

## **ACGME Program Requirements for Graduate Medical Education in the Subspecialties of Pediatrics**

***Common Requirements are in BOLD***

*Effective: February 14, 2006*

### I. Introduction

In addition to complying with the requirements in this document, each program must comply with the program requirements for the respective subspecialty, which may exceed the minimum requirements set forth here.

An accredited pediatric subspecialty program must exist in conjunction with and be an integral part of a core pediatric residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME). Interaction of the subspecialty residents/fellows (hereafter called fellows) and faculty with the residents in the core pediatrics residency program is required. Lines of responsibility for the pediatric residents and the fellows must be clearly defined. The presence of a subspecialty program should not adversely affect the education of the pediatric residents.

This document includes the ACGME Common Program Requirements, involving the incorporation of the competencies into fellowship training. Core and subspecialty program directors should work together to achieve this goal. Close coordination between and among core and subspecialty program directors will foster consistent expectations for residents and fellows with regard to their achievement of competencies, and for faculty with regard to evaluation processes.

#### I.A. Duration of Educational Experience

Unless specified otherwise in the program requirements for a specific subspecialty, pediatric subspecialty programs must provide 3 years of training.

#### I.B. Scope of Educational Experience

Each subspecialty program must be organized and conducted in a way that ensures an appropriate environment for the well-being and care of the patients, and that provides adequate training for the fellows in the diagnosis and management of these subspecialty patients. This must include progressive clinical, technical, and consultative experiences that will enable the fellow to develop expertise as a consultant in the subspecialty.

The subspecialty program must develop in its fellows a commitment to lifelong learning, and must emphasize scholarship, self-instruction, development of critical analysis of clinical problems, and the ability to make appropriate decisions. Progressive acquisition of skill in investigative efforts related to the subspecialty is essential.

The program must provide the fellows with instruction and opportunities to ensure effective interaction with patients, patients' families, professional associates, and others in carrying out their responsibilities as physicians in the

specialty. They must be taught how to create and sustain a therapeutic relationship with patients, and how to work effectively as members or leaders of patient care teams or other groups in which they participate as a researcher, educator, health advocate, or manager.

## **II. Institutions**

### **II.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 institutions.**

II.A.1. The pediatric subspecialty program must be sponsored by the same institution that sponsors the related core pediatrics program.

### **II.B. Participating Institutions**

**II.B.1. Assignment to an institution must be based on a clear educational rationale, integral to the program curriculum, with clearly-stated activities and objectives. When multiple participating institutions are used, there should be assurance of the continuity of the educational experience.**

**II.B.2. Assignment to a participating institution requires a letter of agreement with the sponsoring institution. Such a letter of agreement should:**

**II.B.2.a) identify the faculty who will assume both educational and supervisory responsibilities for fellows;**

**II.B.2.b) specify their responsibilities for teaching, supervision, and formal evaluation of fellows, as specified later in this document;**

**II.B.2.c) specify the duration and content of the educational experience;**

**II.B.2.d) state the policies and procedures that will govern fellow education during the assignment; and**

**II.B.2.e) relate specifically to the subspecialty program; the letter must be current, no more than five years old, at the time of the site visit.**

**II.B.3. Copies of these written arrangements, specifying administrative, organizational, and educational relationships, must accompany an application for initial accreditation. At subsequent reviews, these documents need not be submitted, but must be available for review by the site-visitor.**

II.B.4. An accredited program may occur in one or more institutions. Use of an affiliated institution that provides 6 or more months of the inpatient and/or outpatient training requires approval by the Review Committee.

### III. Program Personnel and Resources

#### III.A. Program Director

III.A.1. **There must be a single program director responsible for the program. The person designated with this authority is accountable for the operation of the program. In the event of a change of either program director or department chair, the program director should promptly notify the executive director of the Residency Review Committee through the Web Accreditation Data System of the Accreditation Council for Graduate Medical Education.**

III.A.2. **The program director, together with the faculty, is responsible for the general administration of the program, and for the establishment and maintenance of a stable educational environment. Adequate lengths of appointment for both the program director and faculty are essential to maintaining such an appropriate continuity of leadership.**

III.A.3. **Qualifications of the program director are as follows:**

III.A.3.a) **The program director must possess the requisite specialty expertise, as well as documented educational and administrative abilities.**

III.A.3.b) **The program director must be certified in the subspecialty by the American Board of Pediatrics, or possess qualifications judged to be acceptable by the Review Committee.**

III.A.3.b).(1) Qualifications other than certification by the American Board of Pediatrics will be considered only in exceptional circumstances. Qualifications would include subspecialty training in the subspecialty area, active participation in national societies, evidence of on-going scholarship documented by contributions to the peer-reviewed literature in the subspecialty, and presentations at national meetings in the subspecialty.

III.A.3.c) **The program director must be appointed in good standing and based at the primary teaching site.**

III.A.3.d) The program director should have a record of ongoing involvement in scholarly activities, including peer review publications, and mentoring (i.e., guiding fellows in the acquisition of competence in the clinical, teaching, research and advocacy skills pertinent to the discipline).

