

1 **ACGME Program Requirements for Graduate Medical Education**
2 **in Blood Banking/Transfusion Medicine**
3

4 **Common Program Requirements are in BOLD**

5 *Proposed general requirements for all Pathology fellowships are in ITALICS*
6 *[for tracking during the revision process]*
7

8 Effective: July 2004
9

10 **Introduction**
11

12 **Int.A. Residency and fellowship programs are essential dimensions of the**
13 **transformation of the medical student to the independent practitioner along**
14 **the continuum of medical education. They are physically, emotionally, and**
15 **intellectually demanding, and require longitudinally-concentrated effort on**
16 **the part of the resident or fellow.**
17

18 **The specialty education of physicians to practice independently is**
19 **experiential, and necessarily occurs within the context of the health care**
20 **delivery system. Developing the skills, knowledge, and attitudes leading to**
21 **proficiency in all the domains of clinical competency requires the resident**
22 **and fellow physician to assume personal responsibility for the care of**
23 **individual patients. For the resident and fellow, the essential learning**
24 **activity is interaction with patients under the guidance and supervision of**
25 **faculty members who give value, context, and meaning to those**
26 **interactions. As residents and fellows gain experience and demonstrate**
27 **growth in their ability to care for patients, they assume roles that permit**
28 **them to exercise those skills with greater independence. This concept—**
29 **graded and progressive responsibility—is one of the core tenets of**
30 **American graduate medical education. Supervision in the setting of**
31 **graduate medical education has the goals of assuring the provision of safe**
32 **and effective care to the individual patient; assuring each resident's and**
33 **fellow's development of the skills, knowledge, and attitudes required to**
34 **enter the unsupervised practice of medicine; and establishing a foundation**
35 **for continued professional growth.**
36

37 ~~Int.B. Definition and Scope of the Subspecialty—Blood banking/transfusion medicine is~~
38 ~~the practice of laboratory and clinical medicine concerned with all aspects of~~
39 ~~blood transfusion. including the scientific basis of transfusion, selection and~~
40 ~~recruitment of blood donors, utilization and quality control, preparation of blood~~
41 ~~components, pretransfusion testing, transfusion of blood components, adverse~~
42 ~~effects of blood transfusion, autoimmunity, transplantation, histocompatibility,~~
43 ~~therapeutic apheresis and phlebotomy, blood substitutes, medicolegal~~
44 ~~considerations of transfusion, management aspects of blood services, including~~
45 ~~regulatory issues, and the history of blood transfusion. Blood banking/transfusion~~
46 ~~medicine fellowship programs provide requires a strong foundation in clinical~~
47 ~~pathology as well as and clinical medicine.~~
48

49 ~~Int.C. Duration and Scope of Education Graduate medical education programs in blood~~
50 ~~banking/transfusion medicine must provide an organized educational experience~~
51 ~~for qualified physicians seeking to acquire additional competence in blood~~

52 ~~banking/transfusion medicine.~~The educational program in blood
53 banking/transfusion medicine pathology must be 12 months in length.

54
55 ~~Int.B.2. Programs will be accredited to offer one year of organized education in all~~
56 ~~aspects of blood banking/transfusion medicine.~~

57
58 **I. Institutions**

59
60 **I.A. Sponsoring Institution**

61
62 **One sponsoring institution must assume ultimate responsibility for the**
63 **program, as described in the Institutional Requirements, and this**
64 **responsibility extends to fellow assignments at all participating sites.**

65
66 **The sponsoring institution and the program must ensure that the program**
67 **director has sufficient protected time and financial support for his or her**
68 **educational and administrative responsibilities to the program.**

69
70 ~~I.A.1. Each blood banking/transfusion medicine program should be~~
71 ~~administratively attached to an Accreditation Council for Graduate~~
72 ~~Medical Education-accredited residency in anatomic and/or clinical~~
73 ~~pathology.~~

74
75 **I.B. Participating Sites**

76
77 **I.B.1. There must be a program letter of agreement (PLA) between the**
78 **program and each participating site providing a required**
79 **assignment. The PLA must be renewed at least every five years.**

80
81 **The PLA should:**

82
83 **I.B.1.a) Identify the faculty who will assume both educational and**
84 **supervisory responsibilities for fellows;**

85
86 **I.B.1.b) specify their responsibilities for teaching, supervision, and**
87 **formal evaluation of fellows, as specified later in this**
88 **document;**

89
90 **I.B.1.c) specify the duration and content of the educational**
91 **experience; and,**

92
93 **I.B.1.d) state the policies and procedures that will govern fellow**
94 **education during the assignment.**

