Accreditation Council for
Graduate Medical Education

ACGME Program Requirements for Graduate Medical Education in Complex General Surgical Oncology

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One-year Common Program Requirements are in BOLD

Introduction

Int.A. Residency and fellowship programs are essential dimensions of the transformation of the medical student to the independent practitioner along the continuum of medical education. They are physically, emotionally, and intellectually demanding, and require longitudinally-concentrated effort on the part of the resident or fellow.

The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident and fellow physician to assume personal responsibility for the care of individual patients. For the resident and fellow, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents and fellows gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept--graded and progressive responsibility--is one of the core tenets of American graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident's and fellow's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

Int.B. A surgical oncologist is a well-qualified surgeon who has obtained additional education and experience in the multidisciplinary approach to the prevention, diagnosis, treatment, and rehabilitation of cancer patients, and who devotes a major portion of his or her professional practice to these activities and to cancer research. Surgical oncologists interact with other oncologic disciplines and provide leadership to the surgical, medical, and lay communities in matters pertaining to cancer.

Int.C. The educational program in complex general surgical oncology must be 24 months in length. (Core)*

I. Institutions

I.A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to fellow assignments at all participating sites. (Core)

52 **The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program.** (Core)

56 I.A.1. The complex general surgical oncology program must be affiliated with an ACGME-accredited general surgery program. Sponsorship of the program must be in compliance with the policy detailed in section 15.00 of the ACGME Manual of Policies and Procedures. (Core)

61 I.A.2. The complex general surgical oncology program must be affiliated with an ACGME-accredited medical oncology program. (Core)

64 **I.B. Participating Sites**

66 **I.B.1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years.** (Core)

70 **The PLA should:**

72 **I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for fellows;** (Detail)

75 **I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of fellows, as specified later in this document;** (Detail)

79 **I.B.1.c) specify the duration and content of the educational experience; and,** (Detail)

82 **I.B.1.d) state the policies and procedures that will govern fellow education during the assignment.** (Detail)

85 **I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all fellows, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).** (Core)

91 I.B.3. Sites that are integrated with the sponsoring institution must have an integration agreement specifying that the program director must: (Detail)

94 I.B.3.a) appoint the members of the faculty at the integrated site; (Detail)

96 I.B.3.b) appoint the chief or director of the teaching service at the integrated site; (Detail)

99 I.B.3.c) appoint all fellows in the program; and, (Detail)

101 I.B.3.d) determine all rotations and assignments for both fellows and faculty supervisors. (Detail)

103
104 I.B.4. Integrated sites should be in close geographic proximity to allow all
105 fellows to attend joint conferences, basic science lectures, and morbidity
106 and mortality reviews regularly and in a central location. (Detail)
107
108 I.B.5. The Review Committee must approve all integrated sites in advance.
109 (Detail)
110
111 **II. Program Personnel and Resources**
112
113 **II.A. Program Director**
114
115 **II.A.1. There must be a single program director with authority and**
116 **accountability for the operation of the program. The sponsoring**
117 **institution's GMEC must approve a change in program director.** (Core)
118
119 **II.A.1.a) The program director must submit this change to the ACGME**
120 **via the ADS.** (Core)
121
122 **II.A.2. Qualifications of the program director must include:**
123
124 **II.A.2.a) requisite specialty expertise and documented educational**
125 **and administrative experience acceptable to the Review**
126 **Committee;** (Core)
127
128 **II.A.2.b) current certification in the subspecialty by the American**
129 **Board of** Surgery **or subspecialty qualifications that are**
130 **acceptable to the Review Committee;** (Core)
131
132 **II.A.2.c) current medical licensure and appropriate medical staff**
133 **appointment;** (Core)
134
135 II.A.2.d) successful completion of a surgical oncology program sponsored
136 by the Society of Surgical Oncology or a complex general surgical
137 oncology program accredited by the ACGME; and, (Core)
138
139 II.A.2.e) scholarly activity in the areas delineated in Section II.B.7 of this
140 document. (Detail)
141
142 **II.A.3. The program director must administer and maintain an educational**
143 **environment conducive to educating the fellows in each of the**
144 **ACGME competency areas.** (Core)
145
146 **The program director must:**
147
148 **II.A.3.a) prepare and submit all information required and requested by**
149 **the ACGME;** (Core)
150
151 **II.A.3.b) be familiar with and oversee compliance with ACGME and**
152 **Review Committee policies and procedures as outlined in the**
153 **ACGME Manual of Policies and Procedures;** (Detail)

154
155 **II.A.3.c)** **obtain review and approval of the sponsoring institution's GMEC/DIO before submitting information or requests to the ACGME, including:** (Core)
158
159 **II.A.3.c).(1)** **all applications for ACGME accreditation of new programs;** (Detail)
161
162 **II.A.3.c).(2)** **changes in fellow complement;** (Detail)
163
164 **II.A.3.c).(3)** **major changes in program structure or length of training;** (Detail)
166
167 **II.A.3.c).(4)** **progress reports requested by the Review Committee;** (Detail)
169
170 **II.A.3.c).(5)** **requests for increases or any change to fellow duty hours;** (Detail)
172
173 **II.A.3.c).(6)** **voluntary withdrawals of ACGME-accredited programs;** (Detail)
175
176 **II.A.3.c).(7)** **requests for appeal of an adverse action; and,** (Detail)
177
178 **II.A.3.c).(8)** **appeal presentations to a Board of Appeal or the ACGME.** (Detail)
180
181 **II.A.3.d)** **obtain DIO review and co-signature on all program application forms, as well as any correspondence or document submitted to the ACGME that addresses:** (Detail)
184
185 **II.A.3.d).(1)** **program citations, and/or,** (Detail)
186
187 **II.A.3.d).(2)** **request for changes in the program that would have significant impact, including financial, on the program or institution.** (Detail)
190
191 II.A.3.e) develop and implement lines of authority specifying expected reporting relationships for fellows and faculty members to maximize quality care and patient safety. (Detail)
194
195 II.A.4. The program director must be appointed for a minimum of three years. (Detail)
197
198 **II.B. Faculty**
199
200 **II.B.1.** **There must be a sufficient number of faculty with documented qualifications to instruct and supervise all fellows.** (Core)
202
203 **II.B.2.** **The faculty must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities and**

demonstrate a strong interest in the education of fellows. (Core)

