

ACGME Program Requirements for Graduate Medical Education in Pediatric Surgery

Common Program Requirements are in BOLD

Effective: July 1, 2007

Introduction

Int.A. Definition and Scope of Specialty

A residency program in pediatric surgery provides advanced knowledge and skills in the surgery of infants and children. At the completion of this education, pediatric surgery residents should function as competent pediatric surgeons. The educational component of the program, therefore, must be of the highest priority.

Int.B. Duration and Scope of Education

Int.B.1. Admission Prerequisites

The resident applicant must have satisfactorily completed a program in general surgery accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada, be admissible to examination by the American Board of Surgery (or its equivalent), or be certified by that board.

Int.B.2. Program Length

Int.B.2.a) The program length is two years, of which 18 months must comprise clinical pediatric surgery. The remaining six months may be devoted to related clinical disciplines designed to enhance the educational experience, or to scholarly activities.

Int.B.2.b) The final 12 months of clinical education must be at the chief level, with responsibility for patient management and semi-independent operative experience under appropriate supervision.

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 resident 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. A pediatric surgery program should be offered in sites accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

or its equivalent and which are classified as general hospitals or children's hospitals. These sites must include facilities and staff with a variety of services, including adequate inpatient surgical admissions, intensive care units for both infants and older children, and departments of radiology, pathology, and emergency in which infants and children can be managed 24 hours a day.

I.A.2. A subspecialty program in pediatric surgery will not be accredited if it has a negative impact on the education of the surgery residents in the core surgery program.

I.A.3. In addition to pediatric surgery there must be a residency program in pediatrics whose residents rotate through the same integrated site(s) as the pediatric surgical residents.

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.

I.B.1.a) A participating site is defined as any site to which residents rotate for assigned experiences.

The PLA should:

I.B.1.b) identify the faculty who will assume both educational and supervisory responsibilities for residents;

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

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

I.B.1.e) state the policies and procedures that will govern resident 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 residents, 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. Clinical assignments to participating (non-integrated) sites may be scheduled only during the first pediatric surgery year. Assignments may not exceed six months in total, and must be approved in advance by the Review Committee.

- I.B.4. Sites may be integrated with the sponsoring institution through an integration agreement specifying that the program director must:
- I.B.4.a) appoint the members of the faculty at the integrated site;
 - I.B.4.b) appoint the chief or director of the teaching service in the integrated site;
 - I.B.4.c) appoint all residents in the program; and,
 - I.B.4.d) determine all rotations and assignments of both residents and members of the faculty.
- I.B.5. As a general rule, integrated sites must be in close geographic proximity to allow all residents to attend joint conferences, basic science lectures, and morbidity and mortality reviews regularly and in a central location. If the sites are geographically so remote that joint conferences cannot be held, an equivalent educational program of lectures and conferences at the integrated site must be fully documented.
- I.B.6. The Review Committee must approve all integrations in advance.

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. The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.**
- II.A.2.a) The length of the appointment, as a normal rule, must be for at least the duration of the program plus one year, i.e., a minimum of three years.
- II.A.3. Qualifications of the program director must include:**
- II.A.3.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;**
 - II.A.3.b) current certification in the specialty by the American Board of Surgery, or specialty qualifications that are acceptable to the Review Committee; and,**

- II.A.3.c) **current medical licensure and appropriate medical staff appointment.**
- II.A.3.d) licensure to practice medicine in a state where the institution that sponsors the program is located, and
- II.A.3.e) demonstrated scholarly activity in at least one of the areas listed in section II.B.5.b.below.
- II.A.4. **The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:**
 - II.A.4.a) **oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;**
 - II.A.4.b) **approve a local director at each participating site who is accountable for resident education;**
 - II.A.4.c) **approve the selection of program faculty as appropriate;**
 - II.A.4.d) **evaluate program faculty and approve the continued participation of program faculty based on evaluation;**
 - II.A.4.e) **monitor resident supervision at all participating sites;**
 - II.A.4.f) **prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;**
 - II.A.4.g) **provide each resident with documented semiannual evaluation of performance with feedback;**
 - II.A.4.h) **ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;**
 - II.A.4.i) **provide verification of residency education for all residents, including those who leave the program prior to completion;**
 - II.A.4.j) **implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:**
 - II.A.4.j).(1) **distribute these policies and procedures to the residents and faculty;**

