Accreditation Council for
Graduate Medical Education

ACGME Program Requirements for Graduate Medical Education in Pediatric Surgery

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Common Program Requirements are in BOLD

Introduction

Int.A. **Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.**

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

Int.B. A fellowship in pediatric surgery provides advanced knowledge and skills in the surgery of infants and children. At the completion of this education, fellows should function as competent pediatric surgeons.

Int.C. The educational program in pediatric surgery must be 24 months in length, of which 48 weeks in each of the two years must comprise clinical pediatric surgery. (Core)*

I. Institutions

I.A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to fellow assignments at all participating sites. (Core)

The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program. (Core)

I.A.1. A pediatric surgery program should be offered in sites accredited by the

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or its equivalent, and which are classified as general hospitals or children's hospitals. (Core)

I.A.1.a) These sites must include facilities and staff with a variety of services, including adequate inpatient surgical admissions, intensive care units for both infants and older children, and departments of radiology, pathology, and emergency in which infants and children can be managed 24 hours a day. (Core)

I.A.2. The educational program must not negatively impact the education of residents in the core surgery program. (Core)

I.A.3. There must be a residency program in pediatrics whose residents rotate through the same integrated site(s) as the pediatric surgical fellows. (Core)

I.B. Participating Sites

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

A participating site is defined as any site to which fellows rotate for assigned experiences.

The PLA should:

I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for fellows; (Detail)

I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of fellows, as specified later in this document; (Detail)

I.B.1.c) specify the duration and content of the educational experience; and, (Detail)

I.B.1.d) state the policies and procedures that will govern fellow education during the assignment. (Detail)

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

I.B.3. Clinical assignments to participating (non-integrated) sites ~~must be scheduled only during the first year of the program, and assignments~~ must not exceed six months in total, and must be approved in advance by the Review Committee. (Core)

I.B.4. Sites may be integrated with the sponsoring institution through an integration agreement specifying that the program director must:

I.B.4.a) appoint the members of the faculty at the integrated site; (Detail)

I.B.4.b) appoint the chief or director of the teaching service in the integrated site; (Detail)

I.B.4.c) appoint all fellows in the program; and, (Detail)

I.B.4.d) determine all rotations and assignments of both fellows and members of the faculty. (Detail)

I.B.5. Integrated sites must be in close geographic proximity to allow all fellows to attend joint conferences, basic science lectures, and morbidity and mortality reviews regularly and in a central location. ((Detail)

I.B.5.a) If the sites are geographically so remote that joint conferences cannot be held, an equivalent educational program of lectures and conferences at the integrated site must be fully documented. (Detail)

I.B.6. The Review Committee must approve all integrations in advance. (Core)

II. Program Personnel and Resources

II.A. Program Director

II.A.1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. (Core)

II.A.1.a) The program director must submit this change to the ACGME via the ADS. (Core)

II.A.2. The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability. (Detail)

II.A.2.a) The length of the appointment must be for at least three years (Detail)

II.A.3. Qualifications of the program director must include:

II.A.3.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee; (Core)

II.A.3.b) current certification in the subspecialty by the American Board of Surgery**, or subspecialty qualifications that are acceptable to the Review Committee;** (Core)

II.A.3.c) **current medical licensure and appropriate medical staff appointment;** (Core)

II.A.3.d) licensure to practice medicine in a state where the sponsoring institution is located; and, (Detail)

II.A.3.e) demonstrated scholarly activity in at least one of the areas listed in section II.B.5.b). (Core)

II.A.4. **The program director must administer and maintain an educational environment conducive to educating the fellows in each of the ACGME competency areas.** (Core)

The program director must:

II.A.4.a) **oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;** (Core)

II.A.4.b) **approve a local director at each participating site who is accountable for fellow education;** (Core)

II.A.4.c) **approve the selection of program faculty as appropriate;** (Core)

II.A.4.d) **evaluate program faculty;** (Core)

II.A.4.e) **approve the continued participation of program faculty based on evaluation;** (Core)

II.A.4.f) **monitor fellow supervision at all participating sites;** (Core)

II.A.4.g) **prepare and submit all information required and requested by the ACGME;** (Core)

II.A.4.g).(1) **This includes, but is not limited to, the program application forms and annual program fellow updates to the ADS, and ensure that the information submitted is accurate and complete.** (Core)

