

1 **ACGME Program Requirements for Graduate Medical Education**
2 **in Female Pelvic Medicine and Reconstructive Surgery**

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

5
6 Effective:

7
8 **Introduction**

9
10 **Int.A. Fellowship is an essential dimension of the transformation of the resident**
11 **to the independent practitioner along the continuum of medical education.**
12 **It is physically, emotionally, and intellectually demanding, and requires**
13 **longitudinally concentrated effort on the part of the 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 fellow**
19 **physician to assume personal responsibility for the care of individual**
20 **patients. For the fellow, the essential learning activity is interaction with**
21 **patients under the guidance and supervision of faculty members who give**
22 **value, context, and meaning to those interactions. As fellows gain**
23 **experience and demonstrate growth in their ability to care for patients, they**
24 **assume roles that permit them to exercise those skills with greater**
25 **independence. This concept—graded and progressive responsibility—is**
26 **one of the core tenets of American graduate medical education.**
27 **Supervision in the setting of graduate medical education has the goals of**
28 **assuring the provision of safe and effective care to the individual patient;**
29 **assuring each fellow’s development of the skills, knowledge, and attitudes**
30 **required to enter the unsupervised practice of medicine; and establishing a**
31 **foundation for continued professional growth.**

32
33 **Int.B. Female pelvic medicine and reconstructive surgery physicians provide**
34 **consultation services and comprehensive management of women with pelvic**
35 **floor disorders, including urinary incontinence, lower urinary tract disorders,**
36 **pelvic organ prolapse, and childbirth-related injuries. Comprehensive**
37 **management includes the preventive, diagnostic, and therapeutic procedures**
38 **necessary for the total care of the female patient with these conditions,**
39 **complications, and sequelae resulting from pelvic floor disorders.**

40
41 **Int.C. The educational program in female pelvic medicine and reconstructive surgery**
42 **must be 36 months in length.**

43
44 **I. Institutions**

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46 **I.A. Sponsoring Institution**

47
48 **One sponsoring institution must assume ultimate responsibility for the**
49 **program, as described in the Institutional Requirements, and this**
50 **responsibility extends to fellow assignments at all participating sites.**
51

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

55
56 I.A.1. The sponsoring institution should also sponsor Accreditation Council for
57 Graduate Medical Education (ACGME)-accredited residency programs in
58 both obstetrics and gynecology and urology.

59
60 I.A.1.a) The program must function as an integral part of an ACGME-
61 accredited residency program in either obstetrics and gynecology
62 or urology.

63
64 I.A.1.b) The female pelvic medicine and reconstructive surgery fellowship
65 program must be affiliated with a Liaison Committee on Medical
66 Education (LCME)-accredited medical school.

67
68 **I.B. Participating Sites**

69
70 **I.B.1. There must be a program letter of agreement (PLA) between the**
71 **program and each participating site providing a required**
72 **assignment. The PLA must be renewed at least every five years.**

73
74 **The PLA should:**

75
76 **I.B.1.a) identify the faculty who will assume both educational and**
77 **supervisory responsibilities for fellows;**

78
79 **I.B.1.b) specify their responsibilities for teaching, supervision, and**
80 **formal evaluation of fellows, as specified later in this**
81 **document;**

82
83 **I.B.1.c) specify the duration and content of the educational**
84 **experience; and,**

85
86 **I.B.1.d) state the policies and procedures that will govern fellow**
87 **education during the assignment.**

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

94
95 **II. Program Personnel and Resources**

96
97 **II.A. Program Director**

98
99 **II.A.1. There must be a single program director with authority and**
100 **accountability for the operation of the program. The sponsoring**
101 **institution's GMEC must approve a change in program director.**
102 **After approval, the program director must submit this change to the**

- 103 **ACGME via the ADS.**
- 104
- 105 **II.A.2. The program director should continue in his or her position for a**
- 106 **length of time adequate to maintain continuity of leadership and**
- 107 **program stability.**
- 108
- 109 **II.A.3. Qualifications of the program director must include:**
- 110
- 111 **II.A.3.a) requisite specialty expertise and documented educational**
- 112 **and administrative experience acceptable to the Review**
- 113 **Committee;**
- 114
- 115 **II.A.3.b) current certification in the subspecialty by the American**
- 116 **Board of Obstetrics and Gynecology or the American Board of**
- 117 **Urology, or subspecialty qualifications that are acceptable to**
- 118 **the Review Committee;**
- 119
- 120 **II.A.3.c) current medical licensure and appropriate medical staff**
- 121 **appointment;**
- 122
- 123 **II.A.3.d) current certification in obstetrics and gynecology by the American**
- 124 **Board of Obstetrics or in urology by the American Board of**
- 125 **Urology;**
- 126
- 127 **II.A.3.e) completion of a female pelvic medicine and reconstructive surgery**
- 128 **fellowship at least five years prior to appointment as the program**
- 129 **director; and,**
- 130
- 131 **II.A.3.f) documented clinical and scholarly expertise in female pelvic**
- 132 **medicine and reconstructive surgery.**
- 133
- 134 **II.A.4. The program director must administer and maintain an educational**
- 135 **environment conducive to educating the fellows in each of the**
- 136 **ACGME competency areas. The program director must:**
- 137
- 138 **II.A.4.a) oversee and ensure the quality of didactic and clinical**
- 139 **education in all sites that participate in the program;**
- 140
- 141 **II.A.4.b) approve a local director at each participating site who is**
- 142 **accountable for fellow education;**
- 143
- 144 **II.A.4.c) approve the selection of program faculty as appropriate;**
- 145
- 146 **II.A.4.d) evaluate program faculty and approve the continued**
- 147 **participation of program faculty based on evaluation;**
- 148
- 149 **II.A.4.e) monitor fellow supervision at all participating sites;**
- 150
- 151 **II.A.4.f) prepare and submit all information required and requested by**
- 152 **the ACGME, including but not limited to the program**
- 153 **information forms and annual program fellow updates to the**