**III.A.4. Responsibilities of the program director are as follows:**

**III.A.4.a) The program director must oversee and organize the activities of the educational program in all institutions that participate in the program. This includes selecting and supervising the faculty and other program personnel at each participating institution, appointing a local site director, and monitoring appropriate fellow supervision at all participating institutions.**

**III.A.4.b) The program director is responsible for preparing an accurate statistical and narrative description of the program as requested by the Review Committee, as well as updating annually both program and fellow records through the ACGME's Accreditation Data System.**

**III.A.4.c) The program director must ensure the implementation of fair policies, grievance procedures, and due process, as established by the sponsoring institution and in compliance with the Institutional Requirements.**

**III.A.4.d) The program director must seek the prior approval of the Review Committee for any changes in the program that may significantly alter the educational experience of the fellows. Such changes, for example, include:**

**III.A.4.d).(1) the addition or deletion of a participating institution;**

**III.A.4.d).(2) a change in the format of the educational program;**

**III.A.4.d).(3) a change in the approved fellow complement for those specialties that approve fellow complement**

**On review of a proposal for any such major change in a program, the Review Committee may determine that a site visit is necessary.**

**III.A.4.e) The program director must ensure that the fellows are mentored in their development of clinical, educational, and administrative skills.**

**III.A.4.f) The program director is also responsible for the creation of a core curriculum in scholarly activities, the identification of a mentor, and the identification and monitoring of a scholarship oversight committee responsible for overseeing and assessing the progress of each fellow. Where appropriate, the core curriculum in scholarly activities should be a collaborative effort involving all of the pediatric subspecialty programs in the institution.**

**III.A.4.g) Lines of supervision of fellows for the care of patients must be described in explicit written guidelines that identify appropriate back-up. Such guidelines must be communicated to all members**

of the program staff. Fellows must be provided with prompt, reliable systems for communication and interaction with supervisory physicians.

III.A.4.h) Monitoring and documenting the procedural skills of the fellows.

III.A.5. Program Administration

III.A.5.a) The program director must devote sufficient time to administration of the program and receive commensurate support.

### **III.B. Faculty**

**III.B.1. At each participating institution, there must be a sufficient number of faculty with documented qualifications to instruct and supervise adequately all fellows in the program.**

III.B.1.a) When assessing the adequacy of the number of faculty, the total number of fellows will be considered.

III.B.1.b) In addition to the subspecialty program director, there must be at least one other member of the teaching staff who is qualified in the subspecialty. In some of the subspecialties, 2 or more additional subspecialists are required. Specific details are included in the related specialty-specific section of the requirements.

III.B.1.c) If the program is conducted at more than one institution, a member of the teaching staff of each participating institution must be designated to assume responsibility for the day-to-day activities of the program at that institution, with overall coordination by the program director.

III.B.1.d) Appropriate teaching and consultant faculty in the full range of pediatric subspecialties and in other related disciplines also must be available. An anesthesiologist, pathologist, and a radiologist who have substantial experience with pediatric problems and who interact with the fellows are essential. The other related disciplines should include medical genetics, child neurology, child and adolescent psychiatry, as well as pediatric surgery and surgical subspecialties, as appropriate to the subspecialty.

**III.B.2. The faculty, furthermore, must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities. They must demonstrate a strong interest in the education of fellows, and must support the goals and objectives of the educational program of which they are a member.**

**III.B.3. Qualifications of the physician faculty are as follows:**

**III.B.3.a) The physician faculty must possess the requisite specialty expertise and competence in clinical care and teaching**

**abilities, as well as documented educational and administrative abilities and experience in their field.**

**III.B.3.b) The physician faculty must be certified in the subspecialty by the American Board of Pediatrics, or possess qualifications judged to be acceptable by the Review Committee.**

III.B.3.b).(1) Acceptable qualifications for the required key subspecialty faculty include:

III.B.3.b).(2) certification, if eligible, by the American Board of Pediatrics (ABP) or other appropriate board of the American Board of Medical Specialties (ABMS); or

III.B.3.b).(3) if trained elsewhere and not eligible for certification, documented subspecialty training and peer-reviewed publications in the field with evidence of active participation in applicable local and national professional societies.

**III.B.3.c) The physician faculty must be appointed in good standing to the staff of an institution participating in the program.**

**III.B.4. The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the faculty, and an active research component must be included in each program. *Scholarship* is defined as the following:**

**III.B.4.a) the scholarship of *discovery*, as evidenced by peer-reviewed funding or by publication of original research in a peer-reviewed journal;**

III.B.4.a).(1) this may be research in a variety of fields related to the subspecialty (e.g., basic science, clinical, health services, health policy, or educational research);

**III.B.4.b) the scholarship of *dissemination*, as evidenced by review articles or chapters in textbooks;**

**III.B.4.c) the scholarship of *application*, as evidenced by the publication or presentation of, for example, case reports or clinical series at local, regional, or national professional and scientific society meetings;**

