**Specialty-specific Duty Hour Definitions**

The Common Program Requirements include revised duty hour standards, effective July 1, 2011. The Review Committees have provided clarification of the following standards, either through the addition of a specialty-specific duty hour definition or Frequently Asked Question (FAQ):

<p>| 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. |
| VI.D.5.a).(1) | Supervision of Residents: In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available. [Each Review Committee will describe the achieved competencies under which PGY-1 residents progress to be supervised indirectly, with direct supervision available.] |
| VI.E. | Clinical Responsibilities: The Clinical Responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services. [Optimal clinical workload will be further specified by each Review Committee.] |
| VI.F. | Teamwork: Residents 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. [Each Review Committee will define the elements that must be present in each specialty.] |
| VI.G.5.b) | Minimum Time Off between Scheduled Duty Periods: Intermediate-level Residents [as defined by the Review Committee] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty. |
| VI.G.5.c) | Minimum Time Off between Scheduled Duty Periods: Residents in the Final Years of Education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. |
| VI.G.5.c).(1) | Minimum Time Off between Scheduled Duty Periods: 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 residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [as defined by the Review Committee] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. |
| VI.G.6. | Maximum Frequency of In-House Night Float: Residents must not be scheduled for more than six consecutive nights of night float. [The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.] |</p>
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| VI.D.1. Licensed Independent Practitioner | | Q: Which licensed independent practitioners are acceptable to provide supervision to residents?  
A: Clinical psychologists, clinical social workers, nurse practitioners, physician assistants, and registered dieticians, for example, may supervise residents’ clinical activities when the program director determines that their special expertise will promote education and provide a level of supervision equivalent to that provided by an attending physician. During these situations, there must also be direct or indirect, as required, supervision by a physician faculty member. |
| VI.D.5.a),(1) Supervision of Residents | Do not have PGY-1 residents in the specialty. | |
| VI.E. Clinical Responsibilities | | Q: What is the optimal clinical workload for an allergy and immunology resident?  
A: A resident’s clinical workload should provide sufficient opportunities to meet all of the program requirements for patient care experiences. Using Case Log data as a reference standard, residents should see an adequate number of patients to reach required diagnoses for at least the tenth percentile of patients. Programs should ensure that patients are evenly distributed across the time dedicated for clinical activity during the residency. Residents’ logs should be monitored during all formal performance evaluation sessions. |
| VI.F. Teamwork | | Q: Which other health care professionals should be a part of the residents’ interprofessional team?  
A: Advanced practice providers, audiologists, billing and administrative staff members, nurses, nutritional consultants, pharmacists, physician assistants, respiratory therapists, social workers, and speech and language pathologists may be included as a part of interprofessional teams.  
Residents must demonstrate the ability to work and to communicate with health care professionals to provide effective, patient-focused care. |
| VI.G.5.b) Intermediate-level Residents | No residents will be designated as being at the intermediate level. | Q: Is a first year allergy and immunology resident considered to be a PGY-1 or intermediate level resident?  
A: Program directors should monitor resident duty hour requirements in a manner consistent with the year of post-graduate education each resident has achieved. The majority of allergy and immunology residents enter specialty education at the PGY-4 or PGY-5 level. From a duty hour perspective, first year allergy and immunology residents should be able to function as advanced residents consistent with program requirement VI.G.5.c). However, some may come to residency with a specialized education schedule, and may only be at the PGY-2 or PGY-3 level. These residents should be monitored as “intermediate” residents for one year. Regardless of level of education, all residents must have immediate access by telecommunication devices (pager, cell phone) with a faculty physician while on duty. |
| VI.G.5.c) Residents in the Final Years of Education | | |

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<td>VI.F. Teamwork</td>
<td>See IV.A.1.a) The education must culminate in sufficiently independent responsibility for clinical decision-making and patient care so that the graduating resident exhibits sound clinical judgment in a wide variety of clinical situations and can function as a leader of peri-operative care teams. (Core) See IV.A.6.d),(4). Residents must actively participate in all patient care activities and as a fully integrated member of the critical care team. (Core)</td>
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<td>VI.G.5.b) Intermediate-</td>
<td>An intermediate-level resident is in the second, third, or fourth year of the four year of anesthesiology residency, and has neither achieved the goals and objectives of all core rotations nor fulfilled all minimum case requirements (Core)</td>
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<td>level Residents</td>
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<td>VI.G.5.c) Residents in the Final Years of Education</td>
<td>A resident in the final years of education has achieved the goals and objectives of all core rotations and fulfilled all minimum case requirements. (Core)</td>
<td>Q: Can the Review Committee clarify the transition from 'intermediate resident' to 'resident in final years of education'? A: Yes. The program requirements specify several core experiences that must be completed by all residents (e.g., at least four months of critical care medicine), as well as several minimum numbers of cases that must be performed by each resident (e.g., care provided for at least 20 patients undergoing cardiac surgery). The resident remains an intermediate resident until all core experiences and the minimum number of cases required for the core rotations are completed. Thereafter, the Review Committee will consider the resident to be in the final year of education and preparing for the transition to the unsupervised practice of medicine. This transition can happen as early as the CA-2 year or as late as the end of the CA-3 year, and is dependent on several factors that include the scheduled order of rotations, leaves of absence, and competency assessment.</td>
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| VI.G.5.c).(1)          | VI.G.5.c).(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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. (Detail) | Q: Can the Review Committee clarify the transition from 'intermediate resident' to 'resident in final years of education'?  
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|                        | VI.G.5.c).(1)(c) Residents in the final years of education may extend the eight-hour duty-free period when called upon to provide continuity of clinical care that is of critical importance to a patient and that provides unique educational value to the resident. (Detail) |                                    |
|                        | VI.G.5.c).(1)(d) Exceptions to the eight-hour duty-free period must be determined in consultation with the supervising faculty member and reported to the program director. (Detail) |                                    |

VI.G.5.c).(1)  
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| VI.G.6. Maximum Frequency of In-House Night Float | Q: Does the Review Committee limit the maximum number of consecutive weeks of night float?  
A: No. However, during an accreditation review, the Committee will determine whether residents on night float are able to take advantage of educational sessions and other opportunities offered during regular daytime hours. If the Committee determines that residents derive little benefit from night float or are unable to participate in other educational sessions as a result of night call responsibilities, the program may be cited for inadequate educational experience on the respective rotation. | |
| Anesthesiology – Adult Cardiothoracic | | |
| VI.D.1. Licensed Independent Practitioner | | |
| VI.D.5.a).(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. | |
| VI.E. Clinical Responsibilities | | |
| VI.F. Teamwork | See II.B.8. The faculty must include individuals with expertise in other subspecialties of anesthesiology. (Core)  
See II.C.1. Physicians with special training and/or experience in cardiovascular disease, clinical cardiac electrophysiology, cardiac and non-cardiac thoracic surgery, general vascular surgery, congenital heart disease, pulmonary diseases, and critical care medicine must be available. (Detail)  
See II.C.2. Allied health staff members and other support personnel who have experience and expertise in the care of cardiothoracic patients must be available. (Detail)  
VI.F.1. Interprofessional teams may include non-physician health care professionals, such as medical assistants, specialized nurses, and technicians. (Detail) | |
<p>| VI.G.5.a) Fellows in the Final Years of Education | Anesthesiology subspecialty fellows are considered to be in the final years of education. (Detail) | |</p>
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VI.G.5.a).(1) Circumstances for Eight Hours Free of Duty.(c). Fellows in the Final Years of Education may extend the eight-hour duty-free period when called upon to provide continuity of clinical care that is of critical importance to the patient and that provides unique educational value to the fellow. (Detail)  
VI.G.5.a).(1) Circumstances for Eight Hours Free of Duty.(d) Exceptions to the eight-hour duty-free period must be determined in consultation with the supervising faculty member. (Detail) | Q: Does the Review Committee limit the maximum number of consecutive weeks of night float?  
A: No. The Review Committee recognizes that under certain circumstances, fellows may derive benefit from night float work, but the benefit should be clear to and understood by both faculty and fellows. During an accreditation review, the Review Committee will determine whether fellows on night float are able to take advantage of educational sessions and other opportunities offered during regular daytime hours. If the Committee determines that fellows derive little benefit from night float or are not able to participate in other educational sessions as a result of night call responsibilities, the program may be cited for inadequate educational experience on the respective rotation. |
<p>| VI.G.6. Maximum Frequency of In-House Night Float | | |
| Anesthesiology – Critical Care Medicine | | |
| VI.D.1. Licensed Independent Practitioner | | |
| VI.D.5.a).(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. | |
| VI.E. Clinical Responsibilities | An optimal clinical workload allows fellows to complete the required case numbers, gain expertise in the required clinical components, and/or develop required competencies in patient care with a focus on learning over meeting service obligations. | |</p>
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<td>See II.B.7. Faculty members with education and certification in other specialties, including diagnostic radiology, emergency medicine, internal medicine and its subspecialties, neurological surgery, neurology, obstetrics and gynecology, pathology, pediatrics, and surgery and its subspecialties, should participate in the program. (Detail) VI.F.1. Interprofessional teams may include non-physician health care professionals, e.g., medical assistants, specialized nurses, and technicians. (Detail)</td>
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| VI.F. Teamwork         | See II.B.6. Faculty members, including those certified in obstetrics and gynecology, maternal-fetal medicine, and neonatology, must be available for consultations and the collaborative management of peripartum patients, as well as instruction and supervision of fellows. (Core)  
See II.B.7. Faculty members certified in adult critical care must be available for consultation and collaborative management of peripartum women with critical care needs. (Core)  
See IV.A.2.a).(1).(a) [Fellows] must demonstrate competence in the comprehensive analgesic/anesthetic management of deliveries, including; (Outcome)  
IV.A.2.a).(1).(a).(i) planned vaginal deliveries with a high-risk maternal co-morbidity; (Outcome)  
IV.A.2.a).(1).(a).(i).(a) This must include obtaining the appropriate diagnostic testing and consultation and communication with the multi-disciplinary team. (Outcome) |  |
| VI.G.5.a) Fellows in the Final Years of Education | Anesthesiology subspecialty fellows are considered to be in the final years of education. |  |
| VI.G.5.a).(1) Circumstances for Eight Hours Free of Duty | 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.  
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<p>| Anesthesiology – Pediatric |  |  |
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<td>VI.D.5.a).(1) Supervision of Residents</td>
<td>Do not have PGY-1 residents in the subspecialty.</td>
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<tr>
<td>VI.E. Clinical Responsibilities</td>
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<tr>
<td>VI.F. Teamwork</td>
<td>See II.D.1.g) [The program must have the following resources and facilities:] prompt access to consultation with other disciplines, including pediatric subspecialties of cardiology, critical care, emergency medicine, neonatology, neurology, pulmonology, radiology, and surgical fields. Core</td>
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<tr>
<td></td>
<td>VI.F.1. Interprofessional teams may include non-physician health care professionals, such as medical assistants, specialized nurses, and technicians. Detail</td>
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<tr>
<td>VI.G.5.a) Fellows in the Final Years of Education</td>
<td>Anesthesiology subspecialty fellows are considered to be in the final years of education.</td>
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<tr>
<td>VI.G.5.a).(1) Circumstances for Eight Hours Free of Duty</td>
<td>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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.</td>
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<td>VI.G.5.a).(1) Circumstances for Eight Hours Free of Duty.(c). Fellows in the Final Years of Education may extend the eight-hour duty-free period when called upon to provide continuity of clinical care that is of critical importance to the patient and that provides unique educational value to the fellow. Detail</td>
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<td></td>
<td>VI.G.5.a).(1) Circumstances for Eight Hours Free of Duty.(d) Exceptions to the eight-hour duty-free period must be determined in consultation with the supervising faculty member. Detail</td>
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<tr>
<td>VI.G.6. Maximum Frequency of In-House Night Float</td>
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<td>Q: Does the Review Committee limit the maximum number of consecutive weeks of night float? A: No. The Review Committee recognizes that under certain circumstances, fellows may derive benefit from night float work, but the benefit should be clear to and understood by both faculty and fellows. During an accreditation review, the Review Committee will determine whether fellows on night float are able to take advantage of educational sessions and other opportunities offered during regular daytime hours. If the Committee determines that fellows derive little benefit from night float or are not able to participate in other educational sessions as a result of night call responsibilities, the program may be cited for inadequate educational experience on the respective rotation.</td>
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</table>
### Specialty/Requirement # | Specialty-specific Duty Hour Definitions | Frequently Asked Questions (FAQs)
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**Colon and Rectal Surgery** | | |
VI.D.1. Licensed Independent Practitioner | | |
VI.D.5.a).(1) Supervision of Residents | **Do not have PGY-1 residents in the specialty.** | |
VI.E. Clinical Responsibilities | | |
VI.F. Teamwork | VI.F.1. Each resident must have the opportunity to interact with other providers, such as enterostomal therapists, mid-level providers, nurses, other specialists, and social workers. | |
VI.G.5.b) Intermediate-level Residents | Colon and rectal surgery residents are considered to be in the final years of education. | |
VI.G.5.c) Residents in the Final Years of Education | Colon and rectal surgery residents are considered to be in the final years of education. | |
VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty | VI.G.5.c).(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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. | |
VI.G.6. Maximum Frequency of In-House Night Float | | |
**Dermatology** | | |
VI.D.1. Licensed Independent Practitioner | | |
VI.D.5.a).(1) Supervision of Residents | | |
VI.E. Clinical Responsibilities | VI.E.1. Assuming that the severity and complexity of illnesses or conditions and available support services are comparable for the patients cared for by residents at each level of education, then PGY-2 residents are expected to carry a clinical case load equal to at least 50 percent of that of PGY-4 residents, and PGY-3 residents are expected to carry a clinical case load equal to at least 75 percent of that of PGY-4 residents. | |

*Duty Hour Definitions*
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<td>VI.F. Teamwork</td>
<td>VI.F.1. Programs must maintain a process that results in referral of patients from a broad group of specialty areas outside of dermatology. Residents must be an integral part of the care of these referred patients, and must play key roles in diagnostic work-up, treatment decisions, measurement of treatment outcomes, and the communication and coordination of these activities with program faculty and referring sources. <em>(Detail)</em></td>
<td>Q: Which other health care professionals may be a part of the interprofessional team? A: The team may include clinic managers, clinical research and hospital staff members, faculty members in dermatology and referral faculty members, laboratory personnel, medical students, nurses, pharmacologists, referring physicians, residents, and schedulers, as appropriate.</td>
</tr>
<tr>
<td>VI.G.5.b) Intermediate-level Residents</td>
<td>First-year (PGY-2) and second-year (PGY-3) residents are considered to be at the intermediate-level.</td>
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<tr>
<td>VI.G.5.c) Residents in the Final Years of Education</td>
<td>Third-year (PGY-4) residents are considered to be in the final years of education.</td>
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<tr>
<td>VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty</td>
<td>VI.G.5.c).(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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.</td>
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**Dermatology – Micrographic Surgery and Dermatologic Oncology**

<p>| VI.D.1. Licensed Independent Practitioner | Physician faculty members must supervise fellows. <em>(Core)</em> | |
| VI.D.5.a).(1) Supervision of Residents | <strong>Do not have PGY-1 residents in the subspecialty.</strong> | |
| VI.E. Clinical Responsibilities | VI.E.1. Each fellow must perform at least 400 Mohs surgery cases and 300 cutaneous reconstructive surgeries as the primary surgeon. <em>(Outcome)</em> | |
| | VI.E.1.a) These surgeries should be scheduled throughout the course of the 12-month fellowship. <em>(Detail)</em> | |
| VI.F. Teamwork | VI.F.1. Fellows must demonstrate the ability to work in an interprofessional team that includes clinic management, receptionists, nursing staff, histo-technicians, program faculty members, and referring clinical personnel. <em>(Outcome)</em> | |
| | VI.F.1.a) Each fellow must be an integral part of the evaluation, management, and coordination of care of his or her surgical patients, and must demonstrate the ability to lead these interprofessional teams. <em>(Outcome)</em> | |
| VI.G.5.a) Fellows in the Final Years of Education | Micrographic surgery and dermatologic oncology fellows are considered to be in the final years of education. | |</p>
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<td>VI.G.5.a).(1)</td>
<td>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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. (Detail)</td>
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<td><strong>Diagnostic Radiology</strong></td>
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<tr>
<td>VI.D.1. Licensed Independent Practitioner</td>
<td>Q: Can residents be supervised by Licensed Independent Practitioners? A: Only licensed physicians who are credentialed to perform imaging procedures may have primary responsibility for the imaging aspects of patient care.</td>
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<tr>
<td>VI.D.5.a).(1) Supervision of Residents</td>
<td>Do not have PGY-1 residents in the specialty.</td>
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<tr>
<td>VI.E. Clinical Responsibilities</td>
<td>Q: What does the Review Committee consider an appropriate patient load for residents? A: Clinical workload must provide the residents with learning experiences without compromising patient care. A reasonable volume of radiologic examinations in the department should be at least 7,000 per year per resident. For example, if there are 20 residents in the program, there should be no less than 140,000 examinations per year. The number of examinations in each of the subspecialty areas must be of sufficient volume to ensure the residents’ educational experience allows them to meet the requirements. Both insufficient patient experiences and excessive patient loads may jeopardize the quality of resident education.</td>
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<tr>
<td>VI.F. Teamwork</td>
<td>Q: Who should be included in the interprofessional teams? A: All interprofessional team members must participate in the education of residents, and team members include ancillary personnel, attending diagnostic radiology physicians, diagnostic radiology technologists, nurse practitioners, nurses, physician assistants, and radiation safety personnel. The team may also include individuals from referring clinical services, medical physicists, and radiopharmacists.</td>
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<tr>
<td>VI.G.5.b) Intermediate-level Residents</td>
<td>R1, R2, and R3 residents are considered to be at the intermediate level.</td>
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<td>VI.G.5.c) Residents in the Final Years of Education</td>
<td>R4 residents are considered to be in the final years of education.</td>
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<td>VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty</td>
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<td>VI.G.6. Maximum Frequency of In-House Night Float</td>
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<tr>
<td>VI.D.1. Licensed</td>
<td>Do not have PGY-1 residents in the subspecialty.</td>
<td>Q: Can residents be supervised by Licensed Independent Practitioners? A: Only licensed physicians who are credentialed to perform imaging procedures may have primary responsibility for the imaging aspects of patient care.</td>
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<td>Independent Practitioner</td>
<td>Supervision of Residents</td>
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<td>VI.E. Clinical</td>
<td>Q: What does the Review Committee consider an optimal clinical workload for fellows? A: Optimal clinical workload must maximize fellows’ learning experience without compromising patient care. The number and distribution of cases will vary with the responsibility appropriate to each fellow’s demonstrated competence over the course of his or her education. Program directors must determine minimum and maximum patient loads by including faculty members’ and fellows’ input into an assessment of the learning environment, including patient safety, fellow education, severity and complexity of patient illness/condition, and available support services. Both insufficient patient experiences and excessive patient loads may jeopardize the quality of fellow education.</td>
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<tr>
<td>Responsibilities</td>
<td>Q: Who should be included in the interprofessional teams? A: All interprofessional team members must participate in the education of residents, and team members include ancillary personnel, attending diagnostic radiology physicians, diagnostic radiology technologists, nurse practitioners, nurses, physician assistants, and radiation safety personnel. The team may also include individuals from referring clinical services, medical physicists, and radiopharmacists.</td>
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<tr>
<td>VI.F. Teamwork</td>
<td>Fellow</td>
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<tr>
<td>VI.G.5.a) Fellows in the Final Years of Education</td>
<td>Fellows in the subspecialties of diagnostic radiology are considered to be in the final years of education.</td>
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<td>VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty</td>
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<td>VI.D.1. Licensed Independent Practitioner</td>
<td>Specialtiespecific Duty Hour Definitions</td>
<td>Q: Under which circumstances can a first-year resident be supervised indirectly with supervision immediately available? A: Programs must assess the independence of each first-year resident based upon the six core competencies in order to progress to indirect supervision with supervision immediately available. Various required experiences may necessitate different sets of skills. For example, if a resident is deemed to have progressed to indirect supervision with supervision immediately available while rotating in the Emergency Department, this may not be the case in a subsequent required experience if it is the resident’s first experience for another rotation such as medical intensive care unit (MICU) or trauma surgery.</td>
</tr>
<tr>
<td>VI.D.5.a),(1) Supervision of Residents</td>
<td>Do not have PGY-1 residents in the subspecialty.</td>
<td>Q: Can residents be supervised by Licensed Independent Practitioners? A: Only licensed physicians who are credentialed to perform imaging procedures may have primary responsibility for the imaging aspects of patient care.</td>
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<tr>
<td>VI.E. Clinical Responsibilities</td>
<td>Specialtiespecific Duty Hour Definitions</td>
<td>Q: What does the Review Committee consider an optimal clinical workload for fellows? A: Optimal clinical workload must maximize the fellow learning experience without compromising patient care. The number and distribution of cases will vary with the responsibility appropriate to each fellow’s demonstrated competence over the course of his or her education. Program directors must determine minimum and maximum patient loads by including faculty members’ and fellows’ input into an assessment of the learning environment, including patient safety, fellow education, severity and complexity of patient illness/condition, and available support services. Both insufficient patient experiences and excessive patient loads may jeopardize the quality of fellow education.</td>
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<td>VI.G.5.a) Fellows in the Final Years of Education</td>
<td>Specialtiespecific Duty Hour Definitions</td>
<td>Q: Who should be included in the interprofessional teams? A: All interprofessional team members must participate in the education of residents, and team members may include ancillary personnel, attending diagnostic radiology physicians, diagnostic radiology technologists, nurse practitioners, nurses, physician assistants, and radiation safety personnel. The team may also include individuals from referring clinical services, medical physicists, and radiopharmacists.</td>
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<td>VI.G.5.a),(1) Circumstances for Eight Hours Free of Duty</td>
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<td><strong>Diagnostic Radiology – Neuroradiology</strong></td>
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| VI.D.1. Licensed Independent Practitioner | | Q: Can residents be supervised by Licensed Independent Practitioners?  
A: Only licensed physicians who are credentialed to perform imaging procedures may have primary responsibility for the imaging aspects of patient care. |
| VI.D.5.a).(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. | |
| VI.E. Clinical Responsibilities | | Q: What does the Review Committee consider an optimal clinical workload for fellows?  
A: Optimal clinical workload must maximize fellows’ learning experience without compromising patient care. The number and distribution of cases will vary with the responsibility appropriate to each fellow’s demonstrated competence over the course of his or her education. Program directors must determine minimum and maximum patient loads by including faculty members’ and fellows’ input into an assessment of the learning environment, including patient safety, fellow education, severity and complexity of patient illness/condition, and available support services.  
Both insufficient patient experiences and excessive patient loads may jeopardize the quality of fellow education. |
| VI.F. Teamwork | | Q: Who should be included in the interprofessional teams?  
A: All interprofessional team members must participate in the education of residents, and team members include ancillary personnel, attending diagnostic radiology physicians, diagnostic radiology technologists, nurse practitioners, nurses, physician assistants, and radiation safety personnel. The team may also include individuals from referring clinical services, medical physicists, and radiopharmacists. |
| VI.G.5.a) Fellows in the Final Years of Education | Fellows in the subspecialties of diagnostic radiology are considered to be in the final years of education. | |
| VI.G.5.a).(1) Circumstances for Eight Hours Free of Duty | | |
| VI.G.6. Maximum Frequency of In-House Night Float | | |
| **Diagnostic Radiology – Nuclear** | | |
| VI.D.1. Licensed Independent Practitioner | | Q: Can residents be supervised by Licensed Independent Practitioners?  
A: Only licensed physicians who are credentialed to perform imaging procedures may have primary responsibility for the imaging aspects of patient care. |
<p>| VI.D.5.a).(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. | |</p>
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A: Optimal clinical workload must maximize fellows’ learning experience without compromising patient care. The number and distribution of cases will vary with the responsibility appropriate to each fellow’s demonstrated competence over the course of his or her education. Program directors must determine minimum and maximum patient loads by including faculty members’ and fellows’ input into an assessment of the learning environment, including patient safety, fellow education, severity and complexity of patient illness/condition, and available support services. Both insufficient patient experiences and excessive patient loads may jeopardize the quality of fellow education. |

| VI.F. Teamwork | See IV.A.2.a),(1),(a) [Fellows] must provide consultation with referring physicians or services. (Outcome)  
See IV.A.2.a),(1),(b) [Fellows] should actively participate in educating diagnostic radiology residents, and if appropriate, medical students and other professional personnel in the care and management of patients. (Outcome) | Q: Who should be included in the interprofessional teams?  
A: All interprofessional team members must participate in the education of residents, and team members may include ancillary personnel, attending diagnostic radiology physicians, diagnostic radiology technologists, nurse practitioners, nurses, physician assistants, and radiation safety personnel. The team may also include individuals from referring clinical services, medical physicists, and radiophonicians. |

| VI.G.5.a) Fellows in the Final Years of Education | Fellows in the subspecialties of diagnostic radiology are considered to be in the final years of education. | |
| VI.G.5.c),(1) Circumstances for Eight Hours Free of Duty | | |
| VI.G.6. Maximum Frequency of In-House Night Float | | |

| Diagnostic Radiology – Pediatric | | |
| VI.D.1. Licensed Independent Practitioner | Q: Can residents be supervised by Licensed Independent Practitioners?  
A: Only licensed physicians who are credentialed to perform imaging procedures may have primary responsibility for the imaging aspects of patient care. |

