Common Program Requirements
Frequently Asked Questions
ACGME

Question	Answer
Institutions	
What is the purpose of Program Letters of Agreement (PLAs)? *[Common Program Requirement: I.B.1.; One-Year Common Program Requirement: I.B.1.]*	PLAs provide details on faculty, supervision, evaluation, educational content, length of assignment, and policy and procedures for each required assignment that occurs outside of an accredited program's sponsoring institution. These documents are intended to protect the program's residents/fellows by ensuring an appropriate educational experience under adequate supervision. PLAs are intended to be brief, informal documents (approximately one-to-two pages in length) that as simply as possible: a) identify the faculty members who will assume both educational and supervisory responsibilities for residents/fellows; b) specify these faculty members' responsibilities for the teaching, supervision, and formal evaluation of residents/fellows; c) specify the duration and content of the educational experience; and, d) state the policies and procedures that will govern resident/fellow education during the assignment. A sample PLA can be found here.
What is the minimum experience for which a PLA needs to exist between an accredited program and a site involved in residency/fellowship education? *[Common Program Requirement: I.B.1.; One-Year Common Program Requirement: I.B.1.]*	There must be PLAs between an accredited program and all sites to which residents/fellows rotate for required education or assignments.

Question	Answer
Are PLAs necessary for "courses," such as the Armed Forces Institute of Pathology course or the Bellevue Hospital Toxicology Course? *[Common Program Requirement: I.B.1.; One-Year Common Program Requirement: I.B.1.]*	These types of courses are not examples of participating sites, and therefore do not require PLAs.
Are PLAs needed when sites are closely associated? For instance, would PLAs be necessary between a university hospital and the children's hospital with which it has close ties? *[Common Program Requirement: I.B.1.; One-Year Common Program Requirement: I.B.1.]*	A program sponsored by a university hospital that requires a rotation/assignment at the children's hospital would require a PLA if the two entities are operated by two different governing bodies (e.g., two separate Boards of Directors). However, if the two sites operate essentially as one entity, that is, they are governed by one governing body (e.g., a single Board of Directors), a PLA is not necessary. This reasoning applies to all closely-associated sites, not only those between university and children's hospitals. A PLA is not required for a rotation to an integrated site if the written document between the sponsor and the integrated site incorporates the elements of the PLAs (Common Program Requirements I.B.1.a)-d)). Including all the required elements in the Integration Agreement will eliminate the need for a separate PLA.
Are PLAs necessary for rotations to physicians' offices, nursing homes, ambulatory surgical centers, and other similar learning environments? *[Common Program Requirement: I.B.1.; One-Year Common Program Requirement: I.B.1.]*	PLAs are not necessary if the following on- or off-campus site is under the governance of the program's Sponsoring Institution or is an office of a physician who is a member of that Sponsoring Institution's teaching faculty/medical staff: nursing and assisted living homes; hospice facilities; faculty patient care offices; private physicians' offices (volunteer faculty); ambulatory surgical centers; diagnostic centers (e.g., imaging, laboratory, etc.); treatment centers (e.g., dialysis, rehabilitation, chemotherapy, etc.); or other similar sites. PLAs are required for rotations to these types of sites if not governed by the program's Sponsoring Institution or if they occur in offices of physicians who are not members of the Sponsoring Institution's teaching faculty/medical staff. Some Review Committees have more stringent criteria, so program directors should consult and review the specialty/subspecialty Program Requirements and the specialty section of the ACGME website for more specific details, when applicable.

Question	Answer
If a program director and/or faculty member functions within multiple participating sites that educate residents/fellows (e.g., the program director oversees the program at the sponsoring university hospital and is also the local director at the VA medical center), does he/she need a PLA with him/herself? *[Common Program Requirement: I.B.1.; One-Year Common Program Requirement: I.B.1.]*	PLAs are not necessary when a rotation/assignment occurs at a site under the governance of the program's sponsor or in an office of a physician who is a member of the Sponsoring Institution's teaching faculty/medical staff. However, in this example, the VA is unlikely to be under the governance of the sponsor, so the program director needs to appoint a local director at the VA site who is accountable for the day-to-day activities of residents/fellows (Common Program Requirement II.A.4.b)). A PLA between the program director and the local director would be necessary in this example.
Who should sign the PLAs for the Sponsoring Institution and for the participating sites? *[Common Program Requirement: I.B.1.; One-Year Common Program Requirement: I.B.1.]*	A PLA should include the signatures of the program director as initiating the letter and the local director at the participating site. The official signing for the participating site to which the residents/fellows rotate should be the individual responsible for supervising and overseeing resident/fellow education at that location (e.g., the local director or, in some cases, the medical director). Although the Requirements do not specify that the PLA include the signature of the designated institutional official (DIO), institutions may find it prudent to include this signature. It is the responsibility of the DIO, in collaboration with the Graduate Medical Education Committee (GMEC) of the Sponsoring Institution, to establish and administer the local policies and procedures regarding PLAs.
Does a subspecialty program need a separate PLA if the specialty (core) program already has one in place with a particular institution? *[Common Program Requirement: I.B.1.; One-Year Common Program Requirement: I.B.1.]*	Although a single PLA that provides the Review Committee with appropriate information (i.e., the content of the experience, supervision, evaluation, length of assignment, policies and procedures) for both the specialty and subspecialty programs would be acceptable, such a document may be long and overly complicated. The preferred strategy would be to develop two separate letters, one for the specialty program, and another for the subspecialty program.