- 154 ADS, and ensure that the information submitted is accurate
155 and complete;
- 156
- 157 **II.A.4.g)** provide each fellow with documented semiannual evaluation
158 of performance with feedback;
- 159
- 160 **II.A.4.h)** ensure compliance with grievance and due process
161 procedures as set forth in the Institutional Requirements and
162 implemented by the sponsoring institution;
- 163
- 164 **II.A.4.i)** provide verification of residency education for all fellows,
165 including those who leave the program prior to completion;
- 166
- 167 **II.A.4.j)** implement policies and procedures consistent with the
168 institutional and program requirements for fellow duty hours
169 and the working environment, including moonlighting, and, to
170 that end, must:
- 171
- 172 **II.A.4.j).(1)** distribute these policies and procedures to the fellows
173 and faculty;
- 174
- 175 **II.A.4.j).(2)** monitor fellow duty hours, according to sponsoring
176 institutional policies, with a frequency sufficient to
177 ensure compliance with ACGME requirements;
- 178
- 179 **II.A.4.j).(3)** adjust schedules as necessary to mitigate excessive
180 service demands and/or fatigue; and,
- 181
- 182 **II.A.4.j).(4)** if applicable, monitor the demands of at-home call and
183 adjust schedules as necessary to mitigate excessive
184 service demands and/or fatigue.
- 185
- 186 **II.A.4.k)** monitor the need for and ensure the provision of back up
187 support systems when patient care responsibilities are
188 unusually difficult or prolonged;
- 189
- 190 **II.A.4.l)** comply with the sponsoring institution's written policies and
191 procedures, including those specified in the Institutional
192 Requirements, for selection, evaluation and promotion of
193 fellows, disciplinary action, and supervision of fellows;
- 194
- 195 **II.A.4.m)** be familiar with and comply with ACGME and Review
196 Committee policies and procedures as outlined in the ACGME
197 Manual of Policies and Procedures;
- 198
- 199 **II.A.4.n)** obtain review and approval of the sponsoring institution's
200 GMEC/DIO before submitting to the ACGME information or
201 requests for the following:
- 202
- 203 **II.A.4.n).(1)** all applications for ACGME accreditation of new
204 programs;

- 205
206 **II.A.4.n).(2)** changes in fellow complement;
207
208 **II.A.4.n).(3)** major changes in program structure or length of
209 training;
210
211 **II.A.4.n).(4)** progress reports requested by the Review Committee;
212
213 **II.A.4.n).(5)** responses to all proposed adverse actions;
214
215 **II.A.4.n).(6)** requests for increases or any change to fellow duty
216 hours;
217
218 **II.A.4.n).(7)** voluntary withdrawals of ACGME-accredited
219 programs;
220
221 **II.A.4.n).(8)** requests for appeal of an adverse action;
222
223 **II.A.4.n).(9)** appeal presentations to a Board of Appeal or the
224 ACGME; and,
225
226 **II.A.4.n).(10)** proposals to ACGME for approval of innovative
227 educational approaches.
228
229 **II.A.4.o)** obtain DIO review and co-signature on all program
230 information forms, as well as any correspondence or
231 document submitted to the ACGME that addresses:
232
233 **II.A.4.o).(1)** program citations, and/or
234
235 **II.A.4.o).(2)** request for changes in the program that would have
236 significant impact, including financial, on the program
237 or institution.
238
239 **II.A.4.p)** The program director must dedicate at least 15 hours per week of
240 his or her professional effort to the administrative and educational
241 activities of the female pelvic medicine and reconstructive surgery
242 program.
243
244 **II.B. Faculty**
245
246 **II.B.1. At each participating site, there must be a sufficient number of**
247 **faculty with documented qualifications to instruct and supervise all**
248 **fellows at that location.**
249
250 **The faculty must:**
251
252 **II.B.1.a) devote sufficient time to the educational program to fulfill**
253 **their supervisory and teaching responsibilities; and to**
254 **demonstrate a strong interest in the education of fellows, and**
255

- 256 **II.B.1.b)** **administer and maintain an educational environment**
257 **conductive to educating fellows in each of the ACGME**
258 **competency areas.**
259
- 260 **II.B.2.** **The physician faculty must have current certification in the in the**
261 **specialty by the American Board of Obstetrics and Gynecology or**
262 **Urology, or possess qualifications acceptable to the Review**
263 **Committee.**
264
- 265 II.B.2.a) The Review Committee accepts only current specialty certification
266 in either obstetrics and gynecology or urology.
267
- 268 **II.B.3.** **The physician faculty must possess current medical licensure and**
269 **appropriate medical staff appointment.**
270
- 271 **II.B.4.** **The non-physician faculty must have appropriate qualifications in**
272 **their field and hold appropriate institutional appointments.**
273
- 274 **II.B.5.** **The faculty must establish and maintain an environment of inquiry**
275 **and scholarship with an active research component.**
276
- 277 **II.B.5.a)** **The faculty must regularly participate in organized clinical**
278 **discussions, rounds, journal clubs, and conferences.**
279
- 280 **II.B.5.b)** **Some members of the faculty should also demonstrate**
281 **scholarship by one or more of the following:**
282
- 283 **II.B.5.b).(1)** **peer-reviewed funding;**
284
- 285 **II.B.5.b).(2)** **publication of original research or review articles in**
286 **peer-reviewed journals, or chapters in textbooks;**
287
- 288 **II.B.5.b).(3)** **publication or presentation of case reports or clinical**
289 **series at local, regional, or national professional and**
290 **scientific society meetings; or,**
291
- 292 **II.B.5.b).(4)** **participation in national committees or educational**
293 **organizations.**
294
- 295 **II.B.5.c)** **Faculty should encourage and support fellows in scholarly**
296 **activities.**
297
- 298 II.B.6. In addition to the program director, there must be at least one other full-
299 time program faculty member who is certified in female pelvic medicine
300 and reconstructive surgery by either the American Board of Obstetrics
301 and Gynecology or the American Board of Urology.
302
- 303 **II.B.7.** **For fellowship programs functioning as part of an ACGME-accredited**
304 **obstetrics and gynecology residency, there should be one FTE core**
305 **faculty member who is a urologist certified by the American Board of**
306 **Urology in female pelvic medicine and reconstructive surgery, or who**