<p>| VI.D.5.a),(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. | |</p>
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| VI.E. Clinical Responsibilities | Specialty-specific Duty Hour Definitions | Q: What does the Review Committee consider an optimal clinical workload for fellows?  
A: Optimal clinical workload must maximize fellows’ learning experience without compromising patient care. The number and distribution of cases will vary with the responsibility appropriate to each fellow’s demonstrated competence over the course of his or her education. Program directors must determine minimum and maximum patient loads by including faculty members’ and fellows’ input into an assessment of the learning environment, including patient safety, fellow education, severity and complexity of patient illness/condition, and available support services.  
Both insufficient patient experiences and excessive patient loads may jeopardize the quality of fellow education. |
| VI.F. Teamwork | See III.B.5. The fellowship program should have close interaction with a diagnostic radiology residency program.  
(Core)  
See III.B.5.a) It is strongly encouraged that fellows should have shared experience with residents in general pediatrics and with fellows in the pediatric-related subspecialties (i.e., surgery, pathology, neonatology, general pediatrics, and adolescent medicine) and cardiology; where appropriate, expert faculty in these disciplines should supervise and teach the fellows.  
(Detail) | Q: Who should be included in the interprofessional teams?  
A: All interprofessional team members must participate in the education of residents, and team members include ancillary personnel, attending diagnostic radiology physicians, diagnostic radiology technologists, nurse practitioners, nurses, physician assistants, and radiation safety personnel. The team may also include individuals from referring clinical services, medical physicists, and radiopharmacists. |
| VI.G.5.a) Fellows in the Final Years of Education | Fellows in the subspecialties of diagnostic radiology are considered to be in the final years of education. |  |
| VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty |  |  |
| VI.G.6. Maximum Frequency of In-House Night Float |  |  |
| Diagnostic Radiology – Vascular and Interventional |  |  |
| VI.D.1. Licensed Independent Practitioner |  | Q: Can residents be supervised by Licensed Independent Practitioners?  
A: The Review Committee will accept licensed or certified individuals on occasion to supervise residents in unique educational settings within the scope of their licensure or certification. Examples may include physician assistants, nurse practitioners, clinical psychologists, licensed clinical social workers, certified nurse midwives, certified registered nurse anesthetists, and doctors of pharmacy. Oversight by a faculty physician during these situations is required. |
| VI.D.5.a).(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. | Q: Can residents be supervised by Licensed Independent Practitioners?  
A: Only licensed physicians who are credentialed to perform imaging procedures may have primary responsibility for the imaging aspects of patient care. |
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| VI.F. Teamwork         | See IV.A.2.a),(1),(a) [Fellows] must provide consultation with referring physicians or services. (Outcome) | Q: What does the Review Committee consider an optimal clinical workload for fellows?  
A: Optimal clinical workload must maximize the fellow learning experience without compromising patient care. The number and distribution of cases will vary with the responsibility appropriate to each fellow’s demonstrated competence over the course of his or her education. Program directors must determine minimum and maximum patient loads by including faculty members’ and fellows’ input into an assessment of the learning environment, including patient safety, fellow education, severity and complexity of patient illness/condition, and available support services.  
Both insufficient patient experiences and excessive patient loads may jeopardize the quality of fellow education. |
| VI.G.5.a) Fellows in the Final Years of Education | See IV.A.2.a),(1),(b) [Fellows] should actively participate in educating diagnostic radiology residents, and if appropriate, medical students and other professional personnel in the care and management of patients. (Outcome) | Q: Who should be included in the interprofessional teams?  
A: All interprofessional team members must participate in the education of residents, and team members may include ancillary personnel, attending diagnostic radiology physicians, diagnostic radiology technologists, nurse practitioners, nurses, physician assistants, and radiation safety personnel. The team may also include individuals from referring clinical services, medical physicists, and radiopharmacists. |
| VI.G.5.a),(1) Circumstances for Eight Hours Free of Duty | Fellows in the subspecialties of diagnostic radiology are considered to be in the final years of education. | |
| VI.G.6. Maximum Frequency of In-House Night Float | | |
| VI.D.1. Licensed Independent Practitioner | | Q: Are there situations in which fellows may be supervised by Licensed Independent Practitioners?  
A: The Review Committee will accept licensed or certified individuals to supervise fellows in unique educational settings within the scope of those individuals’ licensure or certification. Examples may include physician assistants, nurse practitioners, clinical psychologists, licensed clinical social workers, certified nurse midwives, certified registered nurse anesthetists, and doctors of pharmacy. Indirect oversight by a faculty physician member during these situations is required. |
| VI.D.5.a),(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. | Q: What does the Review Committee consider an optimal clinical workload?  
A: Each program must adhere to its graduated responsibility policy. This may vary by area of service, based upon each individual’s level of achieved competence (knowledge, skills, and attitudes), and based upon patient acuity. The milestones must be used to assess each fellow’s competencies. Both insufficient patient experiences and excessive patient loads may jeopardize the quality of fellow education. |
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| VI.F. Teamwork          |                                          | Q: Who should be included in the interprofessional teams?  
A: Physicians, advanced practice providers, case managers, child-life specialists, emergency medical technicians, nurses, pain management specialists, paramedics, pastoral care specialists, pharmacists, physician assistants, psychiatrists, psychologists, rehabilitative therapists, respiratory therapists, and social workers are examples of professional personnel who may be part of interprofessional teams. |
| VI.G.5.c) Residents in the Final Years of Education | Emergency medicine fellows are considered to be in the final years of education. | |
| VI.G.5.a).(1) Circumstances for Eight Hours Free of Duty | 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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. | Q: Are there any circumstances under which fellows may stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty?  
A: Fellows may stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty to maintain continuity of care, to provide counseling to patients and/or families, to participate in care for patients with rare diagnoses or conditions, or to care for a patient with an acute issue. This decision should be made with the timely approval of the program director. |
| VI.G.6. Maximum Frequency of In-House Night Float |                                          | |
| **Family Medicine**     |                                          | |
| VI.D.1. Licensed Independent Practitioner |                                          | |
| VI.D.2. Teleconference Supervision |                                          | Q: What are the expectations of the Committee with respect to compliance when the faculty is precepting the resident via teleconference?  
A: The Committee accepts the important role that telemedicine has in the education of residents, but still requires that the program is in substantial compliance with the Requirements on supervision. It is the responsibility of the program and institution to ensure that in situations where the faculty is precepting via telemedicine (resident has the face-to-face encounter with patient), there is either direct or indirect supervision available to the resident as needed. |
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| VI.D.3.b) Indirect Supervision | | **Q:** What are some examples of indirect supervision?  
**A:**  
**Indirect supervision with direct supervision immediately available:**  
The resident is seeing patients in the FMP and the supervising physician faculty member in the precepting room is immediately available to see the patient together with the resident as needed. The faculty member is in another area of the hospital, but is immediately available to see the patient together with the resident in the labor and delivery department as needed.  
**Indirect supervision with direct supervision available:**  
A resident is on call for the family medicine service and needs advice from the physician faculty member in order to manage a patient’s care. This can be done either by telephone or electronically. After communication with the resident, if the physician faculty member determines additional assistance is needed, he or she is available and able to go to the hospital and see the patient together with the resident.  
**Indirect supervision oversight:**  
A resident is seeing a patient in either a nursing home or at home, and the supervising faculty member can then review the patient chart, discuss the case and any required follow-up with the resident. |
| VI.D.5.a).(1) Supervision of Residents | | **Q:** Under which circumstances can a first-year resident be supervised indirectly with supervision immediately available?  
**A:** Programs must assess the independence of each first-year resident based upon the six Core Competencies in order for a given resident to progress to indirect supervision with supervision immediately available.  
Various required experiences may necessitate different sets of skills. For example, if a resident is deemed to have progressed to indirect supervision with supervision immediately available while on the family medicine service, this may not be the case in a subsequent required experience if it is the resident’s first experience for another rotation, such as inpatient pediatrics or surgery. |
| VI.E. Clinical Responsibilities | VI.E.1. The program director must have the authority and responsibility to set appropriate Clinical Responsibilities (i.e., patient caps) for each resident based on that resident’s PGY level, patient safety, resident education, severity and complexity of patient illness/condition, and available support services. (Core) | **Q:** Who should be included in interprofessional teams?  
**A:** Nurses, physician assistants, advanced practice providers, pharmacists, social workers, child-life specialists, physical and occupational therapists, respiratory therapists, psychologists, and nutritionists are examples of professional personnel who may be part of interprofessional teams with which residents must work as members. |
| VI.F. Teamwork | | **Q:** May patient encounters during internal moonlighting count toward the required 1650 encounters?  
**A:** No. Resident experiences while moonlighting (internal or external) may not be used to meet minimum accreditation standards. |
| VI.G.2. Moonlighting | | **Q:** May patient encounters during internal moonlighting count toward the required 1650 encounters?  
**A:** No. Resident experiences while moonlighting (internal or external) may not be used to meet minimum accreditation standards. |
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<td>PGY-2 residents are considered to be at the intermediate-level.</td>
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<td>VI.G.5.c) Residents in the Final Years of Education</td>
<td>PGY-3 residents are considered to be in the final years of education.</td>
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<td>VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty</td>
<td>VI.G.5.c).(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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. (Detail)</td>
<td>Q: Are there circumstances under which PGY 1-2 level residents may return with fewer than eight hours away from the hospital? A: The language of the requirement allows for “all residents” which would encompass not only the PGY-3 (residents in final years of training) but also PGY 1-2 residents to return to the hospital under certain circumstances, as defined.</td>
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<td>VI.G.6. Maximum Frequency of In-House Night Float</td>
<td>VI.G.6.a) Night float experiences must not exceed 50 percent of a resident’s inpatient experiences. (Core)</td>
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**Internal Medicine**

| VI.D.1. Licensed Independent Practitioner |  |  |
| VI.D.2. Supervision of Residents |  | Q: What is adequate availability of faculty members for resident supervision in the hospital and in the clinic? A: Residents must be supervised in all settings, and the supervision must be on-site. In inpatient settings, supervision need not be continuous on-site, if upper-level residents or fellows are on-site continuously. In inpatient settings, supervision can occur at specified times such as during teaching rounds, with availability at all other times. In outpatient settings, supervision must be continuously available and on-site. Appropriate supervision cannot occur after the patient has left the clinic. Off-site supervision (e.g., an attending is available by phone if a resident has questions) is not acceptable in outpatient settings. This is because the attending must have the opportunity to interview and/or examine all patients at the time he or she reviews the case and provides supervision. Learners do not always realize when additional evaluation or a change in care plan is necessary. Q: Can nurse practitioners or physician assistants supervise residents or fellows in ambulatory settings? A: The Review Committee will allow supervision by non-physician faculty members in specialized outpatient settings for specific learning experiences (i.e., gynecology clinic, STD clinic, wound care clinic, home visits, nursing homes, etc.) where the non-physician faculty members have the appropriate qualifications to perform and supervise the clinical activity. If a non-physician faculty member is acting as a supervisor of the health care provided in a particular setting, the program must ensure that the non-physician faculty member is authorized to do so by applicable institutional policies and state regulations. Under no circumstances does this exception to physician faculty supervision apply to continuity clinic, other general medical clinics, or medicine subspecialty clinics (i.e., pulmonary clinic, general infectious disease clinic, hematology-oncology clinic, etc.). |  |
VI.D.5.

**Q:** Are emergency medicine shifts longer than 12 hours permissible to allow transfer of care? What is an example of an acceptable shift during this rotation?

**A:** No. The Review Committee expects that all clinical activities on emergency medicine rotations, including sign-in and sign-out, will be concluded within the maximum 12-hour duty period. The Review Committee does not suggest that 12 hours is an optimal shift length for ED rotations, but sets 12 hours as the absolute maximum duty period.

Many programs have found 8-hour or 10-hour shifts to provide a better service-education balance on emergency medicine rotations. Shorter shifts also allow for sign-in and sign-out while still staying under the 12-hour limit.

Some programs have assigned residents to cover only 18 or 20 hours of the 24-hour day, with faculty members covering the additional period.

Other programs have scheduled faculty members’ shifts to overlap resident shifts, allowing residents to sign out to faculty members.

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**VI.D.5.a.(1) Supervision of Residents**

See I.A.2.h).(5) [The sponsoring institution and participating sites must provide the resources to ensure the implementation of the following:] residents from other specialties must not supervise internal medicine residents on any internal medicine inpatient rotation. (Core)

See I.A.2.h).(6).(h) [The sponsoring institution and participating sites must provide the resources to ensure the implementation of the following: on inpatient rotations:] second- or third-year internal medicine residents or other appropriate supervisory physicians (e.g., subspecialty residents or attendings) with documented experience appropriate to the acuity, complexity, and severity of patient illness must be available at all times on site to supervise first-year residents. (Core)
| VI.E. Clinical Responsibilities | Q: Is there a cap on night float admissions?  
A: Yes. The Program Requirements set an admission cap for interns at no more than five admissions per 24 hours. In the judgment of the Review Committee, this is the maximum number of new patients that a PGY-1 resident can consistently admit, evaluate thoroughly, and care for safely in a 24-hour period and still have sufficient time for education. The Committee would not approve an increase in the cap simply because the intern was on a night float rotation and would be turning the care of these patients over to a colleague. However, the Committee does not apply the “8 in 48” rule to night floats. In other words, on a night float week (= up to six days), an intern night float could admit up to five patients each night, and a PGY-2 or -3 night float could admit up to 10 patients each night. |
| --- | --- |
| See I.A.2.h),(6),(a) [The sponsoring institution and participating sites must provide the resources to ensure the implementation of the following: on inpatient rotations:] a first-year resident must not be assigned more than five new patients per admitting day; an additional two patients may be assigned if they are in-house transfers from the medical services; (Core) | Q: How does the Review Committee define transfer patients?  
A: The Review Committee defines transfer patients as: (1) transfers from the night float team, or transfers from other medical services, e.g., out of the CCU or MICU; and (2) bounce-back admissions within the same rotation month. |
| See I.A.2.h),(6),(b) [The sponsoring institution and participating sites must provide the resources to ensure the implementation of the following: on inpatient rotations:] a first-year resident must not be assigned more than eight new patients in a 48-hour period; (Core) | Q: How many consults are allowed in the cap?  
A: Consults are not admissions. There are no program requirements for consult numbers. If residents were required to perform an excessive numbers of consults, this would be cited as service versus education related issues. The Review Committee would examine very carefully any instance where interns or residents were expected to complete consultations in addition to inpatient admitting responsibilities. |
| See I.A.2.h),(6),(c) [The sponsoring institution and participating sites must provide the resources to ensure the implementation of the following: on inpatient rotations:] a first-year resident must not be responsible for the ongoing care of more than 10 patients; (Core) | Q: If an admitting resident supervises only one intern, can that supervising resident admit patients on his or her own?  
A: Yes. The supervising resident may supervise or admit a maximum of 10 new patients in an admitting day. In other words, the resident may supervise five intern admissions and admit another five patients without the intern. The supervising resident may also supervise or admit up to four additional “transfer patients.” |
| See I.A.2.h),(6),(d) [The sponsoring institution and participating sites must provide the resources to ensure the implementation of the following: on inpatient rotations:] when supervising more than one first-year resident, the supervising resident must not be responsible for the supervision or admission of more than 10 new patients and four transfer patients per admitting day or more than 16 new patients in a 48-hour period; (Core) | Q: How many patients can be cared for by a team with one resident and a hospitalist?  
A: The Review Committee for Internal Medicine believes it is neither necessary nor feasible to set explicit admission and census caps for every conceivable variation in the composition of the patient care team (intern only, resident with acting intern, resident with intern and nurse practitioner, etc). In assessing the appropriateness of patient load for non-traditional teams, the committee will consider work hours and resident-reported service-education balance. |
<p>| See I.A.2.h),(6),(e) [The sponsoring institution and participating sites must provide the resources to ensure the implementation of the following: on inpatient rotations:] when supervising one first-year resident, the supervising resident must not be responsible for the ongoing care of more than 14 patients; (Core) | | See I.A.2.h),(6),(f) [The sponsoring institution and participating sites must provide the resources to ensure the implementation of the following: on inpatient rotations:] when supervising more than one first-year resident, the supervising resident must not be responsible for the ongoing care of more than 20 patients; (Core) |
| See I.A.2.h),(6),(g) [The sponsoring institution and participating sites must provide the resources to ensure the implementation of the following: on inpatient rotations:] residents must write all orders for patients under their care, with appropriate supervision by the attending physician. In | | | |</p>
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<td>those unusual circumstances when an attending physician or subspecialty resident writes an order on a resident’s patient, the attending or subspecialty resident must communicate his or her action to the resident in a timely manner; (Core) See I.A.2.h),(6).(i) [The sponsoring institution and participating sites must provide the resources to ensure the implementation of the following: on inpatient rotations:] each physician of record has the responsibility to make management rounds on his or her patients and to communicate effectively with the residents participating in the care of these patients at a frequency appropriate to the changing care needs of the patients; (Core) See I.A.2.h),(6).(j) [The sponsoring institution and participating sites must provide the resources to ensure the implementation of the following: on inpatient rotations:] total required transplant rotations in dedicated units should not exceed one month in three years. (Core)</td>
<td>Q: Must every interprofessional team include representation from every profession listed in the requirement? A: No. The Review Committee recognizes that the needs of specific patients change with their health statuses and circumstances. The intent of the requirement is to ensure that the program has access to these professional and paraprofessional personnel and that interprofessional teams will be constituted as appropriate and as needed.</td>
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<td>VI.F. Teamwork</td>
<td>See II.D.6. There must be services available from other health care professionals such as nurses, social workers, case managers, language interpreters, dieticians, etc. to assist with patient care. (Detail) See II.D.7. Consultations from other clinical services must be available in a timely manner in all care settings where the residents work. All consultations should be performed by or under the supervision of a qualified specialist. (Detail) See IV.A.5.a),(1).(a) [Residents are expected to demonstrate the ability to manage patients] in a variety of roles within a health system with progressive responsibility to include serving as the direct provider, the leader or member of a multidisciplinary team of providers, a consultant to other physicians, and a teacher to the patient and other physicians; (Outcome) See V.A.2.b),(1).(f),(ii) [The program must assess the resident in the following:] ability to work in interdisciplinary teams; (Detail)</td>
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<td>VI.G.5.b) Intermediate- level Residents</td>
<td>No residents will be designated as being at the intermediate level.</td>
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<td>VI.G.5.c) Residents in the Final Years of Education</td>
<td>PGY-2 and PGY-3 residents are considered to be in the final years of education.</td>
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<td>VI.G.5.c).(1)</td>
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<td>VI.G.5.c).(1).(b) Under such circumstances, the resident must appropriately hand over care of all other patients to the team responsible for their continuing care, and document the reasons for remaining or returning to care for the patient in question and submit that documentation to the program director. (Detail)</td>
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<td>VI.G.5.c).(1).(c) The program director must review each submission of additional service and track both individual residents’ and program-wide episodes of additional duty. (Detail)</td>
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<td>Maximum In-House On-Call Frequency</td>
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<td>On-Call Frequency</td>
<td>VI.G.7.a) Internal Medicine residency programs must not average in-house call over a four-week period. (Core)</td>
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<td>Internal Medicine – Adult Congenital Heart Disease</td>
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<td>VI.D.1. Licensed</td>
<td>Do not have PGY-1 residents in the subspecialty.</td>
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<td>of Residents</td>
<td>See II.D.4. Patient Population</td>
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<td>See II.D.4.b) There must be patients of each gender, with a broad age range, including geriatric patients. (Core)</td>
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<td>See II.D.4.c) A sufficient number of patients must be available to enable each fellow to achieve the required educational outcomes. (Core)</td>
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<td>This must include:</td>
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<td>II.D.4.c).(1)</td>
<td>at least 200 hospitalized adult patients diagnosed with complications related to congenital heart disease; and, (Core)</td>
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<td>II.D.4.c).(2)</td>
<td>at least 350 ambulatory patient visits (among at least 250 unique individual ambulatory patients) with congenital heart disease. (Core)</td>
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<td>See IV.A.3.a).(6)</td>
<td>[Fellows must have] continuity ambulatory clinic experience that exposes them to the breadth and depth of ACHD. (Core)</td>
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<td>See IV.A.3.a).(6).(a)</td>
<td>This experience should average one half-day each week. (Detail)</td>
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<td>See IV.A.3.a).(6).(b)</td>
<td>This experience must include an appropriate distribution of patients of each gender and a diversity of ages, with attention to age-, gender-, or ethnicity-based differences in disease or care disparities when such occur. (Core)</td>
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<td>This should be accomplished through either:</td>
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<td>IV.A.3.a).(6).(b).(i)</td>
<td>a continuity clinic which provides fellows the opportunity to observe and learn the course of disease; or, (Detail)</td>
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<td>IV.A.3.a).(6).(b).(ii)</td>
<td>selected blocks of at least six months which address specific areas of cardiovascular disease as they relate to congenital heart disease. (Core)</td>
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<td>IV.A.3.a).(6).(c)</td>
<td>Each fellow should, on average, be responsible for four to eight patients during each half-day session. (Detail)</td>
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<td>See IV.A.3.a).(6).(d)</td>
<td>The continuity patient care experience should not be interrupted by more than one month, excluding a fellow's vacation. (Detail)</td>
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<td>See II.C.1 There must be services available from other health care professionals, including dietitians, language interpreters, nurses, occupational therapists, physical therapists, and social workers. (Detail)</td>
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<td>See II.C.2. There must be appropriate and timely consultation from other specialties. (Detail)</td>
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<td>See V.A.2.b).(1).(f).(ii) [The program must use multi-source evaluation, including peers, and non-physician team members to assess each fellow’s:] ability to work in interdisciplinary teams; (Detail)</td>
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<td>VI.G.7. Maximum In-House On-Call Frequency</td>
<td>VI.G.7.a) Internal Medicine fellowships must not average in-house call over a four-week period. (Core)</td>
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**Internal Medicine – Advanced Heart Failure and Transplant Cardiology**

<p>| VI.D.1. Licensed Independent Practitioner | |</p>
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<td>II.D.4.c)(1) 200 hospitalized patients per year diagnosed with heart failure, including both pre- and post-transplant patients and patients with ventricular assist devices; and, (\text{(Core)})</td>
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<td>II.D.4.c)(2) ambulatory patients, including patients with heart failure, transplants, and mechanical circulatory support. (\text{(Core)})</td>
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<td>See IV.A.3.b)(1) Fellows should participate in ambulatory patient care that involves a wide variety of patients with heart failure, transplants, and mechanical circulatory support. (\text{(Detail)})</td>
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<td>See IV.A.3.f) Fellows must have clinical experience in: (\text{(Core)})</td>
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<td>IV.A.3.f)(1) caring for patients in the context of a multidisciplinary disease management program; (\text{(Core)})</td>
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<td>IV.A.3.f)(2) end-of-life care; (\text{(Core)})</td>
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<td>IV.A.3.f)(3) evaluating patients for cardiac transplant or mechanical assist devices; (at least 30 such patients); and, (\text{(Core)})</td>
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<td>IV.A.3.f)(4) the management of diagnostic and therapeutic devices used for the evaluation and management of heart failure in the acute and chronic setting. (\text{(Core)})</td>
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| VI.F. Teamwork         | See II.C.1 There must be services available from other health care professionals, including dietitians, language interpreters, nurses, occupational therapists, physical therapists, and social workers. ([Detail](#))  
See II.C.2. There must be appropriate and timely consultation from other specialties. ([Detail](#))  
See V.A.2.b).(1).(f).(ii) [The program must use multi-source evaluation, including peers, and non-physician team members to assess each fellow's:] ability to work in interdisciplinary teams; ([Detail](#))  
VI.F.1. Fellows must demonstrate competence in managing cardiac transplant patients within the context of a team of transplant professionals. ([Outcome](#)) | Q: Who should be included in the “team of transplant professionals”?  
A: A team of transplant professionals may include physicians, nurses, pharmacists, nutritionists, social workers, exercise physiologists, and other health care professionals with specialized training and skills in heart failure and transplant patient management.  
However, the Review Committee recognizes that the needs of specific patients change with their health statuses and circumstances. The intent of the requirement is to ensure that the program has access to these professional and paraprofessional personnel, and that transplant professional teams will be constituted as appropriate for each patient’s needs.  
Q: Must every interprofessional team include representations from every profession listed in the requirement?  
A: No. The Review Committee recognizes that the needs of specific patients change with their health statuses and circumstances. The intent of the requirement is to ensure that the program has access to these professional and paraprofessional personnel and that interprofessional teams will be constituted as appropriate and as needed. |
| VI.G.5.a) Residents in the Final Years of Education | Internal medicine subspecialty fellows are considered to be in the final years of education. | |
| VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty | VI.G.5.a).(1).(b) In unusual circumstances, fellows may remain beyond their scheduled period of duty or return after their scheduled period of duty to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity of care for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of the patient or family. Such episodes should be rare, must be of the fellows’ own initiative, and need not initiate a new ‘off-duty period’ nor require a change in the scheduled ‘off-duty period.’ ([Detail](#))  
VI.G.5.a).(1).(c) Under such circumstances, the fellow must appropriately hand over care of all other patients to the team responsible for their continuing care, and document the reasons for remaining or returning to care for the patient in question and submit that documentation to the program director. ([Detail](#))  
VI.G.5.a).(1).(d) The program director must review each submission of additional service and track both individual fellows’ and program-wide episodes of additional duty. ([Detail](#)) | |

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<td>VI.G.7. Maximum In-House On-Call Frequency</td>
<td>VI.G.7.a) Internal Medicine fellowships must not average in-house call over a four-week period.</td>
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**Internal Medicine – Cardiovascular Disease**

| VI.D.1. Licensed Independent Practitioner |  |
| VI.D.1. Licensed Independent Practitioner |  |
| VI.D.5.a). Supervision of Residents | **Do not have PGY-1 residents in the subspecialty.** |

**VI.E. Clinical Responsibilities**

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<tr>
<th>VI.E. Clinical Responsibilities</th>
<th>See II.D.6. Patient Population</th>
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<tbody>
<tr>
<td>II.D.6.a) The patient population must have a variety of clinical problems and stages of cardiovascular diseases.</td>
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<td>II.D.6.b) There must be patients of each gender, with a broad age range, including geriatric patients.</td>
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<td>II.D.6.c) A sufficient number of patients must be available to enable each fellow to achieve the required educational outcomes.</td>
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<td>See IV.A.6.c).(2) This experience should average one half-day each week.</td>
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<td>See IV.A.6.c).(3) This experience must include an appropriate distribution of patients of each gender and a diversity of ages.</td>
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<td>This should be accomplished through either:</td>
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<td>IV.A.6.c).(3).(a) a continuity clinic which provides fellows the opportunity to observe and learn the course of disease; or,</td>
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<td>IV.A.6.c).(3).(b) selected blocks of at least six months which address specific areas of disease.</td>
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<td>IV.A.6.c).(4) Each fellow should, on average, be responsible for four to eight patients during each half-day session.</td>
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<td>VI.F. Teamwork</td>
<td>See II.C.1 There must be services available from other health care professionals, including dietitians, language interpreters, nurses, occupational therapists, physical therapists, and social workers. (Detail) See II.C.2. There must be appropriate and timely consultation from other specialties. (Detail) See V.A.2.b).(1).(g).(ii) [The program must use multi-source evaluation, including peers, and non-physician team members to assess each fellow’s:] ability to work in interdisciplinary teams; (Detail)</td>
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| VI.F. Teamwork | See II.C.1. There must be services available from other health care professionals, including dietitians, language interpreters, nurses, occupational therapists, physical therapists, and social workers. (Detail)  
See II.C.2. There must be appropriate and timely consultation from other specialties. (Detail)  
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| VI.G.5.a) Residents in the Final Years of Education | Internal medicine subspecialty fellows are considered to be in the final years of education. | |
| VI.G.5.a).(1) Circumstances for Eight Hours Free of Duty | VI.G.5.a).(1).(b) In unusual circumstances, fellows may remain beyond their scheduled period of duty or return after their scheduled period of duty to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity of care for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of the patient or family. Such episodes should be rare, must be of the fellows’ own initiative, and need not initiate a new ‘off-duty period’ nor require a change in the scheduled ‘off-duty period.’ (Detail)  
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<td>VI.G.5.a).(1).d) The program director must review each submission of additional service and track both individual fellows’ and program-wide episodes of additional duty. (Detail)</td>
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<td>VI.G.5.a).(1) Circumstances for Eight Hours Free of Duty (effective July 1, 2017)</td>
<td>VI.G.5.a).(1).b) In unusual circumstances, fellows may remain beyond their scheduled period of duty or return after their scheduled period of duty to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity of care for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of the patient or family. Such episodes should be rare, should be of the fellows’ own initiative, and need not initiate a new ‘off-duty period’ nor require a change in the scheduled ‘off-duty period.’ (Detail)</td>
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**Internal Medicine – Critical Care Medicine**

<p>| VI.D.1. Licensed Independent Practitioner |  |
| VI.D.5.a).(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. |</p>
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<td></td>
<td>See II.D.6.a).(1) Because critical care medicine is multidisciplinary in nature, the program must provide opportunities to manage adult patients with a wide variety of serious illnesses and injuries requiring treatment in a critical care setting. (Detail)</td>
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<td></td>
<td>See II.D.6.b) There must be patients of each gender, with a broad age range, including geriatric patients. (Core)</td>
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<td></td>
<td>See II.D.6.c) A sufficient number of patients must be available to enable each fellow to achieve the required educational outcomes. (Core)</td>
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<td></td>
<td>See II.D.6.d) There must be an average daily census of at least five patients per fellow during assignments to critical care units. (Detail)</td>
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<td></td>
<td>See IV.A.6.a) A minimum of 12 months must be devoted to clinical experiences. (Core)</td>
<td></td>
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<td></td>
<td>See IV.A.6.a).(1) At least six months must be devoted to the care of critically-ill medical patients (i.e., MICU/CICU or equivalent). (Core)</td>
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<td></td>
<td>See IV.A.6.a).(1).(a) This required MICU/CICU experience may be reduced up to three months by equivalent (month for month) ICU experience completed during a previous two- to three-year ACGME-accredited internal medicine subspecialty fellowship. (Detail)</td>
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<td></td>
<td>See IV.A.6.a).(2) At least three months must be devoted to the care of critically-ill non-medical patients. (Core)</td>
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<td>See IV.A.6.a).(2).(a) This experience should consist of at least one month of direct patient care activity, with the remainder being fulfilled with either consultative activities or with direct care of such patients. (Detail)</td>
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<td>VI.F. Teamwork</td>
<td>See II.C.1. There must be services available from other health care professionals, including dietitians, language interpreters, nurses, occupational therapists, physical therapists, and social workers. (Detail) See II.C.2. Personnel must include nurses and technicians who are skilled in critical care instrumentation, respiratory function, and laboratory medicine. (Detail) See II.C.3. There must be appropriate and timely consultation from other specialties. (Detail) See V.A.2.b).(1).(f).(ii) [The program must use multi-source evaluation, including peers, and non-physician team members to assess each fellow’s:] ability to work in interdisciplinary teams;</td>
<td>Q: Must every interprofessional team include representations from every profession listed in the requirement? A: No. The Review Committee recognizes that the needs of specific patients change with their health statuses and circumstances. The intent of the requirement is to ensure that the program has access to these professional and paraprofessional personnel and that interprofessional teams will be constituted as appropriate and as needed.</td>
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**Internal Medicine – Endocrinology, Diabetes, and Metabolism**

| VI.D.1. Licensed Independent Practitioner | | |
| VI.D.5.a).(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. | |

**VI.E. Clinical Responsibilities**

<p>| | See II.D.5. Patient Population |
| | See II.D.5.a) The patient population must have a variety of clinical problems and stages of diseases. (Core) |
| | See II.D.5.b) There must be patients of each gender, with a broad age range, including geriatric patients. (Core) |
| | See II.D.5.c) A sufficient number of patients must be available to enable each fellow to achieve the required educational outcomes. (Core) |
| | See IV.A.6.c).(1) Fellows must have continuity ambulatory clinic experience that exposes them to the breadth and depth of the subspecialty. (Core) |
| | See IV.A.6.c).(2) This experience should average one half-day each week. (Detail) |
| | See IV.A.6.c).(2).(a) The program must include a minimum of two half-days of ambulatory care per week, averaged over the two years of education, which includes the continuity ambulatory experience. (Detail) |
| | See IV.A.6.c).(2).(b) Three half-days of ambulatory care per week is suggested. (Detail) |
| | See IV.A.6.c).(3) This experience must include an appropriate distribution of patients of each gender and a diversity of ages, (Core) |
| | This should be accomplished through either: |
| | IV.A.6.c).(3).(a) a continuity clinic which provides fellows the opportunity to observe and learn the course of disease; or, (Detail) |
| | IV.A.6.c).(3).(b) selected blocks of at least six months which address specific areas of endocrine disease. (Core) |</p>
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| Specialties/Requirement # | See IV.A.6.c).(4) Each fellow should, on average, be responsible for four to eight patients during each half-day session. (Detail) | Q: Must every interprofessional team include representations from every profession listed in the requirement?  
A: No. The Review Committee recognizes that the needs of specific patients change with their health statuses and circumstances. The intent of the requirement is to ensure that the program has access to these professional and paraprofessional personnel and that interprofessional teams will be constituted as appropriate and as needed. |
<p>| Specialties/Requirement # | See IV.A.6.c).(5) The continuity patient care experience should not be interrupted by more than one month, excluding a fellow's vacation. (Detail) |  |
| VI.F. Teamwork | See II.C.1. There must be services available from other health care professionals, including dietitians, language interpreters, nurses, occupational therapists, physical therapists, and social workers. (Detail) |  |
| Specialties/Requirement # | See II.C.2. There must be a close working relationship with dietary and/or nutrition services, as well as with specialists in general surgery, nephrology, neurological surgery, neurology, obstetrics and gynecology, ophthalmology, pediatricians, podiatry, and urology. (Detail) |  |
| Specialties/Requirement # | See II.C.3. There must be appropriate and timely consultation from other specialties. (Detail) |  |
| Specialties/Requirement # | See V.A.2.b).(1).(f).(ii) [The program must use multi-source evaluation, including peers, and non-physician team members to assess each fellow's] ability to work in interdisciplinary teams; (Detail) |  |
| VI.G.5.b) Intermediate-level Residents | Internal medicine subspecialty fellows are considered to be in the final years of education. |  |
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   (Detail) | |
| VI.G.6. Maximum Frequency of In-House Night Float | | |
| VI.G.7. Maximum In-House On-Call Frequency | VI.G.7.a) Internal Medicine fellowships must not average in-house call over a four-week period.  
   (Core) | |

