

1 **ACGME Program Requirements for Graduate Medical Education**
2 **in Neuropathology**

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

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

7
8 Effective: July 1, 2007
9

10 **Introduction**

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

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

36
37 **Int.B. ~~Neuropathology is the branch of medicine subspecialty of pathology dealing with~~**
38 **~~the tissue-based diagnosis of diseases of the central and peripheral nervous~~**
39 **~~systems, skeletal muscle and eye. morphological and other aspects of disease of~~**
40 **~~the nervous system.~~**

41
42 **Int.C. *The educational program in neuropathology must be 24 months ~~two years~~-in***
43 ***length. ~~and provide a structured educational experience in all current aspects of~~***
44 ***the discipline, including basic science, laboratory management, and patient care***
45 ***consultation.***

46
47 **I. Institutions**

48
49 **I.A. Sponsoring Institution**

50
51 **One sponsoring institution must assume ultimate responsibility for the**

52 program, as described in the Institutional Requirements, and this
53 responsibility extends to fellow assignments at all participating sites.

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

58
59 ~~I.A.1. A neuropathology program should be administratively attached to an~~
60 ~~anatomic pathology or anatomic and clinical pathology residency program~~
61 ~~accredited by the Accreditation Council for Graduate Medical Education~~
62 ~~(ACGME)~~

63
64 ~~I.A.2. Institutions sponsoring a neuropathology program should have additional~~
65 ~~accredited residency programs which include neurology, neurosurgery,~~
66 ~~and neuroradiology.~~

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,**
91 **required for all fellows, of one month full time equivalent (FTE) or**
92 **more through the Accreditation Council for Graduate Medical**
93 **Education (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. Qualifications of the program director must include:**
- 106
- 107 **II.A.2.a) requisite specialty expertise and documented educational**
- 108 **and administrative experience acceptable to the Review**
- 109 **Committee;**
- 110
- 111 **II.A.2.b) current certification in the subspecialty by the American**
- 112 **Board of Pathology (ABP), or subspecialty qualifications that**
- 113 **are acceptable to the Review Committee;**
- 114
- 115 *II.A.2.b).(1) If the program director is not certified in the subspecialty by*
- 116 *the ABP, at least one full-time faculty member must be*
- 117 *certified in the subspecialty.*
- 118
- 119 **II.A.2.c) current medical licensure and appropriate medical staff**
- 120 **appointment; and,**
- 121
- 122 *II.A.2.d) at least three years of active participation as a specialist in*
- 123 *neuropathology following completion of the most recent graduate*
- 124 *medical education program.*
- 125
- 126 **II.A.3. The program director must administer and maintain an educational**
- 127 **environment conducive to educating the fellows in each of the**
- 128 **ACGME competency areas. The program director must:**
- 129
- 130 **II.A.3.a) prepare and submit all information required and requested by**
- 131 **the ACGME;**
- 132
- 133 **II.A.3.b) be familiar with and oversee compliance with ACGME and**
- 134 **Review Committee policies and procedures as outlined in the**
- 135 **ACGME Manual of Policies and Procedures;**
- 136
- 137 **II.A.3.c) obtain review and approval of the sponsoring institution's**
- 138 **GMEC/DIO before submitting to the ACGME information or**
- 139 **requests for the following:**
- 140
- 141 **II.A.3.c).(1) all applications for ACGME accreditation of new**
- 142 **programs;**
- 143
- 144 **II.A.3.c).(2) changes in fellow complement;**
- 145
- 146 **II.A.3.c).(3) major changes in program structure or length of**
- 147 **training;**
- 148
- 149 **II.A.3.c).(4) progress reports requested by the Review Committee;**
- 150
- 151 **II.A.3.c).(5) responses to all proposed adverse actions;**
- 152
- 153 **II.A.3.c).(6) requests for increases or any change to fellow duty**

