

1 **ACGME Program Requirements for Graduate Medical Education**
2 **in Complex General Surgical Oncology**

3
4 **Common Program Requirements are in BOLD**

5 Effective Date: _____
6

7 **Introduction**

8
9 **Int.A. Residency and fellowship programs are essential dimensions of the**
10 **transformation of the medical student to the independent practitioner along**
11 **the continuum of medical education. They are physically, emotionally, and**
12 **intellectually demanding, and require longitudinally-concentrated effort on**
13 **the part of the resident or fellow.**

14
15 **The specialty education of physicians to practice independently is**
16 **experiential, and necessarily occurs within the context of the health care**
17 **delivery system. Developing the skills, knowledge, and attitudes leading to**
18 **proficiency in all the domains of clinical competency requires the resident**
19 **and fellow physician to assume personal responsibility for the care of**
20 **individual patients. For the resident and fellow, the essential learning**
21 **activity is interaction with patients under the guidance and supervision of**
22 **faculty members who give value, context, and meaning to those**
23 **interactions. As residents and fellows gain experience and demonstrate**
24 **growth in their ability to care for patients, they assume roles that permit**
25 **them to exercise those skills with greater independence. This concept—**
26 **graded and progressive responsibility—is one of the core tenets of**
27 **American graduate medical education. Supervision in the setting of**
28 **graduate medical education has the goals of assuring the provision of safe**
29 **and effective care to the individual patient; assuring each resident’s and**
30 **fellow’s development of the skills, knowledge, and attitudes required to**
31 **enter the unsupervised practice of medicine; and establishing a foundation**
32 **for continued professional growth.**

33
34 **Int.B. A surgical oncologist is a well-qualified surgeon who has obtained additional**
35 **education and experience in the multidisciplinary approach to the prevention,**
36 **diagnosis, treatment, and rehabilitation of cancer patients, and devotes a major**
37 **portion of his or her professional practice to these activities and cancer research.**
38 **Surgical oncology specialists interact with other oncologic disciplines and provide**
39 **leadership to the surgical, medical, and lay communities in matters pertaining to**
40 **cancer.**

41
42 **Int.C. The educational program in complex general surgical oncology must be 24**
43 **months in length.**

44
45 **I. Institutions**

46
47 **I.A. Sponsoring Institution**

48
49 **One sponsoring institution must assume ultimate responsibility for the**
50 **program, as described in the Institutional Requirements, and this**
51 **responsibility extends to fellow assignments at all participating sites.**

52
53 **The sponsoring institution and the program must ensure that the program**
54 **director has sufficient protected time and financial support for his or her**
55 **educational and administrative responsibilities to the program.**
56

57 I.A.1. The complex general surgical oncology program must be affiliated with an
58 ACGME-accredited general surgery program.
59

60 I.A.2. The complex general surgical oncology program must be affiliated with an
61 ACGME-accredited medical oncology program.
62

63 **I.B. Participating Sites**
64

65 **I.B.1. There must be a program letter of agreement (PLA) between the**
66 **program and each participating site providing a required**
67 **assignment. The PLA must be renewed at least every five years.**
68

69 **The PLA should:**
70

71 **I.B.1.a) identify the faculty who will assume both educational and**
72 **supervisory responsibilities for fellows;**
73

74 **I.B.1.b) specify their responsibilities for teaching, supervision, and**
75 **formal evaluation of fellows, as specified later in this**
76 **document;**
77

78 **I.B.1.c) specify the duration and content of the educational**
79 **experience; and,**
80

81 **I.B.1.d) state the policies and procedures that will govern fellow**
82 **education during the assignment.**
83

84 **I.B.2. The program director must submit any additions or deletions of**
85 **participating sites routinely providing an educational experience,**
86 **required for all fellows, of one month full time equivalent (FTE) or**
87 **more through the Accreditation Council for Graduate Medical**
88 **Education (ACGME) Accreditation Data System (ADS).**
89

90 I.B.3. Sites that are integrated with the sponsoring institution must have an
91 integration agreement specifying that the program director must:
92

93 I.B.3.a) appoint the members of the faculty at the integrated site;
94

95 I.B.3.b) appoint the chief or director of the teaching service in the
96 integrated site;
97

98 I.B.3.c) appoint all fellows in the program; and,
99

100 I.B.3.d) determine all rotations and assignments for both fellows and
101 faculty supervisors.
102

103 I.B.4. Integrated sites must be in close geographic proximity to allow all fellows
104 to attend joint conferences, basic science lectures, and morbidity and
105 mortality reviews regularly and in a central location. If the sites are
106 geographically so remote that joint conferences cannot be held, an
107 equivalent educational program of lectures and conferences at the
108 integrated site must be fully documented.
109

110 I.B.5. The Review Committee must approve all integrated sites in advance.
111

112 II. Program Personnel and Resources

113 II.A. Program Director

114
115
116 II.A.1. **There must be a single program director with authority and
117 accountability for the operation of the program. The sponsoring
118 institution's GMEC must approve a change in program director.
119 After approval, the program director must submit this change to the
120 ACGME via the ADS.**
121