- II.A.4.j).(2)** monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;
- II.A.4.j).(3)** adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,
- II.A.4.j).(4)** if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.
- II.A.4.k)** monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;
- II.A.4.l)** comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;
- II.A.4.m)** be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;
- II.A.4.n)** obtain review and approval of the sponsoring institution's GMC/DIO before submitting to the ACGME information or requests for the following:
- II.A.4.n).(1)** all applications for ACGME accreditation of new programs;
- II.A.4.n).(2)** changes in resident complement;
- II.A.4.n).(3)** major changes in program structure or length of training;
- II.A.4.n).(4)** progress reports requested by the Review Committee;
- II.A.4.n).(5)** responses to all proposed adverse actions;
- II.A.4.n).(6)** requests for increases or any change to resident duty hours;
- II.A.4.n).(7)** voluntary withdrawals of ACGME-accredited programs;
- II.A.4.n).(8)** requests for appeal of an adverse action;
- II.A.4.n).(9)** appeal presentations to a Board of Appeal or the ACGME; and,

- II.A.4.n).(10) **proposals to ACGME for approval of innovative educational approaches.**
- II.A.4.o) **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.4.o).(1) **program citations, and/or**
 - II.A.4.o).(2) **request for changes in the program that would have significant impact, including financial, on the program or institution.**
- II.A.4.p) seek prior approval from the Review Committee for the addition of fellow and resident positions in non-accredited programs (e.g., overseas or trauma fellows), and
- II.A.4.q) monitor and verify the pediatric surgery resident operative data at least semi-annually.

II.B. Faculty

- II.B.1. **At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location.**
 - The faculty must:**
 - II.B.1.a) **devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents, and**
 - II.B.1.b) **administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.**
- II.B.2. **The physician faculty must have current certification in the specialty by the American Board of Surgery, or possess qualifications acceptable to the Review Committee.**
 - II.B.2.a) In addition to the program director, there must be, for each approved residency position, at least one full-time faculty member whose major function is to support the residency program. These faculty appointments must be of a sufficient length to ensure continuity in the supervision and education of the residents. In addition, the faculty should include at least one neonatologist and one pediatric intensivist to contribute to the education of the resident in the care of critically-ill children.

- II.B.2.b) The physician faculty must be licensed to practice medicine in the state where the sponsoring institution is located.
- II.B.3. The physician faculty must possess current medical licensure and appropriate medical staff appointment.**
- II.B.4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.**
- II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.**
- II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.**
- II.B.5.b) Some members of the faculty should also demonstrate scholarship by one or more of the following:**
- II.B.5.b).(1) peer-reviewed funding;**
- II.B.5.b).(2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;**
- II.B.5.b).(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,**
- II.B.5.b).(4) participation in national committees or educational organizations.**
- II.B.5.c) Faculty should encourage and support residents in scholarly activities.**
- 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 resident education, as defined in the specialty program requirements.**
- II.D.1. The pediatric surgical service must document a sufficient breadth and volume of procedures (i.e., at least 1200 procedures per year).**

II.E. Medical Information Access

Residents 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. Resident Appointments

III.A. Eligibility Criteria

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

III.B. Number of Residents

The program director may not appoint more residents 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 residents appointed to the program.

III.B.1. Both temporary and permanent increases in resident complement must be approved in advance by the Review Committee. Any increase in the complement must be justified in terms of the educational goals of the program.

III.C. Resident Transfers

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

III.C.2. A program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion.

III.D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' education. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.

III.D.1. All residents, fellows, and other students in both ACGME-accredited and non-accredited programs in the sponsoring institution and integrated sites that might affect the experience of the pediatric surgery residents must be identified. At the time of the site-visit, the relationship of these residents and fellows to the pediatric surgery residents must be confirmed.

IV. Educational Program

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

IV.A.1. Overall educational goals for the program, which the program must distribute to residents and faculty annually;

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation;

IV.A.3. Regularly scheduled didactic sessions;

IV.A.4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and,

IV.A.5. ACGME Competencies

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

IV.A.5.a) Patient Care

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents:

IV.A.5.a).(1) must be given responsibility for surgical perioperative management to attain knowledge and experience of:

IV.A.5.a).(1).(a) congenital, neoplastic, infectious, and other acquired conditions of the gastrointestinal system and other abdominal organs; diaphragm and thorax, exclusive of the heart; endocrine glands; head and neck; gonads and reproductive organs; integument; blood and vascular system;

IV.A.5.a).(1).(b) operative and non-operative traumatic conditions of the abdomen, chest, head and neck, and extremities, with sufficient experience in the management of children who have sustained injuries to multiple organs;

IV.A.5.a).(1).(c) endoscopy of the airway and gastrointestinal tract, including laryngoscopy, bronchoscopy, esophagoscopy, gastroduodenoscopy, and lower intestinal endoscopy;