II.B.3. **The physician faculty must have current certification in the subspecialty by the American Board of** Surgery, **or possess qualifications judged acceptable to the Review Committee.** (Core)

II.B.3.a) Surgical faculty members must have successfully completed a ~~surgical oncology program, sponsored by the Society of Surgical Oncology or a~~ complex general surgical oncology program accredited by the ACGME or possess other qualifications found acceptable to the Review Committee. (Core)

II.B.4. **The physician faculty must possess current medical licensure and appropriate medical staff appointment.** (Core)

II.B.5. In addition to the program director, the faculty must include:

II.B.5.a) at least one full-time physician faculty member for each approved fellowship position whose major function is to support the fellowship program; and, (Core)

II.B.5.b) at least one faculty member who is ABMS-certified or who possesses qualifications acceptable to the Review Committee in each of the following areas: medical oncology, interventional radiology; and radiation oncology; or possess qualifications acceptable to the Review Committee. (Core)

II.B.6. Physician faculty members must establish and maintain an environment of inquiry and scholarship with an active research component. (Core)

II.B.7. Some members of the physician faculty should also demonstrate scholarship by one or more of the following:

II.B.7.a) peer-reviewed funding; (Detail)

II.B.7.b) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks; (Detail)

II.B.7.c) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or, (Detail)

II.B.7.d) participation in national committees or educational organizations. (Detail)

II.B.8. Non-physician faculty members must have appropriate qualifications in their fields, and hold appropriate institutional appointments. (Detail)

II.C. **Other Program Personnel**

The institution and the program must jointly ensure the availability of all

256 **necessary professional, technical, and clerical personnel for the effective**
257 **administration of the program.** (Core)
258
259 **II.D. Resources**
260
261 **The institution and the program must jointly ensure the availability of**
262 **adequate resources for fellow education, as defined in the specialty**
263 **program requirements.** (Core)
264
265 II.D.1. Each participating site must provide the following resources:
266
267 II.D.1.a) inpatient surgical admissions services; (Core)
268
269 II.D.1.b) intensive care units; and, (Core)
270
271 II.D.1.c) services, including emergency services, interventional radiology,
272 pathology, and radiology. (Core)
273
274 **II.E. Medical Information Access**
275
276 **Fellows must have ready access to specialty-specific and other appropriate**
277 **reference material in print or electronic format. Electronic medical literature**
278 **databases with search capabilities should be available.** (Detail)
279
280 **III. Fellow Appointments**
281
282 **III.A. Eligibility Requirements – Fellowship Programs**
283
284 **All required clinical education for entry into ACGME-accredited fellowship**
285 **programs must be completed in an ACGME-accredited residency program,**
286 **or in an RCPSC-accredited or CFPC-accredited residency program located**
287 **in Canada. (Core)**
288
289 **III.A.1. Fellowship programs must receive verification of each entering**
290 **fellow's level of competency in the required field using ACGME or**
291 **CanMEDS Milestones assessments from the core residency**
292 **program. (Core)**
293
294 **III.A.2. Fellow Eligibility Exception**
295
296 **A Review Committee may grant the following exception to the**
297 **fellowship eligibility requirements:**
298
299 **An ACGME-accredited fellowship program may accept an**
300 **exceptionally qualified applicant**, who does not satisfy the**
301 **eligibility requirements listed in Sections III.A. and III.A.1., but who**
302 **does meet all of the following additional qualifications and**
303 **conditions: (Core)**
304
305 **III.A.2.a) Assessment by the program director and fellowship selection**
306 **committee of the applicant's suitability to enter the program,**

307 **based on prior training and review of the summative**
308 **evaluations of training in the core specialty; and (Core)**
309
310 **III.A.2.b) Review and approval of the applicant's exceptional**
311 **qualifications by the GMEC or a subcommittee of the GMEC;**
312 **and (Core)**
313
314 **III.A.2.c) Satisfactory completion of the United States Medical**
315 **Licensing Examination (USMLE) Steps 1, 2, and, if the**
316 **applicant is eligible, 3, and; (Core)**
317
318 **III.A.2.d) For an international graduate, verification of Educational**
319 **Commission for Foreign Medical Graduates (ECFMG)**
320 **certification; and, (Core)**
321
322 **III.A.2.e) Applicants accepted by this exception must complete**
323 **fellowship Milestones evaluation (for the purposes of**
324 **establishment of baseline performance by the Clinical**
325 **Competency Committee), conducted by the receiving**
326 **fellowship program within six weeks of matriculation. This**
327 **evaluation may be waived for an applicant who has**
328 **completed an ACGME International-accredited residency**
329 **based on the applicant's Milestones evaluation conducted at**
330 **the conclusion of the residency program. (Core)**
331
332 **III.A.2.e).(1) If the trainee does not meet the expected level of**
333 **Milestones competency following entry into the**
334 **fellowship program, the trainee must undergo a period**
335 **of remediation, overseen by the Clinical Competency**
336 **Committee and monitored by the GMEC or a**
337 **subcommittee of the GMEC. This period of remediation**
338 **must not count toward time in fellowship training. (Core)**
339
340 **** An exceptionally qualified applicant has (1) completed a non-**
341 **ACGME-accredited residency program in the core specialty, and (2)**
342 **demonstrated clinical excellence, in comparison to peers,**
343 **throughout training. Additional evidence of exceptional**
344 **qualifications is required, which may include one of the following:**
345 **(a) participation in additional clinical or research training in the**
346 **specialty or subspecialty; (b) demonstrated scholarship in the**
347 **specialty or subspecialty; (c) demonstrated leadership during or**
348 **after residency training; (d) completion of an ACGME-International-**
349 **accredited residency program.**
350
351 **III.A.3. The Review Committee for** Surgery **does not allow exceptions to the**
352 **Eligibility Requirements for Fellowship Programs in Section III.A.**
353 **(Core)**
354
355 III.A.4. Prior to appointment in the program, fellows must meet at least one of the
356 following:
357

