

# ACGME Program Requirements for Graduate Medical Education in Pediatric Rehabilitation Medicine

*Common Program Requirements are in BOLD*

*Effective: September 16, 2008*

## Introduction

### Int.A. Definition

Pediatric Rehabilitation Medicine (PRM) is the subspecialty that utilizes an interdisciplinary approach to address the prevention, diagnosis, treatment, and management of congenital and childhood-onset physical impairments. These impairments include related or secondary medical, physical, functional, cognitive, psychosocial, and vocational limitations or conditions. Rehabilitation management of children with physical impairments requires identifying functional capabilities and selecting the best rehabilitation intervention strategies, with an understanding of the life course of the disability and of the continuum of care.

### Int.B. Program Design

The director and teaching staff of a program must prepare and comply with written educational goals for the program. All educational components of a residency program should be related to the program goals.

Int.B.1. The Review Committee for Physical Medicine and Rehabilitation must approve the program design as part of the regular review process.

Int.B.2. Participation by any site providing three months or more of education must be approved by the Review Committee.

### Int.C. Duration of Education

Int.C.1. Education in PRM shall be 24 months in duration if it begins after satisfactory completion of an Accreditation Council for Graduate Medical Education (ACGME)-approved residency program in Physical Medicine and Rehabilitation. The program must ensure that the fellow acquires knowledge and skills in general pediatrics, normal childhood development, normal neonatal development, and adolescent medicine including psychosocial issues.

Int.C.2. PRM education shall be 12 months in duration if it begins after satisfactory completion of ACGME-approved combined or consecutive residency education in both Physical Medicine and Rehabilitation and Pediatrics.

### Int.D. Program Goals and Objectives

#### Int.D.1. Goals

An approved subspecialty program must provide an educational experience to ensure that its graduates possess the advanced knowledge and competencies

necessary to practice this subspecialty.

#### Int.D.2. Objectives

The program must provide the fellow opportunities to develop a specific set of attitudes, knowledge, and psychomotor skills in pediatric rehabilitation conditions to ensure their ability to enhance the quality of care available to those individuals and their families. The fellow must become competent in:

- Int.D.2.a) Defining aspects of growth and development in the context of children and adults with congenital and childhood onset disabilities, throughout the life course.
- Int.D.2.b) Identifying age appropriate assessment and measurement tools to evaluate functional status or outcomes of interventions.
- Int.D.2.c) Managing common medical issues in pediatric rehabilitation.
- Int.D.2.d) Describing principles and techniques for general pediatric rehabilitative therapeutic management.
- Int.D.2.e) Evaluating and prescribing age appropriate assistive devices and technologies to enhance function.
- Int.D.2.f) Understanding and performing pediatric rehabilitation procedures.
- Int.D.2.g) Outlining the clinical course of and functional prognosis for common pediatric disabilities.
- Int.D.2.h) Identifying interventions to assist children, adults, and their families to participate successfully in age-appropriate education and other activities.
- Int.D.2.i) Advocating for care needs, systems of care, and research to enhance the care and function of children and adults with congenital or childhood onset disabilities.
- Int.D.2.j) Providing consultation to physiatrists, pediatricians, and other clinicians regarding PRM issues.
- Int.D.2.k) Participating in instruction and conducting research in PRM.
- Int.D.2.l) Applying principles of management and administration.

### 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.A.1. The sponsoring institution must be a center for care of persons with pediatric rehabilitative diagnoses or be affiliated with such a center. Affiliation with an accredited medical school is desirable. The Joint Commission on Accreditation of Healthcare Organizations-Rehabilitation Section or the Commission on Accreditation of Rehabilitation Facilities should accredit the sponsoring institution.
- I.A.2. Accreditation will be granted only when the program is affiliated with an ACGME-accredited residency program in Physical Medicine and Rehabilitation.
- I.A.3. There must be close cooperation between the core residency program and the subspecialty program. The lines of responsibility between fellows in the core program and the subspecialty program must be clearly delineated.
- I.A.4. There should be an institutional policy, reviewed at the time of regular institutional or internal review, governing the educational resources committed to the PRM program assuring cooperation of all involved disciplines.
- I.A.5. The institution must provide for financial resources that include, but are not limited to, salaries, fringe benefits, and opportunities for fellows' continuing education.

