ACGME Program Requirements for Graduate Medical Education in Pediatric Surgery

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ACGME Program Requirements for Graduate Medical Education
in Pediatric Surgery

Common Program Requirements are in BOLD

Where applicable, text in italics describes the underlying philosophy of the requirements in that section. These philosophic statements are not program requirements and are therefore not citable.

The “Specialty Background and Intent” text in the boxes below provide detail regarding the intention behind specific requirements, as well as guidance on how to implement the requirements in a way that supports excellence in residency education. Programs will note that the Pediatric Surgery Subspecialty FAQs companion document has been integrated into this document and, where appropriate, guidance is given on additional Review Committee resource information.

Introduction

Int.A. Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.

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

Int.B. A fellowship in pediatric surgery provides advanced knowledge and skills in the surgery of infants and children. At the completion of this education, fellows should be able to provide diagnostic, operative, and peri-operative care of pediatric surgical patients. This continuum may include one or more of the developmental stages of care with which a surgeon might be involved, including prenatal, neonatal, and infant through adolescent or young adult. Along this continuum, there will be exposure to congenital and acquired conditions, including developmental, inflammatory, infectious, neoplastic, or traumatic conditions. The scope of this discipline is focused in infancy and childhood, but includes the fetus, adolescent, and young adult with special health care needs arising from congenital and acquired
pediatric surgical conditions. Individuals who complete this education should be prepared to function as competent pediatric surgeons.

Int.C. The educational program in pediatric surgery must be 24 months in length, of which 48 weeks in each of the two years must comprise clinical pediatric surgery. *(Core)*

I. Institutions

I.A. Sponsoring Institution

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

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

I.A.1. A pediatric surgery program should be offered in sites accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or its equivalent, and which are classified as general hospitals or children's hospitals. *(Core)*

I.A.1.a) These sites must include facilities and staff with staffing for a variety of services, including adequate inpatient surgical admissions, intensive care units for both infants and older children, and departments of emergency, pathology, and radiology, pathology, and emergency in which infants and children can be managed 24 hours a day. *(Core)*

I.A.2. The educational program must not negatively impact the education of residents in the core surgery program. *(Core)*

I.A.3. There must be a residency program in pediatrics whose residents rotate through the same integrated site(s) as the pediatric surgical fellows. Pediatric surgery fellows must have experience working in interprofessional teams with all members of the pediatric care community, including pediatric medicine residents, at either the primary clinical site or a participating site. *(Core)*

I.B. Participating Sites

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

A participating site is defined as any site to which fellows rotate for assigned experiences.

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

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

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

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

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

I.B.3. Clinical assignments to participating (non-integrated) sites must be scheduled only during the first year of the program, and assignments must not exceed six months in total, and must be approved in advance by the Review Committee. (Core)

I.B.4. Sites may be integrated with the sponsoring institution through an integration agreement specifying that the program director must:

I.B.4.a) appoint the members of the faculty at the integrated site; (Detail)

I.B.4.b) appoint the chief or director of the teaching service in the integrated site; (Detail)

I.B.4.c) appoint all fellows in the program; and, (Detail)

I.B.4.d) determine all rotations and assignments of both fellows and members of the faculty. (Detail)

I.B.5. Integrated Participating sites must be in close geographic proximity or provide for teleconferencing to allow ensure that all fellows are able to attend participate in joint conferences, as well as grand rounds, basic science and clinical conference lectures, and journal club, and ongoing quality improvement and patient safety reviews, such as morbidity and mortality reviews regularly and in a central location. (Detail Core)

I.B.5.a) If the sites are geographically so remote that joint conferences cannot be held, an equivalent educational program of lectures and conferences at the integrated site must be fully documented. (Detail)
I.B.6. Each participating site must be approved by the Review Committee must
approve all integrations in advance prior to assignment of any fellow on
any rotation(s). (Core)

II. Program Personnel and Resources

II.A. Program Director

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

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

II.A.1.b) The Review Committee must approve the qualifications of each
prospective program director. (Core)

II.A.2. The program director should continue in his or her position for a
length of time adequate to maintain continuity of leadership and
program stability. (Detail)

II.A.2.a) The length of the appointment must be for at least three years. (DetailCore)

II.A.3. Qualifications of the program director must include:

II.A.3.a) requisite specialty expertise and documented educational
and administrative experience acceptable to the Review
Committee; (Core)

II.A.3.b) current certification in the subspecialty by the American
Board of Surgery, or subspecialty qualifications that are
acceptable to the Review Committee; (Core)

II.A.3.c) current medical licensure and appropriate medical staff
appointment; (Core)

II.A.3.d) licensure to practice medicine in the state where the sponsoring
institution’s program is located; and, (DetailCore)

II.A.3.e) demonstrated scholarly activity in at least one of the areas listed in
section II.B.5.b); (CoreDetail)

II.A.3.e).(1) Program directors must demonstrate ongoing peer-
reviewed scholarship. (Core)

II.A.3.e).(1).(a) Scholarship should include at least three peer-
reviewed scholarly projects over the most recent
five-year period, or other scholarship acceptable to
the Review Committee. (Detail)
II.A.3.f) at least five years of practice after completion of a pediatric surgery fellowship; and, (Core)

II.A.3.g) at least two years of prior experience in graduate medical education, as a site director, program director, associate program director in a general surgery program, or another position of responsibility in a residency/fellowship program. (Core)

Specialty Background and Intent: The Review Committee believes training pediatric surgery fellows is a complex undertaking, and as such, the accreditation requirements are extensive. Individuals who direct such programs must be prepared to take on the role, must already be a respected member of the medical staff in their Sponsoring Institution, must be senior members of the faculty, and must have reached a stage in their academic practices that enables them to truly devote the time and effort required to oversee a high quality program. New program directors must have a comprehensive understanding of and ability in educational and evaluation methods, active experience in managing and administering a complex organization, and leadership and communication skills. In addition to the experiential requirements, new program directors are advised to have also served at least two years at the Sponsoring Institution, and where applicable, to have been promoted or be eligible for promotion to the position of Associate Professor.

In circumstances where a program director change is complicated by there being no qualified successor or the Sponsoring Institution has not identified a permanent successor, Sponsoring Institutions may request approval of an “interim” program director. Sponsoring Institutions requesting approval of an interim program director will be asked to submit an action plan outlining institutional support for the interim program director, the plan for the recruitment/placement of a permanent program director, and will be asked to provide a progress report to the Review Committee within six months from the date of appointment.

It is important to note that while the Review Committee understands there are a multitude of reasons for program leadership change, programs are encouraged to establish a leadership succession plan that ensures continuity of leadership and program stability.

II.A.4. The program director must administer and maintain an educational environment conducive to educating the fellows in each of the ACGME competency areas. (Core)

The program director must:

II.A.4.a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program; (Core)

II.A.4.b) approve a local director at each participating site who is accountable for fellow education; (Core)

II.A.4.c) approve the selection of program faculty as appropriate; (Core)

II.A.4.d) evaluate program faculty; (Core)
II.A.4.e) approve the continued participation of program faculty based on evaluation; (Core)

II.A.4.f) monitor fellow supervision at all participating sites; (Core)

II.A.4.g) prepare and submit all information required and requested by the ACGME; (Core)

II.A.4.g).(1) This includes, but is not limited to, the program application forms and annual program updates to the ADS, and ensure that the information submitted is accurate and complete. (Core)

II.A.4.h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution; (Detail)

II.A.4.i) provide verification of fellowship education for all fellows, including those who leave the program prior to completion; (Detail)

II.A.4.j) implement policies and procedures consistent with the institutional and program requirements for fellow duty hours and the working environment, including moonlighting, (Core)

and, to that end, must:

II.A.4.j).(1) distribute these policies and procedures to the fellows and faculty; (Detail)

II.A.4.j).(2) monitor fellow duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements; (Core)

II.A.4.j).(3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and, (Detail)

II.A.4.j).(4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue. (Detail)

II.A.4.k) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged; (Detail)

