

ACGME Program Requirements for Graduate Medical Education in Hospice and Palliative Medicine

One-year Common Program Requirements are in BOLD

Effective: February 12, 2008

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 Subspecialty

The subspecialty of hospice and palliative medicine represents the medical component of the broad therapeutic model known as palliative care. These subspecialists reduce the burden of life-threatening conditions by supporting the best quality of life throughout the course of an illness, and by managing factors that contribute to the suffering of the patient and the patient’s family.

Int.B.1. Palliative care addresses physical, psychological, social, and spiritual needs of patients and their families, and provides assistance with medical decision-making.

Int.B.2. The major clinical skills central to the subspecialty of hospice and palliative medicine are the prevention (when possible), assessment and management of physical, psychological and spiritual suffering faced by patients with life-limiting conditions, and their families.

- Int.B.3. Hospice and palliative medicine is distinguished from other disciplines by:
- Int.B.3.a) a high level of expertise in addressing the multidimensional needs of patients with life-threatening illnesses, including a practical skill set in symptom control interventions;
 - Int.B.3.b) a high level of expertise in both clinical and non-clinical issues related to advanced illness, the dying process, and bereavement;
 - Int.B.3.c) a commitment to an interdisciplinary team approach; and,
 - Int.B.3.d) a strong focus on the patient and family as the unit of care.
- Int.C. The duration of a fellowship program in hospice and palliative medicine is 12 months. The program must provide fellows training in the knowledge and skills of primary and consultative practice.

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. A hospice and palliative medicine program will be accredited only if the sponsoring institution also sponsors an Accreditation Council for Graduate Medical Education (ACGME)-accredited program in at least one of the following specialties: anesthesiology, emergency medicine, family medicine, internal medicine, neurology, obstetrics and gynecology, pediatrics, physical medicine and rehabilitation, psychiatry, radiation oncology, or surgery.

I.B. Participating Sites

- I.B.1. There must be a program letter of agreement (PLA) between the program and each participating site providing an 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 a required educational experience of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).**

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) The program director must be fully committed to the program and devote sufficient time to the achievement of educational goals and objectives.
- 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 Anesthesiology, Emergency Medicine, Family Medicine, Internal Medicine, Obstetrics and Gynecology, Pediatrics, Physical Medicine and Rehabilitation, Psychiatry and Neurology, Radiology, or Surgery, or specialty qualifications acceptable to the Review Committee;**
- II.A.2.c) **current medical licensure and applicable medical staff appointment;**
- II.A.2.d) an active clinical practice in hospice and palliative medicine; and,
- II.A.2.e) a record of ongoing involvement in education and scholarly activities, which includes, but is not limited to, mentoring fellows (i.e., guiding fellows in the acquisition of competence in the clinical, teaching, research and advocacy skills pertinent to the discipline), serving as a clinical supervisor in an inpatient or outpatient setting, developing curricula, and/or participating in

didactic activities.

- 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.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 Anesthesiology, Emergency Medicine, Family Medicine, Internal Medicine, Obstetrics and Gynecology, Pediatrics, Physical Medicine and Rehabilitation, Psychiatry and Neurology, Radiology, or Surgery, or possess qualifications acceptable to the Review Committee.**
- II.B.3.a) Because of the interdisciplinary nature of hospice and palliative medicine, the physician faculty should include representatives from appropriate medical subspecialties such as cardiology, critical care medicine, geriatric medicine and oncology, and from other specialties such as anesthesiology, emergency medicine, family medicine, internal medicine, neurology, obstetrics and gynecology, pediatrics, physical medicine and rehabilitation, psychiatry, radiation oncology, and surgery.
- II.B.4. The physician faculty must possess current medical licensure and applicable medical staff appointment.**
- II.B.5. In addition to the program director, there must be at least one other hospice and palliative medicine physician faculty member who devotes sufficient professional time to the program.
- II.B.6. For programs with more than two fellows, there must be additional hospice and palliative medicine physician faculty members who devote sufficient time to the program. Programs with three or four fellows must have three hospice and palliative medicine faculty members who contribute sufficient professional time to the fellowship.
- II.B.7. At least one faculty member must have expertise administering a hospice and palliative medicine program.
- II.B.8. Hospice and palliative medicine faculty members must have a record of ongoing involvement in education and scholarly activities, including, but not limited to, mentoring fellows (i.e., guiding fellows in the acquisition of competence in the clinical, teaching, research and advocacy skills pertinent to the discipline), serving as a clinical supervisor in an inpatient or outpatient setting, developing curricula, and/or participating in didactic activities.
- II.B.9. Fellows must interact regularly with one or more interdisciplinary teams in the conduct of clinical care. This includes participating in regular team conferences with the interdisciplinary teams in order to coordinate the

implementation of recommendations from these teams.