95
96 **I.B.2. The program director must submit any additions or deletions of**
97 **participating sites routinely providing an educational experience,**
98 **required for all fellows, of one month full time equivalent (FTE) or**
99 **more through the Accreditation Council for Graduate Medical**
100 **Education (ACGME) Accreditation Data System (ADS).**

101

- 102 **II. Program Personnel and Resources**
 103
 104 **II.A. Program Director**
 105
 106 **II.A.1. There must be a single program director with authority and**
 107 **accountability for the operation of the program. The sponsoring**
 108 **institution's GMEC must approve a change in program director.**
 109 **After approval, the program director must submit this change to the**
 110 **ACGME via the ADS.**
 111
 112 **II.A.2. Qualifications of the program director must include:**
 113
 114 **II.A.2.a) requisite specialty expertise and documented educational**
 115 **and administrative experience acceptable to the Review**
 116 **Committee;**
 117
 118 **II.A.2.b) current certification in the subspecialty by the American**
 119 **Board of Pathology (ABP), or subspecialty qualifications that**
 120 **are acceptable to the Review Committee;**
 121
 122 **II.A.2.b).(1) *If the program director is not certified in the subspecialty by***
 123 ***the ABP, at least one full-time faculty member must be***
 124 ***certified in the subspecialty.***
 125
 126 **II.A.2.c) current medical licensure and appropriate medical staff**
 127 **appointment; and,**
 128
 129 **II.A.2.d) *at least three years of active participation as a specialist in blood***
 130 ***banking/transfusion medicine following completion of training the***
 131 ***most recent graduate medical education program.***
 132
 133 **II.A.2.e) ~~licensure to practice medicine in the state where the sponsoring~~**
 134 **~~institution is located.~~**
 135
 136 **II.A.3. The program director must administer and maintain an educational**
 137 **environment conducive to educating the fellows in each of the**
 138 **ACGME competency areas. The program director must:**
 139
 140 **II.A.3.a) prepare and submit all information required and requested by**
 141 **the ACGME;**
 142
 143 **II.A.3.b) be familiar with and oversee compliance with ACGME and**
 144 **Review Committee policies and procedures as outlined in the**
 145 **ACGME Manual of Policies and Procedures;**
 146
 147 **II.A.3.c) obtain review and approval of the sponsoring institution's**
 148 **GMEC/DIO before submitting to the ACGME information or**
 149 **requests for the following:**
 150
 151 **II.A.3.c).(1) all applications for ACGME accreditation of new**

- 152 programs;
- 153
- 154 **II.A.3.c).(2)** changes in fellow complement;
- 155
- 156 **II.A.3.c).(3)** major changes in program structure or length of
- 157 training;
- 158
- 159 **II.A.3.c).(4)** progress reports requested by the Review Committee;
- 160
- 161 **II.A.3.c).(5)** responses to all proposed adverse actions;
- 162
- 163 **II.A.3.c).(6)** requests for increases or any change to fellow duty
- 164 hours;
- 165
- 166 **II.A.3.c).(7)** voluntary withdrawals of ACGME-accredited
- 167 programs;
- 168
- 169 **II.A.3.c).(8)** requests for appeal of an adverse action;
- 170
- 171 **II.A.3.c).(9)** appeal presentations to a Board of Appeal or the
- 172 ACGME.
- 173
- 174 **II.A.3.d)** obtain DIO review and co-signature on all program
- 175 information forms, as well as any correspondence or
- 176 document submitted to the ACGME that addresses:
- 177
- 178 **II.A.3.d).(1)** program citations, and/or
- 179
- 180 **II.A.3.d).(2)** request for changes in the program that would have
- 181 significant impact, including financial, on the program
- 182 or institution.
- 183
- 184 **II.A.3.d).(3)** must ensure that lectures, tutorials, seminars, and
- 185 conferences are regularly scheduled and held, with active
- 186 participation of clinical services. The fellows must have the
- 187 opportunity to attend regional or national meetings.
- 188
- 189 **II.A.3.e)** prepare and implement a supervision policy that specifies fellow
- 190 and faculty lines of responsibility; and,
- 191
- 192 **II.A.3.f)** devote at least 35% of his or her time to clinical work with fellows,
- 193 teaching, and fellowship-related administration.
- 194
- 195 **II.B. Faculty**
- 196
- 197 **II.B.1.** There must be a sufficient number of faculty with documented
- 198 qualifications to instruct and supervise all fellows.
- 199
- 200 **II.B.2.** The faculty must devote sufficient time to the educational program
- 201 to fulfill their supervisory and teaching responsibilities and

