FAQs - ACGME Resident and Faculty Survey for Program Directors

AAIM (updated January 2026)

The ACGME resident and faculty surveys are annual assessments required as part of the tools used by the Review Committee for Internal Medicine (RC-IM) to oversee program accreditation. These surveys often cause anxiety for Program Directors (PDs), who cite several reasons for their stress, including the survey's impact on accreditation, unclear and confusing wording, and the pressure to implement program changes based on survey results. Each year, the APDIM Council leadership meets with the RC-IM Chair and staff to address these concerns. As a result, they created the following frequently asked questions (FAQs) document, which they have been updating regularly. This document has been reviewed by the RC-IM to ensure accuracy. Please also see the ACGME website for more information related to the ACGME surveys:

http://www.acgme.org/Data-Collection-Systems/Resident-Fellow-and-Faculty-Surveys

What are implications of an unfavorable survey?

The survey aims to collect comprehensive feedback from residents and faculty about your program, providing insights to both you and the Review Committee for Internal Medicine (RC-IM). As part of the New Accreditation System (NAS), the RC-IM utilizes these resident and faculty surveys as critical data points in its annual review of approximately 3.000 residency and fellowship programs. Research has indicated that suboptimal performance on these surveys is statistically linked to lower scores on the ABIM certification exam (**Relationships Between the ACGME Resident and Faculty Surveys and Program Pass Rates on the ABIM Internal Medicine Certification Examination**). A program being flagged for unfavorable survey results does not automatically result in an accreditation citation. When the RC-IM identifies a program as an outlier in any New Accreditation System (NAS) data element, a comprehensive review is conducted to distinguish between a genuine signal of compliance issues and potential statistical noise.

The RC-IM's evaluation considers multiple factors, including:

- Specific survey sections with high noncompliance rates
- The extent and magnitude of noncompliance
- Correlation with other NAS data element flags
- Total number of flags
- Whether the program has been flagged in previous years or is a first-time occurrence

This approach ensures that a single survey result does not unfairly jeopardize a program's accreditation status, but instead provides an opportunity for targeted improvement and deeper understanding of potential systemic challenges.

When conducting program reviews, the RC-IM takes into account program size, acknowledging that smaller programs with fewer survey respondents may exhibit artificially inflated noncompliance rates. Beyond the resident and faculty surveys, the RC-IM evaluates multiple data elements during its annual review process, including:

- Performance on certification examinations
- Perceived adequacy of clinical experience (assessed through specific resident survey questions in the internal medicine section)
- Faculty and resident/fellow scholarly activity
- Changes in program leadership
- Completeness of information submission in the Accreditation Data System (ADS)
- Compliance with patient census limitations
- Performance of subspecialties, with particular attention to those on probation, under warning, or exhibiting multiple New Accreditation System (NAS) flags

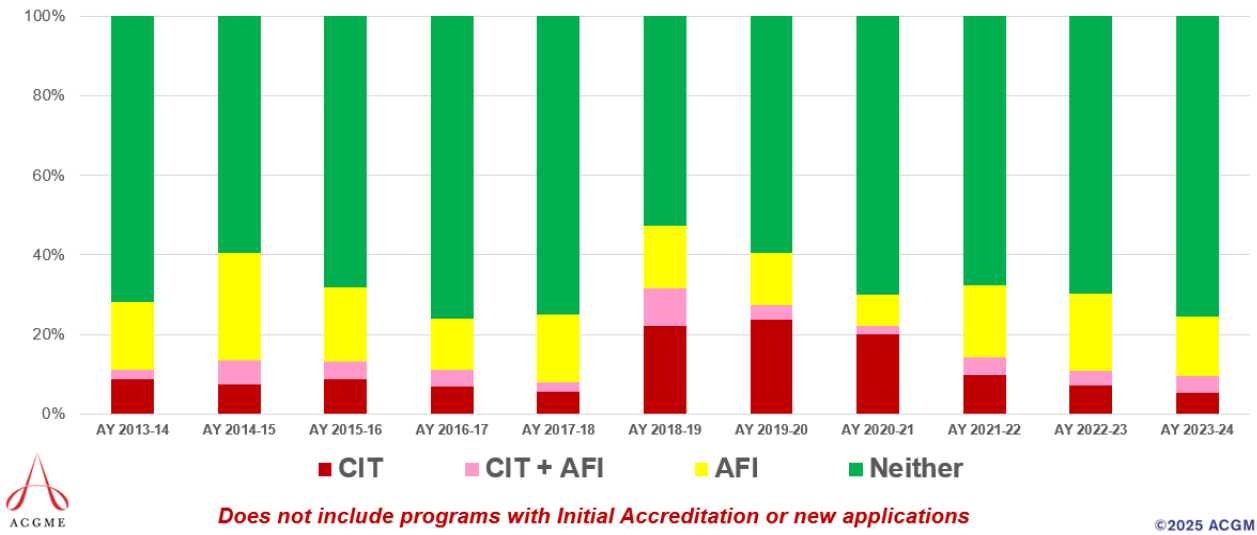
This comprehensive approach ensures a holistic and nuanced evaluation of residency programs, considering multiple indicators of program quality and effectiveness.

