

Program Requirements for Residency Education in Vascular Surgery

I. Introduction

A. Definition and Scope of the Specialty

Vascular Surgery is the surgical specialty involving diseases of the arterial, venous, and lymphatic circulatory systems, exclusive of those circulatory vessels intrinsic to the heart and intracranial vessels. Specialists in this discipline must demonstrate not only the knowledge, skills, and understanding of the medical science relative to the vascular system, but also demonstrate the acquisition of mature technical skills and surgical judgment.

B. Duration and Scope of Education

Education in vascular surgery may be attained through two types of programs:

1. Integrated Program

Residents complete 5 years of vascular surgery education following completion of an MD or DO degree from an institution accredited by the Liaison Committee of Medical Education (LCME) or by the American Osteopathic Association (AOA). Graduates of schools of medicine from countries other than the United States or Canada must present evidence of final certification by the Education Commission for Foreign Medical Graduates (ECFMG).

- a) The integrated curriculum must contain 5 years of clinical surgical education under the authority and direction of the vascular surgery Program Director.
- b) Two of these 5 years must include documented educational experiences in core surgical education, including pre and post operative evaluation and care; critical care and trauma management; and basic technical experience in skin and soft tissue, abdomen and alimentary track, airway management, laparoscopic surgery, and thoracic surgery.
- c) Three of the 5 years must include documented educational experiences concentrated in vascular surgery.
- d) The last year of the program must comprise chief resident responsibility on the vascular surgery service at an integrated institution.
- e) Residents must complete, at minimum, the last 2 years of vascular

surgery education in the same institution.

- f) No more than 6 months of the 5-year program may be dedicated to research.

2. Independent Program

Vascular surgery education in the independent format is limited to one of the following:

- a) A minimum of 3 years of education with progressive responsibility in a general surgery residency program and three years of education with progressive responsibility in vascular surgery in the same institution that is accredited by the Accreditation Council of Graduate Medical Education (ACGME). A transitional year may not be used to fulfill any of the 3 year designated preliminary surgery requirement. The last year of the program must comprise chief resident responsibility on the vascular surgery service at an integrated institution.
- b) A successfully completed general surgery residency program accredited by the ACGME. During the general surgery residency, up to 1 year of credit toward a vascular surgery residency can be achieved as long as there is demonstration of 12 months of appropriate vascular surgery education. This would shorten the subsequent required vascular surgery residency education to 2 years, instead of 3 years. In this format, the residents must complete, at minimum, the last two years of vascular surgery education at the same institution.
- c) A successfully completed general surgery residency portion of the Early Specialization Program (ESP) that has been approved by the RRC. In the ESP, 4 years of general surgery are completed before entering the vascular surgery residency in the same institution. Up to one year of credit toward the vascular surgery residency can be achieved in the first four years of the ESP.

- 3. Before entering the program, each resident must be notified in writing of the required length of the educational program.

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. The program should be conducted in institutions accredited by the Joint Commission on Accreditation of HealthCare Organizations, or its equivalent, and classified as general hospitals.
2. A vascular surgery program may be sponsored by institutions with a general surgery residency program accredited by the ACGME or that are educationally related to an ACGME-accredited general surgery residency program. Requests for an exemption to this policy will be reviewed on a case-by-case basis.

B. Participating Institutions

1. **Assignment to an institution must be based on a clear educational rationale, integral to the program curriculum, with clearly stated objectives and activities. When multiple participating institutions are used, there should be assurance of the continuity of 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. Integrated Institutions

Institutions may be integrated through an integration agreement that must additionally specify that the Program Director must:

- a) appoint the members of the faculty at the integrated institution;
- b) appoint the chief or director of the teaching service in the integrated institution;

- c) appoint all residents in the program; and
- d) determine all rotations and assignments of both residents and members of the faculty.

As a general rule, integrated institutions must be in close geographic proximity to allow all residents to attend joint conferences, basic science lectures, and morbidity and mortality reviews on a regular documented basis at a central location. If the institutions are geographically so remote that joint conferences cannot be held, an equivalent educational program of lectures and conferences in the integrated institution must be fully documented.

Integration will not be approved between two institutions, each with an accredited residency program in the same specialty.

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 in either the Program Director or the department chair, the Program Director should promptly notify the executive director of the Review Committee through the Web Accreditation Data System (WebADS) of the Accreditation Council for Graduate Medical Education (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 the faculty are essential to maintaining such an appropriate continuity of leadership.** The term of appointment, as a general rule, must be for at least the duration of the program plus 1 year.
3. **Qualifications of the Program Director are as follows**
 - a) **The Program Director must possess requisite specialty expertise, as well as documented educational and administrative abilities.** The Program Director must devote his or her principal effort to the management and administration, as well as to the teaching, research and clinical care in the sponsoring and integrated institution. Dedication to surgical education and

scholarship will be evaluated by his or her curriculum vitae.