- 202 **demonstrate a strong interest in the education of fellows.**
203
- 204 II.B.2.a) The faculty must, in aggregate, devote at least 20 hours per week
205 to fellowship-related clinical work and teaching.
206
- 207 **II.B.3. The physician faculty must have current certification in the**
208 **subspecialty by the American Board of Pathology, or possess**
209 **qualifications acceptable to the Review Committee.**
210
- 211 II.B.3.a) Physician faculty members who are not currently certified in blood
212 banking/transfusion medicine must have either completed a
213 fellowship or have three years of practice experience in the
214 subspecialty.
215
- 216 **II.B.4. The physician faculty must possess current medical licensure and**
217 **appropriate medical staff appointment.**
218
- 219 **II.C. Other Program Personnel**
220
- 221 **The institution and the program must jointly ensure the availability of all**
222 **necessary professional, technical, and clerical personnel for the effective**
223 **administration of the program.**
224
- 225 II.C.1. ~~The laboratories and clinical services involved in the program must be~~
226 ~~directed by qualified physicians who are licensed to practice medicine~~
227 ~~and are members in good standing of the institution's medical staff. There~~
228 ~~must be secretarial and qualified laboratory technical personnel to~~
229 ~~support the clinical, teaching, educational, and research activities of the~~
230 ~~fellowship.~~
231
- 232 **II.D. Resources**
233
- 234 **The institution and the program must jointly ensure the availability of**
235 **adequate resources for fellow education, as defined in the specialty**
236 **program requirements.**
237
- 238 II.D.1. *There must be office space, meeting rooms, and laboratory space to*
239 *support teaching, educational, and research activities.*
240
- 241 II.D.2. Clinical material related to the subspecialty area of the fellowship must be
242 provided.
243
- 244 II.D.2.a) Clinical material must be indexed so as to permit retrieval of
245 archived records by specified organ and/or diagnosis in a timely
246 manner.
247
- 248 II.D.2.b) ~~The program must have a sufficient number and wide variety of~~
249 ~~patients to offer training in the widest range of blood~~
250 ~~banking/transfusion medicine clinical material that includes blood~~
251 ~~donors, blood products, immunohematology specimens.~~

252 transfusion reaction work-ups, and coagulopathies from both adult
253 and pediatric patients. There must be a mechanism for the
254 retrieval and review of cases. There must be effective
255 mechanisms to facilitate clinical correlation with laboratory
256 findings.
257

258 ~~II.D.3. The laboratories in all participating sites should be equipped to perform all~~
259 ~~tests that are required for the education of fellows~~

260
261 II.D.3.a) The laboratory must have a blood banking/transfusion medicine
262 information system that is approved by the Food and Drug
263 Administration (FDA) for use in blood banking/transfusion
264 medicine.
265

266 ~~II.D.4. The institutions, laboratories, and clinical services participating in the~~
267 ~~program must be appropriately accredited and/or licensed.~~
268

269 II.E. Medical Information Access

270
271 **Fellows must have ready access to specialty-specific and other appropriate**
272 **reference material in print or electronic format. Electronic medical literature**
273 **databases with search capabilities should be available.**
274

275 III. Fellow Appointments

276 III.A. Eligibility Criteria

277
278 **Each fellow must successfully complete an ACGME-accredited specialty**
279 **program and/or meet other eligibility criteria as specified by the Review**
280 **Committee. The program must document that each fellow has met the**
281 **eligibility criteria.**
282
283

284 III.A.1. ~~Fellows should have completed two years of training in an ACGME-~~
285 ~~accredited pathology residency, which must include at least 18 months of~~
286 ~~clinical pathology, or be certified by a member board of the American~~
287 ~~Board of Medical Specialties. Prior to appointment in the program, fellows~~
288 ~~should have completed two years of a pathology residency accredited by~~
289 ~~the ACGME or the Royal College of Physicians and Surgeons of Canada~~
290 ~~(RCPSC), or have certification in anatomic pathology and clinical~~
291 ~~pathology, or in clinical pathology, or be certified by a member board of~~
292 ~~the American Board of Medical Specialties (ABMS) in one of the~~
293 ~~following: anesthesiology, internal medicine, obstetrics and gynecology,~~
294 ~~pediatrics, surgery, orthopaedic surgery, plastic surgery, colon and rectal~~
295 ~~surgery, neurological surgery, thoracic surgery, or the subspecialty of~~
296 ~~hematology.~~
297

298 III.B. Number of Fellows

299
300 **The program director may not appoint more fellows than approved by the**
301 **Review Committee, unless otherwise stated in the specialty-specific**
302 **requirements. The program's educational resources must be adequate to**

303 support the number of fellows appointed to the program.