- 307 possesses other qualifications acceptable to the Review Committee.
308
- 309 II.B.8. For programs functioning as part of an ACGME-accredited urology
310 residency, there should be one FTE designated faculty member who is an
311 obstetrician-gynecologist certified by the American Board of Obstetrics
312 and Gynecology in female pelvic medicine and reconstructive surgery, or
313 who possesses other qualifications acceptable to the Review Committee.
314
- 315 II.B.9. Other faculty members should include qualified colorectal surgeons and
316 gastroenterologists.
317
- 318 **II.C. Other Program Personnel**
319
- 320 **The institution and the program must jointly ensure the availability of all**
321 **necessary professional, technical, and clerical personnel for the effective**
322 **administration of the program.**
323
- 324 **II.D. Resources**
325
- 326 **The institution and the program must jointly ensure the availability of**
327 **adequate resources for fellow education, as defined in the specialty**
328 **program requirements.**
329
- 330 II.D.1. The primary clinical site must include operating rooms, labor and delivery
331 rooms, ambulatory clinic facilities, recovery rooms, intensive care units,
332 blood banks, diagnostic laboratories, and imaging services.
333
- 334 II.D.1.a) Access to these resources must be available at all times for the
335 management of complications.
336
- 337 II.D.2. The program must have clinical and laboratory research facilities that are
338 equipped to allow fellows to engage in scholarly activities.
339
- 340 **II.E. Medical Information Access**
341
- 342 **Fellows must have ready access to specialty-specific and other appropriate**
343 **reference material in print or electronic format. Electronic medical literature**
344 **databases with search capabilities should be available.**
345
- 346 **III. Fellow Appointments**
347
- 348 **III.A. Eligibility Criteria**
349
- 350 **The program director must comply with the criteria for fellow eligibility as**
351 **specified in the Institutional Requirements.**
352
- 353 III.A.1. To be eligible for appointment at the F1 level, a fellow must have
354 satisfactorily completed an obstetrics and gynecology residency
355 accredited by the ACGME or an obstetrics and gynecology program
356 located in Canada and accredited by the Royal College of Physicians and
357 Surgeons of Canada (RCPSC).

- 358
359 III.A.2. To be eligible for appointment at the F2 level, a fellow must have
360 satisfactorily completed a urology residency accredited by the ACGME or
361 a urology residency located in Canada and accredited by the RCPSC.
362
- 363 III.A.3. Prior to entering the program, each fellow must be informed of the
364 requirements for completing the program, including the criteria to qualify
365 for the subspecialty board examination.
366
- 367 **III.B. Number of Fellows**
368
369 **The program director may not appoint more fellows than approved by the**
370 **Review Committee, unless otherwise stated in the specialty-specific**
371 **requirements. The program’s educational resources must be adequate to**
372 **support the number of fellows appointed to the program.**
373
- 374 III.B.1. There should be at least two fellows in the program at all times.
375
- 376 **III.C. Fellow Transfers**
377
- 378 **III.C.1. Before accepting a fellow who is transferring from another program,**
379 **the program director must obtain written or electronic verification of**
380 **previous educational experiences and a summative competency-**
381 **based performance evaluation of the transferring fellow.**
382
- 383 **III.C.2. A program director must provide timely verification of fellow**
384 **education and summative performance evaluations for fellows who**
385 **leave the program prior to completion.**
386
- 387 **III.D. Appointment of Fellows and Other Learners**
388
389 **The presence of other learners (including, but not limited to, fellows from**
390 **other specialties, residents, PhD students, and nurse practitioners) in the**
391 **program must not interfere with the appointed fellows’ education. The**
392 **program director must report the presence of other learners to the DIO and**
393 **GMEC in accordance with sponsoring institution guidelines.**
394
- 395 **IV. Educational Program**
396
- 397 **IV.A. The curriculum must contain the following educational components:**
398
- 399 **IV.A.1. Overall educational goals for the program, which the program must**
400 **distribute to fellows and faculty annually;**
401
- 402 **IV.A.2. Competency-based goals and objectives for each assignment at**
403 **each educational level, which the program must distribute to fellows**
404 **and faculty annually in either written or electronic form. These**
405 **should be reviewed by the fellow at the start of each rotation.**
406
- 407 IV.A.2.a) At the beginning of the program, each fellow must have an
408 individual educational plan that includes a monthly block rotation

409 diagram displaying the clinical, didactic, and research activities by
410 rotation.

411
412 **IV.A.3. Regularly scheduled didactic sessions;**

413
414 IV.A.3.a) There must be regularly scheduled journal clubs, seminars,
415 didactics, and morbidity and mortality conferences.

416
417 IV.A.3.a).(1) Topics must include:

418
419 IV.A.3.a).(1).(a) anatomy and physiology of the pelvic floor,
420 including the lower urinary tract, and colorectal-anal
421 and vaginal function;

422
423 IV.A.3.a).(1).(b) behavioral, pharmacological, functional, and
424 surgical treatment of urinary incontinence, anal
425 incontinence, and pelvic floor dysfunction, including
426 micturition and defecation disorders, and pelvic
427 organ prolapse;

428
429 IV.A.3.a).(1).(c) diagnosis and evaluation of pelvic floor dysfunction,
430 including urinary incontinence, voiding dysfunction,
431 pelvic organ prolapse, defecation disorders, and
432 sexual dysfunction;

433
434 IV.A.3.a).(1).(d) diagnosis and management of genito-urinary and
435 rectovaginal fistulae, urethral diverticula, injuries to
436 the genitourinary tract, congenital anomalies, and
437 infectious and non-infectious irritative conditions of
438 the lower urinary tract and pelvic floor;

439
440 IV.A.3.a).(1).(e) management of genitourinary complications of
441 vaginal delivery, spinal cord injuries, and medical,
442 psychiatric, and geriatric conditions related to pelvic
443 floor disorders;

444
445 IV.A.3.a).(1).(f) pathophysiology of pelvic floor dysfunction
446 including urinary incontinence, voiding dysfunction,
447 pelvic organ prolapse, defecation disorders and
448 sexual dysfunction; and,

449
450 IV.A.3.a).(1).(g) research design, grant writing, research
451 methodology, and scientific writing and
452 presentation skills.

453
454 **IV.A.4. Delineation of fellow responsibilities for patient care, progressive
455 responsibility for patient management, and supervision of fellows
456 over the continuum of the program; and,**

457
458 **IV.A.5. ACGME Competencies**

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

IV.A.5.a)

Patient Care

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

IV.A.5.a).(1)

must demonstrate competence in:

IV.A.5.a).(1).(a)

assessing the effects of treatment, and recognizing and managing the complications of therapy;

IV.A.5.a).(1).(b)

diagnosing and managing patients with genitourinary and rectovaginal fistulae, anal incontinence, urethral diverticula, injuries to the genitourinary tract, congenital anomalies, and infectious and non-infectious irritative conditions of the lower urinary tract and pelvic floor;

IV.A.5.a).(1).(c)

evaluating the lower urinary tract for abnormalities including neoplasms, and interpreting urinary tract cytology and biopsy results;

IV.A.5.a).(1).(d)

performing advanced laparoscopic, abdominal, and vaginal surgery;

IV.A.5.a).(1).(e)

performing cystoscopy and cystoscopic manipulations, including stent placement retrograde pyelograms and ureteral stent placement;

IV.A.5.a).(1).(f)

performing urodynamic testing; and,

IV.A.5.a).(1).(g)

performing surgery for urinary incontinence, pelvic organ prolapse, and obstetric lacerations, and treatment of related benign conditions occurring in the female pelvis.