- II.B.9.a) The interdisciplinary teams must include physicians, nurses, psychosocial clinicians (such as social workers or psychologists), and chaplains.

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.C.1. The following health care professionals must be involved in teaching and supervising fellows: nurses, psychosocial clinicians (social workers or psychologists), and chaplains.

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. Patient Population

The program must ensure that fellows have access to a patient population adequate to meet the needs of the fellowship program. The population must represent a broad range of diagnoses and palliative care needs, including patients with advanced conditions. The population should include adults and children. The availability of patients of all ages, and the full pediatric age range (neonatal through adolescent/young adult) is suggested. Because fewer expected deaths occur in the pediatric population, inclusion of children with chronic conditions and children with palliative care needs who may recover is suggested. Fellows should be exposed to patients of diverse socioeconomic and cultural backgrounds. Experience with special populations, including the elderly and cognitively impaired, patients with human immunodeficiency virus (HIV), and patients with a history of chemical dependency is suggested.

- II.D.2. Facilities/Training Sites

- II.D.2.a) Fellows must receive clinical training in a minimum of three types of locations including:

- II.D.2.a).(1) an inpatient acute care site;

- II.D.2.a).(1).(a) There must be a minimum of four months or equivalent longitudinal experience in the inpatient setting, which may involve participation on a consultation team or on an inpatient unit, or both.

- II.D.2.a).(1).(b) Fellows should have patient care experiences in

dedicated palliative care/hospice units.

- II.D.2.a).(1).(c) The program must ensure that the inpatient setting provides access to a full range of services usually ascribed to an acute-care general hospital, including availability of diagnostic laboratory and imaging services.
- II.D.2.a).(1).(d) There must be access to a range of consulting physicians, including those with expertise in interventional pain management.
- II.D.2.a).(2) in the community through care in patients' homes and in long-term care facilities; and,
- II.D.2.a).(2).(a) The program must ensure that fellows provide a minimum of 25 hospice home visits during the fellowship year.
- II.D.2.a).(2).(a).(i) All of these visits must be provided through a Medicare-certified program.
- II.D.2.a).(2).(a).(ii) If the hospice program does not care for children, a portion of the visits may be done through a pediatric home care program for children with life-limiting conditions.
- II.D.2.a).(2).(a).(iii) The medical director of the hospice home care program should be certified in hospice and palliative medicine.
- II.D.2.a).(2).(b) Fellows should receive a long-term care experience at a skilled nursing home facility, chronic care hospital, or children's rehabilitation center.
- II.D.2.a).(2).(b).(i) The long-term care experience should comprise a minimum of one month or equivalent and provide access to meaningful longitudinal care of patients either on a consultation team or a hospice or palliative care unit.
- II.D.2.a).(2).(b).(ii) Except in the case of federal institutions, the institutions must be approved by the appropriate licensing agencies of the state, and the standard of facilities and care in each facility must be consistent with those promulgated by the Joint Commission or another entity with reasonably equivalent standards.

- II.D.2.a).(3) an ambulatory practice setting.
- II.D.2.a).(3).(a) Fellows must have supervised experience(s) in an ambulatory setting, such as an outpatient hospice clinic or day hospital, a dedicated palliative care clinic, or other ambulatory practice providing relevant palliative interventions to patients with life-threatening conditions.
- II.D.2.a).(3).(b) The ambulatory experience(s) should occur for at least six months of the program. Interdisciplinary care of patients must be available in the setting.
- II.D.2.b) Across the three clinical settings listed above, the time spent participating in a Medicare-certified or Veteran Administration hospice program must comprise at least 15% of the fellow's time.
- II.D.2.c) The program must ensure that fellows see at least 100 new patients over the course of the year.
- II.D.2.d) Fellows should follow 25 patients longitudinally across settings.

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. Applicants must have completed an ACGME or American Osteopathic Association (AOA)-accredited residency program in anesthesiology, emergency medicine, family medicine, internal medicine, neurology, obstetrics and gynecology, pediatrics, physical medicine and rehabilitation, psychiatry, radiation oncology, or surgery.

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.