**Complementary to the above scholarship is the regular participation of the teaching staff in clinical discussions, rounds, journal clubs, and research conferences in a manner that promotes a spirit of inquiry and scholarship (e.g., the offering of guidance and technical support for fellows involved in research such as research design and statistical analysis); and the provision of support for fellows' participation, as appropriate, in scholarly activities.**

- III.B.4.d) This should include the mentoring of fellows as they apply scientific principles, epidemiology, biostatistics, and evidence-based medicine to the clinical care of patients.
- III.B.4.e) To provide an appropriate environment for the fellows, the fellowship faculty must have a program of ongoing scholarship characterized by peer reviewed funding and publications. The teaching faculty must play a substantial role in conceiving and writing the funding application(s), conducting the project, collecting and analyzing data, and publishing results. A scholarly environment outside of the training program can supplement but not replace the scholarly environment within the training program.
- III.B.4.f) Although an individual faculty member may not be accomplished in all three areas of scholarship, the program faculty must exhibit all three. In particular, a program must provide evidence of an ongoing commitment to, and productivity in, the scholarship of discovery in the relevant pediatric subspecialty area. Recent productivity by the program faculty and by the fellows will be assessed at the time of each Review Committee review of the program. Activity in the following is required as evidence of the commitment to scholarship: projects with peer review for funding, and publications of original research and/or critical meta-analyses, systematic reviews of clinical practice, critical analyses of public policy, or curricular development projects in peer-reviewed journals.

**III.B.5. Qualifications of the nonphysician faculty are as follows:**

- III.B.5.a) **Nonphysician faculty must be appropriately qualified in their field.**
- III.B.5.b) **Nonphysician faculty must possess appropriate institutional appointments.**

**III.C. Other Program Personnel**

**Additional necessary professional, technical, and clerical personnel must be provided to support the program.**

- III.C.1. The professional personnel should include nutritionists, social workers, respiratory therapists, pharmacists, subspecialty nurses, physical and occupational therapists, child life therapists, and speech therapists with pediatric focus and experience, as appropriate to the subspecialty.

**III.D. Resources**

**The program must ensure that adequate resources (e.g., sufficient laboratory space and equipment, computer and statistical consultation services) are available.**

### III.D.1. Inpatient and Outpatient Facilities

Adequate inpatient and outpatient facilities, as specified in the requirements for each subspecialty, must be available. These must be of sufficient size and be appropriately staffed and equipped to meet the educational needs of the subspecialty program.

### III.D.2. Support Services

Support services must include the clinical laboratories, intensive care, nutrition, occupational and physical therapy, pathology, pharmacology, mental health, diagnostic imaging, respiratory therapy, and social services.

### III.D.3. Patient Population

Patients should range in age from newborn through young adulthood, as appropriate. Adequate numbers of pediatric subspecialty inpatients and outpatients, both new and follow-up, must be available to provide a broad experience for the fellows. The program must maintain an appropriate balance among the number and variety of patients, the number of preceptors, and the number of fellows in the program. Occasionally programs may use defined clinical experiences at participating institutions to supplement the clinical experience and patient population at the primary clinical site. Where that is the case, the program director must submit detailed information to demonstrate that the clinical exposure to the population(s) in question is sufficiently consistent to provide each fellow with an adequate experience during the limited time at the affiliated institution(s); (e.g., if a fellow is spending two months at an affiliated institution to meet required exposure to patients with congenital heart disease, annual data regarding numbers and types of patients in this category must be provided).

### III.D.4. Library Facilities and Computer Access

Subspecialty fellows must have access to an on-site library or collection of appropriate texts and journals in each participating institution, or must have access to electronic databases and other data processing applications.

### III.D.5. Resources for Research and Scholarly Activities

There must be adequate resources for scholarly activity, research and critical analysis. These must include adequate laboratory space, equipment, financial support, and computer services.

## IV. Fellow Appointments

### IV.A. Eligibility Criteria

**The program director must comply with the criteria for fellow eligibility as**

**specified in the Institutional Requirements.**

- IV.A.1. Prerequisite training for entry into a pediatric subspecialty program should include the satisfactory completion of an ACGME-accredited pediatric residency or other training judged suitable by the program director. (N.B.: Candidates who do not meet this criterion must be advised in writing by the program director to consult the American Board of Pediatrics or other appropriate board regarding their eligibility for subspecialty certification.)

**IV.B. Number of Fellows**

**The Review Committee may approve the number of fellows based upon the established written criteria that include the adequacy of resources for fellow education (e.g., the quality and volume of patients and related clinical material available for education), faculty-fellow ratio, institutional funding, and the quality of faculty teaching.**

- IV.B.1. Programs planning to implement a modest increase in fellow complement between formal reviews should follow the directions provided on the Pediatrics Home Page of the ACGME website.