Question	Answer
When should PLAs be updated? *[Common Program Requirement: I.B.1.; One-Year Common Program Requirement: I.B.1.]*	Agreements should be updated whenever there are changes in program director or participating site director or in resident/fellow assignments, or when there are revisions to the items specified in Common Program Requirements I.B.1.a)-d). PLAs must be renewed at least every five years. If nothing in the agreement has changed at the end of five years, it is acceptable to add an amendment signifying review and extension of the agreement with signatures.
How are PLAs reviewed for purposes of accreditation? *[Common Program Requirement: I.B.1.; One-Year Common Program Requirement: I.B.1.]*	During a program site visit, a program director should have the PLAs available for review by the site visitor. Program directors and DIOs should contact the Review Committee Executive Director for more specific details or further clarification. The sample PLA template linked on the first page of this document has been prepared to assist DIOs and program directors. It represents the minimal detail acceptable to a Review Committee. Addition of more detail is not required and occurs at the sole discretion of the Sponsoring Institution or participating site according to local policies and procedures.
Is a Sponsoring Institution required to maintain master affiliation agreements with its major participating sites? *[Common Program Requirement: I.B.1.; One-Year Common Program Requirement: I.B.1.]*	No; the Institutional Requirements (effective since 7/1/14, including the most recent revision, effective 7/1/15) no longer require Sponsoring Institutions to maintain master affiliation agreements with their major participating sites.
Resident/Fellow Appointments	
In what settings are the 2016 eligibility requirements applicable? *[Common Program Requirements: III.A. – III.A.2.c); One-Year Common Program Requirements: III.A. – III.A.3.]*	The 2016 eligibility requirements in section III.A. apply to prerequisite training for entry or transfer into ACGME-accredited residency programs. This includes entry at the PGY-2 level (or above) into programs in specialties that require an initial year (or two) prior to entry into a program (e.g., anesthesiology, diagnostic radiology, neurology, nuclear medicine, etc.), and transfer entry at the PGY-2 level (or above) into programs in specialties that do not require an initial year prior to entry into a program (e.g., internal medicine, pediatrics). The new requirements are effective July 1, 2016 (i.e., for entry into residency during Academic Year 2016-2017). Eligibility requirements III.A. and III.A.2. (One-Year Common Program Requirement III.A.) also apply to prerequisite training for entry into ACGME-accredited fellowship programs. They are effective July 1, 2016 (i.e., for entry into fellowship during Academic Year 2016-

Question	Answer
	2017). For initial entry into ACGME-accredited residency programs that require no prerequisite graduate medical education, the eligibility requirements remain unchanged. See Institutional Requirements Section II.A.1.
Why did the ACGME adopt the 2016 eligibility requirements? *[Common Program Requirements: III.A. – III.A.2.c); One-Year Common Program Requirements: III.A. – III.A.3.]*	The 2016 eligibility requirements addressed a heterogeneity of previous ACGME program requirements related to the eligibility of trainees to enter programs at the PGY-2 level or beyond, and to the eligibility for entry into fellowship programs. A more uniform requirement is appropriate to define the ACGME accreditation credential, upon which Medicare, state physician licensing boards, medical certifying boards, and hospital credentials committees rely in the assessment of the trainee's performance of the GME program.
What did the ACGME consider important in adopting the 2016 eligibility requirements for entry into ACGME-accredited residency and fellowship programs? *[Common Program Requirements: III.A. – III.A.2.c); One-Year Common Program Requirements: III.A. – III.A.3.]*	ACGME-accredited residency and fellowship programs operate with a well-developed educational curriculum; qualified faculty; supervision and graduated responsibility; ongoing evaluation of trainee competence; and required program director and Sponsoring Institution oversight. Collectively, these attributes allow trainees to safely and effectively participate in patient care. Furthermore, the physician and other health care colleagues of each resident/fellow make assumptions concerning the resident's/fellow's previous experience, and have reasonable expectations of the competence of the individual. Therefore, the ACGME has the responsibility to maintain accreditation requirements that require that prerequisite training will meet those assumptions and expectations. The implications for fellowship entrants are even more significant because of their engagement in clinical care with reduced supervision, and their role as teachers and supervisors for more junior residents. All members of the health care team have expectations of prior levels of education and demonstrated competence of these advanced trainees. The central theme of the ACGME's Next Accreditation System (NAS) is revision is the tracking of resident/fellow performance and competence continually throughout training, documenting each resident's/fellow's development and performance in areas deemed essential by the profession. This tracking will periodically inform the resident/fellow, as well as the public, of satisfactory progress of each trainee toward independent practice. NAS tracking will document improvement where residents/fellows have previously failed to achieve expectations in relationship to milestones of development in each of the six

Question	Answer
	specialty-specific domains of clinical competency, the Milestones. Through the NAS, the ACGME continually monitors the effectiveness of the educational environment. This developmentally founded, national standard-based tracking of resident/fellow development provides the essential structure for the formation of residents/fellows participating in ACGME-accredited residency/fellowship programs. Residents/fellows who train in environments other than ACGME-accredited programs lack any ACGME accreditation oversight of the educational program. More importantly, these trainees are not evaluated using the ACGME schema, and the results of that evaluation are not tracked by the ACGME. Thus, subject to the exceptions in the new requirements, the ACGME cannot ensure the public of the quality of the required preparation for entry into advanced training positions in ACGME-accredited programs.
Will residents/fellows who are eligible for appointment to ACGME-accredited programs under the 2016 ACGME eligibility requirements also be eligible for certification by the applicable American Board of Medical Specialties (ABMS) boards? *[Common Program Requirements: III.A. – III.A.2.c); One-Year Common Program Requirements: III.A. – III.A.3.]*	Eligibility for appointment to an ACGME-accredited residency or fellowship does not ensure eligibility for board certification. Programs are responsible for advising residents/fellows to contact the applicable ABMS boards regarding eligibility for certification.
Does training in a "dually-accredited" program fulfill eligibility requirements? *[Common Program Requirements: III.A. – III.A.2.c); One-Year Common Program Requirements: III.A. – III.A.3.]*	Training in a program that is "dually accredited" by the ACGME and the American Osteopathic Association (AOA) is regarded the same as that in any other ACGME-accredited program. Such training fulfills the eligibility requirements for entry into residency programs requiring one (or more) years of prerequisite training. Core residency training fulfills requirements for transfer to another ACGME-accredited program in the same specialty. Completion of a residency program fulfills eligibility requirements for a fellowship in that same specialty. (Note that while the AOA refers to these as "dually-accredited programs," the resident complements, curricula, and faculty are not entirely the same).