II.A.4.h) **ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;** (Detail)

II.A.4.i) **provide verification of fellowship education for all fellows, including those who leave the program prior to completion;** (Detail)

II.A.4.j) **implement policies and procedures consistent with the institutional and program requirements for fellow duty hours and the working environment, including moonlighting,** (Core)

and, to that end, must:

II.A.4.j).(1) distribute these policies and procedures to the fellows and faculty; (Detail)

II.A.4.j).(2) monitor fellow duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements; (Core)

II.A.4.j).(3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and, (Detail)

II.A.4.j).(4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue. (Detail)

II.A.4.k) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged; (Detail)

II.A.4.l) comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of fellows, disciplinary action, and supervision of fellows; (Detail)

II.A.4.m) be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures; (Detail)

II.A.4.n) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting information or requests to the ACGME, including: (Core)

II.A.4.n).(1) all applications for ACGME accreditation of new programs; (Detail)

II.A.4.n).(2) changes in fellow complement; (Detail)

II.A.4.n).(3) major changes in program structure or length of training; (Detail)

II.A.4.n).(4) progress reports requested by the Review Committee; (Detail)

II.A.4.n).(5) responses to all proposed adverse actions; (Detail)

II.A.4.n).(6) requests for increases or any change to fellow duty hours; (Detail)

II.A.4.n).(7) voluntary withdrawals of ACGME-accredited programs; (Detail)

II.A.4.n).(8) **requests for appeal of an adverse action;** (Detail)

II.A.4.n).(9) **appeal presentations to a Board of Appeal or the ACGME; and,** (Detail)

II.A.4.n).(10) **proposals to ACGME for approval of innovative educational approaches.** (Detail)

II.A.4.o) **obtain DIO review and co-signature on all program application forms, as well as any correspondence or document submitted to the ACGME that addresses:** (Detail)

II.A.4.o).(1) **program citations, and/or,** (Detail)

II.A.4.o).(2) **request for changes in the program that would have significant impact, including financial, on the program or institution.** (Detail)

II.A.4.p) seek prior approval from the Review Committee for the addition of fellow and resident positions in non-accredited programs (e.g., overseas or trauma); and, (Core)

II.A.4.q) monitor and verify fellows' operative data at least semi-annually. (Core)

II.B. Faculty

II.B.1. **At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all fellows at that location.** (Core)

The faculty must:

II.B.1.a) **devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of fellows, and** (Core)

II.B.1.b) **administer and maintain an educational environment conducive to educating fellows in each of the ACGME competency areas.** (Core)

II.B.2. **The physician faculty must have current certification in the subspecialty by the American Board of** Surgery**, or possess qualifications judged acceptable to the Review Committee.** (Core)

II.B.3. **The physician faculty must possess current medical licensure and appropriate medical staff appointment.** (Core)

II.B.3.a) The physician faculty must be licensed to practice medicine in the state where the sponsoring institution is located. (Detail)

II.B.4. **The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.** (Core)

II.B.5. **The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.** (Core)

II.B.5.a) **The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.** (Detail)

II.B.5.b) **Some members of the faculty should also demonstrate scholarship by one or more of the following:**

II.B.5.b).(1) **peer-reviewed funding;** (Detail)

II.B.5.b).(2) **publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;** (Detail)

II.B.5.b).(3) **publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,** (Detail)

II.B.5.b).(4) **participation in national committees or educational organizations.** (Detail)

II.B.5.c) **Faculty should encourage and support fellows in scholarly activities.** (Core)

II.B.6. In addition to the program director, there must be, for each approved residency position, at least one full-time faculty member whose major function is to support the residency program. (Core)

II.B.6.a) These faculty appointments must be of a sufficient length to ensure continuity in the supervision and education of the fellows. (Core)

II.B.7. To contribute to fellow education in the care of critically-ill children, the faculty should include at least: (Core)

II.B.7.a) one neonatologist; and, (Core)

II.B.7.b) one pediatric intensivist. (Core)

II.C. **Other Program Personnel**

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program. (Core)

II.D. **Resources**

The institution and the program must jointly ensure the availability of adequate resources for fellow education, as defined in the specialty program requirements. (Core)

