

PROGRAM REQUIREMENTS FOR RESIDENCY EDUCATION IN EMERGENCY MEDICINE

I. INTRODUCTION

A. General Characteristics of Accredited Programs

Residencies in emergency medicine are designed to prepare physicians for the practice of emergency medicine. These programs must teach the fundamental skills, knowledge, and humanistic qualities that constitute the foundations of emergency medicine practice and provide progressive responsibility for and experience in the application of these principles to enable effective management of clinical problems. Equal opportunity must be provided for the residents, under the guidance and supervision of a qualified faculty, to develop a satisfactory level of clinical maturity, judgment, and technical skill. On completion of the program, residents should be capable of practicing emergency medicine, able to incorporate new skills and knowledge during their careers, and able to monitor their own physical and mental well being and that of others.

B. Length of the Program

1. The required length of an emergency medicine residency is 36 months in a curriculum under the control of the emergency medicine program director. Accreditation by the Accreditation Council for Graduate Medical Education (ACGME) is required for all years of the educational program.
2. Prior to entry into the program, each resident must be notified in writing of the required length of the program. This period may not be changed for a particular resident during his or her program unless there is a significant break in his or her education or the resident needs remedial education.

II. INSTITUTIONS

The institution(s) involved in the program must provide evidence of commitment to graduate medical education, including emergency medicine. While it is recognized that the practice of emergency medicine occurs within a variety of organizational structures, the administrative and academic structure must be organized in a way that facilitates the provision of an adequate educational experience. There must be evidence of an adequate financial commitment to the program.

A. Medical School Affiliation

Medical school affiliation is desirable. When a medical school affiliation is present, there must be a written affiliation agreement or a letter of understanding documenting the duties and responsibilities of both the medical school and the program. Program core faculty should have appropriate faculty appointments at the medical school.

B. Affiliation Agreements

1. When there is a cooperative educational effort involving multiple institutions, the commitment of each institution to the program must be made explicit in an affiliation agreement with each institution that conforms to ACGME Institutional Requirements Section I.C.1-5.
2. In addition, there must be a current letter of understanding between the program director and the individual responsible for each resident rotation in the program that describes
 - a. the educational objectives and the means by which they will be accomplished and evaluated;
 - b. the resources and facilities in the institution(s) that will be available to each resident, including but not limited to library and medical records;
 - c. the duties and responsibilities the resident will have on each rotation;
 - d. the relationship that will exist between emergency medicine residents and residents and faculty in other programs; and
 - e. the supervision emergency medicine residents will receive on each rotation.
3. For emergency medicine rotations, the physician responsible under the authority of the program director for the teaching and supervision of emergency medicine residents must be identified.

C. Participating Institutions

1. The program should be based at a primary hospital (hereafter referred to as the *primary clinical site*). More of the didactic and clinical experiences should take place at the primary clinical site than at any other single site. Educationally justified exceptions to this requirement will be considered.
2. Programs using multiple hospitals must ensure the provision of a unified educational experience for the residents. Each affiliated institution must offer significant educational opportunities to the overall program. The reasons for including each institution must be stated. Affiliations that merely duplicate experiences otherwise available within the program are not desirable.
3. To maintain program cohesion, continuity, and critical mass, as well as to reduce stress on the residents and their families, mandated rotations to affiliated institutions that are geographically distant from the sponsoring institution are acceptable only if they offer special resources, unavailable locally, that significantly augment the overall educational experience of the program.
4. The number and geographic distribution of participating institutions must not preclude the satisfactory participation by all residents in conferences and other educational exercises.

D. Facilities and Resources

In every hospital in which the emergency department is used as a training site, the following must be provided:

1. Adequate patient care space.
2. Adequate space for clinical support services,
3. Laboratory and diagnostic imaging results, especially those required on a STAT basis, returned on a timely basis.
4. Adequate program support space, including office space for faculty and residents.
5. Current medical library resources, including access to appropriate informational resources and medical databases in the emergency department. In addition, residents must have ready access to a major medical library either at the institution where the residents are located or through arrangement with convenient nearby institutions. Services available should include the electronic retrieval of information from medical databases.
6. Adequate and readily accessible instructional space.
7. Information systems
8. Appropriate security services and systems to ensure a safe working environment.

