

ACGME Program Requirements for Graduate Medical Education in Craniofacial Surgery

One-year Common Program Requirements are in BOLD

Effective: September 1997

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 of the Specialty

Int.B.1. Craniofacial surgery is a subspecialty of plastic surgery that includes the in-depth study and reconstructive treatment of disorders of the soft and hard tissues of the face and cranial areas, such as congenital anomalies and posttraumatic and other acquired conditions. Although craniofacial surgery includes combined intracranial and extracranial surgery, the broad scope of the subspecialty is applicable to other procedures in the craniofacial region. Surgeons trained in craniofacial surgery should be able to manage any hard or soft-tissue reconstruction problem of the craniofacial region.

Int.B.2. The team approach to many problems may be appropriate, resulting in the integration of other specialties into the craniofacial team. In addition to plastic surgery, these specialties should include neurological surgery, ophthalmology, otolaryngology, oral surgery, and orthodontics.

Int.B.3. The primary goals of a craniofacial surgery educational program are to provide a broad education in the art and science of the specialty, and sufficient experience for surgeons to acquire competency as specialists in the field.

Int.C. Duration and Scope of Education

Int.C.1. The length of the educational program in craniofacial surgery is one year. Before entry into the program, each prospective craniofacial surgery fellow must be notified in writing of the length of the program.

Int.C.2. Admission to a craniofacial surgery educational program is open to those who have satisfactorily completed a plastic surgery residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME), or to other appropriately-qualified surgeons.

Int.C.3. The craniofacial surgery program should be associated with an ACGME-accredited program in plastic surgery; exceptions must be educationally justified. The educational relationship should demonstrate the use of shared resources to include, for example, faculty, educational conferences, patient management, and other institutional resources.

Int.D. Program Goals and Objectives

Int.D.1. Although educational programs in craniofacial surgery may differ in format and objectives, each program must demonstrate that fellows are provided with the opportunity to obtain the knowledge, skills, clinical judgment, and attitudes essential to the practice of craniofacial surgery.

Int.D.2. The craniofacial surgery fellow must be provided with progressive senior surgical responsibility in the four essential phases of total patient care: pre-operative evaluation, therapeutic decision making, operative experience, and post-operative management.

Int.D.3. The craniofacial surgery fellow must be provided with sufficient knowledge of the sciences of embryology, anatomy, physiology, and pathology as these relate to the diagnosis and treatment of diseases of the craniofacial areas. Education in the diagnosis and management of disease and deformity involving the jaws, teeth, and occlusion must also be included in the program.

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 provide sufficient resources to meet the educational needs of the fellows and enable the program to comply with the requirements for accreditation.

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. Participation by any site that provides two months or more of the educational program must be approved in advance by the Review Committee.

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 Plastic Surgery, or specialty qualifications that are acceptable to the Review Committee;**
- II.A.2.c) current medical licensure and appropriate medical staff appointment; and,**
 - II.A.2.c).(1) The program director must have licensure to practice medicine in the state where the sponsoring institution is located.
- II.A.2.d) requisite clinical experience in craniofacial surgery acceptable to the Review Committee.
- 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; and,

- 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) submit each fellow's complete operative experience log annually; and,
- II.A.3.f) notify the Executive Director of the Review Committee of any changes that might substantially alter the educational experience (e.g., a change in program director or changes in participating sites).

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 subspecialty by the American Board of Plastic Surgery, 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. A member of the faculty of each participating site must be designated as the local program director to assume responsibility for the day-to-day activities of the program at that site, with overall coordination by the program director.
- II.B.6. Members of the faculty must be able to devote sufficient time to meet their supervisory and teaching responsibilities. The required faculty-to-fellow ratio is 1:1.

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.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.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 in the program.

III.B.1. Written lines of responsibility describing the clinical responsibilities of and relationship between fellows and plastic surgery residents must be supplied to the Review Committee at the time of a program's review.

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.

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.

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; and,

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. The educational program should contain the following components: clinical, basic science, and research conferences; monthly morbidity and mortality sessions; other conferences focused specifically on craniofacial surgery. Conferences must be conducted regularly and as scheduled, and the topics of each must be linked to the goals and objectives for the course of study.