- b) **The Program Director must be certified in Vascular Surgery by the American Board of Surgery or possess qualifications judged to be acceptable by the Residency Review Committee (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 the 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.** The RRC will approve all changes, either permanent or temporary.
 - (4) **a portion of the chief year spent at a participating institution;**

- (5) Participating institutions where residents will be assigned for 6 months or more, as well as for all integrations.

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

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.** In addition to the Program Director, there must be for each approved residency position at least one geographic full-time faculty member whose major function is to support the residency program. These faculty must be appointed for a period long enough to ensure adequate continuity in the supervision of the residents. At minimum, one surgeon on the faculty, in addition to the Program Director, must be certified in Vascular Surgery by the American Board of Surgery, or possess suitable equivalent qualifications as determined by the RRC.
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 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 Vascular Surgery by the American Board of 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.**
 - d) The physician faculty must reflect sufficient diversity of interest to represent the many facets of vascular surgery.
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 one of the following:

- a) **the scholarship of *discovery*, as evidenced by peer-reviewed funding or 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 faculty 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 design and statistical analysis); and the provision of support for residents' participation, as appropriate, in scholarly activities.

- d) Both faculty and residents must participate actively in scholarly activity.

5. Qualifications of the nonphysician faculty are as follows:

- a) **Nonphysician faculty must be appropriately qualified in their field.**
- b) **Nonphysician faculty must possess appropriate institutional appointments.**

C. Other Program Personnel

Additional necessary professional, technical, and clerical personnel must be provided to support the program.

D. Resources

The program must ensure that adequate resources (e.g., sufficient laboratory space and equipment, computer and statistical consultations services) are available.

IV. Resident Appointments

A. Eligibility Criteria

The Program Director must comply with the criteria for resident eligibility as specified in the institutional requirements.

B. Number of Residents

The RRC will approved the number of residents 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.

C. Resident Transfer

To determine the appropriate level of education for a resident who is transferring from another residency program, the Program Director must receive written verification of the previous educational experiences and a statement regarding the performance evaluation of the transferring resident, including an assessment of competence in the six areas described in section V.D., 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.

Although residents may transfer from one program to another, they may not transfer from an independent to an integrated program, or vice versa, without approval in advance by the RRC.

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 of the regularly appointed specialty residents.

E. Interaction with General Surgery Residents

Lines of responsibility for general surgery residents and vascular surgery residents must be clearly defined when both are assigned to the same institution. Ideally, the roles of general and vascular surgery residents should complement each other for a mutual educational benefit in operative experience, patient responsibility, and faculty interaction.

1. A vascular surgery resident may be a teaching assistant for residents other than general surgery chief residents.

2. Although a vascular surgery resident and a chief resident in general surgery may function together on a service with the same junior residents, they may not have primary responsibility for the same patients.

V. Program Curriculum

A. Program Design

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

The program must possess a written statement that outlines the 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 Component**
 - a) The curriculum should encompass education in the entire vascular system. Instruction in each area should be associated with relevant patient exposure. If this is not possible, instructional materials must be provided to ensure adequate education.
 - b) The program must provide instruction, and require residents to become knowledgeable in the fundamental sciences, including anatomy, biology, embryology, microbiology, physiology, and pathology as they relate to the pathophysiology, diagnosis, and treatment of vascular lesions.
 - c) The program must provide teaching in critical thinking, design of experiments and evaluation of data, as well as in the technological advances that relate to vascular surgery and the care of patients with vascular diseases. The program must encourage the participation of residents in clinical and/or laboratory research, and make appropriate facilities available.

- d) Educational conferences must be adequate in quality and quantity to provide a review of vascular surgery as well as recent advances. The conferences should be scheduled to permit the residents to attend on a regular basis. Participation by both residents and faculty must be documented. Active participation by vascular surgery residents in the planning and production of these conferences is essential. The following types of conferences must exist within a program:
- (1) a review, held at least biweekly, of all current complications and deaths, including radiological and pathological correlation of surgical specimens and autopsies when relevant;
 - (2) a course or a structured series of conferences to ensure coverage of the basic and clinical sciences fundamental to vascular surgery (a sole reliance on textbook review is inadequate);
 - (3) regular organized clinical teaching, such as ward rounds and clinical conferences;
 - (4) a regular review of recent literature, such as a journal club format.