122 II.A.2. **Qualifications of the program director must include:**

123
124 II.A.2.a) **requisite specialty expertise and documented educational
125 and administrative experience acceptable to the Review
126 Committee;**
127

128 II.A.2.b) **current certification in the subspecialty by the American
129 Board of Surgery or subspecialty qualifications that are
130 acceptable to the Review Committee;**
131

132 II.A.2.c) **current medical licensure and appropriate medical staff
133 appointment; and,**
134

135 II.A.2.d) **successful completion of a complex general surgical oncology
136 program, sponsored by the Society of Surgical Oncology or
137 accredited by the ACGME.**
138

139 II.A.3. **The program director must administer and maintain an educational
140 environment conducive to educating the fellows in each of the
141 ACGME competency areas. The program director must:**
142

143 II.A.3.a) **prepare and submit all information required and requested by
144 the ACGME;**
145

146 II.A.3.b) **be familiar with and oversee compliance with ACGME and
147 Review Committee policies and procedures as outlined in the
148 ACGME Manual of Policies and Procedures;**
149

150 II.A.3.c) **obtain review and approval of the sponsoring institution's
151 GMEC/DIO before submitting to the ACGME information or
152 requests for the following:**
153

- 154 **II.A.3.c).(1)** all applications for ACGME accreditation of new
155 programs;
- 156
- 157 **II.A.3.c).(2)** changes in fellow complement;
- 158
- 159 **II.A.3.c).(3)** major changes in program structure or length of
160 training;
- 161
- 162 **II.A.3.c).(4)** progress reports requested by the Review Committee;
- 163
- 164 **II.A.3.c).(5)** responses to all proposed adverse actions;
- 165
- 166 **II.A.3.c).(6)** requests for increases or any change to fellow duty
167 hours;
- 168
- 169 **II.A.3.c).(7)** voluntary withdrawals of ACGME-accredited
170 programs;
- 171
- 172 **II.A.3.c).(8)** requests for appeal of an adverse action; and,
- 173
- 174 **II.A.3.c).(9)** appeal presentations to a Board of Appeal or the
175 ACGME.
- 176
- 177 **II.A.3.d)** obtain DIO review and co-signature on all program
178 information forms, as well as any correspondence or
179 document submitted to the ACGME that addresses:
- 180
- 181 **II.A.3.d).(1)** program citations, and/or
- 182
- 183 **II.A.3.d).(2)** request for changes in the program that would have
184 significant impact, including financial, on the program
185 or institution.
- 186
- 187 **II.A.3.e)** develop and implement lines of authority specifying expected
188 reporting relationships for fellows and faculty members to
189 maximize quality care and patient safety.
- 190
- 191 **II.A.4.** The program director must be appointed for a minimum of three years.
- 192
- 193 **II.B. Faculty**
- 194
- 195 **II.B.1.** There must be a sufficient number of faculty with documented
196 qualifications to instruct and supervise all fellows.
- 197
- 198 **II.B.2.** The faculty must devote sufficient time to the educational program
199 to fulfill their supervisory and teaching responsibilities and
200 demonstrate a strong interest in the education of fellows.
- 201
- 202 **II.B.3.** The physician faculty must have current certification in the
203 subspecialty by the American Board of Surgery, or possess
204 qualifications acceptable to the Review Committee.

- 205
206 II.B.3.a) Physician faculty members must have successfully completed a
207 complex general surgical oncology program, sponsored by the
208 Society of Surgical Oncology or accredited by the ACGME.
209
- 210 **II.B.4. The physician faculty must possess current medical licensure and**
211 **appropriate medical staff appointment.**
212
- 213 II.B.5. In addition to the program director, the faculty must include:
214
- 215 II.B.5.a) at least one full-time physician faculty member for each approved
216 fellowship position, whose major function is to support the
217 fellowship program; and,
218
- 219 II.B.5.b) at least one qualified medical oncologist and one qualified
220 radiation oncologist to contribute to the inter-disciplinary education
221 of fellows in the care of cancer patients.
222
- 223 II.B.6. Physician faculty members must establish and maintain an environment
224 of inquiry and scholarship with an active research component.
225
- 226 II.B.7. Some members of the physician faculty should also demonstrate
227 scholarship by one or more of the following:
228
- 229 II.B.7.a) peer-reviewed funding;
230
- 231 II.B.7.b) publication of original research or review articles in peer-reviewed
232 journals, or chapters in textbooks;
233
- 234 II.B.7.c) publication or presentation of case reports or clinical series at
235 local, regional, or national professional and scientific society
236 meetings; or,
237
- 238 II.B.7.d) participation in national committees or educational organizations.
239
- 240 II.B.8. Non-physician faculty members must have appropriate qualifications in
241 their fields, and hold appropriate institutional appointments.
242
- 243 **II.C. Other Program Personnel**
244
- 245 **The institution and the program must jointly ensure the availability of all**
246 **necessary professional, technical, and clerical personnel for the effective**
247 **administration of the program.**
248
- 249 **II.D. Resources**
250
- 251 **The institution and the program must jointly ensure the availability of**
252 **adequate resources for fellow education, as defined in the specialty**
253 **program requirements.**
254
- 255 II.D.1. Each participating site must provide the following resources:

