NATIONAL INSTITUTE FOR HEALTH SPECIALITIES

NIHS Program Requirements for Specialty Education in Emergency Medicine (Emirati Board in Emergency Medicine)

This document is expected to define the specific program aims consistent with the overall mission of its Sponsoring Institution, the needs of the community it serves and that its graduates will serve, and the distinctive capabilities of physicians it intends to graduate. The Program must demonstrate substantial compliance with the Common and specialty-specific Program Requirements. Where applicable, text in italics describes the underlying philosophy of the requirements in that section. These philosophic statements are not program requirements and are therefore not citable.

Issue Date: 21/09/2023

Draft Version 2

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Introduction

Int. A. Preamble

Graduate medical education is an important step of professional development between medical school and independent clinical practice. It is in this vital phase of the continuum of medical education that residents learn to provide best patient care under the supervision of faculty members who not only instruct, but also serve as role models of excellence, compassion, professionalism, and scholarship.

Graduate medical education transforms medical graduates into physician scholars who care for the patient, family, and a diverse community; create and integrate new knowledge into practice; and educate future generations of physicians to serve the public.

Graduate medical education has as a core tenet the graded authority and responsibility for patient care. The care of patients is undertaken with appropriate faculty supervision and conditional independence, allowing residents to attain the knowledge, skills, attitudes, and empathy required for independent practice. Graduate medical education develops physicians who focus on excellence in delivery of safe, equitable, affordable, quality care; and the health of the populations they serve.

Graduate medical education occurs in clinical settings that establish the foundation for practice-based and lifelong learning. The professional development of the physician, begun in medical school, continues through faculty modeling of the effacement of self-interest in a humanistic environment that emphasizes joy in curiosity, problem-solving, academic rigor, and discovery. This transformation is often physically, emotionally, and intellectually demanding and occurs in a variety of clinical learning environments committed to graduate medical education and the well-being of patients, other residents and fellows, faculty members and all members of the health care team.

Int. B. Definition of Specialty

The principal mission of Emergency physician (EP) is to evaluate, manage, treat, and prevent unexpected illness and injury. Trained emergency physicians are expected to provide rapid treatment and stabilization of true emergencies, as well as rapid differentiation between emergent and non-emergent conditions over the spectrum of disease processes hence any emergency medicine training program need to be structured, goal oriented and designed to enrich the physician in training knowledge and skills that qualify him/ her to provide independent acute care to any patient that present to the Emergency Department (ED).

Int. C Length of educational program

Residency programs in emergency medicine are configured in 48 months format (Core)

I. Oversight

I.A. Sponsoring Institution

The Sponsoring Institution is the entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education, consistent with the NIHS Institutional Requirements.

The Sponsoring Institution must be the primary clinical defined as the most utilized rotation site of clinical activity for the program.

Background and Intent: *Participating sites will reflect the health care needs of the community and the educational needs of the residents. A wide variety of organizations may provide a robust educational experience and, thus, Sponsoring Institutions and participating sites may encompass inpatient and outpatient settings.*

I.A.1. The program must be sponsored by one NIHS-accredited Sponsoring Institution. (Core)

I.B. Participating Sites

A participating site is an entity that provides educational experiences or educational assignments/rotations for residents.

I.B.1. The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)

I.B.2. There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)

I.B.2.a) The PLA must:

I.B.2.a)(1) be renewed at least every 5 years; (Core)

I.B.2.a)(2) be approved by the designated institutional official (DIO). (Core)

I.B.2.a)(3) specify the duration and content of the educational experience; (Core)

I.B.2.a)(4) state the policies and procedures that will govern resident education during the assignment; (Core)

I.B.2.a)(5) identify the faculty members who will assume educational and supervisory responsibility for residents; (Core)

I.B.2.a)(6) specify the responsibilities for teaching, supervision, and formal evaluation of residents. (Core)

I.B.3. The program must monitor the clinical learning and working environment at all participating sites. (Core)

I.B.3.a) At each participating site there must be one faculty member, designated by the program director as the site director, who is accountable for resident education at that site, in collaboration with the program director. (Core)

Background and Intent: *While all residency programs must be sponsored by a single NIHS-accredited Sponsoring Institution, many programs will utilize other clinical settings to provide required or elective training experiences. At times it is appropriate to utilize community sites that are not owned by or affiliated with the Sponsoring Institution. Some of these sites may be remote for geographic, transportation, or communication issues. When utilizing such sites, the program must ensure the quality of the educational experience.*

I.B.4. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one-month full time equivalent (FTE) or more through NIHS Accreditation System. (Core)

I.B.4.a) The program should be based at the primary clinical site. (Core)

I.B.4.b) Programs using multiple participating sites must ensure the provision of a unified educational experience for the residents. (Core)

I.B.4.b)(1) Each participating site must offer significant educational opportunities to the overall program. (Core)

I.B.4.c) Required rotations to participating sites that are geographically distant from the sponsoring institution must offer educational opportunities unavailable locally that significantly augment residents' overall educational experience. (Core)

I.B.4.c)(1) The program should ensure that residents are not unduly burdened by required rotations at geographically distant sites. (Core)

I.B.5. Resident assignments away from the Sponsoring Institution should not prevent residents' regular participation in required didactics. (Core)

I.C. Recruitment

The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present),

faculty members, senior administrative staff members, and other relevant members of its academic community. (Core)

I.D. Resources

I.D.1. The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education. (Core)

I.D.1.a) The program must demonstrate the availability of educational resources, including the presence of residents in other specialties, to enhance the training of the emergency medicine residents. (Core)

I.D.1.b) At every site in which the emergency department provides resident education, the following must be provided: (Core)

I.D.1.b)(1) adequate space for patient care; (Core)

I.D.1.b)(2) space for clinical support services; (Core)

I.D.1.b)(3) diagnostic imaging completed and results available on a timely basis, especially those required on a STAT basis; (Core)

I.D.1.b)(4) laboratory studies completed and results available on a timely basis, especially those required on a STAT basis; (Core)

I.D.1.b)(5) office space for core physician faculty members, and residents; (Core)

I.D.1.b)(6) instructional space; (Core)

I.D.1.b)(7) information systems; (Core)

I.D.1.b)(8) appropriate security services and systems to ensure a safe working environment. (Core)

I.D.1.c) Clinical support services must include nursing, clerical, intravenous, electrocardiogram (EKG), respiratory therapy, transporter, and phlebotomy, and must be available on a 24-hour basis so that residents are not burdened with these duties. (Core)

I.D.1.d) Office space for program coordinators and additional support personnel must be provided at the primary clinical site. (Core)

I.D.1.e) Each clinical site must provide timely consultation from services based on a patient's acuity. (Core)

I.D.1.e)(1) If any clinical services are not available for consultation or admission, each clinical site must have a written protocol for provision of these services elsewhere. (Core)

I.D.1.e)(2) Each clinical site must ensure timely consultation decisions by a provider from admitting and consulting services with decision making authority. (Core)

I.D.1.f) The patient population must include patients of all ages and genders as well as patients with a wide variety of clinical problems. (Core)

I.D.1.g) The primary clinical site to which residents rotate must have at least 30,000 emergency department visits annually. (Core)

I.D.1.g)(1) The primary clinical site should have a significant number of critically-ill or critically injured patients constituting at least three percent or 1200 (whichever is greater) of the emergency department patients per year. (Core)

I.D.1.g)(2) All other emergency departments to which residents rotate for four months or longer should each have at least 30,000 emergency department visits annually. (Core)

I.D.1.h) Residents must be provided with prompt, reliable systems for communication and interaction with supervisory physicians. (Core)

I.D.2. The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for (Core):

I.D.2.a) access to food while on duty; (Core)

I.D.2.b) safe, quiet, clean, and private sleep/rest facilities available and accessible for residents with proximity appropriate for safe patient care; (Core)

Background and Intent: *Care of patients within a hospital or health system occurs continually through the day and night. Such care requires that residents' function at their peak abilities, which requires the work environment to provide them with the ability to meet their basic needs within proximity of their clinical responsibilities.*

Access to food and rest are examples of these basic needs, which must be met while residents are working. Residents should have access to refrigeration where food may be stored. Food should be available when residents are required to be in the hospital

overnight. Rest facilities are necessary, even when overnight call is not required, to accommodate the fatigued resident.