304

305 III.B.1. The education of other learners must not dilute the educational
306 experience of the program's fellows.

307

308 **IV. Educational Program**

309

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

311

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

317

318 **IV.A.2. ACGME Competencies**

319

320 **The program must integrate the following ACGME competencies**
321 **into the curriculum:**

322

323 **IV.A.2.a) Patient Care**

324

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

328

329 **IV.A.2.a).(1)** must demonstrate a ~~satisfactory level of~~ diagnostic
330 competence and the ability to provide appropriate and
331 effective consultation in the context of pathology blood
332 banking/transfusion medicine services, including:

333

334 **IV.A.2.a).(1).(a)** perinatal, pediatric transplantation, and trauma
335 patient care;

336

337 **IV.A.2.a).(1).(b)** immunoematology, histocompatibility, and
338 infectious disease testing in donor management,
339 blood component preparation, and blood inventory
340 management;

341

342 **IV.A.2.a).(1).(c)** cellular therapy and tissue banking;

343

344 **IV.A.2.a).(1).(d)** perioperative blood management;

345

346 **IV.A.2.a).(1).(e)** donor and patient regulatory issues;

347

348 **IV.A.2.a).(1).(f)** donor and therapeutic apheresis; and,

349

350 **IV.A.2.a).(1).(g)** management and direction of a transfusion service
351 and blood center.

352

- 353 IV.A.2.a).(2) must demonstrate competence performing essential
 354 procedures, including:
 355
- 356 IV.A.2.a).(2).(a) collecting blood components, including donor
 357 apheresis;
 358
- 359 IV.A.2.a).(2).(b) selecting and using specific apheresis technologies
 360 to ensure appropriate care, clinical management
 361 and safety of patients and donors undergoing
 362 apheresis medicine therapies or blood product
 363 collection procedures;
 364
- 365 IV.A.2.a).(2).(c) preparing blood components;
 366
- 367 IV.A.2.a).(2).(d) testing blood components;
 368
- 369 IV.A.2.a).(2).(e) transfusing blood components;
 370
- 371 IV.A.2.a).(2).(f) histocompatibility testing;
 372
- 373 IV.A.2.a).(2).(g) therapeutic phlebotomy; and,
 374
- 375 IV.A.2.a).(2).(h) blood management.
 376
- 377 ~~IV.A.2.a).(3) ————— must focus on clinical aspects of transfusion medicine~~
 378 ~~throughout the program. Fellows must participate in~~
 379 ~~ongoing clinical consultations regarding all aspects of~~
 380 ~~blood transfusion and have opportunity to develop~~
 381 ~~competence in providing services to patients and other~~
 382 ~~physicians.~~
 383
- 384 **IV.A.2.b) Medical Knowledge**
 385
- 386 **Fellows must demonstrate knowledge of established and**
 387 **evolving biomedical, clinical, epidemiological and social-**
 388 **behavioral sciences, as well as the application of this**
 389 **knowledge to patient care. Fellows:**
 390
- 391 IV.A.2.b).(1) must demonstrate expertise in their knowledge of: develop
 392 comprehensive knowledge of the technical aspects of
 393 blood banking and immunohematology. There must be an
 394 opportunity to acquire knowledge and skills in new
 395 technologies as they become available;
 396
- 397 IV.A.2.b).(1).(a) scientific basis of transfusion;
 398
- 399 IV.A.2.b).(1).(b) selection and recruitment of blood donors;
 400
- 401 IV.A.2.b).(1).(c) adverse effects of blood transfusion, including
 402 transfusion-transmitted diseases and non-infectious
 403 hazards of transfusion;

- 404
405 IV.A.2.b).(1).(d) adverse effects of blood donation;
406
407 IV.A.2.b).(1).(e) immunohematology and platelet immunology;
408
409 IV.A.2.b).(1).(f) transplantation, including hematopoietic, solid
410 organ, and tissue;
411
412 IV.A.2.b).(1).(g) alternatives to blood transfusion;
413
414 IV.A.2.b).(1).(h) cellular therapy;
415
416 IV.A.2.b).(1).(i) blood management;
417
418 IV.A.2.b).(1).(j) coagulation (hemostasis/thrombosis); and,
419
420 IV.A.2.b).(1).(k) history of blood transfusion.
421
422 IV.A.2.b).(2) ~~should have instruction that illustrates usual and unusual~~
423 ~~cases.~~

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:

- 425
426
427
428
429
430 **IV.A.2.c).(1)** **systematically analyze practice using quality**
431 **improvement methods, and implement changes with**
432 **the goal of practice improvement;**
433
434 **IV.A.2.c).(2)** **locate, appraise, and assimilate evidence from**
435 **scientific studies related to their patients' health**
436 **problems;**
437
438 IV.A.2.c).(3) incorporate formative evaluation feedback into daily
439 practice;
440
441 IV.A.2.c).(4) use information technology to optimize learning and
442 improve patient care; and,
443
444 IV.A.2.c).(5) participate in the education of donors, patients, families,
445 students, residents, and other health professionals and
446 community members.
447

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.

