

# ACGME Program Requirements for Graduate Medical Education in Procedural Dermatology

One-year Common Program Requirements are in BOLD

Effective: July 1, 2010

## Introduction

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

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

**Int.B. Definition and Scope of Subspecialty**

Procedural dermatology is the subspecialty of dermatology concerned with the study, diagnosis, and surgical treatment of diseases of the skin and adjacent mucous membranes, cutaneous appendages, hair, nails, and subcutaneous tissue. Procedural dermatology is broadly categorized into the following three areas:

**Int.B.1. Cutaneous oncologic surgery incorporates medical, surgical, and dermatopathological knowledge of cutaneous neoplasms. An especially important technique is Mohs micrographic surgical excision, which is used for certain cancers of the skin and incorporates education in clinical dermatology and dermatopathology as they apply to dermatologic surgery.**

**Int.B.2. Cutaneous reconstructive surgery includes the repair of skin defects that result from the surgical removal of tumors or other skin disease and scar**

revision, and is based upon knowledge of cutaneous anatomy, wound healing and cutaneous repair techniques.

Int.B.3. Cutaneous cosmetic surgery incorporates medical, surgical, and dermatopathologic knowledge of cutaneous disorders and the aging of the skin. It focuses on the study and performance of procedures that have been developed by dermatologists to improve the appearance of the skin and control cutaneous disease.

Int.C. Duration of Education

The educational program in Procedural Dermatology must be 12 months in length.

## **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.**

**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.**

### **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.**

**The PLA should:**

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

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

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

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

**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).

### 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. After approval, the program director must submit this change to the ACGME via the ADS.**

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

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

**II.A.2.b) current certification in the subspecialty by the American Board of Dermatology, or subspecialty qualifications that are acceptable to the Review Committee; and,**

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

**II.A.2.d) completion of an ACGME-accredited procedural dermatology fellowship, American College of Mohs Micrographic Surgery approved fellowship, or experience as a program director of a dermatologic surgery fellowship program for at least 10 years;**

**II.A.2.e) at least five years of patient care experience as a dermatologist and dermatologic surgeon;**

**II.A.2.f) at least five years of experience as a teacher in graduate medical education in dermatology and dermatologic surgery; and,**

**II.A.2.g) an ongoing clinical practice in dermatologic surgery.**

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

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

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

**II.A.3.c) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or**

requests for the following:

- II.A.3.c).(1) all applications for ACGME accreditation of new programs;
- II.A.3.c).(2) changes in fellow complement;
- II.A.3.c).(3) major changes in program structure or length of training;
- II.A.3.c).(4) progress reports requested by the Review Committee;
- II.A.3.c).(5) responses to all proposed adverse actions;
- II.A.3.c).(6) requests for increases or any change to fellow duty hours;
- II.A.3.c).(7) voluntary withdrawals of ACGME-accredited programs;
- II.A.3.c).(8) requests for appeal of an adverse action;
- II.A.3.c).(9) appeal presentations to a Board of Appeal or the ACGME;
- II.A.3.d) obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:
  - II.A.3.d).(1) program citations, and/or
  - II.A.3.d).(2) request for changes in the program that would have significant impact, including financial, on the program or institution.
- II.A.3.e) commit at least 20 hours a week to the administrative and teaching tasks inherent in achieving the educational goals of the program.
- II.A.4. The program director must semi-annually review and confirm the operative experience records of all fellows.
- II.B. **Faculty**
  - II.B.1. **There must be a sufficient number of faculty with documented qualifications to instruct and supervise all fellows.**
    - II.B.1.a) All programs should have at least two faculty, including the program director, who are actively involved in the clinical practice of cutaneous surgery & oncology.

- II.B.2.** The faculty must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities and demonstrate a strong interest in the education of fellows.
- II.B.3.** The physician faculty must have current certification in the subspecialty by the American Board of Dermatology, or possess qualifications acceptable to the Review Committee.
- II.B.4.** The physician faculty must possess current medical licensure and appropriate medical staff appointment.
- II.B.5.** Members of the faculty who have responsibility for fellow education in Mohs micrographic surgery must have completed a 12-month PGY-5 dermatologic surgery fellowship.
- II.B.6.** Other members of the faculty in related disciplines should include members from other specialties with overlapping expertise to include one or more of the following: dermatology; dermatopathology; general surgery; medical oncology; ophthalmology; orthopaedic surgery; otolaryngology; pathology and radiation therapy; plastic surgery and prosthetics.
- II.B.7.** In the short-term absence of the program director, one member of the faculty must assume the responsibility for the direction of the program.

