ACGME Program Requirements for Graduate Medical Education in Pediatric Otolaryngology

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in Pediatric Otolaryngology

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. Pediatric otolaryngologists specialize in the medical and surgical management of
neonates, infants, children, and adolescents 18 years or younger, particularly
those with complex otolaryngologic problems and significant co-morbidities,
generally cared for in tertiary care pediatric institutions.

Int.C. The educational program in pediatric otolaryngology must be 12 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)

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)
I.A.1. The program must be based in a tertiary care pediatric institution where the care of neonates and children can be readily coordinated with other subspecialists. (Core)

I.A.2. The sponsoring institution must also sponsor an Accreditation Council for Graduate Medical Education (ACGME)-accredited otolaryngology program. (Core)

I.B. Participating Sites

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. (Detail)

The PLA should:

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

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

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

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

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)

II. Program Personnel and Resources

II.A. Program Director

II.A.1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution’s GMEC must approve a change in program director. (Core)

II.A.1.a) The program director must submit this change to the ACGME via the ADS. (Core)

II.A.2. Qualifications of the program director must include:

II.A.2.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review
Committee; (Core)

current certification in the subspecialty by the American
Board of Otolaryngology (ABOto), or specialty qualifications
that are acceptable to the Review Committee; and, (Core)

II.A.2.b) current medical licensure and appropriate medical staff
appointment. (Core)

II.A.2.b).(1) The Review Committee only accepts ABOto certification in
otolaryngology. (Core)

II.A.2.b).(2) The program director should have also completed a
pediatric otolaryngology fellowship. (Core)

II.A.2.c) current medical licensure and appropriate medical staff
appointment. (Core)

II.A.3. The program director must administer and maintain an educational
environment conducive to educating the fellows in each of the
ACGME competency areas. (Core)

The program director must:

II.A.3.a) prepare and submit all information required and requested by
the ACGME; (Core)

II.A.3.b) be familiar with and oversee compliance with ACGME and
Review Committee policies and procedures as outlined in the
ACGME Manual of Policies and Procedures; (Detail)

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)

II.A.3.c).(1) all applications for ACGME accreditation of new
programs; (Detail)

II.A.3.c).(2) changes in fellow complement; (Detail)

II.A.3.c).(3) major changes in program structure or length of
training; (Detail)

II.A.3.c).(4) progress reports requested by the Review Committee;
[Detail]

II.A.3.c).(5) responses to all proposed adverse actions; (Detail)

II.A.3.c).(6) requests for increases or any change to fellow duty
hours; (Detail)

II.A.3.c).(7) voluntary withdrawals of ACGME-accredited
programs; (Detail)
II.A.3.c).(8) requests for appeal of an adverse action; and,

II.A.3.c).(9) appeal presentations to a Board of Appeal or the ACGME.

II.A.3.d) obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:

II.A.3.d).(1) program citations, and/or,

II.A.3.d).(2) request for changes in the program that would have significant impact, including financial, on the program or institution.

II.A.3.e) prepare and implement a supervision policy that specifies lines of responsibility for fellows and faculty members, as well as for residents and other learners.

II.B. Faculty

II.B.1. There must be a sufficient number of faculty with documented qualifications to instruct and supervise all fellows.

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.

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

II.B.3.a) The Review Committee only accepts ABOto certification in otolaryngology.

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

II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.

II.B.6. Scholarly activity of each core physician faculty member must include at least one of the following:

II.B.6.a) funded research grants,

II.B.6.b) peer-reviewed publications; or,

II.B.6.c) presentations in regional or national conferences.