III. PERSONNEL

The program leadership and the program faculty are responsible for the general administration of a program, including those activities related to the recruitment, selection, instruction, supervision, counseling, evaluation, and advancement of residents and the maintenance of records related to program accreditation. Specific responsibilities are defined below. Frequent changes in leadership or long periods of temporary leadership may adversely affect the accreditation status of the program.

A. Chair/Chief of Emergency Medicine

The chair/chief of emergency medicine shall

1. be licensed to practice medicine in the state where the institution that sponsors the program is located (Certain federal programs are exempted.);
2. be a member of the program's core teaching faculty;
3. be qualified and have at least 3 years' experience as a clinician, administrator, and educator in emergency medicine;
4. be certified in emergency medicine by the American Board of Emergency Medicine or have appropriate educational qualifications in emergency medicine;
5. demonstrate active involvement in emergency medicine through
 - a. continuing medical education,
 - b. professional societies, and
 - c. scholarly activities; and
6. demonstrate leadership qualities and be capable of mentoring faculty, residents, administrators, and other health-care professionals.

B. Program Director

There must be a single program director responsible for the program. The program director must function within a sound administrative organizational framework and have an effective program faculty as essential elements of an approved residency program. The program director must be a member of the program's core teaching faculty. The program director shall

1. be licensed to practice medicine in the state where the institution that sponsors the program is located (Certain federal programs are exempted.);
2. be qualified and have at least 3 years' experience as a clinician, administrator, and educator in emergency medicine;
3. be certified in emergency medicine by the American Board of Emergency Medicine or have appropriate educational qualifications in emergency medicine;
4. be active full time in emergency medicine, be clinically active, devote sufficient time and effort to the program to provide day-to-day continuity of leadership, and fulfill all of the responsibilities inherent in meeting the educational goals of the program;
5. maintain appointment in good standing, including clinical privileges, and provide clinical supervision at the primary clinical site; he/she should be based at the primary clinical site;
6. demonstrate leadership qualities and the capability to mentor emergency medicine residents;
7. demonstrate active involvement in
 - a. continuing emergency medical education;
 - b. state, regional, or national scientific societies;
 - c. presentations and publications and other scholarly activities;
8. have at least 50% of his or her time protected from clinical service; and
9. have appropriate authority to oversee and to organize the activities of the educational program, including but not limited to
 - a. resident appointments and assignments;
 - b. supervision, direction, and administration of the educational activities; and
 - c. evaluation of the residents, faculty, and residency program.

C. Responsibilities of the Program Director

Responsibilities of the Program Director include the following:

1. Preparation of a written statement outlining the educational goals of the program with respect to knowledge, skills, and other attributes of residents at each level of training and for each major rotation or other program assignment. This statement must be distributed to residents and members of the program faculty. It should be readily available for review.
2. Selection of residents for appointment to the program in accordance with institutional and departmental policies and procedures.

3. Participation in the evaluation of the program faculty and other program personnel at each institution participating in the program.
4. The supervision of residents through explicit written descriptions of supervisory lines of responsibility for the care of patients. Such guidelines must be communicated to all members of the program staff. Residents must be provided with prompt, reliable systems for communication and interaction with supervisory physicians.
5. Regular evaluation of residents' knowledge, skills, and overall performance based on the competency standards listed in this document.
6. Provision of a written final evaluation for each resident who completes the program. The evaluation must include a review of the resident's performance during the final period of training and should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. This final evaluation should be part of the resident's permanent record maintained by the institution.
7. Implementation of fair procedures as established by the sponsoring institution regarding academic discipline and resident complaints or grievances.
8. Monitoring resident stress, including mental or emotional conditions inhibiting performance or learning and drug-and/or alcohol-related dysfunction. Program directors and faculty should be sensitive to the need for timely provision of confidential counseling and psychological support services to residents. Training situations that consistently produce undesirable stress on residents must be evaluated and modified.
9. Preparation of an accurate statistical and narrative description of the program as requested by a review committee.