- 154 hours;
- 155
- 156 **II.A.3.c).(7)** voluntary withdrawals of ACGME-accredited
- 157 programs;
- 158
- 159 **II.A.3.c).(8)** requests for appeal of an adverse action; and,
- 160
- 161 **II.A.3.c).(9)** appeal presentations to a Board of Appeal or the
- 162 ACGME.
- 163
- 164 **II.A.3.d)** obtain DIO review and co-signature on all program
- 165 information forms, as well as any correspondence or
- 166 document submitted to the ACGME that addresses:
- 167
- 168 **II.A.3.d).(1)** program citations, and/or
- 169
- 170 **II.A.3.d).(2)** request for changes in the program that would have
- 171 significant impact, including financial, on the program
- 172 or institution.
- 173
- 174 *II.A.3.e)* prepare and implement a supervision policy that specifies fellow
- 175 and faculty lines of responsibility; and,
- 176
- 177 *II.A.3.f)* devote at least 35% of his or her time to clinical work with fellows,
- 178 teaching, and fellowship-related administration.
- 179
- 180 **II.B. Faculty**
- 181
- 182 **II.B.1.** There must be a sufficient number of faculty with documented
- 183 qualifications to instruct and supervise all fellows.
- 184
- 185 **II.B.2.** The faculty must devote sufficient time to the educational program
- 186 to fulfill their supervisory and teaching responsibilities and
- 187 demonstrate a strong interest in the education of fellows.
- 188
- 189 *II.B.2.a)* The faculty must, in aggregate, devote at least 20 hours per week
- 190 to fellowship-related clinical work and teaching.
- 191
- 192 **II.B.3.** The physician faculty must have current certification in the
- 193 subspecialty by the American Board of Pathology, or possess
- 194 qualifications acceptable to the Review Committee.
- 195
- 196 **II.B.4.** The physician faculty must possess current medical licensure and
- 197 appropriate medical staff appointment.
- 198
- 199 **II.C. Other Program Personnel**
- 200
- 201 The institution and the program must jointly ensure the availability of all
- 202 necessary professional, technical, and clerical personnel for the effective
- 203 administration of the program.
- 204

205 II.C.1. There must be secretarial and laboratory technical personnel to support
206 the clinical, teaching, educational, and research activities of the
207 fellowship.
208

209 II.D. Resources
210
211 **The institution and the program must jointly ensure the availability of**
212 **adequate resources for fellow education, as defined in the specialty**
213 **program requirements.**
214

215 II.D.1. There must be office space, meeting rooms, and laboratory space to
216 support teaching, educational, and research activities.
217

218 II.D.2. Clinical material related to the subspecialty area of the fellowship must be
219 provided.
220

221 II.D.2.a) Clinical material must be indexed so as to permit retrieval of
222 archived records by specified organ and/or diagnosis in a timely
223 manner.
224

225 II.D.2.b) Indexes of usual and unusual cases, course and seminar
226 materials, microscopic slide collections augmented by images
227 photographs, and museum specimens sufficient for the study of
228 conditions and diseases not frequently encountered in routine
229 necropsy and surgical specimens should be readily available to
230 the program for educational purposes.
231

232 II.D.3. ~~Appropriate laboratory space, facilities, and personnel should be available~~
233 ~~for conducting-~~ Laboratories should be equipped to perform all tests that
234 are required for the education of fellows, as well as special
235 neuropathologic procedures, including but not limited to ultrastructural,
236 histochemical, immunopathologic, and molecular-biologic techniques.
237

238 II.E. Medical Information Access
239
240 **Fellows must have ready access to specialty-specific and other appropriate**
241 **reference material in print or electronic format. Electronic medical literature**
242 **databases with search capabilities should be available.**
243

244 III. Fellow Appointments
245

246 III.A. Eligibility Criteria
247
248 **Each fellow must successfully complete an ACGME-accredited specialty**
249 **program and/or meet other eligibility criteria as specified by the Review**
250 **Committee. The program must document that each fellow has met the**
251 **eligibility criteria.**
252

253 III.A.1. Prior to appointment in the program, fellows should have completed two
254 years of a pathology residency accredited by the ACGME or the Royal
255 College of Physicians and Surgeons of Canada (RCPSC), or have

256 certification in anatomic pathology and clinical pathology, in anatomic
257 pathology, or in neurology or neurological surgery by a member board of
258 the American Board of Medical Specialties (ABMS). At a minimum,
259 fellows must have completed one year in an ACGME-accredited anatomic
260 pathology residency program.