**IV.C. Fellow Transfers**

**To determine the appropriate level of education for fellows who are transferring from another residency program, the program director must receive written verification of previous educational experiences and a statement regarding the performance evaluation of the transferring fellow prior to their acceptance into the program. A program director is required to provide verification of residency education for fellows who may leave the program prior to completion of their education.**

**IV.D. Appointment of Fellows and Other Students**

**The appointment of fellows and other specialty residents or students must not dilute or detract from the educational opportunities available to regularly appointed fellows.**

**V. Program Curriculum**

**V.A. Program Design**

**V.A.1. Format**

**The program design and sequencing of educational experiences will be approved by the Review Committee as part of the review process.**

**V.A.2. Goals and Objectives**

**The program must possess a written statement that outlines its educational goals with respect to the knowledge, skills, and other attributes of fellows for each major assignment and for each level of**

**the program. This statement must be distributed to fellows and faculty, and must be reviewed with the fellows prior to their assignments.**

V.A.3. Collaboration Between Programs

There must be documentation of meetings that describe ongoing interaction among pediatric subspecialty and core program directors. These must take place at least semi-annually. These meetings should address a departmental approach to common educational issues and concerns (e.g., core curriculum, competencies, and evaluation).

**V.B. Specialty Curriculum**

**The program must possess a well-organized and effective curriculum, both didactic and clinical. The curriculum must also provide fellows with direct experience in progressive responsibility for patient management.**

V.B.1. The specialty-specific clinical curriculum is found in the program requirements for each subspecialty.

V.B.2. The program must provide a structured curriculum that leads to a working understanding of biostatistics, clinical and laboratory research methodology, study design, preparation of applications for funding and/or approval of clinical research protocols, critical literature review, principles of evidence-based medicine, ethical principles involving clinical research, and the achievement of proficiency in teaching for all subspecialty fellows.

V.B.3. The curriculum should lead to an understanding of the principles of adult learning, and provide skills to participate effectively in curriculum development, delivery of information, provision of feedback to learners, and assessment of educational outcomes.

V.B.4. Graduates should be effective in teaching both individuals and groups of learners in clinical settings, classrooms, lectures, and seminars, and also by electronic and print modalities.

**V.C. Fellows Scholarly Activities**

**Each program must provide an opportunity for fellows to participate in research or other scholarly activities, and fellows must participate actively in such scholarly activities.**

V.C.1. Each fellow must design and conduct a scholarly project in his or her subspecialty area with the guidance of the fellowship Director and a designated mentor.

V.C.2. The program must provide a scholarship oversight committee for each fellow to evaluate the fellow's progress as related to scholarly activity.

- V.C.3. The scholarly experience must begin in the first year and continue for the entire period of training.
- V.C.4. Time must be adequate to allow for the development of requisite skills, project completion, and presentation of results to a local scholarship oversight committee established for this review.
- V.C.5. Where applicable, the process of establishing fellow scholarship oversight committees should be a collaborative effort involving other pediatric subspecialty programs in the institution.

**V.D. ACGME Competencies**

**The residency program must require its fellows to obtain competence in the six areas listed below to the level expected of a new practitioner. Programs must define the specific knowledge, skills, behaviors, and attitudes required, and provide educational experiences as needed in order for their fellows to demonstrate the following:**

**V.D.1. *Patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health;***

V.D.1.a) Clinical Skills

A pediatric subspecialty program must offer supervised training to ensure the acquisition of the necessary clinical skills used in the subspecialty, including development of expertise in the ability to perform a history and physical examination, make diagnostic and therapeutic decisions, develop and carry out management plans, counsel patients and families, and use information technology to optimize patient care.

V.D.1.b) Diagnostic Tests and Procedures

The program must offer supervised experience in performing and interpreting the results of laboratory tests and diagnostic procedures for use in patient care. Instruction and experience must be sufficient for the fellow to acquire the necessary procedural skills and develop an understanding of their indications, risks, and limitations. Each fellow's experience in such procedures must be documented by the program director and such documentation must be available for review.

**V.D.2. *Medical Knowledge about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care;***

V.D.2.a) There must be a formally-structured educational program for the fellows in the clinical and basic sciences related to the subspecialty that utilizes lectures, seminars, and practical experience. Subspecialty conferences must be regularly

scheduled, and should involve active participation by the fellows in the planning and implementation of these meetings.

- V.D.2.b) The curriculum should include basic and fundamental disciplines related to each subspecialty, as appropriate, such as anatomy, physiology, biochemistry, embryology, pathology, microbiology, pharmacology, immunology, genetics, and nutrition/metabolism.
- V.D.2.c) Instruction in the pathophysiology of disease, reviews of recent advances in clinical medicine and biomedical research, conferences dealing with complications and death, and instruction in the scientific, ethical, and legal implications of confidentiality and of informed consent should also be included.
- V.D.2.d) One outcome measure of the quality of an educational program is the performance of its graduates on the certifying examination of the sub-board. In its evaluation of pediatric subspecialty programs, the Review Committee will take into consideration the information in the PIF and that which is provided by the American Board of Pediatrics. A program will be judged deficient if, over a 6 year period, fewer than 75% of fellows eligible for the certifying examination take it and of those who take it, fewer than 75% pass it on the first attempt. The Committee will take into consideration noticeable improvements or declines during this same period. An exception may be made for programs with small numbers of fellows. A subspecialty program director will be expected to provide the requested information at the time of each Review Committee review.
- V.D.3. *Practice-based learning and improvement that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements in patient care;***
- V.D.3.a) Programs are responsible for ensuring that fellows have or develop the skills necessary to utilize information technology in the acquisition of knowledge, including the ability to appraise and assimilate evidence from scientific studies related to their patient's health problems.
- V.D.3.b) The program must provide fellows with the necessary background to participate in clinical/professional quality improvement activities. Evidence of self-evaluation incorporating faculty, peer and patient assessments must be demonstrated in the fellow's development of his or her individual learning plan.
- V.D.3.c) Fellows must actively participate in the education of patients, families, residents, students, and other health professionals. They must be given the opportunity to teach and participate in undergraduate, graduate, and continuing education activities, as well as to assume some departmental administrative