II.D.1. The pediatric surgical service must document a sufficient breadth and volume of procedures to reasonably ensure that each fellow successfully completes the required clinical experience. (Core)

II.D.1.a) There must be at least 1200 procedures performed at the institution annually. (Core)

II.E. Medical Information Access

Fellows must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available. (Detail)

III. Fellow Appointments

III.A. Eligibility Criteria

The program director must comply with the criteria for fellow eligibility as specified in the Institutional Requirements. (Core)

III.A.1. Prior to entry in the program, fellows must: have successfully completed a residency in general surgery accredited by the ACGME or such a program located in Canada and accredited by the Royal College of Physicians and Surgeons of Canada (RCPSC); be admissible to examination by the American Board of Surgery (or its equivalent); or be certified by that board. (Core)

III.B. Number of Fellows

The program's educational resources must be adequate to support the number of fellows appointed to the program. (Core)

III.B.1. The program director may not appoint more fellows than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. (Core)

III.B.2. Both temporary and permanent increases in fellow complement must be approved in advance by the Review Committee. Any increase in the complement must be justified in terms of the educational goals of the program. (Core)

III.C. Fellow Transfers

III.C.1. Before accepting a fellow who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring fellow. (Detail)

III.C.2. **A program director must provide timely verification of fellowship education and summative performance evaluations for fellows who may leave the program prior to completion.** (Detail)

III.D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed fellows' education. (Core)

III.D.1. **The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.** (Detail)

III.D.2. All residents, fellows, and other students in both ACGME-accredited and non-accredited programs in the sponsoring institution and integrated sites who might affect the educational experience of the program fellows must be identified, and, at the time of the site visit, the relationship of these individuals to the program fellows must be confirmed. (Core)

IV. Educational Program

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

IV.A.1. **Overall educational goals for the program, which the program must make available to fellows and faculty;** (Core)

IV.A.2. **Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to fellows and faculty at least annually, in either written or electronic form;** (Core)

IV.A.3. **Regularly scheduled didactic sessions;** (Core)

IV.A.4. **Delineation of fellow responsibilities for patient care, progressive responsibility for patient management, and supervision of fellows over the continuum of the program; and,** (Core)

IV.A.5. **ACGME Competencies**

The program must integrate the following ACGME competencies into the curriculum: (Core)

IV.A.5.a) Patient Care and Procedural Skills

IV.A.5.a).(1) **Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.** (Outcome)

IV.A.5.a).(2) **Fellows must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. Fellows:** (Outcome)

IV.A.5.a).(2).(a) must demonstrate competence in surgical peri-operative management, including: (Outcome)

IV.A.5.a).(2).(a).(i) congenital, neoplastic, infectious, and other acquired conditions of the gastrointestinal system and other abdominal organs; diaphragm and thorax, exclusive of the heart; endocrine glands; head and neck; gonads and reproductive organs; integument; and blood and vascular system;(Outcome)

IV.A.5.a).(2).(a).(ii) operative and non-operative traumatic conditions of the abdomen, chest, head and neck, and extremities, with sufficient experience in the management of children who have sustained injuries to multiple organs; (Outcome)

IV.A.5.a).(2).(a).(iii) endoscopy of the airway and gastrointestinal tract, including laryngoscopy, bronchoscopy, esophagoscopy, gastroduodenoscopy, and lower intestinal endoscopy; (Outcome)

IV.A.5.a).(2).(a).(iv) recognition and management of clotting and coagulation disorders; (Outcome)

IV.A.5.a).(2).(a).(v) advanced laparoscopic and thoracoscopic techniques; and, (Outcome)

IV.A.5.a).(2).(a).(vi) care of the critically-ill infant or child, including: (Outcome)

IV.A.5.a).(2).(a).(vi).(a) cardiopulmonary resuscitation (CPR); (Outcome)

IV.A.5.a).(2).(a).(vi).(b) management of patients on ventilators); and, (Outcome)

IV.A.5.a).(2).(a).(vi).(c) nutritional assessment and management. (Outcome)

IV.A.5.a).(2).(b) must demonstrate competence in the pre-operative evaluation of patients, the making of provisional diagnoses, initiation of diagnostic procedures,

formation of preliminary treatment plans, and provision of outpatient follow-up care of surgical patients. (Outcome)