**Internal Medicine – Gastroenterology**

<p>| VI.D.1. Licensed Independent Practitioner | | |
| VI.D.5.a),(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. | |</p>
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See IV.A.6.c). (1) Fellows must have continuity ambulatory clinic experience that exposes them to the breadth and depth of the subspecialty. (Core)  
See IV.A.6.c). (2) This experience should average one half-day each week. (Detail)  
See IV.A.6.c). (3) This experience must include an appropriate distribution of patients of each gender and a diversity of ages, (Core)  
This should be accomplished through either:  
IV.A.6.c). (3). (a) a continuity clinic which provides fellows the opportunity to observe and learn the course of disease; or, (Detail)  
IV.A.6.c). (3). (b) selected blocks of at least six months which address specific areas of disease. (Core)  
See IV.A.6.c). (4) Each fellow should, on average, be responsible for four to eight patients during each half-day session. (Detail)  
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   See IV.A.6.d).(4) Ambulatory experience must include the longitudinal care of patients with HIV infection under the supervision of a physician experienced in the management of HIV infection. (Core)  
   See IV.A.6.d).(4).(a) Fellows must be assigned to an HIV clinic for a period of at least 12 months. (Detail)  
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<td>See II.C.5. Expertise in the following disciplines should be available to the program to provide multidisciplinary patient care and fellow education: II.C.5.a) genetic counseling; (Detail) II.C.5.b) hospice and palliative care; (Detail) II.C.5.c) oncologic nursing; (Detail) II.C.5.d) pain management; (Detail) II.C.5.e) psychiatry; and, (Detail) II.C.5.f) rehabilitation medicine. (Detail)</td>
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<td>See II.C.2. There must be a close working relationship with dietary and/or nutrition services and social services, as well as with specialists in diagnostic radiology, general surgery, obstetrics and gynecology, pathology, psychiatry, and urology.</td>
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<td>See II.D.6.d) Because critical care medicine is multidisciplinary in nature, the program must provide opportunities to manage adult patients with a wide variety of serious illnesses and injuries requiring treatment in a critical care setting. <em>(Detail)</em></td>
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<td>See IV.A.6.f).(2).(b) For programs with 18-23 months of required clinical rotations, fellows must complete a minimum</td>
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| VI.G.5.c) Residents in the Final Years of Education | Internal medicine subspecialty fellows are considered to be in the final years of education. | |
| VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty | VI.G.5.c).(1).(b) In unusual circumstances, fellows may remain beyond their scheduled period of duty or return after their scheduled period of duty to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity of care for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of the patient or family. Such episodes should be rare, must be of the fellows’ own initiative, and need not initiate a new ‘off-duty period’ nor require a change in the scheduled ‘off-duty period.’ (Detail) | |
|                        | VI.G.5.c).(1).(c) Under such circumstances, the fellow must appropriately hand over care of all other patients to the team responsible for their continuing care, and document the reasons for remaining or returning to care for the patient in question and submit that documentation to the program director, (Detail) | |
|                        | VI.G.5.c).(1).(d) The program director must review each submission of additional service and track both individual fellows’ and program-wide episodes of additional duty. (Detail) | |
| VI.G.6. Maximum Frequency of In-House Night Float | | |
| VI.G.7. Maximum In-House On-Call Frequency | VI.G.7.a) Internal Medicine fellowships must not average in-house call over a four-week period, (Core) | |</p>
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<td>VI.D.5.a),(1) Supervision of Residents</td>
<td>Do not have PGY-1 residents in the subspecialty.</td>
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<td>VI.E. Clinical Responsibilities</td>
<td>See II.D.6. Patient Population</td>
<td>Q: How does the Committee expect programs to demonstrate compliance with the requirements regarding outpatient clinic?</td>
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<td></td>
<td>See II.D.6.a) The patient population must have a variety of clinical problems and stages of diseases. (Core)</td>
<td>A: The Review Committee and rheumatology community recognize that much of the practice of clinical rheumatology occurs in the ambulatory setting. As such, the Program Requirements state that fellows must spend at least two half-days per week averaged over the two years of required education in an ambulatory/outpatient teaching setting. Continuity clinic provides one half-day per week. Thus programs need to provide fellows with an additional half-day per week, averaged over the 24 months of the fellowship. A third half-day is suggested, but not required. Fellowships program directors may organize this additional education in any way that works for their particular programs, as long as they are able to demonstrate 104 ambulatory teaching half-day sessions in two years, over and above continuity clinic.</td>
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<td>See II.D.6.b) There must be patients of each gender, with a broad age range, including geriatric patients. (Core)</td>
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<td>See II.D.6.c) A sufficient number of patients must be available to enable each fellow to achieve the required educational outcomes. (Core)</td>
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<td>See IV.A.6.c).(1) Fellows must have continuity ambulatory clinic experience that exposes them to the breadth and depth of the subspecialty. (Core)</td>
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<td>See IV.A.6.c).(2) This experience should average one half-day each week. (Detail)</td>
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<td>See IV.A.6.c).(3) The program must include a minimum of two half-days of ambulatory care per week, averaged over the two years of education, which includes the continuity ambulatory experience. (Detail)</td>
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<td>See IV.A.6.c).(4) Three half-days per week of ambulatory care are suggested. (Detail)</td>
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<td>See IV.A.6.c).(5) This experience must include an appropriate distribution of patients of each gender and a diversity of ages, (Core)</td>
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<td>This should be accomplished through either:</td>
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<td>IV.A.6.c).(5).a) a continuity clinic which provides fellows the opportunity to learn the course of disease; or, (Detail)</td>
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<td>IV.A.6.c).(5).b) selected blocks of at least six months which address specific areas of rheumatologic diseases. (Detail)</td>
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<td>See IV.A.6.c).(6) Each fellow should, on average, be responsible for four to eight patients during each half-day</td>
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<tr>
<td>VI.F. Teamwork</td>
<td>See II.C.1 There must be services available from other health care professionals, including dietitians, language interpreters, nurses, occupational therapists, physical therapists, and social workers. (Detail)</td>
<td>Q: Must every interprofessional team include representations from every profession listed in the requirement? A: No. The Review Committee recognizes that the needs of specific patients change with their health statuses and circumstances. The intent of the requirement is to ensure that the program has access to these professional and paraprofessional personnel and that interprofessional teams will be constituted as appropriate and as needed.</td>
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<td>VI.G.5.b) Intermediate-level Residents</td>
<td>Internal medicine subspecialty fellows are considered to be in the final years of education.</td>
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<td>VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty</td>
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<td>VI.G.6. Maximum Frequency of In-House Night Float</td>
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<td>VI.G.7. Maximum In-House On-Call Frequency</td>
<td>VI.G.7.a) Internal Medicine fellowships must not average in-house call over a four-week period. (Core)</td>
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<td>Internal Medicine – Transplant Hepatology</td>
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<td><strong>Do not have PGY-1 residents in the subspecialty.</strong></td>
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<td>VI.E. Clinical Responsibilities</td>
<td><strong>See II.D.4. Patient Population</strong>&lt;br&gt;See II.D.4.a) The patient population must have a variety of clinical problems and stages of diseases. (Core)&lt;br&gt;See II.D.4.b) There must be patients of each gender, with a broad age range, including geriatric patients. (Core)&lt;br&gt;See II.D.4.c) Programs with a complement of two or more fellows must perform 20 liver transplantations per year for each approved fellowship position. (Detail)&lt;br&gt;See II.D.4.d) A sufficient number of patients must be available to enable each fellow to achieve the required educational outcomes. (Core)&lt;br&gt;See IV.A.3.k) Fellows must have formal instruction and clinical experience in interpretation of the following diagnostic and therapeutic techniques and procedures:&lt;br&gt;IV.A.3.k).(1) review of native and allograft liver biopsies; (Core)&lt;br&gt;IV.A.3.k).(1).(a) at least 200 reviews of such biopsies must be done; and, (Detail)&lt;br&gt;IV.A.3.k).(2) the appropriate use of ultrasound localized, laparoscopy-guided and transjugular liver biopsies. (Core)</td>
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<td>VI.F. Teamwork</td>
<td>See II.C.1. There must be services available from other health care professionals, including dietitians, language interpreters, nurses, occupational therapists, physical therapists, and social workers. (Detail) See II.C.2. There must be appropriate and timely consultation from other specialties. (Detail) See II.C.3. The program must incorporate a multidisciplinary team to approach issues in donor selection and evaluation, and in recipient criteria. (Core) See V.A.2.b).(1).(f).(ii) [The program must use multi-source evaluation, including peers, and non-physician team members to assess each fellow’s:] ability to work in interdisciplinary teams;</td>
<td>Q: Must every interprofessional team include representations from every profession listed in the requirement? A: No. The Review Committee recognizes that the needs of specific patients change with their health statuses and circumstances. The intent of the requirement is to ensure that the program has access to these professional and paraprofessional personnel and that interprofessional teams will be constituted as appropriate and as needed.</td>
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<td>VI.G.5.a) Residents in the Final Years of Education</td>
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<td>VI.G.5.a).(1) Circumstances for Eight Hours Free of Duty</td>
<td>VI.G.5.a).(1).(b) In unusual circumstances, fellows may remain beyond their scheduled period of duty or return after their scheduled period of duty to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity of care for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of the patient or family. Such episodes should be rare, must be of the fellows’ own initiative, and need not initiate a new ‘off-duty period’ nor require a change in the scheduled ‘off-duty period.’ (Detail) VI.G.5.a).(1).(c) Under such circumstances, the fellow must appropriately hand over care of all other patients to the team responsible for their continuing care, and document the reasons for remaining or returning to care for the patient in question and submit that documentation to the program director. (Detail) VI.G.5.a).(1).(d) The program director must review each submission of additional service and track both individual fellows’ and program-wide episodes of additional duty. (Detail)</td>
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<td>VI.G.6. Maximum Frequency of In-House Night Float</td>
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<td>VI.G.7. Maximum In-House On-Call Frequency</td>
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<td><strong>Interventional Radiology</strong></td>
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<td>VI.D.1. Licensed Independent Practitioner</td>
<td>Licensed Independent Practitioners who may have primary responsibility for patient care must be physicians. <em>(Detail)</em></td>
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<td>VI.D.5.a).(1) Supervision of Residents</td>
<td>Do not have PGY-1 residents in the specialty.</td>
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<td>VI.E. Clinical Responsibilities</td>
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<tr>
<td>VI.F. Teamwork</td>
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<tr>
<td>VI.G.5.b) Intermediate-level Residents</td>
<td>PGY-2, PGY-3, and PGY-4 residents are considered to be at the intermediate level.</td>
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<tr>
<td>VI.G.5.c) Residents in the Final Years of Education</td>
<td>PGY-5, PGY-6 and PGY-7 residents are considered to be in the final years of education.</td>
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<td>VI.G.5.(c).(1) Circumstances for Eight Hours Free of Duty</td>
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<td>VI.G.6. Maximum Frequency of In-House Night Float</td>
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<td><strong>Medical Genetics and Genomics</strong></td>
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| VI.D.1. Licensed Independent Practitioner | Licensed Independent Practitioners who may have primary responsibility for patient care must be physicians. *(Detail)* | Q: Are there situations in which residents can be supervised by Licensed Independent Practitioners?  
A: Genetic counselors may, on occasion, supervise residents in unique educational settings within the scope of their scope of practice. Oversight by a physician faculty member during these situations is required. |
| VI.D.5.a).(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. |                                  |
| VI.E. Clinical Responsibilities | VI.E.1. The workload for a resident at any level must be no more than four patients with a confirmed diagnosis of an inborn error of intermediary metabolism in an intensive care unit (ICU) setting, or six patients with a confirmed diagnosis of an inborn error of intermediary metabolism in a non-ICU setting. *(Detail)* | Q: What are appropriate qualifications and institutional appointments for non-physician faculty members, such as genetic counselors, nurses, and nutritionists?  
A: The Review Committee accepts hospital-approved credentialing or other equivalent qualifications for non-physician faculty members.  
Q: Is there a minimum required amount of time each resident must work with genetic counselors, nurses, nutritionists, and other health care providers?  
A: No. The Review Committee does not specify a minimum amount of time to be spent with these providers, since such providers are involved in the care of most medical genetic patients, and are part of the health care team with which each resident regularly works.  
Q: How does the Review Committee define “intermediary metabolism”?  
A: Intermediary metabolism is any enzyme-catalyzed process within cells that metabolizes macronutrients, carbohydrate, fat, and protein. Examples include aminoacidopathies, organic acidemias, fatty acid oxidation disorders, and disorders of carbohydrate metabolism. This would not include mitochondrial... |
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<td>VI.F. Teamwork</td>
<td>See II.C.1 Genetic counselors, nurses, nutritionists, and other health care professionals who are involved in the provision of clinical medical genetics and genomics services must be available to work on a regular basis with residents. (Detail)</td>
<td>Q: What roles must residents have in the interprofessional health care team? A: As a member of the interprofessional health care team, a resident must have a key role in diagnostic work-up, treatment decisions, measurement of treatment outcomes, and the communication and coordination of these activities with program faculty members and referring sources.</td>
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<tr>
<td>VI.G.5.b) Intermediate-level Residents</td>
<td>Residents in the first year of the program (MG-1) are considered to be at the intermediate level.</td>
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<tr>
<td>VI.G.5.c) Residents in the Final Years of Education</td>
<td>Residents in the second (final) year of the program (MG-2) are considered to be in the final years of education.</td>
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<td>VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty</td>
<td>VI.G.5.c).(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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.</td>
<td>Q: What are examples of circumstances when Residents in the Final Years of Education could stay on duty with fewer than eight hours free of duty? A: Circumstances under which MG-2 residents may stay on duty with fewer than eight hours free of duty include: a) providing care for acutely-ill metabolic patients; b) delivering a child with multiple anomalies, such that emergent genetic evaluation is needed; c) providing end-of-life care for a patient assigned to the resident, including providing support to the family; d) a unique opportunity to learn about a rare genetic condition; or, e) an immediate need to obtain appropriate genetic or metabolic samples prior to or immediately after demise.</td>
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<td>VI.G.6. Maximum Frequency of In-House Night Float</td>
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<td>Medical Genetics and Genomics – Medical Biochemical Genetics</td>
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<td>VI.D.1. Licensed Independent Practitioner</td>
<td>Licensed Independent Practitioners who may have primary responsibility for patient care must be physicians.</td>
<td>Q: Are there situations in which fellows can be supervised by Licensed Independent Practitioners? A: Genetic counselors may, on occasion, supervise fellows in unique educational settings within the scope of their licensure. Oversight by a physician faculty member during these situations is required.</td>
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<td>VI.D.5.a).(1) Supervision of Residents</td>
<td>Do not have PGY-1 residents in the subspecialty.</td>
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<tr>
<td>VI.E. Clinical Responsibilities</td>
<td>VI.E.1. The workload for a fellow at any level must be no more than four patients with a confirmed diagnosis of an inborn error of intermediary metabolism in an ICU setting, or six patients with a confirmed diagnosis of an inborn error of intermediary metabolism in a non-ICU setting. (Detail)</td>
<td>Q: How does the Review Committee define “intermediary metabolism” with respect to the duty hour requirements? A: Intermediary metabolism is any enzyme-catalyzed process within cells that metabolizes macronutrients, carbohydrate, fat, and protein. Examples include aminoacidopathies, organic acidemias, fatty acid oxidation disorders, and disorders of carbohydrate metabolism. This would not include mitochondrial disorders or lysosomal storage disorders.</td>
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Duty Hour Definitions
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| VI.F. Teamwork          | See II.C.1 Fellows must have regular opportunities to work with nurses and nutritionists who are involved in the provision of clinical metabolic disease services. | Q: What roles must fellows have in the interprofessional health care team?  
A: As a member of the interprofessional health care team, fellows must have key roles in diagnostic work-up, treatment decisions, measurement of treatment outcomes, and the communication and coordination of these activities with program faculty members and referring sources. |
| VI.G.5.a) Fellows in the Final Years of Education | Medical biochemical genetics fellows are considered to be in the final years of education. | |
| VI.G.5.a).(1) Circumstances for Eight Hours Free of Duty | 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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. | Q: What are examples of circumstances when fellows could stay on duty with fewer than eight hours free of duty?  
A: Circumstances under which fellows may stay on duty with fewer than eight hours free of duty may be:  
a) providing care for acutely-ill metabolic patients  
b) providing end-of-life care for a patient assigned to the fellow, including providing support to the family  
c) a unique opportunity to learn about a rare genetic condition  
d) an immediate need to obtain appropriate genetic or metabolic samples prior to demise |
| VI.G.6. Maximum Frequency of In-House Night Float | Fellows must not be assigned night float duties. (Detail) | |

**Neurological Surgery**

| VI.D.1. Licensed Independent Practitioner | 
|----------------------------------------|---|
| VI.D.5.a).(1) Supervision of Residents | Q: Are there any situations in which residents may be supervised by non-neurosurgical-Licensed Independent Practitioners?  
A: In certain learning environments, such as the neuro-intensive care unit (ICU), a properly credentialed and privileged critical care physician may supervise a resident. In the operating room environment, a properly credentialed and privileged anesthesiologist may supervise certain procedures, such as central line placement, arterial line placement, and endotracheal intubations.  

Q: What must a PGY-1 resident demonstrate in order to progress to being supervised indirectly with direct supervision available?  
A: Programs must document that residents have had structured education in the procedures listed below equivalent to that available through the boot camps offered by the Society of Neurological Surgeons. Program directors must ensure that a resident has demonstrated competence in each listed procedure and patient management competency to the satisfaction of the supervising faculty member before he or she can be supervised indirectly with direct supervision available for that procedure or patient management competency. Approved procedures and patient management competencies that PGY-1 residents can perform under indirect supervision with direct supervision available are:  

Patient Management Competencies  
1. evaluation and management of a patient admitted to hospital, including initial history and physical examination, formulation of a plan of therapy, and necessary orders for therapy and tests |
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<td>2. pre-operative evaluation and management, including history and physical examination, formulation of a plan of therapy, and specification of necessary tests</td>
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<td>3. evaluation and management of post-operative patients, including the conduct of monitoring, specifying necessary tests to be carried out, and preparing orders for medications, fluid therapy, and nutrition therapy</td>
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<td>4. transfer of patients between hospital units or hospitals</td>
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<td>5. discharge of patients from hospital</td>
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<td>6. interpretation of laboratory results</td>
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<td><strong>Procedural Competencies</strong></td>
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<td>1. carry-out basic venous access procedures, including establishing intravenous access</td>
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<td>2. placement and removal of nasogastric tubes and Foley catheters</td>
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<td>3. arterial puncture for blood gases</td>
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<td><strong>During the early months of the PGY-1, residents must be educated in, directly observed, and assessed in the following:</strong></td>
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<td><strong>Patient Management Competencies</strong></td>
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<td>1. initial evaluation and management of patients in the urgent or emergent situation, including urgent consultations, trauma, and emergency department consultations (ATLS required)</td>
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<td>2. evaluation and management of post-operative complications, including hypotension, hypertension, oliguria, anuria, cardiac arrhythmias, hypoxemia, change in respiratory rate, change in neurologic status, and compartment syndromes</td>
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<td>3. evaluation and management of critically-ill patients, either immediately post-operatively or in the ICU, including monitoring, ventilator management, specification of necessary tests, and orders for medications, fluid therapy, and enteral/parenteral nutrition therapy</td>
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<td>4. management of patients in cardiac arrest (ACLS required)</td>
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<td><strong>Procedural Competencies</strong></td>
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<td>1. carry-out advanced vascular access procedures, including central venous catheterization, temporary dialysis access, and arterial cannulation</td>
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<td>2. repair of surgical incisions of the skin and soft tissues</td>
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<td>3. repair of skin and soft tissue lacerations</td>
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<td>4. excision of lesions of the skin and subcutaneous tissues</td>
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<td>5. tube thoracostomy</td>
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<td>6. paracentesis</td>
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<td>7. joint aspiration</td>
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<td>8. advanced airway management</td>
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<td>a. Endotracheal intubation</td>
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<td>b. Tracheostomy</td>
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<tr>
<td>VI.E. Clinical Responsibilities</td>
<td>VI.E.1. Neurological surgery residents must practice across a diversity of care settings with varying degrees of primary patient responsibility. These situations vary from first call cross-coverage on the floors to possible interaction with a primary intensivist, pediatric, or hospitalist service. (Detail) VI.E.2. Peri-operative inpatient care must be further balanced with resident participation in the operating room. Program directors must consider the following when assigning patient loads: (Detail) VI.E.2.a) adequate coverage and provision of patient care; (Detail) VI.E.2.b) sufficient inpatient clinical responsibility to allow resident progression along clinical care milestones; and, (Detail) VI.E.2.c) meaningful insulation of operative experiences from inpatient care to allow technical progress and facilitate resident development of organizational and triage skills. (Detail)</td>
<td>Q: What is an appropriate patient load for residents? A: The program director must make an assessment of the learning environment with input from faculty members and residents. Minimum patient loads should usually be five on the general inpatient unit and four while on clinical neurological surgery services. However, there may be situations in which lower patient loads may be acceptable. Programs will need to justify lower patient loads with evidence such as severity of illness indicators or other factors. Q: What would an appropriate patient load be for a chief resident or a resident or resident in their final year of education? A: The program director must make an assessment of the learning environment with input from faculty members and residents. Residents in the chief year or final year of education generally take on more patient care responsibilities than earlier in residency. Minimum patient loads should usually be ten on the general inpatient unit, and three in the intensive care unit.</td>
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<tr>
<td>VI.F. Teamwork</td>
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<td>Q: Who should be included in the interprofessional teams? A: Advanced practice providers, audiologists, certified registered nurse anesthetists (CRNAs), child-life specialists, nurses, nutritionists, operating room technicians, pharmacists, physical and occupational therapists, physician assistants, psychologists, radiology technicians, respiratory therapists, social workers, and speech and language pathologists are examples of professional personnel who may be part of interprofessional teams. Q: Must every interprofessional team include representation from every professional listed above? A: No. The Review Committee recognizes that the needs of specific patients change with their health statuses and circumstances. The Review Committee’s intent is to ensure that the program has access to these professional and paraprofessional personnel, and that interprofessional teams be constituted as appropriate and as needed, not to mandate that all be included in every case/care environment. Q: What roles must residents have in the interprofessional health care team? A: As members of the interprofessional health care team, residents must have key roles in diagnostic work-up, operative procedures, treatment decisions, measurement of treatment outcomes, and the communication and coordination of these activities with program faculty members and referring sources.</td>
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<td>Specialty/Requirement #</td>
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</table>
| VI.G.5.b) Intermediate-level Residents | PGY-2 residents are considered to be at the intermediate level. | Q: Why are PGY-2 residents defined as Intermediate-level Residents?  
A: All residents enter the program as interns having participated in the Neurological Surgery Boot Camp offered through the Society of Neurological Surgeons. Boot camp provides intense training and assessment of fundamental professionalism, communication, and procedural skills, which are directly observed and evaluated during the early months of the PGY-1. By the time residents enter the PGY-2, they have had considerable experience as members of operative teams and in other teams providing patient care. Because neurological surgery programs are relatively small (one to three residents per PGY level), residents will assume continuously increasing progressive responsibilities. By the PGY-2, these residents are often the most senior residents on certain rotations (i.e., a pediatric service in a children’s hospital), and in such a role will function as a leader of the team with the attendings. Although neurological surgery programs are long, PGY-2 residents are as prepared to assume the responsibilities of an intermediate resident as are PGY-2 residents in shorter programs in primary care specialties, such as internal medicine or pediatrics. The additional years of neurological surgery education are needed to refine operative skills, not to develop advanced skills in the other competency domains. |
| VI.G.5.c) Residents in the Final Years of Education | Residents at the PGY-3 level and beyond are considered to be in the final years of education. | Q: What responsibilities should residents at the PGY-3 level or beyond have in order to prepare them to enter unsupervised practice of medicine?  
A: It is very important that senior and chief neurological surgical residents have semi-continuous responsibility for groups of patients as part of a team led by an attending surgeon. This type of experience is very similar to the conditions of independent practice which residents at this level will enter soon after graduating, and often occurs in the context of ‘home call’, where the requirement for a 10-hour respite does not apply. Whether during at-home call or during scheduled duty periods, it is important that these residents have this kind of experience.  
Q: Why are residents at the PGY-3 level and beyond considered to be in the final years of education?  
A: Neurological surgery programs are designed such that excellent educational experiences occur when residents are given the responsibility to lead a team of more junior residents under the supervision of an attending whose practice is focused in a specific clinical area. Because most neurological surgery programs have relatively few residents, it is desirable that a resident at the PGY-3 level or beyond assume such a leadership role. For example, if a PGY-3 resident is the senior-most resident working on a dedicated spine service and the operative case runs until 10:30 p.m., the resident should be able to return to lead the service hospital rounds at 6:00 a.m. the following morning. The educational value of this type of leadership experience is important for a resident’s maturation as a clinician and surgeon. NOTE: such experiences must occur in the context of the 80-hour limit and the one-day-off in seven requirements. |
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<tr>
<td>VI.G.5.c).(1)</td>
<td>Residents at the PGY-3 level or beyond may stay on duty or return to the hospital with fewer than eight hours free of duty under specific circumstances. (Detail)</td>
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<tr>
<td>VI.G.5.c).(1).(b)</td>
<td>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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.</td>
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<tr>
<td>VI.G.5.c).(1).(c)</td>
<td>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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.</td>
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<td>VI.G.6. Maximum Frequency of In-House Night Float</td>
<td>Night float should be limited to four months per year, and must not exceed six months per year. (Detail)</td>
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<tr>
<td>Neurology</td>
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<td>VI.D.1. Licensed Independent Practitioner</td>
<td>Q: What Licensed Independent Practitioners may contribute to residents’ education? A: Licensed practitioners may include licensed practical nurses and physician assistants. These practitioners should be licensed in the state, and have appropriate credentials at the hospital, in which they are seeing patients.</td>
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<td>VI.D.5.a).(1) Supervision of Residents</td>
<td>VI.D.5.a).(2) The sponsoring institution and participating sites must provide the resources to ensure that residents from other specialties do not supervise neurology residents on any neurology inpatient rotation. (Detail) VI.D.5.a).(3) The sponsoring institution and participating sites must ensure that second- or third-year neurology residents or other appropriate supervisory physicians (e.g., subspecialty residents or attendings) with documented experience appropriate to the acuity, complexity, and severity of patient illness be available at all times on-site to supervise first-year residents on inpatient rotations. (Detail)</td>
<td>Q: What is an optimal clinical workload? A: The program director must make an assessment of the learning environment, including patient safety, complexity of patient illness/condition, available support services, and level of knowledge, skills and abilities when determining the appropriate clinical workload for each resident.</td>
</tr>
<tr>
<td>VI.E. Clinical Responsibilities</td>
<td>VI.E.1. The program director must have the authority and responsibility to set appropriate Clinical Responsibilities (i.e., patient caps) for each resident. (Detail)</td>
<td>Q: What is an optimal clinical workload? A: The program director must make an assessment of the learning environment, including patient safety, complexity of patient illness/condition, available support services, and level of knowledge, skills and abilities when determining the appropriate clinical workload for each resident.</td>
</tr>
<tr>
<td>VI.F. Teamwork</td>
<td>Q: Who should be included in the interprofessional teams? A: Nurses, pharmacists, physician assistants, social workers, and occupational, physical, and speech therapists, are examples of professional personnel who may be part of interprofessional teams on which residents must work as members. Q: Must every interprofessional team include representation from every profession listed in II.B.2.c)? A: No. The Review Committee recognizes that the needs of specific patients change with their health statuses and circumstances. The Review Committee’s intent is to ensure that the program has access to these professional and paraprofessional personnel, and that interprofessional teams be constituted as appropriate and as needed, not to mandate that all be included in every case.</td>
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<tr>
<td>VI.G.5.b) Intermediate-level Residents</td>
<td>PGY-2 residents are considered to be at the intermediate level.</td>
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<tr>
<td>VI.G.5.c) Residents in the Final Years of Education</td>
<td>PGY-3 and PGY-4 residents are considered to be in the final years of education.</td>
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<tr>
<td>VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty</td>
<td>VI.G.5.c).(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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.</td>
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<td>VI.G.6. Maximum Frequency of In-House Night Float</td>
<td>VI.G.6.a) Residents should not have more than two consecutive weeks of night float or half of a calendar month (maximum 16 days). (Detail)</td>
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### Neurology – Child