261
262 **III.B. Number of Fellows**

263
264 **The program director may not appoint more fellows than approved by the**
265 **Review Committee, unless otherwise stated in the specialty-specific**
266 **requirements. The program's educational resources must be adequate to**
267 **support the number of fellows appointed to the program.**

268
269 *III.B.1. The education of other learners must not dilute the educational*
270 *experience of the program's fellows.*

271
272 **IV. Educational Program**

273
274 **IV.A. The curriculum must contain the following educational components:**

275
276 **IV.A.1. Skills and competencies the fellow will be able to demonstrate at the**
277 **conclusion of the program. The program must distribute these skills**
278 **and competencies to fellows and faculty annually, in either written**
279 **or electronic form. These skills and competencies should be**
280 **reviewed by the fellow at the start of each rotation;**

281
282 **IV.A.2. ACGME Competencies**

283
284 **The program must integrate the following ACGME competencies**
285 **into the curriculum:**

286
287 **IV.A.2.a) Patient Care**

288
289 **Fellows must be able to provide patient care that is**
290 **compassionate, appropriate, and effective for the treatment of**
291 **health problems and the promotion of health. Fellows:**

292
293 **IV.A.2.a).(1) ~~must demonstrate a satisfactory level of diagnostic~~**
294 **~~competence and the ability to provide appropriate and~~**
295 **~~effective consultation in the context of pathology services;~~**

296
297 **IV.A.2.a).(2) ~~must actively participate in the evaluation of~~**
298 **demonstrate**
299 **competence in evaluating a comprehensive body of**
300 **pathological lesions of the central nervous system,**
301 **peripheral nervous system, and neuromuscular systems,**
302 **and eye; and.**

303 **IV.A.2.a).(3) ~~should develop~~ must demonstrate competence in**
304 **morphologic assessment of diseases of muscle and**
305 **peripheral nerves and eye, including morphometric**
306 **analysis and teased nerve fiber preparations; ~~and to study~~**

307		neoplasms and related lesions of peripheral nerves; and
308		the sympathetic and parasympathetic nervous systems;
309		
310	IV.A.2.a).(3).(a)	<u>Each fellow must perform at least 200 necropsies that include examination of the nervous system, including forensic and pediatric cases.</u>
311		
312		
313		
314	IV.A.2.a).(3).(a).(i)	(these may <u>It is suggested that these examinations include brains seen in consultation, brains from complete autopsies, or brain-only autopsies).</u>
315		
316		
317		
318		
319	IV.A.2.a).(3).(b)	<u>Each fellow must examine at least 300 neurosurgical specimens (including consultations) from the brain, spinal cord, pituitary gland, and eyes, to (include neoplastic, degenerative, infectious, and immune disorders of significance in the treatment and management of pediatric and adult patients).</u>
320		
321		
322		
323		
324		
325		
326		
327	IV.A.2.a).(3).(c)	<u>Each fellow must perform at least 50 intraoperative neurosurgical consultations.</u>
328		
329		
330	IV.A.2.b)	Medical Knowledge
331		
332		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:
333		
334		
335		
336		
337	IV.A.2.b).(1)	must demonstrate <u>expertise in their knowledge about of</u> established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences, and the application of this knowledge to pathology;
338		
339		
340		
341		
342	IV.A.2.b).(2)	must learn to integrate neuropathologic information into medical consultations with clinicians in the diagnosis and management of patients.
343		
344		
345		
346	IV.A.2.c)	Practice-based Learning and Improvement
347		
348		Fellows are expected to develop skills and habits to be able to meet the following goals:
349		
350		
351	IV.A.2.c).(1)	systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; and,
352		
353		
354		
355	IV.A.2.c).(2)	locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems.
356		
357		

358
359 IV.A.2.c).(3) investigate and evaluate their diagnostic and consultative
360 practices, appraise and assimilate scientific evidence and
361 improve their patient care practices.
362

363 **IV.A.2.d) Interpersonal and Communication Skills**

364
365 **Fellows must demonstrate interpersonal and communication**
366 **skills that result in the effective exchange of information and**
367 **collaboration with patients, their families, and health**
368 **professionals.**

369
370 IV.A.2.d).(1) Fellow must demonstrate interpersonal and communication
371 skills that result in effective information exchange and
372 teaming with other health care providers, patients, and
373 patients' families. Fellows must demonstrate competence
374 in providing appropriate and effective consultations to
375 other physicians and health professionals, both intra- and
376 inter-departmental.
377

378 IV.A.2.d).(1).(a) Fellows must integrate neuropathologic information
379 into medical consultations with clinicians regarding
380 the diagnosis and management of patients.