I.D.2.c) clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)

Background and Intent: *Sites must provide private and clean locations where residents may lactate and store the milk within a refrigerator. These locations should be in close proximity to clinical responsibilities. It would be helpful to have additional support within these locations that may assist the resident with the continued care of patients, such as a computer and a phone. While space is important, the time required for lactation is also critical for the well-being of the resident and the resident's family.*

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

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

I.D.3. Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core)

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

I.E. Other Learners and Other Care Providers

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

I.E.1. The program must report circumstances when the presence of other learners has interfered with the residents' education to the DIO and to the graduate medical education committee (GMEC). (Core)

Background and Intent: *The clinical learning environment has become increasingly complex and often includes care providers, students, and post-graduate residents and fellows from multiple disciplines. The presence of these practitioners and their learners enrich the learning environment. Programs have a responsibility to monitor the learning environment to ensure that residents' education is not compromised by the presence of other providers and learners.*

II. Personnel

II.A. Program Director

II.A.1. There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core)

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

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

Background and Intent: *While the NIHS recognizes the value of input from numerous individuals in the management of a residency, a single individual must be designated as program director and made responsible for the program. This individual will have dedicated time for the leadership of the residency, and it is this individual's responsibility to communicate with the residents, faculty members, DIO, GMEC, and the NIHS. The program director's nomination is reviewed and approved by the GMEC. Final approval of program directors resides with the Central Accreditation Committee.*

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

Background and Intent*: The success of residency programs is generally enhanced by continuity in the program director position. The professional activities required of a program director are unique and complex and take time to master. All programs are encouraged to undertake succession planning to facilitate program stability when there is necessary turnover in the program director position.*

II.A.2. At a minimum, the program director must be provided with the salary support required to devote 50 percent FTE of non-clinical time to the administration of the program. (Core)

Background and Intent: *Fifty percent FTE is defined as two-and-a-half (2.5) day per week. "Administrative time" is defined as non-clinical time spent meeting the responsibilities of the program director. The requirement does not address the source of funding required to provide the specified salary support.*

II.A.3. Qualifications of the program director

II.A.3.a) must include specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Central Accreditation Committee; (Core)

Background and Intent: *Leading a program requires knowledge and skills that are established during residency and subsequently further developed. The time period from completion of residency until assuming the role of program director allows the individual to cultivate leadership abilities while becoming professionally established. The three-year period is intended for the individual's professional maturation.*

The broad allowance for educational and/or administrative experience recognizes that strong leaders arise through diverse pathways. These areas of expertise are important when identifying and appointing a program director. The choice of a program director should be informed by the mission of the program and the needs of the community.

In certain circumstances, the program and Sponsoring Institution may propose, and the Central Accreditation Committee may accept a candidate for program director who fulfills these goals but does not meet the three-year minimum.

Successful administration of an Emergency Medicine residency program requires administrative time. At least half of the required 0.5 FTE should include blocked time to complete administrative requirements of the residency. Time spent in clinics supervising residents, while important, should not be counted in the required 0.5 FTE of administrative time.

II.A.3.b) must be licensed as consultant and have at least three years post residency documented experience in emergency medicine, or with a specialty qualification that are acceptable to the Central Accreditation Committee; (Core)

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

II.A.3.d) must include ongoing clinical activity. (Core)

Background and Intent*: A program director is a role model for faculty members and residents. The program director must participate in clinical activity consistent with the specialty. This activity will allow the program director to role model the Core Competencies for the faculty members and residents.*

II.A.4. Program Director Responsibilities

The program director must have responsibility, authority, and accountability for administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care. (Core)

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

II.A.4.a)(1) be a role model of professionalism; (Core)

Background and Intent: *The program director, as the leader of the program, must serve as a role model to residents in addition to fulfilling the technical aspects of the role. As residents are expected to demonstrate compassion, integrity, and respect for others, they must be able to look to the program director as an exemplar. It is of utmost importance, therefore, that the program director model outstanding professionalism, high quality patient care, educational excellence, and a scholarly approach to work. The program director creates an environment where respectful discussion is welcome, with the goal of continued improvement of the educational experience.*

II.A.4.a)(2) design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program; (Core)

Background and Intent: *The mission of institutions participating in graduate medical education is to improve the health of the public. Each community has health needs that vary based upon location and demographics. Programs must understand the social determinants of health of the populations they serve and incorporate them in the design and implementation of the program curriculum, with the ultimate goal of addressing these needs and health disparities.*

II.A.4.a)(3) administer and maintain a learning environment conducive to educating the residents. in each of the Core Competency domains; (Core)

Background and Intent: *The program director may establish a leadership team to assist in the accomplishment of program goals. Residency programs can be highly complex. In a complex organization, the leader typically has the ability to delegate authority to others yet remains accountable. The leadership team may include physician and non-physician personnel with varying levels of education, training, and experience.*

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

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

II.A.4.a)(6) have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program; (Core)

Background and Intent: *The program director has the responsibility to ensure that all who educate residents effectively role model the Core Competencies. Working with a resident is a privilege that is earned through effective teaching and professional role modeling. This privilege may be removed by the program director when the standards of the clinical learning environment are not met.*

There may be faculty in a department who are not part of the educational program, and the program director controls who is teaching the residents.

II.A.4.a)(7) submit accurate and complete information required and requested by the DIO, GMEC, and NIHS; (Core)

II.A.4.a)(8) provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s); (Core)

II.A.4.a)(9) provide a learning and working environment in which residents have the opportunity to raise concerns and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; (Core)

II.A.4.a)(10) ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process; (Core)

II.A.4.a)(11) ensure the program's compliance with the Sponsoring Institution's policies and procedures for due process when action is taken to suspend or dismiss, not to promote, or not to renew the appointment of a resident; (Core)

Background and Intent: *A program does not operate independently of its Sponsoring Institution. It is expected that the program director will be aware of the Sponsoring Institution's policies and procedures and will ensure they are followed by the program's leadership, faculty members, support personnel, and residents.*

II.A.4.a)(12) ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; (Core)

II.A.4.a)(13) document verification of program completion for all graduating residents; within 30 days; (Core)

II.A.4.a)(14) provide verification of an individual resident's completion upon the resident's request, within 30 days; (Core)

Background and Intent: *Primary verification of graduate medical education is important to credentialing of physicians for further training and practice. Such verification must be accurate and timely. Sponsoring Institution and program policies for record retention are important to facilitate timely documentation of residents who have previously completed the program. Residents who leave the program prior to completion also require timely documentation of their summative evaluation.*

II.A.4.a)(15) obtain review and approval of the Sponsoring Institution's DIO before submitting information, as required in the Institutional Requirements and outlined in the NIHS guidelines to the Common Program Requirements. (Core)

II.A.5. Associate Program Director (APD)

II.A.5.a) For programs with an approved resident complement of more than 15, the sponsoring institution must appoint an Associate Program director to support the PD by actively participating in administrative and educational activities. (Core)

II.A.5.b) Sponsoring institution to provide APD with 0.3 FTE (or 12 hours per week) of protected time for education and program administration. (Core)

II.A.5.b)(1) The APD must not work more than 0.7 FTE in a clinical capacity. This must be demonstrated through clinical schedules over the entire period since the last accreditation visit or since program inception, whichever is shorter. (Detail)

II.A.5.c) APD should assume the role for a duration suitable for ensuring program continuity and stability. (Core)

II.A.5.d) APD(s) must be clinically active in emergency medicine. (Core)

II.B.5.e) APD(s) must be core faculty members. (Core)

II.B. Faculty

Faculty members are a foundational element of graduate medical education – faculty members teach residents how to care for patients. Faculty members provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they

provide is enhanced by the opportunity to teach. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.

Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves.