Question	Answer
Why does the ACGME accept Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited and College of Family Physicians of Canada (CFPC)-accredited training in Canada? *[Common Program Requirements: III.A.1.a), III.A.1.b), and III.A.2.; One-Year Common Program Requirement: III.A.]*	During the past 25 years, most ACGME specialty requirements have accepted RCPSC-accredited training as prerequisite for entry into ACGME-accredited programs. RCPSC-accredited residency programs utilize a competency-based training paradigm (CanMEDS) that is very similar to the ACGME Milestones. RCPSC-accredited programs are based in specialty departments of Canadian medical schools accredited jointly by the RCPSC and the Liaison Committee on Medical Education (LCME), the group that accredits allopathic medical schools in the United States. Like RCPSC-accredited residency programs, residency programs accredited by the CFPC utilize CanMEDS and are based in specialty departments of Canadian medical schools accredited jointly by the RCPSC and LCME. In addition, the same general standards for the accreditation of postgraduate training programs that are utilized by the RCPSC are also utilized by the CFPC.
For entry into ACGME-accredited residency programs in specialties that do not require an initial year prior to entry into a program, can trainees receive any credit for training completed in programs not accredited by the ACGME or the RCPSC/CFPC? *[Common Program Requirement: III.A.1.b)]*	In specialties that do not require an initial year prior to entry into a program, a credit for one year of training may be allowed, at the program director's discretion, for residents who have completed a residency program in the specialty not accredited by the ACGME, RCPSC, or CFPC. Such residents must enter at the PGY-1 level and may be advanced to the PGY-2 level by the Clinical Competency Committee based on Milestone assessments. The Review Committees do not review or approve this credit for prior training on a per-resident basis. The appropriate ABMS board should be contacted to determine if a resident will receive credit for prior training.
To what training does "…a residency program that was not accredited by the ACGME, RCPSC, or CFPC…" refer? *[Common Program Requirement: III.A.1.b)]*	An example of training referenced in III.A.1.b) is completion of an international residency. Individuals who have completed such training are eligible for admission to an ACGME-accredited program at the PGY-1 level and advancement to the PGY-2 level based on Milestones assessments. Note that this applies only to programs in specialties for which an initial clinical year is not required for entry.

Question	Answer
Will residents who have completed residency programs not accredited by the ACGME, RCPSC, or CFPC be eligible for appointment to an ACGME-accredited residency program that requires completion of a residency as a prerequisite for entry? *[Common Program Requirements: III.A.1.c) and III.A.2.b)]*	Review Committees may grant the exception specified in III.A.2.b) of the Program Requirements for residency programs in specialties that require completion of another prerequisite residency program prior to admission. Note that this applies only to programs in specialties for which an initial clinical year is not required for entry. The Review Committees for Allergy and Immunology and Nuclear Medicine may grant the exception specified in III.A.2.b) of the Program Requirements for residency programs that require completion of another prerequisite residency program prior to admission. The Review Committees for Colon and Rectal Surgery, Plastic Surgery, and Thoracic Surgery will not permit this exception. Nuclear medicine programs accept residents at the NM1 (second post-graduate year) after completion of a clinical base year, at the NM2 level after completion of a residency program in another specialty, and at the NM3 level after completion of a radiology residency. Applicants entering at the NM1 level would need to complete a clinical base year accredited by the ACGME, RCPSC, or CFPC. Applicants who have completed a non-ACGME-accredited residency in another specialty or in diagnostic radiology could apply for entry at the NM2 or NM3 level respectively per III.A.2.b).

Question	Answer
The 2016 eligibility requirements specify that all required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, or in an RCPSC-accredited or CFPC-accredited residency program located in Canada. If an individual was in an AOA-approved residency program at the time that program achieved ACGME Initial Accreditation, would that individual be eligible for appointment to an ACGME-accredited fellowship program? *[Common Program Requirement III.A.2; One-Year Common Program Requirement: III.A.]*	During the transition to a single GME accreditation system, an individual who completes a program after it has achieved ACGME Initial Accreditation is eligible for appointment to an ACGME-accredited fellowship presuming that the core residency program completed by the individual is in a specialty that is an acceptable prerequisite as specified in the applicable subspecialty Program Requirements.
Will residents who have completed a combined residency program not accredited by the ACGME be eligible for appointment to an ACGME-accredited fellowship program? *[Common Program Requirement III.A.2.; One Year Common Program Requirement III.A.]*	Examples of such training include emergency medicine-pediatrics, family medicine-preventive medicine, and psychiatry-pediatrics-child psychiatry. The ACGME website now lists these programs as Combined Specialty Tracks – components individually accredited. If each of the programs participating in the combined programs is ACGME-accredited, residents enrolled in the combined residency program will be eligible for transfer into another ACGME-accredited residency program and graduates of the program will be eligible for appointment to an ACGME-accredited fellowship. While the ACGME does not accredit combined programs (with the exception of internal medicine-pediatrics), the ACGME accredits each of the programs constituting the combined program. Therefore, graduates of these programs have completed their training in ACGME-accredited residency programs.

Question	Answer
If a fellowship program is unable to obtain Milestones assessments from the core residency of a fellow entering the fellowship in a given year, will the program be cited for failing to obtain this information? *[Common Program Requirement: III.A.2.a); One-Year Common Program Requirement: III.A.1.]*	If a program is able to document that the Milestones assessments were requested from the core residency program director, the fellowship program will not be cited for non-compliance even if the core program director does not provide the assessments. A new reporting feature is now available for fellowship programs within the Accreditation Data System (ADS). This feature provides fellowship program directors access to the final Milestones report for an active fellow's most recently completed residency program. There are a few scenarios in which these reports may not be available. The residency Milestones evaluation may be unavailable if the resident completed core residency training in a program not accredited by the ACGME, if the resident completed core residency training prior to the Milestones implementation, or if the resident's previous training could not be matched when entered into the program. For those residents without Milestones reports, programs must contact the specialty program director from the fellow's most recent residency program to obtain the required information. This new feature can be found within ADS by logging in and navigating to the program's "Reports" tab and selecting the Residency Milestone Retrieval option.

Question	Answer
Why does the ACGME require the GMEC or a subcommittee of the GMEC to review and approve all candidates under the “exceptionally qualified applicant” exception? *[Common Program Requirement: III.A.2.b).(2); One-Year Common Program Requirement: III.A.2.b)]*	The requirement that the GMEC or a subcommittee of the GMEC review and approve all candidates under the “exceptionally qualified applicant” exception is to provide a check on candidates qualifying under the definition of this exception. A graduate medical education program is an educational program associated with health care providers that assume a continued presence of a particular number of trainees at a particular knowledge, skill, and competency level, who both provide health care under supervision, and supervise more junior trainees. A gap in that particular number of qualified fellows may be disruptive to the normal provision of health care by these health care providers. In these circumstances, program directors may perceive pressure from individuals within an institution to fill empty slots for the sake of avoiding the disruption, but with less attention to a particular candidate’s knowledge, skill, and competency levels. The Review Committee sets the policy and the program determines if a candidate meets the stated criteria. Because the Review Committee does not review or approve the determination of an exceptionally qualified applicant, the ACGME relies on the Sponsoring Institution to provide oversight in the selection of exceptional candidates and monitoring of their performance. This oversight will promote programs’ exercise of due diligence in selection. The oversight need not be burdensome or intrusive; rather it provides an opportunity for the GMEC to collaborate with programs to ensure that these select candidates fulfill expectations for entry-level competency.