| VI.D.1. Licensed Independent Practitioner | Q: What Licensed Independent Practitioners may contribute to residents’ education?  
A: Licensed practitioners may include nurse practitioners, who should be licensed in the state, and have appropriate credentials at the hospital, in which they are seeing patients. |
| VI.D.5.a).(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. |
| VI.E. Clinical Responsibilities | Q: What does the Review Committee consider an optimal clinical workload?  
A: The program director must make an assessment of the learning environment, including patient safety, complexity of patient illness/condition, available support services, and level of knowledge, skills, and abilities when determining the clinical workload for each resident. |
| VI.F. Teamwork | Q: Who should be included in the interprofessional teams?  
A: Nurses, pharmacists, physician assistants, social workers, and occupational, physical, and speech therapists, are examples of professional personnel who may be part of interprofessional teams on which residents must work as members.  
Q: Must every interprofessional team include representation from every profession listed in the requirements?  
A: No. The Review Committee recognizes that the needs of specific patients change with their health statuses and circumstances. The Review Committee’s intent is to ensure that the program has access to these professional and paraprofessional personnel, and that interprofessional teams be constituted as appropriate and as needed, not to mandate that all be included in every case. |
<p>| VI.G.5.b) Intermediate-level Residents | R1 fellows are considered to be at the intermediate level. |
| VI.G.5.c) Residents in the Final Years of Education | R2 and R3 fellows are considered to be in the final years of education. |
| VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty | VI.G.5.c).(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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. |
| VI.G.6. Maximum Frequency of In-House Night Float | VI.G.6.a) Residents should not have more than two consecutive weeks of night float, and no more than six weeks of night float per year. |</p>
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<td>VI.D.1. Licensed Independent Practitioner</td>
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<tr>
<td>VI.D.5.a).(1) Supervision of Residents</td>
<td>Do not have PGY-1 residents in the subspecialty.</td>
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</table>
| VI.E. Clinical Responsibilities | | Q: What does the Review Committee consider an optimal clinical workload?  
A: The program director must make an assessment of the learning environment, including patient safety, complexity of patient illness/condition, available support services, and level of knowledge, skills, and abilities when determining the clinical workload for each resident. |
| VI.F. Teamwork | | Q: Who should be included in the interprofessional teams?  
A: Nurses, pharmacists, physician assistants, social workers, and occupational, physical, and speech therapists, are examples of professional personnel who may be part of interprofessional teams on which residents must work as members.  
Q: Must every interprofessional team include representation from every profession listed in the requirements?  
A: No. The Review Committee recognizes that the needs of specific patients change with their health statuses and circumstances. The Review Committee’s intent is to ensure that the program has access to these professional and paraprofessional personnel, and that interprofessional teams be constituted as appropriate and as needed, not to mandate that all be included in every case. |
<p>| VI.G.5.a) Fellows in the Final Years of Education | Clinical neurophysiology fellows are considered to be in the final years of education. | |
| VI.G.5.a).(1) Circumstances for Eight Hours Free of Duty | 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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. | |
| VI.G.6. Maximum Frequency of In-House Night Float | | |
| <strong>Neurology – Epilepsy</strong> | | |
| VI.D.1. Licensed Independent Practitioner | | |
| VI.D.5.a).(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. | |
| VI.E. Clinical Responsibilities | | |</p>
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<td>VI.F. Teamwork</td>
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<tr>
<td>VI.G.5.a) Fellows in the Final Years of Education</td>
<td>Epilepsy fellows are considered to be in the final years of education.</td>
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<tr>
<td>VI.G.5.a).(1) Circumstances for Eight Hours Free of Duty</td>
<td>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.</td>
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<td>VI.G.6. Maximum Frequency of In-House Night Float</td>
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<td>Neurology – Neurodevelopment Disabilities</td>
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| VI.D.1. Licensed Independent Practitioner | Q: What Licensed Independent Practitioners may contribute to residents’ education?  
A: Licensed practitioners may include nurse practitioners, who should be licensed in the state, and have appropriate credentials at the hospital, in which they are seeing patients. | |
| VI.D.5.a).(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. | |
| VI.E. Clinical Responsibilities | Q: What does the Review Committee consider an optimal clinical workload?  
A: The program director must make an assessment of the learning environment, including patient safety, complexity of patient illness/condition, available support services, and level of knowledge, skills, and abilities when determining the clinical workload for each resident. | |
| VI.F. Teamwork | Q: Who should be included in the interprofessional teams?  
A: Nurses, pharmacists, physician assistants, social workers, and occupational, physical, and speech therapists, are examples of professional personnel who may be part of interprofessional teams on which residents must work as members.  
Q: Must every interprofessional team include representation from every profession listed in the requirements?  
A: No. The Review Committee recognizes that the needs of specific patients change with their health statuses and circumstances. The Review Committee’s intent is to ensure that the program has access to these professional and paraprofessional personnel, and that interprofessional teams be constituted as appropriate and as needed, not to mandate that all be included in every case. | |
<p>| VI.G.5.b) Intermediate-level Residents | R1 and R2 fellows are considered to be at the intermediate level. | |
| VI.G.5.c) Residents in the Final Years of Education | R3 and R4 fellows are considered to be in the final years of education. | |</p>
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<td>VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty</td>
<td>VI.G.5.c).(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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.</td>
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<tr>
<td>VI.G.5.a) Fellows in the Final Years of Education</td>
<td>Vascular neurology fellows are considered to be in the final years of education.</td>
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<tr>
<td>VI.G.5.a).(1) Circumstances for Eight Hours Free of Duty</td>
<td>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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.</td>
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**Neurology – Vascular**

| VI.D.1. Licensed Independent Practitioner | Do not have PGY-1 residents in the subspecialty. | Q: What Licensed Independent Practitioners may contribute to residents’ education? A: Licensed practitioners may include nurse practitioners, who should be licensed in the state, and have appropriate credentials at the hospital, in which they are seeing patients. |
| VI.D.5.a). (1) Supervision of Residents | The program director must have the authority and responsibility to set appropriate Clinical Responsibilities (i.e., patient caps) for each resident. (Core) | Q: What does the Review Committee consider an optimal clinical workload? A: The program director must make an assessment of the learning environment, including patient safety, complexity of patient illness/condition, available support services, and level of knowledge, skills, and abilities when determining the clinical workload for each resident. |
| VI.E. Clinical Responsibilities | Q: Who should be included in the interprofessional teams? A: Nurses, pharmacists, physician assistants, social workers, and occupational, physical, and speech therapists, are examples of professional personnel who may be part of interprofessional teams on which residents must work as members. Q: Must every interprofessional team include representation from every profession listed in the requirements? A: No. The Review Committee recognizes that the needs of specific patients change with their health statuses and circumstances. The Review Committee’s intent is to ensure that the program has access to these professional and paraprofessional personnel, and that interprofessional teams be constituted as appropriate and as needed, not to mandate that all be included in every case. |
| VI.F. Teamwork | | |

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<td>VI.G.6. Maximum Frequency of In-House Night Float</td>
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<tr>
<td>VI.D.1. Licensed Independent Practitioner</td>
<td>Only licensed physicians who are credentialed to perform nuclear medicine procedures may have primary responsibility for the nuclear medicine aspects of patient care. (Detail)</td>
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<tr>
<td>VI.D.5.a).(1) Supervision of Residents</td>
<td>Do not have PGY-1 residents in the specialty.</td>
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<tr>
<td>VI.E. Clinical Responsibilities</td>
<td>VI.E.1. Optimal clinical workload must maximize the resident learning experience without compromising patient care. (Detail)</td>
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<td>VI.E.2. The number and distribution of cases should vary with the responsibility appropriate to an individual resident's demonstrated competence over the course of his or her education. (Detail)</td>
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<td>VI.E.3. Program directors must determine minimum and maximum patient loads by including faculty member and resident input into an assessment of the learning environment. (Detail)</td>
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<td>VI.E.4. Insufficient patient experiences and excessive patient loads must not jeopardize the quality of resident education. (Detail)</td>
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<tr>
<td>VI.F. Teamwork</td>
<td>VI.F.1. The nuclear medicine patient care team should include ancillary personnel, attending nuclear physicians, nuclear medicine residents, nuclear medicine technologists, and radiation safety personnel. The team also may include medical physicists, other imaging specialists, and radiopharmacists, and individuals from referring services. (Detail)</td>
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<tr>
<td>VI.G.5.b) Intermediate-level Residents</td>
<td>NM-1 and NM-2 residents are considered to be at the intermediate level.</td>
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<tr>
<td>VI.G.5.c) Residents in the Final Years of Education</td>
<td>NM-3 level residents are considered to be in the final years of education.</td>
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<td>VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty</td>
<td>VI.G.5.c).(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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.</td>
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<td>Obstetrics and Gynecology</td>
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| VI.D.1. Licensed Independent Practitioner | See II.B.4.a) Any health professional with appropriate certification, e.g., Certified Nurse Midwife, Nurse Practitioner, Physician Assistant, can be listed as faculty. (Core) | Q: Can PGY1 and PGY2 residents be supervised by any licensed allied health professionals?  
A: PGY1 and PGY2 residents and all residents rotating from programs in other disciplines (e.g., family medicine residents) may be supervised by licensed allied health professionals listed as faculty provided that: the clinical care is within their scope of practice expertise; the level of clinical care is low risk; physician faculty members are available by telephone; and, the program director has approved the supervision with respect to the educational experience. Additionally, PGY3 and PGY4 residents must be supervised by physician faculty members, and allied health professionals cannot substitute for physician faculty members to meet the 24-hour requirement for on-site supervision of resident care. |
<p>| VI.D.5.a).(1) Supervision of Residents | | |
| VI.E. Clinical Responsibilities | | |
| VI.F. Teamwork | | |
| VI.G.5.b) Intermediate-level Residents | PGY-2 residents are considered to be at the intermediate level. | |
| VI.G.5.c) Residents in the Final Years of Education | PGY-3 and PGY-4 residents are considered to be in the final years of education. | |
| VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty | VI.G.5.c).(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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. | |
| VI.G.6. Maximum Frequency of In-House Night Float | | |
| Obstetrics and Gynecology – Gynecologic Oncology | | |
| VI.D.1. Licensed Independent Practitioner | | |
| VI.D.5.a).(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. | |
| VI.E. Clinical Responsibilities | | |
| VI.F. Teamwork | | |
| VI.G.5.b) Intermediate-level Residents | | |
| VI.G.5.c) Residents in the Final Years of Education | Gynecologic oncology fellows are considered to be in the final years of education. | |</p>
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<td>VI.G.6. Maximum Frequency of In-House Night Float</td>
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**Obstetrics and Gynecology – Maternal-Fetal Medicine**

| VI.D.1. Licensed Independent Practitioner | | |
| VI.D.5.a).(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. | |
| VI.E. Clinical Responsibilities | | |
| VI.F. Teamwork | | |
| VI.G.5.b) Intermediate-level Residents | | |
| VI.G.5.c) Residents in the Final Years of Education | Maternal-fetal medicine fellows are considered to be in the final years of education. | |
| VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty | VI.G.5.c).(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 | | |

**Obstetrics and Gynecology – Reproductive Endocrinology and Infertility**

<p>| VI.D.1. Licensed Independent Practitioner | | |
| VI.D.5.a).(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. | |</p>
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<th>Frequently Asked Questions (FAQs)</th>
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</table>
| VI.E. Clinical Responsibilities | VI.E.1. Fellows should not be relied upon to provide a clinical service that exceeds the educational value of the activity, such as follicular monitoring. *(Detail)* | Q: Do the Common Program Requirements for PGY-1 and intermediate-level residents apply to reproductive endocrinology and infertility fellows?  
A: No. The Common Program Requirements (identified in bold font within the subspecialty-specific Program Requirements) are requirements that must be in place in all specialties and subspecialties. Common language may not be changed; however, Review Committees may add more specific requirements, as appropriate. Thus, the Review Committee has included requirement VI.G.5.c) that specifies, "Maternal-fetal medicine fellows are considered to be in the final years of education." |
| VI.F. Teamwork | | |
| VI.G.5.b) Intermediate-level Residents | | |
| VI.G.5.c) Residents in the Final Years of Education | Reproductive endocrinology and infertility fellows are considered to be in the final years of education. | |
| VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty | VI.G.5.c).(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 | | |
| Ophthalmology | | |
| VI.D.1. Licensed Independent Practitioner | | Q: Can an optometrist, orthoptist or ophthalmic technician supervise residents?  
A: Although the Review Committee believes that it is important for residents to acquire experience in leading and participating in health care teams, including those with non-MDs (e.g., optometrists, orthoptists, or ophthalmic technicians), overall supervision of all clinical care rendered by residents and fellows is the responsibility of physician faculty members and the attending physician of record. Non-physicians are not permitted to independently supervise residents. While the attending physician may delegate an appropriately-qualified non-physician to assist a resident in a specific aspect of an eye exam, the ultimate responsibility for resident supervision remains the responsibility of the attending physician. |
<p>| VI.D.5.a).(1) Supervision of Residents | Do not have PGY-1 residents in the specialty. | |</p>
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| VI.E. Clinical Responsibilities | VI.E.1. The program director must establish guidelines for the assignment of residents’ Clinical Responsibilities by PGY-level, including clinic volume, on-call frequency, and backup requirements, as well as appropriate role in surgical procedures. (Core)  
VI.E.2. The guidelines should include key clinical and surgical procedures appropriate for each PGY-level, along with the level of supervision required. (Core)  
VI.E.3. Residents must be provided instruction in recognizing situations in which they are overly fatigued or overburdened with duties, communicating the need for assistance when these situations occur, and recognizing the variation in workload necessary with varying experience and competency of fellow residents. (Core) |  |
| VI.F. Teamwork | VI.F.1. Programs must provide a team-oriented learning environment for patient care which incorporates both outpatient and inpatient exposure. The team may include faculty members and residents in ophthalmology, referring and consulting physicians, laboratory and administrative staff, medical students, nurses, optometrists, orthoptists, pharmacists, and technicians, among others. (Detail)  
VI.F.1.a) Education in effective communication among team members must be provided. (Detail) |  |
<p>| VI.G.5.b) Intermediate-level Residents | PGY-2 and PGY-3 residents are considered to be at the intermediate level. (Detail) |  |
| VI.G.5.c) Residents in the Final Years of Education | PGY-4 residents are considered to be in the final years of education. |  |
| VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty | VI.G.5.c).(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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. |  |
| VI.G.6. Maximum Frequency of In-House Night Float | |  |</p>
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<td>Q: Can an optometrist, orthoptist, or ophthalmic technician supervise residents? A: Although the Review Committee believes that it is important for residents to acquire experience in leading and participating in health care teams, including those with non-MDs (e.g.: optometrists, orthoptists, or ophthalmic technicians), overall supervision of all clinical care rendered by residents and fellows is the responsibility of physician faculty members and the attending physician of record. Non-physicians are not permitted to independently supervise residents. While the attending physician may delegate an appropriately-qualified non-physician to assist a resident in a specific aspect of an eye exam, the ultimate responsibility for supervision remains the responsibility of the attending physician.</td>
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<td>VI.D.5.a).(1) Supervision of Residents</td>
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<td>Q: What does the Review Committee consider an optimal clinical workload? A: An optimal work load affords each resident the maximal level of experience in medical and surgical care of patients while allowing an balance between service and education that does not overwhelm him or her. The program director must determine the optimal workload for each resident with the intent of ensuring that he or she becomes competent to practice independently by the time of graduation from the program.</td>
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<td>VI.E. Clinical Responsibilities</td>
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<td>VI.F. Teamwork</td>
<td>VI.F.1. Programs must provide a team-oriented learning environment for patient care which incorporates both outpatient and inpatient exposure. The team may include faculty members and residents in ophthalmology, referring physicians, consultant physicians in dermatology, neurological surgery, otolaryngology, pathology, and plastic surgery, laboratory and administrative staff, medical students, nurses, and technicians, among others. (Core) VI.F.1.a) Education in effective communication among team members must be provided. (Detail)</td>
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<td>VI.G.5.b) Intermediate-level Residents</td>
<td>Ophthalmic plastic and reconstructive surgery fellows are considered to be in the final years of education.</td>
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<td>VI.G.5.c) Residents in the Final Years of Education</td>
<td>Ophthalmic plastic and reconstructive surgery fellows are considered to be in the final years of education.</td>
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<td>VI.D.1. Licensed</td>
<td>A Licensed Independent Practitioner may include non-physician faculty working in conjunction with the orthopaedic surgery department. (Detail)</td>
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<td>Independent Practitioner</td>
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<td>VI.D.5.a).(1) Supervision</td>
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<td>Q: Who may provide direct supervision to PGY-1 residents? A: Each program is responsible for having clear policies for supervision. Direct supervision requires the supervising individual to be physically present. Supervising individuals must have been credentialed by the program to do a particular procedure or to manage a particular clinical scenario, and may be more senior residents (PGY-2 residents and above who have met the competency requirements for the particular task at-hand), fellows, and attending orthopaedic surgeons. Appropriately credentialed and privileged non-orthopaedic attending physicians, as well as licensed independent practitioners (this may include non-physician faculty members working in conjunction with the orthopaedic surgery department) with whom the program has a clearly defined relationship outlined in the supervision policy, may directly supervise PGY-1 residents. The clinical care supervised by a non-physician must be within the scope of practice of that non-physician professional.</td>
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<td>of Residents</td>
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<td>Q: What is indirect supervision “with direct supervision immediately available”? A: A supervising physician or licensed independent practitioner not physically present may provide indirect supervision by phone or properly encrypted or de-identified electronic communication. When needed (as outlined by the program’s supervision policy) or requested by the resident, the supervising individual must be physically present. Direct supervision should be available within 15 minutes.</td>
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<td>Q: For which tasks may PGY-1 residents be supervised indirectly, and for which tasks should PGY-1 residents have direct supervision until competence is demonstrated? A: Indirect supervision is allowed for: 1. Examples of patient management competencies for which indirect supervision is allowed: a) evaluation and management patients admitted to the hospital, including initial history and physical examination, and formulation and implementation of indicated diagnostic tests and a treatment plan b) pre-operative evaluation and management, including history and physical examination, and formulation and implementation of indicated diagnostic tests and a treatment plan c) evaluation and management of post-operative patients, including monitoring patients and ordering medications, tests, and other indicated treatments d) transfer of patients between hospital units or hospitals e) discharge of patients from the hospital f) interpretation of laboratory results g) interpretation of radiographs</td>
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<td>h) consultation of appropriate inpatient services</td>
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<td>2. Examples of procedural competencies for which indirect supervision is allowed:</td>
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<td>a) performance of basic venous access procedures, including establishing intravenous access</td>
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<td>b) placement and removal of nasogastric tubes and Foley catheters</td>
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<td>c) arterial puncture for blood gases</td>
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<td>d) removal of surgical drains</td>
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<td>e) application of dressings and prefabricated splints</td>
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<td>f) placement of splints for non-displaced fractures</td>
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<td>g) removal of non-absorbable sutures or skin staples</td>
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<td>3. Examples of patient management competencies for which direct supervision is required until competency is demonstrated:</td>
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<td>a) initial evaluation and management of patients in urgent or emergent situations, including: urgent consultations, trauma, and emergency department consultations; and evaluation and management of post-operative complications, including anuria, cardiac arrhythmias, change in neurologic status, change in respiratory rate, compartment syndromes, hypertension, hypotension, hypoxemia, and oliguria</td>
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<td>b) evaluation and management of critically-ill patients, either immediately post-operatively or in the intensive care unit, including the conduct of monitoring, and orders for medications, testing, and other treatments</td>
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<td>c) management of patients in cardiac or respiratory arrest</td>
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<td>d) management of patients with major fractures that are displaced</td>
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<td>e) evaluation and management of patients with infections of the spine, pelvis, or extremities</td>
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<td>4. Examples of procedural competencies for which direct supervision is required until competency is demonstrated:</td>
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<td>a) repair of surgical incisions of the skin and soft tissues</td>
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<td>b) repair of lacerations of the skin and soft tissues</td>
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<td>c) excision of lesions of the skin and subcutaneous tissues</td>
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<td>d) repair of nail bed lacerations or distal digit amputation injuries that do not require management in an operating room setting</td>
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<td>e) incision and drainage of paronychiae, felon, or other abscesses of the hand and forearm that do not require management in an operating room setting</td>
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<td>f) endotracheal intubation</td>
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<td>g) bedside wound debridement</td>
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<td>h) insertion of skeletal traction pins</td>
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<td>i) arthrocentesis</td>
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<td>j) closed reduction of fractures and dislocations</td>
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<td>k) placement of casts</td>
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<td>l) placement of splints for displaced fractures</td>
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| VI.E. Clinical Responsibilities | m) administration of local anesthetic  
|  | n) measurement of compartment pressure | Q: How does the Review Committee determine program compliance with respect to optimal clinical workload?  
A: The program should incorporate graded clinical responsibility for residents. The expectation is that the program will assign cases and procedures that are appropriate to a resident's PGY level and current level of credentialing. The Milestones clearly define the expectation of competence for level of education. |
| VI.F. Teamwork | Q: Who should be included in the interprofessional teams?  
A: Examples of professional personnel who may be part of interprofessional teams include physicians from other specialties, such as infectious disease, neurological surgery, and physical medicine and rehabilitation, as well as advanced practice nurses, certified registered nurse anesthetists (CRNAs), child-life specialists, discharge planners, nurses, nutritionists, operating room technicians, pharmacists, physical and occupational therapists, physician assistants, psychologists, radiology technicians, cast technicians, orthotists, respiratory therapists, and social workers.  
Q: Must every interprofessional team include representation from every professional listed above?  
A: No. The Review Committee recognizes that the needs of specific patients change with their health statuses and circumstances. The Review Committee's intent is to ensure that the program has access to these professional and paraprofessional personnel, and that interprofessional teams be constituted as appropriate and as needed, not to mandate that all be included in every case/care environment.  
Q: What roles must residents have in the interprofessional health care team?  
A: As members of the interprofessional health care team, residents must have key roles in diagnostic work-up, operative procedures, treatment decisions, measurement of treatment outcomes, and the communication and coordination of these activities with program faculty members and referring sources. |
| VI.G.5.b) Intermediate-level Residents | PGY-2 and PGY-3 residents are considered to be at the intermediate level. |
| VI.G.5.c) Residents in the Final Years of Education | PGY-4 and PGY-5 residents are considered to be in the final years of education. |
| VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty | VI.G.5.c).(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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. |
| VI.G.6. Maximum Frequency of In-House Night Float | Night float may not exceed three months per year.  
(Detail) |
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| VI.F. Teamwork | | Q: What skills should members of the interprofessional caregiver team have?  
A: All members of the interprofessional caregiver team should be provided instruction in:  
1. communication, so that if all required tasks cannot be accomplished in a timely fashion, appropriate methods are established to hand off the remaining task(s) to another team member at the end of a duty period;  
2. compliance with work hours limits imposed at the various levels of education;  
3. prioritization of tasks as the dynamics of a patient's needs change;  
4. recognition of and sensitivity to the experience and competency of other team members;  
5. recognizing when an individual becomes overburdened with duties that cannot be accomplished within an allotted time period;  
6. signs and symptoms of fatigue not only in oneself, but in other team members;  
7. team development; and,  
8. time management; |
| VI.G.5.a) Fellows in the Final Years of Education | Fellows in the subspecialties of orthopaedic surgery are considered to be in the final years of education. | |
| VI.G.5.a)(1) Circumstances for Eight Hours Free of Duty | 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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. | |
| VI.G.6. Maximum Frequency of In-House Night Float | Night float may not exceed three months per year. | |
| **Osteopathic Neuromusculoskeletal Medicine** | | |
| VI.D.1. Licensed Independent Practitioner | | |
| VI.D.5.a)(1) Supervision of Residents | Do not have PGY-1 residents in the specialty. | |
| VI.E. Clinical Responsibilities | | |
| VI.F. Teamwork | | |

Duty Hour Definitions  
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**Otalaryngology**

| VI.D.1. Licensed Independent Practitioner | | |
| VI.D.5.a). (2) Each program must define those physician tasks for which PGY-1 residents may be supervised indirectly with direct supervision available, and must define “direct supervision” in the context of the individual program, (Core) | | |
| VI.D.5.a). (3) Each program must define those physician tasks for which PGY-1 residents must be supervised directly until they have demonstrated competence as defined by the program director, and must maintain records of such demonstrations of competence (Core) | | |

Q: Who may supervise residents in the clinical environment?  
A: Appropriately-credentialed and privileged attending physicians in the surgical clinical environment may include appropriately-credentialed American Board of Medical Specialties (ABMS)-certified surgeons from other surgical specialties (e.g., general surgery, pediatric surgery, plastic surgery, etc.). In the critical care clinical environment, procedures must be supervised by appropriately-credentialed ABMS-certified critical care physicians (e.g., anesthesiologists, critical internists, critical care pedidtricians, etc.). While other care providers are expected to be part of interprofessional teams that provide patient care, only appropriately-credentialed and privileged attending physicians may supervise residents.  

Q: What are examples of defined tasks for which PGY-1 residents may be supervised indirectly and examples of defined tasks that PGY-1 residents should have direct supervision until competency is demonstrated?  
A: Indirect supervision is allowed for:
1) Patient Management Competencies  
   a) evaluation and management of a patient admitted to the hospital, including initial history and physical examination, formulation of a plan of therapy, and necessary orders for therapy and tests  
   b) pre-operative evaluation and management, including history and physical examination, formulation of a plan of therapy, and specification of necessary tests  
   c) evaluation and management of postoperative patients, including the conduct of monitoring, specifying necessary tests to be carried out, and preparing orders for medications, fluid therapy, and nutrition therapy  
   d) transfer of patients between hospital units or hospitals  
   e) discharge of patients from the hospital  
   f) interpretation of laboratory results  
2) Procedural Competencies  
   a) carry-out of basic venous access procedures, including establishing intravenous access placement and removal of nasogastric tubes and...
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|                        | Foley catheters arterial puncture for blood gases | Direct supervision is required until competency is demonstrated for:  
1) Patient Management Competencies  
   a) initial evaluation and management of patients in the urgent or emergent situation, including urgent consultations, trauma, and emergency department consultations (ATLS required)  
   b) evaluation and management of post-operative complications, including hypotension, hypertension, oliguria, anuria, cardiac arrhythmias, hypoxemia, change in respiratory rate, change in neurologic status, and compartment syndromes  
   c) evaluation and management of critically-ill patients, either immediately post-operatively or in the intensive care unit, including monitoring, ventilator management, specification of necessary tests, and orders for medications, fluid therapy, and enteral/parenteral nutrition therapy  
   d) management of patients in cardiac arrest (ACLS required)  
2) Procedural Competencies  
   a) carry-out of advanced vascular access procedures, including central venous catheterization, temporary dialysis access, and arterial cannulation  
   b) repair of surgical incisions of the skin and soft tissues  
   c) repair of skin and soft tissue lacerations  
   d) excision of lesions of the skin and subcutaneous tissues  
   e) tube thoracostomy  
   f) paracentesis  
   g) joint aspiration  
   h) advanced airway management  
      i) endotracheal intubation  
      ii) tracheostomy |
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| VI.E. Clinical Responsibilities | VI.E.1. The workload associated with optimal clinical care of surgical patients is a continuum from the moment of admission to the point of discharge. (Detail)  
VI.E.2. During the residency education process, surgical teams should be made up of attending surgeons, residents at various PGY levels, medical students (when appropriate), and other health care providers. (Detail)  
VI.E.3. The work of the caregiver team should be assigned to team members based on each resident’s level of education, experience, and competence. (Detail) | Q: What skills should members of the caregiver team have and how should these be ensured across the team?  
A: All members of the caregiver team should be provided instruction in:  
1. recognition of and sensitivity to the experience and competency of other team members;  
2. time management;  
3. prioritization of tasks as the dynamics of a patient’s needs change;  
4. recognizing when an individual becomes overburdened with duties that cannot be accomplished within an allotted time period;  
5. communication, so that if all required tasks cannot be accomplished in a timely fashion, appropriate methods are established to hand off the remaining task(s) to another team member at the end of a duty period;  
6. signs and symptoms of fatigue not only in oneself, but in other team members;  
7. compliance with work hours limits imposed at the various levels of education; and,  
8. team development. |
| VI.F. Teamwork | VI.F.1. Effective surgical practices entail the involvement of members with a mix of complementary skills and attributes (physicians, nurses, and other staff members). Success requires both an unwavering mutual respect for those skills and contributions, and a shared commitment to the process of patient care. (Detail)  
VI.F.2. Residents must collaborate with fellow surgical residents, and especially with faculty members, other physicians outside of their specialty, and non-traditional health care providers, to best formulate treatment plans for an increasingly diverse patient population. (Detail)  
VI.F.3. Residents 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 in the hours assigned, or, if that is not possible, residents must learn and utilize the established methods for handing off remaining tasks to another member of the resident team so that patient care is not compromised. (Detail)  
VI.F.4. Lines of authority should be defined by programs, and all residents must have a working knowledge of these expected reporting relationships to maximize quality care and patient safety. (Detail) | |
<p>| VI.G.5.b) Intermediate-level Residents | PGY-2 and PGY-3 residents are considered to be at the intermediate level. |
| VI.G.5.c) Residents in the Final Years of Education | PGY-4 and PGY-5 residents are considered to be in the final years of education. |</p>
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<td>VI.G.6. Maximum</td>
<td>Night float rotations cannot exceed two consecutive months in duration, and residents can have no more than three months of night float assignments per year. (Core)</td>
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<td>Frequency of In-House</td>
<td>VI.G.6.b) There must be at least two months between each night float rotation. (Core)</td>
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**Otolaryngology – Neurotology**

| VI.D.1. Licensed       | Who may supervise fellows in the clinical environment? |
| Independent Practitioner | A: Appropriately-credentialed and privileged attending physicians in the surgical clinical environment may include appropriately-credentialed American Board of Medical Specialties (ABMS)-certified surgeons from other surgical specialties (e.g., general surgery, pediatric surgery, plastic surgery, etc.). In the critical care clinical environment, procedures must be supervised by appropriately-credentialed ABMS-certified critical care physicians (e.g., anesthesiologists, critical internists, critical care pediatricians, etc.). While other care providers are expected to be part of interprofessional teams that provide patient care, only appropriately credentialed and privileged attending physicians can supervise fellows. |

**VI.D.5.a).(1) Supervision of Residents**

| Do not have PGY-1 residents in the subspecialty. |

**VI.E. Clinical Responsibilities**

| The workload associated with optimal clinical care of surgical patients is a continuum from the moment of admission to the point of discharge. (Detail) |
| 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. (Detail) |
| The work of the caregiver team should be assigned to team members based on each fellow’s level of education, experience, and competence. (Detail) |

**Q:** What skills should members of the caregiver team have and how should these be ensured across the team? **A:** All members of the caregiver team should be provided instruction in:
1. recognition of and sensitivity to the experience and competency of other team members;
2. time management;
3. prioritization of tasks as the dynamics of a patient’s needs change;
4. recognizing when an individual becomes overburdened with duties that cannot be accomplished within an allotted time period;
5. communication, so that if all required tasks cannot be accomplished in a timely fashion, appropriate methods are established to hand off the remaining task(s) to another team member at the end of a duty period;
6. signs and symptoms of fatigue not only in oneself, but in other team members;
7. compliance with work hours limits imposed at the various levels of education; and,
8. team development.
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<td>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.</td>
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<td>VI.F.2. Members of the interprofessional team should include audiologists, speech language pathologists, electrophysiologists, head and neck surgeons, neurologists, neuroradiologists, neurological surgeons, neuropathologists, and neurotologists, as necessary to meet the needs of each patient.</td>
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<td>VI.F.3. Fellows must collaborate with fellow surgical residents, and especially with faculty, other physicians outside of their specialty, and non-traditional health care providers to best formulate treatment plans for an increasingly diverse patient population.</td>
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<td>VI.F.4. 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.</td>
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| VI.D.1. Licensed Independent Practitioner | | Q: Who may supervise fellows in the clinical environment?  
A: Appropriately-credentialed and privileged attending physicians in the surgical clinical environment may include appropriately-credentialed American Board of Medical Specialties (ABMS)-certified surgeons from other surgical specialties (e.g., general surgery, pediatric surgery, plastic surgery, etc.). In the critical care clinical environment, procedures must be supervised by appropriately-credentialed ABMS-certified critical care physicians (e.g., anesthesiologists, critical internists, critical care pediatricians, etc.). While other care providers are expected to be part of interprofessional teams that provide patient care, only appropriately credentialed and privileged attending physicians can supervise fellows. |
| VI.D.5.a).(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. | |
| VI.E. Clinical Responsibilities | VI.E.1. The workload associated with optimal clinical care of surgical patients is a continuum from the moment of admission to the point of discharge. *(Detail)*  
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. *(Detail)*  
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A: All members of the caregiver team should be provided instruction in:  
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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. (Detail) | |
| VI.G.5.a) Fellows in the Final Years of Education | Pediatric otolaryngology fellows are considered to be in the final years of education. | |
| VI.G.5.a).(1) Circumstances for Eight Hours Free of Duty | 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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. (Detail) | |
| Pathology               |                                        | Q: Can pathology assistants supervise residents?  
A: Although pathology assistants are not Licensed Independent Practitioners, they may be authorized by a department to provide supervision or oversight of dissection of surgical specimens and autopsies. The ultimate responsibility for a patient’s care, however, lies with the attending physician, and cannot belong to a pathology assistant. | |
| VI.D.1. Licensed Independent Practitioner |                                        | |
### Specialty/Requirement # | Specialty-specific Duty Hour Definitions | Frequently Asked Questions (FAQs)
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VI.D.5.a).(1) Supervision of Residents | VI.D.5.a).(2) Each PGY-1 resident must be directly supervised during performance of, at least, his or her three initial procedures in the following areas, if offered by the program: (Core)
- VI.D.5.a).(2).a) apheresis; (Detail)
- VI.D.5.a).(2).b) autopsies (complete or limited); (Detail)
- VI.D.5.a).(2).c) bone marrow biopsies and aspirates; (Detail)
- VI.D.5.a).(2).d) fine needle aspirations and interpretation of the aspirate, or; (Detail)
- VI.D.5.a).(2).e) frozen sections; and, (Detail)
- VI.D.5.a).(2).f) gross dissection of surgical pathology specimens by organ system. (Detail)
- VI.D.5.a).(3) Only a resident who has completed at least 12 months of anatomic pathology education, a pathology assistant, or an attending pathologist may directly supervise the gross dissection of surgical pathology specimens and/or autopsies. (Detail)
- VI.D.5.a).(4) Only a blood banking/transfusion medicine fellow, a clinical hematology-oncology fellow, a clinical nephrology fellow, a resident who has completed at least 12 months of clinical pathology education, including core training in apheresis, or an attending physician credentialed for apheresis may directly supervise apheresis. (Detail) | Q: At what point may the PGY-1 resident be indirectly supervised?  
A: In order for the PGY-1 resident to be indirectly supervised, they must have performed the requisite three procedures in the categories specified in the requirements. [VI.D.5.a.(1) - autopsies (complete or limited), gross dissection of surgical pathology specimens by organ system, frozen sections, apheresis, fine needle aspirations and interpretation of the aspirate.]  
Example: The resident who has met the requirement for direct supervision may be indirectly supervised by a more senior resident, a fellow, a pathology assistant, or an attending physician. The identified supervisor must be available for consultation and assistance, but does not need to be immediately available or in the hospital.
Q: Who are qualified to supervise residents in bone marrow biopsies?  
A: PGY-2 or greater level residents in a CP-only track, PGY-3 or greater level resident in an AP/CP track, hematology oncology fellows, hematopathology fellows and attending pathologists may supervise the performance of bone marrow biopsies.
Q: Who are qualified to supervise residents in apheresis procedures?  
A: PGY-2 or greater level residents in a CP-only track, PGY-3 or greater level residents in an AP/CP track, Blood Banking/Transfusion Medicine fellows, and attending pathologists. Hematopathology fellows may also supervise apheresis procedures if approved to do so by their respective program directors.
Q: Who are qualified to supervise residents in gross dissection of surgical path specimens and/or autopsies?  
A: A PGY-2 or greater level resident in an AP/NP or AP-only track, a PGY-3 or -4 level resident, a fellow, a pathology assistant, or an attending pathologist.