Background and Intent: *"Faculty" refers to the entire teaching force responsible for educating residents. The term "faculty," including "core faculty," does not imply or require an academic appointment or salary support.*

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

II.B.1.a) The ratio of all faculty to residents is a minimum of 1:1. (Core)

II.B.2. Faculty members must:

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

II.B.2.b) demonstrate commitment to the delivery of safe, quality, cost-effective, patient-centered care; (Core)

Background and Intent: *Patients have the right to expect quality, cost-effective care with patient safety at its core. The foundation for meeting this expectation is formed during residency and fellowship. Faculty members model these goals and continually strive for improvement in care and cost, embracing a commitment to the patient and the community they serve.*

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

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

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

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

II.B.2.g) pursue faculty development designed to enhance their skills at least annually: (Core)

Background and Intent: *Faculty development is intended to describe structured programming developed for the purpose of enhancing transference of knowledge, skill, and behavior from the educator to the learner. Faculty development may occur in a variety of configurations (lecture, workshop, etc.) using internal and/or external resources. Programming is typically needs-based (individual or group) and may be specific to the institution or the program. Faculty development programming is to be reported for the residency program faculty in the aggregate.*

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

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

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

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

Background and Intent*: Practice-based learning serves as the foundation for the practice of medicine. Through a systematic analysis of one's practice and review of the literature, one is able to make adjustments that improve patient outcomes and care. Thoughtful consideration to practice-based analysis improves quality of care, as well as patient safety. This allows faculty members to serve as role models for residents in practice-based learning.*

II.B.2.h) Faculty members supervising emergency medicine residents in an adult emergency department must be licensed in emergency medicine. (Core)

II.B.3. Faculty Qualifications

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

II.B.3.a)(1) Faculty members supervising emergency medicine residents on pediatric emergency medicine rotations where pediatric emergency medicine fellows are also present must be licensed in pediatrics, emergency medicine, or pediatric emergency. (Core)

II.B.3.a)(1)(a) Faculty members licensed solely in pediatrics may not supervise emergency medicine residents in the emergency department in all other settings. (Core)

Background and Intent*: The requirements above allow the pediatric emergency medicine fellowship requirements concerning faculty certification and supervision to also apply to emergency medicine residents when rotating on pediatric emergency medicine*

rotations/services where pediatric emergency medicine fellows are also present. According to the Program Requirements for Pediatric Emergency Medicine, it is acceptable for a faculty member certified solely in pediatrics to supervise pediatric emergency medicine fellows. The requirements above permit this supervision for emergency medicine residents on these rotations/services as the only exception.

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

II.B.3.b)(1) have current license in Emergency Medicine or other specialty as required, or possess qualifications judged acceptable to the Central Accreditation Committee. (Core)

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

***Background and Intent**: The provision of optimal and safe patient care requires a team approach. The education of residents by non-physician educators enables the resident to better manage patient care and provides valuable advancement of the residents' knowledge. Furthermore, other individuals contribute to the education of the resident in the basic science of the specialty or in research methodology. If the program director determines that the contribution of a non-physician individual is significant to the education of the residents, the program director may designate the individual as a program faculty member or a program core faculty member.*

II.B.4. Core Faculty

Core faculty members must have a significant role in the education and supervision of residents and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents. (Core)

***Background and Intent**: Core faculty members are critical to the success of resident education. They support the program leadership in developing, implementing, and assessing curriculum and in assessing residents' progress toward achievement of competence in the specialty. Core faculty members should be selected for their broad knowledge of and involvement in the program, permitting them to effectively evaluate the program, including completion of the annual NIHS Faculty annual survey.*

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

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

II.B.4.c) There must be a minimum of one core physician faculty member for every four residents (1:4) in the program. (Core)

II.C. Program Coordinator

II.C.1. There must be a program coordinator. (Core)

II.C.2. At a minimum, the program coordinator must be provided with adequate time for the administration of the program. (Core)

Background and Intent: *Each program requires a lead administrative person, frequently referred to as a program coordinator, administrator, or as titled by the institution. This person will frequently manage the day-to-day operations of the program and serve as an important liaison with learners, faculty and other staff members, and the NIHS. Individuals serving in this role are recognized as program coordinators.*

The program coordinator is a member of the leadership team and is critical to the success of the program. As such, the program coordinator must possess skills in leadership and personnel management. Program coordinators are expected to develop unique knowledge of the NIHS and Program Requirements, policies, and procedures. Program coordinators assist the program director in accreditation efforts, educational programming, and support of residents.

Programs, in partnership with their Sponsoring Institutions, should encourage the professional development of their program coordinators and avail them of opportunities for both professional and personal growth. Programs with fewer residents may not require a full-time coordinator; one coordinator may support more than one program.

II.D. Other Program Personnel

The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective administration of the program. (Core)

Background and Intent: *Multiple personnel may be required to effectively administer a program. These may include staff members with clerical skills, project managers, education experts, and staff members to maintain electronic communication for the program. These personnel may support more than one program in more than one discipline.*

III. Resident Appointments

III.A. Eligibility Requirements

III.A.1. An applicant must meet the following qualifications to be eligible for appointment to a NIHS -accredited program: (Core)

III.A.1.a) Refer to NIHS criteria included in the Training Bylaw. (Core)

III.A.2. All prerequisite post-graduate clinical education required for initial entry or transfer into NIHS-accredited residency programs must be completed in a NIHS-accredited residency programs, or in residency programs approved by the NIHS. (Core)

III.A.2.a) Residency programs must receive verification of each resident's level of competency in the required clinical field using NIHS Milestones evaluations from the prior training program upon matriculation. (Core)

Background and Intent: *Programs with ACGME-I Foundational Accreditation or from institutions with ACGME-I accreditation do not qualify unless the program has also achieved ACGME-I Advanced Specialty Accreditation. To ensure entrants into NIHS-accredited programs from ACGME-I programs have attained the prerequisite milestones for this training, they must be from programs that have ACGME-I Advanced Specialty Accreditation.*

III.A.2.b) Prior to appointment in the program, residents must fulfill the NIHS eligibility criteria. (Core)

III.A.3. A physician who has completed a residency program that was not accredited by NIHS, may enter a NIHS-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director of the NIHS-accredited program and with approval by the GMEC, may be advanced to the PGY-2 level based on NIHS Milestones evaluations at the NIHS-accredited program. (Core)

III.B. Number of Residents

III.B.1. The program director must not appoint more residents than approved by the Central Accreditation Committee. (Core)

III.B.2. All changes in resident complement must be approved by the NIHS Central Accreditation Committee. (Core)

III.B.3. The number of residents appointed to the program must not exceed the program's educational and clinical resources. (Core)

III.C. Resident Transfers

The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring resident, and Milestones evaluations upon matriculation. (Core)

IV. Educational Program

The NIHS accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.

The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.

IV.A. Curriculum Components

The Educational Curriculum must contain the following educational components: (Core)

IV.A.1. A set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates. (Core)

IV.A.2. Competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice which is documented by Milestones evaluation. (Core)

IV.A.3. These goals and objectives must be distributed and available to residents and faculty members. (Core)

IV.A.4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and graded supervision. (Core)

IV.A.4.a) These responsibilities are described for each PGY level and specified in Milestones progress as determined by the Clinical Competency Committee (CCC).

