

1 **ACGME Program Requirements for Graduate Medical Education**
2 **in Pediatric Pathology**
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 1, 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.A. Definition and Scope of the Subspecialty~~
38

39 ~~Int.B. Pediatric pathology is that practice of pathology concerned with the study and~~
40 ~~diagnosis of human disease manifested in the embryo, fetus, infant, child, and~~
41 ~~adolescent.~~
42

43 ~~Int.B. Duration and Scope of Education~~
44

45 ~~Int.B.1. Graduate medical education programs in pediatric pathology must~~
46 ~~provide an organized educational experience for qualified physicians~~
47 ~~seeking to acquire advanced competence in the diagnosis of childhood~~
48 ~~diseases.~~
49

50 ~~Int.B.2. Programs will be accredited to offer one year of organized education in~~
51 ~~pediatric pathology, which must include formal education in diagnostic~~

52 ~~pediatric pathology and placental and fetal pathology as well as~~
53 ~~management and quality assessment issues germane to the pediatric~~
54 ~~laboratory environment.~~

56 Int.C. The educational program in pediatric pathology must be 12 months in length.

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. A pediatric pathology program should be administratively attached to an~~
71 ~~Accreditation Council for Graduate Medical Education~~
72 ~~(ACGME)-accredited residency in anatomic and clinical pathology or~~
73 ~~anatomic pathology.~~

74
75 ~~I.A.2. To facilitate peer interchange and augment the breadth of the educational~~
76 ~~experiences, institutions providing programs in pediatric pathology must~~
77 ~~be affiliated with The sponsoring institution must also sponsor~~
78 ~~Accreditation Council for Graduate Medical Education (ACGME)-~~
79 ~~accredited specialty residency programs in pediatrics, obstetrics, surgery,~~
80 ~~and diagnostic radiology.~~

81
82 **I.B. Participating Sites**

83
84 **I.B.1. There must be a program letter of agreement (PLA) between the**
85 **program and each participating site providing a required**
86 **assignment. The PLA must be renewed at least every five years.**

87
88 **The PLA should:**

89
90 **I.B.1.a) identify the faculty who will assume both educational and**
91 **supervisory responsibilities for fellows;**

92
93 **I.B.1.b) specify their responsibilities for teaching, supervision, and**
94 **formal evaluation of fellows, as specified later in this**
95 **document;**

96
97 **I.B.1.c) specify the duration and content of the educational**
98 **experience; and,**

99
100 **I.B.1.d) state the policies and procedures that will govern fellow**
101 **education during the assignment.**

- 102
103 **I.B.2.** **The program director must submit any additions or deletions of**
104 **participating sites routinely providing an educational experience,**
105 **required for all fellows, of one month full time equivalent (FTE) or**
106 **more through the Accreditation Council for Graduate Medical**
107 **Education (ACGME) Accreditation Data System (ADS).**
108
- 109 **II. Program Personnel and Resources**
110
- 111 **II.A. Program Director**
112
- 113 **II.A.1.** **There must be a single program director with authority and**
114 **accountability for the operation of the program. The sponsoring**
115 **institution’s GMEC must approve a change in program director.**
116 **After approval, the program director must submit this change to the**
117 **ACGME via the ADS.**
118
- 119 **II.A.2.** **Qualifications of the program director must include:**
120
- 121 **II.A.2.a)** **requisite specialty expertise and documented educational**
122 **and administrative experience acceptable to the Review**
123 **Committee;**
124
125 **current certification in the subspecialty by the American**
126 **Board of Pathology (ABP), or subspecialty qualifications that**
127 **are acceptable to the Review Committee;**
128
- 129 **II.A.2.a).(1)** *If the program director is not certified in the subspecialty by*
130 *the ABP, at least one full-time faculty member must be*
131 *certified in the subspecialty.*
132
- 133 **II.A.2.b)** **current medical licensure and appropriate medical staff**
134 **appointment; and,**
135
- 136 **II.A.2.c)** ~~appointment in good standing; the program director must be~~
137 ~~based at the primary teaching site;~~
138
- 139 **II.A.2.d)** *at least three years of active participation as a specialist in*
140 *pediatric pathology following completion of the most recent*
141 *graduate medical education program.*
142
- 143 **II.A.2.e)** ~~licensure to practice medicine in the state where the sponsoring~~
144 ~~institution is located.~~
145
- 146 **II.A.3.** **The program director must administer and maintain an educational**
147 **environment conducive to educating the fellows in each of the**
148 **ACGME competency areas. The program director must:**
149
- 150 **II.A.3.a)** **prepare and submit all information required and requested by**
151 **the ACGME;**