responsibilities.

V.D.3.d) The program should also provide fellows with instruction in curriculum design, information delivery in clinical settings and classrooms, provision of feedback to learners, assessment of educational outcomes, and the development of teaching materials.

**V.D.4. *Interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and other health professionals;***

V.D.4.a) The program must educate the fellow about the unique roles of the consultant, team member and team leader.

**V.D.5. *Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds;***

V.D.5.a) A subspecialty program must provide an environment in which high standards of professionalism and a commitment to continued improvement are evident. Professionalism must be fostered throughout training.

V.D.5.b) Bioethics must be addressed in the formal curriculum, including attention to physician-patient, physician-family, physician-physician/allied health professional, and physician-society relationships.

**V.D.6. *Systems-based practice, as manifested by actions that 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.***

V.D.6.a) In addition to topics covered in the core subspecialty content, the curriculum must include instruction in such topics as the economics of health care and current health care management issues, such as cost-effective patient care, practice management, preventive care, quality improvement, resource allocation, and clinical outcomes.

V.D.6.b) Programs must provide didactics and experience in the prevention of medical errors.

V.E. Instruction in Program Administration

Fellowship programs that are three years must address the following areas of administration:

V.E.1. An awareness of regional and national access to care, resources, workforce, and financing appropriate to their specialty through guided reading and discussion.

- V.E.2. Organization and management of a subspecialty service within one's own delivery system by engaging fellows as active participants in discussions (e.g., through already scheduled division activities/meetings ) that involve:
- V.E.2.a) staffing a service or unit, including managing personnel and making and adhering to a schedule;
  - V.E.2.b) drafting policies and procedures, leading interdisciplinary meetings and conferences, providing in-service teaching sessions;
  - V.E.2.c) discussions/proposals for hospital and community resources including clinical, laboratory and research space, equipment and technology necessary for the program to provide state-of-the-art care while advancing knowledge in the field;
  - V.E.2.d) business planning and practice management that includes billing and coding, personnel management policies and professional liability;
  - V.E.2.e) division or program development, organization, and maintenance; and
  - V.E.2.f) necessary collaborations within (e.g., pathology, radiology, surgery) and beyond the institution (e.g., participation in national specialty societies, cooperative care groups, multi-center research collaboratives) as appropriate to their specialty.

## **VI. Fellow Duty Hours and the Working Environment**

**Providing fellows with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and fellow well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on fellows to fulfill service obligations. Didactic and clinical education must have priority in the allotment of fellows' time and energy. Duty hour assignments must recognize that faculty and fellows collectively have responsibility for the safety and welfare of patients.**

### **VI.A. Supervision of Fellows**

- VI.A.1. All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of fellows at all times. Fellows must be provided with rapid, reliable systems for communicating with supervising faculty.**
- VI.A.2. Faculty schedules must be structured to provide fellows with continuous supervision and consultation.**
- VI.A.3. Faculty and fellows must be educated to recognize the signs of fatigue, and adopt and apply policies to prevent and counteract the potential negative effects.**

**VI.B. Duty Hours**

**VI.B.1. Duty hours are defined as all clinical and academic activities related to the fellowship program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities such as conferences. Duty hours do *not* include reading and preparation time spent away from the duty site.**

**VI.B.2. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.**

**VI.B.3. Fellows must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. *One day* is defined as one continuous 24-hour period free from all clinical, educational, and administrative duties.**

**VI.B.4. Adequate time for rest and personal activities must be provided. This should consist of a 10 hour time period provided between all daily duty periods and after in-house call.**

VI.B.4.a) The Review Committee will not consider requests for a rest period that is less than 10 hours.

**VI.C. On-Call Activities**

**The objective of on-call activities is to provide fellows with continuity of patient care experiences throughout a 24-hour period. *In-house call* is defined as those duty hours beyond the normal work-day, when fellows are required to be immediately available in the assigned institution.**

**VI.C.1. In-house call must occur no more frequently than every third night, averaged over a 4-week period.**

**VI.C.2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Fellows may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics and maintain continuity of medical and surgical care.**

VI.C.2.a) Post-call fellows may not attend any outpatient clinics other than continuity clinics.