II.A.4.l) comply with the sponsoring institution’s written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of fellows, disciplinary action, and supervision of fellows; (Detail)
II.A.4.m) be familiar with and comply with ACGME and Review
Committee policies and procedures as outlined in the ACGME
Manual of Policies and Procedures; *(Detail)*

II.A.4.n) obtain review and approval of the sponsoring institution’s
GMEC/DIO before submitting information or requests to the
ACGME, including: *(Core)*

II.A.4.n).(1) all applications for ACGME accreditation of new
programs; *(Detail)*

II.A.4.n).(2) changes in fellow complement; *(Detail)*

II.A.4.n).(3) major changes in program structure or length of
training; *(Detail)*

II.A.4.n).(4) progress reports requested by the Review Committee;
*(Detail)*

II.A.4.n).(5) requests for increases or any change to fellow duty
hours; *(Detail)*

II.A.4.n).(6) voluntary withdrawals of ACGME-accredited
programs; *(Detail)*

II.A.4.n).(7) requests for appeal of an adverse action; and, *(Detail)*

II.A.4.n).(8) appeal presentations to a Board of Appeal or the
ACGME. *(Detail)*

II.A.4.o) obtain DIO review and co-signature on all program
application forms, as well as any correspondence or
document submitted to the ACGME that addresses:
*(Detail)*

II.A.4.o).(1) program citations, and/or, *(Detail)*

II.A.4.o).(2) request for changes in the program that would have
significant impact, including financial, on the program
or institution. *(Detail)*

II.A.4.p) seek prior approval from the Review Committee for the addition of
fellow and resident positions in non-accredited programs (e.g.,
overseas or trauma); and. *(Core)*

II.A.4.q) review, monitor and verify fellows’ operative data with each fellow
at least semi-annually. *(Core)*

II.B. Faculty
II.B.1. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all fellows at that location. (Core)

The faculty must:

II.B.1.a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of fellows, and (Core)

II.B.1.b) administer and maintain an educational environment conducive to educating fellows in each of the ACGME competency areas. (Core)

II.B.2. The physician faculty must have current certification in the subspecialty by the American Board of Surgery, or possess qualifications judged acceptable to the Review Committee. (Core)

II.B.3. The physician faculty must possess current medical licensure and appropriate medical staff appointment. (Core)

II.B.3.a) Members of the physician faculty must be licensed to practice medicine in the state where the sponsoring institution program or participating site is located. (Detail, Core)

II.B.4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)

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

II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. (Detail)

II.B.5.b) Some members of the faculty should also demonstrate scholarship by one or more of the following:

II.B.5.b.(1) peer-reviewed funding; (Detail)

II.B.5.b.(2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks; (Detail)

II.B.5.b.(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or, (Detail)

II.B.5.b.(4) participation in national committees or educational organizations. (Detail)
II.B.5.c) Faculty should encourage and support fellows in scholarly activities. (Core)

II.B.6. In addition to the program director, there must be, for each approved residency/fellowship position, at least one full-time faculty member whose major function is to support the residency program. (Core)

II.B.6.a) The term of appointment for such faculty members must be of a sufficient length to ensure continuity in the supervision and education of the fellows. (Core)

II.B.7. To contribute to fellow education in the care of critically-ill children, the faculty should include at least: (Core)

II.B.7.a) one neonatologist who is board certified or board eligible in neonatal-perinatal medicine; and, either, (Core)

II.B.7.a),(1) one individual who is board certified or board eligible in pediatric intensivist; or, (Core)

II.B.7.a),(2) one individual who is board certified or board eligible in pediatric surgery and board certified or board eligible in critical care. (Core)

II.C. Other Program Personnel

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

II.D. Resources

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

II.D.1. The pediatric surgical service must document a sufficient breadth and volume of procedures to reasonably ensure that each fellow successfully completes the required clinical experience, such that fellows will satisfy the defined minimum procedure requirements. (Core)

II.D.1.a) There must be at least 1200 procedures performed by pediatric surgeons at the institution program’s approved sites annually. (Core)

II.E. Medical Information Access

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

III. Fellow Appointments
III.A. Eligibility Criteria

The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements. (Core)

III.A.1. Eligibility Requirements – Residency Programs

III.A.1.a) All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, or in Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada. Residency programs must receive verification of each applicant’s level of competency in the required clinical field using ACGME or CanMeds Milestones assessments from the prior training program. (Core)

III.A.1.b) A physician who has completed a residency program that was not accredited by ACGME, RCPSC, or CFPC may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director at the ACGME-accredited program may be advanced to the PGY-2 level based on ACGME Milestones assessments at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry. (Core)

III.A.1.c) A Review Committee may grant the exception to the eligibility requirements specified in Section III.A.2.b) for residency programs that require completion of a prerequisite residency program prior to admission. (Core)

III.A.1.d) Review Committees will grant no other exceptions to these eligibility requirements for residency education. (Core)

III.A.2. Eligibility Requirements – Fellowship Programs

All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, or in an RCPSC-accredited or CFPC- accredited residency program located in Canada. (Core)

Prior to entry in the program, fellows must have successfully completed a residency in general surgery accredited by the ACGME, or such a program located in Canada and accredited by the RCPSC. (Core)

III.A.2.a) Fellowship programs must receive verification of each entering fellow’s level of competency in the required field
III.A.2.b) Fellow Eligibility Exception

A Review Committee may grant the following exception to the fellowship eligibility requirements:

An ACGME-accredited fellowship program may accept an exceptionally qualified applicant**, who does not satisfy the eligibility requirements listed in Sections III.A.2. and III.A.2.a), but who does meet all of the following additional qualifications and conditions: (Core)

III.A.2.b).(1) Assessment by the program director and fellowship selection committee of the applicant’s suitability to enter the program, based on prior training and review of the summative evaluations of training in the core specialty; and (Core)

III.A.2.b).(2) Review and approval of the applicant’s exceptional qualifications by the GMEC or a subcommittee of the GMEC; and (Core)

III.A.2.b).(3) Satisfactory completion of the United States Medical Licensing Examination (USMLE) Steps 1, 2, and, if the applicant is eligible, 3, and; (Core)

III.A.2.b).(4) For an international graduate, verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification; and, (Core)

III.A.2.b).(5) Applicants accepted by this exception must complete fellowship Milestones evaluation (for the purposes of establishment of baseline performance by the Clinical Competency Committee), conducted by the receiving fellowship program within six weeks of matriculation. This evaluation may be waived for an applicant who has completed an ACGME International-accredited residency based on the applicant’s Milestones evaluation conducted at the conclusion of the residency program. (Core)

III.A.2.b).(5).(a) If the trainee does not meet the expected level of Milestones competency following entry into the fellowship program, the trainee must undergo a period of remediation, overseen by the Clinical Competency Committee and monitored by the GMEC or a subcommittee of the GMEC. This period of remediation must not count toward time in fellowship training. (Core)
** An exceptionally qualified applicant has (1) completed a non-ACGME-accredited residency program in the core specialty, and (2) demonstrated clinical excellence, in comparison to peers, throughout training. Additional evidence of exceptional qualifications is required, which may include one of the following: (a) participation in additional clinical or research training in the specialty or subspecialty; (b) demonstrated scholarship in the specialty or subspecialty; (c) demonstrated leadership during or after residency training; (d) completion of an ACGME-International-accredited residency program.

III.A.2.c) The Review Committee for Surgery does not allow exceptions to the Eligibility Requirements for Fellowship Programs in Section III.A.2. (Core)

III.B. Number of Fellows

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

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

III.B.2. Both temporary and permanent increases Any increase in fellow complement must be approved in advance by the Review Committee. Any increase in the complement must be justified in terms of the educational goals of the program. (Core)

Specialty Background and Intent: The Review Committee approves fellow positions for each year of the educational program. An increase in complement in any year and for any reason (e.g., remediation, research year, etc.) must be approved in advance by the Review Committee. Requests for an increase in complement (permanent or temporary) must be submitted through ADS and be accompanied by an educational rationale and block diagram specific to the proposed changes.