358 III.A.4.a) satisfactory completion of a general surgery program accredited
359 by the ACGME, or a general surgery program located in Canada
360 and accredited by the RCPSC; (Core)
361
362 III.A.4.b) be admissible to examination by the American Board of Surgery;
363 or, (Core)
364
365 III.A.4.c) be certified by the American Board of Surgery. (Core)
366
367 **III.B. Number of Fellows**
368
369 **The program's educational resources must be adequate to support the**
370 **number of fellows appointed to the program.** (Core)
371
372 **III.B.1. The program director may not appoint more fellows than approved**
373 **by the Review Committee, unless otherwise stated in the specialty-**
374 **specific requirements.** (Core)
375
376 III.B.2. Both temporary increases longer than three months and permanent
377 increases in fellow complement must be approved in advance by the
378 Review Committee. (Core)
379
380 III.C. The presence of other learners, including residents from other specialties,
381 subspecialty fellows, PhD students, and nurse practitioners, in the program must
382 not interfere with the appointed fellows' education. The program director must
383 report the presence of other learners to the DIO and GMEC in accordance with
384 sponsoring institution guidelines. (Detail)
385
386 **IV. Educational Program**
387
388 **IV.A. The curriculum must contain the following educational components:**
389
390 **IV.A.1. Skills and competencies the fellow will be able to demonstrate at the**
391 **conclusion of the program. The program must distribute these skills**
392 **and competencies to fellows and faculty at least annually, in either**
393 **written or electronic form.** (Core)
394
395 **IV.A.2. ACGME Competencies**
396
397 **The program must integrate the following ACGME competencies**
398 **into the curriculum:** (Core)
399
400 **IV.A.2.a) Patient Care and Procedural Skills**
401
402 **IV.A.2.a).(1) Fellows must be able to provide patient care that is**
403 **compassionate, appropriate, and effective for the**
404 **treatment of health problems and the promotion of**
405 **health.** (Outcome)
406
407 **IV.A.2.a).(2) Fellows must be able to competently perform all**
408 **medical, diagnostic, and surgical procedures**

409 **considered essential for the area of practice. Fellows:**
410 (Outcome)
411
412 IV.A.2.a).(2).(a) must demonstrate competence in evaluating
413 patients pre-operatively, making appropriate
414 provisional diagnoses, initiating diagnostic
415 procedures, and forming preliminary treatment
416 plans; (Outcome)
417
418 IV.A.2.a).(2).(b) must demonstrate competence in oncologic
419 surgical peri-operative management, including:
420 (Outcome)
421
422 IV.A.2.a).(2).(b).(i) advanced laparoscopic techniques; (Outcome)
423
424 IV.A.2.a).(2).(b).(ii) broadly-based oncologic surgical
425 procedures, including those for breast,
426 endocrine, gastrointestinal, gynecological,
427 head and neck, melanoma, and sarcoma
428 conditions; (Outcome)
429
430 IV.A.2.a).(2).(b).(iii) endoscopy; and, (Outcome)
431
432 IV.A.2.a).(2).(b).(iv) staging methodologies and procedures for
433 all common surgical malignancies. (Outcome)
434
435 IV.A.2.a).(2).(c) must demonstrate competence in the care of
436 critically-ill surgical patients, including: (Outcome)
437
438 IV.A.2.a).(2).(c).(i) applying sound principles of pharmacology
439 for each form of therapy; (Outcome)
440
441 IV.A.2.a).(2).(c).(ii) evaluating and managing patients receiving
442 chemotherapy, hormonal therapy, and
443 immunotherapy; and, (Outcome)
444
445 IV.A.2.a).(2).(c).(iii) providing supportive care to cancer patients,
446 including pain management. (Outcome)
447
448 IV.A.2.a).(2).(d) must demonstrate competence in performing
449 cancer-related operative procedures; (Outcome)
450
451 IV.A.2.a).(2).(d).(i) A minimum of 150 cancer-related operative
452 procedures must be performed. (Core)
453
454 IV.A.2.a).(2).(e) must demonstrate competence in the surgical
455 management of patients undergoing predominantly
456 medical therapy, including: (Outcome)
457
458 IV.A.2.a).(2).(e).(i) endoscopic procedures of the aerodigestive
459 tract; (Outcome)

460
461 IV.A.2.a).(2).(e).(ii) insertion of indwelling access devices for
462 systemic or regional chemotherapy; (Outcome)
463
464 IV.A.2.a).(2).(e).(iii) surgical management of distant metastatic
465 disease, including resection; and, (Outcome)
466
467 IV.A.2.a).(2).(e).(iv) minimally invasive surgery, particularly as it
468 applies to the staging of cancer. (Outcome)
469
470 IV.A.2.a).(2).(f) must demonstrate competence in providing state-
471 of-the-art surgical care to patients with complex or
472 recurrent neoplasms, including: (Outcome)
473
474 IV.A.2.a).(2).(f).(i) diagnosis and management of rare or
475 unusual tumors based on knowledge of the
476 natural history of such cancers; and, (Outcome)
477
478 IV.A.2.a).(2).(f).(i).(a) This must include determining the
479 disease stage and treatment options
480 for individual cancer patients at the
481 time of diagnosis and throughout the
482 disease course. (Detail)
483
484 IV.A.2.a).(2).(f).(ii) selecting patients for surgical therapy in
485 combination with other forms of cancer
486 treatment. (Outcome)
487
488 IV.A.2.a).(2).(f).(ii).(a) This must include performing
489 palliative surgical procedures
490 appropriate for each patient. (Detail)
491
492 **IV.A.2.b) Medical Knowledge**
493
494 **Fellows must demonstrate knowledge of established and**
495 **evolving biomedical, clinical, epidemiological and social-**
496 **behavioral sciences, as well as the application of this**
497 **knowledge to patient care. Fellows:** (Outcome)
498
499 IV.A.2.b).(1) must demonstrate competence in their knowledge of:
500
501 IV.A.2.b).(1).(a) the benefits and risks associated with a
502 multidisciplinary approach; (Outcome)
503
504 IV.A.2.b).(1).(b) the fundamental biology of cancer, clinical
505 pharmacology, tumor immunology, and
506 endocrinology, as well as potential complications of
507 multimodality therapy; (Outcome)
508
509 IV.A.2.b).(1).(b).(i) This must include the biologic,
510 pharmacologic, and physiologic rationale for