- 152
- 153 **II.A.3.b)** **be familiar with and oversee compliance with ACGME and**
- 154 **Review Committee policies and procedures as outlined in the**
- 155 **ACGME Manual of Policies and Procedures;**
- 156
- 157 **II.A.3.c)** **obtain review and approval of the sponsoring institution's**
- 158 **GMEC/DIO before submitting to the ACGME information or**
- 159 **requests for the following:**
- 160
- 161 **II.A.3.c).(1)** **all applications for ACGME accreditation of new**
- 162 **programs;**
- 163
- 164 **II.A.3.c).(2)** **changes in fellow complement;**
- 165
- 166 **II.A.3.c).(3)** **major changes in program structure or length of**
- 167 **training;**
- 168
- 169 **II.A.3.c).(4)** **progress reports requested by the Review Committee;**
- 170
- 171 **II.A.3.c).(5)** **responses to all proposed adverse actions;**
- 172
- 173 **II.A.3.c).(6)** **requests for increases or any change to fellow duty**
- 174 **hours;**
- 175
- 176 **II.A.3.c).(7)** **voluntary withdrawals of ACGME-accredited**
- 177 **programs;**
- 178
- 179 **II.A.3.c).(8)** **requests for appeal of an adverse action; and,**
- 180
- 181 **II.A.3.c).(9)** **appeal presentations to a Board of Appeal or the**
- 182 **ACGME.**
- 183
- 184 **II.A.3.d)** **obtain DIO review and co-signature on all program**
- 185 **information forms, as well as any correspondence or**
- 186 **document submitted to the ACGME that addresses:**
- 187
- 188 **II.A.3.d).(1)** **program citations, and/or**
- 189
- 190 **II.A.3.d).(2)** **request for changes in the program that would have**
- 191 **significant impact, including financial, on the program**
- 192 **or institution.**
- 193
- 194 **II.A.3.e)** **prepare and implement a supervision policy that specifies fellow**
- 195 **and faculty lines of responsibility; and,**
- 196
- 197 **II.A.3.f)** **devote at least 35% of his or her time to clinical work with fellows,**
- 198 **teaching, and fellowship-related administration.**
- 199
- 200 **II.A.4.** **ensure that lectures, tutorials, seminars, and conferences with clinical**
- 201 **services including pediatric surgery, pediatric hematology, pediatric**

202 oncology, medical microbiology, medical genetics, pediatric radiology,
203 obstetrics, and pediatrics, must be regularly scheduled and held.

204
205 **II.B. Faculty**

206
207 **II.B.1. There must be a sufficient number of faculty with documented**
208 **qualifications to instruct and supervise all fellows.**

209
210 **II.B.2. The faculty must devote sufficient time to the educational program**
211 **to fulfill their supervisory and teaching responsibilities and**
212 **demonstrate a strong interest in the education of fellows.**

213
214 **II.B.2.a) The faculty must, in aggregate, devote at least 20 hours per week**
215 **to fellowship-related clinical work and teaching.**

216
217 **II.B.3. The physician faculty must have current certification in the**
218 **subspecialty by the American Board of Pathology, or possess**
219 **qualifications acceptable to the Review Committee.**

220
221 **II.B.3.a) Physician faculty members who are not currently certified in**
222 **pediatric pathology must have either completed a fellowship or**
223 **have three years of practice experience in the subspecialty.**

224
225 **II.B.4. The physician faculty must possess current medical licensure and**
226 **appropriate medical staff appointment.**

227
228 **II.C. Other Program Personnel**

229
230 **The institution and the program must jointly ensure the availability of all**
231 **necessary professional, technical, and clerical personnel for the effective**
232 **administration of the program.**

233
234 **II.C.1. There must be secretarial and laboratory technical personnel to support**
235 **the clinical, teaching, educational, and research activities of the**
236 **fellowship.**

237
238 ~~**II.C.2. The laboratories involved in the program must be directed by qualified**~~
239 ~~**physicians who are licensed to practice medicine and are members in**~~
240 ~~**good standing of the institution's medical staff.**~~

241
242 **II.D. Resources**

243
244 **The institution and the program must jointly ensure the availability of**
245 **adequate resources for fellow education, as defined in the specialty**
246 **program requirements.**

247
248 **II.D.1. There must be office space, meeting rooms, and laboratory space to**
249 **support teaching, educational, and research activities.**

250
251 **II.D.2. Clinical material related to the subspecialty area of the fellowship must be**

252 provided.
253
254 II.D.2.a) Clinical material must include a variety of pediatric pathology
255 material that includes autopsy, surgical pathology, perinatal, and
256 clinical pathology samples.
257
258 II.D.2.b) Clinical material must be indexed so as to permit retrieval of
259 archived records by specified organ and/or diagnosis in a timely
260 manner.