IV.A.5. A broad range of structured didactic activities. (Core)

IV.A.4.a) A Residents must be provided with protected time to participate in structured core didactic activities. (Core)

IV.A.4.b) Didactic activities include, but are not limited to, lectures, conferences, courses, labs, asynchronous learning, case discussions, grand rounds, didactic teaching, journal clubs, and education in critical appraisal of medical evidence. (Core)

IV.A.6. Advancement of residents' knowledge of ethical principles essential to medical professionalism. (Core)

IV.A.7. Advancement in the residents' knowledge of the basic principles of scientific inquiry, including how to design, conduct, and evaluate clinical research, explanation of it to patients, and applied to patient care. (Core)

IV.B. Defined Core Competencies

IV.B.1. The program must integrate the following Core Competencies into the curriculum: (Core)

IV.B.1.a) Professionalism

Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)

IV.B.1.a)(1) Residents must demonstrate competence in:

IV.B.1.a)(1)(a) compassion, integrity, and respect for others; (Core)

IV.B.1.a)(1)(b) responsiveness to patient needs that supersedes self-interest; (Core)

IV.B.1.a)(1)(c) respect for patient privacy and autonomy; (Core)

IV.B.1.a)(1)(d) accountability to patients, society, and the profession; (Core)

IV.B.1.a)(1)(e) respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation; (Core)

IV.B.1.a)(1)(f) ability to recognize and develop a plan for one's own professional wellbeing; (Core)

IV.B.1.a)(1)(g) appropriately disclosing and addressing conflict or duality of interest. (Core)

IV.B.1.b) Patient Care and Procedural Skills

IV.B.1.b)(1) Residents must be able to provide patient care that is appropriate, and effective for the treatment or health problems and the promotion of health. (Core)

IV.B.1.b)(1)(a) Residents must demonstrate competence in:

IV.B.1.b)(1)(a)(i) synthesizing essential data necessary for the correct management of a patient with multiple chronic medical problems and, when appropriate, comparing with a prior medical record and identifying significant differences between the current presentation and past presentations; (Core)

IV.B.1.b)(1)(a)(ii) generating an appropriate differential diagnosis; (Core)

IV.B.1.b)(1)(a)(iii) applying the results of diagnostic testing based on the probability of disease and the likelihood of test results altering management; (Core)

IV.B.1.b)(1)(a)(iv) narrowing and prioritizing the list of weighted differential diagnoses to determine appropriate management based on all of the available data; (Core)

IV.B.1.b)(1)(a)(v) implementing an effective patient management plan; (Core)

IV.B.1.b)(1)(a)(vi) selecting and prescribing appropriate pharmaceutical agents based upon relevant considerations, such as: allergies; clinical guidelines; intended effect; financial considerations; institutional policies; mechanism of action; patient preferences; possible adverse effects; and potential drug food and drug-drug interactions; and effectively combining agents and monitoring and intervening in the advent of adverse effects in the emergency department; (Core)

IV.B.1.b)(1)(a)(vii) progressing along a continuum of managing a single patient, to managing multiple patients and resources within the emergency department; (Core)

IV.B.1.b)(1)(a)(viii) providing health care services aimed at preventing health problems or maintaining health; (Core)

IV.B.1.b)(1)(a)(ix) working with health care professionals to provide patient-focused care; (Core)

IV.B.1.b)(1)(a)(x) identifying life-threatening conditions and the most likely diagnosis, synthesizing acquired patient data, and identifying how and when to access current medical information; (Core)

IV.B.1.b)(1)(a)(xi) establishing and implementing a comprehensive disposition

plan that uses appropriate consultation resources, patient education regarding diagnosis, treatment plan, medications, and time and location specific disposition instructions; (Core)

IV.B.1.b)(1)(a)(xii) re-evaluating patients undergoing emergency department observation (and monitoring) and using appropriate data and resources, and, determining the differential diagnosis, treatment plan, and disposition. (Core)

IV.B.1.b)(2) Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)

IV.B.1.b)(2)(a) Residents must demonstrate competence in:

IV.B.1.b)(2)(a)(i) performing diagnostic and therapeutic procedures and emergency stabilization; (Core)

IV.B.1.b)(2)(a)(ii) managing critically-ill and injured patients who present to the emergency department, prioritizing critical initial stabilization action, mobilizing hospital support services in the resuscitation of critically-ill or injured patients and reassessing after a stabilizing intervention; (Core)

IV.B.1.b)(2)(a)(iii) properly sequencing critical actions for patient care and generating a differential diagnosis for an undifferentiated patient; (Core)

IV.B.1.b)(2)(a)(iv) mobilizing and managing necessary personnel and other hospital resources to meet critical needs of multiple patients; (Core)

IV.B.1.b)(2)(a)(v) performing invasive procedures, monitoring unstable patients, and directing major resuscitations of all types on all age groups. (Core)

IV.B.1.b)(2)(b) Residents must perform indicated procedures on all appropriate patients, including those who are uncooperative, at the extremes of age, hemodynamically unstable and who have multiple co-morbidities, poorly defined anatomy, high risk for pain or procedural complications, or require sedation, take steps to avoid potential complications; and recognize the outcome and/or complications resulting from the procedures. (Core)

IV.B.1.b)(2)(c) Residents must demonstrate competence in performing the following key index procedures:

IV.B.1.b)(2)(c)(i) adult medical resuscitation; (Core)

IV.B.1.b)(2)(c)(ii) adult trauma resuscitation; (Core)

IV.B.1.b)(2)(c)(iii) anesthesia and pain management; (Core)

IV.B.1.b)(2)(c)(iii)(a) Residents must provide safe acute pain management, anesthesia, and procedural sedation to patients of all ages regardless of the clinical situation. (Core)

IV.B.1.b)(2)(c)(iv) cardiac pacing; (Core)

IV.B.1.b)(2)(c)(v) chest tubes; (Core)

IV.B.1.b)(2)(c)(vi) cricothyrotomy; (Core)

IV.B.1.b)(2)(c)(vii) dislocation reduction; (Core)

IV.B.1.b)(2)(c)(viii) emergency department bedside ultrasound; (Core)

IV.B.1.b)(2)(c)(viii)(a) Residents must use ultrasound for the bedside diagnostic evaluation of emergency medical conditions and diagnoses, resuscitation of the acutely ill or injured patient, and procedural guidance. (Core)

IV.B.1.b)(2)(c)(ix) intubations; (Core)

IV.B.1.b)(2)(c)(ix)(a) Residents must perform airway management on all appropriate patients, including those who are uncooperative, at the extremes of age, hemodynamically unstable and who have multiple co-morbidities, poorly-defined anatomy, high risk for pain or procedural complications, or require sedation); take steps to avoid potential complications; and recognize the outcome and/or complications resulting from the procedures. (Core)

IV.B.1.b)(2)(c)(x) lumbar puncture; (Core)

IV.B.1.b)(2)(c)(xi) pediatric medical resuscitation; (Core)

IV.B.1.b)(2)(c)(xii) pediatric trauma resuscitation; (Core)

IV.B.1.b)(2)(c)(xiii) pericardiocentesis; (Core)

IV.B.1.b)(2)(c)(xiv) procedural sedation; (Core)

IV.B.1.b)(2)(c)(xv) vaginal delivery; (Core)

IV.B.1.b)(2)(c)(xvi) vascular access; (Core)

IV.B.1.b)(2)(c)(xvi)(a) Residents must successfully obtain vascular access in patients of all ages regardless of the clinical situation. (Core)

IV.B.1.b)(2)(c)(xvii) wound management. (Core)

IV.B.1.b)(2)(c)(xvii)(a) Residents must assess and appropriately manage wounds in patients of all ages regardless of the clinical situation. (Core)

IV.B.1.c) Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social behavioral sciences, as well as the application of this knowledge to patient care. (Core)

IV.B.1.c)(1) Residents must demonstrate appropriate medical knowledge in the care of emergency medicine patients; (Core)

IV.B.1.c)(2) Residents must demonstrate knowledge of the scientific method of problem solving, evidence-based decision making, a commitment to lifelong learning, and an attitude of caring derived from humanistic and professional values. (Core)

IV.B.1.d) Practice-based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, applying scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning. (Core)

IV.B.1.d)(1) Residents must demonstrate competence in:

IV.B.1.d)(1)(a) identifying strengths, deficiencies, and limits in one's knowledge and expertise; (Core)

IV.B.1.d)(1)(b) setting learning and improvement goals; (Core)

IV.B.1.d)(1)(c) identifying and performing appropriate learning activities; (Core)

IV.B.1.d)(1)(d) systematically analyzing practice using quality improvement methods and implementing changes with the goal of practice improvement; (Core)

IV.B.1.d)(1)(e) incorporating feedback and formative evaluation into daily practice; (Core)

IV.B.1.d)(1)(f) locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems; (Core)

IV.B.1.d)(1)(g) using information technology to optimize learning; (Core)

IV.B.1.d)(1)(h) applying knowledge of study design and statistical methods to critically appraise the medical literature; (Core)