511 each form of therapy, as well as the
512 indications, risks, and benefits of regional
513 and systemic therapy in the adjuvant and
514 advanced disease settings. (Detail)
515
516 IV.A.2.b).(1).(c) non-surgical cancer treatment modalities, including
517 radiotherapy, chemotherapy, immunotherapy,
518 interventional radiology, and endocrine therapy;
519 (Outcome)
520
521 IV.A.2.b).(1).(d) non-surgical palliative treatments; (Outcome)
522
523 IV.A.2.b).(1).(e) rehabilitative services in various settings, including
524 reconstructive surgery and physical rehabilitation;
525 and, (Outcome)
526
527 IV.A.2.b).(1).(f) tumor biology, carcinogenesis, epidemiology, tumor
528 markers, and tumor pathology. (Outcome)
529
530 **IV.A.2.c) Practice-based Learning and Improvement**
531
532 **Fellows are expected to develop skills and habits to be able**
533 **to meet the following goals:**
534
535 **IV.A.2.c).(1) systematically analyze practice using quality**
536 **improvement methods, and implement changes with**
537 **the goal of practice improvement;** (Outcome)
538
539 **IV.A.2.c).(2) locate, appraise, and assimilate evidence from**
540 **scientific studies related to their patients' health**
541 **problems; and,** (Outcome)
542
543 IV.A.2.c).(3) demonstrate competence in:
544
545 IV.A.2.c).(3).(a) educating students and physicians in the
546 multimodality management of cancer patients;
547 (Outcome)
548
549 IV.A.2.c).(3).(b) educating non-physicians (physician assistants,
550 oncology nurses, enterostomal therapists, etc.) in
551 specialized cancer care; and, (Outcome)
552
553 IV.A.2.c).(3).(c) organizing and conducting cancer-related public
554 education programs. (Outcome)
555
556 **IV.A.2.d) Interpersonal and Communication Skills**
557
558 **Fellows must demonstrate interpersonal and communication**
559 **skills that result in the effective exchange of information and**
560 **collaboration with patients, their families, and health**
561 **professionals.** (Outcome)

562
563 IV.A.2.d).(1) Fellows must demonstrate competence as consultants
564 across the oncologic continuity of care. (Outcome)
565
566 **IV.A.2.e) Professionalism**
567
568 **Fellows must demonstrate a commitment to carrying out**
569 **professional responsibilities and an adherence to ethical**
570 **principles.** (Outcome)
571
572 **IV.A.2.f) Systems-based Practice**
573
574 **Fellows must demonstrate an awareness of and**
575 **responsiveness to the larger context and system of health**
576 **care, as well as the ability to call effectively on other**
577 **resources in the system to provide optimal health care.** (Outcome)
578
579 IV.A.2.f).(1) Fellows must demonstrate leadership skills to develop and
580 support:
581
582 IV.A.2.f).(1).(a) institutional policies regarding cancer programs and
583 problems; (Outcome)
584
585 IV.A.2.f).(1).(b) institutional programs relating to cancer, including a
586 tumor registry and psychosocial and rehabilitative
587 programs for cancer patients and their families;
588 and, (Outcome)
589
590 IV.A.2.f).(1).(c) interdisciplinary meetings and discussions to
591 include cancer topics, patient care, and the
592 oncology research program. (Outcome)
593
594 IV.A.3. Curriculum Organization and Fellow Experiences
595
596 IV.A.3.a) The curriculum must provide at least:
597
598 IV.A.3.a).(1) 12 months of education in clinical surgical oncology; and,
599 (Core)
600
601 IV.A.3.a).(2) four months of clinical or laboratory research. (Core)
602
603 IV.A.3.a).(2).(a) Fellows must have access to faculty members who
604 can mentor them in basic science research and
605 must have time for such an experience if desired.
606 (Detail)
607
608 IV.A.3.b) The curriculum should include a minimum of one month each in
609 medical oncology, pathology, and radiation oncology, or provide
610 alternative experiences acceptable to the Review Committee. (Core)
611
612 IV.A.3.c) The didactic curriculum must include:

613
614 IV.A.3.c).(1) a structured series of conferences in the basic and clinical
615 sciences fundamental to oncologic surgery, monthly
616 surgical grand rounds, and twice-monthly morbidity and
617 mortality conferences; (Detail)
618
619 IV.A.3.c).(1).(a) Fellows must organize the formal surgical oncology
620 conferences, grand rounds, and morbidity and
621 mortality conferences, and present a significant
622 share of these conferences. (Detail)
623
624 IV.A.3.c).(2) at least weekly teaching rounds by oncologic surgical
625 faculty members; (Detail)
626
627 IV.A.3.c).(3) education in the basic methodology for conducting clinical
628 trials, including biostatistics, clinical research design,
629 ethics, and implementation of computerized databases;
630 and, (Detail)
631
632 IV.A.3.c).(4) monthly relevant multidisciplinary conferences. (Detail)
633
634 IV.A.3.d) Each organized clinical discussion, round, journal club, and
635 conference must include participation by at least one member of
636 the faculty. (Detail)
637
638 IV.A.3.e) Fellow Experiences
639
640 IV.A.3.e).(1) Clinical assignments should include experiences in general
641 surgical oncology, including breast, gastrointestinal
642 oncology, melanoma, sarcoma, and head and neck. (Core)
643
644 IV.A.3.e).(2) Fellows must provide outpatient follow-up care for surgical
645 patients. (Core)
646
647 IV.A.3.e).(2).(a) Follow-up care should include short- and long-term
648 evaluation and progress, particularly with complex,
649 multidisciplinary cancer management. (Detail)
650
651 IV.A.3.e).(2).(b) Fellows must have documented outpatient
652 experience one day per week. (Detail)
653
654 IV.A.3.e).(3) Each fellow must have experiences acting as a teaching
655 assistant in the operating room when documented
656 operative experience justifies a teaching role. (Detail)
657
658 IV.A.3.e).(4) Fellows must not share primary responsibility for patients
659 with the surgery chief resident. (Core)
660
661 IV.A.3.e).(5) Fellows must have significant teaching responsibilities for
662 surgery residents, medical students, or other learners. (Core)
663