261
262 II.D.3. Laboratories should be equipped to perform all tests required for the
263 education of fellows.

264
265 II.D.3.a) This must include: microscopes, including multi-headed
266 microscopes, and computers with access to hospital and
267 laboratory information systems and the Internet.

268
269 II.D.4. ~~The program must have access to an adequate volume and variety of~~
270 ~~pediatric pathology material. The material and files must be indexed to~~
271 ~~permit appropriate retrieval. There must be mechanisms to facilitate~~
272 ~~correlation with anatomical material.~~

273
274 II.D.5. ~~The institutions and laboratories participating in the program must be~~
275 ~~appropriately accredited and/or licensed.~~

276 II.E. Medical Information Access

277
278
279 **Fellows must have ready access to specialty-specific and other appropriate**
280 **reference material in print or electronic format. Electronic medical literature**
281 **databases with search capabilities should be available.**

282 III. Fellow Appointments

283 III.A. Eligibility Criteria

284
285
286
287 **Each fellow must successfully complete an ACGME-accredited specialty**
288 **program and/or meet other eligibility criteria as specified by the Review**
289 **Committee. The program must document that each fellow has met the**
290 **eligibility criteria.**

291
292 ~~III.A.1. Fellows should have completed at least two years of training in an~~
293 ~~ACGME-accredited pathology residency prior to appointment to a~~
294 ~~pediatric pathology program. Prior to appointment in the program, fellows~~
295 ~~should have completed two years of a pathology residency program~~
296 ~~accredited by the ACGME or the Royal College of Physicians and~~
297 ~~Surgeons of Canada (RCPSC), or have certification in anatomic~~
298 ~~pathology and clinical pathology, or in anatomic pathology, or have~~
299 ~~general pathology certification by the RCPSC.~~

300 III.B. Number of Fellows

301
302

303 The program director may not appoint more fellows than approved by the
304 Review Committee, unless otherwise stated in the specialty-specific
305 requirements. The program's educational resources must be adequate to
306 support the number of fellows appointed to the program.
307

308 III.B.1. The education of other learners must not dilute the educational
309 experience of the program's fellows.
310

311 **IV. Educational Program**
312

313 **IV.A. The curriculum must contain the following educational components:**
314

315 **IV.A.1. Skills and competencies the fellow will be able to demonstrate at the**
316 **conclusion of the program. The program must distribute these skills**
317 **and competencies to fellows and faculty annually, in either written**
318 **or electronic form. These skills and competencies should be**
319 **reviewed by the fellow at the start of each rotation;**
320

321 **IV.A.2. ACGME Competencies**
322

323 **The program must integrate the following ACGME competencies**
324 **into the curriculum:**
325

326 **IV.A.2.a) Patient Care**
327

328 **Fellows must be able to provide patient care that is**
329 **compassionate, appropriate, and effective for the treatment of**
330 **health problems and the promotion of health. Fellows:**
331

332 **IV.A.2.a).(1) must demonstrate competence in performing pediatric**
333 **autopsies, including general pediatric, metabolic, forensic,**
334 **perinatal, embryo-fetal, and stillborn autopsies;**
335

336 **IV.A.2.a).(1).(a) The participation in Each fellow must perform or**
337 **supervise at least 40 pediatric autopsies per fellow**
338 **during the program. This experience must include**
339 **general pediatric, metabolic, forensic, perinatal,**
340 **and stillborn autopsies. It is highly desirable that**
341 **this experience also include embryo-fetal autopsies**
342

343 **IV.A.2.a).(1).(a).(i) Fellows must document pediatric autopsies**
344 **performed using the ACGME Case Log**
345 **System.**
346

347 **IV.A.2.a).(2) ~~must have education in pediatric pathology that includes~~**
348 **~~general and systemic aspects of autopsy and surgical~~**
349 **~~pathology (including embryo-fetal, perinatal, and placental~~**
350 **~~pathology as well as pediatric aspects of~~**
351 **~~dermatopathology, gynecological and obstetrical~~**
352 **~~pathology, forensic pathology, and neuropathology);~~**