IV.B.1.d)(1)(i) using information technology to improve patient care; (Core)

IV.B.1.d)(1)(j) evaluating teaching effectiveness; (Core)

IV.B.1.d)(1)(k) teaching different audiences using appropriate strategies based on targeted learning objectives. (Core)

IV.B.1.e) Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Core)

IV.B.1.e)(1) Residents must demonstrate competence in:

IV.B.1.e)(1)(a) communicating effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; (Core)

IV.B.1.e)(1)(b) communicating effectively with physicians, other health professionals and health-related agencies; (Core)

IV.B.1.e)(1)(c) working effectively as a member or leader of a health care team or other professional group; (Core)

IV.B.1.e)(1)(d) educating patients, families, students, residents, and other health professionals; (Core)

IV.B.1.e)(1)(e) acting in a consultative role to other physicians and health professionals; (Core)

IV.B.1.e)(1)(f) maintaining comprehensive, timely, and legible medical records, if applicable; (Core)

IV.B.1.e)(1)(g) communicating sensitive issues or unexpected outcomes, including: (Core)

IV.B.1.e)(1)(g)(i) diagnostic findings; (Core)

IV.B.1.e)(1)(g)(ii) end-of-life issues and death; (Core)

IV.B.1.e)(1)(g)(iii) medical errors. (Core)

IV.B.1.e)(1)(h) leading patient care teams, ensuring effective communication and mutual respect among team members. (Core)

IV.B.1.e)(2) Residents must learn to communicate with patients and families to partner with them to assess their care goals, including, when appropriate, end-of-life goals. (Core)

IV.B.1.f) Systems-based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)

IV.B.1.f)(1) Residents must demonstrate competence in:

IV.B.1.f)(1)(a) working effectively in various health care delivery settings and systems relevant to their clinical specialty; (Core)

IV.B.1.f)(1)(b) coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty; (Core)

IV.B.1.f)(1)(c) advocating for quality patient care and optimal patient care systems; (Core)

IV.B.1.f)(1)(d) working in interprofessional teams to enhance patient safety and improve patient care quality;(Core)

IV.B.1.f)(1)(e) participating in identifying system errors and implementing potential systems solutions; (Core)

IV.B.1.f)(1)(f) incorporating considerations of value, cost awareness, delivery and payment, and risk benefit analysis in patient and/or population-based care as appropriate; (Core)

IV.B.1.f)(1)(g) understanding health care finances and its impact on individual patients' health decisions; (Core)

IV.B.1.f)(1)(h) participation in performance improvement to optimize self-learning, emergency department function, and patient safety; (Core)

IV.B.1.f)(1)(i) using technology to accomplish and document safe health care delivery. (Core)

IV.B.1.f)(2) Residents must learn to advocate for patients within the health care system to achieve the patient's and family's care goals, including, when appropriate, end-of-life goals. (Core)

IV.C. Curriculum Organization and Resident Experiences

IV.C.1. The curriculum must be structured to optimize resident educational experiences, the length of these experiences, and supervisory continuity. (Core)

IV.C.1.a) Clinical experiences should be structured to facilitate learning in a manner that allows the residents to function as part of an effective interprofessional team that works together toward the shared goals of patient safety and quality improvement. (Detail)

IV.C.1.a)(1) The emergency medicine program director is responsible for ensuring the duration of the clinical experiences on all core rotations as defined by the NIHS Emergency Medicine Committee. The rotations requirements Table 1 and the rotation grid per year Table 2 are described below. (Core)

Table 1. Emergency medicine rotation requirements.

Item No.	Rotation description	Duration in No. of blocks
1. 1.a 1.b	Adult Emergency Medicine (AEM) AEM/ED administration (Core) AEM/ED ultrasound (Core)	25
2.	Pediatrics Emergency Medicine (PEM)	6
3.	Toxicology (TOX) (Core)	1
4.	Emergency Medical Services- EMS (Core)	1
5.	Anesthesia (Anes) (Core)	1
6.	Adult Intensive Care (ICU)	4
7.	CCU/ cardiology	1
8.	Pediatric Intensive Care (PICU)	2
9. 9.a	Radiology (Rad) Rad/research	1
10. 10.a	ENT ENT/research	1
11. 11.a	Ophthalmology (Ophth) Ophth/Research	1
12.	Obs/Gyn	1

13.	Internal Medicine (Med) (Can be replaced by AEM)	1
14.	Electives	2
15.	General Surgery (Gen Surg) (Can be replaced by AEM)	1
16.	Trauma	1
17.	Orthopedic (Can be replaced by AEM)	1
18.	Plastic surgery (Can be replaced by AEM)	1
19.	*Research total 1.5 blocks combined with ENT, Ophth and Rad.	

Table 2: Clinical Rotations Grid based on training level													
Block	1	2	3	4	5	6	7	8	9	10	11	12	13
PGY 1	AEM1	Int Med	Trauma	Gen Surg	OB/G	AEM2	AEM3	Plastic	Anes	AEM4	Ophth/ research	Ortho	PEM1
PGY 2	AEM5	Rad/ Research	ICU1	ICU2	CCU/ Card	AEM 6	PICU	PICU	AEM7/ ED US	AEM 8	PEM2	PEM3	AEM9
PGY 3	AEM 10	AEM 11	PEM4	ICU 3	ICU 4	AEM 12	Elective1	AEM13	AEM 14	Elective 2	AEM 15	PEM5	EMS
PGY 4	AEM 16	AEM 17	AEM 18/ ED Admin	PEM6	AEM19	AEM 20	AEM 21	ENT/ research	AEM 22	AEM 23	AEM 24	Tox	AEM 25
*The order of rotations in table 2 is not chronological rather it indicates what rotation will take place in each specific training year.													

IV.C.1.b) Assignment of rotations must be structured with sufficient length (not less than four weeks in total where three weeks are dedicated to clinical service) to provide a quality educational experience, defined by continuity of patient care, ongoing supervision, relationships with faculty members, and high-quality assessment and feedback. (Core)

IV.C.1.c) Clinical experiences should be structured to facilitate learning in a manner that allows residents to function as part of an effective interprofessional team. (Core)

IV.C.2. The program must provide instruction and experience in pain management if applicable in emergency medicine, including recognition of the signs of addiction. (Core)

IV.C.3. Didactics

IV.C.3.a) Didactic experiences must include administrative seminars, journal review, presentations based on the defined curriculum, morbidity and mortality conferences, and research seminars. (Core)

IV.C.3.a)(1) These didactic experiences should include joined conferences co-sponsored with other disciplines. (Core)

IV.C.3.a)(2) Educational methods should include problem-based learning, evidence-based learning, and computer-based instruction. (Core)

Background and Intent: *In some specialties, frequent rotational transitions, inadequate continuity of faculty member supervision, and dispersed patient locations within the hospital have adversely affected optimal resident education and effective team-based care.*

IV.C.3.b) The majority of didactic experiences must occur at the primary clinical site. (Core)

IV.C.3.c) There must be an average of at least five hours per week of planned didactic experiences developed by the program's faculty members. (Core)

IV.C.3.c)(1) Individualized interactive instruction must not exceed 20 percent of the planned didactic experiences. (Core)

IV.C.3.c)(2) All planned didactic experiences must be supervised by core physician faculty members. (Core)

IV.C.3.c)(3) Each core physician faculty member must attend, on average per year, at least 20 percent of planned didactic experiences. (Core)

IV.C.3.c)(4) Emergency medicine faculty members must present at least 50 percent of resident conferences. (Core)

IV.C.3.c)(5) Residents must attend, on average, at least 70 percent of the planned didactic experiences offered. (Core)

IV.C.3.c)(6) All planned didactic experiences must have an evaluative component to measure resident participation and educational effectiveness. (Core)

IV.C.4. Curriculum

The curriculum must include:

IV.C.4.a) four months of dedicated critical care experiences, including critical care of infants and children; (Core)

IV.C.4.a)(1) At least two months of these experiences must be at the PGY-2 level or above. (Core)

IV.C.4.b) at least 10 low-risk normal spontaneous vaginal deliveries; (Core)