D. Program Faculty

1. There must be a sufficient number of program faculty with documented qualifications to instruct and supervise adequately all the residents in the program. Members of the program faculty must be able to devote sufficient time to meet their supervisory and teaching responsibilities. To ensure a sufficient number of faculty to provide adequate on----- 24-hour emergency department attending staff supervision and participation in ongoing scholarly activity and research in support of the emergency medicine residents, there must be a minimum of one core physician faculty member for every three residents in the program. When the total resident complement exceeds 30, the faculty-resident ratio of one core faculty member for every three residents may be altered with appropriate educational justification.
2. A core physician faculty member, a member of the program faculty, is one who provides clinical service and teaching, devotes the majority of his or her professional efforts to the program, and has sufficient time protected from direct service responsibilities to meet the educational requirements of the program. The majority of the core faculty must
 - a. be certified by the American Board of Emergency Medicine or have appropriate educational qualifications in emergency medicine.
 - b. be residency trained in emergency medicine.

- c. show evidence of participation in a spectrum of professional activities within the institution as well as within local, state, regional, and national associations.
 - d. be engaged in research and have protected time and adequate support services to accomplish these tasks.
 - e. be prepared in emergency medicine and actively pursuing certification, according to the guideline of the American Board of Emergency Medicine or its equivalent.
3. All core faculty should be involved in continuing scholarly activity such as publication in peer reviewed journals, textbooks, local publications, formal lectures, and visiting professorships.
 4. All members of the program faculty must demonstrate a strong interest in the education of residents, sound clinical and teaching abilities, support of the goals and objectives of the program, a commitment to their own continuing medical education, and participation in scholarly activities.
 5. A member of the program faculty of each participating institution must be designated to assume responsibility for *the day-to-day activities of the* program at that institution, with overall coordination by the program director.
 6. The program faculty must be organized and have regular documented meetings to review program goals and objectives as well as program effectiveness in achieving them. At least one resident representative should participate in these reviews.
 7. Program faculty members should periodically evaluate the utilization of the resources available to the program, the contribution of each institution participating in the program, the financial and administrative support for the program, the volume and variety of patients available to the program for educational purposes, the performance of members of the teaching staff, and the quality of supervision of residents.
 8. Other attending staff hired to provide resident supervision in any emergency department where residents rotate must be certified by the American Board of Emergency Medicine or have appropriate educational qualifications.

E. Core Faculty Development

Each program should encourage the academic growth of its core faculty. Faculty development opportunities should be made available to each core faculty member. A written plan for each member of the core faculty should be prepared in consultation with the core faculty member for whom the plan is being developed. At the time of the program review, an example of a core faculty development plan must be included in the Program Information Forms.

F. Other Program Personnel

Programs must be provided adequate professional, technical, and clerical personnel needed to support the administration and educational conduct of the program. Clinical support services must be provided on a 24-hour basis. The services must be adequate to meet reasonable and

expected demands and must include the following: nursing, clerical, intravenous, EKG, respiratory therapy, messenger/transporter, and phlebotomy services.

IV. The Educational Program

The director and program faculty of a program must prepare and comply with written educational goals for the program. All educational components of a residency program should be related to program goals. The program design and/or structure must be approved by the Residency Review Committee (RRC) for Emergency Medicine as part of the regular review process.

A. Organization and Structure

1. Patient population

- a. There must be an adequate number of patients of all ages and both sexes with a wide variety of clinical problems to provide a patient population sufficient to meet the educational needs of emergency medicine residents and other residents who are assigned for training in emergency medicine. Except under unusual circumstances, the primary clinical site and other emergency departments where residents rotate for 4 months or longer should have at least 30,000 emergency department visits annually.
- b. Pediatric experience, defined as the care of patients less than 18 years of age, should be at least 16% of all resident emergency department encounters, or 4 months of full-time-equivalent experience dedicated to the care of infants and children. The program can balance a deficit of patients by offering dedicated rotations in the care of infants and children. The formula for achieving this balance is a 1-month rotation equals 4% of patients. Although this experience should include the critical care of infants and children, at least 50% of the 4 months should be in an emergency setting.
- c. The number of critically ill or critically injured patients treated in aggregate by the residents at the primary clinical site should be significant, constituting at least 3% or 1,200 of the emergency department patients per year (whichever is greater) who are admitted to monitored care settings, operative care or the morgue following treatment in the emergency department. Additional critical care experience is required during off-service rotations.
- d. There shall be a policy to provide personal and consultant physicians access to the emergency department for patient care. This policy must be consistent with those for physician access to other special care areas. Consultations from other clinical services in the hospital must be available in a timely manner. All consultations must be provided by or under the supervision of a qualified specialist.