### VI.E. Clinical Responsibilities

Q: What is the optimal clinical workload for residents?  
A: The program director must make an assessment of the learning environment with input from faculty members and residents. There must be an adequate clinical workload to develop competency in all areas specified in the program requirements. Optimal workload may vary from program to program, and will depend on the patients, patient material, program resources, and testing/consultations/procedures done in the primary and participating sites. Clinical workload should include patients and patient material for testing, as well as study sets and other case-based teaching tools.

### VI.F. Teamwork

VI.F.1. Administrative staff members, autopsy assistants, technologists, clinical laboratory staff members, and nurses may be included as part of an interdisciplinary team. (Detail)

VI.F.2. Residents must demonstrate the ability to work and communicate with health care professionals to provide effective, patient-focused care. (Core)

### VI.G.5.b) Intermediate-level Residents

PGY-2 residents are considered to be at the intermediate level.
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<td>VI.G.5.c) Residents in the Final Years of Education</td>
<td>Residents in the final two years of the program for APCP-4 or the final year of the program for AP-3 or CP-3 are considered to be in the final years of education.</td>
<td>Q: For residents enrolled in 3-year Pathology tracks (Clinical Pathology, Anatomic Pathology), or Anatomic Pathology/Neuropathology what level residents are considered to be in their final years of education? A: PGY-2 and PGY-3 level residents in 3-year programs are considered to be in their final years of education and PGY-2 level residents in AP/NP are considered to be in their final years of education.</td>
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<td>VI.G.5.c),(1) Circumstances for Eight Hours Free of Duty</td>
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<td>Q: Are there any circumstances under which residents are permitted to stay on duty or return to the hospital to care for their patients, even if doing so results in fewer than eight hours free of duty between scheduled duty periods? A: Intermediate residents and Residents in the Final Years of Education may stay on duty or return to the hospital to perform intra-operative consultations, apheresis, emergent autopsies (e.g., when a patient’s religion requires rapid burial), fine needle aspirations, immediate evaluation of cytology, transfusion medicine/blood banking emergencies, and hematologic emergencies.</td>
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| VI.F. Teamwork | VI.F.1. Medical laboratory professionals, members of clinical service teams, and other medical professionals may be included as part of an interprofessional team.  
(Vetail)  
VI.F.2. Fellows must demonstrate the ability to work and communicate with health care professionals to provide effective, patient-focused care.  
(Outcome) | |
<p>| VI.G.5.a) Fellows in the Final Years of Education | Pathology subspecialty fellows are considered to be in the final years of education. | |
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| VI.G.6. Maximum Frequency of In-House Night Float | | |
| <strong>Pathology – Cytopathology</strong> | | |
| VI.D.1. Licensed Independent Practitioner | | |
| VI.D.5.a).(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. | |</p>
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| VI.F. Teamwork | VI.F.1. Medical laboratory professionals, members of clinical service teams, and other medical professionals may be included as part of an interprofessional team.  
VI.F.2. Fellows must demonstrate the ability to work and communicate with health care professionals to provide effective, patient-focused care. |  |
| VI.G.5.a) Fellows in the Final Years of Education | Pathology subspecialty fellows are considered to be in the final years of education. |  |
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A: Fellows may stay on duty or return to the hospital to perform fine needle aspirations or for the immediate evaluation of cytopathology procedures. |
| VI.G.6. Maximum Frequency of In-House Night Float |  |  |
| Pathology – Forensic |  |  |
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VI.F.2. Fellows must demonstrate the ability to work and communicate with health care professionals to provide effective, patient-focused care. (Core) | |
| VI.G.5.a) Fellows in the Final Years of Education | Pathology subspecialty fellows are considered to be in the final years of education. | |
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A: Fellows may stay on duty or return to the hospital for scene investigations. |
| VI.G.6. Maximum Frequency of In-House Night Float | Pathology – Hematopathology | |
| VI.D.1. Licensed Independent Practitioner | Q: Is it acceptable for advanced nurse practitioners or physician assistants to supervise fellows during bone marrow procedures?  
A: Yes. | |
| VI.D.5.a).(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. | |
| VI.E. Clinical Responsibilities | VI.F.1. Medical laboratory professionals, members of clinical service teams, and other medical professionals may be included as part of an interprofessional team. (Detail)  
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<td>Do not have PGY-1 residents in the subspecialty.</td>
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| VI.E. Clinical Responsibilities | | Q: What is the optimal clinical workload for fellows?  
A: The program director must make an assessment of the learning environment with input from faculty members and fellows. There must be an adequate clinical workload to develop competency in all areas specified in the Program Requirements. Optimal workload may vary from program to program, and will depend on the patients, patient material, program resources, and testing/consultations/procedures done in the primary and participating sites. Clinical workload should include patients and patient material for testing, as well as study sets and other case-based teaching tools. |
| VI.F. Teamwork | VI.F.1. Medical laboratory professionals, members of clinical service teams, and other medical professionals may be included as part of an interprofessional team. (Detail)  
VI.F.2. Fellows must demonstrate the ability to work and communicate with health care professionals to provide effective, patient-focused care. (Outcome) | |
| VI.G.5.a) Fellows in the Final Years of Education | Pathology subspecialty fellows are considered to be in the final years of education. | |
| VI.G.5.a).(1) Circumstances for Eight Hours Free of Duty.(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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. | Q: Are there any circumstances under which fellows are permitted to stay on duty or return to the hospital to care for their patients, even if doing so results in fewer than eight hours free of duty between scheduled duty periods?  
A: Fellows may stay on duty or return to the hospital to perform intra-operative consultations, including frozen sections, touch preps, and squash preps, as well as for emergent brain removal for special studies where brain tissue must be frozen/fixed within a certain period of time. |
| VI.G.6. Maximum Frequency of In-House Night Float | | |
| Pathology – Pediatric | | |
| VI.D.1. Licensed Independent Practitioner | | |
| VI.D.5.a).(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. | |
| VI.E. Clinical Responsibilities | | |
| VI.F. Teamwork | VI.F.1. Medical laboratory professionals, members of clinical service teams, and other medical professionals may be included as part of an interprofessional team. (Detail)  
VI.F.2. Fellows must demonstrate the ability to work and communicate with health care professionals to provide effective, patient-focused care. (Outcome) | |
<p>| VI.G.5.a) Fellows in the Final Years of Education | Pathology subspecialty fellows are considered to be in the final years of education. | |</p>
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<td>VI.G.5.a). (1)</td>
<td>Circumstances for Eight Hours Free of Duty. (b)</td>
<td>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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.</td>
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<td>VI.G.6. Maximum Frequency of In-House Night Float</td>
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**Pathology – Selective**

| VI.D.1. Licensed Independent Practitioner | | |
| VI.D.5.a). (1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. | |
| VI.E. Clinical Responsibilities | | |
| VI.F. Teamwork | VI.F.1. Medical laboratory professionals, members of clinical service teams, and other medical professionals may be included as part of an interprofessional team.  
VI.F.2. Fellows must demonstrate the ability to work and communicate with health care professionals to provide effective, patient-focused care. | |
| VI.G.5.a) Fellows in the Final Years of Education | Pathology subspecialty fellows are considered to be in the final years of education. | |
| VI.G.5.a). (1) Circumstances for Eight Hours Free of Duty. (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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. | |
| VI.G.6. Maximum Frequency of In-House Night Float | | |

**Pediatrics**

| VI.D.1. Licensed Independent Practitioner | Q: Are there situations when residents may be supervised by Licensed Independent Practitioners?  
A: Physician assistants, nurse practitioners, psychologists, physical and occupational therapists, speech and language pathologists, dieticians/nutritionists, counselors, and audiologists are just some of the providers who see their own patients and may serve as teachers and/or supervisors for residents as appropriate in ambulatory (i.e., school-based health centers, child development clinics) and inpatient (i.e., neonatal intensive care unit (NICU)) settings. Some states may have regulatory rules that won’t allow licensed independent practitioners to supervise residents. | |

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</table>
| VI.D.5.a).(1) Supervision of Residents | VI.D.5.a).(2) PGY-1 residents must always be supervised either directly or indirectly with direct supervision immediately available. | Q: Can PGY-1 residents make “parent concern calls”?  
A: Interns may not take “parent concern calls” from home, but may take “parent concern calls” within the 16-hour duty period from the hospital or other clinical site where supervision is either direct or indirect with direct supervision immediately available. |
| VI.E. Clinical Responsibilities | VI.E.1. The program director must have the authority and responsibility to set appropriate Clinical Responsibilities for each resident based on the PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services. \(\text{(Core)}\)  
VI.E.2. Residents must be responsible for an appropriate patient load. Insufficient patient experiences do not meet educational needs; an excessive patient load suggests an inappropriate reliance on residents for service obligations, which may jeopardize the educational experience. \(\text{(Core)}\) | Q: What is an appropriate patient load for residents?  
A: It is suggested that the patient loads be a minimum of five on the general inpatient unit, and four in the pediatric intensive care unit (PICU) and NICU. However, there may be situations in which lower patient loads may be acceptable. Programs will need to justify lower patient loads with evidence, such as severity of illness indicators or other factors. |
| VI.F. Teamwork | | Q: Who should be included on the interprofessional teams?  
A: Examples of professional personnel who may be part of the interprofessional teams include nurses, physician assistants, advanced practice providers, pharmacists, social workers, child-life specialists, physical and occupational therapists, speech and language pathologists, audiologists, respiratory therapists, psychologists, and nutritionists. |
<p>| VI.G.5.b) Intermediate-level Residents | PGY-2 residents are considered to be at the intermediate level. | |
| VI.G.5.c) Residents in the Final Years of Education | PGY-3 residents are considered to be in the final years of education. | |
| VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty | VI.G.5.c).(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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. | |</p>
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</table>
| VI.G.6. Maximum Frequency of In-House Night Float | VI.G.6.a) Night experiences should be of educational value. (Core) VI.G.6.a).1) In order to accomplish this, night assignments should have formal goals, objectives, and a specific evaluation component. (Detail) | Q: What is the difference between night float, night shift, and night call?  
A: Night call is defined as:  
- “Traditional” Night Call is for those working in the day who will also stay at night to provide patient care.  
- Night call applies to PGY-2 residents and above.  
- Night call must not occur more frequently than every third night when averaged over a four-week period.  
- Night call is limited to 24+ four hours.  
- There may be no additional Clinical Responsibilities after 24 hours.  
- Strategic napping after 16 hours of duty is suggested.  

Night Float is defined as:  
- Night Float involves the episodic coverage of patients just at night, e.g., a resident assigned to a one-month block of cardiology does a series of nights of patient coverage in the PICU.  
- Residents come from another educational experience to do a series of night shifts.  
- There may be no more than six consecutive nights.  

Night Shift is defined as:  
- Night Shift is a scheduled series of nights to provide consistent care at night that mirrors the day shift.  
- This is the new paradigm for PGY-1 residents  
- There is a limit of 16-hour shifts  
- Residents should have 10 hours between shifts and must have eight hours free between scheduled duty periods  
- There may be no more than six consecutive shifts  
- There is no limit on night shift during an educational unit, however:  
  - The balance between day and night must be appropriate, and  
  - Education must occur for residents doing shifts. |
| Pediatrics Subspecialties     |                                                                                                                                                                                                                                           | Q: Are there situations when fellows may be supervised by Licensed Independent Practitioners?  
A: Nurse practitioners, physician assistants, psychologists, physical and occupational therapists, speech and language pathologists, dieticians/nutritionists, counselors, and audiologists may serve as teachers and/or supervisors for fellows, as appropriate. |
<p>| VI.D.1. Licensed Independent Practitioner |                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                  |
| VI.D.5.a).1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty.                                                                                                                                                                                        |                                                                                                                                                                                                                                  |</p>
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<td>VI.E. Clinical Responsibilities</td>
<td>VI.E.1. The program director must have the authority and responsibility to set appropriate Clinical Responsibilities (i.e., patient caps) for each fellow based on the PGY-level, patient safety, fellow education, severity and complexity of patient illness/condition and available support services. (Core) VI.E.2. Fellows must be responsible for maintaining an appropriate patient load. Insufficient patient experiences do not meet educational needs; an excessive patient load suggests an inappropriate reliance on fellows for service obligations, which may jeopardize their educational experience. (Core)</td>
<td>Q: What is an appropriate patient load for fellows? A: The program director must make an assessment of the learning environment with input from faculty members and fellows.</td>
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<tr>
<td>VI.F. Teamwork</td>
<td>VI.F.1. Interprofessional team members should participate in the education of fellows. (Detail)</td>
<td>Q: Who should be included on the interprofessional teams? A: Nurses, physician assistants, advanced practice providers, pharmacists, social workers, child-life specialists, physical and occupational therapists, speech and language pathologists, audiologists, respiratory therapists, psychologists, and nutritionists are examples of professional personnel who may be part of the interprofessional teams.</td>
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<tr>
<td>VI.G.5.c) Residents in the Final Years of Education</td>
<td>Pediatric subspecialty fellows in the PGY-4 level and beyond are considered to be in the final years of education.</td>
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<tr>
<td>VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty</td>
<td>VI.G.5.c).(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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.</td>
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<td>VI.G.6. Maximum Frequency of In-House Night Float</td>
<td>Fellows should not have more than one consecutive week of night float, and not more than four total weeks of night float per year. (Detail)</td>
<td>Q: What is the difference between night float, night shift, and night call? A: Night Call: • “Traditional” Night Call is for those working in the day who will also stay at night to provide patient care • PGY-2 and above • No more frequently than every third night when averaged over a four-week period • Limited to 24+4 hours • No additional Clinical Responsibilities after 24 hours • Strategic napping after 16 hours of duty Night Float: • Night Float involves the episodic coverage of patients just at night • Fellows come from another educational experience to do a series of night shifts • No more than six consecutive nights • Example: Resident on a one-month block of cardiology does a series of nights of patient coverage in the PICU • Night float is limited to one consecutive week, and no more than four total weeks per year</td>
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<td><strong>Night Shift:</strong></td>
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<td>Night Shift is a scheduled series of</td>
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<td>nights to provide consistent care</td>
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<td>at night that mirrors the day shift</td>
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<td>• No more than six consecutive shifts</td>
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<td>• No limit on night shift during a</td>
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<td>block month, however:</td>
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<td>o balance between day and night</td>
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<td>must be appropriate</td>
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<td>o education must occur for fellows</td>
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<td>doing shifts</td>
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<td>Physical Medicine and</td>
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<tr>
<td>Rehabilitation</td>
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<tr>
<td>VI.D.1. Licensed</td>
<td>Q: Are there any non-physician Licensed</td>
<td>A: Advanced nurse practitioners</td>
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<td>Independent Practitioner</td>
<td>Independent Practitioners who may</td>
<td>and psychologists may supervise</td>
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<td>supervise residents?</td>
<td>residents, as appropriate.</td>
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<tr>
<td>VI.D.5.a).(1) Supervision</td>
<td>Q: Under what circumstances can a PGY-1</td>
<td>A: PGY-1 residents participate in</td>
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<td>of Residents</td>
<td>resident be supervised indirectly with</td>
<td>a variety of rotations, including</td>
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<td></td>
<td>supervision immediately available?</td>
<td>in emergency medicine, family</td>
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<td>medicine, internal medicine,</td>
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<td>obstetrics and gynecology,</td>
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<td>pediatrics, and surgery, or in</td>
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<td>subspecialties of internal medicine</td>
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<td>and surgery, as well as up to one</td>
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<td>month in physical medicine and</td>
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<td>rehabilitation. Each of these</td>
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<td>programs must assess the</td>
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<td>independence of each PGY-1 resident</td>
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<td>based upon the six core competencies in order to progress to indirect supervision with supervision immediately available. These different rotations necessitate different sets of skills. That is, if a PGY-1 resident is deemed to have progressed to indirect supervision with supervision immediately available while on the internal medicine service, this may not be the case in a subsequent rotation such as emergency medicine or surgery. When PGY-1 residents are assigned to physical medicine and rehabilitation rotations, second- or third-year (or higher) residents or other appropriate supervisory physicians (e.g., subspecialty residents or attending physicians) with documented experience appropriate to the acuity, complexity, and severity of patient illness must be available at all times on-site to supervise.</td>
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<td>VI.E. Clinical</td>
<td>Q: What is the appropriate patient load</td>
<td>A: PGY-1 residents work on</td>
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<td>Responsibilities</td>
<td>for residents?</td>
<td>primarily non-physical medicine</td>
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<td>and rehabilitation rotations.</td>
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<td>Their workload must comply with</td>
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<td>the respective specialty-specific</td>
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<td>clinical responsibility requirements. For PGY-2-4 residents on inpatient services, the program director must make an assessment of the learning environment with input from faculty members and residents. The optimal case load will allow each resident to see a variety of patients without being overwhelmed by patient care responsibilities, or without compromising his or her educational experience or patient safety. Inpatient loads should generally be a minimum of eight patients averaged over the inpatient rotations, and should not generally exceed 14. There may be situations when lower loads are appropriate due to severity of illness or when higher loads are appropriate due to lower acuity of illness or team support, such as with hospitalists or mid-level providers.</td>
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Duty Hour Definitions
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<td>VI.F. Teamwork</td>
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<td>Q: Who should be included in the interprofessional teams? A: Appropriately credentialed professional staff members in the disciplines of occupational therapy, orthotics and prosthetics, physical therapy, psychology, rehabilitation nursing, social service, speech-language pathology, therapeutic recreation, and vocational counseling should be integrated into residents’ didactic and clinical experience whenever relevant.</td>
</tr>
<tr>
<td>VI.G.5.b) Intermediate-level Residents</td>
<td>PGY-2 and PGY-3 residents are considered to be at the intermediate level.</td>
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<tr>
<td>VI.G.5.c) Residents in the Final Years of Education</td>
<td>PGY-4 residents are considered to be in the final years of education.</td>
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<td>VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty</td>
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<td>VI.G.6. Maximum Frequency of In-House Night Float</td>
<td>Night float cannot exceed more than 18 nights total per year. (Detail)</td>
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### Physical Medicine and Rehabilitation – Spinal Cord Injury Medicine

<p>| VI.D.1. Licensed Independent Practitioner |                              | Q: Are there any non-physician Licensed Independent Practitioners who may supervise residents? A: Advanced nurse practitioners and psychologists may supervise residents, as appropriate. |
| VI.D.5.a).(1) Supervision of Residents | <strong>Do not have PGY-1 residents in the subspecialty.</strong> |                                   |
| VI.E. Clinical Responsibilities |                              | Q: What is the optimal clinical workload for fellows? A: The program director must make an assessment of the learning environment with input from faculty members and residents. Minimum patient loads should be eight on the spinal cord injury (SCI) unit. With experience, the fellow may progress from providing direct care to eight inpatients to supervising physical medicine and rehabilitation residents caring for patients on the inpatient SCI unit. |
| VI.F. Teamwork | See II.C.1. Appropriately-qualified professional staff must be available in the disciplines of occupational therapy, orthotics and prosthetics, physical therapy, psychology, rehabilitation nursing, respiratory therapy, social service, speech-language pathology, therapeutic recreation, and vocational counseling. (Detail) |                                   |
| VI.G.5.a) Fellows in the Final Years of Education | Fellows in the subspecialties of physical medicine and rehabilitation are considered to be in the final years of education. |                                   |</p>
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<td>VI.G.6. Maximum Frequency of In-House Night Float</td>
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</table>
| Physical Medicine and Rehabilitation – Pediatric Rehabilitation Medicine | Q: Are there any non-physician Licensed Independent Practitioners who may supervise residents?  
A: Advanced nurse practitioners and psychologists may supervise residents, as appropriate. |  |
| VI.D.1. Licensed Independent Practitioner |  |  |
| VI.D.5.a).(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. |  |
| VI.E. Clinical Responsibilities | Q: What is the optimal clinical workload for fellows?  
A: The program director must make an assessment of the learning environment with input from faculty members and residents. Minimum patient loads should usually be four on the inpatient rehabilitation unit, and with experience, fellows may supervise the inpatient physical medicine and rehabilitation residents on inpatient pediatric rehabilitation rotations. There may be situations in which lower patient loads may be acceptable. Programs will need to justify lower patient loads with evidence such as severity of illness indicators or other factors. |  |
| VI.F. Teamwork | Q: Who should be included in the interprofessional teams?  
A: Orthotists, pediatric occupational therapists, pediatric physical therapists, pediatric psychologists, pediatric rehabilitation nurses, pediatric social workers, pediatric speech-language pathologists, prosthetists, teachers, and therapeutic recreation specialists should be included, as appropriate, on the interprofessional teams. |  |
| VI.G.5.a) Fellows in the Final Years of Education | Fellows in the subspecialties of physical medicine and rehabilitation are considered to be in the final years of education. |  |
| VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty | VI.G.5.c).(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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. |  |
| VI.G.6. Maximum Frequency of In-House Night Float |  |  |
### Specialty/Requirement # | Specialty-specific Duty Hour Definitions | Frequently Asked Questions (FAQs)
---|---|---
**Plastic Surgery**

**VI.D.1. Licensed Independent Practitioner**

**Q:** Who may supervise residents and fellows in the clinical environment?

**A:** Appropriately-credentialed and privileged attending physicians in the surgical clinical environment include appropriately-credentialed ABMS surgeons (e.g., thoracic surgeries would be supervised by thoracic surgeons, etc.). In the critical care clinical environment, procedures must be supervised by appropriately-credentialed ABMS-certified critical care physicians (e.g., anesthesia critical care physicians, critical care medicine physicians, critical care pediatric physicians, etc.).

**VI.D.5.a).(1) Supervision of Residents**

**Q:** Who may provide direct supervision to PGY-1 residents?

**A:** Each program is responsible for having clear policies for supervision. Direct supervision (physically present) may be provided by individuals who have been credentialed by the program to do a particular procedure or to manage a particular clinical scenario, and includes more senior residents (PGY-2 residents and above who have met the competency requirements for the particular task at hand), fellows, and attending surgeons. Attending physicians such as anesthesia physicians, emergency department physicians, and hospitalists who are appropriately credentialed and with whom the program has a clearly defined relationship outlined in the supervision policy may directly supervise PGY-1 residents.

**Q:** What is indirect supervision "with direct supervision immediately available"?

**A:** Supervision may be provided "indirectly" (supervising physician not physically present) by phone/text/e-mail discussion. When needed (as outlined by the programs supervision policy) or requested by the resident, the supervising physician must be physically present at the start of non-emergent tasks. For emergency situations, direct supervision should be available within 15 minutes.

**Q:** For which tasks may PGY-1 residents be supervised indirectly, and for which tasks should PGY-1 residents have direct supervision until competence is demonstrated?

**A:** Indirect supervision is allowed for the following:

1. **Patient Management Competencies**
   a) evaluation and management of a patient admitted to hospital, including initial history and physical examination, formulation of a plan of therapy, and necessary orders for therapy and tests
   b) pre-operative evaluation and management, including history and physical examination, formulation of a plan of therapy, and specification of necessary tests
   c) evaluation and management of postoperative patients, including the conduct of monitoring, and orders for medications, testing, and other treatments
   d) transfer of patients between hospital units or hospitals
   e) discharge of patients from the hospital
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<tr>
<td></td>
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<td>f) interpretation of laboratory results</td>
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<td>2. Procedural Competencies</td>
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<td>a) performance of basic venous access procedures, including establishing intravenous access</td>
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<td></td>
<td>b) placement and removal of nasogastric tubes and Foley catheters</td>
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<td>c) arterial puncture for blood gases</td>
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<td>Direct supervision is required until competency is demonstrated for:</td>
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<td>1. Patient Management Competencies</td>
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<td>a) repair of surgical incisions of the skin and soft tissues</td>
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<td>b) repair of lacerations of the skin and soft tissues</td>
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<td>c) excision of lesions of the skin and subcutaneous tissues</td>
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<td>d) harvest and inset of skin grafts</td>
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<td>e) wound debridement</td>
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VI.E. Clinical Responsibilities
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<td>VI.F. Teamwork</td>
<td>VI.F.1. Effective surgical practices entail the involvement of interdisciplinary team members with a mix of complementary skills. (Core) VI.F.2. Residents must demonstrate competence in Teamwork by collaborating with fellow surgical residents, and especially with faculty members, other physicians outside of the specialty, and non-physician health care providers, to best formulate treatment plans for an increasingly diverse patient population. (Outcome) VI.F.3. Residents must demonstrate 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 in the hours assigned, or, if that is not possible, residents must demonstrate utilization of the established methods for handing off remaining tasks to another member of the resident team so that patient care is not compromised. (Outcome) VI.F.4. Lines of authority should be defined by programs, and all residents must have a working knowledge of these expected reporting relationships to maximize quality care and patient safety. (Detail)</td>
<td>Q: What skills should members of the interprofessional caregiver team have and how should these be ensured across the team? A: All members of the interprofessional caregiver team should be provided instruction in: 1. communication, so that if all required tasks cannot be accomplished in a timely fashion, appropriate methods are established to hand off the remaining task(s) to another team member at the end of a duty period; 2. compliance with work hour limits imposed at the various levels of education; 3. prioritization of tasks as the dynamics of a patient’s needs change; 4. recognition of and sensitivity to the experience and competence of other team members; 5. recognizing when an individual becomes overburdened with duties that cannot be accomplished within an allotted time period; 6. signs and symptoms of fatigue not only in oneself, but in other team members; 7. team development; and, 8. time management.</td>
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<tr>
<td>VI.G.5.b) Intermediate-level Residents</td>
<td>For independent programs, Y-1, -2, and -3 residents are considered to be in the final years of education. For integrated programs, Y-2 and -3 residents are considered to be at the intermediate level.</td>
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<tr>
<td>VI.G.5.c) Residents in the Final Years of Education</td>
<td>For independent programs, Y-1, -2, and -3 residents are considered to be in the final years of education. For integrated programs, Y-4, -5 and -6 residents are considered to be in the final years of education.</td>
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</table>
### Specialty/Requirement # | Specialty-specific Duty Hour Definitions | Frequently Asked Questions (FAQs)
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VI.G.5.c).(1) | 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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. | Q: Are there any circumstances under which residents may stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty?  
A: Yes. Such circumstances include:  
1. continuity of care for patients, such as for:  
   a. a patient on whom a resident operated/intervened that day who needs to return to the operating room (OR);  
   b. a patient on whom a resident operated/intervened that day who requires transfer to the Intensive Care Unit (ICU) from a lower level of care;  
   c. a patient on whom a resident operated/intervened that day who is in the ICU and is critically unstable;  
   d. a patient on whom a resident operated/intervened during that hospital admission, and who needs to return to the OR for a reason related to the procedure previously performed by the resident; or, a patient or patient’s family with whom a resident needs to discuss the limitation of treatment/DNR/DNI orders for a critically-ill patient on whom the resident operated.  
2. a declared emergency or disaster, for which the residents are included in the disaster plan; or, to perform high profile, low frequency procedures necessary for competence in the field.