353 immunopathologic and histochemical techniques,
354 cytopathology, ultrastructural pathology, cytogenetics,
355 molecular biologic techniques including diagnostic
356 techniques for metabolic diseases, and other advanced
357 diagnostic techniques as they relate to pediatric pathology;
358

359 IV.A.2.a).(3) must have sufficient volume and variety of materials
360 available for educational purposes to ensure the
361 opportunity for:

362
363 IV.A.2.a).(4) must demonstrate competence in diagnosing common and
364 unusual pediatric problems, including metabolic, prenatal,
365 genetic, and neoplastic diseases; and,

366
367 IV.A.2.a).(4).(a) Examination of Each fellow must perform at least
368 2000 gross and/or histologic examinations of
369 pediatric surgical pathology specimens per year,
370 per fellow during the program. This material must
371 be from an adequate mix of cases, including
372 obstetrics-related materials (placentas and
373 abortions) and cytology;

374
375 IV.A.2.a).(5) must demonstrate competence in interpreting the results of
376 laboratory assays used in pediatric pathology, including
377 immunopathologic and histochemical assays, and
378 molecular biological techniques, including diagnostic
379 assays for metabolic diseases.

380
381 IV.A.2.a).(6) should have a number and variety of laboratory tests that
382 are sufficient to give each fellow experience in the range of
383 laboratory examinations typically available and useful in
384 the diagnoses and following both common and unusual
385 pediatric diagnostic problems, including metabolic,
386 prenatal, genetic, neoplastic, and other diseases of the
387 pediatric population;
388

389 IV.A.2.a).(7) must have instruction and experience in the major aspects
390 of a hospital laboratory as it relates to diagnosis in
391 pediatric pathology, including fellow participation in
392 interpretation of laboratory data as part of pediatric patient
393 care consultation, conferences, rounds, laboratory
394 management, quality assurance, data processing,
395 teaching, and scholarly activity;
396

397 **IV.A.2.b) Medical Knowledge**

398
399 **Fellows must demonstrate knowledge of established and**
400 **evolving biomedical, clinical, epidemiological and social-**
401 **behavioral sciences, as well as the application of this**
402 **knowledge to patient care. Fellows:**
403

- 404 IV.A.2.b).(1) must demonstrate expertise in their knowledge of pediatric
405 pathology, including:
406
407 IV.A.2.b).(1).(a) general and systemic aspects of autopsy and
408 surgical pathology, to include embryo-fetal,
409 perinatal, and placental pathology;
410
411 IV.A.2.b).(1).(b) pediatric aspects of dermatopathology,
412 gynecological and obstetrical pathology, forensic
413 pathology, and neuropathology; and,
414
415 IV.A.2.b).(1).(c) cytopathology, ultrastructural pathology, and
416 cytogenetics.
417
418 ~~IV.A.2.b).(2) should have educational experiences that are provided~~
419 ~~through separate, exclusive rotations or by rotations that~~
420 ~~combine more than one area or by other means;~~
421
422 ~~IV.A.2.b).(3) should have instruction that includes using study sets of~~
423 ~~usual and unusual cases and other educational materials.~~
424
425 IV.A.2.c) **Practice-based Learning and Improvement**
426
427 **Fellows are expected to develop skills and habits to be able**
428 **to meet the following goals:**
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; and,**
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.d) Interpersonal and Communication Skills**
439
440 **Fellows must demonstrate interpersonal and communication**
441 **skills that result in the effective exchange of information and**
442 **collaboration with patients, their families, and health**
443 **professionals.**
444
445 ~~IV.A.2.d).(1) must demonstrate a satisfactory level of diagnostic~~
446 ~~competence and the ability to provide appropriate and~~
447 ~~effective consultation in the context of pathology services.~~
448 ~~Fellows must demonstrate competence in providing~~
449 ~~appropriate and effective consultations to other physicians~~
450 ~~and health professionals, both intra- and inter-~~
451 ~~departmental.~~
452
453 ~~IV.A.2.d).(1).(a) The performance of Each fellow must provide at~~