III.C. Fellow Transfers

III.C.1. Before accepting a fellow who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring fellow. (Detail)

III.C.2. A program director must provide timely verification of fellowship education and summative performance evaluations for fellows who may leave the program prior to completion. (Detail)

III.D. Appointment of Fellows and Other Learners
The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed fellows’ education. (Core)

III.D.1. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines. (Detail)

III.D.2. All residents, fellows, and other students in both ACGME-accredited and non-accredited programs in the sponsoring institution and integrated sites who might affect the educational experience of the program fellows must be identified, and, at the time of the site visit, the relationship of these individuals to the program fellows must be confirmed. (Core)

III.D.3. The educational program must not negatively affect the education of residents in the affiliated general surgery residency program. (Core)

IV. Educational Program

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

IV.A.1. Overall educational goals for the program, which the program must make available to fellows and faculty; (Core)

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to fellows and faculty at least annually, in either written or electronic form; (Core)

IV.A.3. Regularly scheduled didactic sessions; (Core)

IV.A.4. Delineation of fellow responsibilities for patient care, progressive responsibility for patient management, and supervision of fellows over the continuum of the program; and, (Core)

IV.A.5. ACGME Competencies

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

IV.A.5.a) Patient Care and Procedural Skills

IV.A.5.a).(1) Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. (Outcome)

IV.A.5.a).(2) Fellows must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. Fellows: (Outcome)
must demonstrate competence in surgical and perioperative management, including: (Outcome)

congenital, neoplastic, infectious, and other acquired conditions of the gastrointestinal system and other abdominal organs; diaphragm and thorax, exclusive of the heart; endocrine glands; head and neck; gonads and reproductive organs; integument; and blood and vascular system; (Outcome)

operative and non-operative traumatic conditions of the abdomen, chest, head and neck, and extremities, with sufficient experience in the management of children who have sustained injuries to multiple organs; (Outcome)

endoscopy of the airway and gastrointestinal tract, including laryngoscopy, bronchoscopy, esophagoscopy, gastroduodenoscopy, and lower intestinal endoscopy; (Outcome)

recognition and management of clotting and coagulation disorders; (Outcome)

advanced laparoscopic and thoracoscopic techniques; and, (Outcome)

care of the critically-ill infant or child, including: (Outcome)

cardiopulmonary resuscitation (CPR); (Outcome)

management of patients on ventilators; and, (Outcome)

nutritional assessment and management. (Outcome)

must demonstrate competence in the pre-operative evaluation of patients, the making of provisional diagnoses, initiation of diagnostic procedures, formation of preliminary treatment plans, and provision of outpatient follow-up care of surgical patients. (Outcome)
Follow-up care should include not only both short-term but and long-term evaluation and progress, extended periodic longitudinal care as well, particularly with major congenital anomalies or neoplasm cases, and neoplastic disorders. (Core)

Medical Knowledge

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

must demonstrate competence in their knowledge of the basic principles applicable to the pediatric population of cardiothoracic surgery, gynecology, neurological surgery, orthopaedic surgery, otolaryngology, anesthesia, urology, vascular surgery, transplant surgery, and the management of burns; (Outcome)

must demonstrate knowledge of the principles in the management of patients on ventilators and extracorporeal membrane oxygenation (ECMO); and, (Outcome)

must demonstrate competence in their knowledge of invasive and non-invasive monitoring techniques and interpretation. (Outcome)

Practice-based Learning and Improvement

Fellows must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. (Outcome)

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

identify strengths, deficiencies, and limits in one’s knowledge and expertise; (Outcome)

set learning and improvement goals; (Outcome)

identify and perform appropriate learning activities; (Outcome)

systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; (Outcome)
IV.A.5.c).(5) incorporate formative evaluation feedback into daily practice; (Outcome)

IV.A.5.c).(6) locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems; (Outcome)

IV.A.5.c).(7) use information technology to optimize learning; (Outcome)

IV.A.5.c).(8) participate in the education of patients, families, students, fellows and other health professionals; and, (Outcome)

IV.A.5.c).(9) participate in formal pediatric surgery conferences, including quality improvement and/or patient safety conferences that are specialty-specific and interdisciplinary in nature. (Outcome)

IV.A.5.c).(9).(a) During the final year of their educational program, fellows should organize such conferences. (Outcome)

IV.A.5.c).(9).(b) Fellows must have significant responsibilities for teaching junior residents and medical students. (Outcome)

IV.A.5.d) Interpersonal and Communication Skills

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

Fellows are expected to:

IV.A.5.d).(1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; (Outcome)

IV.A.5.d).(2) communicate effectively with physicians, other health professionals, and health related agencies; (Outcome)

IV.A.5.d).(3) work effectively as a member or leader of a health care team or other professional group; (Outcome)

IV.A.5.d).(4) act in a consultative role to other physicians and health professionals; (Outcome)

IV.A.5.d).(5) maintain comprehensive, timely, and legible medical records, if applicable; and, (Outcome)
IV.A.5.d).(6) provide care as consultants either in a consultative role or as a member of the primary patient care team, under appropriate supervision; and,

IV.A.5.d).(7) demonstrate the ability to participate in multispecialty teams in the Emergency Department and with other specialists, such as neonatologists and intensivists. (Outcome)

IV.A.5.e) Professionalism

Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. (Outcome)

Fellows are expected to demonstrate:

IV.A.5.e).(1) compassion, integrity, and respect for others; (Outcome)

IV.A.5.e).(2) responsiveness to patient needs that supersedes self-interest; (Outcome)

IV.A.5.e).(3) respect for patient privacy and autonomy; (Outcome)

IV.A.5.e).(4) accountability to patients, society and the profession; and, (Outcome)

IV.A.5.e).(5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation. (Outcome)

IV.A.5.f) Systems-based Practice

Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. (Outcome)

Fellows are expected to:

IV.A.5.f).(1) work effectively in various health care delivery settings and systems relevant to their clinical specialty; (Outcome)

IV.A.5.f).(2) coordinate patient care within the health care system relevant to their clinical specialty; (Outcome)

IV.A.5.f).(3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate; (Outcome)
IV.A.5.f).(4) advocate for quality patient care and optimal patient care systems; (Outcome)

IV.A.5.f).(5) work in interprofessional teams to enhance patient safety and improve patient care quality; and, (Outcome)

IV.A.5.f).(6) participate in identifying system errors and implementing potential systems solutions. (Outcome)

IV.A.6. Curriculum Organization and Fellow Patient Care Experiences

IV.A.6.a) Fellows must have completed advanced life support training specific to pediatric patients (e.g., Pediatric Advanced Life Support [PALS]) before beginning critical care rotations. (Core) During the first 12 months of the program, no more than six months may be devoted to related clinical disciplines designed to enhance the educational experience, including: (Core)

IV.A.6.b) The program must be structured to include:

IV.A.6.b).(1) a minimum of 20 months in general pediatric surgery; (Core)

IV.A.6.b).(2) a maximum of four months dedicated to related clinical disciplines, including: (Core)

IV.A.6.b).(2).(a) a maximum of two months dedicated to pediatric critical care and/or neonatal intensive care; and, (Core)

IV.A.6.b).(2).(b) a maximum of two months of clinical assignments rotations in cardiothoracic surgery, gynecology, neurological surgery, orthopaedic surgery, otolaryngology, anesthesia, vascular surgery, transplant surgery, urology, and the management of burns. (Detail/Core)

IV.A.6.c) Optimal clinical care of surgical patients must include demonstrable involvement in pre- and post-operative care and, when applicable, follow-up that corresponds to the patient’s unique surgical problem(s), with longevity of follow-up directly correlated to what is known about the natural history of the disease process(es). (Core)

IV.A.6.d) The final 12 months of clinical education must be at the chief level, with responsibility for patient management, and semi independent operative experience under appropriate supervision. (Core)

IV.A.6.e) Fellows must have an academic program which emphasizes the scholarly attributes of self-instruction, teaching, basic sciences,
skilled clinical analysis, sound surgical judgment, and research creativity. (Core)

IV.A.6.f) Fellows must be provided with primary patient care responsibility, under the supervision of pediatric surgery faculty members, in the care of critically-ill surgical patients to allow them to acquire the requisite specialty-specific knowledge and skills, and to obtain competence in the pre-, intra-, and post-operative care of such patients. (Core)

IV.A.6.f).(1) Fellows must develop competence in the management of surgical, trauma, and other peri-operative patients who are receiving total parenteral nutrition (TPN), are on extracorporeal membrane oxygenation (ECMO), and are on fluids/vasopressors and ventilators, and must be involved in the integrated decision-making around care. (Outcome)

Specialty Background and Intent: Pediatric surgery fellows are integral members of the patient care/rounding team, making decisions about patient care, and in particular, about the surgical care of the patient. In addition, pediatric surgery fellows (with appropriate supervision) have primary care of these patients while in the operating room and participate in the continuum of care, which extends to the outpatient and long-term care setting depending on the patient’s needs. With this expanse of patient management, pediatric surgery fellows must have the medical knowledge and experience required to manage pediatric surgery patients who require TPN, ECMO, fluids/vasopressors, and ventilators.