2. Supervision

- a. All residents within the emergency department must be under the supervision of emergency medicine faculty in the emergency department at all times, except when

residents from other services provide supervised care to patients on their service. In such circumstances, they must be supervised by emergency medicine faculty or by faculty from their services. Sufficient faculty must be present to provide supervision appropriate to the care of each patient.

- b. All residents assigned to the emergency department must have supervision commensurate to their level of training.
 - c. Allied health professionals, such as physician assistants and nurse practitioners, and residents from other specialties who rotate through the emergency department must not compromise the educational objectives of the emergency medicine program by diluting the training experience or preventing appropriate progressive responsibility for the emergency medicine residents.
 - d. The program director should ensure that all emergency medicine residents, while on rotation on other services, are appropriately supervised and are provided with an educational experience equivalent to that of an ACGME-approved residency in that specialty.
3. Progressive responsibility
The program director must ensure that the degree of professionals responsibility accorded to a resident is progressively increased through the course of training commensurate with skill and experience. Included should be opportunities to develop clinical and administrative judgment in the areas of patient care, teaching, administration, and leadership.
4. Number of residents
- a. There should be a minimum of six residents per year of training to achieve a major impact in the emergency department, to ensure meaningful attendance at emergency medicine conferences, to provide for progressive responsibility, and to foster a sense of residency program and departmental identity. Exceptions to these standards will require justification based on sound educational principles and must demonstrate substantial compliance with the intent of this requirement.
 - b. The program should request a number or range (minimum-maximum) of emergency medicine residents per year. The RRC will approve a range (minimum-maximum) or number of residents per year based on the educational resources of the program.
5. Presence of other residencies and other educational resources
The sponsoring institution for emergency medicine education must have a major educational commitment, as evidenced by training programs in other major specialties. The program must demonstrate the availability of residencies in other specialties or educational resources for the education of emergency medicine residents. A lack of such resources will adversely affect the accreditation status of the program.
6. Fellowships
Programs must notify the RRC if they sponsor any emergency medicine-related fellowships within institutions participating in the program. Documentation must be provided describing the fellowship's relationship to and impact on the residency.

- a. The appointment of other individuals for special training or education, such as fellows, must not dilute or detract from the educational opportunities of regularly appointed emergency medicine residents.
 - b. Addition or integration of such individuals into an existing residency program requires a clear statement of the areas of education, clinical responsibilities, duration of training, and overall impact on the educational needs of existing emergency medicine residents.
7. Duty hours
- a. Emergency medicine rotations
 - 1) As a minimum, residents shall be allowed 1 full day in 7 days away from the institution and free of any clinical or academic responsibilities, including planned educational experiences.
 - 2) While on duty in the emergency department, residents may not work longer than 12 continuous scheduled hours. There must be at least an equivalent period of continuous time off between scheduled work periods.
 - 3) A resident should not work more than 60 scheduled hours per week seeing patients in the emergency department and no more than 72 duty hours per week. Duty hours comprise all clinical duty time and conferences, whether spent within or outside the educational program, including all on-call hours.
 - b. Other rotations

The program director must ensure that all residents have appropriate duty hours when rotating on other clinical services, in accordance with the ACGME-approved program requirements of that specialty.
 - c. Extracurricular activities

Activities that fall outside the educational program may not be mandated, nor may they interfere with the resident's performance in the educational process as defined in the agreement between the institution and the resident.