IV.A.5.a).(2)

completing the F1 year must demonstrate competence in:

IV.A.5.a).(2).(a)

evaluating and managing hematuria;

IV.A.5.a).(2).(b)

evaluating and managing painful bladder, including interstitial cystitis;

IV.A.5.a).(2).(c)

evaluating and managing neurogenic voiding dysfunction;

IV.A.5.a).(2).(d)

evaluating and treating urinary tract infections; and,

- 511 IV.A.5.a).(2).(e) performing a female pelvic exam, including
512 quantification of pelvic organ prolapse.
513
- 514 IV.A.5.a).(3) completing the F2 year must demonstrate competence in
515 the behavioral, pharmacological, functional, non-surgical,
516 and surgical treatment of:
517
- 518 IV.A.5.a).(3).(a) micturition and defecation disorders;
519
- 520 IV.A.5.a).(3).(b) pelvic organ prolapse; and,
521
- 522 IV.A.5.a).(3).(c) urinary incontinence.
523
- 524 IV.A.5.a).(4) completing the F3 year must demonstrate competence in:
525
- 526 IV.A.5.a).(4).(a) diagnosing and managing genitourinary and
527 rectovaginal fistulae, anal incontinence, urethral
528 diverticula, injuries to the genitourinary tract, and
529 congenital anomalies; and,
530
- 531 IV.A.5.a).(4).(b) managing genitourinary complications of vaginal
532 delivery and spinal cord injuries.
533

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:

- 541 IV.A.5.b).(1) completing the F1 year must demonstrate competence in
542 their knowledge of:
543
- 544 IV.A.5.b).(1).(a) the epidemiology of urinary incontinence, pelvic
545 organ prolapse, and defecation disorders, including
546 birth, aging, and neurologic disease;
547
- 548 IV.A.5.b).(1).(b) the impact of urinary incontinence, pelvic organ
549 prolapse, and defecation disorders on quality of life;
550
- 551 IV.A.5.b).(1).(c) the use and interpretation of disease-specific and
552 global health questionnaires to evaluate the impact
553 of pelvic floor disorders on quality of life;
554
- 555 IV.A.5.b).(1).(d) the scientific method of problem solving and
556 evidence-based decision making; and,
557
- 558 IV.A.5.b).(1).(e) indications, contraindications, limitations,
559 complications, techniques, and interpretation of
560 results of those diagnostic and therapeutic
561 procedures integral to the discipline, to include:

| | | |
|-----|-------------------------|---|
| 562 | | |
| 563 | IV.A.5.b).(1).(e).(i) | the indications for and use of screening |
| 564 | | tests and procedures including urinalysis, |
| 565 | | urine cytology, and pad test; and, |
| 566 | | |
| 567 | IV.A.5.b).(1).(e).(ii) | use and interpretation of a voiding diary. |
| 568 | | |
| 569 | IV.A.5.b).(2) | completing the F2 year must demonstrate competence in |
| 570 | | their knowledge of: |
| 571 | | |
| 572 | IV.A.5.b).(2).(a) | the anatomy, physiology, and pathophysiology of |
| 573 | | the pelvic floor, including the lower urinary tract, |
| 574 | | and colorectal-anal and vaginal functioning; |
| 575 | | |
| 576 | IV.A.5.b).(2).(b) | clinically pertinent areas of pathology, infectious |
| 577 | | disease, geriatric medicine, physical therapy, pain |
| 578 | | management, sexual dysfunction, and psychosocial |
| 579 | | aspects of pelvic floor disorders; and, |
| 580 | | |
| 581 | IV.A.5.b).(2).(c) | indications, contraindications, limitations, |
| 582 | | complications, techniques, and interpretation of |
| 583 | | results of screening, diagnostic, and therapeutic |
| 584 | | procedures for the treatment and evaluation of |
| 585 | | pelvic floor disorders, to include: |
| 586 | | |
| 587 | IV.A.5.b).(2).(c).(i) | pelvic imaging studies for the diagnostic |
| 588 | | evaluation of urinary and anal incontinence, |
| 589 | | pelvic floor dysfunction, and prolapse; and, |
| 590 | | |
| 591 | IV.A.5.b).(2).(c).(ii) | urodynamic assessment. |
| 592 | | |
| 593 | IV.A.5.b).(3) | completing the F3 year must demonstrate competence in |
| 594 | | their knowledge of: |
| 595 | | |
| 596 | IV.A.5.b).(3).(a) | assessment and treatment of systemic neurologic |
| 597 | | diseases that affect the lower urinary tract; |
| 598 | | |
| 599 | IV.A.5.b).(3).(b) | indications, contraindications, limitations, |
| 600 | | complications, techniques, and interpretation of |
| 601 | | results of screening, diagnostic, and therapeutic |
| 602 | | procedures for surgery for: |
| 603 | | |
| 604 | IV.A.5.b).(3).(b).(i) | pelvic organ prolapse; |
| 605 | | |
| 606 | IV.A.5.b).(3).(b).(ii) | rectovaginal fistula related to obstetric |
| 607 | | trauma; |
| 608 | | |
| 609 | IV.A.5.b).(3).(b).(iii) | urinary incontinence; and, |
| 610 | | |
| 611 | IV.A.5.b).(3).(b).(iv) | vesicovaginal fistula. |
| 612 | | |

613 IV.A.5.b).(3).(c) quantitative techniques, including biostatistics,
614 epidemiology, research design, and research
615 methods.
616

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

618
619 **Fellows must demonstrate the ability to investigate and**
620 **evaluate their care of patients, to appraise and assimilate**
621 **scientific evidence, and to continuously improve patient care**
622 **based on constant self-evaluation and life-long learning.**
623 **Fellows are expected to develop skills and habits to be able**
624 **to meet the following goals:**

625
626 **IV.A.5.c).(1) identify strengths, deficiencies, and limits in one's**
627 **knowledge and expertise;**

628
629 **IV.A.5.c).(2) set learning and improvement goals;**

630
631 **IV.A.5.c).(3) identify and perform appropriate learning activities;**

632
633 **IV.A.5.c).(4) systematically analyze practice using quality**
634 **improvement methods, and implement changes with**
635 **the goal of practice improvement;**

636
637 **IV.A.5.c).(5) incorporate formative evaluation feedback into daily**
638 **practice;**

639
640 **IV.A.5.c).(6) locate, appraise, and assimilate evidence from**
641 **scientific studies related to their patients' health**
642 **problems;**