IV. Educational Program

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

IV.A.1. Skills and competencies the fellow will be able to demonstrate at the conclusion of the program. The program must distribute these skills and competencies to fellows and faculty annually, in either written or electronic form. These skills and competencies should be reviewed by the fellow at the start of each rotation;

IV.A.2. ACGME Competencies

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

IV.A.2.a) Patient Care

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

IV.A.2.a).(1) are expected to demonstrate assessment, interdisciplinary care planning, management, coordination and follow-up of patients with life-threatening illness;

IV.A.2.a).(1).(a) The care provided will be patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering.

IV.A.2.a).(1).(b) Fellows will provide palliative care throughout the continuum of illness while addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice.

IV.A.2.a).(2) are expected to coordinate, orchestrate, and facilitate key events in patient care, such as family meetings, consultation around goals of care, advance directive completion, conflict resolution, withdrawal of life-sustaining therapies, and palliative sedation, involving other team members as appropriate;

IV.A.2.a).(3) are expected to provide care to patients and families that reflects unique characteristics of different settings along the palliative care spectrum;

IV.A.2.a).(4) are expected to recognize signs and symptoms of impending death and appropriately care for the imminently dying patient and their family members; and,

IV.A.2.a).(5) are expected to provide treatment and counseling to the bereaved.

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 learn the scientific method of problem solving and evidence-based decision making and develop commitment to lifelong learning, and an attitude of caring that is derived from humanistic and professional values.

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; and,**

IV.A.2.c).(3) demonstrate knowledge of ethical issues, clinical utilization, and financial outcomes of palliative care.

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.

Fellows must:

IV.A.2.d).(1) demonstrate the ability to educate patients/families about the medical, social and psychological issues associated with life-limiting illness;

IV.A.2.d).(2) demonstrate the above skills in common situations occurring with serious, life-threatening illness and at the end of life, and write an informative, sensitive note in the medical record;

IV.A.2.d).(3) organize and lead or co-facilitate a family meeting;

IV.A.2.d).(4) collaborate effectively with others as a member or leader of an interdisciplinary team; and,

IV.A.2.d).(5) collaborate effectively with all elements of the palliative care continuum, including hospitals, palliative care units, nursing homes, home and inpatient hospice, and other community resources.

IV.A.2.e) Professionalism

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

IV.A.2.e).(1) Fellows must demonstrate the ability to recognize one's own role and the role of the system in disclosure and prevention of medical error.

IV.A.2.e).(2) Fellows must demonstrate the capacity to reflect on personal attitudes, values, strengths, vulnerabilities, and personal experiences to optimize personal wellness and capacity to meet the needs of patients and families.

IV.A.2.f) Systems-based Practice

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

IV.A.2.f).(1) Fellows must evaluate and implement systems improvement based on clinical practice or patient and family satisfaction data, in personal practice, team practice, and within institutional settings.

IV.A.2.f).(2) Fellows must demonstrate knowledge of the various settings and related structures for organizing, regulating, and financing care for patients at the end of life.

IV.A.3. Curriculum Organization and Fellow Experiences

IV.A.3.a) The curriculum, including competency-based goals and objectives, should be aligned with and substantially cover the competencies as outlined in the Companion Document: Core Competencies for Hospice & Palliative Medicine Fellowship Training.

IV.A.3.b) Conferences or seminars/workshops in Hospice and Palliative Medicine for the fellow should be specifically designed to augment the clinical experiences.

IV.A.3.c) There must be a journal club or other activity that fosters interaction and develops skills in interpreting the medical

literature.

- IV.A.3.d) Fellows must participate as both learners and teachers in supplemental educational offerings at conferences, communication skill workshops, lecture series, and similar activities.
- IV.A.3.e) Fellows must have the opportunity to teach personnel such as nurses, allied health personnel, medical students, residents, and/or other fellows.
- IV.A.3.f) Fellows must spend at least one month or equivalent of elective time in a clinically relevant field. Electives may include ethics consultations, geriatric medicine, interventional pain management, medical psychiatry, pediatrics, HIV clinic, radiation oncology, pulmonary, cardiology, neurology clinics, or other experiences determined to be appropriate by the program director.
- IV.A.3.g) Fellows must receive training in the organizational and administrative aspects of operating and maintaining a hospice care program.

IV.B. Fellows' Scholarly Activities

Fellows should complete a scholarly or quality improvement project during the fellowship program.

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.E.1. The program director must have the authority and responsibility to set appropriate clinical responsibilities (i.e., patient caps) for each fellow.

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.
- Hospice and palliative medicine 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.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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