IV.A.6.f).(2) During the two-year fellowship, critical care experience must include:

IV.A.6.f).(2).(a) the documented care of 20 neonatal surgical patients; (Core)

IV.A.6.f).(2).(b) one month in the neonatal intensive care unit; (Core)

IV.A.6.f).(2).(c) the documented care of 10 critically-ill pediatric surgical patients; and, (Core)

IV.A.6.f).(2).(d) one month in the pediatric intensive care unit. (Core)

IV.A.6.f).(3) To meet these goals/objectives, there must be coordination of care and collegial relationships between pediatric surgeons, neonatologists, and critical care intensivists concerning the management of medical problems in these complex critically-ill patients. (Core)

IV.A.6.f).(4) During the critical care experience, fellows must have primary responsibility, including decision-making and leadership, in the care of patients with primary surgical problems. (Core)
IV.A.6.f).(5) Faculty members for neonatology, pediatric critical care, and/or pediatric surgical critical care must attest to the experience gained by each fellow in meeting the critical care requirements at the end of each critical care rotation. (Core)

IV.A.6.f).(6) Exceptions to the critical care requirement or decreases of this experience to one month must be approved in advance by the Review Committee, and must be limited to exceptional circumstances. (Core)

Specialty Background and Intent: Under exceptional circumstances, programs may request an exception to the critical care requirement for individual fellows. One example of a circumstance that would be considered is a program demonstrating an established, pediatric critical care curriculum that exceeds the minimum requirements. Another example of a circumstance that would be considered for exception is a pediatric surgery fellow who has previously completed an ACGME-accredited surgical critical care program with a focus on pediatric critical care and who is American Board of Surgery-eligible or certified in surgical critical care.

IV.A.6.g) Fellows must document an appropriate breadth, volume, and balance of operative experience as primary surgeon. (Core)

IV.A.6.g).(1) Fellows must document a total performance of a minimum of 800 major pediatric surgery procedures as surgeon during the program. (Core)

IV.A.6.g).(2) Fellows must participate in a minimum of 50 Teaching Assistant cases and may participate in a maximum of 50 additional Teaching Assistant cases for a maximum of 100 Teaching Assistant cases. (Core)

IV.A.6.g).(2).(a) Fellows should, if not a surgery chief resident, act as a Teaching Assistant when their operative experiences justify a teaching role. (Detail)

IV.A.6.h) Fellows must not share primary responsibility for the same patient with, or serve as teaching assistants for, a general surgery chief resident. (Core)

IV.A.6.i) Fellows must document at least one half-day of outpatient experience weekly, averaged over the 48 weeks of each year of clinical education. (Core)

IV.A.6.j) The program must provide fellows with an environment that emphasizes the scholarly attributes of self-instruction, teaching, basic sciences, skilled clinical analysis, sound surgical judgment, and research creativity. (Core)

IV.B. Fellows' Scholarly Activities
IV.B.1. The curriculum must advance fellows’ knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. (Core)

IV.B.2. Fellows should participate in scholarly activity. (Core)

IV.B.2.a) Fellows should understand and demonstrate knowledge of design, implementation, and interpretation of clinical research studies. (Outcome)

IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate fellow involvement in scholarly activities. (Detail)

V. Evaluation

V.A. Fellow Evaluation

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

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

V.A.1.a).(1) The program director may appoint additional members of the Clinical Competency Committee. (Core)

V.A.1.a).(1).(a) These additional members must be physician faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program’s fellows in patient care and other health care settings. (Core)

V.A.1.a).(1).(b) Chief residents who have completed core residency programs in their specialty and are eligible for specialty board certification may be members of the Clinical Competency Committee. (Core)

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

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

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

V.A.1.b).(1).(b) prepare and ensure the reporting of Milestones evaluations of each fellow semi-annually to ACGME; and, (Core)
V.A.1.b).(1).(c) advise the program director regarding fellow progress, including promotion, remediation, and dismissal. (Detail)

V.A.2. Formative Evaluation

V.A.2.a) The faculty must evaluate fellow performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment. (Core)

V.A.2.b) The program must:

V.A.2.b).(1) provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones; (Core)

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

V.A.2.b).(3) document progressive fellow performance improvement appropriate to educational level; and, (Core)

V.A.2.b).(4) provide each fellow with documented semiannual evaluation of performance with feedback. (Core)

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

V.A.3. Summative Evaluation

V.A.3.a) The specialty-specific Milestones must be used as one of the tools to ensure fellows are able to practice core professional activities without supervision upon completion of the program. (Core)

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

This evaluation must:

V.A.3.b).(1) become part of the fellow’s permanent record maintained by the institution, and must be accessible for review by the fellow in accordance with institutional policy; (Detail)
V.A.3.b).(2) document the fellow’s performance during the final period of education; and,

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

V.B. Faculty Evaluation

V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program.

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

V.B.3. This evaluation must include at least annual written confidential evaluations by the fellows.

V.C. Program Evaluation and Improvement

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

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

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

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

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

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

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

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

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

V.C.1.b) The program must assess and incorporate, into the Annual Program Evaluation, the impact of other learners, including
residents and fellows in both ACGME-accredited and non-accredited programs at the Sponsoring Institution and at all participating sites. (Core)

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

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

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

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

V.C.2.b).(1) The program must provide documentation of faculty member participation in annual faculty development activities in fellow evaluation and teaching. (Core)

V.C.2.c) graduate performance, including performance of program graduates on the certification examination; (Core)

V.C.2.c).(1) The performance of program graduates on the certification examination must be used as one measure of evaluating program effectiveness. (Outcome)

V.C.2.c).(1).(a) At least 60 percent of the program’s graduates from the preceding seven years, for programs with fellows and graduates taking the American Board of Surgery examinations; for pediatric surgery for the first time must pass. (Outcome)

V.C.2.c).(1).(a).(i) at least 65 percent of a program’s graduates from the preceding seven years who take the Pediatric Surgery Qualifying Examination must pass; and, (Outcome)

V.C.2.c).(1).(a).(ii) at least 65 percent of a program’s graduates from the preceding seven years who have taken the Pediatric Surgery Certifying Examination must have passed. (Outcome)

V.C.2.d) program quality; and, (Core)

V.C.2.d).(1) Fellows and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and (Detail)

V.C.2.d).(2) The program must use the results of fellows’ and faculty members’ assessments of the program together with other program evaluation results to improve the program. (Detail)
V.C.2.e) progress on the previous year’s action plan(s). (Core)

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

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

V.C.4. Programs should use the American Board of Surgery Pediatric Surgery In-training Examination, or an equivalent examination, for the formative evaluation of fellows and to inform program needs during the Annual Program Evaluation. (Detail)

VI. The Learning and Working Environment

Fellowship education must occur in the context of a learning and working environment that emphasizes the following principles:

- Excellence in the safety and quality of care rendered to patients by fellows today
- Excellence in the safety and quality of care rendered to patients by today’s fellows in their future practice
- Excellence in professionalism through faculty modeling of:
  - the effacement of self-interest in a humanistic environment that supports the professional development of physicians
  - the joy of curiosity, problem-solving, intellectual rigor, and discovery
- Commitment to the well-being of the students, residents/fellows, faculty members, and all members of the health care team