- 256
257 II.D.1.a) inpatient surgical admissions services;
258
259 II.D.1.b) intensive care units; and,
260
261 II.D.1.c) services, including emergency services, pathology, and radiology.
262

263 **II.E. Medical Information Access**

264
265 **Fellows must have ready access to specialty-specific and other appropriate**
266 **reference material in print or electronic format. Electronic medical literature**
267 **databases with search capabilities should be available.**
268

269 **III. Fellow Appointments**

270
271 **III.A. Eligibility Criteria**

272
273 **Each fellow must successfully complete an ACGME-accredited specialty**
274 **program and/or meet other eligibility criteria as specified by the Review**
275 **Committee. The program must document that each fellow has met the**
276 **eligibility criteria.**
277

278 III.A.1. Prior to appointment, fellows must meet at least one of the following:

279
280 III.A.1.a) satisfactorily complete a general surgery program accredited by
281 the ACGME, or a general surgery program in Canada accredited
282 by the Royal College of Physicians and Surgeons of Canada;

283
284 III.A.1.b) be admissible to examination by the American Board of Surgery;
285 or,

286
287 III.A.1.c) be certified by the American Board of Surgery.
288

289 **III.B. Number of Fellows**

290
291 **The program director may not appoint more fellows than approved by the**
292 **Review Committee, unless otherwise stated in the specialty-specific**
293 **requirements. The program's educational resources must be adequate to**
294 **support the number of fellows appointed to the program.**
295

296 III.B.1. Both temporary increases longer than three months and permanent
297 increases in fellow complement must be approved in advance by the
298 Review Committee.
299

300 III.C. The presence of other learners, including residents from other specialties,
301 subspecialty fellows, PhD students, and nurse practitioners, in the program must
302 not interfere with the appointed fellows' education. The program director must
303 report the presence of other learners to the DIO and GMEC in accordance with
304 sponsoring institution guidelines.
305

306 **IV. Educational Program**

- 307
308 **IV.A. The curriculum must contain the following educational components:**
309
- 310 **IV.A.1. Skills and competencies the fellow will be able to demonstrate at the**
311 **conclusion of the program. The program must distribute these skills**
312 **and competencies to fellows and faculty annually, in either written**
313 **or electronic form. These skills and competencies should be**
314 **reviewed by the fellow at the start of each rotation;**
315
- 316 **IV.A.2. ACGME Competencies**
317
- 318 **The program must integrate the following ACGME competencies**
319 **into the curriculum:**
320
- 321 **IV.A.2.a) Patient Care**
322
- 323 **Fellows must be able to provide patient care that is**
324 **compassionate, appropriate, and effective for the treatment of**
325 **health problems and the promotion of health. Fellows:**
326
- 327 IV.A.2.a).(1) must demonstrate competence in evaluating patients pre-
328 operatively, making appropriate provisional diagnoses,
329 initiating diagnostic procedures, and forming preliminary
330 treatment plans;
331
- 332 IV.A.2.a).(2) must demonstrate competence in oncologic surgical peri-
333 operative management, including:
334
- 335 IV.A.2.a).(2).(a) advanced laparoscopic techniques;
336
- 337 IV.A.2.a).(2).(b) broadly-based oncologic surgical procedures,
338 including those for breast, endocrine,
339 gastrointestinal, gynecological, head and neck,
340 melanoma, and sarcoma conditions.
341
- 342 IV.A.2.a).(2).(c) endoscopy; and,
343
- 344 IV.A.2.a).(2).(d) staging methodologies and procedures for all
345 common surgical malignancies.
346
- 347 IV.A.2.a).(3) must demonstrate competence in the care of critically-ill
348 surgical patients, including:
349
- 350 IV.A.2.a).(3).(a) applying sound principles of pharmacology for each
351 form of therapy;
352
- 353 IV.A.2.a).(3).(b) evaluating and managing patients receiving
354 chemotherapy, hormonal therapy, and
355 immunotherapy; and,
356
- 357 IV.A.2.a).(3).(c) providing supportive care to cancer patients,