Question	Answer
Why does the exception to the new fellowship eligibility requirements provide for particular consideration of ACGME International-accredited training? *[Common Program Requirements: III.A.2.b)* and II.A.2.b).(5); One-Year Common Program Requirements: III.A.2.* and III.A.2.e)]*	The ACGME International (ACGME-I) provides accreditation oversight similar to that provided by the ACGME. ACGME-I-accredited residency programs evaluate resident competency using the Milestones framework, determine resident progress through a Clinical Competency Committee based on multidimensional evaluation systems approved by the ACGME-I, and report achievement of those Milestones semiannually to the ACGME-I. Completion of an ACGME-I-accredited residency program is recognized and relied upon by licensing and other authorities in the country in which the residency program is located, as well as regionally. Currently, however, no ABMS board accepts ACGME-I training as fulfilling training requirements for certification. ACGME-I-accredited program graduates who have completed a residency in the core specialty and who have demonstrated clinical excellence, in comparison to peers, throughout training are considered to have fulfilled—by the nature of that training—the "additional evidence of exceptional qualifications" requirement in III.A.2.b) (One-Year Common Program Requirement III.A.2.)*.
How will fellowship programs conduct a Milestones assessment of fellows appointed through the "exceptionally qualified applicant" pathway? *[Common Program Requirement: III.A.2.b).(5); One-Year Common Program Requirement: III.A.2.e)]*	Within six weeks of matriculation, programs will conduct a Milestones assessment of such a fellow's competency. That assessment will ensure that the fellow has at least entry-level competency in the specialty. The program may choose to use the subspecialty Milestones, the core specialty Milestones, or a combination. The assessment may be conducted by the fellowship Clinical Competency Committee (CCC) independently, or in collaboration with the sponsoring core program's CCC. Programs may use one or more evaluation tools (e.g., global faculty evaluations, CEX, Simulation Center, OSCE, etc.) in this assessment.
Is an international medical graduate applying to an ACGME-accredited fellowship program as an exceptionally qualified applicant required to pass Step 3 of the USMLE prior to appointment? *[Common Program Requirement: III.A.2.b).(3); One-Year Common Program Requirement: III.A.2.c)]*	International medical graduates who have passed the USMLE Steps 1 and 2 and obtained ECFMG certification are eligible to take the USMLE Step 3. However, the USMLE program recommends that for Step 3 eligibility, applicants should have completed, or be near completion of, at least one post-graduate training year in a US-accredited graduate medical education program that meets state board licensing requirements. International medical graduates who adhere to this recommendation and have not taken the USMLE Step 3, but who meet all of the other criteria for exceptionally qualified applicants, will be eligible for appointment to an ACGME-accredited fellowship if the applicable Review Committee permits these exceptions.

Question	Answer
Evaluation	
What is the role of the program director on the CCC? *[Common Program Requirement: V.A.1.; One-Year Common Program Requirement: V.A.1.]*	The requirements regarding the CCC do not preclude or limit a program director's participation on the CCC. The intent is to leave flexibility for each program to decide the best structure for its own circumstances, but a program should consider: its program director's other roles as resident/fellow advocate, advisor, and confidante; the impact of the program director's presence on the other CCC members' discussions and decisions; the size of the program faculty; and other program-relevant factors. The program director has final responsibility for the program's evaluation and promotion decisions.
How can small programs have three members of the program faculty on the CCC? *[Common Program Requirement: V.A.1.a); One-Year Common Program Requirement: V.A.1.a)]*	The intent is to have enough members to broaden the input in a resident's/fellow's evaluation. Program faculty can include more than the physician faculty such as other physicians and non-physicians who teach and evaluate the program's residents/fellows. For example, a fellowship may include faculty members from the core program or from required rotations in other specialties.
Are non-physicians permitted to serve on the CCC? *[Common Program Requirement: V.A.1.a).(1).(a); One-Year Common Program Requirement: V.A.1.a).(1).(a)]*	The requirements are intended to provide the program director with sufficient flexibility to select individuals he/she believes have the background and experience needed to evaluate resident/fellow performance based on the Milestones. This may include health professionals who have extensive contact and experience with residents. Examples include, but are not limited to, nurses, PhDs, physicians' assistants, and therapists.
What is the role of the program coordinator on the CCC? *[Common Program Requirement: V.A.1.a).(1).(a); One-Year Common Program Requirement: V.A.1.a).(1).(a]*	Program coordinators play a critical role in their residency/fellowship programs and may, through the program's resident/fellow evaluation system, provide valuable insight on resident/fellow performance in areas such as interpersonal and communication skills, teamwork, and professionalism. Further, the program coordinator may, at the program director's discretion, attend CCC meetings to support the activities of the CCC, such as collation of data on each resident/fellow, taking meeting minutes, recording decisions, and managing the submission of Milestones data to the ACGME. However, evaluation of resident/fellow competence related to the Milestones for patient care and medical knowledge is a vital responsibility of the CCC and these assessments should be made by individuals with background and experience in health care. Therefore, program coordinators, although they may administratively serve the CCC and take part in the 360 assessments of the resident/fellow, may not serve as voting members of the CCC.

Question	Answer
What role can program residents, including chief residents who have not completed the program, play on the CCC? *[Common Program Requirement: V.A.1.a).(1).(b); One-Year Common Program Requirement: V.A.1.a).(1).(b)]*	Program residents and chief residents in accredited years of the program may provide input to the CCC Chair and/or the program director, outside the context of the CCC meetings, through the evaluation system. However, to ensure that residents' peers are not providing promotion and graduation decisions, and that they are not involved in recommendations for remediation or disciplinary actions, these residents may not serve as CCC members or attend CCC meetings.
When would it be acceptable to not include a resident/fellow on the Program Evaluation Committee (PEC)? *[Common Program Requirement: V.C.1.a).(1); One-Year Common Program Requirement: V.C.1.a).(1)]*	A resident/fellow must always be included on a PEC unless there are no residents/fellows enrolled in the program. The PEC must meet annually, even when there are no residents/fellows enrolled in the program, to evaluate and review the program.
The specialty-specific Program Requirements stipulate a minimum percentage of program graduates that must take the certifying examination offered by the applicable ABMS member board. Must osteopathic graduates take the ABMS board examination rather than the examination offered by the applicable AOA certifying board?	No. Programs in which some or all graduates take the applicable AOA certifying exam may not achieve the required minimum "take rate" for the applicable ABMS board examination as specified in the specialty-specific Program Requirements. When this occurs the program will not receive a citation and the program's accreditation status will not be adversely impacted on the basis of non-compliance with this requirement. The ACGME believes that the goal of ACGME-accredited residency/fellowship education is to produce physicians who seek and receive certifying board certification, recognizing that some graduates will be eligible for both exams and will have the freedom to choose which exam to take. This expectation will be addressed in the Common Program Requirements at the time of their next major revision.

