

ACGME Program Requirements for Graduate Medical Education in Pediatric Urology

One-year Common Program Requirements are in BOLD

Effective: July 1, 2009

Introduction

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

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

Int.B. Definition and Scope of the Fellowship

Fellowship education in pediatric urology consists of the diagnosis, management, and treatment of fetal, perinatal, child, and adolescent genitourinary and adrenal abnormalities and diseases, and the promotion of health with prevention of disease. This includes specifically: experience with fetal and genetic evaluation; pediatric endocrinology; issues of renal disease, such as chronic renal insufficiency, and transplantation; congenital and acquired neurological diseases affecting the urinary tract such as spina bifida and neurogenic bladder; the treatment and management of congenital genitourinary abnormalities, and reconstructive urology. For the full integration of patient management in these areas, the following are required: education in advanced imaging of the pediatric genitourinary tract; radiation and imaging safety risks; pharmacology and safety of commonly used agents, and pediatric pain management.

Int.C. Duration of Education

Fellows must have successfully completed a urology residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada (RCPSC). The length of a pediatric urology clinical program is one year of clinical education.

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 pediatric urology program must be centered at a children's hospital or a medical center with pediatric medical, surgical, and imaging subspecialties.

I.A.2. To be accredited, the pediatric urology program must have written documentation of an educational relationship from the ACGME-accredited core urology program director.

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.2.a) Participating sites offering more than three months of education for the 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.1.a)** When the sponsoring institution also sponsors a core urology program, the pediatric urology program director must be involved in the education of the core urology program.
- II.A.1.b)** The minimum term of appointment for the program director should be three years to provide for educational stability.
- 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 Urology, 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).(2).(a) Any permanent or temporary increase in resident complement must be approved in advance by the Review Committee.
- 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) select and supervise the local site director and faculty at each participating site;
- II.A.3.f) confirm and document the fellow data entry into the ACGME web-based operative log and submission of the resident's final log to the ACGME on graduation;
- II.A.3.g) ensure that conferences include MMQA and reflect multidisciplinary patient evaluation including urologic and journal review;
- II.A.3.h) ensure that morbidity and mortality conferences for all participating sites, urological imaging, and journal review be documented;

II.A.3.i) ensure that a list of conferences is maintained and available at the site visit. The list must include the names of those attending, the subjects discussed, and the principal speaker. Attendance must be documented;

II.A.3.j) be involved in the core urology residency program.

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.2.a) There should be a minimum of one pediatric urology faculty member, in addition to the program director, for each pediatric urology resident, i.e., there should be two faculty members to one pediatric urology resident.

II.B.3. The physician faculty must have current certification in the specialty by the American Board of Urology, 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) A faculty member must supervise each conference.

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. The program should have technologically-current and pediatric-specific diagnostic and treatment facilities, e.g., body-imaging and urodynamics equipment, interventional radiology, and anesthesia and pain management suitable for the care of pediatric patients.

II.D.2. The program must ensure adequate space and equipment for the educational program, i.e., meeting rooms and classrooms, educational aides, and sufficient office space for residents and staff.

II.D.3. The sponsoring institution must provide a sufficient volume and variety of pediatric urology experience to meet the needs of the pediatric urology fellow without compromising the quality of resident education in the core urology program.

II.D.4. To be considered for accreditation, the sponsoring institution should have the following resources available for fellow education: a broad spectrum of urologic diseases; a sufficient volume and broad variety of pediatric urology surgical procedures consisting of 500 procedures per year and 2000 pediatric urologic outpatient visits per year, including urology subspecialty clinics.

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. Graduation from an ACGME- or RCPSC-accredited urology program is the prerequisite education.

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. Transfers in 12-month programs are discouraged.

III.B.2. In any given year, the program may not graduate more pediatric urology surgery fellows than the number approved by the Review Committee. Any change in the number of fellows, whether permanent or temporary, must be approved in advance by the Review Committee. Such requests must be based upon a sufficient educational rationale that considers the educational quality of the current pediatric urology fellows admitted to the program.

III.B.3. At the time of the site visit, the operative log experiences of each additional resident or fellow who is provided with experience in pediatric urology at the site must be attached to the PIF.

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:

are expected to have experience in:

- IV.A.2.a).(1) the surgical aspects of pediatric urology that are documented in an accurate, comprehensive, operative log maintained by the fellow and reviewed by the program director quarterly. All operative procedures in which the pediatric urology fellow acts as a surgeon or teaching assistant should be separately documented;
- IV.A.2.a).(2) inpatient and outpatient consultations requiring management of pediatric urologic disease, with graded responsibility for patient care;
- IV.A.2.a).(3) imaging modalities used in the care of pediatric patients (including but not limited to: ultrasonography, fluoroscopy, computed tomography, magnetic resonance imaging, nuclear scintigraphy);
- IV.A.2.a).(4) performance and evaluation of urodynamic studies;
- IV.A.2.a).(5) multidisciplinary management of patients with urologic tumors;
- IV.A.2.a).(6) multidisciplinary management of patients with urologic trauma;
- IV.A.2.a).(7) multidisciplinary management of nephrological and endocrinologic (adrenal) disease;

- IV.A.2.a).(8) pre- and post-operative management and treatment of severely ill neonates, children, and adolescents with genitourinary problems who require intensive medical care (i.e., neonatal or pediatric intensive care unit management);
- IV.A.2.a).(9) multidisciplinary management of myelomeningocele and other neuropathic bladder entities;
- IV.A.2.a).(10) multidisciplinary management of patients with problems relating to sexual development and medical aspects of intersex states;
- IV.A.2.a).(11) performance of prenatal and postnatal genetic counseling for genitourinary tract anomalies;
- IV.A.2.a).(12) management of genitourinary infections.