Background and Intent: The revised requirements are intended to provide greater flexibility within an established framework, allowing programs and residents more discretion to structure clinical education in a way that best supports the above principles of professional development. With this increased flexibility comes the responsibility for programs and residents to adhere to the 80-hour maximum weekly limit (unless a rotation-specific exception is granted by a Review Committee), and to utilize flexibility in a manner that optimizes patient safety, resident education, and resident well-being. The requirements are intended to support the development of a sense of professionalism by encouraging residents to make decisions based on patient needs and their own well-being, without fear of jeopardizing their program’s accreditation status. In addition, the proposed requirements eliminate the burdensome documentation requirement for residents to justify clinical and educational work hour variations.
Clinical and educational work hours represent only one part of the larger issue of conditions of the learning and working environment, and Section VI has now been expanded to include greater attention to patient safety and resident and faculty member well-being. The requirements are intended to support programs and residents as they strive for excellence, while also ensuring ethical, humanistic training. Ensuring that flexibility is used in an appropriate manner is a shared responsibility of the program and residents. With this flexibility comes a responsibility for residents and faculty members to recognize the need to hand off care of a patient to another provider when a resident is too fatigued to provide safe, high quality care and for programs to ensure that residents remain within the 80-hour maximum weekly limit.

VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability

VI.A.1. Patient Safety and Quality Improvement

All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Graduate medical education must prepare fellows to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by fellows who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.

Fellows must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating fellows will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

It is necessary for fellows and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.

VI.A.1.a) Patient Safety

VI.A.1.a).(1) Culture of Safety

A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.

VI.A.1.a).(1).(a) The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety.

(Core)
VI.A.1.a).(1).(b) The program must have a structure that promotes safe, interprofessional, team-based care. (Core)

VI.A.1.a).(2) Education on Patient Safety

Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)

Background and Intent: Optimal patient safety occurs in the setting of a coordinated interprofessional learning and working environment.

VI.A.1.a).(3) Patient Safety Events

Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.

VI.A.1.a).(3).(a) Residents, fellows, faculty members, and other clinical staff members must:

VI.A.1.a).(3).(a).(i) know their responsibilities in reporting patient safety events at the clinical site; (Core)

VI.A.1.a).(3).(a).(ii) know how to report patient safety events, including near misses, at the clinical site; and, (Core)

VI.A.1.a).(3).(a).(iii) be provided with summary information of their institution’s patient safety reports. (Core)

VI.A.1.a).(3).(b) Fellows must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)

VI.A.1.a).(4) Fellow Education and Experience in Disclosure of Adverse Events
Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for fellows to develop and apply.

VI.A.1.a).(4).(a) All fellows must receive training in how to disclose adverse events to patients and families. (Core)

VI.A.1.a).(4).(b) Fellows should have the opportunity to participate in the disclosure of patient safety events, real or simulated. (Detail)

VI.A.1.b) Quality Improvement

VI.A.1.b).(1) Education in Quality Improvement

A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.

VI.A.1.b).(1).(a) Fellows must receive training and experience in quality improvement processes, including an understanding of health care disparities. (Core)

VI.A.1.b).(2) Quality Metrics

Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.

VI.A.1.b).(2).(a) Fellows and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)

VI.A.1.b).(3) Engagement in Quality Improvement Activities

Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.

VI.A.1.b).(3).(a) Fellows must have the opportunity to participate in interprofessional quality improvement activities. (Core)

VI.A.1.b).(3).(a).(i) This should include activities aimed at reducing health care disparities. (Detail)
VI.A.2. Supervision and Accountability

VI.A.2.a)  Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.

Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each fellow’s development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

VI.A.2.a).(1) Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient’s care. (Core)

VI.A.2.a).(1).(a) This information must be available to fellows, faculty members, other members of the health care team, and patients. (Core)

VI.A.2.a).(1).(b) Fellows and faculty members must inform each patient of their respective roles in that patient’s care when providing direct patient care. (Core)

VI.A.2.b) Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced fellow. Other portions of care provided by the fellow can be adequately supervised by the immediate availability of the supervising faculty member or fellow physician, either on site or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of fellow-delivered care with feedback.

VI.A.2.b).(1) The program must demonstrate that the appropriate level of supervision in place for all fellows is based on each fellow’s level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)

VI.A.2.c) Levels of Supervision
To promote oversight of fellow supervision while providing for graded authority and responsibility, the program must use the following classification of supervision: (Core)

VI.A.2.c).(1) Direct Supervision – the supervising physician is physically present with the fellow and patient. (Core)

VI.A.2.c).(2) Indirect Supervision:

VI.A.2.c).(2).(a) with Direct Supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision. (Core)

VI.A.2.c).(2).(b) with Direct Supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision. (Core)

VI.A.2.c).(3) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. (Core)

VI.A.2.d) The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members. (Core)

VI.A.2.d).(1) The program director must evaluate each fellow’s abilities based on specific criteria, guided by the Milestones. (Core)

VI.A.2.d).(1).(a) The program must review and document each fellow’s required level of supervision at least annually. (Core)

VI.A.2.d).(1).(b) The program’s supervision policy must outline volume-based and experiential definitions of required competencies for the performance of procedures and participation in pediatric and neonatal critical care. (Core)

VI.A.2.d).(2) Faculty members functioning as supervising physicians must delegate portions of care to fellows based on the needs of the patient and the skills of each fellow. (Core)
VI.A.2.d).(2).(a) Faculty members must have knowledge of each fellow’s prescribed level of supervision and must evaluate each fellow’s supervision needs with each rotation. Core)

VI.A.2.d).(3) Fellows should serve in a supervisory role to residents or junior fellows in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)

VI.A.2.e) Programs must set guidelines for circumstances and events in which fellows must communicate with the supervising faculty member(s). Core)

VI.A.2.e).(1) Each fellow must know the limits of their scope of authority, and the circumstances under which the fellow is permitted to act with conditional independence. Outcome)

Background and Intent: The ACGME Glossary of Terms defines conditional independence as: Graded, progressive responsibility for patient care with defined oversight.

VI.A.2.e).(2) Programs must distribute these guidelines as a written chain of command to fellows and faculty members at least annually. Core)

VI.A.2.f) Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each fellow and to delegate to the fellow the appropriate level of patient care authority and responsibility. Core)

SPECIALTY BACKGROUND AND INTENT: Appropriately-credentialed and privileged attending physicians in the surgical clinical environment include appropriately-credentialed American Board of Medical Specialties (ABMS) board-certified surgeons (e.g., pediatric surgeries would be supervised by pediatric surgeons, etc.). In the critical care clinical environment, procedures must be supervised by appropriately-credentialed ABMS board-certified critical care physicians (e.g., anesthesia critical care physicians, critical care medicine physicians, critical care pediatric physicians, etc.).

VI.B. Professionalism

VI.B.1. Programs, in partnership with their Sponsoring Institutions, must educate fellows and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients. Core)

VI.B.2. The learning objectives of the program must:
VI.B.2.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; (Core)

VI.B.2.b) be accomplished without excessive reliance on fellows to fulfill non-physician obligations; (Core)

Background and Intent: Routine reliance on residents to fulfill non-physician obligations increases work compression for residents and does not provide an optimal educational experience. Non-physician obligations are those duties which in most institutions are performed by nursing and allied health professionals, transport services, or clerical staff. Examples of such obligations include transport of patients from the wards or units for procedures elsewhere in the hospital; routine blood drawing for laboratory tests; routine monitoring of patients when off the ward; and clerical duties, such as scheduling. While it is understood that residents may be expected to do any of these things on occasion when the need arises, these activities should not be performed by residents routinely and must be kept to a minimum to optimize resident education.

