

**ACGME Program Requirements  
for Graduate Medical Education in Orthopaedic Surgery**

**Common Program Requirements Appear in Bold**  
Specialty Specific Requirements Are Not Bolded

- I. Introduction
  - A. Definition and Scope of the Specialty Orthopaedic surgery is the medical specialty that includes the study and prevention of musculoskeletal diseases, disorders, and injuries and their treatment by medical, surgical, and physical methods.
  - B. Duration and Scope of Education
    1. Orthopaedic residencies will be accredited to offer 5 years of graduate medical education. The orthopaedic residency director is responsible for the design, implementation, and oversight of a PGY-1 year that will prepare residents for specialty education in orthopaedic surgery. This year must include resident participation in clinical and didactic activities that will give them the opportunity to;
      - a. develop the knowledge, attitudes, and skills needed to formulate principles and assess, plan, and initiate treatment of adult and pediatric patients with surgical and/or medical problems;
      - b. be involved in the care of patients with surgical and medical emergencies, multiple organ system trauma, soft tissue wounds, nervous system injuries and diseases, peripheral vascular injuries and diseases, and rheumatologic and other medical diseases;
      - c. gain experience in the care of critically ill surgical and medical patients;
      - d. participate in the pre-, intra -and post-operative care of surgical patients; and
      - e. develop an understanding of surgical anesthesia, including anesthetic risks and the management of intra-operative anesthetic complications.
    2. In order to meet these goals the PGY-1 year must include;
      - a. a minimum of six months of structured education in surgery, to include multi-system trauma, plastic surgery/burn care, intensive care, and vascular surgery;
      - b. a minimum of one month of structured education in at least three of the following: emergency medicine, medical/cardiac intensive care, internal medicine, neurology, neurological surgery, pediatric surgery or pediatrics, rheumatology, anesthesiology, musculoskeletal imaging, and rehabilitation; and
      - c. a maximum of three months of orthopaedic surgery.
    3. The program director is also responsible for the design, implementation and oversight of PGY-2 through PGY-5 years that;
      - a. must include at least 3 years of rotations on orthopaedic services; and
      - b. may include rotations on related services such as plastic surgery, physical medicine and rehabilitation, hematology, or neurological surgery.

## II. Institutions

### A. Sponsoring Institution

**One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating institutions.**

1. One primary site must provide most of the residents' basic science and research education.
  - a. Residents' clinical education at the primary site should include extensive experience in patient care. Preoperative evaluation and postoperative follow-up, as well as evaluation and treatment of patients not requiring surgery, must be included.
  - b. Basic science education and the principal clinical conferences should be provided at the primary site. Supplemental conferences may also be provided at other locations, but the program's didactic activities should be provided at the program's primary site.
2. The governing body of the sponsoring institution must provide support for the program director in teaching, recruiting staff, selecting residents, assigning residents to an appropriate workload, and dismissing residents whose performance is unsatisfactory and must encourage continuity in the program directorship.
3. In communities where the didactic programs of several residencies are combined, the staff of each accredited program must actively and consistently participate in the combined effort.
4. To provide an adequate interdisciplinary educational experience, the institution that sponsors the orthopaedic program should also participate in ACGME-accredited programs in general surgery, internal medicine, and pediatrics.

### B. Participating Institutions

1. **Assignment to an institution must be based on a clear educational rationale, integral to the program curriculum, with clearly-stated activities and objectives. When multiple participating institutions are used, there should be assurance of the continuity of the educational experience.**
2. **Assignment to a participating institution requires a letter of agreement with the sponsoring institution. Such a letter of agreement should:**
  - a. **identify the faculty who will assume both educational and supervisory responsibilities for residents;**
  - b. **specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;**
  - c. **specify the duration and content of the educational experience; and**
  - d. **state the policies and procedures that will govern resident education during the assignment.**
3. Affiliations should be avoided with institutions that are at such a distance from the sponsoring institution as to make resident participation in program conferences and rounds difficult, unless the participating institution provides comparable activities.

4. The program director must have the responsibility and authority to coordinate program activities at all participating institutions and must maintain a file of written descriptions of the educational activities provided at each institution involved in the program.