**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.**

**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.**

- II.D.1.** Adequate space must be dedicated to the performance of dermatologic surgery procedures; this must include a Mohs micrographic frozen section laboratory and examination areas for surgical patients.
- II.D.1.a)** The space should be accredited by the appropriate oversight bodies as required by federal, state and local laws.
- II.D.1.b)** The frozen section laboratory must be adjacent to the operating suite or rooms in which dermatologic surgery is performed.
- II.D.1.c)** Program laboratories must be in compliance with all federal, state and local regulations regarding a work environment.
- II.D.2.** Frozen section slides for Mohs micrographic surgery must be reviewed

and approved, as part of an on-going Quality Assurance process, by an appropriate peer-reviewed organization.

II.D.3. There should be appropriate space for fellows to read, study, and complete their paperwork.

II.D.4. The program must provide a sufficient volume and variety of surgical cases for fellows to acquire the experience of a subspecialist in procedural dermatology.

II.D.4.a) At least 1000 dermatologic surgical procedures per fellow must be available. At least 500 of that minimum total must be Mohs micrographic surgery procedures.

## **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.**

## **III. Fellow Appointments**

### **III.A. Eligibility Criteria**

**Each fellow must successfully complete an ACGME-accredited specialty program and/or meet other eligibility criteria as specified by the Review Committee. The program must document that each fellow has met the eligibility criteria.**

III.A.1. Prior to appointment in the program, fellows must have successfully completed an ACGME-accredited residency program in dermatology.

### **III.B. Number of Fellows**

**The program director may not appoint more fellows than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program's educational resources must be adequate to support the number of fellows appointed to the program.**

III.B.1. Appointment of additional fellows into non-accredited positions must not adversely impact the education of fellows in accredited positions.

## **IV. Educational Program**

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

**IV.A.1. Skills and competencies the fellow will be able to demonstrate at the conclusion of the program. The program must distribute these skills and competencies to fellows and faculty annually, in either written or electronic form. These skills and competencies should be reviewed by the fellow at the start of each rotation;**

IV.A.1.a) The program must provide an organized, systematic, and progressive educational experience for physicians seeking to acquire advanced competence as a dermatologic surgeon.

**IV.A.2. ACGME Competencies**

**The program must integrate the following ACGME competencies into the curriculum:**

**IV.A.2.a) Patient Care**

**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. Fellows:**

IV.A.2.a).(1) must demonstrate proficiency in decisions regarding patient treatment, including instances in which the patient should be referred to a different specialty or individual;

IV.A.2.a).(2) must demonstrate proficiency in performing procedures and must:

IV.A.2.a).(2).(a) be competent in skin neoplasm destruction techniques, excision, and Mohs micrographic surgery;

IV.A.2.a).(2).(b) be competent in cutaneous reconstructive surgery, including random pattern and axial flap repair, grafting techniques, and staged reconstructive techniques; and,

IV.A.2.a).(2).(c) perform at least 400 surgical cases of which at least 200 are Mohs micrographic surgery procedures.

IV.A.2.a).(3) must demonstrate advanced evaluation and management skills for all cutaneous surgical patients regardless of diagnosis, including preoperative, perioperative, and postoperative evaluation;

IV.A.2.a).(4) must demonstrate proficiency in the early identification of benign premalignant and malignant skin lesions through unaided and aided visual morphologic recognition; and,

IV.A.2.a).(5) must maintain certification in advanced cardiac life support (ACLS).

**IV.A.2.b) Medical Knowledge**

**Fellows must demonstrate knowledge of established and**

**evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Fellows:**

- IV.A.2.b).(1) must demonstrate knowledge of related disciplines including surgical anatomy, sterilization of equipment, aseptic technique, anesthesia, closure materials, and instrumentation; and,
- IV.A.2.b).(2) must demonstrate in-depth knowledge of clinical diagnosis, biology, and pathology of skin tumors, as well as laboratory interpretation related to diagnosis and surgical treatment.