358		including pain management.
359		
360	IV.A.2.a).(4)	must demonstrate competence in performing cancer-
361		related operative procedures (a minimum of 150 cancer-
362		related operative procedures must be performed);
363		
364	IV.A.2.a).(5)	must demonstrate competence in the surgical
365		management of patients undergoing predominantly
366		medical therapy, including:
367		
368	IV.A.2.a).(5).(a)	endoscopic procedures of the aerodigestive tract;
369		
370	IV.A.2.a).(5).(b)	insertion of indwelling access devices for systemic
371		or regional chemotherapy;
372		
373	IV.A.2.a).(5).(c)	management of distant metastatic disease,
374		including resection; and,
375		
376	IV.A.2.a).(5).(d)	minimally invasive surgery, particularly as it applies
377		to the staging of cancer.
378		
379	IV.A.2.a).(6)	must demonstrate competence in providing state-of-the-art
380		surgical care to patients with complex or recurrent
381		neoplasms, including:
382		
383	IV.A.2.a).(6).(a)	diagnosis and management of rare or unusual
384		tumors based on knowledge of the natural history
385		of such cancers; and,
386		
387	IV.A.2.a).(6).(a).(i)	This must include determining the disease
388		stage and treatment options for individual
389		cancer patients at the time of diagnosis and
390		throughout the disease course.
391		
392	IV.A.2.a).(6).(b)	selecting patients for surgical therapy in
393		combination with other forms of cancer treatment.
394		
395	IV.A.2.a).(6).(b).(i)	This must include performing palliative
396		surgical procedures appropriate for each
397		patient.
398		
399	IV.A.2.b)	Medical Knowledge
400		
401		Fellows must demonstrate knowledge of established and
402		evolving biomedical, clinical, epidemiological and social-
403		behavioral sciences, as well as the application of this
404		knowledge to patient care. Fellows:
405		
406	IV.A.2.b).(1)	must demonstrate competence in their knowledge of:
407		

408	IV.A.2.b).(1).(a)	the benefits and risks associated with a multidisciplinary approach;
409		
410		
411	IV.A.2.b).(1).(b)	the fundamental biology of cancer, clinical pharmacology, tumor immunology, and endocrinology, as well as potential complications of multimodality therapy;
412		
413		
414		
415		
416	IV.A.2.b).(1).(b).(i)	This must include the biologic, pharmacologic, and physiologic rationale for each form of therapy, as well as the indications, risks, and benefits of regional and systemic therapy in the adjuvant and advanced disease settings.
417		
418		
419		
420		
421		
422		
423	IV.A.2.b).(1).(c)	nonsurgical cancer treatment modalities, including radiotherapy, chemotherapy, immunotherapy, and endocrine therapy;
424		
425		
426		
427	IV.A.2.b).(1).(d)	nonsurgical palliative treatments;
428		
429	IV.A.2.b).(1).(e)	rehabilitative services in various settings, including reconstructive surgery and physical rehabilitation;
430		and,
431		
432		
433	IV.A.2.b).(1).(f)	tumor biology, carcinogenesis, epidemiology, tumor markers, and tumor pathology.
434		

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:

435		
436	IV.A.2.c)	Practice-based Learning and Improvement
437		
438		Fellows are expected to develop skills and habits to be able to meet the following goals:
439		
440		
441	IV.A.2.c).(1)	systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
442		
443		
444		
445	IV.A.2.c).(2)	locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;
446		
447		
448		
449	IV.A.2.c).(3)	demonstrate competence in:
450		
451	IV.A.2.c).(3).(a)	educating students and physicians in the multimodality management of cancer patients;
452		
453		
454	IV.A.2.c).(3).(b)	educating non-physicians (physician assistants, oncology nurses, enterostomal therapists, etc.) in specialized cancer care; and,
455		
456		
457		

458 IV.A.2.c).(3).(c) organizing and conducting cancer-related public
459 education programs.

460
461 **IV.A.2.d) Interpersonal and Communication Skills**

462
463 **Fellows must demonstrate interpersonal and communication**
464 **skills that result in the effective exchange of information and**
465 **collaboration with patients, their families, and health**
466 **professionals.**

467
468 IV.A.2.d).(1) Fellows must demonstrate competence as consultants in
469 the emergency department and with other specialists,
470 including neonatologists and intensivists.

471
472 **IV.A.2.e) Professionalism**

473
474 **Fellows must demonstrate a commitment to carrying out**
475 **professional responsibilities and an adherence to ethical**
476 **principles.**

477
478 **IV.A.2.f) Systems-based Practice**

479
480 **Fellows must demonstrate an awareness of and**
481 **responsiveness to the larger context and system of health**
482 **care, as well as the ability to call effectively on other**
483 **resources in the system to provide optimal health care.**

484
485 IV.A.2.f).(1) Fellows must demonstrate leadership skills to develop and
486 support:

487
488 IV.A.2.f).(1).(a) institutional policies regarding cancer programs and
489 problems;

490
491 IV.A.2.f).(1).(b) institutional programs relating to cancer, including a
492 tumor registry and psychosocial and rehabilitative
493 programs for cancer patients and their families;
494 and,

495
496 IV.A.2.f).(1).(c) interdisciplinary meetings and discussions to
497 include cancer topics, patient care, and the
498 oncology research program.