Question	Answer
The Learning and Working Environment	
According to the Common and Institutional Requirements, programs and Sponsoring Institutions must have oversight for clinical and educational work hours [Common Program Requirement II.A.4.j).(2) and Institutional Requirement IV.J.]. Does this mean that a Sponsoring Institution must do electronic, "real-time" monitoring of clinical and educational work hours for all accredited programs? *[Common Program Requirement: II.A.4.j).(2); Institutional Requirement: IV.J.]*	The ACGME requires that programs and their Sponsoring Institutions monitor resident/fellow clinical and educational work hours to ensure they comply with the requirements, but does not specify how monitoring and tracking of clinical and educational work hours should be accomplished. The ACGME does not mandate a specific monitoring approach, since the ideal approach should be tailored to each program and its Sponsoring Institution. For example, the approach best suited for neurological surgery will be different from the one most appropriate for preventive medicine, dermatology, or pediatrics, etc.
The philosophical statement in the Introduction to Section VI references effacement of self-interest as a component of professionalism. Isn't this in conflict with the emphasis on physician well-being reflected in the new requirements? *[Common Program Requirement: VI. Introduction; One-Year Common Program Requirement: VI. Introduction]*	Effacement of self-interest is an essential component of professionalism for physicians, but does not imply that physicians should jeopardize their own well-being to prioritize the well-being of their patients. Prioritization of physician well-being is important in ensuring that physicians remain fit to provide care for their patients. Requirement VI.C.2. requires a process to ensure continuity of care in the event that a resident or fellow is unable to perform their patient care duties, and Requirement VI.B.5. addresses the expectation that residents/fellows and faculty members demonstrate responsiveness to patient needs that supersedes self-interest and emphasizes that in some circumstances, the best interests of the patient may be served by transitioning the patient's care to another qualified and rested provider.

Question	Answer
Are the new requirements related to patient safety and quality improvement intended to apply solely in inpatient settings? *[Common Program Requirement: VI.A.1.; One-Year Common Program Requirement: VI.A.1.]*	The new requirements related to patient safety and quality improvement are not limited to inpatient experiences, and thus are inclusive of care provided in outpatient settings.
With regards to the requirement relating to provision of data to residents/fellows and faculty members on quality metrics and benchmarks related to their patient populations, is the expectation that individual data regarding clinical performance must be provided? *[Common Program Requirement: VI.A.1.b).(2).(a); One-Year Common Program Requirement: VI.A.1.b).(2).(a)]*	Providing individual, specialty-specific data is desirable, but not required. The requirement seeks to ensure that quality metrics used by the institution are shared with residents/fellows and faculty members. Examples of metrics include, but are not limited to, those provided by the following: Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), Centers for Medicaid and Medicare Services (CMS), Press Gainey, and National Surgical Quality Improvement Program (NSQIP).
How should the appropriate level of supervision be determined for each resident or fellow? *[Common Program Requirements: VI.A.2.c)-VI.A.2.c).(3); One-Year Common Program Requirements: VI.A.2.c)-c).(3)]*	The assignment of progressive responsibility for patient care to residents and fellows is an essential component of graduate medical education and is necessary to prepare residents and fellows to be independent practitioners. While decisions regarding the appropriate level of supervision are made by the program director and faculty, the Common Program Requirements provide a framework for the progression from direct supervision to oversight. The level of supervision for an individual resident or fellow is determined both by the abilities of the resident and the needs of each patient. Therefore, the level of supervision required for a resident or fellow will have to vary based on the circumstances.

Question	Answer
How can residents and fellows identify the accountable attending physician for each patient for whom they are providing care? *[Common Program Requirement: VI.A.2.a).(1); One-Year Common Program Requirement: VI.A.2.a).(1)]*	Residents and fellows must know who the accountable attending physician is prior to making any clinical decisions on behalf of a patient. The program and institution are responsible for providing that information to all residents and fellows. Residents and fellows are responsible for keeping the accountable physician informed.
How do residents communicate with the accountable physician? *[Common Program Requirement: VI.A.2.a).(1); One-Year Common Program Requirement: VI.A.2.a).(1)]*	This communication may occur in-person or via portal, fax, text, phone, or e-mail. It is essential that each patient's primary physician be listed in the patient's chart. If that information is not included in the chart, the patient should be asked to provide the name of their primary physician. If the patient does not have one, a determination regarding who will assume responsibility for overall care must be made and documented in the patient's chart.
How will compliance with the requirement regarding accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data be assessed? *[Common Program Requirement: VI.B.4.f); One-Year Common Program Requirement: VI.B.4.f)]*	Approaches for monitoring and documenting are left to the discretion of program and institutional leadership, who should decide on the optimal way to ensure accuracy of reporting.

