



Proposed ACGME Common Program Requirement Changes

What Could They Mean for Emergency Medicine?

**PROPOSED-
NOT YET FINAL**

**OPEN FOR COMMENT THROUGH
OCT. 22, 2026**

TWO SEPARATE PROCESSES

The ACGME recently approved revised Emergency Medicine Program Requirements, effective in 2028. Separately, the ACGME is proposing revisions to the Common Program Requirements (CPRs) that apply across residency programs.

WHY THIS MATTERS FOR EM

In several areas, the proposed CPRs may remove existing specialty-specific requirements and/or remove or narrow Review Committee authority to further specify requirements. This could impact how emergency medicine residency training is defined nationally.

TOPIC	CURRENT 2028 EM REQUIREMENTS	PROPOSED CPRs	POTENTIAL IMPACT FOR EM
1 Work-Hour Protections 	≤12 continuous scheduled hours in the ED - Equivalent time off between scheduled ED work periods ≤60 scheduled ED patient-care hours/week and ≤72 total hours/week ≤6 consecutive days in the ED - One 24-hour period free every 7 days, without four-week averaging EM §6.17.a1-5	≤80 hours/week, averaged over a max of 4 weeks (§6.29) - One day free in 7, averaged over a max of 4 weeks (§6.32) ≤24 hours continuous scheduled clinical assignments + up to 4 additional hours for transitions/education (§§6.33-6.33.a) - Existing specialty-specific requirements in these sections would be deleted. - Review Committee authority to further specify §6.29-6.39 is proposed for deletion	EM-specific limits on shift length, weekly hours, consecutive days, and non-averaged days off may no longer be accreditation requirements. Bottom Line: Without granted authority, it is unclear how the EM-RRC could preserve the current EM-specific work-hour protections.
2 Core Faculty Requirements 	Minimum 1 core faculty member for every 3 residents. EM §2.11.b	The Review Committee must specify either a minimum number of core faculty OR a core faculty-to-resident ratio that does not require more than 1 faculty member for every 5 residents. CPR §2.25	EM-RRC could not retain the current 1:3 requirement as a ratio. Bottom Line: Could reduce the minimum required core faculty resources to support resident education.
3 Program Director Qualifications & Leadership Continuity 	- PD must have current ABEM or AOBEM certification; RRC-EM currently specifies only ABEM/ABMS or AOBEM/AOA certification as acceptable. ≥3 years documented educational/administrative experience, or qualifications acceptable to EM-RRC. - Ongoing clinical activity, core faculty status, and demonstrated leadership experience. EM §2.5	- PD retention/continuity requirement (§2.9) is proposed for deletion. - PD generally must have specialty certification; if not eligible for certification, GMEC approval may be obtained through a process that will be determined by the ACGME (§2.12). - PD with <3 years educational/administrative experience may serve with a documented mentorship plan (§2.11). - Existing RRC authority to specify that only ABMS/AOA certification is acceptable is proposed for deletion.	Removes the explicit requirement addressing continuity of program leadership. Could create a pathway for a PD who is not eligible for specialty board certification to serve with GMEC approval. Could affect RRC-EM's ability to preserve its current certification standard. Bottom Line: Could loosen PD qualifications and reduce specialty-specific control over EM residency leadership.
4 Physician Faculty Qualifications & Supervision 	- Physician faculty generally must have ABEM/AOBEM certification or qualifications acceptable to RRC-EM. - Faculty supervising EM residents seeing patients in an ED must be EM physicians who completed an EM residency, with defined exceptions for pediatric and low-resource/low-acuity experiences. EM §2.10	- Physician faculty must have specialty board certification; individuals not eligible for certification may receive GMEC approval (§2.24). - The prior provision allowing the Review Committee to accept alternative physician qualifications is deleted. - Same-specialty supervision requirements "should include flexibility" permitting some resident clinical experience to be supervised by qualified faculty in other specialties (§2.22).	Could affect EM-RRC's ability to maintain some current specialty-specific faculty qualification requirements. Could result in greater flexibility for cross-specialty supervision than exists under current EM-specific requirements. Bottom Line: Could loosen specialty-specific faculty qualification and supervision requirements.
5 Patient Care, Procedural Skills & Medical Knowledge 	The 2028 EM Program Requirements establish specialty-specific expectations for EM patient care, clinical experiences, procedural skills, and medical knowledge. EM §4.4-4.6 and §4.11	- Shift language from what residents "must demonstrate" toward what programs must provide instruction in and assessment of (§4.4-4.6). - Existing specialty-specific requirements associated with these sections are proposed for removal (§4.4-4.6). - Review Committee authority to further specify Patient Care (§4.4), Procedural Skills (§4.5), and Medical Knowledge (§4.6) is proposed for deletion.	Bottom Line: Could limit EM-RRC's ability to maintain specialty-specific accreditation requirements defining essential EM patient-care competencies, procedural skills, and medical knowledge.
6 Scholarship Requirements 	- Programs must support resident and faculty scholarship. - Faculty collectively must demonstrate accomplishments across at least three scholarly domains and dissemination of scholarly work, including peer-reviewed publication. EM §4.13 and §4.14	- Each core/required faculty member must complete at least one qualifying activity every 3 years (§4.18.a). - Each resident must complete at least one qualifying activity before graduation (§4.18.b). - Qualifying activities include didactics/presentations, curricula, assessment/program-evaluation tools, committee or editorial service, research, QI/patient safety, grants/manuscripts, and specified advocacy activities. - Existing Review Committee authority to further specify resident scholarship is proposed for deletion.	Lowers the minimum accreditation threshold for faculty and resident scholarship. A broad range of activities, including a didactic presentation, could satisfy the requirement. Bottom Line: Could diminish expectations for generating and disseminating new knowledge across EM and the broader house of medicine.

OTHER NOTABLE PROPOSED CHANGES

Board Certification Outcomes (§5.16)

≥90% of board-eligible graduates who seek certification must obtain certification within seven years; several existing examination-specific pass-rate provisions are proposed for deletion.

Self-Study (§5.14.h)

The requirement to complete a Self-Study and submit it to the DIO is proposed for deletion.

Post-call recovery (§6.31)

Required time free after 24 hours of in-house call changes from 14 → 12 hours.

Every-third-night call limit (§6.38)

The common requirement limiting in-house call to every third night, averaged over four weeks, is proposed for deletion.

Technology/AI (§4.3, §4.9)

Two competencies explicitly incorporate appropriate use of technology, including artificial intelligence.

THE BIG PICTURE FOR EM

The potential impact comes not simply from changing individual requirements, but from three changes occurring together: broader common standards, deletion of some existing specialty-specific requirements, and removal or narrowing of Review Committee authority to further specify requirements. That combination could alter the role of specialty-specific accreditation standards in defining Emergency Medicine residency training nationally.

Programs can choose to exceed ACGME minimum requirements. **However, local program expectations are not equivalent to specialty-wide accreditation standards.**

DISCLAIMER/SOURCE NOTE

This infographic was developed by CORD and was not created by or endorsed by the ACGME. It is intended as an educational summary of selected proposed changes and their potential implications for Emergency Medicine.

Readers are strongly encouraged to review the full proposed ACGME Common Program Requirements and the Emergency Medicine Program Requirements directly and to submit feedback to both CORD and the ACGME.