### **III. Program Personnel and Resources**

#### **A. Program Director**

1. **There must be a single program director responsible for the program. The person designated with this authority is accountable for the operation of the program. In the event of a change of either program director or department chair, the program director should promptly notify the executive director of the RRC through the Web Accreditation Data System of the ACGME.**
2. **The Program Director, together with the faculty, is responsible for the general administration of the program, and for the establishment and maintenance of a stable educational environment. Adequate lengths of appointment for both the program director and faculty are essential to maintaining such an appropriate continuity of leadership. Programs that have acting directors for more than one year will be subject to review, which may include a site visit.**
3. **Qualifications of the program director are as follows:**
  - a. **The program director must possess the requisite specialty expertise, as well as documented educational and administrative abilities.**
  - b. **The program director must be certified in the specialty by the American Board of Orthopaedic Surgery, or possess qualifications judged to be acceptable by the RRC.**
  - c. **The program director must be appointed in good standing and based at the primary teaching site.**
4. **Responsibilities of the program director are as follows:**
  - a. **The program director must oversee and organize the activities of the educational program in all institutions that participate in the program. This includes selecting and supervising the faculty and other program personnel at each participating institution, appointing a local site director, and monitoring appropriate resident supervision at all participating institutions.**
  - b. **The program director is responsible for preparing an accurate statistical and narrative description of the program as requested by the RRC, as well as updating annually both program and resident records through the ACGME's Accreditation Data System.**
  - c. **The program director must ensure the implementation of fair policies, grievance procedures, and due process, as established by the sponsoring institution and in compliance with the Institutional Requirements.**

d. **The program director must seek the prior approval of the RRC for any changes in the program that may significantly alter the educational experience of the residents. Such changes, for example, include:**

1. **the addition or deletion of a participating institution;**
2. **a change in the format of the educational program;**
3. **a change in the approved resident complement for those specialties that approve resident complement.**

**On review of a proposal for any such major change in a program, the RRC may determine that a site visit is necessary.**

- e. Ensuring the provision of adequate facilities, teaching staff, resident staff, teaching beds, educational resource materials, outpatient facilities, and research facilities.
- f. Maintaining a file of current, written institutional and interinstitutional agreements, resident agreements, patient care statistics, the operative experience of individual residents, policies on duty hours and supervision, and regular assessments of resident performance. These documents must be provided on request to the RRC or to the site visitor.

## **B. Faculty**

1. **At each participating institution, there must be a sufficient number of faculty with documented qualifications to instruct and supervise adequately all residents in the program.**

- a. All programs must have at least three faculty who devote at least 20 hours each week to the program.
- b. There must be at least one full-time faculty equivalent (one FTE equals 45 hours per week devoted to the residency) for every four residents in the program (excluding residents in non-orthopaedic education).
- c. It is the responsibility of the teaching staff to ensure that the structure and content of the residency reflect an education-to service ratio that identifies residents as students and provide adequate experience in preoperative and postoperative, as well as intraoperative, patient care.
- d. The teaching staff must provide direct supervision appropriate to a resident's competence and level of training in all patient care settings, including operative, inpatient, outpatient, and emergency.

2. **The faculty, furthermore, must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities. They must demonstrate a strong interest in the education of residents, and must support the goals and objectives of the educational program of which they are a member.**

3. **Qualifications of the physician faculty are as follows:**

- a. **The physician faculty must possess the requisite specialty expertise and competence in clinical care and teaching abilities, as well as documented educational and administrative abilities and experience in their field.**

- b. **The physician faculty must be certified in the specialty by the American Board of Orthopaedic Surgery, or possess qualifications judged to be acceptable by the RRC.**
    - c. **The physician faculty must be appointed in good standing to the staff of an institution participating in the program.**
- 4. **The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the faculty, and an active research component must be included in each program. *Scholarship* is defined as the following:**
  - a. **the scholarship of *discovery*, as evidenced by peer-reviewed funding or by publication of original research in a peer reviewed journal;**
  - b. **the scholarship of *dissemination*, as evidenced by review articles or chapters in textbooks;**
  - c. **the scholarship of *application*, as evidenced by the publication or presentation of, for example, case reports or clinical series at local, regional, or national professional and scientific society meetings. Complementary to the above scholarship is the regular participation of the teaching staff in clinical discussions, rounds, journal clubs, and research conferences in a manner that promotes a spirit of inquiry and scholarship (e.g., the offering of guidance and technical support for residents involved in research such as research design and statistical analysis); and the provision of support for residents'**
  - d. **participation, as appropriate, in scholarly activities.**
- 5. **Qualifications of the non-physician faculty are as follows:**
  - a. **Non-physician faculty must be appropriately qualified in their field.**
  - b. **Non-physician faculty must possess appropriate institutional appointments.**
  - c. **Other Program Personnel Additional necessary professional, technical, and clerical personnel**
  - d. **must be provided to support the program.**
  - e. **Resources**
  - f. **The program must ensure that adequate resources (e.g., sufficient laboratory space and equipment, computer and statistical consultation services) are available.**
- 1. **Residents must have ready access to a major medical library, either at the institution where the residents are located or through arrangement with convenient nearby institutions.**
- 2. **Library resources must include current and past orthopaedic periodicals and reference books that are readily accessible to all orthopaedic residents in the program.**
- 3. **Library services should include the electronic retrieval of information from medical databases.**
- 4. **There must be access to an on-site library or to a collection of appropriate texts and journals in each institution participating in a residency program. On-site libraries and/or collections of texts and journals must be readily available during nights and weekends.**