II.B.7. To enhance fellows’ educational experience, there must be participation
from appropriately-qualified faculty members from other related pediatric disciplines, including: \(^\text{(Core)}\)

II.B.7.a) anesthesiology; \(^\text{(Core)}\)

II.B.7.b) audiology and speech pathology; \(^\text{(Core)}\)

II.B.7.c) child and adolescent psychiatry; \(^\text{(Core)}\)

II.B.7.d) gastroenterology; \(^\text{(Core)}\)

II.B.7.e) medical genetics; \(^\text{(Core)}\)

II.B.7.f) neonatology; \(^\text{(Core)}\)

II.B.7.g) neurology; \(^\text{(Core)}\)

II.B.7.h) pathology; \(^\text{(Core)}\)

II.B.7.i) plastic surgery; \(^\text{(Core)}\)

II.B.7.j) prenatal and fetal medicine; \(^\text{(Core)}\)

II.B.7.k) pulmonology; \(^\text{(Core)}\)

II.B.7.l) radiology; and, \(^\text{(Core)}\)

II.B.7.m) sleep medicine. \(^\text{(Core)}\)

II.C. Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program. \(^\text{(Core)}\)

II.D. Resources

The institution and the program must jointly ensure the availability of adequate resources for fellow education, as defined in the specialty program requirements. \(^\text{(Core)}\)

II.D.1. Program resources must include:

II.D.1.a) inpatient and outpatient facilities. \(^\text{(Core)}\)

II.D.1.b) an emergency department; \(^\text{(Core)}\)

II.D.1.c) neonatal and pediatric intensive care units; \(^\text{(Core)}\)

II.D.1.d) facilities for the diagnostic assessment of infants and children with otolaryngologic disorders, including audiologic, voice, speech,
language and developmental assessments; and, (Core)

facilities to support clinical research. (Core)

Fellows must be provided with prompt reliable systems for communication and interaction with supervising physicians. (Core)

II.D.2.

II.E. Medical Information Access

Fellows must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available. (Detail)

III. Fellow Appointments

III.A. Eligibility Criteria

Each fellow must successfully complete an ACGME-accredited specialty program and/or meet other eligibility criteria as specified by the Review Committee. (Core)

III.A.1. The program must document that each fellow has met the eligibility criteria. (Detail)

III.A.2. Prior to appointment in the program, fellows must have successfully completed an otolaryngology residency accredited by the ACGME, or an otolaryngology residency located in Canada and accredited by the Royal College of Physicians and Surgeons of Canada. (Core)

III.B. Number of Fellows

The program’s educational resources must be adequate to support the number of fellows appointed to the program. (Core)

III.B.1. The program director may not appoint more fellows than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. (Core)

III.C. Other Learners

The presence of other learners, including otolaryngology residents, residents from other specialties, unaccredited pediatric otolaryngology fellows, other subspecialty fellows, PhD students, and nurse practitioners, must not interfere with the appointed fellows’ education. (Core)

IV. Educational Program

IV.A. The curriculum must contain the following educational components:

IV.A.1. Skills and competencies the fellow will be able to demonstrate at the conclusion of the program. The program must distribute these skills
and competencies to fellows and faculty at least annually, in either written or electronic form. (Core)

IV.A.2. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum: (Core)

IV.A.2.a) Patient Care and Procedural Skills

IV.A.2.a).(1) Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. (Outcome)

IV.A.2.a).(2) Fellows must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. Fellows: (Outcome)

must demonstrate competence in:

IV.A.2.a).(2).(a) evaluating neonates, infants, children, and adolescents 18 years and younger with congenital abnormalities, infectious and inflammatory disorders, and inherited and acquired conditions of the head and neck, including hearing loss and other communication impairments; (Outcome)

IV.A.2.a).(2).(b) diagnosing and managing the medical and surgical treatment of the aerodigestive tract, ear, nose, sinus, throat, voice and speech, and head and neck and disorders of neonates, infants, children, and adolescents 18 years and younger; (Outcome)

IV.A.2.a).(2).(c) performing procedures in the following domains with an emphasis on neonates, infants, children younger than three years of age, and children and adolescents with significant co-morbidities as defined by American Society of Anesthesiology (ASA) status: (Outcome)

IV.A.2.a).(2).(c).(i) closed and open airways; (Outcome)