**VI.C.3. No new patients may be accepted after 24 hours of continuous duty.**

VI.C.3.a) A new patient is defined as any patient for whom the fellow has not provided care during the previous 24 hour period or who is not a part of the fellow's continuity panel or the panel of the fellow's continuity team, if such exists.

- VI.C.4.** ***At-home call (or pager call)*** is defined as a call taken from outside the assigned institution.
- VI.C.4.a)** The frequency of at-home call is not subject to the every-third-night limitation. At-home call must not be so frequent as to preclude rest and reasonable personal time for each fellow. Fellows taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.
- VI.C.4.b)** When fellows are called into the hospital from home, the hours they spend in-house are counted toward the 80-hour limit.
- VI.C.4.c)** The program director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.
- VI.C.4.d)** When evaluating the acceptability of a program's schedule for at-home call, the Review Committee will take into consideration the number and frequency of calls taken by the fellows, the number of consecutive nights fellows have such call, and include the number of times the fellow comes into the hospital.
- VI.D. Moonlighting**
- VI.D.1.** Because fellowship education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the fellow to achieve the goals and objectives of the educational program.
- VI.D.2.** The program director must comply with the sponsoring institution's written policies and procedures regarding moonlighting, in compliance with the ACGME Institutional Requirements.
- VI.D.3.** Any hours a fellow works for compensation at the sponsoring institution or any of the sponsor's primary clinical sites must be considered part of the 80-hour weekly limit on duty hours. This refers to the practice of *internal moonlighting*.
- VI.E. Oversight**
- VI.E.1.** Each program must have written policies and procedures consistent with the Institutional and Program Requirements for fellow duty hours and the working environment. These policies must be distributed to the fellows and the faculty. Duty hours must be monitored with a frequency sufficient to ensure an appropriate balance between education and service.

**VI.E.2. Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create fellow fatigue sufficient to jeopardize patient care.**

**VI.F. Duty Hours Exceptions**

**A Review Committee may grant exceptions for up to 10% of the 80-hour limit to individual programs based on a sound educational rationale. Prior permission of the institution's GMEC, however, is required.**

**VI.F.1. The Review Committee for Pediatrics will not consider requests for exceptions to the 80 hour limit to a fellow's work week.**

**VII. Evaluation**

**VII.A. Fellow**

**VII.A.1. Formative Evaluation**

**The faculty must evaluate in a timely manner the fellows whom they supervise. In addition, the fellowship program must demonstrate that it has an effective mechanism for assessing fellow performance throughout the program, and for utilizing the results to improve fellow performance.**

**VII.A.1.a) Assessment should include the use of methods that produce an accurate assessment of fellows' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.**

**VII.A.1.b) Assessment should include the regular and timely performance feedback to fellows that includes at least semiannual written evaluations. Such evaluations are to be communicated to each fellow in a timely manner, and maintained in a record that is accessible to each fellow.**

**VII.A.1.c) Assessment should include the use of assessment results, including evaluation by faculty, patients, peers, self, and other professional staff, to achieve progressive improvements in fellows' competence and performance.**

**VII.A.2. Final Evaluation**

**The program director must provide a final evaluation for each fellow who completes the program. This evaluation must include a review of the fellow's performance during the final period of education, and should verify that the fellow has demonstrated sufficient professional ability to practice competently and independently. The final evaluation must be part of the fellow's permanent record**

**maintained by the institution.**

**VII.B. Faculty**

**The performance of the faculty must be evaluated by the program no less frequently than at the midpoint of the accreditation cycle, and again prior to the next site visit. The evaluations should include a review of their teaching abilities, commitment to the educational program, clinical knowledge, and scholarly activities. This evaluation must include annual written confidential evaluations by fellows.**

VII.B.1. Faculty should receive formal feedback from these evaluations.

**VII.C. Program**

**The educational effectiveness of a program must be evaluated at least annually in a systematic manner.**

VII.C.1. **Representative program personnel (i.e., at least the program director, representative faculty, and one fellow) must be organized to review program goals and objectives, and the effectiveness with which they are achieved. This group must conduct a formal documented meeting at least annually for this purpose. In the evaluation process, the group must take into consideration written comments from the faculty, the most recent report of the GMEC of the sponsoring institution, and the fellows' confidential written evaluations. If deficiencies are found, the group should prepare an explicit plan of action, which should be approved by the faculty and documented in the minutes of the meeting.**

VII.C.1.a) The annual evaluation should include the use of the resources available to the program.

VII.C.1.b) The contribution of the participating institutions, the financial and administrative support of the program, the volume and variety of patients available for educational purposes, the performance of the teaching staff, and the quality of supervision of fellows should be considered in the evaluation.

VII.C.1.c) Information gained from these evaluations should be used to implement improvements in the program.