IV.A.5.a).(2).(b).(i) Follow-up care should include not only short-term but long-term evaluation and progress as well, particularly with major congenital anomalies or neoplasm cases., (Core)

IV.A.5.b) Medical Knowledge

Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Fellows: (Outcome)

IV.A.5.b).(1) must demonstrate competence in their knowledge of the basic principles of cardiothoracic surgery, gynecology, neurological surgery, orthopaedic surgery, otolaryngology, anesthesia, urology, vascular surgery, transplant surgery, and the management of burns; (Outcome)

IV.A.5.b).(2) must demonstrate knowledge of the principles in the management of patients on ventilators and extracorporeal membrane oxygenation (ECMO); and (Outcome)

IV.A.5.b).(3) must demonstrate competence in their knowledge of invasive monitoring techniques and interpretation. (Outcome)

IV.A.5.c) Practice-based Learning and Improvement

Fellows must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. (Outcome)

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

IV.A.5.c).(1) identify strengths, deficiencies, and limits in one's knowledge and expertise; (Outcome)

IV.A.5.c).(2) set learning and improvement goals; (Outcome)

IV.A.5.c).(3) identify and perform appropriate learning activities; (Outcome)

IV.A.5.c).(4) systematically analyze practice using quality improvement methods, and implement changes with

the goal of practice improvement; (Outcome)

IV.A.5.c).(5) **incorporate formative evaluation feedback into daily practice;** (Outcome)

IV.A.5.c).(6) **locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;** (Outcome)

IV.A.5.c).(7) **use information technology to optimize learning;** (Outcome)

IV.A.5.c).(8) **participate in the education of patients, families, students, fellows and other health professionals;** (Outcome)

IV.A.5.c).(9) during their chief pediatric year, personally organize the formal pediatric conferences and morbidity and mortality conferences, and be directly responsible for a significant share of these conferences; and, (Outcome)

IV.A.5.c).(10) have significant responsibilities for teaching junior residents and medical students. (Outcome)

IV.A.5.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. (Outcome)

Fellows are expected to:

IV.A.5.d).(1) **communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;** (Outcome)

IV.A.5.d).(2) **communicate effectively with physicians, other health professionals, and health related agencies;** (Outcome)

IV.A.5.d).(3) **work effectively as a member or leader of a health care team or other professional group;** (Outcome)

IV.A.5.d).(4) **act in a consultative role to other physicians and health professionals;** (Outcome)

IV.A.5.d).(5) **maintain comprehensive, timely, and legible medical records, if applicable; and,** (Outcome)

IV.A.5.d).(6) provide care as consultants, under appropriate supervision, in the emergency department and with other

specialists such as neonatologists and intensivists. (Outcome)

IV.A.5.e) Professionalism

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

Fellows are expected to demonstrate:

IV.A.5.e).(1) **compassion, integrity, and respect for others;** (Outcome)

IV.A.5.e).(2) **responsiveness to patient needs that supersedes self-interest;** (Outcome)

IV.A.5.e).(3) **respect for patient privacy and autonomy;** (Outcome)

IV.A.5.e).(4) **accountability to patients, society and the profession; and,** (Outcome)

IV.A.5.e).(5) **sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.** (Outcome)

IV.A.5.f) Systems-based Practice

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

Fellows are expected to:

IV.A.5.f).(1) **work effectively in various health care delivery settings and systems relevant to their clinical specialty;** (Outcome)

IV.A.5.f).(2) **coordinate patient care within the health care system relevant to their clinical specialty;** (Outcome)

IV.A.5.f).(3) **incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;** (Outcome)

IV.A.5.f).(4) **advocate for quality patient care and optimal patient care systems;** (Outcome)

IV.A.5.f).(5) **work in interprofessional teams to enhance patient safety and improve patient care quality; and,** (Outcome)

IV.A.5.f).(6) **participate in identifying system errors and implementing potential systems solutions.** (Outcome)

IV.A.6. Curriculum Organization and Fellow Experiences

IV.A.6.a) During the first 12 months of the program, no more than six months may be devoted to related clinical disciplines designed to enhance the educational experience, including: (Core)

IV.A.6.a).(1) clinical assignments in cardiothoracic surgery, gynecology, neurological surgery, orthopaedic surgery, otolaryngology, anesthesia, vascular surgery, transplant surgery, and the management of burns. (Detail)