IV.A.2.a).(2).(c).(ii) congenital anomalies; (Outcome)

IV.A.2.a).(2).(c).(iii) endoscopic airways; (Outcome)

IV.A.2.a).(2).(c).(iv) facial plastics; (Outcome)

IV.A.2.a).(2).(c).(v) facial trauma; (Outcome)
IV.A.2.a).(2).(c).(vii) otology; (Outcome)

IV.A.2.a).(2).(c).(viii) rhinology; and, (Outcome)

IV.A.2.a).(2).(c).(ix) complex and uncommon pediatric procedures infrequently encountered in the general practice of otolaryngology. (Outcome)

IV.A.2.a).(3) Fellows must document surgical experience as assistant surgeon, surgeon, and resident supervisor in the ACGME Case Log System, recording patient age and ASA classification for each documented case. (Core)

IV.A.2.b) Medical Knowledge

Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Fellows: (Outcome)

IV.A.2.b).(1) must demonstrate proficiency in their knowledge of medical and surgical management of neonatal, infant, childhood, and adolescent diseases of the head and neck to a level appropriate for unsupervised practice as defined by the didactic curriculum. (Outcome)

IV.A.2.c) Practice-based Learning and Improvement

Fellows are expected to develop skills and habits to be able to meet the following goals:

IV.A.2.c).(1) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; and, (Outcome)

IV.A.2.c).(2) locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems. (Outcome)

IV.A.2.d) Interpersonal and Communication Skills

Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Outcome)

IV.A.2.e) Professionalism
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Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. (Outcome)

IV.A.2.e).(1) Fellows must demonstrate competence in advocating for quality patient care when facilitating patient management in the home, school, or institutional setting. (Outcome)

IV.A.2.f) Systems-based Practice

Fellows must 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. (Outcome)

IV.A.3. Curriculum Organization and Fellow Experiences

IV.A.3.a) The didactic curriculum must include basic science, clinical, and research conferences and seminars, as well as journal club activities pertaining to pediatric otolaryngology. (Core)

IV.A.3.a).(1) Didactic topics must include:

IV.A.3.a).(1).(a) developmental anatomy and physiology, embryology, microbiology, oncology, and psychology of the infant and child as related to the head and neck; (Detail)

IV.A.3.a).(1).(b) diagnosis and care of uncommon and complex congenital and acquired conditions involving the aerodigestive tract, nose and paranasal sinuses, and ear, as well as diseases and disorders of the laryngotracheal complex and the head and neck; (Detail)

IV.A.3.a).(1).(c) diagnosis, treatment, and management of childhood disorders of hearing, language, speech, and voice; and, (Detail)

IV.A.3.a).(1).(d) genetics. (Detail)

IV.A.3.a).(2) Quality improvement conferences must take place at least quarterly. (Detail)

IV.A.3.a).(3) Fellows must participate in planning and conducting conferences. (Detail)

IV.A.3.a).(4) Both faculty members and fellows must attend and participate in multidisciplinary conferences. (Detail)

IV.A.3.a).(5) Faculty and fellow attendance at conferences must be
Fellows’ clinical experiences must include:

IV.A.3.b.(1) participation in a multispecialty, interdisciplinary team to manage and treat conditions for at least three of the following: cochlear implant, craniofacial disorders, tumors, or vascular anomalies; and,

IV.A.3.b.(2) attendance at a minimum of four clinic sessions per month.

IV.B. Fellows’ Scholarly Activities

IV.B.1. Fellows’ scholarly activity initiated or completed during the program, including scientific study, production of review articles or chapters, or creation of online educational activities, must be documented.