B. Curriculum

- 1. The program director must provide each resident and member of the faculty, in writing and in advance of the experience, a comprehensive curriculum specific to the educational needs of the emergency medicine resident and designed to accomplish the defined goals and core competencies of the emergency medicine training program. The curriculum shall be readily available for review. It shall include
 - a. the educational objectives for each rotation or other program assignment;
 - b. methods of implementation, including specific educational experiences used to meet each objective;
 - c. evaluation processes that are linked to the accomplishment of objectives; and
 - d. feedback mechanisms.
- 2. Goals of Education

Residency programs in emergency medicine should produce emergency physicians prepared with the following basic competencies:

- a. Provide the recognition, resuscitation, stabilization, evaluation, and care of the full range of patients who present to the emergency department
 - b. Apply critical thinking to determine the priorities for evaluation and treatment of multiple emergency department patients with different complaints and needs
 - c. Arrange appropriate follow-up or referral as required
 - d. Manage the out-of-hospital care of the acutely ill or injured patient
 - e. Participate in the administration of the emergency medical services system providing out-of-hospital care
 - f. Provide appropriate patient education directed toward the prevention of illness and injury
 - g. Engage in the administration of emergency medicine
 - h. Teach of emergency medicine
 - i. Understand and evaluate research methodologies and their application
 - j. Understand and apply the principles and practice of continuous quality improvement
 - k. Manage resource utilization effectively
 - l. Utilize information resources effectively and apply evidence-based medicine to update their clinical practice
 - m. Communicate effectively with patients, families, and health care professionals
 - n. Utilize resources to address domestic violence and other public health issues, including violence prevention
 - o. Demonstrate the fundamental qualities of professionalism
 - p. Demonstrate how optimal patient care is provided in the context of a larger health-care delivery system by effectively using system resources to support the care of patients
3. Planned educational experiences
 - a. Each program must offer its residents an average of at least 5 hours per week of planned educational experiences (not including change of shift report) developed by the emergency medicine residency program.
 - b. These educational experiences should include presentations based on the defined curriculum, morbidity and mortality conferences, journal review, administrative seminars, and research methods. They may include but are not limited to problem-based learning, evidence-based learning, laboratories, and computer-based instruction, as well as joint conferences cosponsored with other disciplines.
 - c. Emergency medicine faculty are expected to attend and meaningfully participate in these planned educational experiences. Participation in resident conferences should be one component in the annual evaluation of the core emergency medicine faculty.
 4. The program should ensure that residents are relieved of clinical duties to attend these planned educational experiences. Although release from some off-service rotations may not be possible, the program should require that each resident participate in at least 70% of the

- planned emergency medicine educational experiences offered (excluding vacations). Attendance should be monitored and documented.
5. The curriculum must include didactic and clinical information to enable the residents to achieve the goals and competencies of the training program. These include knowledge- and skill-based competencies as listed in the Core Content of Emergency Medicine.
 6. The curriculum must include at least 2 months of inpatient critical care rotations, during which the residents should have decision-making experience that allows them to develop the skills and judgment necessary to manage critically ill and injured patients who present to the emergency department.
 7. The program must develop a system that provides and documents efforts to teach residents the importance of patient follow-up. This should involve a representative sample of patients who are admitted to the hospital and who are discharged from the emergency department. Acceptable methods include but are not limited to
 - a. written documentation of individual resident efforts (ward/ICU visits, telephone calls, and chart review);
 - b. timely provision of patient discharge summaries, operative reports, autopsy summaries, and/or consultation notes; and
 - c. regular case conferences (other than morbidity and mortality conference) that cover a representative sample of patient follow-ups.
 8. At least 50% of the training beyond the first year must take place in the emergency department. Excessive clinical time in the emergency department should not preclude adequate experience in off-service areas needed to cover the curriculum.
 9. Of the total educational experience, no less than 50% should take place under the supervision of emergency medicine faculty. Such experiences can include emergency medical services, toxicology, pediatric emergency medicine, sports medicine, emergency medicine administration, and research in emergency medicine.
 10. Out-of-hospital care
Since out-of-hospital care is an integral and vital part of emergency medicine, there must be a formal, structured resident experience. This should include participation in paramedic base station communications; emergency transportation and care in the field, including ground units and if possible air ambulance units; teaching and oversight of out-of-hospital personnel; and disaster planning and drills. If residents are required to ride in ground or air ambulance units, they must be notified of this requirement during the resident recruitment process.
 11. Resuscitations and procedures
Each resident must have sufficient opportunities to perform invasive procedures, monitor unstable patients, and direct major resuscitations of all types on all age groups. A major resuscitation is patient care for which prolonged physician attention is needed and interventions such as defibrillation, cardiac pacing, treatment of shock, intravenous use of drugs (eg, thrombolytics, vasopressors, neuromuscular blocking agents), or invasive procedures (eg, cutdowns, central line insertion, tube thoracostomy, endotracheal intubation) that are necessary

for stabilization and treatment. The resident must have the opportunity to make admission recommendations and direct resuscitations.