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<td>VI.G.6. Maximum Frequency of In-House Night Float</td>
<td>Residents must not have more than four consecutive weeks of night float assignment, and night float cannot exceed one month per year. (Core)</td>
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Plastic Surgery – Craniofacial Surgery

| VI.D.1. Licensed Independent Practitioner | | Q: Who may supervise residents and fellows in the clinical environment?  
A: Appropriately-credentialed and privileged attending physicians in the surgical clinical environment include appropriately-credentialed ABMS Board Member-certified surgeons (e.g., thoracic surgeries would be supervised by thoracic surgeons, etc.). In the critical care clinical environment, procedures must be supervised by appropriately-credentialed ABMS Member-certified critical care physicians (e.g. anesthesia critical care physicians, critical care medicine physicians, critical care pediatric physicians, etc.). |

| VI.D.5.a).(1) Supervision of Residents | | Q: Who may provide direct supervision to PGY-1 residents?  
A: Each program is responsible for having clear policies for supervision. Direct supervision (physically present) may be provided by individuals who have been credentialed by the program to do a particular procedure or to manage a particular clinical scenario, and includes more senior residents (PGY-2 residents and above who have met the competency requirements for the particular task at hand), fellows, and attending surgeons. Attending physicians such as anesthesia physicians, emergency department physicians, and hospitalists who are appropriately credentialed and with whom the program has a clearly defined relationship outlined in the supervision policy may directly supervise PGY-1 residents.  
Q: What is indirect supervision “with direct supervision immediately available”? |
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<td>A: Supervision may be provided “indirectly” (supervising physician not physically present) by phone/text/e-mail discussion. When needed (as outlined by the programs supervision policy) or requested by the resident, the supervising physician must be physically present at the start of non-emergent tasks. For emergency situations, direct supervision should be available within 15 minutes.</td>
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<td>Q: For which tasks may PGY-1 residents be supervised indirectly, and for which tasks should PGY-1 residents have direct supervision until competence is demonstrated?</td>
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<td>A: Indirect supervision is allowed for the following:</td>
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<td>a) Patient Management Competencies</td>
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<td>1. evaluation and management of a patient admitted to hospital, including initial history and physical examination, formulation of a plan of therapy, and necessary orders for therapy and tests</td>
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<td>2. pre-operative evaluation and management, including history and physical examination, formulation of a plan of therapy, and specification of necessary tests</td>
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<td>3. evaluation and management of post-operative patients, including the conduct of monitoring, and orders for medications, testing, and other treatments</td>
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<td>4. transfer of patients between hospital units or hospitals</td>
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<td>5. discharge of patients from the hospital</td>
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<td>6. interpretation of laboratory results</td>
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<td>b) Procedural Competencies</td>
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<td>1. performance of basic venous access procedures, including establishing intravenous access</td>
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<td>2. placement and removal of nasogastric tubes and Foley catheters</td>
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<td>3. arterial puncture for blood gases</td>
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<td>Direct supervision is required until competency is demonstrated for:</td>
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<td>2. evaluation and management of post-operative complications, including anuria, cardiac arrhythmias, change in neurologic status, change in respiratory rate, compartment syndromes, hypertension, hypotension, hypoxemia, oliguria</td>
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<td>3. evaluation and management of critically-ill patients, either immediately post-operatively or in the intensive care unit, including the conduct of monitoring, and orders for medications, testing, and other treatments</td>
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<td>4. management of patients in cardiac or respiratory arrest (ACLS required)</td>
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<td>VI.E. Clinical Responsibilities</td>
<td>VI.E.1. Lines of authority should be defined by programs, and all fellows must have a working knowledge of these expected reporting relationships to maximize quality care and patient safety. (Detail) VI.E.2. There must be written lines of responsibility describing the Clinical Responsibilities of and relationship between craniofacial surgery fellows and plastic surgery residents, and these must be supplied to the Review Committee at the time of a program’s review. (Core)</td>
<td>5. evaluation of tissue perfusion, including new flaps, and management of flap compromise 6. evaluation and management of pressure sores 7. evaluation patients with wounds and generation of proper wound care recommendations</td>
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<td>VI.F. Teamwork</td>
<td>VI.F.1. Effective surgical practices entail the involvement of interdisciplinary team members with a mix of complementary skills. (Outcome) VI.F.2. Fellows must collaborate with fellow surgical residents, and especially with faculty members, other physicians outside of the specialty, and non-physician health care providers, to best formulate treatment plans for an increasingly diverse patient population. (Detail) 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 in 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 team so that patient care is not compromised. (Detail)</td>
<td>Q: What skills should members of the interprofessional caregiver team have and how should these be ensured across the team? A: All members of the interprofessional caregiver team should be provided instruction in: 1. communication, so that if all required tasks cannot be accomplished in a timely fashion, appropriate methods are established to hand off the remaining task(s) to another team member at the end of a duty period; 2. compliance with work hour limits imposed at the various levels of education; 3. prioritization of tasks as the dynamics of a patient’s needs change; 4. recognition of and sensitivity to the experience and competence of other team members; 5. recognizing when an individual becomes overburdened with duties that cannot be accomplished within an allotted time period; 6. signs and symptoms of fatigue not only in oneself, but in other team members; 7. team development; and, 8. time management.</td>
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<td>VI.G.5.b) Intermediate-level Residents</td>
<td>Craniofacial plastic surgery fellows are considered to be in the final years of education.</td>
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<td>VI.G.5.c) Residents in the Final Years of Education</td>
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| VI.G.5.c).(1)          | Circumstances for Eight Hours Free of Duty | Q: Are there any circumstances under which residents may stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty?  
A: Yes. Such circumstances include:  
a) continuity of care for patients, such as for:  
1. a patient on whom a resident operated/intervened that day who needs to return to the operating room (OR);  
2. a patient on whom a resident operated/intervened that day who requires transfer to the Intensive Care Unit (ICU) from a lower level of care;  
3. a patient on whom a resident operated/intervened that day who is in the ICU and is critically unstable;  
4. a patient on whom a resident operated/intervened during that hospital admission, and who needs to return to the OR for a reason related to the procedure previously performed by the resident; or, a patient or patient’s family with whom a resident needs to discuss the limitation of treatment/DNR/DNI orders for a critically-ill patient on whom the resident operated.  
b) a declared emergency or disaster, for which the residents are included in the disaster plan; or, to perform high profile, low frequency procedures necessary for competence in the field. |
| VI.G.6. Maximum Frequency of In-House Night Float | Preventive Medicine | Q: Can PM-1 and PM-2 residents be supervised by any licensed allied health professionals?  
A: PM-1 and PM-2 residents may be supervised by licensed allied health professionals who are identified as faculty members, provided that:  
• the clinical care is within their scope of practice expertise;  
• the level of clinical care is low risk;  
• physician faculty members are available by telephone; and,  
• the program director has approved the supervision with respect to the educational experience.  
Allied health professionals cannot substitute for physician faculty members to meet the 24-hour requirement for on-site supervision of resident care. |
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| VI.D.5.a).(1) Supervision of Residents | | Q: What are some examples of indirect supervision?  
A:  
**Indirect Supervision with direct supervision immediately available:**  
The resident is seeing patients in a clinic and the supervising physician faculty member in the precepting room is immediately available to see the patient together with the resident as needed. The faculty member is in another area of the hospital, but is immediately available to see the patient together with the resident in the clinic as needed.  
**Indirect Supervision with direct supervision available:**  
A resident is on call for the clinic service and needs advice from the physician faculty member in order to manage a patient’s care. This can be done either by telephone or electronically. After communication with the resident, if the attending determines additional assistance is needed, the attending physician is available and able to go to the clinic to see the patient together with the resident.  
**Indirect Supervision oversight:**  
A resident is seeing a patient in either the nursing home or at home, and the supervising faculty member can then review the patient chart, discuss the case and any required follow-up with the resident, and evaluate the resident. |
| VI.E. Clinical Responsibilities | An optimal clinical workload allows residents to develop the required competencies in patient care with a focus on learning over meeting service obligations. ([Detail](#)) | Q: Must every interprofessional team include representation from every profession?  
A: No. The Review Committee recognizes that the needs of specific patients change with their health statuses and circumstances. The Review Committee’s intent is to ensure that the program has access to professional and paraprofessional personnel, and that interprofessional teams be constituted as appropriate and as needed, not to mandate that all be included in every case. |
<p>| VI.F. Teamwork | | |
| VI.G.5.b) Intermediate-level Residents | PM-1 residents are considered to be at the intermediate level. | |
| VI.G.5.c) Residents in the Final Years of Education | PM-2 residents are considered to be in the final years of education. | |
| VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty | VI.G.5.c).(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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. | |
| VI.G.6. Maximum Frequency of In-House Night Float | | |
| Psychiatry | | |
| VI.D.1. Licensed Independent Practitioner | | |</p>
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| VI.D.5.a).(1) Supervision of Residents | VI.D.5.a).(2) PGY-1 residents should progress to being supervised indirectly with direct supervision available only after demonstrating competence in:  
  VI.D.5.a).(2).(a) the ability and willingness to ask for help when indicated;  
  VI.D.5.a).(2).(b) gathering an appropriate history;  
  VI.D.5.a).(2).(c) the ability to perform an emergent psychiatric assessment; and,  
  VI.D.5.a).(2).(d) presenting patient findings and data accurately to a supervisor who has not seen the patient. | Q: What is an appropriate patient load for residents?  
A: In addition to the factors listed in PR VI.E, the patient care setting and complexity of the patient’s treatment, and the resident’s role in carrying out patient care, must also be considered. For example, with psychiatric inpatients, an average case load of five-to-10 is usually appropriate, depending on the length of stay. Outpatient and consultation settings typically involve less intensive patient care responsibilities, and therefore patient loads would be higher. However, there may be situations in which lower patient loads may be acceptable, as when a resident is providing multiple and/or complicated interventions in patient care, or if a resident is assigned to multiple clinical settings at one time. The program director must make an assessment of the learning environment with input from faculty members and residents in light of these factors. Programs will need to justify different patient loads with evidence such as severity of illness indicators or other factors. |
| VI.E. Clinical Responsibilities | VI.F.1. Contributors to effective interprofessional teams should include consulting physicians, psychologists, psychiatric nurses, social workers, and other professional and paraprofessional mental health personnel involved in the evaluation and treatment of patients. | Q: Must every interprofessional team include representation from every profession listed in the requirement?  
A: No. The Review Committee recognizes that the needs of specific patients change with their health status and circumstances. The intent of the requirement is to ensure that the program has access to these professional and paraprofessional personnel, and that interprofessional teams will be constituted as appropriate and as needed. |
<p>| VI.F. Teamwork | | |
| VI.G.5.b) Intermediate-level Residents | PGY-2 residents are considered to be at the intermediate level. | |
| VI.G.5.c) Residents in the Final Years of Education | Residents at the PGY-3 level or beyond are considered to be in the final years of education. | |
| VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty | There are no circumstances under which Residents in the Final Years of Education may stay on duty with fewer than eight hours off. | |</p>
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| VI.G.6. Maximum Frequency of In-House Night Float | VI.G.6.a) Residents should not be scheduled for more than four consecutive weeks of night float during the required one-year, full-time outpatient psychiatry experience. (Detail)  
VI.G.6.b) Residents should not be scheduled for more than a total of eight weeks of night float during the one-year of consecutive outpatient experience. (Detail) | |
| VI.G.7. | VI.G.7.a) On psychiatry rotations, in-house call must occur no more frequently than every fourth night, averaged over a four-week period. (Core) | |
| Psychiatry – Addiction | | |
| VI.D.1. Licensed Independent Practitioner | Only Licensed Independent Practitioners as consistent with state regulations and medical staff bylaws may have primary responsibility for a patient. (Detail) | |
| VI.D.5.a). (1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. | |
| VI.E. Clinical Responsibilities | | Q: What is an appropriate patient load for residents?  
A: All of the factors listed in the program requirements must contribute to the determination of an appropriate patient load for each resident. In addition, the patient care setting, the complexity of the patient’s treatment, and a resident’s role in carrying out that treatment must also be considered. For example, with psychiatric inpatients, an average case load of five-to-10 is usually appropriate, depending on the length of stay. Outpatient and consultation settings typically involve less intensive patient care responsibilities, and therefore caseloads would be higher. However, there may be situations in which lower patient caseloads may be acceptable, as when a resident is providing multiple and/or complicated interventions in patient care, or if a resident is assigned to multiple clinical settings at one time. The program director must make an assessment of the learning environment with input from faculty members and residents in light of these factors. Program directors will need to justify different patient loads with evidence such as severity of illness indicators or other factors. | |
| VI.F. Teamwork | VI.F.1. Contributors to effective interprofessional teams include consulting physicians, psychologists, psychiatric nurses, social workers and other professional and paraprofessional mental health personnel involved in the evaluation and treatment of patients. (Detail) | Q: Must every interprofessional team include representation from every profession listed in the requirement?  
A: No. The Review Committee recognizes that the needs of specific patients change with their health status and circumstances. The intent of the requirement is to ensure that the program has access to these professional and paraprofessional personnel, and that interprofessional teams will be constituted as appropriate and as needed; it is not to mandate that all be included in every case. | |
| VI.G.5.a) Fellows in the Final Years of Education | Addiction psychiatry fellows are considered to be in the final years of education. | |
| VI.G.5.c). (1) Circumstances for Eight Hours Free of Duty | There are no circumstances under which fellows may stay on duty with fewer than eight hours off. | |

Duty Hour Definitions  
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<td>VI.E. Clinical Responsibilities</td>
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<td>Q: What is an appropriate patient load for fellows? A: All of the factors listed in the Program Requirements must contribute to the determination of an appropriate patient load for each fellow. In addition, the patient care setting, the complexity of the patient’s treatment, and the fellow’s role in carrying out that treatment must also be considered. For example, with psychiatric inpatients, an average case load of five-to-10 is usually appropriate, depending on the length of stay. Outpatient and consultation settings typically involve less intensive patient care responsibilities, and therefore caseloads would be higher. However, there may be situations in which lower patient caseloads may be acceptable, as when a fellow is providing multiple and/or complicated interventions in patient care, or if a fellow is assigned to multiple clinical settings at one time. The program director must make an assessment of the learning environment with input from faculty members and fellows in light of these factors. Program directors will need to justify different patient loads with evidence such as severity of illness indicators or other factors.</td>
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<td>VI.F. Teamwork</td>
<td>VI.F.1. Contributors to effective interprofessional teams should include consulting physicians, psychologists, psychiatric nurses, social workers, other professional and paraprofessional mental health personnel, pediatricians, teachers, and other school personnel involved in the evaluation and treatment of patients. (Detail)</td>
<td>Q: Must every interprofessional team include representation from every profession listed in the requirement? A: No. The Review Committee recognizes that the needs of specific patients change with their health status and circumstances. The intent of the requirement is to ensure that the program has access to these professional and paraprofessional personnel, and that interprofessional teams will be constituted as appropriate and as needed.</td>
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<td>VI.G.5.b) Intermediate-level Residents</td>
<td>PGY-2 residents are considered to be at the intermediate level.</td>
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<td>VI.G.5.c) Residents in the Final Years of Education</td>
<td>Residents at the PGY-3 level or beyond are considered to be in the final years of education.</td>
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<tr>
<td>VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty</td>
<td>There are no circumstances under which Residents in the Final Years of Education may stay on duty with fewer than eight hours off.</td>
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<td>Psychiatry – Forensic</td>
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<td>VI.D.1. Licensed Independent Practitioner</td>
<td>Only Licensed Independent Practitioners as consistent with state regulations and medical staff bylaws may have primary responsibility for a patient. (Detail)</td>
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| VI.D.5.a).(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. | Q: What is an appropriate patient load for residents?  
A: All of the factors listed in the program requirements must contribute to the determination of an appropriate patient load for each resident. In addition, the patient care setting, the complexity of the patient’s treatment, and a resident’s role in carrying out that treatment must also be considered. For example, with psychiatric inpatients, an average case load of five-to-10 is usually appropriate, depending on the length of stay. Outpatient and consultation settings typically involve less intensive patient care responsibilities, and therefore caseloads would be higher. However, there may be situations in which lower patient caseloads may be acceptable, as when a resident is providing multiple and/or complicated interventions in patient care, or if a resident is assigned to multiple clinical settings at one time. The program director must make an assessment of the learning environment with input from faculty members and residents in light of these factors. Program directors will need to justify different patient loads with evidence such as severity of illness indicators or other factors. |
| VI.E. Clinical Responsibilities | | |
| VI.F. Teamwork | VI.F.1. Contributors to effective interprofessional teams include consulting physicians, psychologists, psychiatric nurses, social workers, and other professional and paraprofessional mental health personnel involved in the evaluation and treatment of patients.  
(Q) | Q: Must every interprofessional team include representation from every profession listed in the requirement?  
A: No. The Review Committee recognizes that the needs of specific patients change with their health status and circumstances. The intent of the requirement is to ensure that the program has access to these professional and paraprofessional personnel, and that interprofessional teams will be constituted as appropriate and as needed; it is not to mandate that all be included in every case. |
| VI.G.5.a) Fellows in the Final Years of Education | Forensic psychiatry fellows are considered to be in the final years of education. | |
| VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty | There are no circumstances under which fellows may stay on duty with fewer than eight hours off. | |
| VI.G.6. Maximum Frequency of In-House Night Float | | |
| **Psychiatry – Geriatric** | | |
| VI.D.1. Licensed Independent Practitioner | Only Licensed Independent Practitioners as consistent with state regulations and medical staff bylaws may have primary responsibility for a patient.  
(Q) | |
<p>| VI.D.5.a).(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. | |</p>
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| VI.E. Clinical Responsibilities | | Q: What is an appropriate patient load for residents?  
A: All of the factors listed in the program requirements must contribute to the determination of an appropriate patient load for each resident. In addition, the patient care setting, the complexity of the patient’s treatment, and a resident’s role in carrying out that treatment must also be considered. For example, with psychiatric inpatients, an average case load of five-to-10 is usually appropriate, depending on the length of stay. Outpatient and consultation settings typically involve less intensive patient care responsibilities, and therefore caseloads would be higher. However, there may be situations in which lower patient caseloads may be acceptable, as when a resident is providing multiple and/or complicated interventions in patient care, or if a resident is assigned to multiple clinical settings at one time. The program director must make an assessment of the learning environment with input from faculty members and residents in light of these factors. Program directors will need to justify different patient loads with evidence such as severity of illness indicators or other factors. |
| VI.F. Teamwork | VI.F.1. Contributors to effective interprofessional teams include consulting physicians, psychologists, psychiatric nurses, social workers and other professional and paraprofessional mental health personnel involved in the evaluation and treatment of patients. | Q: Must every interprofessional team include representation from every profession listed in the requirement?  
A: No. The Review Committee recognizes that the needs of specific patients change with their health status and circumstances. The intent of the requirement is to ensure that the program has access to these professional and paraprofessional personnel, and that interprofessional teams will be constituted as appropriate and as needed; it is not to mandate that all be included in every case. |
<p>| VI.G.5.a) Fellows in the Final Years of Education | | Geriatric psychiatry fellows are considered to be in the final years of education. |
| | VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty | There are no circumstances under which fellows may stay on duty with fewer than eight hours off. |
| VI.G.6. Maximum Frequency of In-House Night Float | | |
| <strong>Psychiatry – Psychosomatic Medicine</strong> | | |
| VI.D.1. Licensed Independent Practitioner | Only Licensed Independent Practitioners as consistent with state regulations and medical staff bylaws may have primary responsibility for a patient. | |
| VI.D.5.a).(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. | |</p>
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| VI.E. Clinical Responsibilities | Specialty-specific Duty Hour Definitions | Q: What is an appropriate patient load for residents?  
A: All of the factors listed in the program requirements must contribute to the determination of an appropriate patient load for each resident. In addition, the patient care setting, the complexity of the patient’s treatment, and a resident’s role in carrying out that treatment must also be considered. For example, with psychiatric inpatients, an average case load of five-to-10 is usually appropriate, depending on the length of stay. Outpatient and consultation settings typically involve less intensive patient care responsibilities, and therefore caseloads would be higher. However, there may be situations in which lower patient caseloads may be acceptable, as when a resident is providing multiple and/or complicated interventions in patient care, or if a resident is assigned to multiple clinical settings at one time. The program director must make an assessment of the learning environment with input from faculty members and residents in light of these factors. Program directors will need to justify different patient loads with evidence such as severity of illness indicators or other factors. |
| VI.F. Teamwork | VI.F.1. Contributors to effective interprofessional teams include consulting physicians, psychologists, psychiatric nurses, social workers, and other professional and paraprofessional mental health personnel involved in the evaluation and treatment of patients. (Detail) | Q: Must every interprofessional team include representation from every profession listed in the requirement?  
A: No. The Review Committee recognizes that the needs of specific patients change with their health status and circumstances. The intent of the requirement is to ensure that the program has access to these professional and paraprofessional personnel, and that interprofessional teams will be constituted as appropriate and as needed; it is not to mandate that all be included in every case. |
| VI.G.5.a) Fellows in the Final Years of Education | Psychosomatic medicine fellows are considered to be in the final years of education. | |
| VI.G.5.c.(1) Circumstances for Eight Hours Free of Duty | There are no circumstances under which fellows may stay on duty with fewer than eight hours off. | |
| VI.G.6. Maximum Frequency of In-House Night Float | | |
| Radiation Oncology | | Q: Are there any licensed independent practitioners that the Review Committee recognizes as qualified to supervise residents?  
A: No. The Review Committee’s opinion is that it is not relevant to our specialty to have other licensed independent practitioners supervise residents. Physician extenders may be present in some clinics, but the Review Committee does not view them as primarily responsible for patient care delivered by residents. |
<p>| VI.D.1. Licensed Independent Practitioner | Do not have PGY-1 residents in the specialty. | |</p>
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| VI.E. Clinical Responsibilities | See IV.A.6.e) Each resident must treat at least 450 patients with external beam radiation therapy. (Core)  
See IV.A.6.e)(1) Holman Pathway residents must treat 350 patients. (Detail)  
See IV.A.6.e)(2) A resident should treat no more than 250 patients with external beam radiation therapy in any one year. (Detail) | |
| VI.F. Teamwork | VI.F.1. Interprofessional teams within the department should include radiation oncologists, medical physicists, radiation therapists, dosimetrists, nurses, dieticians and social workers. (Detail)  
VI.F.2. Interprofessional teams outside of the department should include surgical oncologists, medical oncologists, radiologists, pathologists and primary care physicians. (Detail) | |
| VI.G.5.b) Intermediate-level Residents | R1, R2, and R3 residents are considered to be at the intermediate level. | |
| VI.G.5.c) Residents in the Final Years of Education | R4 residents are considered to be in the final years of education. | |
| VI.G.6. Maximum Frequency of In-House Night Float | | |
| Surgery | VI.D.1. Licensed Independent Practitioner | Q: Who may supervise residents and fellows in the clinical environment?  
A: Appropriately-credentialed and privileged attending physicians in the surgical clinical environment include appropriately-credentialed American Board of Medical Specialties (ABMS)-certified surgeons (e.g., thoracic surgeries would be supervised by thoracic surgeons, etc.). In the critical care clinical environment, procedures must be supervised by appropriately-credentialed ABMS-certified critical care physicians (e.g. anesthesia critical care physicians, critical care medicine physicians, critical care pediatric physicians, etc.). |
| VI.D.5.a).(1) Supervision of Residents | VI.D.5.a).(1),(a) The program must define those physician tasks for which PGY-1 residents may be supervised indirectly, with direct supervision available, and must define “direct supervision” in the context of the program. (Detail)  
VI.D.5.a).(1),(b) The program must define those physician tasks for which PGY-1 residents must be supervised directly until they have demonstrated competence as defined by the program director, and must maintain records of such | Q: Who may provide direct supervision to PGY-1 residents?  
A: Each program is responsible for having clear policies for supervision. Direct supervision (physically present) may be provided by individuals who have been credentialed by the program to do a particular procedure or manage a particular clinical scenario and include more senior residents (PGY-2 residents and above who have met the competency requirements for the particular task at hand), fellows, and attending surgeons. Attending physicians such as anesthesia physicians, emergency department physicians, and hospitalists who are appropriately credentialed and with whom the program has a clearly defined |
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<td>demonstrations of competence. (Detail)</td>
<td>relationship outlined in the supervision policy may directly supervise PGY-1 residents.</td>
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| VI.D.5.a),(1),(c) The program should use the template of definitions provided in the FAQ or a variation of the template to develop these definitions. (Detail) | **Q:** What does "indirectly with direct supervision immediately available" mean?  
**A:** For certain tasks, supervision may be provided "indirectly" (supervising physician not physically present) by phone/text/e-mail discussion. When needed (as outlined by the programs supervision policy) or requested by the resident, the supervising physician must be physically present at the start of non-emergent tasks. For emergency situations, direct supervision should be available within 15 minutes. |

**Q:** What are examples of defined tasks for which PGY-1 residents may be supervised indirectly and examples of defined tasks for which PGY-1 residents should have direct supervision until competency is demonstrated?  
**A:** Indirect supervision is allowed for:

1. **Patient Management Competencies**
   a) evaluation and management of a patient admitted to hospital, including initial history and physical examination, formulation of a plan of therapy, and necessary orders for therapy and tests
   b) pre-operative evaluation and management, including history and physical examination, formulation of a plan of therapy, and specification of necessary tests
   c) evaluation and management of post-operative patients, including the conduct of monitoring, and orders for medications, testing, and other treatments
   d) transfer of patients between hospital units or hospitals
   e) discharge of patients from the hospital
   f) interpretation of laboratory results

2. **Procedural Competencies**
   a) performance of basic venous access procedures, including establishing intravenous access
   b) placement and removal of nasogastric tubes and Foley catheters
   c) arterial puncture for blood gases

Direct supervision is required until competency is demonstrated for:

1. **Patient Management Competencies**
   a) initial evaluation and management of patients in the urgent or emergent situation, including urgent consultations, trauma, and emergency department consultations (ATLS required)
   b) evaluation and management of post-operative complications, including hypotension, hypertension, oliguria, anuria, cardiac arrhythmias, hypoxemia, change in respiratory rate, change in neurologic status, and compartment syndromes
   c) evaluation and management of critically-ill patients, either immediately post-operatively or in the intensive care unit, including the conduct of monitoring, and orders for medications, testing, and other treatments
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<td>d) management of patients in cardiac or respiratory arrest (ACLS required) 2. Procedural Competencies a) carry-out of advanced vascular access procedures, including central venous catheterization, temporary dialysis access, and arterial cannulation b) repair of surgical incisions of the skin and soft tissues c) repair of skin and soft tissue lacerations d) excision of lesions of the skin and subcutaneous tissues e) tube thoracostomy f) paracentesis g) endotracheal intubation h) bedside debridement</td>
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<td>VI.F. Teamwork</td>
<td>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. (Detail) VI.F.2. Residents must collaborate with fellow surgical residents, and especially with faculty, other physicians outside of their specialty, and non-traditional health care providers, to best formulate treatment plans for an increasingly diverse patient population. (Detail) VI.F.3. Residents 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 in the hours assigned, or, if that is not possible,</td>
<td>Q: What skills should members of the caregiver team have and how should these be ensured across the team? A: All members of the caregiver team should be provided instruction in: 1. recognition of and sensitivity to the experience and competency of other team members; 2. time management; 3. prioritization of tasks as the dynamics of a patient’s needs change; 4. recognizing when an individual becomes overburdened with duties that cannot be accomplished within an allotted time period; 5. communication, so that if all required tasks cannot be accomplished in a timely fashion, appropriate methods are established to hand off the remaining task(s) to another team member at the end of a duty period; 6. signs and symptoms of fatigue not only in oneself, but in other team members; 7. compliance with work hours limits imposed at the various levels of education; and, 8. team development.</td>
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<td>residents must learn and utilize the established methods for handing off remaining tasks to another member of the resident team so that patient care is not compromised. (Detail) VI.F.4. Lines of authority should be defined by programs, and all residents must have a working knowledge of these expected reporting relationships to maximize quality care and patient safety. (Detail)</td>
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<td>VI.G.5.b) Intermediate-level Residents</td>
<td>PGY-2 and PGY-3 residents are considered to be at the intermediate level.</td>
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<td>VI.G.5.c) Residents in the Final Years of Education</td>
<td>Residents at the PGY-4 level and beyond are considered to be in the final years of education.</td>
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<td>VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty</td>
<td>VI.G.5.c).(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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.</td>
<td>Q: Are there any circumstances under which residents may stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty? A: Yes. Such circumstances include: 1. Continuity of care for patients, such as for: a) a patient on whom a resident operated/intervened that day who needs return to the operating room (OR); b) a patient on whom a resident operated/intervened that day who requires transfer to the Intensive Care Unit (ICU) from a lower level of care; c) a patient on whom a resident operated/intervened that day who is in the ICU and is critically unstable; d) a patient on whom a resident operated/intervened during that hospital admission, and who needs to return to the OR for a reason related to the procedure previously performed by resident; or, a patient or patient’s family with whom a resident needs to discuss limitation of treatment/DNR/DNI orders for critically-ill patient on whom the resident operated. 2. a declared emergency or disaster, for which the residents are included in the disaster plan; or, to perform high profile, low frequency procedures necessary for competence in the field.</td>
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| VI.G.6. Maximum Frequency of In-House Night Float | VI.G.6.a) Night float rotations must not exceed two months in duration, four months of night float per PGY level, and 15 months for the entire program. **(Core)** | Q: If a program offers a one-month acute care surgery rotation that has residents working 12-hour shifts alternating weeks of nights and day shifts, is this considered a night float rotation?  
A: Yes. These residents cannot work more than six consecutive nights during the night shift weeks, there must be one month off between such rotations, and the two weeks of night shifts count toward the total time on night float.  
Q: If a program offers a one-month rotation with four residents where, in lieu of call every fourth night, each resident groups their call into no more than five or six consecutive nights as a night shift, is this considered a night float rotation?  
A: No. The consecutive nights would not count as one week toward the total amount of night float, and a one-month hiatus would not be required between such rotations.  
Q: Is it acceptable for a program to offer a rotation for two successive months alternating night shifts for two weeks with day shifts for two weeks?  
A: Yes. The four weeks of night shifts would count toward the 15-month maximum allowable for any resident over the five-year residency. There must be a one month hiatus between such rotations. A rotation that includes any component of night float must not exceed two months in duration.  
Q: For a resident who completed four months of night float during one year as a preliminary resident, would the maximum number of night float months allowed during the five-year categorical residency 15 months or only 11 months?  
A: If such a resident starts the program as a PGY-1 categorical resident, he or she would be allowed to work 15 months of night call over the five years. If he or she matches as a PGY-2 resident, only 11 months would be allowed.  
Q: What is the maximum number of months of night float allowed, during the final three years of the program, for a resident who completed two years as a categorical resident (during which time he or she worked seven months on night float rotations) and who then completed two years in the lab (during which time he or she worked two months on night float rotations)?  
A: In such a case, the resident would be allowed eight months of night float since he or she worked seven during the first two years of her clinical education. The two months worked during the lab time should not be counted toward the 15-month total.  
Q: What is the maximum number of months of night float allowed, during the final year of the program, for a resident who completed two years as a categorical resident in one program (during which time he or she worked eight months on night float rotations) and who then transferred to another program as a PGY-3?  
A: In such a case, the resident would be allowed a maximum of seven months since he or she already worked eight months at the other program, and the maximum number of night float months must not exceed 15 during the five years of clinical education for any one resident. |
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<td>VI.D.1. Licensed</td>
<td>Licensed Independent Practitioner</td>
<td>Q: What types of physicians are acceptable as identifiable appropriately-credentialed and privileged attending physicians who are ultimately responsible for each patient’s care? A: Appropriately-credentialed and privileged attending physicians in the surgical clinical environment include ABMS appropriately-credentialed surgeons (e.g., thoracic surgeries would be supervised by thoracic surgeons, etc.). In the critical care clinical environment, procedures must be supervised by appropriately credentialed ABMS-certified critical care physicians (e.g., anesthesia critical care physicians, critical care medicine physicians, critical care pediatric physicians, etc.).</td>
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<td>Do not have PGY-1 residents in the subspecialty.</td>
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<td>VI.E. Clinical</td>
<td>VI.E.1. As fellows progress through levels of increasing</td>
<td>Q: What skills should members of the caregiver team have and how should these be ensured across the team? A: All members of the caregiver team should be provided instruction in: 1. recognition of and sensitivity to the experience and competency of other team members; 2. time management; 3. prioritization of tasks as the dynamics of a patient’s needs change; 4. recognizing when an individual becomes overburdened with duties that cannot be accomplished within an allotted time period; 5. communication, so that if all required tasks cannot be accomplished in a timely fashion, appropriate methods are established to hand off the remaining task(s) to another team member at the end of a duty period; 6. signs and symptoms of fatigue not only in oneself, but in other team members; 7. compliance with work hours limits imposed at the various levels of education; and, 8. team development.</td>
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<td>VI.F.2. The work of the caregiver team should be assigned to team members based on each member’s level of education, experience, and competence.</td>
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<td>VI.F.3. Fellows must collaborate with fellow surgical residents, and especially with faculty members, other physicians outside of their subspecialty, and non-traditional health care providers, to best formulate treatment plans for an increasingly diverse patient population.</td>
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<td>VI.F.4. 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 in the hours assigned, or, if that is not possible, residents must learn and utilize the established methods for handing off remaining tasks to another member of the health care team so that patient care is not compromised.</td>
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<td>VI.G.5.a) Fellows in the Final Years of Education</td>
<td>Complex general surgical oncology fellows are considered to be in the final years of education.</td>
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<td>VI.G.5.a),(1) (1)</td>
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<td>Q: Are there any circumstances under which residents may stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty? A: Yes. Such circumstances include: 1. continuity of care for patients, such as for: a) a patient on whom a resident operated/intervened that day who needs return to the operating room (OR); b) a patient on whom a resident operated/intervened that day who requires transfer to the Intensive Care Unit (ICU) from a lower level of care; c) a patient on whom a resident operated/intervened that day who is in the ICU and is critically unstable; d) a patient on whom a resident operated/intervened during that hospital admission, and who needs to return to the OR for a reason related to the procedure previously performed by resident; or, a patient or patient’s family with whom a resident needs to discuss limitation of treatment/DNR/DNI orders for critically-ill patient on whom the resident operated. 2. a declared emergency or disaster, for which the residents are included in the disaster plan; or, to perform high profile, low frequency procedures necessary for competence in the field.</td>
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<td>VI.G.6.a) The total amount of night float for any fellow must be no more than two months per PG year.</td>
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<td>Surgery – Pediatric</td>
<td>Q: Who may supervise residents and fellows in the clinical environment? A: Appropriately-credentialed and privileged attending physicians in the surgical clinical environment include appropriately-credentialed ABMS Member Board-certified surgeons (e.g., thoracic surgeries would be supervised by thoracic surgeons, etc.). In the critical care clinical environment, procedures must be supervised by appropriately-credentialed ABMS Member Board-certified critical care physicians (e.g. anesthesia critical care physicians, critical care medicine physicians, critical care pediatric physicians, etc.).</td>
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<td>Q: What skills should members of the caregiver team have and how should these be ensured across the team? A: All members of the caregiver team should be provided instruction in: 1. recognition of and sensitivity to the experience and competency of other team members; 2. time management; 3. prioritization of tasks as the dynamics of a patient’s needs change; 4. recognizing when an individual becomes overburdened with duties that cannot be accomplished within an allotted time period; 5. communication, so that if all required tasks cannot be accomplished in a timely fashion, appropriate methods are established to hand off the remaining task(s) to another team member at the end of a duty period; 6. signs and symptoms of fatigue not only in oneself, but in other team members; 7. compliance with work hours limits imposed at the various levels of education; and, 8. team development.</td>
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<td>VI.G.5.c) Residents in the Final Years of Education</td>
<td>Pediatric surgery fellows are considered to be in the final years of education.</td>
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| VI.G.5.c),(1)           | VI.G.5.c),(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. | Q: Are there any circumstances under which residents may stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty?  
A: Yes. Such circumstances include:  
1. Continuity of care for patients, such as for:  
   a) a patient on whom a resident operated/intervened that day who needs return to the operating room (OR);  
   b) a patient on whom a resident operated/intervened that day who requires transfer to the Intensive Care Unit (ICU) from a lower level of care;  
   c) a patient on whom a resident operated/intervened that day who is in the ICU and is critically unstable;  
   d) a patient on whom a resident operated/intervened during that hospital admission, and who needs to return to the OR for a reason related to the procedure previously performed by resident; or, a patient or patient’s family with whom a resident needs to discuss limitation of treatment/DNR/DNI orders for critically-ill patient on whom the resident operated.  
2. a declared emergency or disaster, for which the residents are included in the disaster plan; or, to perform high profile, low frequency procedures necessary for competence in the field. |
| VI.G.6. Maximum Frequency of In-House Night Float | VI.G.6.a) Any rotation that requires fellows to work nights in succession is considered a night float rotation, and the total time on nights is counted toward the maximum allowable time for each fellow.  
VI.G.6.b) Night float rotations must not exceed two months in succession, or three months in succession for rotations with night shifts alternating with day shifts. (Core)  
VI.G.6.c) There can be no more than four months of night float per year. (Core)  
VI.G.6.d) There must be at least two months between each night float rotation. (Core) | Q: A program offers a one-month acute care surgery rotation that has residents working 12-hour shifts alternating weeks of nights and day shifts. Is this considered a night float rotation?  
A: Yes. These residents cannot work more than six consecutive nights during the night shift weeks, there must be two months off between such rotations, and the two weeks of night shifts count toward the total time on night float.  
Q: A program offers a one-month rotation with four residents where, in lieu of call every fourth night, each resident groups their call into five or six consecutive nights as a night shift. Is this considered a night float rotation?  
A: Yes in part. The consecutive nights would count as one week toward the total amount of night float, but a two-month hiatus would not be required between such rotations.  
Q: A program offers a rotation for three successive months alternating night shifts for two weeks with day shifts for two weeks. Is this allowed?  
A: Yes. The six weeks of night shifts would count toward the 15-month maximum allowable for any resident over the five-year residency. There must be two months between such rotations. |
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| VI.D.1. Licensed Independent Practitioner | **VI.E. Clinical Responsibilities**

VI.E.1. The workload associated with optimal clinical care of surgical patients is a continuum from the moment of admission to the point of discharge. (Detail)

VI.E.2. During the residency education process, surgical teams should be made up of attending surgeons, residents at various PG levels, medical students (when appropriate), and other health care providers. (Detail)

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

VI.E.4. As fellows progress through levels of increasing competence and responsibility, it is expected that work assignments will keep pace with their advancement. (Detail)

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**Q:** Who may supervise residents and fellows in the clinical environment?

**A:** Appropriately-credentialed and privileged attending physicians in the surgical clinical environment include appropriately-credentialed ABMS Member Board-certified surgeons (e.g., thoracic surgeons would be supervised by thoracic surgeons, etc.). In the critical care clinical environment, procedures must be supervised by appropriately-credentialed ABMS Member Board-certified critical care physicians (e.g. anesthesia critical care physicians, critical care medicine physicians, critical care pediatric physicians, etc.).

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**Q:** What skills should members of the caregiver team have and how should these be ensured across the team?

**A:** All members of the caregiver team should be provided instruction in:

1. recognition of and sensitivity to the experience and competency of other team members;
2. time management;
3. prioritization of tasks as the dynamics of a patient’s needs change;
4. recognizing when an individual becomes overburdened with duties that cannot be accomplished within an allotted time period;
5. communication, so that if all required tasks cannot be accomplished in a timely fashion, appropriate methods are established to hand off the remaining task(s) to another team member at the end of a duty period;
6. signs and symptoms of fatigue not only in oneself, but in other team members;
7. compliance with work hours limits imposed at the various levels of education; and,
8. team development.
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<td>handing off remaining tasks to another member of the fellow team so that patient care is not compromised. <em>(Detail)</em></td>
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<td>VI.F.4. Lines of authority should be defined by programs, and all fellows must have a working knowledge of these expected reporting relationships to maximize quality care and patient safety. <em>(Detail)</em></td>
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<tr>
<td>VI.G.5.a) Fellows in the Final Years of Education</td>
<td>Surgical critical care fellows are considered to be in the final years of education.</td>
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<tr>
<td>VI.G.5.a).(1) Circumstances for Eight Hours Free of Duty</td>
<td>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.</td>
<td>Q: Are there any circumstances under which residents may stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty? A: Yes. Such circumstances include: 1. Continuity of care for patients, such as for: a) a patient on whom a resident operated/intervened that day who needs return to the operating room (OR); b) a patient on whom a resident operated/intervened that day who requires transfer to the Intensive Care Unit (ICU) from a lower level of care; c) a patient on whom a resident operated/intervened that day who is in the ICU and is critically unstable; d) a patient on whom a resident operated/intervened during that hospital admission, and who needs to return to the OR for a reason related to the procedure previously performed by resident; or, a patient or patient’s family with whom a resident needs to discuss limitation of treatment/DNR/DNI orders for critically-ill patient on whom the resident operated. 2. A declared emergency or disaster, for which the residents are included in the disaster plan; or, to perform high profile, low frequency procedures necessary for competence in the field.</td>
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**Surgery – Vascular**

**VI.D.1. Licensed Independent Practitioner**

**VI.D.5.a),(1) Supervision of Residents**

VI.D.5.a),(1).a) The program must define those physician tasks for which PGY-1 residents may be supervised indirectly, with direct supervision available, and must define “direct supervision” in the context of the program. (Core)

VI.D.5.a),(1).b) The program must define those physician tasks for which PGY-1 residents must be supervised directly until they have demonstrated competence as defined by the program director, and must maintain records of such demonstrations of competence. (Core)

**VI.E. Clinical Responsibilities**

VI.E.1. The workload associated with optimal clinical care of surgical patients is a continuum from the moment of admission to the point of discharge. (Core)

VI.E.2. During the residency education process, surgical teams should be made up of attending surgeons, residents at various PG levels, medical students (when appropriate), and other health care providers. (Core)

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

VI.E.4. As fellows progress through levels of increasing

**Frequently Asked Questions (FAQs)**

Q: A program offers a one-month acute care surgery rotation that has residents working 12-hour shifts alternating weeks of nights and day shifts. Is this considered a night float rotation?

A: Yes. These residents cannot work more than six consecutive nights during the night shift weeks, there must be two months off between such rotations, and the two weeks of night shifts count toward the total time on night float.

Q: A program offers a one-month rotation with four residents where, in lieu of call every fourth night, each resident groups their call into five or six consecutive nights as a night shift. Is this considered a night float rotation?

A: Yes in part. The consecutive nights would count as one week toward the total amount of night float, but a two-month hiatus would not be required between such rotations.

Q: A program offers a rotation for three successive months alternating night shifts for two weeks with day shifts for two weeks. Is this allowed?

A: Yes. The six weeks of night shifts would count toward the 15-month maximum allowable for any resident over the five-year residency. There must be two months between such rotations.

Q: What skills should members of the caregiver team have and how should these be ensured across the team?

A: All members of the caregiver team should be provided instruction in:

1. recognition of and sensitivity to the experience and competency of other team members;
2. time management;
3. prioritization of tasks as the dynamics of a patient’s needs change;
4. recognizing when an individual becomes overburdened with duties that cannot be accomplished within an allotted time period;
5. communication, so that if all required tasks cannot be accomplished in a timely fashion, appropriate methods are established to hand off the remaining task(s) to another team member at the end of a duty period;
6. signs and symptoms of fatigue not only in oneself, but in other team members;
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| VI.F. Teamwork          | 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. *(Core)*  
VI.F.2. Fellows must collaborate with fellow surgical residents, and especially with faculty, other physicians outside of their specialty, and non-traditional health care providers, to best formulate treatment plans for an increasingly diverse patient population. *(Core)*  
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 in 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. *(Core)*  
VI.F.4. Lines of authority should be defined by programs, and all fellows must have a working knowledge of these expected reporting relationships to maximize quality care and patient safety. *(Core)* | 7. compliance with work hours limits imposed at the various levels of education; and,  
8. team development. |
| VI.G.5.b) Intermediate-level Residents | For independent programs, vascular surgery fellows are considered to be in the final years of education.  
For integrated programs, PGY-2 and PGY-3 residents are considered to be at the intermediate level. |  |
| VI.G.5.c) Residents in the Final Years of Education | For independent programs, vascular surgery fellows are considered to be in the final years of education.  
For integrated programs, residents at the PGY-4 level and beyond are considered to be in the final years of education. |  |
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| VI.G.5.c).(1)           | The Review Committee defines such     | **Q:** Are there any circumstances under which residents may stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty?  
| Circumstances for Eight | 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. | **A:** Yes. Such circumstances include:  
1. Continuity of care for patients, such as for:  
   a) a patient on whom a resident operated/intervened that day who needs return to the operating room (OR);  
   b) a patient on whom a resident operated/intervened that day who requires transfer to the Intensive Care Unit (ICU) from a lower level of care;  
   c) a patient on whom a resident operated/intervened that day who is in the ICU and is critically unstable;  
   d) a patient on whom a resident operated/intervened during that hospital admission, and who needs to return to the OR for a reason related to the procedure previously performed by resident; or, a patient or patient’s family with whom a resident needs to discuss limitation of treatment/DNR/DNI orders for critically-ill patient on whom the resident operated.  
2. a declared emergency or disaster, for which the residents are included in the disaster plan; or, to perform high profile, low frequency procedures necessary for competence in the field. |
| Hours Free of Duty      | VI.G.5.c).(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. |  

| VI.G.6. Maximum         | VI.G.6.a) Night float rotations must not exceed two months in succession, or three months in succession for rotations with night shifts alternating with day shifts.  
| Frequency of In-House   |   (Detail)  
| Night Float             | VI.G.6.b) There can be no more than four months of night float per year.  
|                         |   (Detail)  
|                         | VI.G.6.c) There must be at least two months between each night float rotation.  
|                         |   (Detail)  
|                         | VI.G.6.d) The total amount of night float for any fellow in a two-year fellowship must be no more than eight months.  
|                         |   (Detail)  
|                         | VI.G.6.e) The total amount of night float for any resident over a five-year residency must be no more than 15 months.  
|                         |   (Detail)  
|                         | VI.G.6.e).(1) Any rotation that requires residents to work nights in succession, is considered a night float rotation, and the total time on nights is counted toward the maximum allowable time for each resident over the five-year residency.  
|                         |   (Core)  
|                         | **Q:** A program offers a one-month acute care surgery rotation that has residents working 12-hour shifts alternating weeks of nights and day shifts. Is this considered a night float rotation?  
|                         | **A:** Yes. These residents cannot work more than six consecutive nights during the night shift weeks, there must be two months off between such rotations, and the two weeks of night shifts count toward the total time on night float.  
|                         | **Q:** A program offers a one-month rotation with four residents where, in lieu of call every fourth night, each resident groups their call into five or six consecutive nights as a night shift. Is this considered a night float rotation?  
|                         | **A:** Yes in part. The consecutive nights would count as one week toward the total amount of night float, but a two-month hiatus would not be required between such rotations.  
|                         | **Q:** A program offers a rotation for three successive months alternating night shifts for two weeks with day shifts for two weeks. Is this allowed?  
<p>|                         | <strong>A:</strong> Yes. The six weeks of night shifts would count toward the 15-month maximum allowable for any resident over the five-year residency. There must be two months between such rotations. |</p>
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<td>VI.D.1. Licensed</td>
<td><strong>Independent Practitioner</strong></td>
<td>Q: What types of physicians are acceptable as identifiable appropriately-credentialed and privileged attending physicians who are ultimately responsible for each patient’s care? A: Appropriately-credentialed and privileged attending physicians in the clinical environment include ABMS member board-certified physicians and surgeons (i.e., thoracic surgeons would be supervised by thoracic surgeons, etc.).</td>
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<td>VI.D.5.a).(1) Supervision</td>
<td><strong>of Residents</strong></td>
<td>Q: For which tasks may PGY-1 residents be supervised indirectly, and for which tasks should PGY-1 residents have direct supervision until competence is demonstrated? A: I. Indirect supervision allowed</td>
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<td>VI.D.5.a).(2) The program must define those physician tasks for which PGY-1 residents may be supervised indirectly, with direct supervision available, and must define “direct supervision” in the context of the program. The program must also define tasks for which PGY-1 residents must be supervised directly until they have demonstrated competence as defined by the program director, and must maintain records of such demonstrations of competence. (Core)</td>
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<td></td>
<td><strong>Patient Management Competencies</strong></td>
<td>a. Patient Management Competencies</td>
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<td>1. Evaluation and management of a patient admitted to hospital, including initial history and physical examination, formulation of a plan of therapy, and necessary orders for therapy and tests</td>
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<td>2. Pre-operative evaluation and management, including history and physical examination, formulation of a plan of therapy, and specification of necessary tests</td>
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<td>3. Evaluation and management of post-operative patients, including the conduct of monitoring and orders for medications, testing and other treatments</td>
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<td>4. Transfer patients between hospital units or hospitals</td>
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<td>5. Discharge patients from hospital</td>
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<td>6. Interpretation of laboratory results</td>
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<td></td>
<td><strong>Procedural Competencies</strong></td>
<td>b. Procedural Competencies</td>
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<td>1. Perform basic venous access procedures, including establishing of intravenous access</td>
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<td>2. Placement and removal of nasogastric tubes and Foley catheters</td>
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<td></td>
<td>3. Arterial puncture for blood gases</td>
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<td><strong>II. Direct supervision required until competency demonstrated</strong></td>
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<td></td>
<td>a. Patient Management Competencies</td>
<td>II. Direct supervision required until competency demonstrated</td>
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<td>1. Initial evaluation and management of patients in the urgent or emergent situation, including urgent consultations, trauma, and emergency department consultations (ATLS required)</td>
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<td></td>
<td>2. Evaluation and management of postoperative complications, including anuria, cardiac arrhythmias, change in neurologic status, change in respiratory rate, compartment syndromes, hypertension, hypotension, hypoxemia, and oliguria</td>
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<td></td>
<td>3. Evaluation and management of critically-ill patients, either immediately post-operatively or in the intensive care unit, including the conduct of monitoring and orders for medications, testing and other treatments</td>
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Specialty/Requirement # | Specialty-specific Duty Hour Definitions | Frequently Asked Questions (FAQs)
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|  |  | 4. Management of patients in cardiac or respiratory arrest (ACLS required) |
|  |  | c. Procedural Competencies |
|  |  | 1. Carry out advanced vascular access procedures, including central venous catheterization, temporary dialysis access, and arterial cannulation. |
|  |  | 2. Repair of surgical incisions of the skin and soft tissues |
|  |  | 3. Repair of lacerations of the skin and soft tissues |
|  |  | 4. Excision of lesions of the skin and subcutaneous tissues |
|  |  | 5. Tube thoracostomy |
|  |  | 6. Paracentesis |
|  |  | 7. Endotracheal intubation |
|  |  | 8. Bedside debridement |

VI.E. Clinical Responsibilities

VI.F. Teamwork

**Q:** What are the elements of an effective interprofessional team?

**A:** Effective surgical practices entail the involvement of interprofessional team members with a mix of complementary skills. Residents must collaborate with fellow surgical residents and faculty members, other physicians outside of the specialty, and non-traditional health care providers to best formulate treatment plans for an increasingly diverse patient population. Residents 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 in the hours assigned, or, if that is not possible, residents must learn and utilize the established methods for handing off remaining tasks to another member of the resident team so that patient care is not compromised.

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

**Q:** What skills should members of the interprofessional caregiver team have and how should these be ensured across the team?

**A:** All members of the interprofessional caregiver team should be provided instruction in:

1. Communication, so that if all required tasks cannot be accomplished in a timely fashion, appropriate methods are established to hand off the remaining task(s) to another team member at the end of a duty period;
2. Compliance with work hours limits imposed at the various levels of education;
3. Prioritization of tasks as the dynamics of a patient’s needs change;
4. Recognition of and sensitivity to the experience and competency of other team members;
5. Recognizing when an individual becomes overburdened with duties that
### Specialty/Requirement # | Specialty-specific Duty Hour Definitions | Frequently Asked Questions (FAQs)
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|  |  | can be accomplished within an allotted time period; signs and symptoms of fatigue not only in oneself, but in other team members; team development; and, time management; |
|  |  | Q: What is the optimum clinical workload for residents? A: Optimum workload may be very different between individual residents at the same level, and between residents at different levels, related to experience, speed of learning, and personal efficiency. Optimum work is achieved when a resident is busy and engaged in direct patient care for 60-90% of his or her normal duty hours, with the exception of extended hours of call where “busy” is more likely 10-50% of clinical activities in the on-call period. It is appropriate to challenge residents to take on progressively more responsibility and to develop efficient multi-tasking skills necessary for the work of a thoracic surgeon. |

**VI.G.5.b) Intermediate-level Residents**

For independent programs, Y-1, -2, and -3 residents are considered to be in the final years of education.

For integrated programs, Y-2 and -3 fellows are considered to be at the intermediate level.

**VI.G.5.c) Residents in the Final Years of Education**

For independent programs, Y-1, -2, and -3 residents are considered to be in the final years of education.

For integrated programs, Y-4, -5, and -6 level residents are considered to be in the final years of education.

**VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty**

**VI.G.5.c).(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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.

**Q:** Are there any circumstances under which residents may stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty? **A:** Yes. These include:

1. continuity of care for patients;
   a. A patient on whom a resident operated/intervened that day needs return to the operating room (OR).
   b. A patient on whom a resident operated/intervened that day requires transfer to an intensive care unit (ICU) from a lower level of care.
   c. A patient on whom a resident operated/intervened that day in ICU is critically unstable.
   d. A patient on whom a resident operated/intervened during that hospital admission needs to return to the OR related to an operation or procedure previously performed by that resident.
   e. A patient or patient’s family needs to discuss treatment of a critically-ill patient on whom the resident has operated or is responsible for care.
2. a declared emergency or disaster, for which residents are included in the disaster plan; and,
3. to perform high profile, low frequency procedures necessary for competence in the field.
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<td>VI.G.6. Maximum Frequency of In-House Night Float</td>
<td>VI.G.6.a) Residents must not have more than four consecutive weeks of night float assignment, and night float cannot exceed one month per year. (Detail)</td>
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<td>Thoracic Surgery – Congenital Cardiac Surgery</td>
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| VI.D.1. Licensed Independent Practitioner | | Q: What types of physicians are acceptable as identifiable appropriately-credentialed and privileged attending physicians who are ultimately responsible for each patient’s care?  
A: Appropriately-credentialed and privileged attending physicians in the clinical environment include ABMS appropriately-credentialed physicians and surgeons (e.g. thoracic surgeries would be supervised by thoracic surgeons, etc.). |
| VI.D.5.a).(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. | |
| VI.E. Clinical Responsibilities | | Q: What skills should members of the interprofessional caregiver team have and how should these be ensured across the team?  
A: All members of the interprofessional caregiver team should be provided instruction in:  
1. communication, so that if all required tasks cannot be accomplished in a timely fashion, appropriate methods are established to hand off the remaining task(s) to another team member at the end of a duty period;  
2. compliance with work hours limits imposed at the various levels of education;  
3. prioritization of tasks as the dynamics of a patient’s needs change;  
4. recognition of and sensitivity to the experience and competency of other team members;  
5. recognizing when an individual becomes overburdened with duties that cannot be accomplished within an allotted time period;  
6. signs and symptoms of fatigue not only in oneself, but in other team members;  
7. team development; and,  
8. time management;  
Q: What is the optimum clinical workload?  
A: Optimum workload may be very different between individual residents at the same level, and between residents at different levels, related to experience, speed of learning, and personal efficiency. Optimum work is achieved when a resident is busy and engaged in direct patient care for 60-90% of his or her normal duty hours, with the exception of extended hours of call where “busy” is more likely 10-50% of clinical activities in the on-call period. It is appropriate to challenge residents to take on progressively more responsibility and to develop efficient multi-tasking skills necessary. |
### Specialty/Requirement # | Specialty-specific Duty Hour Definitions | Frequently Asked Questions (FAQs)
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**VI.F. Teamwork** |  | Q: What are the elements of an effective interprofessional team?  
A: Effective surgical practices entail the involvement of interprofessional team members with a mix of complementary skills. Residents must collaborate with fellow surgical residents and faculty, other physicians outside of their specialty, and non-traditional health care providers, to best formulate treatment plans for an increasingly diverse patient population.  
Residents 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 in the hours assigned, or, if that is not possible, residents must learn and utilize the established methods for handing off remaining tasks to another member of the resident team so that patient care is not compromised.  
Lines of authority should be defined by programs, and all residents must have a working knowledge of these expected reporting relationships to maximize quality care and patient safety.

**VI.G.5.a).(1)** Circumstances for Eight Hours Free of Duty | Congenital cardiac thoracic surgery fellows are considered to be in the final years of education.  
**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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.  
Q: Are there any circumstances under which residents may stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty?  
A: Yes. These include:  
1. continuity of care for patients;  
   a. A patient on whom a resident operated/intervened that day needs return to the operating room (OR).  
   b. A patient on whom a resident operated/intervened that day requires transfer to an intensive care unit (ICU) from a lower level of care.  
   c. A patient on whom a resident operated/intervened that day in the ICU is critically unstable.  
   d. A patient on whom a resident operated/intervened during that hospital admission requires a return to the OR related to an operation or procedure previously performed by that resident.  
   e. A patient or patient’s family needs to discuss treatment of a critically-ill patient on whom the resident has operated or is responsible for care.  
2. a declared emergency or disaster, for which the residents are included in the disaster plan; and,  
3. to perform high profile, low frequency procedures necessary for competence in the field.