V. Evaluation

V.A. Fellow Evaluation

V.A.1. The program director must appoint the Clinical Competency Committee. (Core)

V.A.1.a) At a minimum the Clinical Competency Committee must be composed of three members of the program faculty. (Core)

V.A.1.a).(1) Others eligible for appointment to the committee include faculty from other programs and non-physician members of the health care team. (Detail)

V.A.1.b) There must be a written description of the responsibilities of the Clinical Competency Committee. (Core)

V.A.1.b).(1) The Clinical Competency Committee should:

V.A.1.b).(1).(a) review all fellow evaluations semi-annually; (Core)

V.A.1.b).(1).(b) prepare and assure the reporting of Milestones evaluations of each fellow semi-annually to ACGME; and, (Core)

V.A.1.b).(1).(c) advise the program director regarding fellow progress, including promotion, remediation, and dismissal. (Detail)

V.A.2. Formative Evaluation

V.A.2.a) The faculty must evaluate fellow performance in a timely manner. (Core)
V.A.2.b) The program must:

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)

V.A.2.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff); and, (Detail)

V.A.2.b).(3) provide each fellow with documented semiannual evaluation of performance with feedback. (Core)

V.A.2.c) The evaluations of fellow performance must be accessible for review by the fellow, in accordance with institutional policy. (Detail)

V.A.2.d) The program director must meet with each fellow in person to review his or her cumulative operative experience and Case Log data at least semiannually to ensure balanced progress towards achieving experience with a variety and complexity of surgical procedures. (Core)

V.A.3. Summative Evaluation

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)

V.A.3.b) The program director must provide a summative evaluation for each fellow upon completion of the program. (Core)

This evaluation must:

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)

V.A.3.b).(2) document the fellow’s performance during their education; and, (Detail)

V.A.3.b).(3) verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision. (Detail)

V.B. Faculty Evaluation
V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program. (Core)

V.B.2. These evaluations should include a review of the faculty’s clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities. (Detail)

V.C. Program Evaluation and Improvement

V.C.1. The program director must appoint the Program Evaluation Committee (PEC). (Core)

V.C.1.a) The Program Evaluation Committee:

V.C.1.a).(1) must be composed of at least two program faculty members and should include at least one fellow; (Core)

V.C.1.a).(2) must have a written description of its responsibilities; and, (Core)

V.C.1.a).(3) should participate actively in:

V.C.1.a).(3).(a) planning, developing, implementing, and evaluating educational activities of the program; (Detail)

V.C.1.a).(3).(b) reviewing and making recommendations for revision of competency-based curriculum goals and objectives; (Detail)

V.C.1.a).(3).(c) addressing areas of non-compliance with ACGME standards; and, (Detail)

V.C.1.a).(3).(d) reviewing the program annually using evaluations of faculty, fellows, and others, as specified below. (Detail)

V.C.2. The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written and Annual Program Evaluation (APE). (Core)

The program must monitor and track each of the following areas:

V.C.2.a) fellow performance; (Core)

V.C.2.b) faculty development; and, (Core)

V.C.2.c) progress on the previous year’s action plan(s). (Core)

V.C.3. The PEC must prepare a written plan of action to document
initiatives to improve performance in one or more of the areas listed in section V.C.2., as well as delineate how they will be measured and monitored. (Core)

V.C.3.a) The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes. (Detail)

V.C.4. The faculty must meet at least annually to review program goals and objectives and program effectiveness in achieving them. At least one fellow should participate in these reviews. (Detail)

VI. Fellow Duty Hours in the Learning and Working Environment

VI.A. Professionalism, Personal Responsibility, and Patient Safety

VI.A.1. Programs and sponsoring institutions must educate fellows and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients. (Core)

VI.A.2. The program must be committed to and responsible for promoting patient safety and fellow well-being in a supportive educational environment. (Core)

VI.A.3. The program director must ensure that fellows are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs. (Core)

VI.A.4. The learning objectives of the program must:

VI.A.4.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and, (Core)

VI.A.4.b) not be compromised by excessive reliance on fellows to fulfill non-physician service obligations. (Core)

VI.A.5. The program director and sponsoring institution must ensure a culture of professionalism that supports patient safety and personal responsibility. (Core)

VI.A.6. Fellows and faculty members must demonstrate an understanding and acceptance of their personal role in the following:

VI.A.6.a) assurance of the safety and welfare of patients entrusted to their care; (Outcome)

VI.A.6.b) provision of patient- and family-centered care; (Outcome)

VI.A.6.c) assurance of their fitness for duty; (Outcome)
VI.A.6.d) management of their time before, during, and after clinical assignments; (Outcome)
VI.A.6.e) recognition of impairment, including illness and fatigue, in themselves and in their peers; (Outcome)
VI.A.6.f) attention to lifelong learning; (Outcome)
VI.A.6.g) the monitoring of their patient care performance improvement indicators; and, (Outcome)
VI.A.6.h) honest and accurate reporting of duty hours, patient outcomes, and clinical experience data. (Outcome)

VI.A.7. All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. They must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient’s care to another qualified and rested provider. (Outcome)

VI.B. Transitions of Care

VI.B.1. Programs must design clinical assignments to minimize the number of transitions in patient care. (Core)

VI.B.2. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. (Core)

VI.B.3. Programs must ensure that fellows are competent in communicating with team members in the hand-over process. (Outcome)

VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and fellows currently responsible for each patient’s care. (Detail)

VI.C. Alertness Management/Fatigue Mitigation

VI.C.1. The program must:

VI.C.1.a) educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation; (Core)

VI.C.1.b) educate all faculty members and fellows in alertness management and fatigue mitigation processes; and, (Core)

VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules. (Detail)
VI.C.2. Each program must have a process to ensure continuity of patient
care in the event that a fellow may be unable to perform his/her
patient care duties. \(^{(Core)}\)

VI.C.3. The sponsoring institution must provide adequate sleep facilities
and/or safe transportation options for fellows who may be too
fatigued to safely return home. \(^{(Core)}\)

VI.D. Supervision of Fellows

VI.D.1. In the clinical learning environment, each patient must have an
identifiable, appropriately-credentialed and privileged attending
physician (or licensed independent practitioner as approved by each
Review Committee) who is ultimately responsible for that patient’s
care. \(^{(Core)}\)

VI.D.1.a) This information should be available to fellows, faculty
members, and patients. \(^{(Detail)}\)

VI.D.1.b) Fellows and faculty members should inform patients of their
respective roles in each patient’s care. \(^{(Detail)}\)

VI.D.2. The program must demonstrate that the appropriate level of
supervision is in place for all fellows who care for patients. \(^{(Core)}\)

Supervision may be exercised through a variety of methods. Some
activities require the physical presence of the supervising faculty
member. For many aspects of patient care, the supervising
physician may be a more advanced fellow. Other portions of care
provided by the fellow can be adequately supervised by the
immediate availability of the supervising faculty member or fellow
physician, either in the institution, or by means of telephonic and/or
electronic modalities. In some circumstances, supervision may
include post-hoc review of fellow-delivered care with feedback as to
the appropriateness of that care. \(^{(Detail)}\)

VI.D.3. Levels of Supervision

To ensure oversight of fellow supervision and graded authority and
responsibility, the program must use the following classification of
supervision: \(^{(Core)}\)

VI.D.3.a) Direct Supervision – the supervising physician is physically
present with the fellow and patient. \(^{(Core)}\)

VI.D.3.b) Indirect Supervision:

VI.D.3.b).(1) with direct supervision immediately available – the
supervising physician is physically within the hospital
or other site of patient care, and is immediately
available to provide Direct Supervision. \(^{(Core)}\)
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)

VI.D.3.c) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. (Core)

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)

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)

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)

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)

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)

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)

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)

VI.E. Clinical Responsibilities

VI.E.1. 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)

The workload associated with optimal clinical care of surgical patients is a
VI.E.2. During the fellowship education process, surgical teams should be made up of attending surgeons, fellows, residents at various PGY levels, medical students (when appropriate), and other health care providers.

VI.E.3. The work of the caregiver team should be assigned to team members based on each individual’s level of education, experience, and competence.