**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).**

I.B.3. Participating sites should be in the same geographic location, and be conveniently and safely accessible to fellows.

## **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 specialty by the American Board of Physical Medicine and Rehabilitation, or specialty qualifications that are acceptable to the Review Committee; and,**

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

**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) be responsible for the supervision of fellows through explicit written descriptions of supervisory lines of responsibility for care of patients. Such guidelines must be communicated to all members of the program staff. Fellows must be provided with prompt, reliable systems for communications and interaction with supervisory physicians;
- II.A.3.f) ensure documentation of staff and fellow attendance at conferences;
- II.A.3.g) monitor, in accord with written policies, on-duty assignments as well as activities outside the program.
  
- II.A.4. The level of supervision of the fellows should be determined by the program director based on formal and informal evaluations.
- II.A.5. The program director should assign a member of the faculty as supervisor to each fellow. Written objectives for each clinical rotation must be provided to each fellow.
- II.A.6. The program director should demonstrate active participation in research and scholarly activities in PRM.

**II.B. Faculty**

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

**II.B.2. The faculty must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities and demonstrate a strong interest in the education of fellows.**

**II.B.3. The physician faculty must have current certification in the specialty by the American Board of Physical Medicine and Rehabilitation, 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.4.a) In addition to the program director there must be at least one other faculty member with expertise in PRM who is dedicated to the program.

II.B.4.b) Educational activities must be carried out under the direct supervision of faculty members.

**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. Education in PRM should include experience in both inpatient and outpatient facilities. The sponsoring institution and participating sites must operate or have access to a service delivery system dedicated to the care of persons with pediatric rehabilitative disorders. Necessary resources include

II.D.1.a) Inpatient pediatric rehabilitation beds;

II.D.1.b) A designated outpatient clinic or examination area for persons with pediatric rehabilitative disorders; and,

II.D.1.c) Transitional services for home care, community entry, schooling, etc.

II.D.2. The sponsoring institution must have the equipment, electrodiagnostic devices, radiology services, laboratory services, and clinical facilities

necessary to provide appropriate care to persons with pediatric rehabilitative disorders. Facilities for teaching services must be available, in addition to a medical records system that allows for efficient case retrieval.

- II.D.3. The sponsoring institution must have specialty consulting services essential to the care of persons with pediatric rehabilitative disorders. These services include anesthesia, emergency medicine, family medicine, genetics, neurological surgery, neurology, orthopedic surgery, pathology, pediatrics (including the relevant subspecialties), pediatric surgery, plastic surgery, psychiatry, radiology, surgery, urology, and other relevant health care professionals.
- II.D.4. Home care and specialized schooling must be available.
- II.D.5. The patient population must be of sufficient size and diversity of pediatric age groups to allow fellows to care for an adequate number of persons, in both inpatient and outpatient settings, in all pediatric rehabilitative diagnostic categories.
- II.D.6. The fellow must have the opportunity to meet and share experience with residents in the core program and in other specialties. It is desirable for the fellow to interact with peers in primary care and relevant subspecialties. Fellows should have the opportunity to teach other fellows, medical students, and other health care professionals.
- II.D.7. Rotation to the PRM program by medical students, and residents and fellows from other specialties or subspecialties is desirable.

## **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. The applicant must be licensed for unrestricted practice in a state or province of the United States or Canada.

### **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. The program shall establish written policies and procedures regarding selection and appointment of fellows. There should be at least one fellow in the program at all times.
- III.B.2. The program shall have and implement written policies and procedures, based on the clinical and educational resources available, for determining the number of fellow positions.
- III.B.3. The program shall have and implement written policies and procedures, based on the clinical and educational resources available, regarding changes in fellow complement or filling vacant 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.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 have a sufficient variety, depth, and volume of clinical experiences. The educational program should take into consideration the fellow's documented past educational and patient care experiences. The program must provide for the fellow to spend a significant amount of time with responsibility for the direct care of hospitalized as well as non-hospitalized patients. Fellows must devote at least 1/3 of their clinical experience to the care of hospitalized patients and at least 1/3 to non-hospitalized patients;

IV.A.2.a).(2) must attain knowledge and competency in the following areas of PRM:

IV.A.2.a).(2).(a) normal growth and development, including, physical growth, developmental skills attainment

(language and communication skills, physical skills, cognitive skills, emotional skills and maturity, academic achievement/learning skills), transitional issues, metabolic status, biomechanics, the effects of musculoskeletal development on function, sexuality, avocational interest development, wellness and health promotion, and aging issues for adults with congenital or childhood onset disabilities;

IV.A.2.a).(2).(b)

applications, efficacy, and selection of PRM assessment tools, including enabling/disabling process, general health measures, developmental attainment measures, general functional measures, and specific outcomes measures;

IV.A.2.a).(2).(c)

identification and management of common pediatric rehabilitation medical conditions and complications, including nutrition, bowel management, bladder management, gastroesophageal reflux, skin protection, pulmonary hygiene and protection, sensory impairments, sleep disorders, spasticity, DVT prophylaxis, congenital and acquired lymphedema, feeding disorders, swallowing dysfunction, seizure management, and behavioral problems;

IV.A.2.a).(2).(d)

principles and techniques for general pediatric rehabilitative therapeutic management, including early intervention, age appropriate functional training, programs of therapy, play (avocation), therapeutic exercise, electrical stimulation and other modalities, communication strategies, oral motor interventions, discharge planning, educational and vocational planning, transitional planning, adjustment to disability support, and prevention strategies;

IV.A.2.a).(2).(e)

evaluation and prescription for assistive devices technology, including orthotics, prosthetics, wheelchairs and positioning, ADL aids, interfaces and environmental controls, augmentative/alternative communication, environmental accessibility, electrical stimulation, and dynamic splinting;

IV.A.2.a).(2).(f)

principles and techniques of PRM procedures, including spasticity management and electrodiagnosis;

- IV.A.2.a).(2).(g) interpretation of diagnostic studies commonly ordered in PRM;
- IV.A.2.a).(2).(h) rehabilitation management of:
- IV.A.2.a).(2).(h).(i) musculoskeletal disorders and trauma, including sports injuries;
- IV.A.2.a).(2).(h).(ii) cerebral palsy;
- IV.A.2.a).(2).(h).(iii) spinal dysraphism, and other congenital anomalies;
- IV.A.2.a).(2).(h).(iv) pediatric spinal cord injury;
- IV.A.2.a).(2).(h).(v) pediatric traumatic brain injury;
- IV.A.2.a).(2).(h).(vi) limb deficiency/ amputation;
- IV.A.2.a).(2).(h).(vii) neuromuscular disorders;
- IV.A.2.a).(2).(h).(viii) rheumatologic and connective tissue disorders, including but not limited to specific conditions, such as juvenile rheumatoid arthritis, spondyloarthropathies, dermatomyositis, and lyme disease;
- IV.A.2.a).(2).(h).(ix) burns in the pediatric patient;
- IV.A.2.a).(2).(h).(x) peripheral nerve injuries.
- IV.A.2.a).(2).(i) administration, including principles of organizational behaviors and leadership, quality assurance, cost efficiency, knowledge of health care systems, community resources, and support services regulations pertaining to service provision (external reviews, inpatient services, outpatient services, home care, school based programs and capabilities), skills for effective advocacy, medical legal aspects, (child protective services, guardianship, liability), professionalism, and ethics;
- IV.A.2.a).(2).(j) psychological, social and behavioral aspects of rehabilitation management, including family-centered care;
- IV.A.2.a).(2).(k) requesting appropriate medical/surgical consultations from other specialties.
- IV.A.2.a).(3) should follow individual patients longitudinally as well as the ability to encounter a wide variety of patient problems;

IV.A.2.a).(4) should have progressive responsibility with lesser degrees of supervision as they advance and demonstrate additional competencies. The program should be flexible but sufficiently structured to allow for such graded responsibility.

**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) should have basic science didactic curriculum taught by faculty and a self-directed learning program to address the theoretical and clinical principles that form the fundamentals for managing patients with pediatric medicine disorders. Pathophysiology, discussion and knowledge of clinical manifestations, and management problems should constitute the major topics for study;

IV.A.2.b).(2) should have specialty content including faculty in anesthesiology, emergency medicine, family medicine, genetics, neurology, neurosurgery, orthopedic surgery, pediatrics (including the relevant subspecialties), pediatric surgery, plastic surgery, psychiatry, radiology, surgery, and urology taking an active role in providing instruction in the areas of their practices relevant to PRM;

IV.A.2.b).(3) must have conferences that include case-oriented multidisciplinary conferences, journal clubs, and quality management seminars relevant to clinical care in PRM;

IV.A.2.b).(4) must have conferences of sufficient quality and frequency to provide in-depth coverage of the major topics in PRM.