**VII.C.2. The program should use fellow performance and outcome assessment in its evaluation of the educational effectiveness of the residency program. Performance of program graduates on the certification examination should be used as one measure of evaluating program effectiveness. The program should maintain a process for using assessment results together with other program evaluation results to improve the fellowship program.**

VII.D. Collaboration with Core on Evaluation Mechanisms

The same evaluation mechanisms used in the related pediatrics residency program must be adapted for and implemented in all of the pediatric subspecialty programs that function with it. In order to maintain the confidentiality of responses from fellows in small programs, evaluations of faculty may be consolidated with the core faculty evaluations.

VII.E. Evaluation by the Review Committee

Each subspecialty program will be evaluated by the Review Committee at regular intervals, in conjunction with a review of the related core pediatrics program when possible.

**VIII. Experimentation and Innovation**

**Since responsible innovation and experimentation are essential to improving professional education, experimental projects along sound educational principles are encouraged. Requests for experimentation or innovative projects that may deviate from the program requirements must be approved in advance by the Review Committee, and must include the educational rationale and method of evaluation. The sponsoring institution and program are jointly responsible for the quality of education offered to fellows for the duration of such a project.**

**IX. Certification**

**Fellows who plan to seek certification in the specific subspecialty by the American Board of Pediatrics should communicate with the office of the board regarding the full requirements for certification.**

ACGME Approved: February 14, 2006

Minor Revision: June 27, 2006

Effective: January 1, 2007

Editorial Revision: July 1, 2009

## ACGME Program Requirements for Graduate Medical Education in the Sports Medicine

*Effective: June, 2000*

### X. Scope and Duration of Training

X.A. An educational program in sports medicine must be organized to provide a well-supervised experience at a level sufficient for the resident to acquire the competence of a physician with added qualifications in this field. It shall be 12 months in duration.

X.B. The practice of sports medicine is the application of the physician's knowledge, skills, and attitudes to those engaged in sports and exercise. Thus, the program must provide training in the development of the clinical competencies needed to diagnose and manage medical illnesses and injuries related to sports and exercise, for example, first-degree sprains, strains, and contusions, including appropriate referrals of, for example, fractures, dislocations, and third-degree sprains. Clinical experience must include injury prevention, preparticipation evaluation, management of acute and chronic illness or injury, and rehabilitation, as applied to a broad spectrum of undifferentiated patients. There must be experience functioning as a team physician and in the promotion of physical fitness and wellness.

X.C. The program should emphasize physiology and biomechanics; principles of nutrition; pathology and pathophysiology of illness and injury; pharmacology; effects of therapeutic, performance-enhancing, and mood-altering drugs; psychological aspects of exercise, performance, and competition; ethical principles; and medical-legal aspects of exercise and sports.

### XI. Program Personnel and Resources

#### XI.A. Program Director

The Program Director must be certified in the specialty by the American Board of Emergency Medicine, Family Medicine, Internal Medicine, Pediatrics, or Physical Medicine and Rehabilitation, or possess qualifications judged to be acceptable by the RRC. Directors must possess a CAQ in Sports Medicine. The RRC will determine the adequacy of alternate qualifications.

#### XI.B. Faculty

The physician faculty must be certified in the specialty by the American Board of Emergency Medicine, Family Medicine, Internal Medicine, Pediatrics, or Physical Medicine and Rehabilitation, or possess qualifications judged to be acceptable by the RRC.

#### XI.C. Teaching Staff

XI.C.1. In addition to the program director, each program must have at least one other faculty member with similar qualifications who devotes a substantial

portion of professional time to the training program.

XI.C.2. The teaching staff must include orthopedic surgeons who are engaged in the operative management of sports injuries and other conditions and who are readily available to teach and provide consultation to the residents. Teaching staff from the disciplines of nutrition, pharmacology, pathology, exercise physiology, physical therapy, behavioral science, and clinical imaging also should be available to assist in the educational program. Coaches and athletic trainers also should be included.

XI.D. Resources

The program must include the following:

XI.D.1. Patient Population

A patient population that is unlimited by age or gender and is adequate in number and variety to meet the needs of the training program must be available. The program director must ensure that residents are accorded meaningful patient responsibility with the supervision of a faculty member at all facilities and sites.

XI.D.2. Sports Medicine Clinic

XI.D.2.a) There must be an identifiable clinic that offers continuing care to patients who seek consultation regarding sports- or exercise-related health problems. The nonsurgical trainees must be supervised by a physician who has qualifications in sports medicine and is certified by the American Board of Emergency Medicine, Family Medicine, Internal Medicine, Pediatrics or Physical Medicine and rehabilitation who possesses suitable equivalent qualifications.

XI.D.2.b) Adequate, up-to-date diagnostic imaging and rehabilitation services must be readily available and accessible to clinic patients. Consultation in medical and surgical subspecialties, physical therapy, nursing, nutrition, and pharmacy must be available. The opportunity to render continuing care and to organize recommendations from other specialties and disciplines is mandatory and will require that medical records include information pertinent to the assessment and management of patients with health problems related to sports and exercise.

XI.D.3. Sporting Events/Team Sports/Mass-Participation Events

The program must have access to sporting events, team sports, and mass-participation events during which the resident can have meaningful patient responsibility.