IV.A.6.b) The final 12 months of clinical education must be at the chief level, with responsibility for patient management, and semi-independent operative experience under appropriate supervision. (Core)

IV.A.6.c) Fellows must have an academic program which emphasizes the scholarly attributes of self-instruction, teaching, basic sciences, skilled clinical analysis, sound surgical judgment, and research creativity. (Core)

IV.A.6.d) Fellows must be provided with primary responsibility, under the supervision of pediatric surgery faculty members, in the care of critically-ill surgical patients to allow them to acquire the requisite specialty-specific knowledge and skills, and to obtain competence in the pre-, intra-, and post-operative care of such patients. ((Core)

IV.A.6.d).(1) To meet these goals, there must be coordination of care and collegial relationships between pediatric surgeons, neonatologists, and critical care intensivists concerning the management of medical problems in these complex critically-ill patients. (Core)

IV.A.6.e) Fellows must document an appropriate breadth, volume, and balance of operative experience as primary surgeon. (Core)

IV.A.6.f) Fellows must document a total of 800 major pediatric surgery procedures as surgeon during the program. (Core)

IV.A.6.f).(1) Fellows should, if not a surgery chief resident, act as a teaching assistant when their operative experiences justify a teaching role. (Detail)

IV.A.6.g) Fellows must not share primary responsibility for the same patient with, or serve as teaching assistants for a general surgery chief resident. (Core)

IV.A.6.h) Fellows must document one half-day of outpatient experience weekly. (Core)

IV.B. Fellows' Scholarly Activities

IV.B.1. The curriculum must advance fellows' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. (Core)

IV.B.2. Fellows should participate in scholarly activity. (Core)

IV.B.2.a) Fellows should understand design, implementation, and interpretation of clinical research studies. (Outcome)

IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate fellow involvement in scholarly activities. (Detail)

V. Evaluation

V.A. Fellow Evaluation

V.A.1. The program director must appoint the Clinical Competency Committee. **(Core)**

V.A.1.a) At a minimum the Clinical Competency Committee must be composed of three members of the program faculty. **(Core)**

V.A.1.a).(1) Others eligible for appointment to the committee include faculty from other programs and non-physician members of the health care team. **(Detail)**

V.A.1.b) There must be a written description of the responsibilities of the Clinical Competency Committee. **(Core)**

V.A.1.b).(1) The Clinical Competency Committee should:

V.A.1.b).(1).(a) review all fellow evaluations semi-annually; **(Core)**

V.A.1.b).(1).(b) prepare and assure the reporting of Milestones evaluations of each fellow semi-annually to ACGME; and, **(Core)**

V.A.1.b).(1).(c) advise the program director regarding fellow progress, including promotion, remediation, and dismissal. **(Detail)**

V.A.2. Formative Evaluation

V.A.2.a) The faculty must evaluate fellow performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment. (Core)

V.A.2.b) **The program must:**

V.A.2.b).(1) **provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones;** (Core)

V.A.2.b).(2) **use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);** (Detail)

V.A.2.b).(3) **document progressive fellow performance improvement appropriate to educational level; and,** (Core)

V.A.2.b).(4) **provide each fellow with documented semiannual evaluation of performance with feedback.** (Core)

V.A.2.c) **The evaluations of fellow performance must be accessible for review by the fellow, in accordance with institutional policy.** (Detail)

V.A.3. **Summative Evaluation**

V.A.3.a) **The specialty-specific Milestones must be used as one of the tools to ensure fellows are able to practice core professional activities without supervision upon completion of the program.** (Core)

V.A.3.b) **The program director must provide a summative evaluation for each fellow upon completion of the program.** (Core)

This evaluation must:

V.A.3.b).(1) **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;** (Detail)

V.A.3.b).(2) **document the fellow's performance during the final period of education; and,** (Detail)

V.A.3.b).(3) **verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision.** (Detail)

V.B. **Faculty Evaluation**

V.B.1. **At least annually, the program must evaluate faculty performance as**

it relates to the educational program. (Core)

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.** (Detail)

V.B.3. **This evaluation must include at least annual written confidential evaluations by the fellows.** (Detail)

V.C. Program Evaluation and Improvement

V.C.1. **The program director must appoint the Program Evaluation Committee (PEC).** **(Core)**