IV.A.4. Basic science components to the program curriculum must include:

- IV.A.4.a) normal and abnormal embryology and fetal development of the head and neck, with special emphasis on the development of the cranium, the maxillary and mandibular complex, the mechanisms of clefting, and the development of the temporomandibular joint and surrounding musculature;
- IV.A.4.b) normal growth and development of the cranium and face, with special attention to dental development and occlusion and to the consequences of congenital anomalies, trauma, surgery, and radiation;
- IV.A.4.c) dental radiographs, cephalometric analysis, and study models; construction of splints and their use in craniofacial and maxillofacial surgery;
- IV.A.4.d) interpretation of sophisticated diagnostic imaging modalities used in craniofacial surgery, such as computed tomography, magnetic resonance imaging, and arteriography;
- IV.A.4.e) standards of beauty and normalcy as they relate to the face, and an understanding of the relationship of cephalometric values to soft-tissue features;
- IV.A.4.f) bone healing, including primary healing, malunion, nonunion, osteomyelitis, and the physiology and methods of bone grafting;
- IV.A.4.g) use of alloplastic materials used for reconstruction; and,
- IV.A.4.h) congenital, developmental, and secondary deformities of the head and face, including the embryology, pathogenesis, anatomy, natural history, and course of the disease following treatment.

IV.A.5. Congenital Anomalies and Disorders

The foundation of this subspecialty is the treatment of congenital craniofacial anomalies. Because such treatment can be applied to a variety of acquired deformities, the program must include in-depth training, education, and participation in the diagnosis, planning, operative treatment, and post-operative care of craniofacial problems, including:

- IV.A.5.a) craniosynostosis;
- IV.A.5.b) congenital and developmental deformities of the face that may be related to craniosynostosis, including midface hypoplasia and facial asymmetries;
- IV.A.5.c) syndromal malformations of the face, such as Treacher Collins, hemifacial microsomia;
- IV.A.5.d) congenital orbital dysmorphologies, including orbitofacial clefts

- and hypertelorism;
- IV.A.5.e) facial cleft deformities;
- IV.A.5.f) atrophic and hypertrophic disorders, such as Romberg's disease, bone dysplasia;
- IV.A.5.g) craniofacial manifestations of systemic disorders, such as neurofibromatosis and vascular malformations and lymphatic disorders;
- IV.A.5.h) posttraumatic complex skull and facial deformities;
- IV.A.5.i) congenital and acquired disorders of the facial skeleton and occlusal relationships; and,
- IV.A.5.j) craniofacial concepts in the exposure and/or reconstruction in cranial base oncologic surgery.

IV.A.6. Clinical Activities

The clinical education should include active participation in an integrated craniofacial team with sufficient patient volume to provide an exposure to diverse craniofacial problems. In addition to plastic surgery, the craniofacial team should include neurological surgery, ophthalmology, otolaryngology, dentistry, and orthodontics. Clinical activities should include:

- IV.A.6.a) education, training, and participation in the surgical methods of craniofacial surgery, including rigid fixation of skull facial bones and training in the fabrication of dental splints;
 - IV.A.6.b) preoperative assessment and decision making regarding methods and timing of intervention in craniofacial disorders;
 - IV.A.6.c) management of craniofacial patients from the preoperative through the postoperative stages; and,
 - IV.A.6.d) knowledge of critical care in the postoperative management of craniofacial patients.
- IV.A.7. Education and experience in the following areas are desirable:
- IV.A.7.a) diagnostic methods and treatment techniques of temporomandibular joint disorders;
 - IV.A.7.b) aesthetic contour deformities, such as masseteric hypertrophy and frontal cranial remodeling;
 - IV.A.7.c) elective orthognathic surgery for orthodontic problems;

- IV.A.7.d) surgical correction of congenital clefts of the lip and palate, with emphasis on both primary and late repairs and revisions; and,
- IV.A.7.e) reconstructive management of defects after ablative surgery for malignancy about the maxillofacial region, including pedicle and free flap surgery and bone grafting techniques.
- IV.A.8. Operative Experience
- IV.A.8.a) Programs in craniofacial surgery must provide a sufficient number and variety of surgical experiences to ensure that fellows receive sufficient exposure to a wide range of diseases and injuries to the soft and hard tissues of the craniofacial region.
- IV.A.8.b) The fellows must be allowed senior responsibility as the operating surgeon while performing critical portions of the surgery in the operative management of a range of common craniofacial surgery procedures.
- IV.A.8.c) The craniofacial surgery fellow is not a substitute for faculty, and should not act on a regular basis as a teaching assistant to the chief resident in plastic surgery. If the fellow and the plastic surgery resident share operative experience, only one surgeon may receive credit as surgeon for the experience.

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.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 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.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.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.
- 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.

Craniofacial plastic surgery 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.6.a) Fellows must not have more than four consecutive weeks of night float assignment, and night float cannot exceed one month per year.

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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