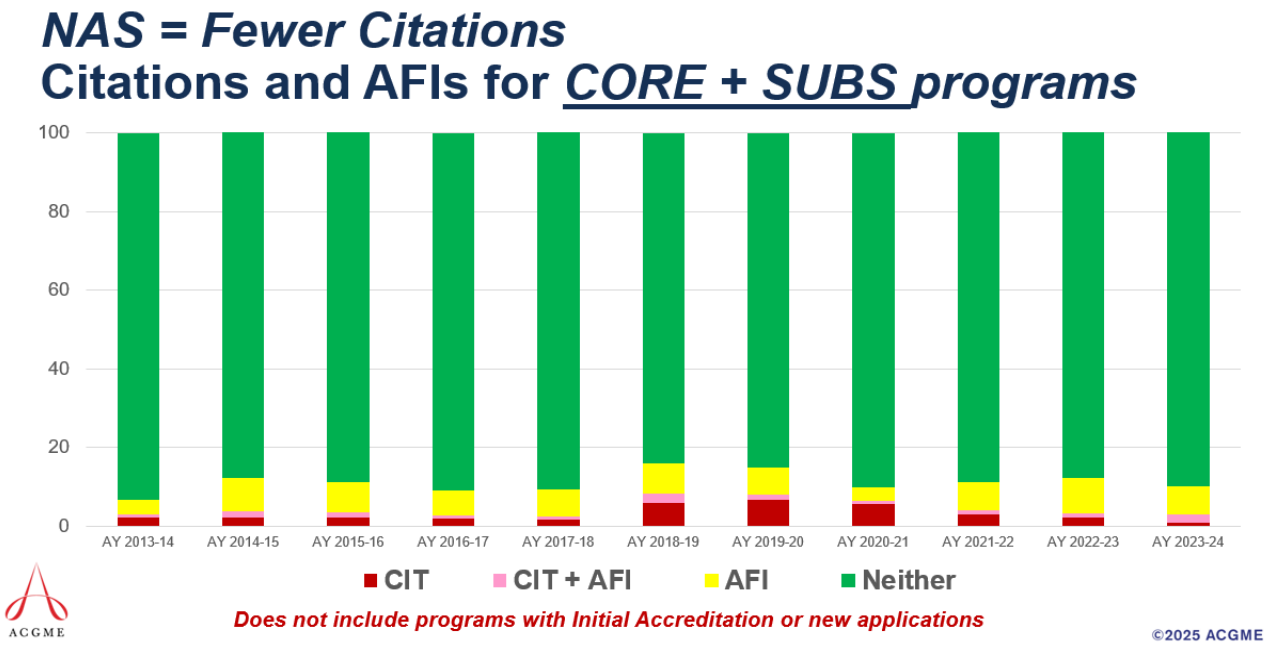
Does an unfavorable survey mean I will have a citation?

No, an unfavorable survey does not necessarily mean that the program will receive a citation. It's crucial to understand the broader context of accreditation status. Currently, the majority of internal medicine programs within the New Accreditation System (NAS) maintain Continued Accreditation without citations.

Historical data provides valuable perspective:

- Less than 5% of all internal medicine programs (including residency and subspecialty) currently have citations.