664 **IV.B. Fellows' Scholarly Activities**
665
666 IV.B.1. Each fellow must complete a course on clinical research on human
667 subjects, such as the courses approved by the National Institutes of
668 Health Office for Human Research Protections, or an institution-based
669 equivalent. (Core)
670
671 IV.B.2. Fellows must demonstrate the ability to: design and implement a
672 prospective data base; conduct clinical cancer research, especially
673 prospective clinical trials; use statistical methods to properly evaluate
674 results of published research studies; guide other learners or other
675 personnel in laboratory or clinical oncology research; and navigate the
676 interface of basic science with clinical cancer care to facilitate
677 translational research. (Outcome)
678
679 **V. Evaluation**
680
681 **V.A. Fellow Evaluation**
682
683 **V.A.1. The program director must appoint the Clinical Competency**
684 **Committee. (Core)**
685
686 **V.A.1.a) At a minimum the Clinical Competency Committee must be**
687 **composed of three members of the program faculty. (Core)**
688
689 **V.A.1.a).(1) The program director may appoint additional members**
690 **of the Clinical Competency Committee.**
691
692 **V.A.1.a).(1).(a) These additional members must be physician**
693 **faculty members from the same program or**
694 **other programs, or other health professionals**
695 **who have extensive contact and experience**
696 **with the program's fellows in patient care and**
697 **other health care settings. (Core)**
698
699 **V.A.1.a).(1).(b) Chief residents who have completed core**
700 **residency programs in their specialty and are**
701 **eligible for specialty board certification may be**
702 **members of the Clinical Competency**
703 **Committee. (Core)**
704
705 **V.A.1.b) There must be a written description of the responsibilities of**
706 **the Clinical Competency Committee. (Core)**
707
708 **V.A.1.b).(1) The Clinical Competency Committee should:**
709
710 **V.A.1.b).(1).(a) review all fellow evaluations semi-annually; (Core)**
711
712 **V.A.1.b).(1).(b) prepare and ensure the reporting of Milestones**
713 **evaluations of each fellow semi-annually to**
714 **ACGME; and, (Core)**

715
716 **V.A.1.b).(1).(c)** **advise the program director regarding fellow progress, including promotion, remediation, and dismissal.** (Detail)
717
718
719
720 **V.A.2.** **Formative Evaluation**
721
722 **V.A.2.a)** **The faculty must evaluate fellow performance in a timely manner.** (Core)
723
724
725 **V.A.2.b)** **The program must:**
726
727 **V.A.2.b).(1)** **provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones;** (Core)
728
729
730
731
732
733
734 **V.A.2.b).(2)** **use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff); and,** (Detail)
735
736
737 **V.A.2.b).(3)** **provide each fellow with documented semiannual evaluation of performance with feedback.** (Core)
738
739
740 V.A.2.b).(3).(a) The semiannual review must include review of the fellow's operative data. (Core)
741
742
743 **V.A.2.c)** **The evaluations of fellow performance must be accessible for review by the fellow, in accordance with institutional policy.** (Detail)
744
745
746
747 **V.A.3.** **Summative Evaluation**
748
749 **V.A.3.a)** **The specialty-specific Milestones must be used as one of the tools to ensure fellows are able to practice core professional activities without supervision upon completion of the program.** (Core)
750
751
752
753
754 **V.A.3.b)** **The program director must provide a summative evaluation for each fellow upon completion of the program.** (Core)
755
756
757 **This evaluation must:**
758
759 **V.A.3.b).(1)** **become part of the fellow's permanent record maintained by the institution, and must be accessible for review by the fellow in accordance with institutional policy;** (Detail)
760
761
762
763
764 **V.A.3.b).(2)** **document the fellow's performance during their education; and,** (Detail)
765

766
767 **V.A.3.b).(3)** **verify that the fellow has demonstrated sufficient**
768 **competence to enter practice without direct**
769 **supervision.** (Detail)
770
771 **V.B. Faculty Evaluation**
772
773 **V.B.1. At least annually, the program must evaluate faculty performance as**
774 **it relates to the educational program.** (Core)
775
776 **V.B.2. These evaluations should include a review of the faculty's clinical**
777 **teaching abilities, commitment to the educational program, clinical**
778 **knowledge, professionalism, and scholarly activities.** (Detail)
779
780 **V.C. Program Evaluation and Improvement**
781
782 **V.C.1. The program director must appoint the Program Evaluation**
783 **Committee (PEC). (Core)**
784
785 **V.C.1.a) The Program Evaluation Committee:**
786
787 **V.C.1.a).(1) must be composed of at least two program faculty**
788 **members and should include at least one fellow; (Core)**
789
790 **V.C.1.a).(2) must have a written description of its responsibilities;**
791 **and, (Core)**
792
793 **V.C.1.a).(3) should participate actively in:**
794
795 **V.C.1.a).(3).(a) planning, developing, implementing, and**
796 **evaluating educational activities of the**
797 **program; (Detail)**
798
799 **V.C.1.a).(3).(b) reviewing and making recommendations for**
800 **revision of competency-based curriculum goals**
801 **and objectives; (Detail)**
802
803 **V.C.1.a).(3).(c) addressing areas of non-compliance with**
804 **ACGME standards; and, (Detail)**
805
806 **V.C.1.a).(3).(d) reviewing the program annually using**
807 **evaluations of faculty, fellows, and others, as**
808 **specified below. (Detail)**
809
810 **V.C.2. The program, through the PEC, must document formal, systematic**
811 **evaluation of the curriculum at least annually, and is responsible for**
812 **rendering a written, annual program evaluation.** (Core)
813
814 **The program must monitor and track each of the following areas:**
815
816 **V.C.2.a) fellow performance; (Core)**