IV.C.4.c) five months, or 20 percent of all emergency department encounters, dedicated to the care of pediatric patients less than 18 years of age in the pediatric emergency department or other pediatric settings; (Core)

IV.C.4.d) at least 60 percent of each resident's clinical experience, including experiences dedicated to the care of pediatric patients less than 18 years of age in the pediatric emergency department, must take place in the emergency department under the supervision of emergency medicine faculty members. (Core)

IV.C.4.d)(1) Residents should treat a significant number of critically-ill or critically injured patients at participating sites. (Core)

IV.C.4.d)(1)(a) These patients should be those admitted to intensive care units, operative care, or the morgue following treatment in the emergency department. (Core)

IV.C.5. Resident Experiences

IV.C.5.a) Each resident must maintain, in an accurate and timely manner, a record of all major resuscitations and procedures performed throughout the entire educational program. (Core)

IV.C.5.a)(1) The record must document each procedure type, adult or pediatric patient, and circumstances of each procedure (live or simulation). (Core)

IV.C.5.a)(2) Only one resident must be credited with the direction of each resuscitation and the performance of each procedure. (Core)

IV.C.5.a)(3) Resident experiences with major resuscitations and procedures must at least meet the procedural minimums as defined by the Central Accreditation Committee where indicated. (Core)

IV.C.5.b) Residents must have experience in emergency medical services (EMS), emergency preparedness, and disaster management. (Core)

IV.C.5.b)(1) EMS experiences must include ground unit runs and should include direct medical oversight. (Core)

IV.C.5.b)(2) This should include participation in multi-casualty incident drills. (Core)

IV.C.5.b)(3) If programs allow residents to ride in air ambulance units, the residents must be notified in writing of the associated risks prior to their first flight. (Core)

IV.C.5.b)(3)(a) Residents must be given the opportunity to opt out of riding in air ambulance units at any point in residency. (Core)

IV.D. Scholarship

Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through resident participation in scholarly activities. Scholarly activities must include discovery, integration, application and teaching.

IV.D.1. Program Responsibilities

IV.D.1.a) The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)

IV.D.1.b) The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities. (Core)

IV.D.1.c) The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. (Core)

Background and Intent: *Elements of a scholarly approach to patient care include:*

- *Asking meaningful questions to stimulate residents to utilize learning resources to create a differential diagnosis, a diagnostic algorithm, and treatment plan*
- *Challenging the evidence that the residents use to reach their medical decisions so that they understand the benefits and limits of the medical literature*
- *When appropriate, dissemination of scholarly learning in a peer-reviewed manner (publication or presentation)*
- *Improving resident learning by encouraging them to teach using a scholarly approach*

IV.D.2. Faculty Scholarly Activity

IV.D.2.a) Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core)

- Research in basic science, education, translational science, patient care, or population health
- Peer-reviewed journal publications, case-presentation publications
- Quality improvement and/or patient safety initiatives
- Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports
- Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials
- Contribution to professional committees, educational organizations, or editorial boards
- Innovations in education

IV.D.2.b) The program must demonstrate scholarly activity by the following methods: (Core)

IV.D.2.b)(1) faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium

presentations, reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; (Core)

IV.D.2.b)(2) peer-reviewed publication incl. case-discussion and letters to the editor. (Core)

IV.D.3. Resident Scholarly Activity

IV.D.3.a) While in the program, residents must engage in at least one of the following scholarly activities: participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor. (Core)

IV.D.3.b) Residents must participate in scholarly project. (Core)

IV.D.3.b)(1) Residents must complete a scholarly project relevant to the specialty which was conducted under supervision of a faculty member. (Core)

IV.D.3.b)(2) The project, shall be prepared in a form which can be used for publication or presentation and submitted for publication in a specialty specific journal or presented in a national or international specialty conference. (Core)

IV.D.3.b)(3) The proof of project submission for publication, or presentation in a medical conference, will be part of the resident's portfolio and will be documented in the final summative evaluation prior to Board Certification, in accordance with NIHS guidelines.

V. Evaluation

V.A. Resident Evaluation

V.A.1. Feedback and Evaluation

Formative and summative evaluation have distinct definitions.

Formative evaluation is monitoring resident learning and providing ongoing feedback that can be used by residents to improve their learning.

More specifically, formative evaluations help:

- residents identify their strengths and weaknesses and target areas that need work
- program directors and faculty members recognize where residents are struggling and address problems immediately.

Summative evaluation is evaluating a resident's learning by comparing the residents against the goals and objectives of the rotation and program, respectively and is utilized to make decisions about promotion to the next level of training, or program completion.

End-of-rotation and end-of-year evaluations have both summative and formative components. Information from a summative evaluation can be used formatively when residents or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the residency program.

V.A.1.a) Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)

This feedback will allow for the development of the learner as they strive to achieve the Milestones. More frequent feedback is strongly encouraged for residents who have deficiencies that may result in a poor final rotation evaluation.

V.A.1.b) Evaluation must be documented at the completion of the assignment. (Core)

V.A.1.b)(1) For block rotations of greater than three months in duration, evaluation must be documented at least every three months. (Core)

V.A.1.b)(2) For block rotations of any duration, a written evaluation must be provided at the end of the rotation. (Core)

V.A.1.b)(3) Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion. (Core)

V.A.1.c) The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones, and must: (Core)

V.A.1.c)(1) use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members) (Core)

V.A.1.c)(2) provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. (Core)

V.A.1.d) The program director or their designee, with input from the Clinical Competency Committee, must:

V.A.1.d)(1) Meet with and review with each resident their documented semi-annual evaluation of performance, including progress and the specialty-specific Milestones (Core)

V.A.1.d)(1)(a) Review of resident Case-Logs must be a part of the semi-annual review. (Detail)

V.A.1.d)(1)(a) The program director must verify each resident's records of major resuscitations and procedures as part of the semiannual evaluation. (Core)

V.A.1.d)(2) assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; (Core)

V.A.1.d)(3) develop plans for residents failing to progress, following both the NIHS Emirati Board and institutional policies and procedures. (Core)

Residents who are experiencing difficulties with achieving progress in the Milestones may require intervention to address specific deficiencies. Such intervention, documented in an individual remediation plan developed by the program director or a faculty mentor and the resident, will take a variety of forms based on the specific learning needs of the resident. However, the NIHS recognizes that there are situations which require more significant intervention that may alter the time course of resident progression. To ensure due process, it is essential that the program director follow NIHS and institutional policies and procedures.

V.A.1.d)(3)(a) A plan to remedy deficiencies must be in writing and on file. (Core)

V.A.1.d)(3)(a)(i) Progress and improvement must be monitored at a minimum of every

three months if a resident has been identified as needing a remediation plan. (Core)

V.A.1.e) At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable. (Core)

V.A.1.e)(1) At least annually, each resident's competency in procedures and resuscitations must be formally evaluated by the program director. (Core)

V.A.1.f) The evaluations of a resident's performance must be accessible for review by the resident. (Core)

V.A.1.g) Assessment should specifically monitor the resident's knowledge by use of a formal In-Training Examination or other cognitive exams. Tests results should not be the sole criterion of resident knowledge and should not be used as the sole criterion for promotion to a subsequent PG level. (Detail)

V.A.1.h) Resident Promotion

- Residents are eligible to sit for Part 1 of the Emirati Board Exam after completing PGY2 and should complete it by the end of PGY3 as a prerequisite to being promoted to PGY4.
- Residents who fail the Part 1 exam after PGY3 are required to repeat the year. Refer to NIHS eligibility criteria included in the Training Bylaw.