- IV.A.5.a).(1).(d) advanced laparoscopic and thoracoscopic techniques;
- IV.A.5.a).(1).(e) the care of the critically-ill infant or child, including:
- IV.A.5.a).(1).(e).(i) cardiopulmonary resuscitation;
- IV.A.5.a).(1).(e).(ii) the management of patients on ventilators and extracorporeal membrane oxygenation (ECMO);
- IV.A.5.a).(1).(e).(iii) invasive monitoring techniques and interpretation;
- IV.A.5.a).(1).(e).(iv) nutritional assessment and management; and,
- IV.A.5.a).(1).(e).(v) the recognition and management of clotting and coagulation disorders.
- IV.A.5.a).(2) must be provided with primary responsibility, under the supervision of pediatric surgery faculty, in the care of critically ill surgical patients. This will allow them to acquire the requisite specialty-specific knowledge and skills, and to obtain competence in the pre-, intra-, and post-operative care of such patients. To meet these goals, the coordination of care and collegial relationships between pediatric surgeons, neonatologists, and critical care intensivists concerning the management of medical problems in these complex critically ill patients is essential;
- IV.A.5.a).(3) having clinical assignments to cardiothoracic surgery, gynecology, neurological surgery, orthopaedic surgery, otolaryngology, anesthesia, vascular surgery, transplant surgery, and the management of burns is desirable. However, gaining an understanding of the principles of these subspecialties through an adequately structured curriculum in these surgical areas will serve as compliance with this standard;
- IV.A.5.a).(4) must document an appropriate breadth, volume, and balance of operative experience as primary surgeon;
- IV.A.5.a).(5) must document a total of 800 (during the two-year program) major pediatric surgery procedures as surgeon;
- IV.A.5.a).(6) may, if not a surgery chief resident, act as a teaching assistant when their operative experience justifies a teaching role;

- IV.A.5.a).(7) may not share primary responsibility with the surgery chief resident for the same patients;
- IV.A.5.a).(8) must have the opportunity to evaluate patients preoperatively, make appropriate provisional diagnoses, initiate diagnostic procedures, and form preliminary treatment plans. They must be provided with the opportunity for outpatient follow-up care of surgical patients. Follow-up care should include not only short-term but long-term evaluation and progress as well, particularly with major congenital anomalies or neoplasm cases; and,
- IV.A.5.a).(9) must document one half-day weekly of outpatient experience.

IV.A.5.b) Medical Knowledge

Residents 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. Residents:

- IV.A.5.b).(1) should have an academic program which emphasizes the scholarly attributes of self-instruction, teaching, skilled clinical analysis, sound surgical judgment, and research creativity;
- IV.A.5.b).(2) must have a structured series of conferences in the basic and clinical sciences fundamental to pediatric surgery;
- IV.A.5.b).(3) must have structured educational activities including:
- IV.A.5.b).(3).(a) monthly pediatric surgical grand rounds, and twice-monthly morbidity and mortality conferences;
- IV.A.5.b).(3).(b) monthly relevant multidisciplinary conferences, (e.g., pediatric radiology, surgical pathology and tumor conferences);
- IV.A.5.b).(3).(c) educational opportunities to gain adequate knowledge in the basic principles of cardiothoracic surgery, gynecology, neurological surgery, orthopaedic surgery, otolaryngology, anesthesia, urology, vascular surgery, transplant surgery, and the management of burns;
- IV.A.5.b).(3).(d) design, implementation, and interpretation of clinical research studies; and,
- IV.A.5.b).(3).(e) at least weekly bedside teaching rounds by the surgical faculty.

IV.A.5.c) Practice-based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:

- IV.A.5.c).(1) identify strengths, deficiencies, and limits in one's knowledge and expertise;**
- IV.A.5.c).(2) set learning and improvement goals;**
- IV.A.5.c).(3) identify and perform appropriate learning activities;**
- IV.A.5.c).(4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;**
- IV.A.5.c).(5) incorporate formative evaluation feedback into daily practice;**
- IV.A.5.c).(6) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;**
- IV.A.5.c).(7) use information technology to optimize learning; and,**
- IV.A.5.c).(8) participate in the education of patients, families, students, residents and other health professionals.**
- IV.A.5.c).(9) during their chief pediatric year, personally organize the formal pediatric conferences, grand rounds, and mortality and morbidity conferences, and be directly responsible for a significant share of these conferences, and**
- IV.A.5.c).(10) have significant teaching responsibilities for junior residents and medical students.**

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

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:

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

- IV.A.5.d).(2)** communicate effectively with physicians, other health professionals, and health related agencies;
- IV.A.5.d).(3)** work effectively as a member or leader of a health care team or other professional group;
- IV.A.5.d).(4)** act in a consultative role to other physicians and health professionals; and,
- IV.A.5.d).(5)** maintain comprehensive, timely, and legible medical records, if applicable.
- IV.A.5.d).(6)** provide care as consultants under appropriate supervision in the emergency department and with other specialists such as neonatologists and intensivists.