- 454
 455 IV.A.2.d).(1) Fellows must demonstrate competence in providing
 456 appropriate and effective consultations to other physicians
 457 and health professionals, both intra- and inter-
 458 departmental.
 459
 460 IV.A.2.d).(1).(a) Consultations should include providing medical
 461 advice on the diagnosis and management of
 462 transfusion medicine issues.
 463
 464 IV.A.2.d).(2) Fellows must demonstrate the ability to communicate
 465 effectively, both verbally and in writing, with:
 466
 467 IV.A.2.d).(2).(a) donors, patients, families, and the public, as
 468 appropriate, across a broad range of
 469 socioeconomic, educational, and cultural
 470 backgrounds; and,
 471
 472 IV.A.2.d).(2).(b) physicians, other health professionals, and health-
 473 related agencies.
 474
 475 IV.A.2.d).(3) Fellows must maintain comprehensive, timely, and legible
 476 medical records.
 477
 478 **IV.A.2.e) Professionalism**
 479
 480 **Fellows must demonstrate a commitment to carrying out**
 481 **professional responsibilities and an adherence to ethical**
 482 **principles.**
 483
 484 ~~IV.A.2.e).(1) Fellows must demonstrate a sensitivity to a diverse patient~~
 485 ~~population.~~
 486
 487 **IV.A.2.f) Systems-based Practice**
 488
 489 **Fellows must demonstrate an awareness of and**
 490 **responsiveness to the larger context and system of health**
 491 **care, as well as the ability to call effectively on other**
 492 **resources in the system to provide optimal health care.**
 493
 494 IV.A.2.f).(1) Fellows must demonstrate the ability to:
 495
 496 IV.A.2.f).(1).(a) coordinate quality and safety for donors and
 497 patients within the health care system relevant to
 498 blood banking/transfusion medicine;
 499
 500 IV.A.2.f).(1).(b) incorporate cost considerations and risk-benefit
 501 analysis in patient and population-based care;
 502
 503 IV.A.2.f).(1).(c) contribute to quality improvement projects and
 504 quality assurance audits;

505		
506	IV.A.2.f).(1).(d)	<u>participate in identifying system errors and implementing potential systems solutions; and,</u>
507		
508		
509	IV.A.2.f).(1).(e)	<u>follow regulatory and accreditation requirements for blood banking/transfusion medicine, including those of the FDA, the American Association of Blood Banks, the College of American Pathologists, and the Joint Commission.</u>
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511		
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513		
514		
515	IV.A.3.	<u>Curriculum Organization and Fellow Experiences</u>
516		
517	IV.A.3.a)	<u>Fellows must participate in ongoing clinical consultations regarding all aspects of blood transfusion.</u>
518		
519		
520	IV.A.3.b)	<u>Fellows must participate in the interpretation of laboratory data as part of patient care decision making and patient care consultation.</u>
521		
522		
523	IV.A.3.c)	<u>Fellows must have direct responsibility, with appropriate supervision, to make decisions in the laboratory.</u>
524		
525		
526	IV.A.3.d)	<u><i>Fellows' clinical experience should be augmented through didactic sessions, review of the medical literature in the subspecialty area, and the use of study sets of unusual cases.</i></u>
527		
528		
529		
530	IV.A.3.e)	<u>The didactic curriculum must include teaching conferences in blood banking/transfusion medicine, journal clubs, and joint conferences with the Pathology Department, as well as with clinical services involved in the diagnosis and management of patient care utilizing transfusion medicine.</u>
531		
532		
533		
534		
535		
536	IV.A.3.e).(1)	<u>Fellows should participate in conferences, on average, at least once per month, and should give a minimum of two presentations per year.</u>
537		
538		
539		
540	IV.A.3.e).(2)	<u>Didactic instruction should illustrate common and unusual cases.</u>
541		
542		
543	IV.B.	Fellows' Scholarly Activities
544		
545	IV.B.1.	<u><i>Each fellow should participate in scholarly activity, including at least one of the following:</i></u>
546		
547		
548	IV.B.1.a)	<u><i>research;</i></u>
549		
550	IV.B.1.b)	<u><i>evidence-based presentations at journal club or meetings (local, regional or national); or,</i></u>
551		
552		
553	IV.B.1.c)	<u><i>preparation/submission of articles for peer-reviewed publications.</i></u>
554		
555	V.	Evaluation