499
500 **IV.A.3. Curriculum Organization and Fellow Experiences**

501
502 IV.A.3.a) The curriculum must provide at least:

503
504 IV.A.3.a).(1) 12 months of education in clinical surgical oncology; and,

505
506 IV.A.3.a).(2) four months of clinical or laboratory research.

507
508 IV.A.3.a).(2).(a) Fellows must have access to faculty members who

509 can mentor them in basic science research and
510 have time for such an experience if desired.
511
512 IV.A.3.b) The curriculum should include a minimum of one month each in
513 medical oncology, radiation oncology, and pathology, or provide
514 alternative experiences acceptable to the Review Committee.
515
516 IV.A.3.c) The didactic curriculum must include:
517
518 IV.A.3.c).(1) a structured series of conferences in the basic and clinical
519 sciences fundamental to oncologic surgery, monthly
520 surgical grand rounds, and twice-monthly morbidity and
521 mortality conferences;
522
523 IV.A.3.c).(1).(a) Fellows must organize the formal surgical oncology
524 conferences, grand rounds, and morbidity and
525 mortality conferences, and present a significant
526 share of these conferences.
527
528 IV.A.3.c).(2) at least weekly teaching rounds by oncologic surgical
529 faculty members;
530
531 IV.A.3.c).(3) education in the basic methodology for conducting clinical
532 trials, including biostatistics, clinical research design,
533 ethics, and implementation of computerized databases;
534 and,
535
536 IV.A.3.c).(4) monthly relevant multidisciplinary conferences.
537
538 IV.A.3.d) Each organized clinical discussion, round, journal club, and
539 conference must include participation by at least one member of
540 the faculty.
541
542 IV.A.3.e) Fellow Experiences
543
544 IV.A.3.e).(1) Clinical assignments should include experiences in general
545 surgical oncology, including breast, gastrointestinal
546 oncology, melanoma, sarcoma, and head and neck.
547
548 IV.A.3.e).(2) Fellows must provide outpatient follow-up care for surgical
549 patients.
550
551 IV.A.3.e).(2).(a) Follow-up care should include short- and long-term
552 evaluation and progress, particularly with complex,
553 multi-disciplinary cancer management.
554
555 IV.A.3.e).(2).(b) Fellows must have documented outpatient
556 experience one day per week.
557

- 558 IV.A.3.e).(3) Each fellow must have experiences acting as a teaching
 559 assistant in the operating room when documented
 560 operative experience justifies a teaching role.
 561
 562 IV.A.3.e).(4) Fellows must not share primary responsibility for patients
 563 with the surgery chief resident.
 564
 565 IV.A.3.e).(5) Fellows must have significant teaching responsibilities for
 566 surgery residents, medical students, or other learners.
 567

568 **IV.B. Fellows' Scholarly Activities**

- 569
 570 IV.B.1. Each fellow must complete a course on clinical research on human
 571 subjects, such as the courses approved by the National Institutes of
 572 Health Office for Human Research Protections, or an institution-based
 573 equivalent.
 574
 575 IV.B.2. Fellows must demonstrate the ability to: design and implement a
 576 prospective data base; conduct clinical cancer research, especially
 577 prospective clinical trials; use statistical methods to properly evaluate
 578 results of published research studies; guide other learners or other
 579 personnel in laboratory or clinical oncology research; and navigate the
 580 interface of basic science with clinical cancer care to facilitate
 581 translational research.
 582

583 **V. Evaluation**

584 **V.A. Fellow Evaluation**

585 **V.A.1. Formative Evaluation**

- 586
 587
 588
 589 **V.A.1.a) The faculty must evaluate fellow performance in a timely**
 590 **manner.**
 591
 592 **V.A.1.b) The program must:**
 593
 594 **V.A.1.b).(1) provide objective assessments of competence in**
 595 **patient care, medical knowledge, practice-based**
 596 **learning and improvement, interpersonal and**
 597 **communication skills, professionalism, and systems-**
 598 **based practice;**
 599
 600 **V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients,**
 601 **self, and other professional staff); and,**
 602
 603 **V.A.1.b).(3) provide each fellow with documented semiannual**
 604 **evaluation of performance with feedback.**
 605
 606 **V.A.1.b).(3).(a) The semiannual review must include review of the**
 607 **surgical oncology fellow operative data.**
 608