VI.B.2.c) ensure manageable patient care responsibilities; and, (Core)

VI.B.2.d) be accomplished without excessive reliance on fellows to fulfill obligations of a non-educational nature or those activities that are not directly associated with the educational program. (Core)

Background and Intent: The Common Program Requirements do not define “manageable patient care responsibilities” as this is variable by specialty and PGY level. Review Committees will provide further detail regarding patient care responsibilities in the applicable specialty-specific Program Requirements and accompanying FAQs. However, all programs, regardless of specialty, should carefully assess how the assignment of patient care responsibilities can affect work compression, especially at the PGY-1 level.

VI.B.3. The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)

VI.B.4. Fellows and faculty members must demonstrate an understanding of their personal role in the:

VI.B.4.a) provision of patient- and family-centered care; (Outcome)

VI.B.4.b) safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; (Outcome)

Background and Intent: This requirement emphasizes that responsibility for reporting unsafe conditions and adverse events is shared by all members of the team and is not solely the responsibility of the resident.
VI.B.4.c) assurance of their fitness for work, including: (Outcome)

Background and Intent: This requirement emphasizes the professional responsibility of faculty members and residents to arrive for work adequately rested and ready to care for patients. It is also the responsibility of faculty members, residents, and other members of the care team to be observant, to intervene, and/or to escalate their concern about resident and faculty member fitness for work, depending on the situation, and in accordance with institutional policies.

VI.B.4.c).(1) management of their time before, during, and after clinical assignments; and, (Outcome)

VI.B.4.c).(2) recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team. (Outcome)

VI.B.4.d) commitment to lifelong learning; (Outcome)

VI.B.4.e) monitoring of their patient care performance improvement indicators; and, (Outcome)

VI.B.4.f) accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data. (Outcome)

VI.B.5. All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient’s care to another qualified and rested provider. (Outcome)

VI.B.6. Programs must provide a professional, respectful, and civil environment that is free from mistreatment, abuse, or coercion of students, residents/fellows, faculty, and staff. Programs, in partnership with their Sponsoring Institutions, should have a process for education of fellows and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)

Specially Background and Intent: Programs are advised to provide the caregiver team instruction in the recognition of and sensitivity to the experience and competency of other team members; time management; prioritization of tasks as the dynamics of a patient’s needs change; recognizing when an individual becomes overburdened with responsibilities that cannot be accomplished within an allotted time period; 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 as necessary; recognizing signs and symptoms of fatigue not only in oneself, but in other team members; compliance with work hour limits; and, team development.

VI.C. Well-Being
In the current health care environment, fellows and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician. Self-care is an important component of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of fellowship training. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as they do to evaluate other aspects of fellow competence.

Background and Intent: The ACGME is committed to addressing physician well-being for individuals and as it relates to the learning and working environment. The creation of a learning and working environment with a culture of respect and accountability for physician well-being is crucial to physicians’ ability to deliver the safest, best possible care to patients. The ACGME is leveraging its resources in four key areas to support the ongoing focus on physician well-being: education, influence, research, and collaboration. Information regarding the ACGME’s ongoing efforts in this area is available on the ACGME website.

As these efforts evolve, information will be shared with programs seeking to develop and/or strengthen their own well-being initiatives. In addition, there are many activities that programs can utilize now to assess and support physician well-being. These include culture of safety surveys, ensuring the availability of counseling services, and attention to the safety of the entire health care team.

VI.C.1. This responsibility must include:

VI.C.1.a) efforts to enhance the meaning that each fellow finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; (Core)

VI.C.1.b) attention to scheduling, work intensity, and work compression that impacts fellow well-being; (Core)

VI.C.1.c) evaluating workplace safety data and addressing the safety of fellows and faculty members; (Core)

VI.C.1.d) policies and programs that encourage optimal fellow and faculty member well-being; and, (Core)

Background and Intent: This requirement emphasizes the responsibility shared by the Sponsoring Institution and its programs to gather information and utilize systems that monitor and enhance resident and faculty member safety, including physical safety. Issues to be addressed include, but are not limited to, monitoring of workplace injuries, physical or emotional violence, vehicle collisions, and emotional well-being after adverse events.
Background and Intent: Well-being includes having time away from work to engage with family and friends, as well as to attend to personal needs and to one’s own health, including adequate rest, healthy diet, and regular exercise.

VI.C.1.d).(1) Fellows must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core)

Background and Intent: The intent of this requirement is to ensure that residents have the opportunity to access medical and dental care, including mental health care, at times that are appropriate to their individual circumstances. Residents must be provided with time away from the program as needed to access care, including appointments scheduled during their working hours.

VI.C.1.e) attention to fellow and faculty member burnout, depression, and substance abuse. The program, in partnership with its Sponsoring Institution, must educate faculty members and fellows in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Fellows and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must; (Core)

Background and Intent: Programs and Sponsoring Institutions are encouraged to review materials in order to create systems for identification of burnout, depression, and substance abuse. Materials and more information are available on the Physician Well-being section of the ACGME website (http://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being).

VI.C.1.e).(1) encourage fellows and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence; (Core)

Background and Intent: Individuals experiencing burnout, depression, substance abuse, and/or suicidal ideation are often reluctant to reach out for help due to the stigma associated with these conditions, and are concerned that seeking help may have a negative impact on their career. Recognizing that physicians are at increased risk in these areas, it is essential that residents and faculty members are able to report their concerns when another resident or faculty member displays signs of any of these conditions, so that the program director or other designated personnel, such as the department chair, may assess the situation and intervene as necessary to facilitate access to appropriate care. Residents and faculty members must know which personnel, in addition to the program director, have been designated with this responsibility; those personnel and the program director should be familiar with the
institution’s impaired physician policy and any employee health, employee assistance, and/or wellness programs within the institution. In cases of physician impairment, the program director or designated personnel should follow the policies of their institution for reporting.

VI.C.1.e). (2) provide access to appropriate tools for self-screening; and, (Core)

VI.C.1.e). (3) provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)

Background and Intent: The intent of this requirement is to ensure that residents have immediate access at all times to a mental health professional (psychiatrist, psychologist, Licensed Clinical Social Worker, Primary Mental Health Nurse Practitioner, or Licensed Professional Counselor) for urgent or emergent mental health issues. In-person, telemedicine, or telephonic means may be utilized to satisfy this requirement. Care in the Emergency Department may be necessary in some cases, but not as the primary or sole means to meet the requirement.

The reference to affordable counseling is intended to require that financial cost not be a barrier to obtaining care.

VI.C.2. There are circumstances in which fellows may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. Each program must have policies and procedures in place that ensure coverage of patient care in the event that a fellow may be unable to perform their patient care responsibilities. These policies must be implemented without fear of negative consequences for the fellow who is unable to provide the clinical work. (Core)

VI.D. Fatigue Mitigation

VI.D.1. Programs must:

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

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

VI.D.1.c) encourage fellows to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. (Detail)

Background and Intent: Providing medical care to patients is physically and mentally demanding. Night shifts, even for those who have had enough rest, cause fatigue. Experiencing fatigue in a supervised environment during training prepares residents for
managing fatigue in practice. It is expected that programs adopt fatigue mitigation processes and ensure that there are no negative consequences and/or stigma for using fatigue mitigation strategies.

This requirement emphasizes the importance of adequate rest before and after clinical responsibilities. Strategies that may be used include, but are not limited to, strategic napping; the judicious use of caffeine; availability of other caregivers; time management to maximize sleep off-duty; learning to recognize the signs of fatigue, and self-monitoring performance and/or asking others to monitor performance; remaining active to promote alertness; maintaining a healthy diet; using relaxation techniques to fall asleep; maintaining a consistent sleep routine; exercising regularly; increasing sleep time before and after call; and ensuring sufficient sleep recovery periods.

VI.D.2. Each program must ensure continuity of patient care, consistent with the program’s policies and procedures referenced in VI.C.2, in the event that a fellow may be unable to perform their patient care responsibilities due to excessive fatigue. (Core)

VI.D.3. The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for fellows who may be too fatigued to safely return home. (Core)

VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care

VI.E.1. Clinical Responsibilities

The clinical responsibilities for each fellow must be based on PGY level, patient safety, fellow ability, severity and complexity of patient illness/condition, and available support services. (Core)

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

VI.E.1.b) 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.1.c) 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.1.d) Work assignments should keep pace with residents’ increased competence and responsibility as they progress through the program. (Detail)

Background and Intent: The changing clinical care environment of medicine has meant that work compression due to high complexity has increased stress on residents. Faculty members and program directors need to make sure residents function in an
environment that has safe patient care and a sense of resident well-being. Some Review Committees have addressed this by setting limits on patient admissions, and it is an essential responsibility of the program director to monitor resident workload. Workload should be distributed among the resident team and interdisciplinary teams to minimize work compression.

