throughout their careers.***	[None]	**Well-Being** ***Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of residency training.*** ***Residents and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. A positive culture in a clinical learning environment models constructive behaviors, and prepares residents with the skills and attitudes needed to thrive throughout their careers.***
VI.C.1.	The responsibility of the program, in partnership with the Sponsoring Institution, must include:	6.13.	The responsibility of the program, in partnership with the Sponsoring Institution, must include:
VI.C.1.a)	attention to scheduling, work intensity, and work compression that impacts resident well-being; (Core)	6.13.a.	attention to scheduling, work intensity, and work compression that impacts resident well-being; (Core)
VI.C.1.b)	evaluating workplace safety data and addressing the safety of residents and faculty members; (Core)	6.13.b.	evaluating workplace safety data and addressing the safety of residents and faculty members; (Core)
VI.C.1.c)	policies and programs that encourage optimal resident and faculty member well-being; and, (Core)	6.13.c.	policies and programs that encourage optimal resident and faculty member well-being; and, (Core)
VI.C.1.c).(1)	Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core)	6.13.c.1.	Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core)
VI.C.1.d)	education of residents and faculty members in:	6.13.d.	education of residents and faculty members in:
VI.C.1.d).(1)	identification of the symptoms of burnout, depression, and substance use disorders, suicidal ideation, or potential for violence, including means to assist those who experience these conditions; (Core)	6.13.d.1.	identification of the symptoms of burnout, depression, and substance use disorders, suicidal ideation, or potential for violence, including means to assist those who experience these conditions; (Core)
VI.C.1.d).(2)	recognition of these symptoms in themselves and how to seek appropriate care; and, (Core)	6.13.d.2.	recognition of these symptoms in themselves and how to seek appropriate care; and, (Core)
VI.C.1.d).(3)	access to appropriate tools for self-screening. (Core)	6.13.d.3.	access to appropriate tools for self-screening. (Core)
VI.C.1.e)	providing access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)	6.13.e.	providing access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)

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VI.C.2.	There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and medical, parental, or caregiver leave. Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities. (Core)	6.14.	There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and medical, parental, or caregiver leave. Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities. (Core)
VI.C.2.a)	The program must have policies and procedures in place to ensure coverage of patient care and ensure continuity of patient care. (Core)	6.14.a.	The program must have policies and procedures in place to ensure coverage of patient care and ensure continuity of patient care. (Core)
VI.C.2.b)	These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work. (Core)	6.14.b.	These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work. (Core)
VI.D.	Fatigue Mitigation	6.15.	Fatigue Mitigation Programs must educate all residents and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes. (Detail)
VI.D.1.	Programs must educate all residents and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes. (Detail)	6.15.	Fatigue Mitigation Programs must educate all residents and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes. (Detail)
VI.D.2.	The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. (Core)	6.16.	The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. (Core)
VI.E.	Clinical Responsibilities, Teamwork, and Transitions of Care	[None]	
VI.E.1.	Clinical Responsibilities The clinical responsibilities for each resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services. (Core)	6.17.	Clinical Responsibilities The clinical responsibilities for each resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services. (Core)
VI.E.2.	Teamwork Residents must care for patients in an environment that maximizes communication and promotes safe, interprofessional, team-based care in the specialty and larger health system. (Core)	6.18.	Teamwork Residents must care for patients in an environment that maximizes communication and promotes safe, interprofessional, team-based care in the specialty and larger health system. (Core)
VI.E.3.	Transitions of Care	6.19.	Transitions of Care Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)
VI.E.3.a)	Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)	6.19.	Transitions of Care Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)
VI.E.3.b)	Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety. (Core)	6.19.a.	Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety. (Core)
VI.E.3.c)	Programs must ensure that residents are competent in communicating with team members in the hand-off process. (Outcome)	6.19.b.	Programs must ensure that residents are competent in communicating with team members in the hand-off process. (Outcome)

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VI.F.	**Clinical Experience and Education** ***Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.***	[None]	**Clinical Experience and Education** ***Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.***
VI.F.1.	**Maximum Hours of Clinical and Educational Work per Week** **Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)**	6.20.	**Maximum Hours of Clinical and Educational Work per Week** **Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)**
VI.F.2.	**Mandatory Time Free of Clinical Work and Education**	6.21.	**Mandatory Time Free of Clinical Work and Education** **Residents should have eight hours off between scheduled clinical work and education periods. (Detail)**
VI.F.2.a)	**Residents should have eight hours off between scheduled clinical work and education periods. (Detail)**	6.21.	**Mandatory Time Free of Clinical Work and Education** **Residents should have eight hours off between scheduled clinical work and education periods. (Detail)**
VI.F.2.b)	**Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)**	6.21.a.	**Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)**
VI.F.2.c)	**Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. (Core)**	6.21.b.	**Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. (Core)**
VI.F.3.	**Maximum Clinical Work and Education Period Length**	6.22.	**Maximum Clinical Work and Education Period Length** **Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core)**
VI.F.3.a)	**Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core)**	6.22.	**Maximum Clinical Work and Education Period Length** **Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core)**
VI.F.3.a).(1)	**Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time. (Core)**	6.22.a.	**Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time. (Core)**
VI.F.4.	**Clinical and Educational Work Hour Exceptions**	6.23.	**Clinical and Educational Work Hour Exceptions** **In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events. (Detail)**

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VI.F.4.a)	**In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events. (Detail)**	6.23.	**Clinical and Educational Work Hour Exceptions** **In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events. (Detail)**
VI.F.4.b)	**These additional hours of care or education must be counted toward the 80-hour weekly limit. (Detail)**	6.23.a.	**These additional hours of care or education must be counted toward the 80-hour weekly limit. (Detail)**
VI.F.4.c)	**A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.** The Review Committee for Anesthesiology will not consider requests for exceptions to the 80-hour limit to the residents' work week.	6.24.	**A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.** The Review Committee for Anesthesiology will not consider requests for exceptions to the 80-hour limit to the residents' work week.
VI.F.5.	**Moonlighting**	6.25.	**Moonlighting** **Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. (Core)**
VI.F.5.a)	**Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. (Core)**	6.25.	**Moonlighting** **Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. (Core)**
VI.F.5.b)	**Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core)**	6.25.a.	**Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core)**
VI.F.5.c)	**PGY-1 residents are not permitted to moonlight. (Core)**	6.25.b.	**PGY-1 residents are not permitted to moonlight. (Core)**
VI.F.6.	**In-House Night Float** **Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. (Core)**	6.26.	**In-House Night Float** **Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. (Core)**
VI.F.7.	**Maximum In-House On-Call Frequency** **Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core)**	6.27.	**Maximum In-House On-Call Frequency** **Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core)**
VI.F.8.	**At-Home Call**	6.28.	**At-Home Call** **Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. (Core)**

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirement Language
VI.F.8.a)	Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. (Core)	6.28.	At-Home Call Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. (Core)
VI.F.8.a).(1)	At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core)	6.28.a.	At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core)