What is work compression and why is it addressed in the new requirements? *[Common Program Requirement: VI.C.1.b); One-Year Common Program Requirement: VI.C.1.b)]*	In the context of the Common Program Requirements, work compression occurs when physicians are required to do the same amount of work in less time, and has been addressed in the new requirements to ensure that programs consider the impact of work compression on well-being and how the impact can be minimized. To help frame the issue, a review of the literature relevant to work compression is provided below. Research has found high workload and work compression associated with reduced empathy in medical interns (Bellini, 2002), with residents selectively discharging older inpatients earlier (Hilson, 1993), with increased risk for mortality (Hilson, 1992, Ong 2007) and readmission (Thanarajasingam, 2012), lower patient satisfaction (Griffith, 1998), greater use of diagnostic tests (Griffith, 1996), and shifting from active patient care to monitoring to keep workload manageable (Cao, 2008). Studies of the effect of workload on resident outcomes found reduced educational participation with higher workload (Arora, 2008), an inverse relationship between workload and intern perceptions of the quality of their education and their own professionalism (Auger, 2012), and improved conference attendance with a limit on patient admissions (Thanarajasingam, 2012). Bellini LM, Baime M, Shea JA. 2002. Variation of mood and empathy during internship. *JAMA* 287:3143–46 Hilson SD, Rich EC, Dowd BE, et al. 1993. The impact of intern workload on length of hospital stay for elderly patients. *Gerontol. Geriatr. Educ.* 14(2):33–40 Hillson SD, Rich EC, Dowd B, et al. 1992. Call nights and patients care: effects on inpatients at one teaching hospital. *J. Gen. Intern. Med.* 7(4):405–10 Ong M, Bostrom A, Vidyarthi A, et al. 2007. House staff team workload and organization effects on patient outcomes in an academic general internal medicine inpatient service. *Arch. Intern. Med.* 167(1):47–52 Thanarajasingam U, McDonald FS, Halvorsen AJ, et al. 2012. Service census caps and unit-based admissions: resident workload, conference attendance, duty hour compliance, and patient safety. *Mayo Clin. Proc.* 87(4):320–27 Griffith CH 3rd, Wilson JF, Rich EC. 1998. The effect at one teaching hospital of interns' workloads on the satisfaction of their patients. *Acad. Med.* 73(4):427–29 Griffith CH 3rd, Desai NS, Wilson JF, et al. 1996. Housestaff experience, workload, and test ordering in a neonatal intensive care unit. *Acad. Med.* 71(10):1106–8 Cao CG, Weinger MB, Slagle J, et al. 2008. Differences in day and night shift clinical performance in anesthesiology. *Hum. Factors* 50(2):276–90

Question	Answer
	Arora VM, Georgitis E, Siddique J, et al. 2008. Association of on-call workload of medical interns with sleep duration, shift duration, and participation in educational activities. *JAMA* 300(10):1146–53 Auger KA, Landrigan CP, Gonzalez del Rey JA, et al. 2012. Better rested, but more stressed? Evidence of the effects of resident work hour restrictions. *Acad Pediatr*. Jul-Aug;12(4):335-43
Can residents/fellows be required to take vacation or sick time when attending appointments during scheduled working hours? *[Common Program Requirement: VI.C.1.d).(1); One-Year Common Program Requirement: VI.C.1.d).(1)]*	The requirements do not specify whether residents/fellows will be required to use vacation or sick time for medical, dental, and mental health appointments. Programs should comply with their institution's policies regarding time off for such appointments.
Can residents/fellows be encouraged to schedule medical, mental health, and dental care appointments on days they are not assigned call? *[Common Program Requirement: VI.C.1.d).(1); One-Year Common Program Requirement: VI.C.1.d).(1)]*	The intent of this requirement is to ensure that residents and fellows are able to attend appointments as needed, and that their work schedule not prevent them from seeking care when they need it, including during scheduled call days. Programs must not place restrictions on when residents and fellows may schedule these appointments, nor place pressure on them to schedule appointments on days when they are not assigned call.
How can programs located in areas where 24/7 in-person access to mental health professionals is not possible comply with this requirement? *[Common Program Requirement: VI.C.1.e).(3); One-Year Common Program Requirement: VI.C.1.e).(3)]*	The requirement is intended to ensure that residents and fellows have immediate access at all times to a mental health professional (psychiatrist, psychologist, Licensed Clinical Social Worker, Primary Mental Health Nurse Practitioner, or Licensed Professional Counselor) for urgent or emergent mental health issues. Access to a psychiatrist or other mental health professional in the Emergency Department satisfies the expectation for 24/7 access to emergency care. In addition, telemedicine, or telephonic means may be utilized to satisfy this requirement.

Question	Answer
What are the ACGME's expectations regarding transitions of care, and how should programs and institutions monitor effective transitions of care and minimize the number of such transitions? *[Common Program Requirement: VI.E.3.; One-Year Common Program Requirement: VI.E.3.]*	Transitions of care are critical elements in patient safety and must be organized such that complete and accurate clinical information on all involved patients is transmitted between the outgoing and incoming individuals and/or teams responsible for the specific patient or group of patients. Programs and institutions are expected to have a documented process in place for ensuring the effectiveness of transitions. Scheduling of on-call assignments should be optimized to ensure a minimal number of transitions, and there should be documentation of the process involved in arriving at the final schedule. Specific schedules will depend upon various factors, including the size of the program, the acuity and quantity of the workload, and the level of resident/fellow education.
How do the ACGME common clinical and educational work hour requirements apply to research activities? *[Common Program Requirement: VI.F.; One-Year Common Program Requirement: VI.F.]*	The clinical and educational work hour requirements pertain to all required hours in the program (the only exceptions are reading and self-learning). When research is a formal part of the residency/fellowship and occurs during the accredited years of the program, research hours or any combination of research and patient care activities must comply with the weekly limit on hours and other pertinent clinical and educational work hour requirements. When programs offer an additional research year that is not part of the accredited years, or when residents/fellows conduct research on their own time, making these hours identical to other personal pursuits, these hours do not count toward the limit on clinical and educational work hours. The combined hours spent on self-directed research and program-required activities should meet the test for a reasonably rested and alert resident/fellow when he or she participates in patient care. Some programs have added clinical activities to "pure" research rotations, such as having research residents/fellows cover "night float." This combination of research and clinical assignments could result in hours that exceed the weekly limit and could also seriously undermine the goals of the research rotation. Review Committees have traditionally been concerned that required research not be diluted by combining it with significant patient care assignments.

Question	Answer
Is there a provision for training pathways with alternative schedules to accommodate the needs of those with the ability to become excellent physicians but an inability to take on the demanding usual schedule described in the requirements? *[Common Program Requirement: VI.F.; One-Year Common Program Requirement: VI.F.]*	There is nothing in the requirements that prevents a program from providing an alternate pathway based on the needs of individuals, as long as the pathway adheres to other relevant dimensions of the requirements, including the maximums specified for clinical experience and education.
What is included in the definition of clinical and educational work hours under the requirement limiting them to 80 hours per week? *[Common Program Requirement: VI.F.1.; One-Year Common Program Requirement: VI.F.1.]*	Clinical and educational work hours are defined as all clinical and academic activities related to the residency/fellowship program. This includes inpatient and outpatient clinical care, in-house call, short call, night float and day float, transfer of patient care, and administrative activities related to patient care, such as completing medical records, ordering and reviewing lab tests, and signing orders. For call from home, time devoted to clinical work done from home and time spent in the hospital after being called in to provide patient care count toward the 80-hour weekly limit. Types of work from home that must be counted include using an electronic health record and taking calls. Reading done in preparation for the following day's cases, studying, and research done from home do not count toward the 80 hours. Hours spent on activities that are required in the accreditation requirements, such as membership on a hospital committee, or that are accepted practice in residency/fellowship programs, such as residents'/fellows' participation in interviewing residency/fellowship candidates, must be included in the count of clinical and educational work hours. Time residents and fellows devote to military commitments counts toward the 80-hour limit only if that time is spent providing patient care.