556		
557	V.A.	Fellow Evaluation
558		
559	V.A.1.	Formative Evaluation
560		
561	V.A.1.a)	The faculty must evaluate fellow performance in a timely manner.
562		
563		
564	V.A.1.b)	The program must:
565		
566	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;
567		
568		
569		
570		
571		
572	V.A.1.b).(2)	use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff); and,
573		
574		
575	V.A.1.b).(3)	provide each fellow with documented semiannual evaluation of performance with feedback.
576		
577		
578	V.A.1.c)	The evaluations of fellow performance must be accessible for review by the fellow, in accordance with institutional policy.
579		
580		
581	V.A.2.	Summative Evaluation
582		
583		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:
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585		
586		
587		
588		
589	V.A.2.a)	document the fellow's performance during their education, and
590		
591		
592	V.A.2.b)	verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision.
593		
594		
595	V.B.	Faculty Evaluation
596		
597	V.B.1.	At least annually, the program must evaluate faculty performance as it relates to the educational program.
598		
599		
600	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.
601		
602		
603		
604	V.C.	Program Evaluation and Improvement
605		

- 606 **V.C.1.** The program must document formal, systematic evaluation of the
607 curriculum at least annually. The program must monitor and track
608 each of the following areas:
609
- 610 **V.C.1.a)** fellow performance, and
611
- 612 **V.C.1.b)** faculty development.
613
- 614 **V.C.2.** If deficiencies are found, the program should prepare a written plan
615 of action to document initiatives to improve performance in the
616 areas listed in section V.C.1. The action plan should be reviewed
617 and approved by the teaching faculty and documented in meeting
618 minutes.
619
- 620 **V.C.3.** 60 percent of the program's graduates from the preceding five years
621 taking the ABP certifying examination for blood banking/transfusion
622 medicine for the first time must pass.
623
- 624 **VI. Fellow Duty Hours in the Learning and Working Environment**
625
- 626 **VI.A. Professionalism, Personal Responsibility, and Patient Safety**
627
- 628 **VI.A.1.** Programs and sponsoring institutions must educate fellows and
629 faculty members concerning the professional responsibilities of
630 physicians to appear for duty appropriately rested and fit to provide
631 the services required by their patients.
632
- 633 **VI.A.2.** The program must be committed to and responsible for promoting
634 patient safety and fellow well-being in a supportive educational
635 environment.
636
- 637 **VI.A.3.** The program director must ensure that fellows are integrated and
638 actively participate in interdisciplinary clinical quality improvement
639 and patient safety programs.
640
- 641 **VI.A.4.** The learning objectives of the program must:
642
- 643 **VI.A.4.a)** be accomplished through an appropriate blend of supervised
644 patient care responsibilities, clinical teaching, and didactic
645 educational events; and,
646
- 647 **VI.A.4.b)** not be compromised by excessive reliance on fellows to fulfill
648 non-physician service obligations.
649
- 650 **VI.A.5.** The program director and sponsoring institution must ensure a
651 culture of professionalism that supports patient safety and personal
652 responsibility. Fellows and faculty members must demonstrate an
653 understanding and acceptance of their personal role in the
654 following:
655

- 656 VI.A.5.a) assurance of the safety and welfare of patients entrusted to
657 their care;
658
- 659 VI.A.5.b) provision of patient- and family-centered care;
660
- 661 VI.A.5.c) assurance of their fitness for duty;
662
- 663 VI.A.5.d) management of their time before, during, and after clinical
664 assignments;
665
- 666 VI.A.5.e) recognition of impairment, including illness and fatigue, in
667 themselves and in their peers;
668
- 669 VI.A.5.f) attention to lifelong learning;
670
- 671 VI.A.5.g) the monitoring of their patient care performance improvement
672 indicators; and,
673
- 674 VI.A.5.h) honest and accurate reporting of duty hours, patient
675 outcomes, and clinical experience data.
676
- 677 VI.A.6. All fellows and faculty members must demonstrate responsiveness
678 to patient needs that supersedes self-interest. Physicians must
679 recognize that under certain circumstances, the best interests of the
680 patient may be served by transitioning that patient's care to another
681 qualified and rested provider.
682
- 683 VI.B. Transitions of Care
684
- 685 VI.B.1. Programs must design clinical assignments to minimize the number
686 of transitions in patient care.
687
- 688 VI.B.2. Sponsoring institutions and programs must ensure and monitor
689 effective, structured hand-over processes to facilitate both
690 continuity of care and patient safety.
691
- 692 VI.B.3. Programs must ensure that fellows are competent in communicating
693 with team members in the hand-over process.
694
- 695 VI.B.4. The sponsoring institution must ensure the availability of schedules
696 that inform all members of the health care team of attending
697 physicians and fellows currently responsible for each patient's care.
698
- 699 VI.C. Alertness Management/Fatigue Mitigation
700
- 701 VI.C.1. The program must:
702
- 703 VI.C.1.a) educate all faculty members and fellows to recognize the
704 signs of fatigue and sleep deprivation;
705