V.C.1.a) **The Program Evaluation Committee:**

V.C.1.a).(1) **must be composed of at least two program faculty members and should include at least one fellow;** **(Core)**

V.C.1.a).(2) **must have a written description of its responsibilities; and,** **(Core)**

V.C.1.a).(3) **should participate actively in:**

V.C.1.a).(3).(a) **planning, developing, implementing, and evaluating educational activities of the program;** **(Detail)**

V.C.1.a).(3).(b) **reviewing and making recommendations for revision of competency-based curriculum goals and objectives;** **(Detail)**

V.C.1.a).(3).(c) **addressing areas of non-compliance with ACGME standards; and,** **(Detail)**

V.C.1.a).(3).(d) **reviewing the program annually using evaluations of faculty, fellows, and others, as specified below.** **(Detail)**

V.C.2. **The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written and Annual Program Evaluation (APE).** **(Core)**

The program must monitor and track each of the following areas:

V.C.2.a) **fellow performance;** **(Core)**

V.C.2.b) **faculty development;** **(Core)**

V.C.2.c) **graduate performance, including performance of program graduates on the certification examination;** **(Core)**

V.C.2.c).(1) At least 60 percent of the program's graduates from the preceding seven years taking the American Board of Surgery examination for pediatric surgery for the first time must pass. (Outcome)

V.C.2.d) program quality; and, (Core)

V.C.2.d).(1) Fellows and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and (Detail)

V.C.2.d).(2) The program must use the results of fellows' and faculty members' assessments of the program together with other program evaluation results to improve the program. (Detail)

V.C.2.e) progress on the previous year's action plan(s). (Core)

V.C.3. The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section V.C.2., as well as delineate how they will be measured and monitored. (Core)

V.C.3.a) The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes. (Detail)

V.C.4. Programs should use the American Board of Surgery Pediatric Surgery In-training Examination for formative fellow and program evaluation. (Detail)

VI. Fellow Duty Hours in the Learning and Working Environment

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

VI.A.1. Programs and sponsoring institutions must educate fellows and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients. (Core)

VI.A.2. The program must be committed to and responsible for promoting patient safety and fellow well-being in a supportive educational environment. (Core)

VI.A.3. The program director must ensure that fellows are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs. (Core)

VI.A.4. The learning objectives of the program must:

VI.A.4.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic

educational events; and, (Core)

VI.A.4.b) **not be compromised by excessive reliance on fellows to fulfill non-physician service obligations.** (Core)

VI.A.5. **The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility.** (Core)

VI.A.6. **Fellows and faculty members must demonstrate an understanding and acceptance of their personal role in the following:**

VI.A.6.a) **assurance of the safety and welfare of patients entrusted to their care;** (Outcome)

VI.A.6.b) **provision of patient- and family-centered care;** (Outcome)

VI.A.6.c) **assurance of their fitness for duty;** (Outcome)

VI.A.6.d) **management of their time before, during, and after clinical assignments;** (Outcome)

VI.A.6.e) **recognition of impairment, including illness and fatigue, in themselves and in their peers;** (Outcome)

VI.A.6.f) **attention to lifelong learning;** (Outcome)

VI.A.6.g) **the monitoring of their patient care performance improvement indicators; and,** (Outcome)

VI.A.6.h) **honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.** (Outcome)

VI.A.7. **All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. They must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.** (Outcome)

VI.B. Transitions of Care

VI.B.1. **Programs must design clinical assignments to minimize the number of transitions in patient care.** (Core)

VI.B.2. **Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.** (Core)

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

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

VI.C. Alertness Management/Fatigue Mitigation

VI.C.1. The program must:

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

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

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

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

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

VI.D. Supervision of Fellows

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

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

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

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

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

telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of fellow-delivered care with feedback as to the appropriateness of that care. (Detail)

VI.D.3. Levels of Supervision

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

VI.D.3.a) Direct Supervision – the supervising physician is physically present with the fellow and patient. (Core)

VI.D.3.b) Indirect Supervision:

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

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

VI.D.3.c) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. (Core)

VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each fellow must be assigned by the program director and faculty members. (Core)

VI.D.4.a) The program director must evaluate each fellow's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria. (Core)