- a. Programs must maintain a record of all major resuscitations and procedures performed by each resident. The record must document their role, ie, participant or director: the type of procedure(s); the location (ED, ICU, etc); age of patient; and admission diagnosis. Only one resident may be credited with the direction of each resuscitation and the performance of each procedure.
- b. These records should be verified by the residency director and should be the basis for documenting the total number of resuscitations and procedures in the program. They should be available for review by the site visitor.

12. Systems-based practices and performance improvement

Each resident must actively participate in emergency department continuous performance quality improvement (PI) programs. Program components should include

- a. basic principles and application of PI;
- b. formal regular clinical discussions, rounds, and conferences that provide critical review of patient care and promote PI and quality care, such as mortality and morbidity conferences that analyze system factors in medical errors; efforts should be made to gain permission for postmortem examinations and to review the results of these examinations;
- c. evidence of development, implementation and assessment of a project to improve care, such as a clinical pathway, a patient satisfaction survey, or improvement of a recognized problem area.

13. Research and scholarly activity

Graduate medical education must take place in an environment of inquiry and scholarship in which residents participate in the development of new knowledge, learn to evaluate research findings, and develop habits of inquiry as a continuing professional responsibility. The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the program faculty. The staff as a whole must demonstrate broad involvement in scholarly activity. This activity should include the following:

- a. Active participation of the program faculty in clinical discussions, rounds, and conferences in a manner that promotes a spirit of inquiry and scholarship. Scholarship implies an in-depth understanding of basic mechanisms of normal and abnormal states and the application of current knowledge to practice.
- b. Participation in journal clubs and research conferences.
- c. Active participation in regional or national professional and scientific societies, particularly through presentations at the organizations' meetings and publications in their journals.
- d. Participation in research, particularly in projects that are funded following peer review and/or result in publications or presentations at regional and national scientific meetings.
- e. Offering of guidance and technical support (eg, research design, statistical analysis) for residents involved in research.

- f. Provision of support for resident participation in scholarly activities. The curriculum should include resident experience in scholarly activity prior to completion of the program. Some examples of suitable resident scholarly activities are the preparation of a scholarly paper such as a collective review or case report, active participation in a research project, or formulation and implementation of an original research project.
 - g. Residents must be taught an understanding of basic research methodologies, statistical analysis, and critical analysis of current medical literature.
14. Physician wellness
- Physical and mental well being are critical to the emergency physician's ability to provide proper care in a stressful environment. The residents should be taught to balance personal and professional responsibilities. Emergency medicine residencies should include opportunities to address physician wellness within the educational program, as well as to address stress, circadian rhythms, and substance abuse among health-care professionals.
15. Professionalism
- Residents should be taught the fundamental qualities of professionalism in emergency medicine. These include
- a. provision of compassionate emergency medical care with the best interest of the patient as the focus of decision making;
 - b. respect, regard, integrity, and a responsiveness to the needs of patients and society that supersedes self-interest, that assumes responsibility and acts responsibly, and that demonstrates commitment to excellence and ongoing professional development;
 - c. commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices; and
 - d. sensitivity and responsiveness to cultural differences, including awareness of their own and their patients' cultural perspectives.
16. Interpersonal skills and communication
- Residency programs must ensure that residents develop appropriate communication skills to effectively create a therapeutic relationship with patients, to educate and provide useful information to patients and families, and to work collaboratively in health-care teams for the benefit of their patients.
17. Family violence
- There must be instruction on the presentation, detection, and management of domestic violence, including child, partner, and elder abuse (physical and sexual) as well as neglect. Such instruction should promote the understanding of its effects on both victims and perpetrators.