V.A.2. Final Evaluation

V.A.2.a) The program director must provide a final evaluation for each resident upon completion of the program. (Core)

V.A.2.a)(1) The specialty-specific Milestones, and when applicable the specialty-specific Case Logs, must be used as tools to document performance and verify that the resident has demonstrated sufficient competence to be able to engage in autonomous practice upon completion of the program, and once he/she obtain the license to practice in his/her speciality. (Core)

V.A.2.a)(2) The final evaluation must:

V.A.2.a)(2)(a) become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy; (Core)

V.A.2.a)(2)(b) verify that the resident has demonstrated the knowledge, skills, and behaviours necessary to enter autonomous practice; (Core)

V.A.2.a)(2)(c) consider recommendations from the Clinical Competency Committee (Core)

V.A.2.a)(2)(d) be shared with the resident upon completion of the program. (Core)

V.A.3. A Clinical Competency Committee must be appointed by the program director. (Core)

V.A.3.a) The Clinical Competency Committee must include at least three members of the program faculty, at least one of whom is a core faculty member. (Core)

V.A.3.a)(1) Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents. (Core)

V.A.3.a)(2) The Program Director has final responsibility for resident evaluation and promotion decisions. (Core)

V.A.3.b) The Clinical Competency Committee must:

V.A.3.b)(1) Review all residents evaluation at least semi-annually; (Core)

V.A.3.b)(2) determine each resident's progress on achievement of the specialty-specific Milestones; and, (Core)

V.A.3.b)(3) meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress. (Core)

V.B. Faculty Evaluation

V.B.1. The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)

V.B.1.a) This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, review of patient outcomes, professionalism, research, and scholarly activities. (Core)

V.B.1.b) This evaluation must include written, anonymous, and confidential evaluations by the residents. (Core)

V.B.2. Faculty members must receive feedback on their evaluations at least annually. (Core)

V.B.3. Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)

V.B.4. The program has the responsibility to evaluate and improve the program faculty members' teaching, scholarship, professionalism, and quality care. Therefore, the annual review of the program's faculty members is mandatory and can be used as input into the Annual Program Evaluation. (Core)

V.C. Program Evaluation and Improvement

V.C.1. The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)

The performance of residents and faculty members reflects program quality and will use metrics to reflect the program's goals.

The Program Evaluation Committee must present the Annual Program Evaluation Report in a written form to be discussed with all program faculty and residents as a part of continuous improvement plans.

V.C.1.a) The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident. (Core)

V.C.1.b) Program Evaluation Committee responsibilities must include:

V.C.1.b)(1) acting as an advisor to the program director, through program oversight; (Core)

V.C.1.b)(2) review of the program's requirements, both NIHS Emirati Board required and program self-determined goals, and the progress toward meeting them; (Core)

V.C.1.b)(3) guiding ongoing program improvement, including developing new goals based upon outcomes; (Core)

V.C.1.b)(4) review of the current operating environment to identify strengths, challenges, opportunities, and threats related to the program's mission and aims. (Core)

V.C.1.c) The Program Evaluation Committee should consider the following elements in its assessment of the program:

V.C.1.c)(1) program curriculum; (Core)

V.C.1.c)(2) outcomes from prior Annual Program Evaluation(s); (Core)

V.C.1.c)(3) NIHS letters of notification including citations, areas for improvement, and comments; (Core)

V.C.1.c)(4) the quality and safety of patient care; (Core)

V.C.1.c)(5) Aggregate residents and the faculty:

V.C.1.c)(5)(a) well-being; (Core)

V.C.1.c)(5)(b) recruitment and retention following institutional policies; (Core)

V.C.1.c)(5)(c) workforce diversity following institutional policies; (Core)

V.C.1.c)(5)(d) engagement in quality improvement and patient safety; (Core)

V.C.1.c)(5)(e) scholarly activity; (Core)

V.C.1.c)(5)(f) Resident and Faculty Surveys; (Core)

V.C.1.c)(5)(g) written evaluations of the program (see above). (Core)

V.C.1.c)(6) Aggregate resident:

V.C.1.c)(6)(a) achievement of the Milestones; (Core)

V.C.1.c)(6)(b) in-training examination results ; (Core)

V.C.1.c)(6)(c) board pass and certification rates (Core)

V.C.1.c)(6)(d) graduates' performance. (Core)

V.C.1.c)(7) Aggregate faculty:

V.C.1.c)(7)(a) faculty evaluation; (Core)

V.C.1.c)(7)(b) professional development. (Core)

V.C.1.d) The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)

V.C.1.e) The Annual Program Evaluation review, including the action plan, must:

V.C.1.e)(1) be distributed to and discussed with the members of the teaching faculty and the residents (Core)

V.C.1.e)(2) be submitted to the DIO. (Core)

V.C.2. The program will be accredited and reaccredited by the NIHS according with NIHS Accreditation bylaws. (Core)

V.C.2.a) The program must complete a Self-Study before its reaccreditation Site Visit. (Core)

V.C.2.b) The Self-Study is an objective, comprehensive evaluation of the residency program with the aim to improve it. (Core)

V.C.3. The goal of NIHS-accredited education is to train physicians who seek and achieve a board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.

V.C.4. Under the guidance of the Program Director all eligible program graduates should take the certifying examination conducted by the NIHS Emirati Board of Urology to obtain the Board Certification. (Core)

V.C.5. During the residency, the Residents are strongly encouraged to sit for an organized Annual In-Training Examination. (Core)

VI. The Learning and Working Environment

Residency education must occur in the context of a learning and working environment that emphasizes the following principles:

- Excellence in the safety and quality of care rendered to patients by residents today
- Excellence in the safety and quality of care rendered to patients by today's residents in their future practice
- Excellence in professionalism through faculty modeling of:
    - the effacement of self-interest in a humanistic environment that supports the professional development of physicians
    - the joy of curiosity, problem-solving, intellectual rigor, and discovery
- Commitment to the well-being of the students, residents, faculty members, and all members of the health care team

VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability

VI.A.1. Patient Safety and Quality Improvement

All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Graduate medical education must prepare residents to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by residents who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.

Residents must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating residents will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

It is necessary for residents and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.

VI.A.1.a) Patient Safety

VI.A.1.a)(1) Culture of Safety

A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.

VI.A.1.a)(1)(a) The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)

VI.A.1.a)(1)(b) The program must have a structure that promotes safe, inter-professional, team-based care. (Core)

VI.A.1.a)(2) Education on Patient Safety

Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)

Background and Intent: *Optimal patient safety occurs in the setting of a coordinated inter-professional learning and working environment.*

VI.A.1.a)(3) Patient Safety Events

Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.

VI.A.1.a)(3)(a) Residents, fellows, faculty members, and other clinical staff members must:

- know their responsibilities in reporting patient safety events at the clinical site; (Core)
- know how to report patient safety events, including near misses, at the clinical site; (Core)
- be provided with summary information of their institution's patient safety reports. (Core)

VI.A.1.a)(3)(b) Residents must participate as team members in real and/or simulated inter-professional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)

VI.A.1.a)(4) Resident Education and Experience in Disclosure of Adverse Events

Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for residents to develop and apply.

VI.A.1.a)(4)(a) All residents must receive training in how to disclose adverse events to patients and families. (Core)

VI.A.1.a)(4)(b) Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated. (Detail)

VI.A.1.b) Quality Improvement

VI.A.1.b)(1) Education in Quality Improvement

A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.

Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities. (Core)

VI.A.1.b)(2) Quality Metrics

Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.

Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)

VI.A.1.b)(3) Engagement in Quality Improvement Activities

Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.

Residents must have the opportunity to participate in inter-professional quality improvement activities. (Core)

VI.A.2. Supervision and Accountability

VI.A.2.a) Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.

Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

VI.A.2.a)(1) Each patient must have an identifiable and appropriately-credentialed and privileged attending physician who is responsible and accountable for the patient's care. (Core)

VI.A.2.a)(1)(a) This information must be available to residents, faculty members, other members of the health care team, and patients. (Core)

VI.A.2.a)(1)(b) Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. (Core)

VI.A.2.b) Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the appropriate availability of the supervising faculty member, fellow, or senior resident physician, either on site or by means of telecommunication technology. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.