817
818 **V.C.2.b)** **faculty development; and,** **(Core)**
819
820 **V.C.2.c)** **progress on the previous year's action plan(s).** **(Core)**
821
822 **V.C.3.** **The PEC must prepare a written plan of action to document**
823 **initiatives to improve performance in one or more of the areas listed**
824 **in section V.C.2., as well as delineate how they will be measured and**
825 **monitored.** **(Core)**
826
827 **V.C.3.a)** **The action plan should be reviewed and approved by the**
828 **teaching faculty and documented in meeting minutes.** **(Detail)**
829
830 **VI. Fellow Duty Hours in the Learning and Working Environment**
831
832 **VI.A. Professionalism, Personal Responsibility, and Patient Safety**
833
834 **VI.A.1.** **Programs and sponsoring institutions must educate fellows and**
835 **faculty members concerning the professional responsibilities of**
836 **physicians to appear for duty appropriately rested and fit to provide**
837 **the services required by their patients.** (Core)
838
839 **VI.A.2.** **The program must be committed to and responsible for promoting**
840 **patient safety and fellow well-being in a supportive educational**
841 **environment.** (Core)
842
843 **VI.A.3.** **The program director must ensure that fellows are integrated and**
844 **actively participate in interdisciplinary clinical quality improvement**
845 **and patient safety programs.** (Core)
846
847 **VI.A.4.** **The learning objectives of the program must:**
848
849 **VI.A.4.a)** **be accomplished through an appropriate blend of supervised**
850 **patient care responsibilities, clinical teaching, and didactic**
851 **educational events; and,** (Core)
852
853 **VI.A.4.b)** **not be compromised by excessive reliance on fellows to fulfill**
854 **non-physician service obligations.** (Core)
855
856 **VI.A.5.** **The program director and sponsoring institution must ensure a**
857 **culture of professionalism that supports patient safety and personal**
858 **responsibility.** (Core)
859
860 **VI.A.6.** **Fellows and faculty members must demonstrate an understanding**
861 **and acceptance of their personal role in the following:**
862
863 **VI.A.6.a)** **assurance of the safety and welfare of patients entrusted to**
864 **their care;** (Outcome)
865
866 **VI.A.6.b)** **provision of patient- and family-centered care;** (Outcome)
867

868 **VI.A.6.c)** **assurance of their fitness for duty;** (Outcome)
869
870 **VI.A.6.d)** **management of their time before, during, and after clinical**
871 **assignments;** (Outcome)
872
873 **VI.A.6.e)** **recognition of impairment, including illness and fatigue, in**
874 **themselves and in their peers;** (Outcome)
875
876 **VI.A.6.f)** **attention to lifelong learning;** (Outcome)
877
878 **VI.A.6.g)** **the monitoring of their patient care performance improvement**
879 **indicators; and,** (Outcome)
880
881 **VI.A.6.h)** **honest and accurate reporting of duty hours, patient**
882 **outcomes, and clinical experience data.** (Outcome)
883
884 **VI.A.7.** **All fellows and faculty members must demonstrate responsiveness**
885 **to patient needs that supersedes self-interest. They must recognize**
886 **that under certain circumstances, the best interests of the patient**
887 **may be served by transitioning that patient's care to another**
888 **qualified and rested provider.** (Outcome)
889
890 **VI.B.** **Transitions of Care**
891
892 **VI.B.1.** **Programs must design clinical assignments to minimize the number**
893 **of transitions in patient care.** (Core)
894
895 **VI.B.2.** **Sponsoring institutions and programs must ensure and monitor**
896 **effective, structured hand-over processes to facilitate both**
897 **continuity of care and patient safety.** (Core)
898
899 **VI.B.3.** **Programs must ensure that fellows are competent in communicating**
900 **with team members in the hand-over process.** (Outcome)
901
902 **VI.B.4.** **The sponsoring institution must ensure the availability of schedules**
903 **that inform all members of the health care team of attending**
904 **physicians and fellows currently responsible for each patient's care.**
905 (Detail)
906
907 **VI.C.** **Alertness Management/Fatigue Mitigation**
908
909 **VI.C.1.** **The program must:**
910
911 **VI.C.1.a)** **educate all faculty members and fellows to recognize the**
912 **signs of fatigue and sleep deprivation;** (Core)
913
914 **VI.C.1.b)** **educate all faculty members and fellows in alertness**
915 **management and fatigue mitigation processes; and,** (Core)
916
917 **VI.C.1.c)** **adopt fatigue mitigation processes to manage the potential**
918 **negative effects of fatigue on patient care and learning, such**