VI.F. Teamwork

Fellows must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty.

VI.F.1. Effective surgical practices entail the involvement of members with a mix of complementary skills and attributes (physicians, nurses, and other staff). Success requires both an unwavering mutual respect for those skills and contributions, and a shared commitment to the process of patient care.

VI.F.2. Fellows must collaborate with fellow surgical residents, and with especially faculty, other physicians outside of their specialty, and non-traditional health care providers to best formulate treatment plans for an increasingly diverse patient population.

VI.F.3. Fellows must assume personal responsibility to complete all tasks to which they are assigned (or which they voluntarily assume) in a timely fashion. These tasks must be completed within the hours assigned, or, if that is not possible, fellows must learn and utilize the established methods for handing off remaining tasks to another member of the fellow team so that patient care is not compromised.

VI.F.4. Lines of authority should be defined by programs, and all fellows must have a working knowledge of expected reporting relationships to maximize quality care and patient safety.

VI.G. Fellow Duty Hours

VI.G.1. Maximum Hours of Work per Week

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.

VI.G.1.a) Duty Hour Exceptions

A Review Committee may grant exceptions for up to 10% or a
maximum of 88 hours to individual programs based on a sound educational rationale. (Detail)

The Review Committee for Otolaryngology will not consider requests for exceptions to the 80-hour limit to the fellows’ work week.

VI.G.1.a).(1) In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures. (Detail)

VI.G.1.a).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution’s GMEC and DIO. (Detail)

VI.G.2. Moonlighting

VI.G.2.a) Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program. (Core)

VI.G.2.b) Time spent by fellows in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit. (Core)

VI.G.3. Mandatory Time Free of Duty

Fellows must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days. (Core)

VI.G.4. Maximum Duty Period Length

Duty periods of fellows may be scheduled to a maximum of 24 hours of continuous duty in the hospital. (Core)

VI.G.4.a) Programs must encourage fellows to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested. (Detail)

VI.G.4.b) It is essential for patient safety and fellow education that effective transitions in care occur. Fellows may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours. (Core)

VI.G.4.c) Fellows must not be assigned additional clinical
responsibilities after 24 hours of continuous in-house duty.

VI.G.4.d) In unusual circumstances, fellows, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

VI.G.4.d).(1) Under those circumstances, the fellow must:

VI.G.4.d).(1).(a) appropriately hand over the care of all other patients to the team responsible for their continuing care; and,

VI.G.4.d).(1).(b) document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

VI.G.4.d).(2) The program director must review each submission of additional service, and track both individual fellow and program-wide episodes of additional duty.

VI.G.5. Minimum Time Off between Scheduled Duty Periods

VI.G.5.a) Fellows must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

Pediatric otolaryngology fellows are considered to be in the final years of education.

VI.G.5.a).(1) This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that fellows have eight hours free of duty between scheduled duty periods, there may be circumstances when these fellows must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

VI.G.5.a).(1).(a) Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by fellows must be monitored by the program director.

VI.G.5.a).(1).(b) The Review Committee defines such circumstances as: required continuity of care for a
severely ill or unstable patient, or a complex patient with whom the fellow has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. (Detail)

VI.G.6. Maximum Frequency of In-House Night Float

Fellows must not be scheduled for more than six consecutive nights of night float. (Core)

VI.G.6.a) Night float rotations must not exceed two months in duration, and there can be no more than three months of night float assignments per year. (Core)

VI.G.6.b) There must be at least two months between each night float rotation. (Core)

VI.G.7. Maximum In-House On-Call Frequency

Fellows must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period). (Core)

VI.G.8. At-Home Call

VI.G.8.a) Time spent in the hospital by fellows on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks. (Core)

VI.G.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each fellow. (Core)

VI.G.8.b) Fellows are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”. (Detail)

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*Core Requirements:* Statements that define structure, resource, or process elements essential to every graduate medical educational program.

*Detail Requirements:* Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

*Outcome Requirements:* Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.