#### IV. Resident Appointments

##### A. Eligibility Criteria

**The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements.** Programs are encouraged to recognize the value and importance of recruiting qualified women and minority students.

##### B. Number of Residents

**The RRC will approve the number of residents to be educated in the program and at each level of the program based upon established written criteria that include the adequacy of resources for resident education (e.g., the quality and volume of patients and related clinical material available for education), faculty-resident ratio, institutional funding, and the quality of faculty teaching.** It is important that the resident complement be sufficient in number to sustain an educational environment.

##### C. Resident Transfers

**To determine the appropriate level of education for residents who are transferring from another residency program, the program director must receive written verification of previous educational experiences and a statement regarding the performance evaluation of the transferring resident prior to their acceptance into the program. A program director is required to provide verification of residency education for residents who may leave the program prior to completion of their education.**

##### D. Appointment of Fellows and Other Students

**The appointment of fellows and other specialty residents or students must not dilute or detract from the educational opportunities available to regularly appointed residents.**

#### V. Program Curriculum

##### A. Program Design

###### 1. Format

**The program design and sequencing of educational experiences will be approved by the RRC as part of the review process.**

###### 2. Goals and Objectives

**The program must possess a written statement that outlines its educational goals with respect to the knowledge, skills, and other attributes of residents for each major assignment and for each level of the program. This statement must be distributed to residents and faculty, and must be reviewed with residents prior to their assignments.**

##### B. Specialty Curriculum

**The program must possess a well-organized and effective curriculum, both didactic and clinical. The curriculum must also provide residents with direct experience in progressive responsibility for patient management.**

###### 1. Didactic Components

###### a. Basic Medical Sciences

**Basic science education must include substantial instruction in anatomy, biomechanics, pathology, and physiology. The basic science program must also include resident education in embryology, immunology, pharmacology, biochemistry, and microbiology.**

1. Instruction in anatomy must include study and dissection of anatomic specimens by the residents and lectures or other formal sessions.
  2. Instruction in pathology must include organized instruction in correlative pathology in which gross and microscopic pathology are related to clinical and roentgenographic findings.
  3. Instruction in biomechanics should be presented in seminars or conferences emphasizing principles, terminology, and application to orthopaedics.
  4. Organized instruction in the basic medical sciences must be integrated into the daily clinical activities by clearly linking the pathophysiologic process and findings to the diagnosis, treatment, and management of clinical disorders.
  5. Organized instruction in the appropriate use and interpretation of radiographic and other imaging techniques must be provided for all residents.
- b. Related Areas of Instruction  
Resident education must include orthopaedic oncology, rehabilitation of neurologic injury and disease, spinal cord injury rehabilitation, orthotics and prosthetics, and the ethics of medical practice.
- c. Teaching Rounds and Conferences  
Faculty and residents must attend and participate in regularly scheduled and held teaching rounds, lectures, and conferences. Treatment indications, clinical outcomes, complications, morbidity, and mortality must be critically reviewed and discussed on a regular basis. Subjects of mutual interest and the changing practice of medicine should be discussed at interdisciplinary conferences. On average, there must be at least 4 hours of formal teaching activities each week.

## 2. Clinical Components

- a. Clinical Resources  
Clinical problems must be of sufficient variety and volume to afford the residents adequate experience in the diagnosis and management of adult and pediatric orthopaedic disorders. The residents' clinical experience must include adult orthopaedics, including joint reconstruction; pediatric orthopaedics, including pediatric trauma; trauma, including multisystem trauma; surgery of the spine, including disk surgery, spinal trauma, and spinal deformities; hand surgery; foot surgery in adults and children; athletic injuries, including arthroscopy; metastatic disease; and orthopaedic rehabilitation, including amputations and post amputation care.
- b. Continuity of Care  
All residents must have the opportunity to develop competence in the preadmission care, hospital care, operative care, and follow-up care (including rehabilitation) of patients. Opportunities for resident involvement in all aspects of care of the same patient should be maximized.
- c. Non-operative Outpatient Experience  
Residents must have adequate experience in non-operative outpatient diagnosis and care, including all orthopaedic anatomic areas and patients of all age groups. Each week residents must have at least one-half day and should have two-half days of outpatient clinical experience in physician offices or hospital clinics with a minimum of 10 patients per session on all clinical rotations. Residents must be directly supervised by faculty and instructed in pre- and post-operative assessment as well as the operative and non-operative care of general and subspecialty orthopaedic patients.