919 **as naps or back-up call schedules.** (Detail)
920
921 **VI.C.2. Each program must have a process to ensure continuity of patient**
922 **care in the event that a fellow may be unable to perform his/her**
923 **patient care duties.** (Core)
924
925 **VI.C.3. The sponsoring institution must provide adequate sleep facilities**
926 **and/or safe transportation options for fellows who may be too**
927 **fatigued to safely return home.** (Core)
928
929 **VI.D. Supervision of Fellows**
930
931 **VI.D.1. In the clinical learning environment, each patient must have an**
932 **identifiable, appropriately-credentialed and privileged attending**
933 **physician (or licensed independent practitioner as approved by each**
934 **Review Committee) who is ultimately responsible for that patient's**
935 **care.** (Core)
936
937 **VI.D.1.a) This information should be available to fellows, faculty**
938 **members, and patients.** (Detail)
939
940 **VI.D.1.b) Fellows and faculty members should inform patients of their**
941 **respective roles in each patient's care.** (Detail)
942
943 **VI.D.2. The program must demonstrate that the appropriate level of**
944 **supervision is in place for all fellows who care for patients.** (Core)
945
946 **Supervision may be exercised through a variety of methods. Some**
947 **activities require the physical presence of the supervising faculty**
948 **member. For many aspects of patient care, the supervising**
949 **physician may be a more advanced fellow. Other portions of care**
950 **provided by the fellow can be adequately supervised by the**
951 **immediate availability of the supervising faculty member or fellow**
952 **physician, either in the institution, or by means of telephonic and/or**
953 **electronic modalities. In some circumstances, supervision may**
954 **include post-hoc review of fellow-delivered care with feedback as to**
955 **the appropriateness of that care.** (Detail)
956
957 **VI.D.3. Levels of Supervision**
958
959 **To ensure oversight of fellow supervision and graded authority and**
960 **responsibility, the program must use the following classification of**
961 **supervision:** (Core)
962
963 **VI.D.3.a) Direct Supervision – the supervising physician is physically**
964 **present with the fellow and patient.** (Core)
965
966 **VI.D.3.b) Indirect Supervision:**
967
968 **VI.D.3.b).(1) with direct supervision immediately available – the**
969 **supervising physician is physically within the hospital**

970 or other site of patient care, and is immediately
971 available to provide Direct Supervision. (Core)
972
973 **VI.D.3.b).(2)** **with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.** (Core)
979
980 **VI.D.3.c)** **Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.** (Core)
983
984 **VI.D.4.** **The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members.** (Core)
988
989 **VI.D.4.a)** **The program director must evaluate each fellow's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.** (Core)
992
993 **VI.D.4.b)** **Faculty members functioning as supervising physicians should delegate portions of care to fellows, based on the needs of the patient and the skills of the fellows.** (Detail)
996
997 **VI.D.4.c)** **Fellows should serve in a supervisory role of residents or junior fellows in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual fellow.** (Detail)
1001
1002 **VI.D.5.** **Programs must set guidelines for circumstances and events in which fellows must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.** (Core)
1006
1007 **VI.D.5.a)** **Each fellow must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.** (Outcome)
1010
1011 **VI.D.6.** **Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each fellow and delegate to him/her the appropriate level of patient care authority and responsibility.** (Detail)
1015
1016 **VI.E.** **Clinical Responsibilities**
1017
1018 **The clinical responsibilities for each fellow must be based on PGY-level, patient safety, fellow education, severity and complexity of patient illness/condition and available support services.** (Core)

1021
1022 VI.E.1. As fellows progress through levels of increasing competence and
1023 responsibility, work assignments must keep pace with their level of
1024 advancement. (Detail)
1025
1026 **VI.F. Teamwork**
1027
1028 **Fellows must care for patients in an environment that maximizes effective**
1029 **communication. This must include the opportunity to work as a member of**
1030 **effective interprofessional teams that are appropriate to the delivery of care**
1031 **in the specialty.** (Core)
1032
1033 VI.F.1. During the fellow education process, surgical teams should be made up
1034 of attending surgeons, fellows, residents at various PG levels, medical
1035 students (when appropriate), and other health care providers. (Detail)
1036
1037 VI.F.2. The work of the caregiver team should be assigned to team members
1038 based on each member's level of education, experience, and
1039 competence. (Detail)
1040
1041 VI.F.3. Fellows must collaborate with fellow surgical residents, and especially
1042 with faculty members, other physicians outside of their subspecialty, and
1043 non-traditional health care providers, to best formulate treatment plans for
1044 an increasingly diverse patient population. (Detail)
1045
1046 VI.F.4. Fellows must assume personal responsibility to complete all tasks to
1047 which they are assigned (or which they voluntarily assume) in a timely
1048 fashion. These tasks must be completed in the hours assigned, or, if that
1049 is not possible, residents must learn and utilize the established methods
1050 for handing off remaining tasks to another member of the health care
1051 team so that patient care is not compromised. (Detail)
1052
1053 **VI.G. Fellow Duty Hours**
1054
1055 **VI.G.1. Maximum Hours of Work per Week**
1056
1057 **Duty hours must be limited to 80 hours per week, averaged over a**
1058 **four-week period, inclusive of all in-house call activities and all**
1059 **moonlighting.** (Core)
1060
1061 **VI.G.1.a) Duty Hour Exceptions**
1062
1063 **A Review Committee may grant exceptions for up to 10% or a**
1064 **maximum of 88 hours to individual programs based on a**
1065 **sound educational rationale.** (Detail)
1066
1067 The Review Committee for General Surgery will not consider
1068 requests for exceptions to the 80-hour limit to the fellow's work
1069 week.
1070
1071 **VI.G.1.a).(1) In preparing a request for an exception the program**