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

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

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

- IV.A.2.c).(2) **locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;**

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

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

**IV.A.2.e) Professionalism**

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

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

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

- IV.A.3. Programs must be structured so that fellows are involved in procedural dermatology throughout the year.

- IV.A.4. Didactic sessions must be provided, including regularly scheduled and held lectures, tutorials, seminars, conferences with clinical services and

conferences to consider complications and outcomes and utilization review.

- IV.A.5. Programs must provide organized education in all current aspects of procedural dermatology. This must include:
- IV.A.5.a) instruction in the basic sciences, anatomy, anesthesia, ethics, pre- and postoperative management, surgical technique, wound healing, laboratory technique, interpretation of pathologic specimens related to Mohs micrographic surgery, cutaneous reconstruction of surgical defects, chemical peel, hair transplantation, dermabrasion, rhinophyma correction, cutaneous oncology, epidemiology, medicolegal and regulatory issues, and quality assurance;
  - IV.A.5.b) instruction and experience in electrosurgery for benign and malignant lesions, cryosurgery, curettage and electrosurgery, scalpel surgery, laser surgery and Mohs micrographic surgery, wound healing, and reconstruction of defects;
  - IV.A.5.c) experience in staged reconstruction techniques, chemical destructive techniques, nail surgery, grafts, local flaps, sclerotherapy, wedge excision, and complex cutaneous closures; and,
  - IV.A.5.d) instruction and experience in procedures of an aesthetic nature including cutaneous soft tissue augmentation with injectable filler material, chemo denervation, tumescent liposuction and fat transplantation, hair replacement surgery, skin resurfacing and tightening techniques, and cosmetic laser procedures.
- IV.A.6. The program must provide each fellow with education in setting up and operating a frozen section laboratory capable of processing sections for Mohs micrographic surgery. The program must provide experience in supervising and training laboratory personnel.
- IV.A.7. Fellows must have experience working with health care personnel from dermatology, dermatopathology and medical oncology. Fellow experience should also include interaction with general surgery, ophthalmology, otolaryngology, plastic surgery and radiation oncology.
- IV.A.8. Fellows must be actively engaged in teaching.

#### **IV.B. Fellows' Scholarly Activities**

Each fellow must demonstrate scholarly activity through at least one of the following:

- IV.B.1. preparation of one or more manuscripts suitable for submission to a peer-reviewed publication; or

IV.B.2. one or more presentations at local, regional, or national professional society meetings on topics relevant to procedural dermatology.

## **V. Evaluation**

### **V.A. Fellow Evaluation**

#### **V.A.1. Formative Evaluation**

**V.A.1.a) The faculty must evaluate fellow performance in a timely manner.**

**V.A.1.b) The program must:**

**V.A.1.b).(1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;**

**V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff); and,**

**V.A.1.b).(3) provide each fellow with documented semiannual evaluation of performance with feedback.**

**V.A.1.c) The evaluations of fellow performance must be accessible for review by the fellow, in accordance with institutional policy.**

#### **V.A.2. Summative Evaluation**

**The program director must provide a summative evaluation for each fellow upon completion of the program. This evaluation must 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. This evaluation must:**

**V.A.2.a) document the fellow's performance during their education, and**

**V.A.2.b) verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision.**

**V.A.2.c) be completed using the evaluation form available on the American Board of Dermatology website.**

### **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.C. Program Evaluation and Improvement**

**V.C.1.** The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:

**V.C.1.a)** fellow performance, and

**V.C.1.b)** faculty development.

**V.C.2.** If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.

**VI. Fellow Duty Hours in the Learning and Working Environment**

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

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

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

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

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

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

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

**VI.A.5.** The program director and sponsoring institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Fellows and faculty members must demonstrate an understanding and acceptance of their personal role in the

following:

- VI.A.5.a) assurance of the safety and welfare of patients entrusted to their care;
- VI.A.5.b) provision of patient- and family-centered care;
- VI.A.5.c) assurance of their fitness for duty;
- VI.A.5.d) management of their time before, during, and after clinical assignments;
- VI.A.5.e) recognition of impairment, including illness and fatigue, in themselves and in their peers;
- VI.A.5.f) attention to lifelong learning;
- VI.A.5.g) the monitoring of their patient care performance improvement indicators; and,
- VI.A.5.h) honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.

VI.A.6. All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.