Opportunities for resident involvement in all aspects of outpatient care of the same patient should be maximized.

d. Progressive Responsibility

Residents must have the opportunity to assume increasing responsibility for patient care, under direct faculty supervision (as appropriate for each resident's ability and experience), as they progress through a program. Inpatient and outpatient experience with all age groups is necessary.

e. Basic Motor Skills

Instruction in basic motor skills must include experience in the proper use of surgical instruments and operative techniques. Evaluation of new or experimental techniques and/or materials should be emphasized. The application of basic motor skills must be integrated into daily clinical activities, especially in the operating room.

**C. Residents Scholarly Activities**

**Each program must provide an opportunity for residents to participate in research or other scholarly activities, and residents must participate actively in such scholarly activities.**

1. Resources for scholarly activity by residents must include laboratory space and equipment, computer and data analysis services, statistical consultation services, research conferences, faculty expertise and supervision, support personnel, time, and funding.
2. To develop the abilities to critically evaluate medical literature, research, and other scholarly activity, resident education must include instruction in experimental design, hypothesis testing, and other current research methods, as well as participation in clinical or basic research.
3. Program directors must maintain a current record of research activity by residents and faculty.

**D. ACGME Competencies**

**The residency program must require its residents to obtain competence in the six areas listed below to the level expected of a new practitioner. Programs must define the specific knowledge, skills, behaviors, and attitudes required, and provide educational experiences as needed in order for their residents to demonstrate the following:**

1. ***Patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.*** Residents are expected to:
  - a. communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families;
  - b. gather essential and accurate information about their patients;
  - c. make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to date scientific evidence, and clinical judgment;
  - d. develop and carry out patient management plans;
  - e. counsel and educate patients and their families;
  - f. demonstrate the ability to practice culturally competent medicine;
  - g. use information technology to support patient care decisions and patient education;

- h. perform competently all medical and invasive procedures considered essential for the area of practice;
  - i. provide health care services aimed at preventing health problems or maintaining health; and
  - j. work with health care professionals, including those from other disciplines, to provide patient-focused care.
2. **Medical Knowledge about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care.** Residents are expected to:
- b. demonstrate an investigatory and analytic thinking approach to clinical situations; and
  - c. know and apply the basic and clinically supportive sciences which are appropriate to orthopaedic surgery.
3. **3 Practice-based learning and improvement that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements in patient care.** Residents are expected to:
- b. analyze practice experience and perform practice-based improvement activities using a systematic methodology;
  - c. locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;
  - d. obtain and use information about their own population of patients and the larger population from which their patients are drawn;
  - e. apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness;
  - f. use information technology to manage information, access on-line medical information, and support their own education; and
  - g. facilitate the learning of students and other health care professionals.
4. **Interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and other health professionals.** Residents are expected to:
- a. create and sustain a therapeutic and ethically sound relationship with patients;
  - b. use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills; and
  - c. c work effectively with others as a member or leader of a healthcare team or other professional group.
5. **Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds.** Residents are expected to:

- a. demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society and the profession; and a commitment to excellence and ongoing professional development;
  - b. demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices;
  - c. demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities; and
  - d. demonstrate sensitivity and responsiveness to fellow health care professionals' culture, age, gender, and disabilities.
6. **Systems-based practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.** Residents are expected to:
- a. understand how their patient care and other professional practices affect other healthcare professionals, the healthcare organization, and the larger society and how these elements of the system affect their own practice;
  - b. know how types of medical practice and delivery systems differ from one another, including methods of controlling healthcare costs and allocating resources;
  - c. practice cost-effective health care and resources allocation that does not compromise quality of care;
  - d. advocate for quality patient care and assist patients in dealing with system complexities; and
  - e. know how to partner with health care managers and healthcare procedures to assess, coordinate, and improve health care and know how these activities can affect system performance.