643
644 **IV.A.5.c).(7) use information technology to optimize learning; and,**

645
646 **IV.A.5.c).(8) participate in the education of patients, families,**
647 **students, residents and other health professionals.**

648
649 **IV.A.5.d) Interpersonal and Communication Skills**

650
651 **Fellows must demonstrate interpersonal and communication**
652 **skills that result in the effective exchange of information and**
653 **collaboration with patients, their families, and health**
654 **professionals. Fellows are expected to:**

655
656 **IV.A.5.d).(1) communicate effectively with patients, families, and**
657 **the public, as appropriate, across a broad range of**
658 **socioeconomic and cultural backgrounds;**

659
660 **IV.A.5.d).(2) communicate effectively with physicians, other health**
661 **professionals, and health related agencies;**

662
663 **IV.A.5.d).(3) work effectively as a member or leader of a health care**

| | | |
|-----|----------------------|--|
| 664 | | team or other professional group; |
| 665 | | |
| 666 | IV.A.5.d).(4) | act in a consultative role to other physicians and health professionals; and, |
| 667 | | |
| 668 | | |
| 669 | IV.A.5.d).(5) | maintain comprehensive, timely, and legible medical records, if applicable. |
| 670 | | |
| 671 | | |
| 672 | IV.A.5.e) | Professionalism |
| 673 | | |
| 674 | | Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Fellows are expected to demonstrate: |
| 675 | | |
| 676 | | |
| 677 | | |
| 678 | IV.A.5.e).(1) | compassion, integrity, and respect for others; |
| 679 | | |
| 680 | IV.A.5.e).(2) | responsiveness to patient needs that supersedes self-interest; |
| 681 | | |
| 682 | | |
| 683 | IV.A.5.e).(3) | respect for patient privacy and autonomy; |
| 684 | | |
| 685 | IV.A.5.e).(4) | accountability to patients, society and the profession; and, |
| 686 | | |
| 687 | | |
| 688 | 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. |
| 689 | | |
| 690 | | |
| 691 | | |
| 692 | | |
| 693 | IV.A.5.f) | Systems-based Practice |
| 694 | | |
| 695 | | 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. Fellows are expected to: |
| 696 | | |
| 697 | | |
| 698 | | |
| 699 | | |
| 700 | | |
| 701 | IV.A.5.f).(1) | work effectively in various health care delivery settings and systems relevant to their clinical specialty; |
| 702 | | |
| 703 | | |
| 704 | | |
| 705 | IV.A.5.f).(2) | coordinate patient care within the health care system relevant to their clinical specialty; |
| 706 | | |
| 707 | | |
| 708 | IV.A.5.f).(3) | incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate; |
| 709 | | |
| 710 | | |
| 711 | | |
| 712 | IV.A.5.f).(4) | advocate for quality patient care and optimal patient care systems; |
| 713 | | |
| 714 | | |

| | | |
|-----|----------------------|---|
| 715 | IV.A.5.f).(5) | work in inter-professional teams to enhance patient safety and improve patient care quality; and, |
| 716 | | |
| 717 | | |
| 718 | IV.A.5.f).(6) | participate in identifying system errors and implementing potential systems solutions. |
| 719 | | |
| 720 | | |
| 721 | IV.A.6. | Curriculum Organization and Fellow Experiences |
| 722 | | |
| 723 | IV.A.6.a) | The program director should use the American Board of Obstetrics and Gynecology/American Board of Urology <i>Guide to Learning in Female Pelvic Medicine and Reconstructive Surgery</i> as the basis for curriculum development. |
| 724 | | |
| 725 | | |
| 726 | | |
| 727 | | |
| 728 | IV.A.6.b) | Following completion of the first year of the program, each fellow must submit a research plan to the American Board of Obstetrics and Gynecology and the American Board of Urology that includes his or her thesis title, hypothesis, and research design. |
| 729 | | |
| 730 | | |
| 731 | | |
| 732 | | |
| 733 | IV.A.6.c) | Prior to completion of the program, all fellows must satisfactorily complete two university graduate level courses, through a Master's degree in public health, another equivalent degree, or graduate studies. |
| 734 | | |
| 735 | | |
| 736 | | |
| 737 | | |
| 738 | IV.A.6.c).(1) | One course must be in quantitative techniques, including biostatistics. |
| 739 | | |
| 740 | | |
| 741 | IV.A.6.c).(2) | One course must be in epidemiology, research design, or another topic relevant to female pelvic medicine and reconstructive surgery. |
| 742 | | |
| 743 | | |
| 744 | | |
| 745 | IV.A.6.c).(3) | Both courses must be approved by the American Board of Obstetrics and Gynecology Division of Female Pelvic Medicine and Reconstructive Surgery or the American Board of Urology to meet requirements for subspecialty certification application. |
| 746 | | |
| 747 | | |
| 748 | | |
| 749 | | |
| 750 | | |
| 751 | IV.A.6.d) | Fellows must have both inpatient and outpatient experiences. |
| 752 | | |
| 753 | IV.A.6.d).(1) | Fellows should have supervised responsibility for the total care of the patient, including initial evaluation, establishment of diagnosis, selection of appropriate therapy, and management of complications. |
| 754 | | |
| 755 | | |
| 756 | | |
| 757 | | |
| 758 | IV.A.6.d).(2) | Fellows must participate in continuity of patient care through pre-operative and post-operative clinics and inpatient contact. |
| 759 | | |
| 760 | | |
| 761 | | |
| 762 | IV.A.6.d).(3) | Fellows must record all surgical procedures in which they have a significant role in the ACGME Case Log System. |
| 763 | | |
| 764 | | |
| 765 | IV.A.6.d).(4) | The total time devoted to these experiences should not |

- 766 exceed 24 months.
- 767
- 768 IV.A.6.e) The 12 months of the program not devoted to inpatient and
 769 outpatient experiences should be devoted to research and/or
 770 other elective experiences.
- 771
- 772 IV.A.6.f) A fellow must not spend more than 10% of his or her time, when
 773 averaged over a four-week period, performing duties outside of
 774 female pelvic medicine and reconstructive surgery.
- 775
- 776 IV.A.6.g) Fellows should participate in the diagnosis and management of
 777 clinically pertinent areas of pathology, infectious disease, geriatric
 778 medicine, physical therapy, pain management, sexual dysfunction,
 779 and psychosocial aspects of pelvic floor disorders.
- 780

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

782

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

786

787 **IV.B.2. Fellows should participate in scholarly activity.**

788

789 IV.B.2.a) Each fellow, under the direction of a faculty mentor, must
 790 complete a comprehensive written scholarly paper or quality
 791 improvement project (thesis) during the program that
 792 demonstrates the following:

793

794 IV.B.2.a).(1) utilization of advanced research methodology and
 795 techniques, including research design and quantitative
 796 analysis;

797

798 IV.B.2.a).(2) collection and statistical analysis of information obtained
 799 from a structured basic laboratory and/or clinical research
 800 setting; and,

801

802 IV.B.2.a).(3) synthesis of the scientific literature, hypothesis testing, and
 803 description of findings and results.