- 706 **VI.C.1.b)** educate all faculty members and fellows in alertness
707 management and fatigue mitigation processes; and,
708
- 709 **VI.C.1.c)** adopt fatigue mitigation processes to manage the potential
710 negative effects of fatigue on patient care and learning, such
711 as naps or back-up call schedules.
712
- 713 **VI.C.2.** Each program must have a process to ensure continuity of patient
714 care in the event that a fellow may be unable to perform his/her
715 patient care duties.
716
- 717 **VI.C.3.** The sponsoring institution must provide adequate sleep facilities
718 and/or safe transportation options for fellows who may be too
719 fatigued to safely return home.
720
- 721 **VI.D.** **Supervision of Fellows**
722
- 723 **VI.D.1.** In the clinical learning environment, each patient must have an
724 identifiable, appropriately-credentialed and privileged attending
725 physician (or licensed independent practitioner as approved by each
726 Review Committee) who is ultimately responsible for that patient's
727 care.
728
- 729 **VI.D.1.a)** This information should be available to fellows, faculty
730 members, and patients.
731
- 732 **VI.D.1.b)** Fellows and faculty members should inform patients of their
733 respective roles in each patient's care.
734
- 735 **VI.D.2.** The program must demonstrate that the appropriate level of
736 supervision is in place for all fellows who care for patients.
737
- 738 **Supervision may be exercised through a variety of methods. Some**
739 **activities require the physical presence of the supervising faculty**
740 **member. For many aspects of patient care, the supervising**
741 **physician may be a more advanced fellow. Other portions of care**
742 **provided by the fellow can be adequately supervised by the**
743 **immediate availability of the supervising faculty member or fellow**
744 **physician, either in the institution, or by means of telephonic and/or**
745 **electronic modalities. In some circumstances, supervision may**
746 **include post-hoc review of fellow-delivered care with feedback as to**
747 **the appropriateness of that care.**
748
- 749 **VI.D.3.** **Levels of Supervision**
750
- 751 **To ensure oversight of fellow supervision and graded authority and**
752 **responsibility, the program must use the following classification of**
753 **supervision:**
754
- 755 **VI.D.3.a)** **Direct Supervision – the supervising physician is physically**

756 present with the fellow and patient.
757
758 **VI.D.3.b) Indirect Supervision:**
759
760 **VI.D.3.b).(1)** with direct supervision immediately available – the
761 supervising physician is physically within the hospital
762 or other site of patient care, and is immediately
763 available to provide Direct Supervision.
764
765 **VI.D.3.b).(2)** with direct supervision available – the supervising
766 physician is not physically present within the hospital
767 or other site of patient care, but is immediately
768 available by means of telephonic and/or electronic
769 modalities, and is available to provide Direct
770 Supervision.
771
772 **VI.D.3.c)** Oversight – the supervising physician is available to provide
773 review of procedures/encounters with feedback provided
774 after care is delivered.
775
776 **VI.D.4.** The privilege of progressive authority and responsibility, conditional
777 independence, and a supervisory role in patient care delegated to
778 each fellow must be assigned by the program director and faculty
779 members.
780
781 **VI.D.4.a)** The program director must evaluate each fellow’s abilities
782 based on specific criteria. When available, evaluation should
783 be guided by specific national standards-based criteria.
784
785 **VI.D.4.b)** Faculty members functioning as supervising physicians
786 should delegate portions of care to fellows, based on the
787 needs of the patient and the skills of the fellows.
788
789 **VI.D.4.c)** Fellows should serve in a supervisory role of residents or
790 junior fellows in recognition of their progress toward
791 independence, based on the needs of each patient and the
792 skills of the individual fellow.
793
794 **VI.D.5.** Programs must set guidelines for circumstances and events in
795 which fellows must communicate with appropriate supervising
796 faculty members, such as the transfer of a patient to an intensive
797 care unit, or end-of-life decisions.
798
799 **VI.D.5.a)** Each fellow must know the limits of his/her scope of
800 authority, and the circumstances under which he/she is
801 permitted to act with conditional independence.
802
803 **VI.D.6.** Faculty supervision assignments should be of sufficient duration to
804 assess the knowledge and skills of each fellow and delegate to
805 him/her the appropriate level of patient care authority and

806 responsibility.

