News from the ACGME: Case Minimum Changes
Part 1: Philosophy and Background
April 2024

Competency-based medical education (CBME) has been established as a national priority by the ACGME and the American Board of Medical Specialties (ABMS) for all medical professions.[1,2] CBME asks the question: what is required during the graduate medical education (GME) process to become a competent physician in each specialty? This question is then used to establish a framework of specific competencies to provide clear goals for learners. CBME is designed to ensure that all graduates are competent in the essential domains that have been defined by their profession. As such, the framework of CBME consists not only of the traditional emphasis on medical knowledge, but also of patient care skills and professional behaviors. The emphasis on these three domains within the GME experience is designed to prepare residents for independent practice of orthopaedic surgery with safeguards to protect the public.

In orthopaedic surgery, the initial CBME assessment framework has been set up with the American Board of Orthopaedic Surgery's (ABOS) Knowledge, Skills, and Behavior program, with participation required by the ABOS for all programs as of July 1, 2025. The Knowledge, Skills, and Behavior program provides assessment tools for faculty members to give residents feedback regarding their progress at regular intervals longitudinally over the course of education and training. However, it does not establish specific criteria for evaluation. The next step is to establish the curriculum.

A central component of building the curriculum for orthopaedic surgery education and training is to define the surgical procedures that are required during residency. This group of procedures needs to span both the **breadth** and the **depth** of orthopaedic surgery.

The **breadth** of orthopaedic surgery is analogous to a liberal arts education, which includes sciences, arts, and humanities to allow broad exposure to many areas of knowledge. Similarly, in orthopaedic surgery every resident needs to have exposure to every subspecialty area and anatomic area treated. Residents do not need to become experts in each area, but they should experience a minimum case exposure for a well-rounded orthopaedic surgery education.

Residents should also gain greater **depth** of experience in key procedures common to orthopaedic surgery. These are *common* orthopaedic procedures that are *core* to the profession, in which each resident should be *competent* at the time of graduation. This group of *common*, *core*, and *competent* procedures are the **3C procedures**, which require a **depth** of surgical skill for each orthopaedic surgery resident.

The ACGME Review Committee for Orthopaedic Surgery established case minimums over a decade ago. (Table 1). This first attempt at defining the common core procedures within the profession has often been viewed as a "low bar," meaning that this list fails to adequately address both **breadth** and **depth** within orthopaedic surgery residency. It is now time for a

case minimum review and update, bringing minimums into the era of CBME.

Category	Minimum
Knee arthroscopy	30
Shoulder arthroscopy	20
ACL reconstruction	10
THA	30
TKA	30
Hip fractures	30
Carpal tunnel release	10
Spine decompression/posterior spine fusion	15
Ankle fracture fixation	15
Closed reduction forearm/wrist	20
Ankle and hind and mid-foot artho	5
Suprachondylar humerus perc	5
Operative treatment of femoral and tibial shaft fractures	25
All pediatric procedures	200
All oncology procedures	10

Table 1: Current case minimums, orthopaedic surgery

The Review Committee for Orthopaedic Surgery has been hard at work in establishing new case minimums for orthopaedic surgery. The case minimums will represent the **breadth** of orthopaedic surgery, with requirements in nine anatomic/specialty areas, as well as the **depth** of orthopaedic surgery in sixteen 3C categories as shown in Table 2. The proposed numbers associated with this framework were available for public comment starting in the spring of 2023, and the final recommendations may change from the list below.

Table 2: Proposed Categories of Case Minimums

Breadth of Orthopaedic Surgery (Anatomic and Subspecialty Areas)	**Depth of Orthopaedic Surgery (3C Procedures)**
Pelvis/Hip	Primary TKA
Femur/Knee	Primary THA
Leg/Ankle/Foot	Knee arthroscopy
Shoulder	Shoulder arthroscopy
Humerus/Elbow	Femur/tibia IM nailing
Forearm/Wrist/Hand	Operative management of femoral neck/IT fracture
Spine	Operative management of forearm/distal radius fracture
Pediatrics*	Operative management of rotational ankle fracture
Oncology*	Operative management of pediatric distal humerus fracture
	Application of external fixator*
	Prophylactic fracture fixation
	Closed management of fracture/dislocation with manipulation
	Deep metal removal*
	Carpal tunnel decompression

	Lower extremity major tendon repair
	Irrigation and debridement (fractures, joint/arthroplasty sepsis) *
	Fasciotomy
	Lower limb amputation

All cases will count toward anatomic area minimums, except for those indicated with *.

This article is the first of a four-part series outlining the upcoming changes addressing the new ACGME orthopaedic surgery case minimum requirements.

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1. American Board of Medical Specialties. 2024. “CBME: A Promising Framework.” January 26. https://www.abms.org/newsroom/cbme-a-promising-framework/.
2. ACGME. 2021. “#ACGME2021 Session Summary: Moving Urgently toward Competency-Based Assessment in GME.” March 9. https://www.acgme.org/newsroom/blog/2021/3/acgme2021-session-summary-moving-urgently-toward-competency-based-assessment-in-gme/.