- In the final year of the Old Accreditation System (pre-July 1, 2013), approximately 80% of internal medicine programs had at least one citation

How do I respond to an unfavorable survey?

Begin by conducting an open and transparent dialogue with your residents and faculty to deeply understand the underlying reasons for lower survey compliance rates. This internal assessment will help you determine whether programmatic changes are necessary.

Key Steps for Addressing Survey Concerns:

• Conduct comprehensive internal discussions with residents and faculty

• Identify specific areas of lower compliance

• Analyze potential root causes of survey results

• Develop a targeted improvement strategy

Leverage the ACGME Accreditation Data System (ADS) as a key communication tool. Use the "major changes and other updates" section to provide context and demonstrate your proactive approach to addressing survey concerns. Even a concise, well-crafted narrative can effectively show the Residency Committee for Internal Medicine (RC-IM) that your program leadership has carefully reviewed the results and is committed to continuous improvement. **Entering even a few sentences in this space assures the RC-IM that the program and institutional leadership have seen and reviewed the survey results and are working to address any areas with lower compliance rates**.

A program director can enter information in the “major changes and other updates” field in ADS at any time, even multiple times within an academic year. The timing of when the PD enters the information is up to the PD, as comments are time stamped when entered. The RC-IM will only review the “major changes and other updates” in ADS if there is a flag on any NAS data elements. The RC-IM encourages PDs to provide comments on any issues they want, whenever they want to, as often as they feel they need. The RC-IM staff also encourages PDs to reach out to them directly if they have questions about the ADS updates or timing of the response.

Link to ACGME Program Requirements ACGME Program Requirements

Do I need to adjust my curriculum to make my survey more positive?

The ACGME survey provides formative feedback, not a mandate for change. Program directors should assess results objectively, prioritizing educational objectives over resident preferences. Core training goals matter more than momentary dissatisfaction. If a rotation is educationally essential, its value supersedes survey sentiment. The focus remains on maintaining high-quality medical education. Program leadership should use surveys as a constructive dialogue tool, informing potential improvements without compromising fundamental training standards. The survey results should not be perceived as punitive.

What can I tell my residents and/or faculty about the survey?

The ACGME encourages PDs to provide their residents and faculty with information about the survey and its questions. You can be a translator for the survey definitions and terms. This is especially important for the potentially ambiguous language for some elements of common program requirements, such as "non-physician obligations" in the resident survey (see below). Residents and faculty should be encouraged to answer the survey honestly and to clarify questions they do not understand. APDIM Council developed the linked presentations for you to share with your residents and faculty to explain and clarify the language of the ACGME. Each toolkit includes speaker notes for certain slides. Both toolkits are uploaded on the AAIM website under "resources".

What does the question about education compromised by non-physician obligations mean in the resident survey?

The resident survey includes a question about whether education is compromised by "**non-physician obligations."** These refer to tasks typically handled by nursing staff, allied health professionals, transport services, or clerical personnel, such as moving patients within the hospital, drawing routine blood samples, monitoring patients away from the ward, or managing scheduling and paperwork. While residents, like other physicians, may occasionally perform these duties, they should not be routinely responsible for them, as excessive involvement can interfere with their education. **Resident education encompasses both patient care and formal teaching activities**. Faculty should recognize that residents will be asked about these non-physician obligations on the survey, as an undue burden of these tasks may detract from their learning experience.

What are the ACGME Resident and Faculty Survey Common Program Requirements Crosswalk documents? How can it help me understand my ACGME resident survey results?

This relatively new resource assists programs in interpreting their ACGME survey results by linking survey questions to the relevant Common Program Requirements (CPRs). When a resident or faculty survey item shows low compliance, the crosswalk document helps identify specific areas needing improvement to meet CPR standards. Additionally, this tool can be used to help residents better understand the purpose behind individual survey questions.