804

805 **IV.B.3. The sponsoring institution and program should allocate adequate**
 806 **educational resources to facilitate fellow involvement in scholarly**
 807 **activities.**

808

809 **V. Evaluation**

810

811 **V.A. Fellow Evaluation**

812

813 **V.A.1. Formative Evaluation**

814

815 **V.A.1.a) The faculty must evaluate fellow performance in a timely**
 816 **manner during each rotation or similar educational**

- 817 **assignment, and document this evaluation at completion of**
818 **the assignment.**
819
- 820 V.A.1.a).(1) Each fellow's scholarly activity must be monitored by a
821 faculty member and confirmed by a competency
822 assessment committee that includes at least one physician
823 scientist not affiliated with the program.
824
- 825 **V.A.1.b) The program must:**
826
- 827 **V.A.1.b).(1) provide objective assessments of competence in**
828 **patient care, medical knowledge, practice-based**
829 **learning and improvement, interpersonal and**
830 **communication skills, professionalism, and systems-**
831 **based practice;**
832
- 833 **V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients,**
834 **self, and other professional staff);**
835
- 836 **V.A.1.b).(3) document progressive fellow performance**
837 **improvement appropriate to educational level; and,**
838
- 839 **V.A.1.b).(4) provide each fellow with documented semiannual**
840 **evaluation of performance with feedback.**
841
- 842 **V.A.1.c) The evaluations of fellow performance must be accessible for**
843 **review by the fellow, in accordance with institutional policy.**
844
- 845 **V.A.2. Summative Evaluation**
846
- 847 **The program director must provide a summative evaluation for each**
848 **fellow upon completion of the program. This evaluation must**
849 **become part of the fellow's permanent record maintained by the**
850 **institution, and must be accessible for review by the fellow in**
851 **accordance with institutional policy. This evaluation must:**
852
- 853 **V.A.2.a) document the fellow's performance during the final period of**
854 **education; and,**
855
- 856 V.A.2.a).(1) Each fellow must give an oral presentation of his or her
857 scholarly project (thesis), which must be formally assessed
858 by the faculty, including a written evaluation.
859
- 860 **V.A.2.b) verify that the fellow has demonstrated sufficient competence**
861 **to enter practice without direct supervision.**
862
- 863 **V.B. Faculty Evaluation**
864
- 865 **V.B.1. At least annually, the program must evaluate faculty performance as**
866 **it relates to the educational program.**
867

- 868 **V.B.2.** **These evaluations should include a review of the faculty’s clinical**
869 **teaching abilities, commitment to the educational program, clinical**
870 **knowledge, professionalism, and scholarly activities.**
871
- 872 **V.B.3.** **This evaluation must include at least annual written confidential**
873 **evaluations by the fellows.**
874
- 875 **V.C. Program Evaluation and Improvement**
876
- 877 **V.C.1.** **The program must document formal, systematic evaluation of the**
878 **curriculum at least annually. The program must monitor and track**
879 **each of the following areas:**
880
- 881 **V.C.1.a)** **fellow performance;**
882
- 883 **V.C.1.b)** **faculty development;**
884
- 885 **V.C.1.c)** **graduate performance, including performance of program**
886 **graduates on the certification examination; and,**
887
- 888 **V.C.1.c).(1)** **At least 75% of in the program’s graduates from the**
889 **preceding five years must have taken the subspecialty**
890 **certification examination of the American Board of**
891 **Obstetrics and Gynecology or American Board of Urology.**
892
- 893 **V.C.1.c).(2)** **At least 75% of the program’s graduates from the**
894 **preceding five years who took the certifying examination**
895 **for female pelvic medicine and reconstructive surgery for**
896 **the first time must have passed. In those programs with**
897 **fewer than 10 graduates in the past five years, at least**
898 **75% of the 10 most recent graduates must have passed.**
899
- 900 **V.C.1.d)** **program quality. Specifically:**
901
- 902 **V.C.1.d).(1)** **Fellows and faculty must have the opportunity to**
903 **evaluate the program confidentially and in writing at**
904 **least annually, and**
905
- 906 **V.C.1.d).(2)** **The program must use the results of fellows’**
907 **assessments of the program together with other**
908 **program evaluation results to improve the program.**
909
- 910 **V.C.2.** **If deficiencies are found, the program should prepare a written plan**
911 **of action to document initiatives to improve performance in the**
912 **areas listed in section V.C.1. The action plan should be reviewed**
913 **and approved by the teaching faculty and documented in meeting**
914 **minutes.**
915
- 916 **VI. Fellow Duty Hours in the Learning and Working Environment**
917
- 918 **VI.A. Professionalism, Personal Responsibility, and Patient Safety**

- 919
920 **VI.A.1. Programs and sponsoring institutions must educate fellows and**
921 **faculty members concerning the professional responsibilities of**
922 **physicians to appear for duty appropriately rested and fit to provide**
923 **the services required by their patients.**
924
- 925 **VI.A.2. The program must be committed to and responsible for promoting**
926 **patient safety and fellow well-being in a supportive educational**
927 **environment.**
928
- 929 **VI.A.3. The program director must ensure that fellows are integrated and**
930 **actively participate in interdisciplinary clinical quality improvement**
931 **and patient safety programs.**
932
- 933 **VI.A.4. The learning objectives of the program must:**
934
- 935 **VI.A.4.a) be accomplished through an appropriate blend of supervised**
936 **patient care responsibilities, clinical teaching, and didactic**
937 **educational events; and,**
938
- 939 **VI.A.4.b) not be compromised by excessive reliance on fellows to fulfill**
940 **non-physician service obligations.**
941
- 942 **VI.A.5. The program director and institution must ensure a culture of**
943 **professionalism that supports patient safety and personal**
944 **responsibility. Fellows and faculty members must demonstrate an**
945 **understanding and acceptance of their personal role in the**
946 **following:**
947
- 948 **VI.A.5.a) assurance of the safety and welfare of patients entrusted to**
949 **their care;**
950
- 951 **VI.A.5.b) provision of patient- and family-centered care;**
952
- 953 **VI.A.5.c) assurance of their fitness for duty;**
954
- 955 **VI.A.5.d) management of their time before, during, and after clinical**
956 **assignments;**
957
- 958 **VI.A.5.e) recognition of impairment, including illness and fatigue, in**
959 **themselves and in their peers;**
960
- 961 **VI.A.5.f) attention to lifelong learning;**
962
- 963 **VI.A.5.g) the monitoring of their patient care performance improvement**
964 **indicators; and,**
965
- 966 **VI.A.5.h) honest and accurate reporting of duty hours, patient**
967 **outcomes, and clinical experience data.**
968
- 969 **VI.A.6. All fellows and faculty members must demonstrate responsiveness**