- 454 least 50 intraoperative consultations (~~frozen~~
455 ~~sections, smears~~) per fellow during the program.
- 456
- 457 IV.A.2.d).(1).(b) Consultations should include providing medical
458 advice on the diagnosis and management of
459 pediatric disorders.
- 460
- 461 IV.A.2.d).(2) Fellows must demonstrate competence in educating others
462 in the knowledge, skills, and abilities related to pediatric
463 pathology.
- 464
- 465 **IV.A.2.e) Professionalism**
- 466
- 467 **Fellows must demonstrate a commitment to carrying out**
468 **professional responsibilities and an adherence to ethical**
469 **principles.**
- 470
- 471 **IV.A.2.f) Systems-based Practice**
- 472
- 473 **Fellows must demonstrate an awareness of and**
474 **responsiveness to the larger context and system of health**
475 **care, as well as the ability to call effectively on other**
476 **resources in the system to provide optimal health care.**
- 477
- 478 IV.A.3. Curriculum Organization and Fellow Experiences
- 479
- 480 IV.A.3.a) The didactic curriculum must include teaching conferences in
481 pediatric pathology, journal clubs, and joint conferences with the
482 pathology department, as well as with clinical services involved in
483 the diagnosis and management of patient care utilizing pediatric
484 pathology.
- 485
- 486 IV.A.3.a).(1) Fellows should participate in conferences, on average, at
487 least once per month, and should give a minimum of two
488 presentations per year.
- 489
- 490 IV.A.3.a).(2) Fellows must have instruction and experience in quality
491 assurance.
- 492
- 493 IV.A.3.a).(3) Didactic instruction should include the use of study sets of
494 common and unusual cases and interpretation of results
495 with generation of narrative reports.
- 496
- 497 **IV.B. Fellows' Scholarly Activities**
- 498
- 499 *IV.B.1. Each fellow should participate in scholarly activity, including at least one*
500 *of the following:*
- 501
- 502 *IV.B.1.a) research;*
- 503
- 504 *IV.B.1.b) evidence-based presentations at journal club or meetings (local,*

- 505 *regional or national); or,*
506
507 *IV.B.1.c) preparation/submission of articles for peer-reviewed publications.*
508
509 **V. Evaluation**
510
511 **V.A. Fellow Evaluation**
512
513 **V.A.1. Formative Evaluation**
514
515 **V.A.1.a) The faculty must evaluate fellow performance in a timely**
516 **manner.**
517
518 **V.A.1.b) The program must:**
519
520 **V.A.1.b).(1) provide objective assessments of competence in**
521 **patient care, medical knowledge, practice-based**
522 **learning and improvement, interpersonal and**
523 **communication skills, professionalism, and systems-**
524 **based practice;**
525
526 **V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients,**
527 **self, and other professional staff); and,**
528
529 **V.A.1.b).(3) provide each fellow with documented semiannual**
530 **evaluation of performance with feedback.**
531
532 **V.A.1.c) The evaluations of fellow performance must be accessible for**
533 **review by the fellow, in accordance with institutional policy.**
534
535 **V.A.2. Summative Evaluation**
536
537 **The program director must provide a summative evaluation for each**
538 **fellow upon completion of the program. This evaluation must**
539 **become part of the fellow’s permanent record maintained by the**
540 **institution, and must be accessible for review by the fellow in**
541 **accordance with institutional policy. This evaluation must:**
542
543 **V.A.2.a) document the fellow’s performance during their education,**
544 **and**
545
546 **V.A.2.b) verify that the fellow has demonstrated sufficient competence**
547 **to enter practice without direct supervision.**
548
549 **V.B. Faculty Evaluation**
550
551 **V.B.1. At least annually, the program must evaluate faculty performance as**
552 **it relates to the educational program.**
553
554 **V.B.2. These evaluations should include a review of the faculty’s clinical**