VI.A.2.b)(1) The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)

VI.A.2.b)(2) The program must define when physical presence of a supervising physician is required. (Core)

VI.A.2.c) Levels of Supervision

To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision: (Core)

VI.A.2.c)(1) Direct Supervision: the supervising physician is physically present with the resident during the key portions of the patient interaction. (Core)

PGY-1 residents must initially be supervised directly. (Core)

VI.A.2.c)(1)(a) The program must have clear guidelines that delineate which competencies must be demonstrated to determine when a resident can progress to indirect supervision. (Core)

VI.A.2.c)(1)(b) The program director must ensure that clear expectations exist and are communicated to the residents, and that these expectations outline specific situations in which a resident would still require direct supervision. (Core)

VI.A.2.c)(2) Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision. (Core)

VI.A.2.c)(3) Oversight: the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. (Core)

VI.A.2.d) The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. (Core)

VI.A.2.d)(1) The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones. (Core)

VI.A.2.d)(2) Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. (Core)

VI.A.2.d)(3) Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)

VI.A.2.e) Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). (Core)

VI.A.2.e)(1) Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. (Outcome)

VI.A.2.f) Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and

to delegate to the resident the appropriate level of patient care authority and responsibility. (Core)

VI.B. Professionalism

VI.B.1. Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients. (Core)

VI.B.2. The learning objectives of the program must:

VI.B.2.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; (Core)

VI.B.2.b) be accomplished without excessive reliance on residents to fulfill non-physician obligations; (Core)

VI.B.2.c) ensure manageable patient care responsibilities. (Core)

VI.B.3. The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)

VI.B.4. Residents and faculty members must demonstrate an understanding of their personal role in the:

VI.B.4.a) provision of patient- and family-centered care; (Core)

VI.B.4.b) safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; (Core)

Background and Intent: *This requirement emphasizes that responsibility for reporting unsafe conditions and adverse events is shared by all members of the team and is not solely the responsibility of the resident.*

VI.B.4.c) assurance of their fitness for work, including: (Core)

VI.B.4.c)(1) management of their time before, during, and after clinical assignments; and, (Core)

VI.B.4.c)(2) recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team. (Core)

VI.B.4.d) commitment to lifelong learning; (Core)

VI.B.4.e) monitoring of their patient care performance improvement indicators; (Core)

VI.B.4.f) accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data. (Core)

VI.B.5. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider. (Core)

VI.B.6. Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff. (Core)

VI.B.7. Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)

VI.C. Well-Being

Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of residency training.

Residents and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. For example, a culture which encourages covering for colleagues after an illness without the expectation of reciprocity reflects the ideal of professionalism. A positive culture, in a clinical learning environment, models constructive behaviors and prepares residents with the skills and attitudes needed to thrive throughout their careers.

VI.C.1. The responsibility of the program, in partnership with the Sponsoring Institution, to address well-being must include:

VI.C.1.a) efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; (Core)

VI.C.1.b) attention to scheduling, work intensity, and work compression that impacts resident well-being; (Core)

VI.C.1.c) evaluating workplace safety data and addressing the safety of residents and faculty members; (Core)

VI.C.1.d) policies and programs that encourage optimal resident and faculty member well-being; (Core)

VI.C.1.e) attention to resident and faculty member burnout, depression, and substance use disorders. The program, in partnership with its Sponsoring Institution, must educate faculty members and residents in identification of the symptoms of burnout, depression, and substance use disorders, including means to assist those who experience these conditions. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must: (Core)

VI.C.1.e)(1) encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, a substance use disorder, suicidal ideation, or potential for violence; (Core)

VI.C.1.e)(2) provide access to appropriate tools for self-screening; and, (Core)

VI.C.1.e)(3) provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)

VI.C.2. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and parental leave. Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities. (Core)

VI.C.2.a) The program must have policies and procedures in place to ensure coverage of patient care. (Core)

VI.C.2.b) These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work. (Core)

Background and Intent: *Residents may need to extend their length of training depending on length of absence and specialty board eligibility requirements. Teammates should assist colleagues in need and equitably reintegrate them upon return.*

VI.D. Fatigue Mitigation

VI.D.1. Programs must:

VI.D.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation; (Core)

VI.D.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; (Core)

VI.D.1.c) encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. (Detail)

VI.D.2. Each program must ensure continuity of patient care, consistent with the program's policies and procedures, if a resident may be unable to perform their patient care responsibilities due to excessive fatigue. (Core)

VI.D.3. The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. (Core)

VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care

VI.E.1. Clinical Responsibilities

The clinical responsibilities for each resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services. (Core)

VI.E.1.a) When emergency medicine residents are on emergency medicine rotations, the following standards apply: (Core)

VI.E.1.a)(1) While on duty in the emergency department, residents may not work longer than 12 continuous scheduled hours. (Core)

VI.E.1.a)(1)(a) There must be at least one equivalent period of continuous time off between scheduled work period. (Core)

VI.E.1.a)(2) A resident must not work more than 60 scheduled hours per week seeing patients in the emergency department, and no more than 72 total hours per week. (Core)

VI.E.1.a)(3) Emergency medicine residents must have a minimum of one day (24-hour period) free per each seven-day period. This cannot be averaged over a four-week period. (Core)

***Background and Intent**: The changing clinical care environment of medicine has meant that work compression due to high complexity has increased stress on residents. Faculty members and program directors need to make sure residents function in an environment that has safe patient care and a sense of resident well-being. It is an essential responsibility of the program director to monitor resident workload. Workload should be distributed among the resident team and interdisciplinary teams to minimize work compression.*

VI.E.2. Teamwork

Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty and larger health system. (Core)

VI.E.2.a) Interprofessional teams should be used to ensure effective and efficient communication for appropriate patient care for emergency medicine department admissions, transfers, and discharges. (Detail)

***Background and Intent**: Examples of professional personnel who may be part of interprofessional teams, all members of which must participate in the education of residents, include advanced practice providers, case managers, child-life specialists, emergency medical technicians, nurses, pain management specialists, pastoral care specialists, pharmacists, physician assistants, physicians, psychiatrists, psychologists, rehabilitative therapists, respiratory therapists, and social workers.*

VI.E.3. Transitions of Care

VI.E.3.a) Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)

VI.E.3.b) Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. (Core)

VI.E.3.c) Programs must ensure that residents are competent in communicating with team members in the hand-over process. (Core)

VI.E.3.d) Programs and clinical sites must maintain and communicate schedules of attending physicians and residents currently responsible for care. (Core)

VI.E.3.e) Each program must ensure continuity of patient care, consistent with the program's policies and procedures, if a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency. (Core)

VI.F. Clinical Experience and Education

Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.

VI.F.1. Maximum Hours of Clinical and Educational Work per Week

Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities and clinical work done from home. (Core)

VI.F.2. Mandatory Time Free of Clinical Work and Education

VI.F.2.a) The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being. (Core)

VI.F.2.b) Residents should have eight hours off between scheduled clinical work and education periods. (Detail)

There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements. (Detail)

VI.F.2.c) Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)

VI.F.2.d) Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when

averaged over four weeks). At-home call cannot be assigned on these free days. (Core)

VI.F.3. Maximum Clinical Work and Education Period Length

VI.F.3.a) Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core)

VI.F.3.a)(1) Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. (Core)

VI.F.3.a)(1)(a) Additional patient care responsibilities must not be assigned to a resident during this time. (Core)

VI.F.4. Clinical and Educational Work Hour Exceptions

VI.F.4.a) In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:

VI.F.4.a)(1) to continue to provide care to a single severely ill or unstable patient; (Detail)

VI.F.4.a)(2) humanistic attention to the needs of a patient or family; (Detail)

VI.F.4.a)(3) to attend unique educational events. (Detail)

VI.F.4.b) These additional hours of care or education will be counted toward the 80-hour weekly limit. (Detail)

VI.F.5. Moonlight

Residents are not permitted to moonlight. (Core)

VI.F.6. In-House Night Float

Night float must occur within the context of the 80-hour and one- day-off-in-seven requirements. (Core)

VI.F.7. Maximum In-House On-Call Frequency

Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core)

VI.F.8. At-Home Call

VI.F.8.a) Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. (Core)

VI.F.8.b) Residents are permitted to return to the hospital while on at- home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit. (Detail)

*Core Requirements: Statements that define structure, resource, or process elements essential to every graduate medical educational program.

†Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

‡Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.

Acknowledgement

A special gratitude to the Emergency Medicine Scientific Committee for their contribution in preparing NIHS Emergency Medicine Residency Program Requirements.

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