- 970 to patient needs that supersedes self-interest. Physicians must
971 recognize that under certain circumstances, the best interests of the
972 patient may be served by transitioning that patient's care to another
973 qualified and rested provider.
974
- 975 **VI.B. Transitions of Care**
976
- 977 **VI.B.1. Programs must design clinical assignments to minimize the number**
978 **of transitions in patient care.**
979
- 980 **VI.B.2. Sponsoring institutions and programs must ensure and monitor**
981 **effective, structured hand-over processes to facilitate both**
982 **continuity of care and patient safety.**
983
- 984 **VI.B.3. Programs must ensure that fellows are competent in communicating**
985 **with team members in the hand-over process.**
986
- 987 **VI.B.4. The sponsoring institution must ensure the availability of schedules**
988 **that inform all members of the health care team of attending**
989 **physicians and fellows currently responsible for each patient's care.**
990
- 991 **VI.C. Alertness Management/Fatigue Mitigation**
992
- 993 **VI.C.1. The program must:**
994
- 995 **VI.C.1.a) educate all faculty members and fellows to recognize the**
996 **signs of fatigue and sleep deprivation;**
997
- 998 **VI.C.1.b) educate all faculty members and fellows in alertness**
999 **management and fatigue mitigation processes; and,**
1000
- 1001 **VI.C.1.c) adopt fatigue mitigation processes to manage the potential**
1002 **negative effects of fatigue on patient care and learning, such**
1003 **as naps or back-up call schedules.**
1004
- 1005 **VI.C.2. Each program must have a process to ensure continuity of patient**
1006 **care in the event that a fellow may be unable to perform his/her**
1007 **patient care duties.**
1008
- 1009 **VI.C.3. The sponsoring institution must provide adequate sleep facilities**
1010 **and/or safe transportation options for fellows who may be too**
1011 **fatigued to safely return home.**
1012
- 1013 **VI.D. Supervision of Fellows**
1014
- 1015 **VI.D.1. In the clinical learning environment, each patient must have an**
1016 **identifiable, appropriately-credentialed and privileged attending**
1017 **physician (or licensed independent practitioner as approved by each**
1018 **Review Committee) who is ultimately responsible for that patient's**
1019 **care.**
1020

- 1021 **VI.D.1.a)** This information should be available to fellows, faculty
1022 members, and patients.
1023
- 1024 **VI.D.1.b)** Fellows and faculty members should inform patients of their
1025 respective roles in each patient's care.
1026
- 1027 **VI.D.2.** The program must demonstrate that the appropriate level of
1028 supervision is in place for all fellows who care for patients.
1029
- 1030 Supervision may be exercised through a variety of methods. Some
1031 activities require the physical presence of the supervising faculty
1032 member. For many aspects of patient care, the supervising
1033 physician may be more advanced resident or fellow. Other portions
1034 of care provided by the fellow can be adequately supervised by the
1035 immediate availability of the supervising faculty member or fellow
1036 physician, either in the institution, or by means of telephonic and/or
1037 electronic modalities. In some circumstances, supervision may
1038 include post-hoc review of fellow-delivered care with feedback as to
1039 the appropriateness of that care.
1040
- 1041 **VI.D.3.** Levels of Supervision
1042
- 1043 To ensure oversight of fellow supervision and graded authority and
1044 responsibility, the program must use the following classification of
1045 supervision:
1046
- 1047 **VI.D.3.a)** Direct Supervision – the supervising physician is physically
1048 present with the fellow and patient.
1049
- 1050 **VI.D.3.b)** Indirect Supervision:
1051
- 1052 **VI.D.3.b).(1)** with direct supervision immediately available – the
1053 supervising physician is physically within the hospital
1054 or other site of patient care, and is immediately
1055 available to provide Direct Supervision.
1056
- 1057 **VI.D.3.b).(2)** with direct supervision available – the supervising
1058 physician is not physically present within the hospital
1059 or other site of patient care, but is immediately
1060 available by means of telephonic and/or electronic
1061 modalities, and is available to provide Direct
1062 Supervision.
1063
- 1064 **VI.D.3.c)** Oversight – the supervising physician is available to provide
1065 review of procedures/encounters with feedback provided
1066 after care is delivered.
1067
- 1068 **VI.D.4.** The privilege of progressive authority and responsibility, conditional
1069 independence, and a supervisory role in patient care delegated to
1070 each fellow must be assigned by the program director and faculty
1071 members.

- 1072
1073 **VI.D.4.a)** **The program director must evaluate each fellow’s abilities**
1074 **based on specific criteria. When available, evaluation should**
1075 **be guided by specific national standards-based criteria.**
1076
- 1077 **VI.D.4.b)** **Faculty members functioning as supervising physicians**
1078 **should delegate portions of care to fellows, based on the**
1079 **needs of the patient and the skills of the fellows.**
1080
- 1081 **VI.D.4.c)** **Senior residents or fellows should serve in a supervisory role**
1082 **of junior resident in recognition of their progress toward**
1083 **independence, based on the needs of each patient and the**
1084 **skills of the individual resident or fellow.**
1085
- 1086 **VI.D.5.** **Programs must set guidelines for circumstances and events in**
1087 **which fellows must communicate with appropriate supervising**
1088 **faculty members, such as the transfer of a patient to an intensive**
1089 **care unit, or end-of-life decisions.**
1090
- 1091 **VI.D.5.a)** **Each fellow must know the limits of his/her scope of**
1092 **authority, and the circumstances under which he/she is**
1093 **permitted to act with conditional independence.**
1094
- 1095 **VI.D.5.a).(1)** **In particular, PGY-1 residents should be supervised**
1096 **either directly or indirectly with direct supervision**
1097 **immediately available.**
1098
- 1099 **VI.D.6.** **Faculty supervision assignments should be of sufficient duration to**
1100 **assess the knowledge and skills of each fellow and delegate to**
1101 **him/her the appropriate level of patient care authority and**
1102 **responsibility.**
1103
- 1104 **VI.E.** **Clinical Responsibilities**
1105
- 1106 **The clinical responsibilities for each fellow must be based on PGY-level,**
1107 **patient safety, fellow education, severity and complexity of patient**
1108 **illness/condition and available support services.**
1109
- 1110 **VI.F.** **Teamwork**
1111
- 1112 **Fellows must care for patients in an environment that maximizes effective**
1113 **communication. This must include the opportunity to work as a member of**
1114 **effective interprofessional teams that are appropriate to the delivery of care**
1115 **in the specialty.**
1116
- 1117 **VI.G.** **Fellow Duty Hours**
1118
- 1119 **VI.G.1.** **Maximum Hours of Work per Week**
1120
- 1121 **Duty hours must be limited to 80 hours per week, averaged over a**
1122 **four-week period, inclusive of all in-house call activities and all**

1123 moonlighting.