VI.E.2. Teamwork

Fellows must care for patients in an environment that maximizes 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 and larger health system. (Core)

VI.E.2.a) Effective surgical practices entail the involvement of team members with a mix of complementary skills and attributes (physicians, nurses, and other staff). Programs should ensure that faculty and fellows demonstrate Success requires both an unwavering mutual respect for those skills and contributions, and a shared commitment to the process of patient care. (Detail)

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

VI.E.2.c) Fellows must collaborate with surgical team members as well as residents, fellows, and faculty members from other departments outside of their surgical specialty. (Outcome)

VI.E.2.d) Fellows must develop collaborative relationships to deliver patient care with nurse practitioners and physicians assistants as important members of the care team. (Outcome)

VI.E.2.e) Through all of their patient care experiences, fellows must continue to develop the necessary sensitivity and professionalism to expand their cultural competence to best formulate care plans for a diverse patient population. Fellows must collaborate with surgical residents, and especially with faculty members, other physicians outside of their specialties, and non-traditional health care providers, to best formulate treatment plans for an increasingly diverse patient population. (OutcomeDetail)

VI.E.2.f) Fellows must assume personal responsibility to complete all tasks to which they are assigned (or which they voluntarily assume) in a timely fashion. (DetailOutcome)

VI.E.2.f).(1) 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 care fellow team so that patient care is not compromised. (DetailCore)
VI.E.2.g) Lines of authority should be defined by programs, and all Fellows must have a working knowledge of the expected reporting relationships to maximize quality care and patient safety.

(Detail, Outcome)

VI.E.3. Transitions of Care

VI.E.3.a) Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)

VI.E.3.b) Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. (Core)

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

VI.E.3.d) Programs and clinical sites must maintain and communicate schedules of attending physicians and fellows currently responsible for care. (Core)

VI.E.3.e) Each program must ensure continuity of patient care, consistent with the program’s policies and procedures referenced in VI.C.2, in the event that a fellow may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency. (Core)

VI.F. Clinical Experience and Education

Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide fellows with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.

Background and Intent: In the new requirements, the terms “clinical experience and education,” “clinical and educational work,” and “clinical and educational work hours” replace the terms “duty hours,” “duty periods,” and “duty.” These changes have been made in response to concerns that the previous use of the term “duty” in reference to number of hours worked may have led some to conclude that residents’ duty to “clock out” on time superseded their duty to their patients.

VI.F.1. Maximum Hours of Clinical and Educational Work per Week

Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)
Background and Intent: Programs and residents have a shared responsibility to ensure that the 80-hour maximum weekly limit is not exceeded. While the requirement has been written with the intent of allowing residents to remain beyond their scheduled work periods to care for a patient or participate in an educational activity, these additional hours must be accounted for in the allocated 80 hours when averaged over four weeks.

Scheduling
While the ACGME acknowledges that, on rare occasions, a resident may work in excess of 80 hours in a given week, all programs and residents utilizing this flexibility will be required to adhere to the 80-hour maximum weekly limit when averaged over a four-week period. Programs that regularly schedule residents to work 80 hours per week and still permit residents to remain beyond their scheduled work period are likely to exceed the 80-hour maximum, which would not be in substantial compliance with the requirement. These programs should adjust schedules so that residents are scheduled to work fewer than 80 hours per week, which would allow residents to remain beyond their scheduled work period when needed without violating the 80-hour requirement. Programs may wish to consider using night float and/or making adjustments to the frequency of in-house call to ensure compliance with the 80-hour maximum weekly limit.

Oversight
With increased flexibility introduced into the Requirements, programs permitting this flexibility will need to account for the potential for residents to remain beyond their assigned work periods when developing schedules, to avoid exceeding the 80-hour maximum weekly limit, averaged over four weeks. The ACGME Review Committees will strictly monitor and enforce compliance with the 80-hour requirement. Where violations of the 80-hour requirement are identified, programs will be subject to citation and at risk for an adverse accreditation action.

Work from Home
While the requirement specifies that clinical work done from home must be counted toward the 80-hour maximum weekly limit, the expectation remains that scheduling be structured so that residents are able to complete most work on site during scheduled clinical work hours without requiring them to take work home. The new requirements acknowledge the changing landscape of medicine, including electronic health records, and the resulting increase in the amount of work residents choose to do from home. The requirement provides flexibility for residents to do this while ensuring that the time spent by residents completing clinical work from home is accomplished within the 80-hour weekly maximum. Types of work from home that must be counted include using an electronic health record and taking calls from home. Reading done in preparation for the following day’s cases, studying, and research done from home do not count toward the 80 hours. Resident decisions to leave the hospital before their clinical work has been completed and to finish that work later from home should be made in consultation with the resident’s supervisor. In such circumstances, residents should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality.

During the public comment period many individuals raised questions and concerns related to this change. Some questioned whether minute by minute tracking would be required; in other words, if a resident spends three minutes on a phone call and then a few hours later spends two minutes on another call, will the resident need to report that
time. Others raised concerns related to the ability of programs and institutions to verify the accuracy of the information reported by residents. The new requirements are not an attempt to micromanage this process. Residents are to track the time they spend on clinical work from home and to report that time to the program. Decisions regarding whether to report infrequent phone calls of very short duration will be left to the individual resident. Programs will need to factor in time residents are spending on clinical work at home when schedules are developed to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks. There is no requirement that programs assume responsibility for documenting this time. Rather, the program’s responsibility is ensuring that residents report their time from home and that schedules are structured to ensure that residents are not working in excess of 80 hours per week, averaged over four weeks.

**PGY-1 and PGY-2 Residents**

PGY-1 and PGY-2 residents may not have the experience to make decisions about when it is appropriate to utilize flexibility or may feel pressured to use it when unnecessary. Programs are responsible for ensuring that residents are provided with manageable workloads that can be accomplished during scheduled work hours. This includes ensuring that a resident’s assigned direct patient load is manageable, that residents have appropriate support from their clinical teams, and that residents are not overburdened with clerical work and/or other non-physician duties.

**VI.F.2. Mandatory Time Free of Clinical Work and Education**

**VI.F.2.a)** The program must design an effective program structure that is configured to provide fellows with educational opportunities, as well as reasonable opportunities for rest and personal well-being. *(Core)*

**VI.F.2.b)** Fellows should have eight hours off between scheduled clinical work and education periods. *(Detail)*

**VI.F.2.b).(1)** There may be circumstances when fellows choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements. *(Detail)*

*SPECIALTY BACKGROUND AND INTENT: The Review Committee recognizes that there are circumstances under which fellows may choose to stay at the hospital or may return to the hospital to care for patients. Most often, this is likely to happen when fellows have a role in a particular patient’s continuity of care.

Examples of these circumstances include:

A patient on whom a fellow operated/intervened that day who needs to return to the operating room (OR).

A patient on whom a fellow operated/intervened that day who requires transfer to an intensive care unit (ICU) from a lower level of care.

A patient on whom a fellow operated/intervened that day who is critically unstable.
A patient on whom a fellow operated/intervened during that hospital admission who needs to return to the OR related to an operation or procedure previously performed by that resident. A patient or patient’s family needs to discuss treatment of a critically-ill patient on whom the fellow has operated or is responsible for care.

Fellows may also have fewer than eight hours off between scheduled clinical work and education periods in the event of a declared emergency or disaster, for which fellows are included in the disaster plan, or to perform high profile, low frequency procedures necessary for competence in the field.