XI.D.4. Acute-Care Facility

There must be an acute-care hospital with a full range of services associated with and in proximity to the sponsoring residency. This facility must be readily accessible to patients served by the program.

XII. Resident Eligibility Criteria

Residents appointed to the sports medicine programs should have completed an ACGME-accredited residency in emergency medicine, family medicine, internal medicine, pediatrics, or physical medicine and rehabilitation.

XIII. Specialty Curriculum

XIII.A. The curriculum must provide the educational experiences necessary for the residents to achieve the cognitive knowledge, psychomotor skills, interpersonal skills, professional attitudes, and practical experience required of physicians in the care of patients with health problems related to sports and exercise.

XIII.B. Didactic as well as clinical learning opportunities must be provided as part of the required curriculum for all residents. Conferences or seminars/workshops in sports medicine should be specifically designed for the residents to augment the clinical experiences. All educational activities must be adequately supervised, while allowing the resident to assume progressive responsibility for patient care. The clinical activities in sports medicine should represent a minimum of 50% of the time in the program. The remainder of the time should be spent in didactic, teaching, and/or research activities and in the primary care, emergency medicine, physical medicine and rehabilitation, or ambulatory facility.

XIII.C. Residents must spend 1/2 day per week maintaining their skills in their primary specialty.

XIII.D. Participation in the following must be required of all residents:

XIII.D.1. Preparticipation Evaluation of the Athlete

The program must ensure that all sports medicine residents are involved in the development and conduct of preparticipation examination programs.

XIII.D.2. Acute Care

The resident must have appropriate authority and responsibility to participate meaningfully in the medical care that is provided to acute-care patients (see Scope and Duration of Training, above). In addition, the program should arrange for residents to observe - representative in patient and outpatient operative orthopedic procedures.

XIII.D.3. Sports Medicine Clinic Experience

XIII.D.3.a) The resident must attend patients in a continuing, comprehensive manner, providing consultation for health problems related to sports and exercise. The resident shall spend at least 1 day per week for 10 months of the training period in this activity.

XIII.D.3.b) If patients are hospitalized, the resident should follow them during their inpatient stay and resume outpatient care following the hospitalization. Consultation with other physicians and professionals in other disciplines should be encouraged.

XIII.D.4. On-Site Sports Care

The resident should participate in planning and implementation of all aspects of medical care at various sporting events. The program must ensure that supervised sports medicine residents provide on-site care and management to participants in these events. In addition, the resident must participate in the provision of comprehensive and continuing care to a sports team. Preferably, the experience should include several teams that engage in seasonal sports.

XIII.D.5. Mass-Participation Sports Events

The resident should participate in the planning and implementation of the provision of medical coverage for at least one mass-participation event. The program must ensure that its residents have experience that includes providing medical consultation, direct patient care, event planning, protection of participants, coordination with local EMS systems, and other medical aspects of those events.

XIV. Specific Knowledge and Skills

XIV.A. Clinical

The program must provide educational experiences that enable residents to develop clinical competence in the overall field of sports medicine. The curriculum must include but not be limited to the following content and skill areas:

XIV.A.1. Anatomy, physiology, and biomechanics of exercise

XIV.A.2. Basic nutritional principles and their application to exercise

XIV.A.3. Psychological aspects of exercise, performance, and competition

XIV.A.4. Guidelines for evaluation prior to participation in exercise and sport

XIV.A.5. Physical conditioning requirements for various activities

XIV.A.6. Special considerations related to age, gender, and disability

- XIV.A.7. Pathology and pathophysiology of illness and injury as they relate to exercise
- XIV.A.8. Effects of disease, e.g., diabetes, cardiac conditions, arthritis, on exercise and the use of exercise in the care of medical problems
- XIV.A.9. Prevention, evaluation, management, and rehabilitation of injuries
- XIV.A.10. Understanding pharmacology and effects of therapeutic, performance-enhancing, and mood-altering drugs
- XIV.A.11. Promotion of physical fitness and healthy lifestyles
- XIV.A.12. Functioning as a team physician
- XIV.A.13. Ethical principles as applied to exercise and sports
- XIV.A.14. Medical-legal aspects of exercise and sports
- XIV.A.15. Environmental effects on exercise
- XIV.A.16. Growth and development related to exercise
- XIV.B. Patient Education/Teaching

The program must provide the experiences necessary for the residents to develop and demonstrate competence in patient education regarding sports and exercise. They must have experience teaching others, e.g., nurses, allied health personnel, medical students, residents, coaches, athletes, other professionals, and members of patients' families. There must also be relevant experience working in a community sports medicine network involving parents, coaches, certified athletic trainers, allied medical personnel, residents, and physicians.

## XV. Certification

Residents who plan to seek certification by the American Board of Emergency Medicine, the Family Practice, the Internal Medicine, the Pediatrics, or the Physical Medicine and Rehabilitation should communicate with the office of the board regarding the full requirements for certification.

\*\*\*

ACGME: June 2000 Effective: June 2000

Editorial Revision (Common Program Requirements): July 2004

ACGME-Approved Minor Revision: February 12, 2008      Effective: April 12, 2008