- 609 **V.A.1.c)** The evaluations of fellow performance must be accessible for
610 review by the fellow, in accordance with institutional policy.
611
- 612 **V.A.2.** **Summative Evaluation**
613
614 The program director must provide a summative evaluation for each
615 fellow upon completion of the program. This evaluation must
616 become part of the fellow’s permanent record maintained by the
617 institution, and must be accessible for review by the fellow in
618 accordance with institutional policy. This evaluation must:
619
- 620 **V.A.2.a)** document the fellow’s performance during their education,
621 and
622
- 623 **V.A.2.b)** verify that the fellow has demonstrated sufficient competence
624 to enter practice without direct supervision.
625
- 626 **V.B.** **Faculty Evaluation**
627
- 628 **V.B.1.** At least annually, the program must evaluate faculty performance as
629 it relates to the educational program.
630
- 631 **V.B.2.** These evaluations should include a review of the faculty’s clinical
632 teaching abilities, commitment to the educational program, clinical
633 knowledge, professionalism, and scholarly activities.
634
- 635 **V.C.** **Program Evaluation and Improvement**
636
- 637 **V.C.1.** The program must document formal, systematic evaluation of the
638 curriculum at least annually. The program must monitor and track
639 each of the following areas:
640
- 641 **V.C.1.a)** fellow performance, and
642
- 643 **V.C.1.b)** faculty development
644
- 645 **V.C.2.** If deficiencies are found, the program should prepare a written plan
646 of action to document initiatives to improve performance in the
647 areas listed in section V.C.1. The action plan should be reviewed
648 and approved by the teaching faculty and documented in meeting
649 minutes.
650
- 651 **VI.** **Fellow Duty Hours in the Learning and Working Environment**
652
- 653 **VI.A.** **Professionalism, Personal Responsibility, and Patient Safety**
654
- 655 **VI.A.1.** Programs and sponsoring institutions must educate fellows and
656 faculty members concerning the professional responsibilities of
657 physicians to appear for duty appropriately rested and fit to provide
658 the services required by their patients.
659

- 660 VI.A.2. The program must be committed to and responsible for promoting
661 patient safety and fellow well-being in a supportive educational
662 environment.
663
- 664 VI.A.3. The program director must ensure that fellows are integrated and
665 actively participate in interdisciplinary clinical quality improvement
666 and patient safety programs.
667
- 668 VI.A.4. The learning objectives of the program must:
669
- 670 VI.A.4.a) be accomplished through an appropriate blend of supervised
671 patient care responsibilities, clinical teaching, and didactic
672 educational events; and,
673
- 674 VI.A.4.b) not be compromised by excessive reliance on fellows to fulfill
675 non-physician service obligations.
676
- 677 VI.A.5. The program director and sponsoring institution must ensure a
678 culture of professionalism that supports patient safety and personal
679 responsibility. Fellows and faculty members must demonstrate an
680 understanding and acceptance of their personal role in the
681 following:
682
- 683 VI.A.5.a) assurance of the safety and welfare of patients entrusted to
684 their care;
685
- 686 VI.A.5.b) provision of patient- and family-centered care;
687
- 688 VI.A.5.c) assurance of their fitness for duty;
689
- 690 VI.A.5.d) management of their time before, during, and after clinical
691 assignments;
692
- 693 VI.A.5.e) recognition of impairment, including illness and fatigue, in
694 themselves and in their peers;
695
- 696 VI.A.5.f) attention to lifelong learning;
697
- 698 VI.A.5.g) the monitoring of their patient care performance improvement
699 indicators; and,
700
- 701 VI.A.5.h) honest and accurate reporting of duty hours, patient
702 outcomes, and clinical experience data.
703
- 704 VI.A.6. All fellows and faculty members must demonstrate responsiveness
705 to patient needs that supersedes self-interest. Physicians must
706 recognize that under certain circumstances, the best interests of the
707 patient may be served by transitioning that patient's care to another
708 qualified and rested provider.
709
- 710 VI.B. Transitions of Care

- 711
712 **VI.B.1.** **Programs must design clinical assignments to minimize the number**
713 **of transitions in patient care.**
714
- 715 **VI.B.2.** **Sponsoring institutions and programs must ensure and monitor**
716 **effective, structured hand-over processes to facilitate both**
717 **continuity of care and patient safety.**
718
- 719 **VI.B.3.** **Programs must ensure that fellows are competent in communicating**
720 **with team members in the hand-over process.**
721
- 722 **VI.B.4.** **The sponsoring institution must ensure the availability of schedules**
723 **that inform all members of the health care team of attending**
724 **physicians and fellows currently responsible for each patient's care.**
725
- 726 **VI.C. Alertness Management/Fatigue Mitigation**
727
- 728 **VI.C.1. The program must:**
729
- 730 **VI.C.1.a) educate all faculty members and fellows to recognize the**
731 **signs of fatigue and sleep deprivation;**
732
- 733 **VI.C.1.b) educate all faculty members and fellows in alertness**
734 **management and fatigue mitigation processes; and,**
735
- 736 **VI.C.1.c) adopt fatigue mitigation processes to manage the potential**
737 **negative effects of fatigue on patient care and learning, such**
738 **as naps or back-up call schedules.**
739
- 740 **VI.C.2. Each program must have a process to ensure continuity of patient**
741 **care in the event that a fellow may be unable to perform his/her**
742 **patient care duties.**
743
- 744 **VI.C.3. The sponsoring institution must provide adequate sleep facilities**
745 **and/or safe transportation options for fellows who may be too**
746 **fatigued to safely return home.**
747
- 748 **VI.D. Supervision of Fellows**
749
- 750 **VI.D.1. In the clinical learning environment, each patient must have an**
751 **identifiable, appropriately-credentialed and privileged attending**
752 **physician (or licensed independent practitioner as approved by each**
753 **Review Committee) who is ultimately responsible for that patient's**
754 **care.**
755
- 756 **VI.D.1.a) This information should be available to fellows, faculty**
757 **members, and patients.**
758
- 759 **VI.D.1.b) Fellows and faculty members should inform patients of their**
760 **respective roles in each patient's care.**
761