ACGME Resident Survey Crosswalk

ACGME Resident Survey Crosswalk

ACGME Faculty Survey Crosswalk

ACGME Faculty Survey Crosswalk

APDIM Annual Survey Toolkit

You can download the APDIM Toolkit to Better Understand the ACGME Resident Survey (**APDIM ACGME Annual Survey Toolkit**) and customize the slides by adding extra details to clarify any survey questions for your residents. The slide set is updated every year in winter, just before the survey is released. The ACGME also has resources dedicated to the survey ACGME Resident/Fellow and Faculty Survey

Resources:

ACGME Program Requirements	ACGME Program Requirements
ACGME Resident Survey Crosswalk	ACGME Resident Survey Crosswalk
ACGME Faculty Survey Crosswalk	ACGME Faculty Survey Crosswalk
APDIM ACGME Annual Survey Toolkit	APDIM ACGME Annual Survey Toolkit

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Survey Content Areas

	Resident/Fellow	Faculty
Resources	• Education compromised by non-physician obligations • Impact of other learners on education • Appropriate balance between education (e.g., clinical teaching, conferences, lectures) and patient care • Faculty members discuss cost awareness in patient care decisions • Time to interact with patients • Protected time to participate in structured learning activities • Able to attend personal appointments • Able to access confidential mental health counseling or treatment • Satisfied with safety and health conditions	• Program director effectiveness • Faculty members committed to educating • Faculty members satisfied with process for evaluation as educators • Sufficient time to supervise residents/fellows • Performance as educator evaluated at least once per year

Professionalism	• Residents/fellows encouraged to feel comfortable calling supervisor with questions • Faculty members act professionally when teaching • Faculty members act professionally when providing care • Process in place for confidential reporting of unprofessional behavior • Able to raise concerns without fear of intimidation or retaliation • Satisfied with process for dealing confidentially with problems and concerns • Personally experienced abuse, harassment, mistreatment, discrimination, or coercion • Witnessed abuse, harassment, mistreatment, discrimination, or coercion	• Satisfied with process for problems and concerns • Experienced or witnessed abuse • Residents/fellows comfortable calling supervisor with for questions • Faculty members act unprofessionally • Process for confidential reporting of unprofessional behavior
Patient Safety and Teamwork	• Information not lost during shift changes, patient transfers, or the hand-off process • Culture reinforces personal responsibility for patient safety • Know how to report patient safety events • Interprofessional teamwork skills modeled or taught • Participate in safety event investigation and analysis • Process to transition patient care and clinical duties when fatigued	• Know how to report patient safety events • Culture emphasizes patient safety • Effective teamwork in patient care • Information not lost during shift changes or patient transfers • Interprofessional teamwork skills modeled or taught • Residents/fellows participate in adverse event analysis • Process to transition care when residents/fellows fatigued

Faculty Teaching and Supervision	• Faculty members interested in education • Faculty effectively creates environment of inquiry • Appropriate level of supervision • Appropriate amount of teaching in all clinical and didactic activities • Quality of teaching received in all clinical and didactic activities • Extent to which increasing clinical responsibility granted, based on resident's/fellow's training and ability	• Program director effectiveness • Faculty members committed to educating • Faculty members satisfied with process for evaluation as educators • Sufficient time to supervise residents/fellows • Performance as educator evaluated at least once per year
Evaluation	• Access to performance evaluations • Opportunity to confidentially evaluate faculty members at least annually • Opportunity to confidentially evaluate program at least annually • Satisfied with faculty members' feedback	
Educational Content	• Instruction on minimizing effects of sleep deprivation • Instruction on maintaining physical and emotional well-being • Instruction on scientific inquiry principles • Education in assessing patient goals (e.g., end-of-life care) • Opportunities to participate in scholarly activities • Taught about health care disparities • Program instruction in how to recognize the symptoms of and when to seek care regarding 1. Burnout 2. Depression 3. Fatigue and sleep deprivation 4. Substance use disorder	• Learning environment conducive to education • Residents/fellows instructed in cost-effectiveness • Residents/fellows prepared for unsupervised practice

Clinical Experience and Education	• 80-hour week (averaged over a four-week period) • Four or more days free in 28-day period • Taken in-hospital call more than every third night • Less than 14 hours free after 24 hours of work • More than 28 consecutive hours work • Additional responsibilities after 24 consecutive hours of work • Adequately manage patient care within 80 hours • Pressured to work more than 80 hours	
Overall	• Overall evaluation of program • Overall opinion of program	• Overall evaluation of program