**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.c).(3) teach other hospital personnel and health care providers, patients, and patient support systems about the rehabilitation and longitudinal needs in PRM;
- IV.A.2.c).(4) teach medical students, fellows, and other health care professionals;
- IV.A.2.c).(5) understand and utilize learning theory, including assessment of learning needs, development of objectives and curriculum plans, effective use of audiovisual aids and other teaching materials, and evaluation of teaching outcomes;
- IV.A.2.c).(6) participate in educational activities within the interdisciplinary PRM care team.

**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.d).(1) Fellows are expected to learn, understand, and apply principles of organizational and group behavior, leadership and management styles, evaluation and modification of performance, labor management issues, cost accounting containment, and quality assurance techniques. The fellow should gain an understanding and some proficiency in the areas of budget planning and presentation, preparation of management briefings, information systems, and external reviews such as the Commission for the Accreditation of Rehabilitation Facilities.

**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.2.f).(1) Fellows are expected to develop a management style compatible with an interdisciplinary team process.

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

## **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.a).(1) Remedial objectives may be established.

V.A.1.a).(2) Evaluation should be based on the program objectives and on the fellow's individualized program objectives. These include fellow knowledge, skills, and overall performance, including the development of professional attitudes consistent with being a physician.

V.A.1.a).(3) Fellows should be advanced to positions of higher responsibility based solely on evidence of their satisfactory progressive scholarship and professional growth.

V.A.1.a).(4) The following areas should be evaluated:

V.A.1.a).(4).(a) Acquisition of competencies outlined in IV.A.5.V.

V.A.1.a).(4).(b) Problem solving skills

V.A.1.a).(4).(c) Interpersonal relationship skills

V.A.1.a).(4).(d) Ability to access, retrieve, and critically evaluate the literature

V.A.1.a).(4).(e) Information management.

V.A.1.a).(4).(f) Quality and cost-effectiveness measures of patient care

V.A.1.a).(4).(g) Research and other scholarly accomplishments

##### **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.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.**

**V.C.3. 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. Fellow satisfaction at the completion of the program should also be assessed. If deficiencies are found, the group should prepare an explicit plan of action, which should be approved by the faculty and documented in the meeting minutes.

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

### **VI.A. Principles**

**VI.A.1. The program must be committed to and be responsible for promoting patient safety and fellow well-being and to providing a supportive educational environment.**

**VI.A.2. Duty hour assignments must recognize that faculty and fellows collectively have responsibility for the safety and welfare of patients.**

### **VI.B. Supervision of Fellows**

**The program must ensure that qualified faculty provide appropriate supervision of fellows in patient care activities.**

**VI.B.1. The supervisor is responsible for the educational experience according to the written plan developed at the beginning of the program. The supervisor must meet regularly with the program director and fellow for appropriate monitoring and feedback.**

### **VI.C. Duty Hours (the terms in this section are defined in the ACGME Glossary and apply to all programs)**

**Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative 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.C.1. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.**

**VI.C.2. Fellows must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call.**

**VI.C.3. 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.D. On-call Activities**

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

- VI.D.2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Fellows may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.**
- VI.D.3. No new patients may be accepted after 24 hours of continuous duty.**
- VI.D.3.a) A new patient is defined as any patient for whom the fellow has not previously provided care.
- VI.D.4. At-home call (or pager call)**
- VI.D.4.a) **The frequency of at-home call is not subject to the every-third-night, or 24+6 limitation. However at-home call must not be so frequent as to preclude rest and reasonable personal time for each fellow.**
- VI.D.4.b) **Fellows taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.**
- VI.D.4.c) **When fellows are called into the hospital from home, the hours fellows spend in-house are counted toward the 80-hour limit.**
- VI.E. Moonlighting**
- Internal moonlighting must be considered part of the 80-hour weekly limit on duty hours.**

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