- 762 **VI.D.2.** **The program must demonstrate that the appropriate level of**
763 **supervision is in place for all fellows who care for patients.**
764
765 **Supervision may be exercised through a variety of methods. Some**
766 **activities require the physical presence of the supervising faculty**
767 **member. For many aspects of patient care, the supervising**
768 **physician may be a more advanced fellow. Other portions of care**
769 **provided by the fellow can be adequately supervised by the**
770 **immediate availability of the supervising faculty member or fellow**
771 **physician, either in the institution, or by means of telephonic and/or**
772 **electronic modalities. In some circumstances, supervision may**
773 **include post-hoc review of fellow-delivered care with feedback as to**
774 **the appropriateness of that care.**
775
776 **VI.D.3.** **Levels of Supervision**
777
778 **To ensure oversight of fellow supervision and graded authority and**
779 **responsibility, the program must use the following classification of**
780 **supervision:**
781
782 **VI.D.3.a)** **Direct Supervision – the supervising physician is physically**
783 **present with the fellow and patient.**
784
785 **VI.D.3.b)** **Indirect Supervision:**
786
787 **VI.D.3.b).(1)** **with direct supervision immediately available – the**
788 **supervising physician is physically within the hospital**
789 **or other site of patient care, and is immediately**
790 **available to provide Direct Supervision.**
791
792 **VI.D.3.b).(2)** **with direct supervision available – the supervising**
793 **physician is not physically present within the hospital**
794 **or other site of patient care, but is immediately**
795 **available by means of telephonic and/or electronic**
796 **modalities, and is available to provide Direct**
797 **Supervision.**
798
799 **VI.D.3.c)** **Oversight – the supervising physician is available to provide**
800 **review of procedures/encounters with feedback provided**
801 **after care is delivered.**
802
803 **VI.D.4.** **The privilege of progressive authority and responsibility, conditional**
804 **independence, and a supervisory role in patient care delegated to**
805 **each fellow must be assigned by the program director and faculty**
806 **members.**
807
808 **VI.D.4.a)** **The program director must evaluate each fellow’s abilities**
809 **based on specific criteria. When available, evaluation should**
810 **be guided by specific national standards-based criteria.**
811
812 **VI.D.4.b)** **Faculty members functioning as supervising physicians**

813 should delegate portions of care to fellows, based on the
814 needs of the patient and the skills of the fellows.
815

816 **VI.D.4.c)** Fellows should serve in a supervisory role of residents or
817 junior fellows in recognition of their progress toward
818 independence, based on the needs of each patient and the
819 skills of the individual fellow.
820

821 **VI.D.5.** Programs must set guidelines for circumstances and events in
822 which fellows must communicate with appropriate supervising
823 faculty members, such as the transfer of a patient to an intensive
824 care unit, or end-of-life decisions.
825

826 **VI.D.5.a)** Each fellow must know the limits of his/her scope of
827 authority, and the circumstances under which he/she is
828 permitted to act with conditional independence.
829

830 **VI.D.6.** Faculty supervision assignments should be of sufficient duration to
831 assess the knowledge and skills of each fellow and delegate to
832 him/her the appropriate level of patient care authority and
833 responsibility.
834

835 **VI.E. Clinical Responsibilities**
836

837 The clinical responsibilities for each fellow must be based on PGY-level,
838 patient safety, fellow education, severity and complexity of patient
839 illness/condition and available support services.
840

841 **VI.E.1.** As fellows progress through levels of increasing competence and
842 responsibility, work assignments must keep pace with their level of
843 advancement.
844

845 **VI.F. Teamwork**
846

847 Fellows must care for patients in an environment that maximizes effective
848 communication. This must include the opportunity to work as a member of
849 effective interprofessional teams that are appropriate to the delivery of care
850 in the specialty.
851

852 **VI.F.1.** During the fellow education process, surgical teams should be made up
853 of attending surgeons, fellows, residents at various PG levels, medical
854 students (when appropriate), and other health care providers.
855

856 **VI.F.2.** The work of the caregiver team should be assigned to team members
857 based on each member's level of education, experience, and
858 competence.
859

860 **VI.F.3.** Fellows must collaborate with fellow surgical residents, and especially
861 with faculty members, other physicians outside of their subspecialty, and
862 non-traditional health care providers, to best formulate treatment plans for
863 an increasingly diverse patient population.