IV.A.5.e) Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:

- IV.A.5.e).(1)** compassion, integrity, and respect for others;
- IV.A.5.e).(2)** responsiveness to patient needs that supersedes self-interest;
- IV.A.5.e).(3)** respect for patient privacy and autonomy;
- IV.A.5.e).(4)** accountability to patients, society and the profession; and,
- IV.A.5.e).(5)** sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

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

Residents 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. Residents are expected to:

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

- IV.A.5.f).(2) **coordinate patient care within the health care system relevant to their clinical specialty;**
- IV.A.5.f).(3) **incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;**
- IV.A.5.f).(4) **advocate for quality patient care and optimal patient care systems;**
- IV.A.5.f).(5) **work in interprofessional teams to enhance patient safety and improve patient care quality; and,**
- IV.A.5.f).(6) **participate in identifying system errors and implementing potential systems solutions.**

IV.B. Residents' Scholarly Activities

- IV.B.1. **The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.**
- IV.B.2. **Residents should participate in scholarly activity.**
- IV.B.3. **The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.**

V. Evaluation

V.A. Resident Evaluation

V.A.1. Formative Evaluation

- V.A.1.a) **The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.**
- 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);**

- V.A.1.b).(3) document progressive resident performance improvement appropriate to educational level; and,
- V.A.1.b).(4) provide each resident with documented semiannual evaluation of performance with feedback.
- V.A.1.c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.
- V.A.2. **Summative Evaluation**
- The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. This evaluation must:
- V.A.2.a) document the resident's performance during the final period of education, and
- V.A.2.b) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.
- V.B. **Faculty Evaluation**
- V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program.
- V.B.2. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.
- V.B.3. This evaluation must include at least annual written confidential evaluations by the residents.
- 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) resident performance;
- V.C.1.b) faculty development;
- V.C.1.c) graduate performance, including performance of program graduates on the certification examination; and,
- V.C.1.d) program quality. Specifically:

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

V.C.1.d).(2) The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.

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. Programs should use the ABS In-training Examination for formative resident and program evaluation.

VI. Resident 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 resident well-being and to providing a supportive educational environment.

VI.A.2. The learning objectives of the program must not be compromised by excessive reliance on residents to fulfill service obligations.

VI.A.3. Didactic and clinical education must have priority in the allotment of residents' time and energy.

VI.A.4. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

VI.B. Supervision of Residents

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

VI.B.1. The attending physician has both an ethical and legal responsibility, both for the overall care of the individual patient and for the supervision of residents. Although senior residents require less direction than junior residents do, even the most senior must be supervised. A chain of command that emphasizes graded authority and increasing responsibility as experience is gained must be established. Judgments on this delegation of responsibility must be made by the attending surgeon who is ultimately responsible for the patient's care. Such judgments shall be based on the attending surgeon's direct observation and knowledge of the pediatric surgery resident's skill and ability.

VI.C. Fatigue

Faculty and residents must be educated to recognize the signs of fatigue and sleep deprivation and must adopt and apply policies to prevent and counteract its potential negative effects on patient care and learning.

VI.D. 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.D.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.D.2. Residents 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.D.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.E. On-call Activities

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

VI.E.2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents 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.E.3. No new patients may be accepted after 24 hours of continuous duty.

VI.E.3.a) A new patient is defined as any patient for whom the surgery service or department has not previously provided care. The pediatric surgery resident should evaluate the patient before surgery.

VI.E.4. At-home call (or pager call)

VI.E.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 resident.

VI.E.4.b) Residents 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.E.4.c) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

VI.F. Moonlighting

VI.F.1. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

VI.F.2. Internal moonlighting must be considered part of the 80-hour weekly limit on duty hours.

VI.G. Duty Hours 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. 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.2. Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.

VII. Experimentation and Innovation

Requests for experimentation or innovative projects that may deviate from the institutional, common and/or specialty specific program requirements must be approved in advance by the Review Committee. In preparing requests, the program director must follow Procedures for Approving Proposals for Experimentation or Innovative Projects located in the ACGME Manual on Policies and Procedures. Once a Review Committee approves a project, the sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.

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