1124

1125 **VI.G.1.a) Duty Hour Exceptions**

1126

1127 **A Review Committee may grant exceptions for up to 10% or a**

1128 **maximum of 88 hours to individual programs based on a**

1129 **sound educational rationale.**

1130

1131 The Review Committee will not consider requests for exceptions

1132 to the 80-hour limit to the fellows' work week.

1133

1134 **VI.G.1.a).(1) In preparing a request for an exception the program**

1135 **director must follow the duty hour exception policy**

1136 **from the ACGME Manual on Policies and Procedures.**

1137

1138 **VI.G.1.a).(2) Prior to submitting the request to the Review**

1139 **Committee, the program director must obtain approval**

1140 **of the institution's GMEC and DIO.**

1141

1142 **VI.G.2. Moonlighting**

1143

1144 **VI.G.2.a) Moonlighting must not interfere with the ability of the fellow**

1145 **to achieve the goals and objectives of the educational**

1146 **program.**

1147

1148 **VI.G.2.b) Time spent by fellows in Internal and External Moonlighting**

1149 **(as defined in the ACGME Glossary of Terms) must be**

1150 **counted towards the 80-hour Maximum Weekly Hour Limit.**

1151

1152 **VI.G.2.c) PGY-1 residents are not permitted to moonlight.**

1153

1154 **VI.G.3. Mandatory Time Free of Duty**

1155

1156 **Fellows must be scheduled for a minimum of one day free of duty**

1157 **every week (when averaged over four weeks). At-home call cannot**

1158 **be assigned on these free days.**

1159

1160 **VI.G.4. Maximum Duty Period Length**

1161

1162 **VI.G.4.a) Duty periods of PGY-1 residents must not exceed 16 hours in**

1163 **duration.**

1164

1165 **VI.G.4.b) Duty periods of PGY-2 residents and above may be**

1166 **scheduled to a maximum of 24 hours of continuous duty in**

1167 **the hospital. Programs must encourage fellows to use**

1168 **alertness management strategies in the context of patient**

1169 **care responsibilities. Strategic napping, especially after 16**

1170 **hours of continuous duty and between the hours of 10:00**

1171 **p.m. and 8:00 a.m., is strongly suggested.**

1172

1173 **VI.G.4.b).(1) It is essential for patient safety and fellow education**

1174 that effective transitions in care occur. Fellows may be
1175 allowed to remain on-site in order to accomplish these
1176 tasks; however, this period of time must be no longer
1177 than an additional four hours.
1178

1179 **VI.G.4.b).(2)** Fellows must not be assigned additional clinical
1180 responsibilities after 24 hours of continuous in-house
1181 duty.
1182

1183 **VI.G.4.b).(3)** In unusual circumstances, fellows, on their own
1184 initiative, may remain beyond their scheduled period
1185 of duty to continue to provide care to a single patient.
1186 Justifications for such extensions of duty are limited
1187 to reasons of required continuity for a severely ill or
1188 unstable patient, academic importance of the events
1189 transpiring, or humanistic attention to the needs of a
1190 patient or family.
1191

1192 **VI.G.4.b).(3).(a)** Under those circumstances, the fellow must:

1193

1194 **VI.G.4.b).(3).(a).(i)** appropriately hand over the care of all
1195 other patients to the team responsible
1196 for their continuing care; and,
1197

1198 **VI.G.4.b).(3).(a).(ii)** document the reasons for remaining to
1199 care for the patient in question and
1200 submit that documentation in every
1201 circumstance to the program director.
1202

1203 **VI.G.4.b).(3).(b)** The program director must review each
1204 submission of additional service, and track
1205 both individual fellow and program-wide
1206 episodes of additional duty.
1207

1208 **VI.G.5. Minimum Time Off between Scheduled Duty Periods**

1209

1210 **VI.G.5.a)** PGY-1 residents should have 10 hours, and must have eight
1211 hours, free of duty between scheduled duty periods.
1212

1213 **VI.G.5.b)** Intermediate-level residents should have 10 hours free of
1214 duty, and must have eight hours between scheduled duty
1215 periods. They must have at least 14 hours free of duty after 24
1216 hours of in-house duty.
1217

1218 Female pelvic medicine and reconstructive surgery fellows are
1219 considered to be in the final years of education.
1220

1221 **VI.G.5.c)** Residents in the final years of education must be prepared to
1222 enter the unsupervised practice of medicine and care of
1223 patients over irregular or extended periods.
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| 1225 | VI.G.5.c).(1) | This preparation must occur within the context of the 80-hour, maximum duty period length, and on-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 residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. |
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| 1234 | 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. |
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| 1240 | 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 resident has been involved; events of exceptional educational value; or, humanistic attention to the needs of a patient or family. |
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| 1247 | VI.G.6. | Maximum Frequency of In-House Night Float |
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| 1249 | | Fellows must not be scheduled for more than six consecutive nights of night float. |
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| 1252 | VI.G.7. | Maximum In-House On-Call Frequency |
| 1253 | | |
| 1254 | | 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). |
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| 1258 | VI.G.8. | At-Home Call |
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| 1260 | 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. |
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| 1266 | 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. |
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| 1270 | VI.G.8.b) | Fellows are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”. |
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1276 **VII. Innovative Projects**

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1278 **Requests for innovative projects that may deviate from the institutional, common**
1279 **and/or specialty specific program requirements must be approved in advance by**
1280 **the Review Committee. In preparing requests, the program director must follow**
1281 **Procedures for Approving Proposals for Innovative Projects located in the**
1282 **ACGME Manual on Policies and Procedures. Once a Review Committee approves**
1283 **a project, the sponsoring institution and program are jointly responsible for the**
1284 **quality of education offered to fellows for the duration of such a project.**

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