807

808 **VI.E. Clinical Responsibilities**

809

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

813

814 *[Optimal clinical workload will be further specified by each Review Committee.]*

815

816 **VI.F. Teamwork**

817

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

822

823 *[Each Review Committee will define the elements that must be present in each
824 specialty.]*

825

826 **VI.G. Fellow Duty Hours**

827

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

829

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

833

834 **VI.G.1.a) Duty Hour Exceptions**

835

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

839

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

843

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

847

848 **VI.G.2. Moonlighting**

849

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

853

854 **VI.G.2.b)** Time spent by fellows in Internal and External Moonlighting
855 (as defined in the ACGME Glossary of Terms) must be

856 counted towards the 80-hour Maximum Weekly Hour Limit.
857
858 **VI.G.3. Mandatory Time Free of Duty**
859
860 Fellows must be scheduled for a minimum of one day free of duty
861 every week (when averaged over four weeks). At-home call cannot
862 be assigned on these free days.
863
864 **VI.G.4. Maximum Duty Period Length**
865
866 Duty periods of fellows may be scheduled to a maximum of 24 hours
867 of continuous duty in the hospital. Programs must encourage
868 fellows to use alertness management strategies in the context of
869 patient care responsibilities. Strategic napping, especially after 16
870 hours of continuous duty and between the hours of 10:00 p.m. and
871 8:00 a.m., is strongly suggested.
872
873 **VI.G.4.a)** It is essential for patient safety and fellow education that
874 effective transitions in care occur. Fellows may be allowed to
875 remain on-site in order to accomplish these tasks; however,
876 this period of time must be no longer than an additional four
877 hours.
878
879 **VI.G.4.b)** Fellows must not be assigned additional clinical
880 responsibilities after 24 hours of continuous in-house duty.
881
882 **VI.G.4.c)** In unusual circumstances, fellows, on their own initiative,
883 may remain beyond their scheduled period of duty to
884 continue to provide care to a single patient. Justifications for
885 such extensions of duty are limited to reasons of required
886 continuity for a severely ill or unstable patient, academic
887 importance of the events transpiring, or humanistic attention
888 to the needs of a patient or family.
889
890 **VI.G.4.c).(1)** Under those circumstances, the fellow must:
891
892 **VI.G.4.c).(1).(a)** appropriately hand over the care of all other
893 patients to the team responsible for their
894 continuing care; and,
895
896 **VI.G.4.c).(1).(b)** document the reasons for remaining to care for
897 the patient in question and submit that
898 documentation in every circumstance to the
899 program director.
900
901 **VI.G.4.c).(2)** The program director must review each submission of
902 additional service, and track both individual fellow and
903 program-wide episodes of additional duty.
904
905 **VI.G.5. Minimum Time Off between Scheduled Duty Periods**

- 906
907 **VI.G.5.a)** **Fellows in the final years of education [as defined by the**
908 **Review Committee] must be prepared to enter the**
909 **unsupervised practice of medicine and care for patients over**
910 **irregular or extended periods.**
- 911
912 **VI.G.5.a).(1)** **This preparation must occur within the context of the**
913 **80-hour, maximum duty period length, and one-day-**
914 **off-in-seven standards. While it is desirable that**
915 **fellows in their final years of education have eight**
916 **hours free of duty between scheduled duty periods,**
917 **there may be circumstances [as defined by the Review**
918 **Committee] when these fellows must stay on duty to**
919 **care for their patients or return to the hospital with**
920 **fewer than eight hours free of duty.**
- 921
922 **VI.G.5.a).(1).(a)** **Circumstances of return-to-hospital activities**
923 **with fewer than eight hours away from the**
924 **hospital by fellows in their final years of**
925 **education must be monitored by the program**
926 **director.**
- 927
928 **VI.G.6.** **Maximum Frequency of In-House Night Float**
929
930 **Fellows must not be scheduled for more than six consecutive nights**
931 **of night float.**
932
933 *[The maximum number of consecutive weeks of night float, and maximum*
934 *number of months of night float per year may be further specified by the*
935 *Review Committee.]*
936
- 937 **VI.G.7.** **Maximum In-House On-Call Frequency**
938
939 **Fellows must be scheduled for in-house call no more frequently than**
940 **every-third-night (when averaged over a four-week period).**
941
- 942 **VI.G.8.** **At-Home Call**
943
- 944 **VI.G.8.a)** **Time spent in the hospital by fellows on at-home call must**
945 **count towards the 80-hour maximum weekly hour limit. The**
946 **frequency of at-home call is not subject to the every-third-**
947 **night limitation, but must satisfy the requirement for one-day-**
948 **in-seven free of duty, when averaged over four weeks.**
949
- 950 **VI.G.8.a).(1)** **At-home call must not be so frequent or taxing as to**
951 **preclude rest or reasonable personal time for each**
952 **fellow.**
953
- 954 **VI.G.8.b)** **Fellows are permitted to return to the hospital while on at-**
955 **home call to care for new or established patients. Each**

956
957
958
959
960

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”.