2. Clinical Component

- a) Operative skill is essential for surgeons and can be acquired only through personal experience and education. The program must provide sufficient operative experience to educate competent vascular surgeons. A sufficient number and distribution of complex cases, as determined by the RRC, must be provided for the achievement of adequate operative skill and surgical judgment. The Program Director must ensure that the operative experience of individual residents in the same program is comparable.
- (1) In an integrated program, residents should perform a minimum of 500 operations, to include 200 major vascular reconstructive procedures that reflect an adequate representation of current trends, as well as a breadth and balance of experience in the surgical care of vascular diseases. Operative experience in excess of 1500 total cases must be justified by the Program Director.
 - (2) In an independent program, residents should perform a

minimum of 200 major vascular reconstructive procedures that reflect an adequate representation of current trends as well as a breadth and balance of experience in the surgical care of vascular diseases. Operative experience in excess of 900 total cases must be justified by the Program Director.

- b) A resident is considered to be the surgeon when he or she can document a significant role in the following aspects of patient management: determination or confirmation of the diagnosis; provision of preoperative care; selection and accomplishment of the appropriate operative procedure; direction of postoperative care; and accomplishment of sufficient follow-up to be acquainted with both the course of the disease and the outcome of its treatment. Participation in the operation only, without preoperative and postoperative care, is inadequate.
- c) Continuity of primary responsibility for patient care must be taught in a longitudinal way, and must include ambulatory care, inpatient care, referral and consultation, and utilization of community resources.
- d) Residents must be provided with progressive senior surgical responsibilities in the total care of vascular surgery patients, including preoperative evaluation, therapeutic decision-making, operative experience, and postoperative management
- e) Residents must have the opportunity to provide consultation with faculty supervision. They should have clearly defined educational responsibilities for other residents, medical students, and professional personnel. These teaching experiences should correlate basic biomedical knowledge with the clinical aspects of vascular surgery.
- f) When operative experience justifies a teaching role, residents should act as teaching assistants and should report such cases to the RRC during the final 2 years of their residency.
- g) Residents must receive education in the special diagnostic techniques for the management of vascular disease. It is essential that residents understand the methods and techniques of angiography, CT scanning, MRI and MRA and other vascular imaging modalities. They should be competent in the assessment of the vascular portion of such images. Residents must also have experience in the application, assessment, and limitations of noninvasive vascular diagnostic techniques.

- h) Outpatient activities constitute an essential component of adequate experience in continuity of patient care. One-half day per week, on average, should be devoted to these outpatient activities.

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 scholarly activities.

D. ACGME Competencies

NB: Education in the Competencies is required for the vascular surgery integrated and 3+3 educational formats only, as those residents completing a general surgery residency prior to the independent vascular surgery format will have completed these aspects of the curriculum.

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 must be able to:
 - a) demonstrate manual dexterity appropriate for their educational level;
 - b) develop and execute patient care plans appropriate for their educational level.
2. ***Medical Knowledge* about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care.**

Residents must also be able to critically evaluate and demonstrate knowledge of pertinent scientific information.

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 must also be able to:

- a) critique personal practice outcomes;
 - b) demonstrate a recognition of the importance of lifelong learning in surgical practice.
4. ***Interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and other health professionals.*** Residents must also be able to:
- a) communicate effectively with other health care professionals ;
 - b) counsel and educate patients and families;
 - c) effectively document practice activities.
5. ***Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds.*** Residents must also be able to:
- a) maintain high standards of ethical behavior;
 - b) demonstrate a commitment to continuity of patient care;
 - c) demonstrate sensitivity to age, gender and culture of patients and other health care professionals.
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 must also be able to:
- a) practice high quality, cost effective patient care;
 - b) demonstrate a knowledge of risk-benefit analysis ;
 - c) demonstrate an understanding of the role of different specialists and other health care professionals in overall patient management.

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 the potential negative effects.**
4. The attending physician has both an ethical and a legal responsibility for the overall care of the individual patient and for the supervision of the resident involved in the care of that patient. Although senior residents require less direction than junior residents, even the most senior must be supervised. A chain of command that emphasizes graded authority and increasing responsibility as experience is gained must be established. Judgments on this delegation of responsibility must be made by the attending surgeon, who is ultimately responsible for the patient's care; such judgments shall be based on the attending surgeon's direct observation and on knowledge of each resident's skills and ability.
5. A vascular surgery resident may not supervise general surgery chief residents.

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 related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic 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 one 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 vascular surgery service or department has not previously provided care. The resident should evaluate the patient before surgery.**
- 4. *At-home call (pager call)* is defined as 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 Institutional Requirements.**
- 3. Any hours a resident works for compensation at the sponsoring institution 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 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 Exception

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 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. 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 Surgery should communicate with the office of the Board regarding the full requirements for certification.

Approved: February 14, 2006

Effective: July 1, 2006