- 555 teaching abilities, commitment to the educational program, clinical
556 knowledge, professionalism, and scholarly activities.
557
- 558 **V.C. Program Evaluation and Improvement**
559
- 560 **V.C.1. The program must document formal, systematic evaluation of the**
561 **curriculum at least annually. The program must monitor and track**
562 **each of the following areas:**
563
- 564 **V.C.1.a) fellow performance, and**
565
- 566 **V.C.1.b) faculty development**
567
- 568 **V.C.2. If deficiencies are found, the program should prepare a written plan**
569 **of action to document initiatives to improve performance in the**
570 **areas listed in section V.C.1. The action plan should be reviewed**
571 **and approved by the teaching faculty and documented in meeting**
572 **minutes.**
573
- 574 **V.C.3. 60 percent of the program's graduates from the preceding five years**
575 **taking the ABP certifying examination for pediatric pathology for the first**
576 **time must pass.**
577
- 578 **VI. Fellow Duty Hours in the Learning and Working Environment**
579
- 580 **VI.A. Professionalism, Personal Responsibility, and Patient Safety**
581
- 582 **VI.A.1. Programs and sponsoring institutions must educate fellows and**
583 **faculty members concerning the professional responsibilities of**
584 **physicians to appear for duty appropriately rested and fit to provide**
585 **the services required by their patients.**
586
- 587 **VI.A.2. The program must be committed to and responsible for promoting**
588 **patient safety and fellow well-being in a supportive educational**
589 **environment.**
590
- 591 **VI.A.3. The program director must ensure that fellows are integrated and**
592 **actively participate in interdisciplinary clinical quality improvement**
593 **and patient safety programs.**
594
- 595 **VI.A.4. The learning objectives of the program must:**
596
- 597 **VI.A.4.a) be accomplished through an appropriate blend of supervised**
598 **patient care responsibilities, clinical teaching, and didactic**
599 **educational events; and,**
600
- 601 **VI.A.4.b) not be compromised by excessive reliance on fellows to fulfill**
602 **non-physician service obligations.**
603
- 604 **VI.A.5. The program director and sponsoring institution must ensure a**

605 culture of professionalism that supports patient safety and personal
606 responsibility. Fellows and faculty members must demonstrate an
607 understanding and acceptance of their personal role in the
608 following:

- 609
- 610 **VI.A.5.a)** assurance of the safety and welfare of patients entrusted to
611 their care;
- 612
- 613 **VI.A.5.b)** provision of patient- and family-centered care;
- 614
- 615 **VI.A.5.c)** assurance of their fitness for duty;
- 616
- 617 **VI.A.5.d)** management of their time before, during, and after clinical
618 assignments;
- 619
- 620 **VI.A.5.e)** recognition of impairment, including illness and fatigue, in
621 themselves and in their peers;
- 622
- 623 **VI.A.5.f)** attention to lifelong learning;
- 624
- 625 **VI.A.5.g)** the monitoring of their patient care performance improvement
626 indicators; and,
- 627
- 628 **VI.A.5.h)** honest and accurate reporting of duty hours, patient
629 outcomes, and clinical experience data.
- 630
- 631 **VI.A.6.** All fellows and faculty members must demonstrate responsiveness
632 to patient needs that supersedes self-interest. Physicians must
633 recognize that under certain circumstances, the best interests of the
634 patient may be served by transitioning that patient's care to another
635 qualified and rested provider.

636

637 **VI.B. Transitions of Care**

638

- 639 **VI.B.1.** Programs must design clinical assignments to minimize the number
640 of transitions in patient care.
- 641
- 642 **VI.B.2.** Sponsoring institutions and programs must ensure and monitor
643 effective, structured hand-over processes to facilitate both
644 continuity of care and patient safety.
- 645
- 646 **VI.B.3.** Programs must ensure that fellows are competent in communicating
647 with team members in the hand-over process.
- 648
- 649 **VI.B.4.** The sponsoring institution must ensure the availability of schedules
650 that inform all members of the health care team of attending
651 physicians and fellows currently responsible for each patient's care.

652

653 **VI.C. Alertness Management/Fatigue Mitigation**

654

- 655 **VI.C.1.** **The program must:**
656
657 **VI.C.1.a)** **educate all faculty members and fellows to recognize the**
658 **signs of fatigue and sleep deprivation;**
659
660 **VI.C.1.b)** **educate all faculty members and fellows in alertness**
661 **management and fatigue mitigation processes; and,**
662
663 **VI.C.1.c)** **adopt fatigue mitigation processes to manage the potential**
664 **negative effects of fatigue on patient care and learning, such**
665 **as naps or back-up call schedules.**
666
667 **VI.C.2.** **Each program must have a process to ensure continuity of patient**
668 **care in the event that a fellow may be unable to perform his/her**
669 **patient care duties.**
670
671 **VI.C.3.** **The sponsoring institution must provide adequate sleep facilities**
672 **and/or safe transportation options for fellows who may be too**
673 **fatigued to safely return home.**
674
675 **VI.D.** **Supervision of Fellows**
676
677 **VI.D.1.** **In the clinical learning environment, each patient must have an**
678 **identifiable, appropriately-credentialed and privileged attending**
679 **physician (or licensed independent practitioner as approved by each**
680 **Review Committee) who is ultimately responsible for that patient’s**
681 **care.**
682
683 **VI.D.1.a)** **This information should be available to fellows, faculty**
684 **members, and patients.**
685
686 **VI.D.1.b)** **Fellows and faculty members should inform patients of their**
687 **respective roles in each patient’s care.**
688
689 **VI.D.2.** **The program must demonstrate that the appropriate level of**
690 **supervision is in place for all fellows who care for patients.**
691
692 **Supervision may be exercised through a variety of methods. Some**
693 **activities require the physical presence of the supervising faculty**
694 **member. For many aspects of patient care, the supervising**
695 **physician may be a more advanced fellow. Other portions of care**
696 **provided by the fellow can be adequately supervised by the**
697 **immediate availability of the supervising faculty member or fellow**
698 **physician, either in the institution, or by means of telephonic and/or**
699 **electronic modalities. In some circumstances, supervision may**
700 **include post-hoc review of fellow-delivered care with feedback as to**
701 **the appropriateness of that care.**
702
703 **VI.D.3.** **Levels of Supervision**
704