Question	Answer
If some of a program's residents/fellows attend a conference that requires travel, how should the hours be counted for clinical and educational work hour compliance? *[Common Program Requirement: VI.F.1.; One-Year Common Program Requirement: VI.F.1.]*	If attendance at the conference is required by the program, or if the resident/fellow is a representative for the program (e.g., he/she is presenting a paper or poster), the hours should be included as clinical and educational work hours. Travel time and non-conference hours while away do not meet the definition of "clinical and educational work hours" in the ACGME requirements.
What are the expectations in terms of a program structure that balances resident/fellow educational opportunities with opportunities for rest and personal well-being? *[Common Program Requirement: VI.F.2.a); One-Year Common Program Requirement: VI.F.2.a)]*	The intent of the requirement is to ensure that programs recognize the need to balance educational experiences with time away from the program. If an imbalance exists, it is expected that it would be manifest in other aspects of the learning environment, requiring the program to make adjustments as needed.
What is meant by "should have eight hours off"? *[Common Program Requirements: VI.F.2.b)-VI.F.2.b).(1); One-Year Common Program Requirements: VI.F.2.b) – VI.F.2.b).(1)]*	While it is expected that residents' and fellows' schedules will be structured to ensure they are provided with a minimum of eight hours off between scheduled work periods, it is recognized that individual residents or fellows may choose to remain beyond their scheduled time, or return to the clinical site during this time-off period, to care for a patient. The requirement preserves the flexibility for the resident or fellow to make those choices. It is also noted that the 80-hour weekly limit (averaged over four weeks) is a deterrent for scheduling fewer than eight hours off between clinical and education work periods, as it would be difficult for a program to design a schedule that provides fewer than eight hours off without violating the 80-hour rule. It is important to remember that when an abbreviated rest period is offered under special circumstances, the program director and faculty members must monitor residents/fellows for signs of excessive fatigue.

Question	Answer
If a post-call resident/fellow remains on-site for up to four additional hours as described in the requirements, does the required 14-hour time-off period begin at the end of the scheduled 24-hour period, or when the resident leaves the hospital? *[Common Program Requirements: VI.F.2.c), VI.F.3.a).(1); One-Year Common Program Requirements: VI.F.2.c), VI.F.3.a).(1)]*	The 14-hour time-off period begins when the resident/fellow leaves the hospital, regardless of when the resident was scheduled to leave.
Since the common clinical and educational work hour requirements state that residents/fellows must be provided with one day in seven free from all responsibilities, with one day defined as one continuous 24-hour period, how should programs interpret this requirement if the "day off" occurs after a resident's/fellow's on-call day? *[Common Program Requirement: VI.F.2.d); One-Year Common Program Requirement: VI.F.2.d)]*	The common clinical and educational work hour requirements specify a 24-hour day off. Many Review Committees have recommended that this day off should ideally be a calendar day (i.e., the resident/fellow wakes up in his or her home and has a whole day available). Review Committees have also noted that it is not permissible to have the day off regularly or frequently scheduled on a resident's/fellow's post-call day, but understand that in smaller programs it may occasionally be necessary to have the day off fall on the post-call day. Note that in this case, a resident/fellow would need to leave the hospital post-call early enough to allow for 24 hours off from clinical and educational work. Because call from home does not require a rest period, the day after home call may be used as a day off.
What activities are permitted during the four hours allowed for activities related to patient safety and/or resident education? *[Common Program Requirements: VI.F.3.a).(1)-VI.F.3.a).(1).(a); One-Year Common Program Requirements: VI.F.3.a).(1) - VI.F.3.a).(1).(a)]*	Residents/fellows who have completed a 24-hour clinical and educational work period may spend up to an additional four hours on-site to ensure an appropriate, effective, and safe transition of care (including rounds), to maintain continuity of patient care, and to participate in educational activities, such as conferences. During this four-hour period, residents/fellows must not be permitted to participate in the care of new patients in any patient care setting; must not be assigned to outpatient clinics, including continuity clinics; and must not be assigned to participate in a new procedure, such as an elective scheduled surgery. Residents/fellows who have satisfactorily completed the transition of care may attend an educational conference that occurs during this four-hour period.

Question	Answer
Can clinical and educational work hours for surgical chief residents be extended to 88 hours per week? *[Common Program Requirements: VI.F.4.c)-VI.F.4.c).(2); One-Year Common Program Requirements: VI.F.4.c)-c).(2)]*	Programs interested in extending the clinical and educational work hours for specific rotations for their chief residents can use the "88-hour exception" to request an increase of up to 10 percent in clinical and educational work hours on a program-by-program basis, with endorsement of the Sponsoring Institution's Graduate Medical Education Committee (GMEC) and the approval of the Review Committee. If approved, the exception will be reviewed annually by the Review Committee. A request for an exception must be based on a sound educational justification. Most Review Committees categorically do not permit programs to use the 10 percent exception. The Review Committee for Neurological Surgery is currently the only Review Committee that allows exceptions.
What qualifies as a "sound educational justification" for a rotation-specific increase in the weekly clinical and educational work hour limit by up to 10 percent? *[Common Program Requirements: VI.F.4.c)-VI.F.4.c).(2); One-Year Common Program Requirements: VI.F.4.c)-c).(2)]*	The ACGME specifies that a rotation-specific increase in clinical and educational work hours above 80 hours per week can be granted only when there is a very high likelihood that this will improve residents'/fellows' educational experiences. This requires that all hours in the extended work week contribute to resident/fellow education. Programs may ask for an extension that is less than the maximum of eight additional weekly hours, and/or for a subgroup of the residents/fellows in the program.