#### VI.B. Transitions of Care

- VI.B.1. Programs must design clinical assignments to minimize the number of transitions in patient care.
- VI.B.2. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.
- VI.B.3. Programs must ensure that fellows are competent in communicating with team members in the hand-over process.
- VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and fellows currently responsible for each patient's care.

#### VI.C. Alertness Management/Fatigue Mitigation

- VI.C.1. The program must:
  - VI.C.1.a) educate all faculty members and fellows to recognize the signs of fatigue and sleep deprivation;

- VI.C.1.b) educate all faculty members and fellows in alertness management and fatigue mitigation processes; and,
- VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.
- VI.C.2. Each program must have a process to ensure continuity of patient care in the event that a fellow may be unable to perform his/her patient care duties.
- VI.C.3. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for fellows who may be too fatigued to safely return home.

**VI.D. Supervision of Fellows**

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

VI.D.1.a) This information should be available to fellows, faculty members, and patients.

VI.D.1.b) Fellows and faculty members should inform patients of their respective roles in each patient's care.

VI.D.2. The program must demonstrate that the appropriate level of supervision is in place for all fellows who care for patients.

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

**VI.D.3. Levels of Supervision**

To ensure oversight of fellow supervision and graded authority and responsibility, the program must use the following classification of supervision:

- VI.D.3.a) Direct Supervision – the supervising physician is physically present with the fellow and patient.**
- VI.D.3.b) Indirect Supervision:**
- VI.D.3.b).(1) with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.**
- VI.D.3.b).(2) with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.**
- VI.D.3.c) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.**
- VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members.**
- VI.D.4.a) The program director must evaluate each fellow’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.**
- VI.D.4.b) Faculty members functioning as supervising physicians should delegate portions of care to fellows, based on the needs of the patient and the skills of the fellows.**
- VI.D.4.c) Fellows should serve in a supervisory role of residents or junior fellows in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual fellow.**
- VI.D.5. Programs must set guidelines for circumstances and events in which fellows must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.**
- VI.D.5.a) Each fellow must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.**
- VI.D.6. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each fellow and delegate to**

**him/her the appropriate level of patient care authority and responsibility.**

**VI.E. Clinical Responsibilities**

**The clinical responsibilities for each fellow must be based on PGY-level, patient safety, fellow education, severity and complexity of patient illness/condition and available support services.**

VI.E.1. Optimal clinical workload is defined as at least 1000 dermatologic surgical procedures (approximately 20 cases in which fellow is directly involved per week) per fellow must be scheduled over the duration of the fellowship. At least 500 of that minimum total must be Mohs micrographic surgery procedures.

**VI.F. Teamwork**

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

VI.F.1. Programs must maintain a process that results in referral of patients for dermatologic procedures. Fellows must be an integral part of the care of these referred patients, and must play key roles in diagnostic work-up, treatment decisions, measurement of treatment outcomes, and the communication and coordination of these activities with clinic management, receptionists, nursing staff, histo-technicians, program faculty, and referring sources.

**VI.G. Fellow Duty Hours**

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

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

**VI.G.1.a) Duty Hour Exceptions**

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

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

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

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

**VI.G.2. Moonlighting**

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

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

**VI.G.3. Mandatory Time Free of Duty**

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

**VI.G.4. Maximum Duty Period Length**

Duty periods of fellows may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage fellows to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.

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

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

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

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

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

- VI.G.4.c).(1).(b)** document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.
- VI.G.4.c).(2)** The program director must review each submission of additional service, and track both individual fellow and program-wide episodes of additional duty.
- VI.G.5. Minimum Time Off between Scheduled Duty Periods**
- VI.G.5.a) Fellows must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.**
- Procedural dermatology fellows are considered to be in the final years of education.
- VI.G.5.a).(1) This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that fellows have eight hours free of duty between scheduled duty periods, there may be circumstances when these fellows must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.**
- VI.G.5.a).(1).(a) Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by fellows must be monitored by the program director.**
- VI.G.5.a).(1).(b) The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the fellow has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.**
- VI.G.6. Maximum Frequency of In-House Night Float**
- Fellows must not be scheduled for more than six consecutive nights of night float.**
- VI.G.7. Maximum In-House On-Call Frequency**
- Fellows must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).**
- VI.G.8. At-Home Call**

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

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

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

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