381
382 IV.A.2.d).(1).(b) Consultations should include providing medical
383 advice on diagnosis and management of neurologic
384 disorders.

385
386 IV.A.2.d).(1).(c) ~~Fellow must demonstrate interpersonal and~~
387 ~~communication skills that result in~~ Consultations
388 must include effective information exchange and
389 teaming with other health care providers, patients,
390 and patients' families.
391

392 **IV.A.2.e) Professionalism**

393
394 **Fellows must demonstrate a commitment to carrying out**
395 **professional responsibilities and an adherence to ethical**
396 **principles.**

397
398 IV.A.2.e).(1) ~~Fellows must demonstrate commitment to carrying out~~
399 ~~professional responsibilities, adherence to ethical~~
400 ~~principles, and sensitivity to a diverse patient population.~~

401
402 **IV.A.2.f) Systems-based Practice**

403
404 **Fellows must demonstrate an awareness of and**
405 **responsiveness to the larger context and system of health**
406 **care, as well as the ability to call effectively on other**
407 **resources in the system to provide optimal health care.**
408

- 409 IV.A.2.f).(1) ~~Fellows must demonstrate an awareness and~~
410 ~~responsiveness to the larger context and system of health~~
411 ~~care and the ability to call on system resources to provide~~
412 ~~pathology services that are of optimal value. Resources~~
413 ~~must include pathology services.~~
414
415 IV.A.3. Curriculum Organization and Fellow Experiences
416
417 IV.A.3.a) Fellows' clinical experience should be augmented through didactic
418 sessions, review of the medical literature in the subspecialty area,
419 and use of study sets of unusual cases.
420
421 IV.A.3.b) ~~Fellows should regularly participate in basic neuroscience~~
422 ~~activities. The didactic curriculum must include teaching~~
423 ~~conferences in neuropathology, journal clubs, and joint~~
424 ~~conferences with the Pathology Department, ~~and as well as with~~~~
425 ~~clinical services involved in the diagnosis and management of~~
426 ~~neurological disorders patient care utilizing neuropathology.~~
427
428 IV.A.3.c) ~~Fellows Didactic instruction should include be provided with the~~
429 ~~exposure to neuro-oncology and neurogenetics the diagnosis and~~
430 ~~management of patients with neurological disorders, including~~
431 ~~those patients whose treatment require neuro-oncologic and~~
432 ~~neuro-genetic components.~~
433
434 IV.A.3.d) Fellows must actively participate in conferences, on average, at
435 least once per month, and should give a minimum of two
436 presentations per year.
437
438 **IV.B. Fellows' Scholarly Activities**
439
440 IV.B.1. Each fellow should participate in scholarly activity, including at least one
441 of the following:
442
443 IV.B.1.a) research;
444
445 IV.B.1.b) evidence-based presentations at journal club or meetings (local,
446 regional, or national); or,
447
448 IV.B.1.c) preparation/submission of articles for peer-reviewed publications.
449
450 **V. Evaluation**
451
452 **V.A. Fellow Evaluation**
453
454 **V.A.1. Formative Evaluation**
455
456 **V.A.1.a) The faculty must evaluate fellow performance in a timely**
457 **manner.**
458
459 **V.A.1.b) The program must:**