Question	Answer
In addition to the 80-hour maximum weekly limit, do all other clinical and educational work hour rules apply to moonlighting (maximum clinical and educational work period length, minimum time off between shifts, etc.)? *[Common Program Requirements: VI.F.5.a)-c); One-Year Common Program Requirements: VI.F.5.a)-b)]*	The hours spent moonlighting are counted toward the total hours worked for the week. No other clinical and educational work hour requirements apply, but the following requirements do: 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." VI.B.3.-VI.B.4.c).(2) "The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. Residents and faculty members must demonstrate an understanding of their personal role in the: provision of patient- and family-centered care; safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; assurance of their fitness for work, including: management of their time before, during, and after clinical assignments; and, recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team."
How many times in a row can a resident/fellow take call every other night? *[Common Program Requirement: VI.F.7.; One-Year Common Program Requirement: VI.F.7.]*	The objectives for allowing the averaging of in-house call (in all specialties except internal medicine) is to offer flexibility in scheduling, not to permit call every other night for any extended length of time, even if done in the interest of creating longer periods of free time on weekends or later in the month. For example, it is not permissible for a resident/fellow to be on call every other night for two weeks straight and then be off for two weeks.
Is it permissible for residents/fellows to take call from home for extended periods, such as a month? *[Common Program Requirement: VI.F.8.a); One-Year Common Program Requirement: VI.F.8.a)]*	No. The requirement for one day free every week prohibits being assigned home call for an entire month. Assignment of a partial month (more than six days but fewer than 28 days) is possible. However, keep in mind that call from home is appropriate if service intensity and frequency of being called is low. Program directors are expected to monitor the intensity and workload resulting from home call through periodic assessment of workload and intensity of in-house activities.

Question	Answer
Can PGY-1 residents take at-home call, and if so, what are the work hour restrictions for this? *[Common Program Requirement: VI.A.2.e).(1).(a)]*	PGY-1 residents are not initially allowed to take at-home call because appropriate supervision (either direct supervision or indirect supervision with direct supervision immediately available) is not possible when a resident is on at-home call. However, a Review Committee may specify the circumstances and achieved competencies required for residents to progress to be supervised indirectly with direct supervision available at some point after the beginning, but before the end, of the PGY-1 year. Program directors should review the specialty-specific requirements for further clarification.
The new requirements specify that clinical work done from home must count toward the 80-hour weekly maximum, averaged over four weeks. Why was this change made? *[Common Program Requirement: VI.F.1.; One-Year Common Program Requirement: VI.F.1.]*	The requirements acknowledge the changes in medicine, including electronic health records, and the increase in the amount of work residents and fellows choose to do from home. Resident decisions to complete work at home should be made in consultation with the resident's/fellow's supervisor. In such circumstances, residents/fellows should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality. The requirement provides flexibility for residents/fellows to do this while ensuring that the time spent completing clinical work from home is accomplished within the 80-hour weekly maximum.
What are the expectations regarding tracking and monitoring clinical work done from home? *[Common Program Requirements: VI.F.1., VI.F.8.a); One-Year Common Program Requirements: VI.F.1., VI.F.8.a)]*	Types of work from home that must be counted include using an electronic health record and responding to patient care questions. Reading done in preparation for the following day's cases, studying, and research done from home do not count toward the 80 hours. Residents and fellows are expected to track the time spent on these activities and report this time to the program director. The program director then will use this information when developing schedules to ensure that residents and fellows are not exceeding 80 hours per week, averaged over four weeks. Decisions about whether to report brief periods devoted to clinical work (e.g., a phone call that lasts just a couple of minutes) are left to the individual resident or fellow. There is no requirement regarding how this time is tracked and documented and no expectation that the program director assume a role in verifying the time reported by the residents and fellows.

Question	Answer
Which requirements apply to time in the hospital after being called in from home call? *[Common Program Requirements: VI.F.8.a)-b); One-Year Common Program Requirements: VI.F.8.a)-b)]*	For call taken from home (home or pager call), the time the resident/fellow spends in the hospital after being called in counts toward the weekly clinical and educational work hour limit. The only other numeric clinical and educational work hour requirement that applies is the one day free of clinical and educational work every week that must be free of all patient care responsibilities, which includes at-home call. Program directors must monitor the intensity and workload resulting from at-home call through periodic assessment of the frequency of being called into the hospital, and the length and intensity of the in-house activities. When residents/fellows assigned to at-home call return to the hospital to care for patients, a new time-off period is not initiated, and therefore the requirement for eight hours between shifts does not apply. The frequency and duration of clinical work done from home and time returning to the hospital must not preclude rest or reasonable personal time for residents/fellows.
General Questions	
How should the averaging of the clinical and educational work hour requirements (e.g., 80-hour weekly limit, one day free of clinical and educational work every week, and call no more frequently than every third night) be handled? For example, what should be done if a resident/fellow takes a vacation week?	Averaging must occur by rotation. This is done over one of the following: a four-week period; a one-month period (28-31 days); or the period of the rotation if it is shorter than four weeks. When rotations are shorter than four weeks in length, averaging must be made over these shorter assignments. This avoids heavy and light assignments being combined to achieve compliance. If a resident/fellow takes vacation or other leave, the ACGME requires that vacation or leave days be omitted from the numerator and the denominator for calculating clinical and educational work hours, call frequency, or days off. The requirements do not permit a “rolling” average, because this may mask compliance problems by averaging across high and low clinical and educational work hour rotations. The rotation with the greatest hours and frequency of call must comply with the common clinical and educational work hour requirements.

Question	Answer
Many of the new requirements address responsibilities that must be shared by programs and Sponsoring Institutions. Will the Institutional Requirements be revised to address the Sponsoring Institution's responsibilities in these areas?	The statement "Programs, in partnership with their Sponsoring Institutions," throughout Section VI reflects the need for programs and institutions to work together and recognize that institutional support will be necessary for programs to comply with the new requirements. The next revision of the Institutional Requirements will include changes to align the Institutional Requirements with the new Section VI of the Common Program Requirements.
Can the clinical and educational work hour requirements be relaxed over holidays or during other times when a hospital is short-staffed, during periods when some residents/fellows are ill or on leave, or when there is an unusually large patient census or demand for care?	The ACGME expects that clinical and educational work hours in any given four-week period comply with all applicable requirements. This includes months with holidays, during which institutions may have fewer staff members available. During the holiday period, scheduling for the rotation (generally four weeks or a month) must comply with the common and specialty-specific clinical and educational work hour requirements. Further, the schedule during the holidays themselves may not violate common clinical and educational work hour requirements (such as the requirement for adequate rest between clinical and educational work periods), or specialty-specific requirements.
What determines clinical and educational work hour limits for residents/fellows who rotate in another accredited program?	The clinical and educational work hour limits of the program in which the resident/fellow rotates apply to all residents/fellows, both those in the program and rotators from another specialty. This expectation also applies when a program has an exception, but it helps to remember that the standard defines the maximum allowable hours, not required hours or hours for all residents/fellows, so that it is always possible to work fewer hours than the limit.