VI.D.4.b) Faculty members functioning as supervising physicians should delegate portions of care to fellows, based on the needs of the patient and the skills of the fellows. (Detail)

VI.D.4.c) Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)

VI.D.5. Programs must set guidelines for circumstances and events in which fellows must communicate with appropriate supervising

faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions. (Core)

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

VI.D.5.a).(1) **In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.** (Core)

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

VI.E. Clinical Responsibilities

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

VI.E.1. The workload associated with optimal clinical care of surgical patients must reflect the continuum from the moment of admission to the point to discharge. (Core)

VI.E.2. During the residency education process, surgical teams should be made up of attending surgeons, residents at various PG levels, medical students (when appropriate), and other health care providers. (Detail)

VI.E.3. The work of the caregiver team should be assigned to team members based on each member's level of education, experience, and competence. (Detail)

VI.E.4. Work assignments should keep pace with residents' increased competence and responsibility as they progress through the program. (Detail)

VI.F. Teamwork

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

VI.F.1. Effective surgical practices entail the involvement of members with a mix of complementary skills and attributes (physicians, nurses, and other staff). Success requires both an unwavering mutual respect for those skills and contributions, and a shared commitment to the process of patient care. (Detail)

VI.F.2. Fellows must collaborate with surgical residents, and especially with faculty members, other physicians outside of their specialties, and non-traditional health care providers, to best formulate treatment plans for an increasingly diverse patient population. (Detail)

VI.F.3. Fellows must assume personal responsibility to complete all tasks to which they are assigned (or which they voluntarily assume) in a timely fashion. ((Detail)

VI.F.3.a) These tasks must be completed in the hours assigned, or, if that is not possible, fellows must learn and utilize the established methods for handing off remaining tasks to another member of the fellow team so that patient care is not compromised. (Detail)

VI.F.4. Lines of authority should be defined by programs, and all fellows must have a working knowledge of the expected reporting relationships to maximize quality care and patient safety. (Detail)

VI.G. Fellow Duty Hours

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

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

VI.G.1.a) Duty Hour Exceptions

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

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

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

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

VI.G.2. Moonlighting

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

VI.G.2.b) Time spent by fellows in Internal and External Moonlighting

(as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit. (Core)

VI.G.2.c) **PGY-1 residents are not permitted to moonlight.** (Core)

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

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

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

VI.G.4.a) **Duty periods of PGY-1 residents must not exceed 16 hours in duration.** (Core)

VI.G.4.b) **Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital.** (Core)

VI.G.4.b).(1) **Programs must encourage fellows to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.** (Detail)

VI.G.4.b).(2) **It is essential for patient safety and fellow education that effective transitions in care occur. Fellows may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.** (Core)

VI.G.4.b).(3) **Fellows must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.** (Core)

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

VI.G.4.b).(4).(a) **Under those circumstances, the fellow must:**

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

VI.G.4.b).(4).(a).(ii) **document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.** (Detail)

VI.G.4.b).(4).(b) **The program director must review each submission of additional service, and track both individual fellow and program-wide episodes of additional duty.** (Detail)

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

VI.G.5.a) **PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.** (Core)

VI.G.5.b) **Intermediate-level residents should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.** (Core)

VI.G.5.c) **Residents in the final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.** (Outcome)

Pediatric surgery fellows are considered to be in the final years of education.

VI.G.5.c).(1) **This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these fellows must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.** (Detail)

VI.G.5.c).(1).(a) **Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.** (Detail)

VI.G.5.c).(1).(b) The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient with whom the fellow has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family.

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

Fellows must not be scheduled for more than six consecutive nights of night float. (Core)

VI.G.6.a) Any rotation that requires residents to work nights in succession is considered a night float rotation, and the total time on nights is counted toward the maximum allowable time for each resident over the duration of the program.

VI.G.6.b) Night float rotations must not exceed two months in succession, or three months in succession for rotations with night shifts alternating with day shifts. (Core)

VI.G.6.c) There must be no more than four months of night float per year. (Core)

VI.G.6.d) There must be at least two months between each night float rotation. (Core)

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

PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period). (Core)

VI.G.8. At-Home Call

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

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. (Core)

VI.G.8.b) Fellows are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period". (Detail)

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*__Core Requirements:__ Statements that define structure, resource, or process elements essential to every graduate medical educational program.

__Detail Requirements:__ Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.