705 To ensure oversight of fellow supervision and graded authority and
706 responsibility, the program must use the following classification of
707 supervision:
708

709 **VI.D.3.a)** Direct Supervision – the supervising physician is physically
710 present with the fellow and patient.

711 **VI.D.3.b)** Indirect Supervision:

712 **VI.D.3.b).(1)** with direct supervision immediately available – the
713 supervising physician is physically within the hospital
714 or other site of patient care, and is immediately
715 available to provide Direct Supervision.
716

717 **VI.D.3.b).(2)** with direct supervision available – the supervising
718 physician is not physically present within the hospital
719 or other site of patient care, but is immediately
720 available by means of telephonic and/or electronic
721 modalities, and is available to provide Direct
722 Supervision.
723

724 **VI.D.3.c)** Oversight – the supervising physician is available to provide
725 review of procedures/encounters with feedback provided
726 after care is delivered.
727

728 **VI.D.4.** The privilege of progressive authority and responsibility, conditional
729 independence, and a supervisory role in patient care delegated to
730 each fellow must be assigned by the program director and faculty
731 members.
732

733 **VI.D.4.a)** The program director must evaluate each fellow’s abilities
734 based on specific criteria. When available, evaluation should
735 be guided by specific national standards-based criteria.
736

737 **VI.D.4.b)** Faculty members functioning as supervising physicians
738 should delegate portions of care to fellows, based on the
739 needs of the patient and the skills of the fellows.
740

741 **VI.D.4.c)** Fellows should serve in a supervisory role of residents or
742 junior fellows in recognition of their progress toward
743 independence, based on the needs of each patient and the
744 skills of the individual fellow.
745

746 **VI.D.5.** Programs must set guidelines for circumstances and events in
747 which fellows must communicate with appropriate supervising
748 faculty members, such as the transfer of a patient to an intensive
749 care unit, or end-of-life decisions.
750

751 **VI.D.5.a)** Each fellow must know the limits of his/her scope of
752 authority, and the circumstances under which he/she is
753
754

755 permitted to act with conditional independence.
756
757 **VI.D.6.** Faculty supervision assignments should be of sufficient duration to
758 assess the knowledge and skills of each fellow and delegate to
759 him/her the appropriate level of patient care authority and
760 responsibility.
761
762 **VI.E.** **Clinical Responsibilities**
763
764 The clinical responsibilities for each fellow must be based on PGY-level,
765 patient safety, fellow education, severity and complexity of patient
766 illness/condition and available support services.
767
768 *[Optimal clinical workload will be further specified by each Review Committee.]*
769
770 **VI.F.** **Teamwork**
771
772 Fellows must care for patients in an environment that maximizes effective
773 communication. This must include the opportunity to work as a member of
774 effective interprofessional teams that are appropriate to the delivery of care
775 in the specialty.
776
777 *[Each Review Committee will define the elements that must be present in each*
778 *specialty.]*
779
780 **VI.G.** **Fellow Duty Hours**
781
782 **VI.G.1.** **Maximum Hours of Work per Week**
783
784 Duty hours must be limited to 80 hours per week, averaged over a
785 four-week period, inclusive of all in-house call activities and all
786 moonlighting.
787
788 **VI.G.1.a)** **Duty Hour Exceptions**
789
790 A Review Committee may grant exceptions for up to 10% or a
791 maximum of 88 hours to individual programs based on a
792 sound educational rationale.
793
794 **VI.G.1.a).(1)** In preparing a request for an exception the program
795 director must follow the duty hour exception policy
796 from the ACGME Manual on Policies and Procedures.
797
798 **VI.G.1.a).(2)** Prior to submitting the request to the Review
799 Committee, the program director must obtain approval
800 of the institution's GMEC and DIO.
801
802 **VI.G.2.** **Moonlighting**
803
804 **VI.G.2.a)** **Moonlighting must not interfere with the ability of the fellow**