1072 **director must follow the duty hour exception policy**
1073 **from the ACGME Manual on Policies and Procedures.**
1074 (Detail)
1075
1076 **VI.G.1.a).(2)** **Prior to submitting the request to the Review**
1077 **Committee, the program director must obtain approval**
1078 **of the institution's GMEC and DIO.** (Detail)
1079
1080 **VI.G.2.** **Moonlighting**
1081
1082 **VI.G.2.a)** **Moonlighting must not interfere with the ability of the fellow**
1083 **to achieve the goals and objectives of the educational**
1084 **program.** (Core)
1085
1086 **VI.G.2.b)** **Time spent by fellows in Internal and External Moonlighting**
1087 **(as defined in the ACGME Glossary of Terms) must be**
1088 **counted towards the 80-hour Maximum Weekly Hour Limit.**
1089 (Core)
1090
1091 **VI.G.3.** **Mandatory Time Free of Duty**
1092
1093 **Fellows must be scheduled for a minimum of one day free of duty**
1094 **every week (when averaged over four weeks). At-home call cannot**
1095 **be assigned on these free days.** (Core)
1096
1097 **VI.G.4.** **Maximum Duty Period Length**
1098
1099 **Duty periods of fellows may be scheduled to a maximum of 24 hours**
1100 **of continuous duty in the hospital.** (Core)
1101
1102 **VI.G.4.a)** **Programs must encourage fellows to use alertness**
1103 **management strategies in the context of patient care**
1104 **responsibilities. Strategic napping, especially after 16 hours**
1105 **of continuous duty and between the hours of 10:00 p.m. and**
1106 **8:00 a.m., is strongly suggested.** (Detail)
1107
1108 **VI.G.4.b)** **It is essential for patient safety and fellow education that**
1109 **effective transitions in care occur. Fellows may be allowed to**
1110 **remain on-site in order to accomplish these tasks; however,**
1111 **this period of time must be no longer than an additional four**
1112 **hours.** (Core)
1113
1114 **VI.G.4.c)** **Fellows must not be assigned additional clinical**
1115 **responsibilities after 24 hours of continuous in-house duty.**
1116 (Core)
1117
1118 **VI.G.4.d)** **In unusual circumstances, fellows, on their own initiative,**
1119 **may remain beyond their scheduled period of duty to**
1120 **continue to provide care to a single patient. Justifications for**
1121 **such extensions of duty are limited to reasons of required**
1122 **continuity for a severely ill or unstable patient, academic**

1123 **importance of the events transpiring, or humanistic attention**
1124 **to the needs of a patient or family.** (Detail)
1125
1126 **VI.G.4.d).(1)** **Under those circumstances, the fellow must:**
1127
1128 **VI.G.4.d).(1).(a)** **appropriately hand over the care of all other**
1129 **patients to the team responsible for their**
1130 **continuing care; and,** (Detail)
1131
1132 **VI.G.4.d).(1).(b)** **document the reasons for remaining to care for**
1133 **the patient in question and submit that**
1134 **documentation in every circumstance to the**
1135 **program director.** (Detail)
1136
1137 **VI.G.4.d).(2)** **The program director must review each submission of**
1138 **additional service, and track both individual fellow and**
1139 **program-wide episodes of additional duty.** (Detail)
1140
1141 **VI.G.5.** **Minimum Time Off between Scheduled Duty Periods**
1142
1143 **VI.G.5.a)** **Fellows must be prepared to enter the unsupervised practice**
1144 **of medicine and care for patients over irregular or extended**
1145 **periods.** (Outcome)
1146
1147 Complex general surgical oncology fellows are considered to be in
1148 the final years of education.
1149
1150 **VI.G.5.a).(1)** **This preparation must occur within the context of the**
1151 **80-hour, maximum duty period length, and one-day-**
1152 **off-in-seven standards. While it is desirable that**
1153 **fellows have eight hours free of duty between**
1154 **scheduled duty periods, there may be circumstances**
1155 **when these fellows must stay on duty to care for their**
1156 **patients or return to the hospital with fewer than eight**
1157 **hours free of duty.** (Detail)
1158
1159 **VI.G.5.a).(1).(a)** **Circumstances of return-to-hospital activities**
1160 **with fewer than eight hours away from the**
1161 **hospital by fellows must be monitored by the**
1162 **program director.** (Detail)
1163
1164 VI.G.5.a).(1).(b) The Review Committee defines such
1165 circumstances as: required continuity of care for a
1166 severely ill or unstable patient, or a complex patient
1167 with whom the fellow has been involved; events of
1168 exceptional educational value; or, humanistic
1169 attention to the needs of a patient or family. (Detail)
1170
1171 **VI.G.6.** **Maximum Frequency of In-House Night Float**
1172
1173 **Fellows must not be scheduled for more than six consecutive nights**

1174 **of night float.** (Core)
1175
1176 VI.G.6.a) The total amount of night float for any fellow must be no more than
1177 two months per PG year. (Detail)
1178
1179 **VI.G.7. Maximum In-House On-Call Frequency**
1180
1181 **Fellows must be scheduled for in-house call no more frequently than**
1182 **every-third-night (when averaged over a four-week period).** (Core)
1183
1184 **VI.G.8. At-Home Call**
1185
1186 **VI.G.8.a) Time spent in the hospital by fellows on at-home call must**
1187 **count towards the 80-hour maximum weekly hour limit. The**
1188 **frequency of at-home call is not subject to the every-third-**
1189 **night limitation, but must satisfy the requirement for one-day-**
1190 **in-seven free of duty, when averaged over four weeks.** (Core)
1191
1192 **VI.G.8.a).(1) At-home call must not be so frequent or taxing as to**
1193 **preclude rest or reasonable personal time for each**
1194 **fellow.** (Core)
1195
1196 **VI.G.8.b) Fellows are permitted to return to the hospital while on at-**
1197 **home call to care for new or established patients. Each**
1198 **episode of this type of care, while it must be included in the**
1199 **80-hour weekly maximum, will not initiate a new "off-duty**
1200 **period".** (Detail)
1201
1202 ***
1203
1204 ***Core Requirements:** Statements that define structure, resource, or process elements essential to every
1205 graduate medical educational program.
1206 **Detail Requirements:** Statements that describe a specific structure, resource, or process, for achieving
1207 compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance
1208 with the Outcome Requirements may utilize alternative or innovative approaches to meet Core
1209 Requirements.
1210 **Outcome Requirements:** Statements that specify expected measurable or observable attributes
1211 (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical
1212 education.
1213
1214 **Osteopathic Recognition**
1215 For programs seeking Osteopathic Recognition for the entire program, or for a track within the
1216 program, the Osteopathic Recognition Requirements are also applicable.
1217 (http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/Osteopathic_Recognition_Requirements.pdf)