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) are expected to have core knowledge in pediatric urology as detailed in the curriculum, and also demonstrate specialty-specific additional knowledge in fetal and perinatal nephrology, endocrinology, radiation safety, appropriate pain management, chronic renal diseases, and pharmacology of commonly used drugs and chemicals.

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

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

- IV.A.2.c).(1) **systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;**
- IV.A.2.c).(2) **locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems.**

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

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

IV.A.2.e)

Professionalism

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

IV.A.2.f)

Systems-based Practice

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

IV.B.

Fellows' Scholarly Activities

Fellows' documentation of their scholarly activity may be demonstrated by manuscript preparation, lectures, teaching activities, abstracts, and active performance of research, or participation in clinical studies and reviews.

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

VI. Fellow Duty Hours in the Learning and Working Environment

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

- VI.A.1. Programs and sponsoring institutions must educate fellows and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.**
- VI.A.2. The program must be committed to and responsible for promoting patient safety and fellow well-being in a supportive educational environment.**
- VI.A.3. The program director must ensure that fellows are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.**

- VI.A.4. The learning objectives of the program must:**
- VI.A.4.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,**
 - VI.A.4.b) not be compromised by excessive reliance on fellows to fulfill non-physician service obligations.**
- VI.A.5. The program director and sponsoring institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Fellows and faculty members must demonstrate an understanding and acceptance of their personal role in the following:**
- VI.A.5.a) assurance of the safety and welfare of patients entrusted to their care;**
 - VI.A.5.b) provision of patient- and family-centered care;**
 - VI.A.5.c) assurance of their fitness for duty;**
 - VI.A.5.d) management of their time before, during, and after clinical assignments;**
 - VI.A.5.e) recognition of impairment, including illness and fatigue, in themselves and in their peers;**
 - VI.A.5.f) attention to lifelong learning;**
 - VI.A.5.g) the monitoring of their patient care performance improvement indicators; and,**
 - VI.A.5.h) honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.**
- VI.A.6. All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.**
- VI.B. Transitions of Care**
- VI.B.1. Programs must design clinical assignments to minimize the number of transitions in patient care.**
 - VI.B.2. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.**

VI.B.3. Programs must ensure that fellows are competent in communicating with team members in the hand-over process.

VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and fellows currently responsible for each patient's care.

VI.C. Alertness Management/Fatigue Mitigation

VI.C.1. The program must:

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

VI.C.1.b) educate all faculty members and fellows in alertness management and fatigue mitigation processes; and,

VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.

VI.C.2. Each program must have a process to ensure continuity of patient care in the event that a fellow may be unable to perform his/her patient care duties.

VI.C.3. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for fellows who may be too fatigued to safely return home.

VI.D. Supervision of Fellows

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

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

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

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

Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced fellow. Other portions of care provided by the fellow can be adequately supervised by the

immediate availability of the supervising faculty member or fellow physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of fellow-delivered care with feedback as to the appropriateness of that care.

VI.D.3. Levels of Supervision

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

- VI.D.3.a) Direct Supervision – the supervising physician is physically present with the fellow and patient.**
- VI.D.3.b) Indirect Supervision:**
 - VI.D.3.b).(1) with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.**
 - VI.D.3.b).(2) with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.**
- VI.D.3.c) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.**
- VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members.**
 - VI.D.4.a) The program director must evaluate each fellow’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.**
 - VI.D.4.b) Faculty members functioning as supervising physicians should delegate portions of care to fellows, based on the needs of the patient and the skills of the fellows.**
 - VI.D.4.c) Fellows should serve in a supervisory role of residents or junior fellows in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual fellow.**

VI.D.5. Programs must set guidelines for circumstances and events in which fellows must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.

VI.D.5.a) Each fellow must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

VI.D.6. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each fellow and delegate to him/her the appropriate level of patient care authority and responsibility.

VI.E. Clinical Responsibilities

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

VI.F. Teamwork

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

VI.F.1. Each resident must have the opportunity to interact with other providers such as nurses, other specialists, social workers, and mid-level providers.

VI.G. Fellow Duty Hours

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

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

VI.G.1.a) Duty Hour Exceptions

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

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

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

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

VI.G.2. Moonlighting

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

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

VI.G.3. Mandatory Time Free of Duty

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

VI.G.4. Maximum Duty Period Length

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

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

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

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

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

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

- VI.G.4.c).(1).(b)** document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.
- VI.G.4.c).(2)** The program director must review each submission of additional service, and track both individual fellow and program-wide episodes of additional duty.
- VI.G.5. Minimum Time Off between Scheduled Duty Periods**
- VI.G.5.a)** Fellows must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.
- Pediatric urology 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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.
- VI.G.6. Maximum Frequency of In-House Night Float**
- Fellows must not be scheduled for more than six consecutive nights of night float.
- VI.G.7. Maximum In-House On-Call Frequency**
- Fellows must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).
- VI.G.8. At-Home Call**

- VI.G.8.a)** Time spent in the hospital by fellows on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
- VI.G.8.a).(1)** At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each fellow.
- VI.G.8.b)** Fellows are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”.

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