864
865 VI.F.4. Fellows must assume personal responsibility to complete all tasks to
866 which they are assigned (or which they voluntarily assume) in a timely
867 fashion. These tasks must be completed in the hours assigned, or, if that
868 is not possible, residents must learn and utilize the established methods
869 for handing off remaining tasks to another member of the health care
870 team so that patient care is not compromised.
871

872 **VI.G. Fellow Duty Hours**

873

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

875
876 **Duty hours must be limited to 80 hours per week, averaged over a**
877 **four-week period, inclusive of all in-house call activities and all**
878 **moonlighting.**
879

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

881
882 **A Review Committee may grant exceptions for up to 10% or a**
883 **maximum of 88 hours to individual programs based on a**
884 **sound educational rationale.**
885

886 **VI.G.1.a).(1) In preparing a request for an exception the program**
887 **director must follow the duty hour exception policy**
888 **from the ACGME Manual on Policies and Procedures.**
889

890 **VI.G.1.a).(2) Prior to submitting the request to the Review**
891 **Committee, the program director must obtain approval**
892 **of the institution's GMEC and DIO.**
893

894 **VI.G.2. Moonlighting**

895

896 **VI.G.2.a) Moonlighting must not interfere with the ability of the fellow**
897 **to achieve the goals and objectives of the educational**
898 **program.**
899

900 **VI.G.2.b) Time spent by fellows in Internal and External Moonlighting**
901 **(as defined in the ACGME Glossary of Terms) must be**
902 **counted towards the 80-hour Maximum Weekly Hour Limit.**
903

904 **VI.G.3. Mandatory Time Free of Duty**

905
906 **Fellows must be scheduled for a minimum of one day free of duty**
907 **every week (when averaged over four weeks). At-home call cannot**
908 **be assigned on these free days.**
909

910 **VI.G.4. Maximum Duty Period Length**

911
912 **Duty periods of fellows may be scheduled to a maximum of 24 hours**
913 **of continuous duty in the hospital. Programs must encourage**
914 **fellows to use alertness management strategies in the context of**

915 patient care responsibilities. Strategic napping, especially after 16
916 hours of continuous duty and between the hours of 10:00 p.m. and
917 8:00 a.m., is strongly suggested.
918

919 **VI.G.4.a)** It is essential for patient safety and fellow education that
920 effective transitions in care occur. Fellows may be allowed to
921 remain on-site in order to accomplish these tasks; however,
922 this period of time must be no longer than an additional four
923 hours.
924

925 **VI.G.4.b)** Fellows must not be assigned additional clinical
926 responsibilities after 24 hours of continuous in-house duty.
927

928 **VI.G.4.c)** In unusual circumstances, fellows, on their own initiative,
929 may remain beyond their scheduled period of duty to
930 continue to provide care to a single patient. Justifications for
931 such extensions of duty are limited to reasons of required
932 continuity for a severely ill or unstable patient, academic
933 importance of the events transpiring, or humanistic attention
934 to the needs of a patient or family.
935

936 **VI.G.4.c).(1)** Under those circumstances, the fellow must:
937

938 **VI.G.4.c).(1).(a)** appropriately hand over the care of all other
939 patients to the team responsible for their
940 continuing care; and,
941

942 **VI.G.4.c).(1).(b)** document the reasons for remaining to care for
943 the patient in question and submit that
944 documentation in every circumstance to the
945 program director.
946

947 **VI.G.4.c).(2)** The program director must review each submission of
948 additional service, and track both individual fellow and
949 program-wide episodes of additional duty.
950

951 **VI.G.5.** **Minimum Time Off between Scheduled Duty Periods**
952

953 **VI.G.5.a)** Fellows in the final years of education must be prepared to
954 enter the unsupervised practice of medicine and care for
955 patients over irregular or extended periods.
956

957 Complex general surgical oncology fellows are considered to be in
958 the final years of education.
959

960 **VI.G.5.a).(1)** This preparation must occur within the context of the
961 80-hour, maximum duty period length, and one-day-
962 off-in-seven standards. While it is desirable that
963 fellows in their final years of education have eight
964 hours free of duty between scheduled duty periods,
965 there may be circumstances when these fellows must

966 stay on duty to care for their patients or return to the
967 hospital with fewer than eight hours free of duty.
968

969 **VI.G.5.a).(1).(a)**

Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by fellows in their final years of education must be monitored by the program director.

974
975 **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.

981
982 **VI.G.6.**

Maximum Frequency of In-House Night Float

983
984 **Fellows must not be scheduled for more than six consecutive nights of night float.**

985
986
987 **VI.G.6.a)**

The total amount of night float for any fellow must be no more than two months per PG year.

988
989
990 **VI.G.7.**

Maximum In-House On-Call Frequency

991
992 **Fellows must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).**

993
994
995 **VI.G.8.**

At-Home Call

996
997 **VI.G.8.a)**

998 **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.**

1000
1001
1002
1003 **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.

1004
1005
1006
1007 **VI.G.8.b)**

1008 **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".**

1009
1010
1011
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1013 ***