805 to achieve the goals and objectives of the educational
806 program.
807

808 **VI.G.2.b)** Time spent by fellows in Internal and External Moonlighting
809 (as defined in the ACGME Glossary of Terms) must be
810 counted towards the 80-hour Maximum Weekly Hour Limit.
811

812 **VI.G.3.** **Mandatory Time Free of Duty**
813
814 Fellows must be scheduled for a minimum of one day free of duty
815 every week (when averaged over four weeks). At-home call cannot
816 be assigned on these free days.
817

818 **VI.G.4.** **Maximum Duty Period Length**
819
820 Duty periods of fellows may be scheduled to a maximum of 24 hours
821 of continuous duty in the hospital. Programs must encourage
822 fellows to use alertness management strategies in the context of
823 patient care responsibilities. Strategic napping, especially after 16
824 hours of continuous duty and between the hours of 10:00 p.m. and
825 8:00 a.m., is strongly suggested.
826

827 **VI.G.4.a)** It is essential for patient safety and fellow education that
828 effective transitions in care occur. Fellows may be allowed to
829 remain on-site in order to accomplish these tasks; however,
830 this period of time must be no longer than an additional four
831 hours.
832

833 **VI.G.4.b)** Fellows must not be assigned additional clinical
834 responsibilities after 24 hours of continuous in-house duty.
835

836 **VI.G.4.c)** In unusual circumstances, fellows, on their own initiative,
837 may remain beyond their scheduled period of duty to
838 continue to provide care to a single patient. Justifications for
839 such extensions of duty are limited to reasons of required
840 continuity for a severely ill or unstable patient, academic
841 importance of the events transpiring, or humanistic attention
842 to the needs of a patient or family.
843

844 **VI.G.4.c).(1)** Under those circumstances, the fellow must:
845

846 **VI.G.4.c).(1).(a)** appropriately hand over the care of all other
847 patients to the team responsible for their
848 continuing care; and,
849

850 **VI.G.4.c).(1).(b)** document the reasons for remaining to care for
851 the patient in question and submit that
852 documentation in every circumstance to the
853 program director.
854

855 VI.G.4.c).(2) The program director must review each submission of
856 additional service, and track both individual fellow and
857 program-wide episodes of additional duty.
858

859 VI.G.5. Minimum Time Off between Scheduled Duty Periods
860

861 VI.G.5.a) Fellows in the final years of education *[as defined by the*
862 *Review Committee]* must be prepared to enter the
863 unsupervised practice of medicine and care for patients over
864 irregular or extended periods.
865

866 VI.G.5.a).(1) This preparation must occur within the context of the
867 80-hour, maximum duty period length, and one-day-
868 off-in-seven standards. While it is desirable that
869 fellows in their final years of education have eight
870 hours free of duty between scheduled duty periods,
871 there may be circumstances *[as defined by the Review*
872 *Committee]* when these fellows must stay on duty to
873 care for their patients or return to the hospital with
874 fewer than eight hours free of duty.
875

876 VI.G.5.a).(1).(a) Circumstances of return-to-hospital activities
877 with fewer than eight hours away from the
878 hospital by fellows in their final years of
879 education must be monitored by the program
880 director.
881

882 VI.G.6. Maximum Frequency of In-House Night Float
883

884 Fellows must not be scheduled for more than six consecutive nights
885 of night float.
886

887 *[The maximum number of consecutive weeks of night float, and maximum*
888 *number of months of night float per year may be further specified by the*
889 *Review Committee.]*
890

891 VI.G.7. Maximum In-House On-Call Frequency
892

893 Fellows must be scheduled for in-house call no more frequently than
894 every-third-night (when averaged over a four-week period).
895

896 VI.G.8. At-Home Call
897

898 VI.G.8.a) Time spent in the hospital by fellows on at-home call must
899 count towards the 80-hour maximum weekly hour limit. The
900 frequency of at-home call is not subject to the every-third-
901 night limitation, but must satisfy the requirement for one-day-
902 in-seven free of duty, when averaged over four weeks.
903

904 VI.G.8.a).(1) At-home call must not be so frequent or taxing as to

905
906
907
908
909
910
911
912
913
914

VI.G.8.b)

preclude rest or reasonable personal time for each fellow.

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”.