## **VI. Resident Duty Hours and the Working Environment**

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

### **A. Supervision of Residents**

- 1. All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of residents at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty.**
- 2. Faculty schedules must be structured to provide residents with continuous supervision and consultation.**
- 3. Faculty and residents must be educated to recognize the signs of fatigue, and adopt and apply policies to prevent and counteract its potential negative effects.**

## B. Duty Hours

1. Duty hours are defined as all clinical and academic activities related to the residency program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities such as conferences. Duty hours do *not* include reading and preparation time spent away from the duty site.
2. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
3. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. *One day* is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties.
4. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

## C. On-call Activities

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

1. In-house call must occur no more frequently than every third night, averaged over a 4-week period.
2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.
3. No new patients may be accepted after 24 hours of continuous duty.  
A new patient is defined as any patient for whom the orthopaedic surgery service or department has not previously provided care. The resident should evaluate the patient before participating in surgery.
4. *At-home call (or pager call)* is defined as a call taken from outside the assigned institution.
  - a. The frequency of at-home call is not subject to the every-third night limitation. At-home call, however, must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.
  - b. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.
  - c. The program director and the faculty must monitor the demands of at-home call in their programs, and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

## D. Moonlighting

1. Because residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
2. The program director must comply with the sponsoring institution's written policies and procedures regarding moonlighting, in compliance with the ACGME Institutional Requirements.
3. Any hours a resident works for compensation at the sponsoring institution or any of the sponsor's primary clinical sites must be considered part of the 80-hour weekly limit on duty hours. This refers to the practice of *internal moonlighting*.

#### **E. Oversight**

1. Each program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment. These policies must be distributed to the residents and the faculty. Duty hours must be monitored with a frequency sufficient to ensure an appropriate balance between education and service.
2. Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.

#### **F. Duty Hours Exceptions**

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

### **VII. Evaluation**

#### **A. Resident**

##### **1. Formative Evaluation**

The faculty must evaluate in a timely manner the residents whom they supervise. In addition, the residency program must demonstrate that it has an effective mechanism for assessing resident performance throughout the program, and for utilizing the results to improve resident performance.

- a. Assessment should include the use of methods that produce an accurate assessment of residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.
- b. Assessment should include the regular and timely performance feedback to residents that includes at least semiannual written evaluations. Such evaluations are to be communicated to each resident in a timely manner, and maintained in a record that is accessible to each resident.
- c. Assessment should include the use of assessment results, including evaluation by faculty, patients, peers, self, and other professional staff, to achieve progressive improvements in residents' competence and performance.

##### **2. Final Evaluation**

The program director must provide a final evaluation for each resident who completes the program. This evaluation must include a review of the resident's performance during the

final period of education, and should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. The final evaluation must be part of the resident's permanent record maintained by the institution.

**B. Faculty**

The performance of the faculty must be evaluated by the program no less frequently than at the midpoint of the accreditation cycle, and again prior to the next site visit. The evaluations should include a review of their teaching abilities, commitment to the educational program, clinical knowledge, and scholarly activities. This evaluation must include annual written confidential evaluations by residents.

**C. Program**

The educational effectiveness of a program must be evaluated at least annually in a systematic manner.

1. Representative program personnel (i.e., at least the program director, representative faculty, and one resident) must be organized to review program goals and objectives, and the effectiveness with which they are achieved. This group must conduct a formal documented meeting at least annually for this purpose. In the evaluation process, the group must take into consideration written comments from the faculty, the most recent report of the GMEC of the sponsoring institution, and the residents' confidential written evaluations. If deficiencies are found, the group should prepare an explicit plan of action, which should be approved by the faculty and documented in the minutes of the meeting.
2. The program should use resident performance and outcome assessment in its evaluation of the educational effectiveness of the residency program. Performance of program graduates on the certification examination should be used as one measure of evaluating program effectiveness. Program graduates should take both Part I and Part II of the American Board of Orthopaedic Surgery examinations and at least 75% of those who take the exams for the first time should pass.
  - b. The program should maintain a process for using assessment results together with other program evaluation results to improve the residency program.

**VIII. Experimentation and Innovation**

Since responsible innovation and experimentation are essential to improving professional education, experimental projects along sound educational principles are encouraged. Requests for experimentation or innovative projects that may deviate from the program requirements must be approved in advance by the RRC, and must include the educational rationale and method of evaluation. The sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.

**IX. Certification**

Residents who plan to seek certification by the American Board of Orthopaedics Surgery should communicate with the office of the board regarding the full requirements for certification.

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