**VI.G.6. Maximum Frequency of In-House Night Float** | Fellows must not have more than four consecutive weeks of night float assignment, and night float cannot exceed one month per year.  
**Transitional Year**

**VI.D.1. Licensed Independent Practitioner** | See II.B.1.c) [The faculty must] provide equivalent teaching and supervision for transitional year residents as that provided to categorical residents in the participating programs.  
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<tr>
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<th>Frequently Asked Questions (FAQs)</th>
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<tr>
<td>VI.D.5.a).(1) Supervision of Residents</td>
<td>Do not have PGY-1 residents in the subspecialty.</td>
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<tr>
<td>VI.E. Clinical Responsibilities</td>
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<tr>
<td>VI.F. Teamwork</td>
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<tr>
<td>VI.G.5.b) Intermediate-level Residents</td>
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<td>VI.G.5.c) Residents in the Final Years of Education</td>
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<tr>
<td>VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty</td>
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</table>
| VI.G.6. Maximum Frequency of In-House Night Float | | Q: What are the requirements for night float rotations?  
A: The Review Committee believes that educational experiences in night medicine can offer residents valuable educational and professional benefits, and that transitional year residents should be treated the same as categorical residents on night float rotations. The Review Committee expects that night float or night medicine rotations correspond to the block rotation to which a resident is currently assigned. Additionally, night float rotations should have a set of formal goals, objectives, and learning activities that should include strategies for fatigue and alertness management.  
An appropriate level of supervision must be available for all transitional year residents on night float. The Program Requirements state that transitional year residents must not be scheduled for more than six consecutive nights of night float. Residents should also not be assigned for more than four contiguous weeks of night float, and should have no more than six total weeks of night float during the transitional year residency. |
<p>| <strong>Urology</strong> | | |
| VI.D.1. Licensed Independent Practitioner | VI.D.1.c) The Review Committee recognizes only physician faculty members as appropriate faculty supervisors for residents. | |
| VI.D.5.a).(1) Supervision of Residents | Do not have PGY-1 residents in the specialty. | |
| VI.E. Clinical Responsibilities | VI.E.1. The program director must establish guidelines for the assignment of Clinical Responsibilities by the PGY level, including clinic volume, on-call frequency and back-up requirements, and the appropriate role in surgical procedures. | |
| VI.F. Teamwork | VI.F.1. Each resident must have the opportunity to interact with nurses, other specialists, social workers, and mid-level providers. | |
| VI.G.5.b) Intermediate-level Residents | URO-1 and URO-2 residents are considered to be at the intermediate level. | |</p>
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<tr>
<td>VI.G.5.c) Residents in the Final Years of Education</td>
<td>URO-3 and URO-4 residents are considered to be in the final years of education.</td>
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<tr>
<td>VI.G.5.c),(1) Circumstances for Eight Hours Free of Duty</td>
<td>VI.G.5.c),(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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.</td>
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<tr>
<td>VI.G.6. Maximum Frequency of In-House Night Float</td>
<td>VI.G.6.a) Residents cannot be assigned more than eight weeks of night float per year. (Detail)</td>
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<td>VI.G.6.b) Night float rotations must not exceed 16 weeks total during URO-1 and URO-2. (Detail)</td>
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<td><strong>Urology – Pediatric</strong></td>
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<tr>
<td>VI.D.1. Licensed Independent Practitioner</td>
<td><strong>Do not have PGY-1 residents in the subspecialty.</strong></td>
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<tr>
<td>VI.D.5.a),(1) Supervision of Residents</td>
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<tr>
<td>VI.E. Clinical Responsibilities</td>
<td>VI.E.1. The program director must establish guidelines for the assignment of Clinical Responsibilities by fellows, including clinic volume, on-call frequency and back up requirements, and the appropriate role in surgical procedures. (Core)</td>
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<tr>
<td>VI.F. Teamwork</td>
<td>VI.F.1. Each resident must have the opportunity to interact with other providers such as nurses, other specialists, social workers, and mid-level providers. (Core)</td>
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<tr>
<td>VI.G.5.a) Fellows in the Final Years of Education</td>
<td>Pediatric urology fellows are considered to be in the final years of education.</td>
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<tr>
<td>VI.G.5.a),(1) Circumstances for Eight Hours Free of Duty</td>
<td>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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.</td>
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<tr>
<td>VI.G.6. Maximum Frequency of In-House Night Float</td>
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<tr>
<td><strong>MULTIDISCIPLINARY SUBSPECIALTIES</strong></td>
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<tr>
<td>Clinical Informatics (subspecialty of Anesthesiology, Diagnostic Radiology, Emergency Medicine, Family Medicine, Internal Medicine, Medical Genetics, Pathology, Pediatrics, or Preventive Medicine)</td>
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<td>VI.D.1. Licensed Independent Practitioner</td>
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<tr>
<td>VI.D.5.a),(1) Supervision of Residents</td>
<td><strong>Do not have PGY-1 residents in the subspecialty.</strong></td>
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<td>VI.F. Teamwork</td>
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<tr>
<td>VI.G.5.a) Fellows in the Final Years of Education</td>
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<tr>
<td>VI.G.5.a).(1) Circumstances for Eight Hours Free of Duty</td>
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<td>VI.G.6. Maximum Frequency of In-House Night Float</td>
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**Dermatopathology (subspecialty of Dermatology or Pathology)**

| VI.D.1. Licensed Independent Practitioner | | |
| VI.D.5.a).(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. | |
| VI.E. Clinical Responsibilities | VI.E.1. This optimal case number and distribution of case load over time will vary with the individual fellow, and will also vary with the increasing responsibility appropriate to his or her demonstrated competence in dermatopathology over the course of the fellowship year. The optimal case load will allow each fellow to see as many cases as possible, without being overwhelmed by patient care responsibilities. (Detail) | |
| VI.F. Teamwork | VI.F.1. The program must ensure that appropriate professional interaction is initiated and maintained between fellows and other physicians involved in the care of a patient. Such interactions would include participation in interdisciplinary conferences (e.g., tumor board) and reporting unexpected or critical findings and information to the physician responsible for the clinical care of a particular patient. (Detail) | |
| VI.G.5.a) Fellows in the Final Years of Education | Dermatopathology fellows are considered to be in the final years of education. | |
| VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty | There are no circumstances under which Residents in the Final Years of Education may stay on duty without eight hours off. | |

**Q:** Who is qualified to supervise fellows in patient care activities?  
**A:** In both the clinic setting, where fellows see patients, and in pathology or dermatopathology, where fellows work up and sign out biopsies or excisions, there must be a qualified attending staff physician who reviews and signs off on a fellow’s diagnosis and treatment plan or pathology report. Since there is graded responsibility over the fellowship year as competency is documented, the attending physician may exercise indirect and/or possibly oversight supervision.
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<tr>
<td>VI.G.6. Maximum Frequency of In-House Night Float</td>
<td>Endovascular Surgical Neuroradiology (subspecialty of Neurological Surgery, Neurology, or Diagnostic Radiology)</td>
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</tbody>
</table>
| VI.D.1. Licensed Independent Practitioner | **Q:** Are there any situations when fellows may be supervised by non-neurosurgical Licensed Independent Practitioners?  
**A:** In the angiographic suite, a properly credentialed and privileged interventional neuroradiologist or interventional neurologist may supervise a fellow. | |
| VI.D.5.a)(1) Supervision of Residents | **Do not have PGY-1 residents in the subspecialty.** | |
| VI.E. Clinical Responsibilities | **Q:** What is an appropriate patient load for fellows?  
**A:** While a minimum clinical workload might be considered to be comparable to that of a neurological surgery chief resident or transition-to-practice level (10 general inpatients and three intensive care unit (ICU) patients), further specification will hinder development of advanced skills. The program director must make an assessment of the learning environment, including patient safety, complexity of patient illness/condition, available support services, and level of fellow knowledge, skills, and abilities when determining when and how much to deviate from this minimum. | |
| VI.F. Teamwork | **Q:** Who should be included in the interprofessional teams?  
**A:** Advanced practice providers, audiologists, certified registered nurse anesthetists (CRNAs), child-life specialists, nurses, nutritionists, operating room (OR) technicians, pharmacists, physical and occupational therapists, physician assistants, psychologists, radiology technicians, respiratory therapists, social workers, and speech and language pathologists are examples of professional personnel who may be part of the interprofessional teams.  
**Q:** Must every interprofessional team include representation from every professional listed above?  
**A:** No. The Review Committee recognizes that the needs of specific patients change with their health statuses and circumstances. The Review Committee’s intent is to ensure that the program has access to these professional and paraprofessional personnel, and that interprofessional teams be constituted as appropriate and as needed, not to mandate that all be included in every case/care environment.  
**Q:** What roles must fellows have in the interprofessional health care team?  
**A:** As members of the interprofessional health care team, fellows must have key roles in diagnostic work-up, operative procedures, treatment decisions, measurement of treatment outcomes, and the communication and coordination of these activities with program faculty and referring sources. | |
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<td>VI.G.5.a).(1)</td>
<td>Fellows may stay on duty with fewer than eight hours free of duty; (Detail)</td>
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<tr>
<td>Circumstances for Eight Hours Free of Duty</td>
<td>VI.G.5.a).(1).(b) to continue to provide care for a severely ill or unstable patient; (Detail)</td>
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<td>VI.G.5.a).(1).(b).(i) to participate in end-of-life care or management of a complication related to an earlier procedure in which the fellow was involved; (Detail)</td>
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<td>VI.G.5.a).(1).(b).(ii) to provide humanistic attention to the needs of a patient or a patient’s family; or, (Detail)</td>
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<td>VI.G.5.a).(1).(b).(iii) for the academic importance of the events transpiring, including the opportunity to participate in a procedure that provides a unique or otherwise hard-to-obtain experience. (Detail)</td>
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<td>VI.G.6. Maximum</td>
<td>Fellows must have no more than six consecutive weeks of night float rotations, and no more than four months of night float rotations in total per year. (Detail)</td>
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<tr>
<td>Frequency of In-House Night Float</td>
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**Female Pelvic Medicine and Reconstructive Surgery (subspecialty of Obstetrics and Gynecology or Urology)**

| VI.D.1. Licensed Independent Practitioner |                                  |                                  |
| VI.D.5.a).(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. |                                  |
| VI.E. Clinical Responsibilities |                                  |                                  |
| VI.F. Teamwork | The interprofessional team may include: physicians from other specialties such as colorectal surgery and gastroenterology, credentialed registered nurses (RNs), certified nurses, certified nurse specialists (CNSs), certified dieticians, mental health providers, nurse practitioners (NPs), other advanced practice nurses, other advanced practice providers, pharmacists, physical and occupational therapists, physician assistants (PAs) and social workers should be integrated into both the didactic and clinical experience of the fellow as clinically relevant. (Detail) |                                  |
| VI.G.5.b) Intermediate-level Residents |                                  |                                  |
| VI.G.5.c) Residents in the Final Years of Education | Female pelvic medicine and reconstructive surgery fellows are considered to be in the final years of education. |                                  |
### Specialty/Requirement # | Specialty-specific Duty Hour Definitions | Frequently Asked Questions (FAQs)
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VI.G.5.c).(1) | **Circumstances for Eight Hours Free of Duty**
| (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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. (Detail) |  |

### Geriatric Medicine (subspecialty of Family Medicine or Internal Medicine)

**VI.D.1. Licensed Independent Practitioner**

Q: Are there situations when fellows may be supervised by Licensed Independent Practitioners?

A: While there is an expectation that the fellows and faculty members have ultimate responsibility for the overall care of a patient, there may be circumstances where a Licensed Independent Practitioner or physician extender may also be involved in a supervisory role for the fellow. In such instances, the non-physician is expected to provide that supervision within the legal limits of his or her particular license.

**VI.D.5.a).(1) Supervision of Residents**

Q: What is an optimal clinical workload?

A: The program director must ensure fellow patient loads are appropriate. The optimal case load will allow each fellow to see as many cases as possible, without being overwhelmed by patient care responsibilities, or without compromising a fellow's educational experience.

**VI.D.5.a).(1) Supervision of Residents**

Q: Are there situations when fellows may be supervised by Licensed Independent Practitioners?

A: While there is an expectation that the fellows and faculty members have ultimate responsibility for the overall care of a patient, there may be circumstances where a Licensed Independent Practitioner or physician extender may also be involved in a supervisory role for the fellow. In such instances, the non-physician is expected to provide that supervision within the legal limits of his or her particular license.

**VI.D.5.a).(1) Supervision of Residents**

Q: What is an optimal clinical workload?

A: The program director must ensure fellow patient loads are appropriate. The optimal case load will allow each fellow to see as many cases as possible, without being overwhelmed by patient care responsibilities, or without compromising a fellow's educational experience.
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<tr>
<td>VI.F.1.c)</td>
<td>Physician assistants or nurse practitioners should be available to provide team or collaborative care of geriatric patients.</td>
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<td>VI.F.1.d)</td>
<td>Regular geriatric team conferences must be held as dictated by the needs of the individual patient.</td>
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<tr>
<td>VI.G.5.a) Fellows in the Final Years of Education</td>
<td>Geriatric medicine fellows are considered to be in the final years of education.</td>
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<tr>
<td>VI.G.5.a).(1) Circumstances for Eight Hours Free of Duty</td>
<td>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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.</td>
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<tr>
<td>VI.G.6. Maximum Frequency of In-House Night Float</td>
<td>Fellows are not expected or obligated to assume a night float role. Should a program director determine a need for an ongoing night float requirement for a particular fellow, an educational rationale must be submitted to the Review Committee for review prior to implementation.</td>
<td>Q: Should fellows be assigned night float rotations? A: Fellows are not expected or obligated to assume a night float role. Should a program director determine a need for an ongoing night float requirement for a particular fellow, an educational rationale must be submitted to the Review Committee for review prior to implementation.</td>
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<tr>
<td>VI.G.7.a)</td>
<td>Geriatric medicine fellowships must not average in-house call over a four-week period.</td>
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<tr>
<td>Hand Surgery (subspecialties of General Surgery, Orthopaedic Surgery, or Plastic Surgery)</td>
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<td>VI.D.1. Licensed Independent Practitioner</td>
<td>Licensed Independent Practitioners include non-physician faculty members working in conjunction with the orthopaedic, general, and plastic surgery departments.</td>
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<tr>
<td>VI.D.5.a).(1) Supervision of Residents</td>
<td>Do not have PGY-1 residents in the subspecialty.</td>
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<td>VI.E. Clinical Responsibilities</td>
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<tr>
<td>VI.F. Teamwork</td>
<td>Q: What skills should members of the interprofessional caregiver team have? A: All members of the interprofessional caregiver team should be provided instruction in: 1. communication, so that if all required tasks cannot be accomplished in a timely fashion, appropriate methods are established to hand off the remaining task(s) to another team member at the end of a duty period; 2. compliance with work hours limits imposed at the various levels of education; 3. prioritization of tasks as the dynamics of a patient’s needs change; 4. recognition of and sensitivity to the experience and competency of other team members; 5. recognizing when an individual becomes overburdened with duties that cannot be accomplished within an allotted time period; 6. signs and symptoms of fatigue not only in oneself, but in other team members; 7. team development; and,</td>
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<tr>
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<td>Specialty-specific Duty Hour Definitions</td>
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<td>8. time management.</td>
<td>Q: Who should be included in the interprofessional teams? A: Physicians from physical medicine and rehabilitation and infectious diseases, as well as certified registered nurse anesthetists (CRNAs), child-life specialists, discharge planners, nurses, operating room (OR) technicians, pharmacists, physical and occupational therapists, physician assistants, radiology technicians, and social workers are examples of professional personnel who may be part of the interprofessional teams.</td>
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<tr>
<td>Q: Must every interprofessional team include representation from every professional listed above? A: No. The Review Committee recognizes that the needs of specific patients change with their health statuses and circumstances. The Review Committee’s intent is to ensure that the program has access to these professional and paraprofessional personnel, and that interprofessional teams be constituted as appropriate and as needed, not to mandate that all be included in every case/care environment.</td>
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<td>Q: What roles must residents have in the interprofessional health care team? A: As members of the interprofessional health care team, residents must have key roles in diagnostic work-up, operative procedures, treatment decisions, measurement of treatment outcomes, and the communication and coordination of these activities with program faculty and referring sources.</td>
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| VI.G.5.a) Fellows in the Final Years of Education | Hand surgery fellows are considered to be in the final years of education. |
| VI.G.5.a).(1) Circumstances for Eight Hours Free of Duty | 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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. |
| VI.G.6. Maximum Frequency of In-House Night Float | Night float assignments must not exceed three months per year. (Detail) |

**Hospice and Palliative Medicine (subspecialty of Anesthesiology, Family Medicine, Internal Medicine, Pediatrics, Psychiatry, or Radiation Oncology)**

<p>| VI.D.1. Licensed Independent Practitioner | See II.C.1. Nurses, psychosocial clinicians (social workers or psychologists), and chaplains must be involved in teaching fellows. (Core) |
| VI.D.5.a).(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. |
| VI.E. Clinical Responsibilities | VI.E.1. The program director must have the authority and responsibility to set appropriate Clinical Responsibilities (i.e., patient caps) for each fellow. (Core) |</p>
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<td>VI.F. Teamwork</td>
<td>VI.F.1. Fellows must interact regularly with one or more interdisciplinary teams in the conduct of clinical care. This includes participating in regular team conferences with the interdisciplinary teams in order to coordinate the implementation of recommendations from these teams. (Core) VI.F.1.a) The interdisciplinary teams must include physicians, nurses, psychosocial clinicians (such as a social workers or psychologists), and chaplains (Core)</td>
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<tr>
<td>VI.G.5.a) Fellows in the Final Years of Education</td>
<td>Hospice and palliative medicine fellows are considered to be in the final years of education.</td>
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<tr>
<td>VI.G.5.a).(1) Circumstances for Eight Hours Free of Duty</td>
<td>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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.</td>
<td>Q: Are there any circumstances under which may fellows stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty? A: Fellows may stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty to maintain continuity of care, to provide counseling to patients and/or families, to participate in care for patients with rare diagnoses or conditions, or to care for a patient with an acute issue. This decision should be made with the timely approval of the program director.</td>
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<td>VI.G.6. Maximum Frequency of In-House Night Float</td>
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<td><strong>Medical Toxicology (subspecialty of Emergency Medicine or Preventive Medicine)</strong></td>
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<td>VI.D.1. Licensed Independent Practitioner</td>
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<td>Q: Are there situations in which fellows may be supervised by Licensed Independent Practitioners? A: The Review Committee will accept licensed or certified individuals to supervise fellows in unique educational settings within the scope of those individuals’ licensure or certification. Examples may include physician assistants, nurse practitioners, clinical psychologists, licensed clinical social workers, certified nurse midwives, certified registered nurse anesthetists, and doctors of pharmacy. Indirect oversight by a faculty physician member during these situations is required.</td>
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<td>VI.D.2.a)</td>
<td>Fellows must be provided with prompt, reliable systems for communication and interactions with supervisory physicians. (Core)</td>
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<tr>
<td>VI.D.5.a).(1) Supervision of Residents</td>
<td>Do not have PGY-1 residents in the subspecialty.</td>
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<tr>
<td>VI.E. Clinical Responsibilities</td>
<td>VI.E.1. The program must provide progressive responsibility for and experience in the management of clinical problems. (Core)</td>
<td>Q: What does the Review Committee consider an optimal clinical workload? A: Each program must adhere to its graduated responsibility policy. This may vary by area of service, based upon each individual fellow’s level of achieved competence (knowledge, skills, and attitudes), and based upon patient acuity. The milestones must be used to assess each fellow’s competencies. Both insufficient patient experiences and excessive patient loads may jeopardize the quality of fellow education.</td>
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| VI.F. Teamwork         | See II.C.2. Consultants from appropriate medical and non-medical specialties must be available for consultation and didactic sessions. (Core)  
See II.C.2.a) Medical consultants should include, but not limited to, individuals with special expertise in the following areas: cardiology, dermatology, gastroenterology, hyperbaric medicine, immunology, nephrology, ophthalmology, pathology, pulmonary medicine, and surgical subspecialties. (Detail)  
See II.C.2.b) Non-medical consultants should include individuals with special expertise in the following areas: biostatistics, botany, disaster and mass casualty incident management, epidemiology, environmental toxicology, forensic toxicology, hazardous materials, herpetology, industrial hygiene, laboratory toxicology, mycology, occupational toxicology, pharmacology, public health, and zoology. (Detail)  
VI.F.1. Contributors to effective interprofessional teams may include consulting physicians, nurses, pharmacologists, botanists, herpetologists, mycologists, police officers, and other professional and paraprofessional personnel involved in the assessment and treatment of patients. (Detail) | Q: Who should be included in the interprofessional teams?  
A: Physicians, advanced practice providers, botanists, case managers, child-life specialists, herpetologists, mycologists, nurses, pain management specialists, pastoral care specialists, pharmacists, physician assistants, psychiatrists, psychologists, rehabilitative therapists, respiratory therapists, social workers, and toxicologists are examples of professional personnel who may be part of interprofessional teams. |
| VI.G.5.c) Residents in the Final Years of Education | Medical toxicology fellows are considered to be in the final years of education. | |
| VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty | VI.G.5.c).(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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. | Q: Are there any circumstances under which fellows may stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty?  
A: Fellows may stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty to maintain continuity of care, to provide counseling to patients and/or families, to participate in care for patients with rare diagnoses or conditions, or to care for a patient with an acute issue. This decision should be made with the timely approval of the program director. |
| VI.G.6. Maximum Frequency of In-House Night Float | | |
| Molecular Genetic Pathology (subspecialty of Medical Genetics or Pathology) | | |
| VI.D.1. Licensed Independent Practitioner | Q: Who may supervise fellows?  
A: Attending pathologists, medical geneticists, or molecular geneticists may supervise in the diagnostic laboratory or clinical genetics setting. A pathology assistant (PA) may supervise grossing and/or autopsy for clinical geneticists enrolled in a molecular genetic pathology fellowship. | |
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<tr>
<td>VI.D.5.a),(1) Supervision of Residents</td>
<td>Do not have PGY-1 residents in the subspecialty.</td>
<td>Q: What does the Review Committee consider an optimal clinical workload for fellows? A: The program director must make an assessment of the learning environment with input from faculty members and fellows. There must be an adequate clinical workload to develop competency in all areas specified in the Program Requirements. Optimal workload may vary from program to program, and will depend on the patient material, program resources, and testing/consultations/procedures done in the primary and participating sites. Clinical workload should include patient material for testing, as well as study sets and other case-based teaching tools.</td>
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<tr>
<td>VI.E. Clinical Responsibilities</td>
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<tr>
<td>VI.F. Teamwork</td>
<td>VI.F.1. Fellows must have regular opportunities to work with genetic counselors, nurses, and other health care professionals who are involved in the provision of clinical medical genetics services.</td>
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<tr>
<td>VI.G.5.a) Fellows in the Final Years of Education</td>
<td>Molecular genetic pathology fellows are considered to be in the final years of education.</td>
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<tr>
<td>VI.G.5.c),(1) Circumstances for Eight Hours Free of Duty</td>
<td>There are no circumstances under which fellows may stay on duty without eight hours off.</td>
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<tr>
<td>VI.G.6. Maximum Frequency of In-House Night Float</td>
<td>Fellows must not be assigned night float duties.</td>
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**Neuromuscular Medicine (subspecialty of Neurology or Physical Medicine and Rehabilitation)**

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<td>VI.D.1. Licensed Independent Practitioner</td>
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<td>Q: What licensed independent practitioners may contribute to residents’ education? A: Licensed practitioners may include nurse practitioners, who should be licensed in the state, and have appropriate credentials at the hospital, in which they are seeing patients.</td>
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<tr>
<td>VI.D.5.a),(1) Supervision of Residents</td>
<td>Do not have PGY-1 residents in the subspecialty.</td>
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<td>VI.E. Clinical Responsibilities</td>
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<td>VI.F. Teamwork</td>
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<tr>
<td>VI.G.5.a) Fellows in the Final Years of Education</td>
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<tr>
<td>VI.G.5.a).(1) Circumstances for Eight Hours Free of Duty</td>
<td>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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.</td>
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<tr>
<td>VI.G.6. Maximum Frequency of In-House Night Float</td>
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<tr>
<td>Pain Medicine (subspecialty of Anesthesiology, Neurology, or Physical Medicine and Rehabilitation)</td>
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<tr>
<td>VI.D.1. Licensed Independent Practitioner</td>
<td>Only Licensed Independent Practitioners as consistent with state regulations and medical staff bylaws may have primary responsibility for a patient.</td>
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<td>VI.D.5.a).(1) Supervision of Residents</td>
<td>Do not have PGY-1 residents in the subspecialty.</td>
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<tr>
<td>VI.E. Clinical Responsibilities</td>
<td>VI.E.1. An optimal clinical workload allows fellows to complete the required case numbers and develop the required competencies in patient care with a focus on learning over meeting service obligations. (Detail)</td>
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| VI.F. Teamwork | Q: Who should be part of the interprofessional teams?  
A: Contributors to effective interprofessional teams in pain medicine may include consulting physicians, psychologists, psychiatric nurses, social workers and other professional and paraprofessional mental health personnel involved in the treatment of patients. | |
<p>| VI.G.5.c) Residents in the Final Years of Education | Pain medicine fellows are considered to be in the final years of education. | |
| VI.G.5.c).(1) Circumstances for Eight Hours Free of Duty | VI.G.5.c).(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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. (Detail) | |
| | VI.G.5.c).(1).(c) Exceptions to the eight-hour duty-free period must be determined in collaboration with the supervising faculty member. (Detail) | |
| VI.G.6. Maximum Frequency of In-House Night Float | | |
| Sleep Medicine (subspecialty of Internal Medicine, Neurology, Pediatrics, or Psychiatry) | | |
| VI.D.1. Licensed Independent Practitioner | | |
| VI.D.5.a).(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. | |</p>
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<td>VI.E. Clinical Responsibilities</td>
<td>VI.F.1. Contributors to effective interprofessional teams may include consulting physicians, psychologists, psychiatric nurses, social workers and other professional and paraprofessional mental health personnel involved in the evaluation and treatment of patients (Detail)</td>
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<td>VI.F. Teamwork</td>
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<tr>
<td>VI.G.5.a) Fellows in the Final Years of Education</td>
<td>Sleep medicine fellows are considered to be in the final years of education.</td>
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| VI.G.5.a)(1) Circumstances for Eight Hours Free of Duty | VI.G.5.a)(1)(b) In unusual circumstances, fellows may remain beyond their scheduled period of duty or return after their scheduled period of duty to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity of care for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of the patient or family. Such episodes should be rare, must be of the fellows’ own initiative, and need not initiate a new 'off-duty period' nor require a change in the scheduled ‘off-duty period.' (Detail)  
VI.G.5.a)(1)(c) Under such circumstances, the fellow must appropriately hand over care of all other patients to the team responsible for their continuing care, and document the reasons for remaining or returning to care for the patient in question and submit that documentation to the program director. (Detail)  
VI.G.5.a)(1)(d) The program director must review each submission of additional service and track both individual residents’ and program-wide episodes of additional duty. (Detail) | |
| VI.G.6. Maximum Frequency of In-House Night Float | | |
| VI.G.7. | VI.G.7 a) Sleep medicine fellowships must not average in-house call over a four-week period. (Core) | |

**Sports Medicine (subspecialty of Emergency Medicine, Family Medicine, Pediatrics, or Physical Medicine and Rehabilitation)**
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| VI.D.1. Licensed Independent Practitioner | | Q: Are there situations when fellows may be supervised by licensed independent practitioners?  
A: While there is an expectation that fellows and faculty members have ultimate responsibility for the overall care of each patient, there may be circumstances where a licensed independent practitioner or physician extender may also be involved in a supervisory role for the fellow. In such instances, the non-physician is expected to provide that supervision within the legal limits of his or her particular license. |
| VI.D.5.a),(1) Supervision of Residents | Do not have PGY-1 residents in the subspecialty. | |
| VI.E. Clinical Responsibilities | VI.E.1. The program director must have the authority and responsibility to set appropriate Clinical Responsibilities (i.e., patient caps) for each fellow. *(Core)* | Q: What is an optimal clinical workload?  
A: The program director must ensure fellow patient loads are appropriate. The optimal case load allows each fellow to see as many cases as possible, without being overwhelmed by patient care responsibilities, and without compromising a fellow’s educational experience. |
| VI.F. Teamwork | See II.C.1. The sports medicine team must include coaches and certified athletic trainers with whom the fellows interact. *(Detail)*  
See II.C.2. Qualified staff members in behavioral science, clinical imaging, clinical pharmacology, exercise physiology, nutrition, and physical therapy must be available to provide consultations and to assist with teaching fellows. *(Detail)* | Q: Who should be included in the interprofessional teams?  
A: Physicians, advanced practice providers, case managers, certified athletic trainers, child-life specialists, coaches, emergency medical technicians, nurses, pain management specialists, paramedics, pastoral care specialists, pharmacists, physician assistants, psychiatrists, psychologists, rehabilitative therapists, respiratory therapists, and social workers are examples of professional personnel who may be part of interprofessional teams. |
| VI.G.5.a) Fellows in the Final Years of Education | Sports medicine fellows are considered to be in the final years of education. | |
| VI.G.5.a),(1) Circumstances for Eight Hours Free of Duty | 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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. | Q: Are there any circumstances under which fellows may stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty?  
A: Fellows may stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty to maintain continuity of care, to provide counseling to patients and/or patients’ families, to participate in care for patients with rare diagnoses or conditions, or to care for a patient with an acute issue. This decision should be made with the timely approval of the program director. |
<p>| VI.G.6. Maximum Frequency of In-House Night Float | Undersea and Hyperbaric Medicine (subspecialty of Emergency Medicine or Preventive Medicine) |</p>
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| VI.D.1. Licensed Independent Practitioner | | Q: Are there situations in which fellows may be supervised by Licensed Independent Practitioners?  
A: The Review Committee will accept licensed or certified individuals to supervise fellows in unique educational settings within the scope of their licensure or certification. Examples may include physician assistants, nurse practitioners, clinical psychologists, licensed clinical social workers, certified nurse midwives, certified registered nurse anesthetists, and doctors of pharmacy. Indirect oversight by a faculty physician member during these situations is required. |
| VI.E. Clinical Responsibilities | Do not have PGY-1 residents in the subspecialty. | Q: What does the Review Committee consider an optimal clinical workload?  
A: Each program must adhere to its graduated responsibility policy. This may vary by area of service, based upon each individual’s level of achieved competence (knowledge, skills, and attitudes), and based upon patient acuity. The milestones must be used to assess each fellow’s competencies. Both insufficient patient experiences and excessive patient loads may jeopardize the quality of fellow education. |
| VI.F. Teamwork | See II.B.10. Consultants from appropriate medical subspecialties should be available for consultation and didactic teaching including those with experience and understanding of such fields of medicine as preventive medicine, infectious disease, orthopaedic surgery, vascular surgery, plastic surgery, anesthesiology, critical care, emergency medicine, ophthalmology, rehabilitative medicine and other disciplines as they pertain to the comprehensive treatment of the clinical hyperbaric patient. (Detail) | Q: Who should be included in the interprofessional teams?  
A: Physicians, advanced practice providers, case managers, child-life specialists, emergency medical technicians, hyperbaric technologists, nurses, pain management specialists, paramedics, pastoral care specialists, pharmacists, physician assistants, psychiatrists, psychologists, rehabilitative therapists, respiratory therapists, and social workers are examples of professional personnel who may be part of interprofessional teams. |
| VI.G.5.a) Fellows in the Final Years of Education | Undersea and hyperbaric medicine fellows are considered to be in the final years of education. | |