Background and Intent: While it is expected that resident schedules will be structured to ensure that residents are provided with a minimum of eight hours off between scheduled work periods, it is recognized that residents may choose to remain beyond their scheduled time, or return to the clinical site during this time-off period, to care for a patient. The requirement preserves the flexibility for residents to make those choices. It is also noted that the 80-hour weekly limit (averaged over four weeks) is a deterrent for scheduling fewer than eight hours off between clinical and education work periods, as it would be difficult for a program to design a schedule that provides fewer than eight hours off without violating the 80-hour rule.

**VI.F.2.c)** Fellows must have at least 14 hours free of clinical work and education after 24 hours of in-house call. *(Core)*

**VI.F.2.d)** Fellows must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. *(Core)*

Background and Intent: Residents have a responsibility to return to work rested, and thus are expected to use this time away from work to get adequate rest. In support of this goal, residents are encouraged to prioritize sleep over other discretionary activities.

**VI.F.3.** Maximum Clinical Work and Education Period Length

Background and Intent: The requirement provides flexibility for programs to distribute days off in a manner that meets program and resident needs. It is strongly recommended that residents’ preference regarding how their days off are distributed be considered as schedules are developed. It is desirable that days off be distributed throughout the month, but some residents may prefer to group their days off to have a “golden weekend,” meaning a consecutive Saturday and Sunday free from work. The requirement for one free day in seven should not be interpreted as precluding a golden weekend. Where feasible, schedules may be designed to provide residents with a weekend, or two consecutive days, free of work. The applicable Review Committee will evaluate the number of consecutive days of work and determine whether they meet educational objectives. Programs are encouraged to distribute days off in a fashion that optimizes resident well-being, and educational and personal goals. It is noted that a day off is defined in the ACGME Glossary of Terms as “one (1) continuous 24-hour period free from all administrative, clinical, and educational activities.”
VI.F.3.a) Clinical and educational work periods for fellows must not exceed 24 hours of continuous scheduled clinical assignments. (Core)

Background and Intent: The Task Force examined the question of “consecutive time on task.” It examined the research supporting the current limit of 16 consecutive hours of time on task for PGY-1 residents; the range of often conflicting impacts of this requirement on patient safety, clinical care, and continuity of care by resident teams; and resident learning found in the literature. Finally, it heard a uniform request by the specialty societies, certifying boards, membership societies and organizations, and senior residents to repeal this requirement. It heard conflicting perspectives from resident unions, a medical student association, and a number of public advocacy groups, some arguing for continuation of the requirement, others arguing for extension of the requirement to all residents.

Of greatest concern to the Task Force were the observations of disruption of team care and patient care continuity brought about with residents beyond the PGY-1 level adhering to differing requirements. The graduate medical education community uniformly requested that the Task Force remove this requirement. The most frequently-cited reason for this request was the complete disruption of the team, separating the PGY-1 from supervisory faculty members and residents who were best able to judge the ability of the resident and customize the supervision of patient care for each PGY-1. Cited nearly as frequently was the separation of the PGY-1 from the team, delaying maturation of clinical skills, and threatening to create a “shift” mentality in disciplines where overnight availability to patients is essential in delivery of care.

The Task Force examined the impact of the request to consider 16-consecutive-hour limits for all residents, and rejected the proposition. It found that model incompatible with the actual practice of medicine and surgery in many specialties, excessively limiting in configuration of clinical services in many disciplines, and potentially disruptive of the inculcation of responsibility and professional commitment to altruism and placing the needs of patients above those of the physician.

After careful consideration of the information available, the testimony and position of all parties submitting information, and presentations to the Task Force, the Task Force removed the 16-hour-consecutive-time-on-task requirement for PGY-1 residents. It remains crucial that programs ensure that PGY-1 residents are supervised in compliance with the applicable Program Requirements, and that resident well-being is prioritized as described in Section VI.C. of these requirements.

 VI.F.3.a).(1) Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or fellow education. (Core)

 VI.F.3.a).(1).(a) Additional patient care responsibilities must not be assigned to a fellow during this time. (Core)

Background and Intent: The additional time referenced in VI.F.3.a).(1) should not be used for the care of new patients. It is essential that the resident continue to function as
a member of the team in an environment where other members of the team can assess resident fatigue, and that supervision for post-call residents is provided. This 24 hours and up to an additional four hours must occur within the context of 80-hour weekly limit, averaged over four weeks.

**VI.F.4. Clinical and Educational Work Hour Exceptions**

**VI.F.4.a) In rare circumstances, after handing off all other responsibilities, a fellow, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:**

**VI.F.4.a).(1) to continue to provide care to a single severely ill or unstable patient; (Detail)**

**VI.F.4.a).(2) humanistic attention to the needs of a patient or family; or, (Detail)**

**VI.F.4.a).(3) to attend unique educational events. (Detail)**

**VI.F.4.b) These additional hours of care or education will be counted toward the 80-hour weekly limit. (Detail)**

This requirement is intended to provide residents with some control over their schedules by providing the flexibility to voluntarily remain beyond the scheduled responsibilities under the circumstances described above. It is important to note that a resident may remain to attend a conference, or return for a conference later in the day, only if the decision is made voluntarily. Residents must not be required to stay. Programs allowing residents to remain or return beyond the scheduled work and clinical education period must ensure that the decision to remain is initiated by the resident and that residents are not coerced. This additional time must be counted toward the 80-hour maximum weekly limit.

**VI.F.4.c) A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.**

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

**VI.F.4.c).(1) In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the *ACGME Manual of Policies and Procedures.* (Core)**

**VI.F.4.c).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval from the Sponsoring Institution's GMEC and DIO. (Core)**
Background and Intent: The provision for exceptions for up to 88 hours per week has been modified to specify that exceptions may be granted for specific rotations if the program can justify the increase based on criteria specified by the Review Committee. As in the past, Review Committees may opt not to permit exceptions. The underlying philosophy for this requirement is that while it is expected that all residents should be able to train within an 80-hour work week, it is recognized that some programs may include rotations with alternate structures based on the nature of the specialty. DIO/GMEC approval is required before the request will be considered by the Review Committee.

VI.F.5. Moonlighting

VI.F.5.a) Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program, and must not interfere with the fellow’s fitness for work nor compromise patient safety. (Core)

VI.F.5.b) Time spent by fellows in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core)

Background and Intent: For additional clarification of the expectations related to moonlighting, please refer to the Common Program Requirement FAQs (available at http://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements).

VI.F.6. In-House Night Float

Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. (Core)

VI.F.6.a) Any rotation that requires residents fellows to work multiple nights in succession is considered a night float rotation, and the total time on nights must be counted toward the maximum allowable time for each resident fellow over the duration of the program. (Core)

VI.F.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.F.6.c) There must be no more than four months of night float per year for each fellow in the program. (Core)

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

Background and Intent: The requirement for no more than six consecutive nights of night float was removed to provide programs with increased flexibility in scheduling.

VI.F.7. Maximum In-House On-Call Frequency
Fellows must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). *(Core)*

**VI.F.8. At-Home Call**

**VI.F.8.a) Time spent on patient care activities by fellows on at-home call must count toward the 80-hour maximum weekly limit.**

The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. *(Core)*

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

**VI.F.8.b) Fellows are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit. *(Detail)*

**Background and Intent:** This requirement has been modified to specify that clinical work done from home when a resident is taking at-home call must count toward the 80-hour maximum weekly limit. This change acknowledges the often significant amount of time residents devote to clinical activities when taking at-home call, and ensures that taking at-home call does not result in residents routinely working more than 80 hours per week. At-home call activities that must be counted include responding to phone calls and other forms of communication, as well as documentation, such as entering notes in an electronic health record. Activities such as reading about the next day’s case, studying, or research activities do not count toward the 80-hour weekly limit.

In their evaluation of residency/fellowship programs, Review Committees will look at the overall impact of at-home call on resident/fellow rest and personal time.

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

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

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

**Osteopathic Recognition**

For programs seeking Osteopathic Recognition for the entire program, or for a track within the program, the Osteopathic Recognition Requirements are also applicable. ([http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/Osteopathic_Recognition_Requirements.pdf](http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/Osteopathic_Recognition_Requirements.pdf))