V. EVALUATION

There must be effective, ongoing evaluation of all components of the residency program. This evaluation process must relate to the educational objectives of the program and provide a mechanism to effect change.

A. Evaluation of Residents

1. At least semiannually, there must be an evaluation of the knowledge, skills, and professional growth in emergency medicine of each resident, using appropriate criteria and procedures. Documentation of management of patients with emergency conditions, to include major trauma, medical and pediatric resuscitations, and performance of emergency procedures by each resident in the program, must be kept and reviewed periodically by the program director.
2. Formal evaluation of each resident during training is required and must include oral and written examinations. In addition, there must be a mechanism for formal evaluation of the resident on each rotation. A summary of the evaluations must be communicated in writing to and should be signed by the resident. Discussions of these results between the resident and the program director or his or her designee must be held on at least a semiannual basis.
3. Residents should be advanced to positions of higher responsibility on the basis of evidence of their satisfactory progressive scholarship and professional growth.
4. A plan to remedy deficiencies must be in writing and on file.- Progress and improvement must be monitored at a minimum of every 3 months if a resident has been identified as needing a remediation plan.
5. A permanent record of evaluation for each resident must be maintained and must be accessible to the resident and other authorized personnel.
6. A written final evaluation must be provided for each resident who completes the program. The evaluation must include a review of the resident's performance during the final period of training and should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. This final evaluation should be part of the resident's permanent record maintained by the institution.

B. Evaluation of Faculty

1. At least annually, individual faculty members must be formally evaluated by the chair/chief of emergency medicine, who should include information from the program director and the emergency medicine residents. A mechanism for preserving resident confidentiality in the evaluation process must be implemented.
2. Faculty evaluations should include documentation of teaching ability, clinical knowledge, administrative and interpersonal skills, participation and contributions to resident conferences, and scholarly contributions. A summary of the evaluations should be communicated in writing to each faculty member.

C. Evaluation of the Program

1. At least annually, the educational effectiveness of the entire program, including the quality of the curriculum and the clinical rotations, must be evaluated by residents and faculty in a systematic

manner. The extent to which the educational goals have been met by residents must be assessed. Written evaluations by residents should be used in this process. The results of these evaluations must be kept on file.

2. The RRC will take into consideration information provided by the American Board of Emergency Medicine performance of the program's graduates on the certifying examinations over a period of several years.

VI. OTHER

A. Notice of Changes in the Program

1. The program leadership is responsible for notifying the Executive Director of the RRC within 30 days, in writing, of any major changes in the program that may significantly alter the educational experience for the residents, including the following:
 - a. Changes in leadership of the department or the program
 - b. Changes in administrative structure, such as an alteration in the hierarchical status of the program/department within the institution
 - c. A drop in the core faculty complement below the required minimum number or if one-third or more of the core faculty leave within 1 year
 - d. A drop below the minimum approved number of residents in the program for 2 consecutive years

Should the RRC determine that a significant alteration of the educational resources has occurred, an immediate resurvey of the program may be performed.

2. The program director must obtain prior approval for the following changes in the program in order for the RRC to determine if an adequate educational environment exists to support these changes:
 - a. The addition or deletion of any participating institution to which a resident will rotate for 4 months or longer.
 - b. The addition or deletion of any rotation of 4 months or longer.
 - c. Any change in the approved resident complement of the program. (Prior approval is not required for temporary changes in resident numbers due to makeup or remedial time for currently enrolled residents or to fill vacancies at the same level of education in which the vacancy occurs.)
 - d. Any change in the length or educational format of the program. On review of a proposal for a major change in a program, the RRC may determine that a site visit is necessary.

B. Combined Programs

The RRC will review combined education program proposals only after the review and approval of the American Board of Emergency Medicine. Review by the RRC will consider

only whether the residency has sufficient resources to support combined education without diluting the experience of the regularly appointed residents. The RRC does not accredit the combined education. The proposal must be submitted to the RRC prior to the implementation of required education.

C. Certification

Residents who plan to seek certification by the American Board of Emergency Medicine should communicate with the Secretary of that Board for information regarding the requirements for certification.

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