460		
461	V.A.1.b).(1)	provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;
462		
463		
464		
465		
466		
467	V.A.1.b).(2)	use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff); and,
468		
469		
470	V.A.1.b).(3)	provide each fellow with documented semiannual evaluation of performance with feedback.
471		
472		
473	V.A.1.c)	The evaluations of fellow performance must be accessible for review by the fellow, in accordance with institutional policy.
474		
475		
476	V.A.2.	Summative Evaluation
477		
478		The program director must provide a summative evaluation for each fellow upon completion of the program. This evaluation must become part of the fellow’s permanent record maintained by the institution, and must be accessible for review by the fellow in accordance with institutional policy. This evaluation must:
479		
480		
481		
482		
483		
484	V.A.2.a)	document the fellow’s performance during their education, and
485		
486		
487	V.A.2.b)	verify that the fellow has demonstrated sufficient competence to enter practice without direct supervision.
488		
489		
490	V.B.	Faculty Evaluation
491		
492	V.B.1.	At least annually, the program must evaluate faculty performance as it relates to the educational program.
493		
494		
495	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.
496		
497		
498		
499	V.C.	Program Evaluation and Improvement
500		
501	V.C.1.	The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:
502		
503		
504		
505	V.C.1.a)	fellow performance, and
506		
507	V.C.1.b)	faculty development
508		
509	V.C.2.	If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the
510		

- 511 areas listed in section V.C.1. The action plan should be reviewed
512 and approved by the teaching faculty and documented in meeting
513 minutes.
514
- 515 V.C.3. 60 percent of the program's graduates from the preceding five years
516 taking the ABP certifying examination for neuropathology for the first time
517 must pass.
518
- 519 **VI. Fellow Duty Hours in the Learning and Working Environment**
520
- 521 **VI.A. Professionalism, Personal Responsibility, and Patient Safety**
522
- 523 **VI.A.1. Programs and sponsoring institutions must educate fellows and**
524 **faculty members concerning the professional responsibilities of**
525 **physicians to appear for duty appropriately rested and fit to provide**
526 **the services required by their patients.**
527
- 528 **VI.A.2. The program must be committed to and responsible for promoting**
529 **patient safety and fellow well-being in a supportive educational**
530 **environment.**
531
- 532 **VI.A.3. The program director must ensure that fellows are integrated and**
533 **actively participate in interdisciplinary clinical quality improvement**
534 **and patient safety programs.**
535
- 536 **VI.A.4. The learning objectives of the program must:**
537
- 538 **VI.A.4.a) be accomplished through an appropriate blend of supervised**
539 **patient care responsibilities, clinical teaching, and didactic**
540 **educational events; and,**
541
- 542 **VI.A.4.b) not be compromised by excessive reliance on fellows to fulfill**
543 **non-physician service obligations.**
544
- 545 **VI.A.5. The program director and sponsoring institution must ensure a**
546 **culture of professionalism that supports patient safety and personal**
547 **responsibility. Fellows and faculty members must demonstrate an**
548 **understanding and acceptance of their personal role in the**
549 **following:**
550
- 551 **VI.A.5.a) assurance of the safety and welfare of patients entrusted to**
552 **their care;**
553
- 554 **VI.A.5.b) provision of patient- and family-centered care;**
555
- 556 **VI.A.5.c) assurance of their fitness for duty;**
557
- 558 **VI.A.5.d) management of their time before, during, and after clinical**
559 **assignments;**
560
- 561 **VI.A.5.e) recognition of impairment, including illness and fatigue, in**

- 562 themselves and in their peers;
563
564 VI.A.5.f) attention to lifelong learning;
565
566 VI.A.5.g) the monitoring of their patient care performance improvement
567 indicators; and,
568
569 VI.A.5.h) honest and accurate reporting of duty hours, patient
570 outcomes, and clinical experience data.
571
572 VI.A.6. All fellows and faculty members must demonstrate responsiveness
573 to patient needs that supersedes self-interest. Physicians must
574 recognize that under certain circumstances, the best interests of the
575 patient may be served by transitioning that patient's care to another
576 qualified and rested provider.
577
578 VI.B. Transitions of Care
579
580 VI.B.1. Programs must design clinical assignments to minimize the number
581 of transitions in patient care.
582
583 VI.B.2. Sponsoring institutions and programs must ensure and monitor
584 effective, structured hand-over processes to facilitate both
585 continuity of care and patient safety.
586
587 VI.B.3. Programs must ensure that fellows are competent in communicating
588 with team members in the hand-over process.
589
590 VI.B.4. The sponsoring institution must ensure the availability of schedules
591 that inform all members of the health care team of attending
592 physicians and fellows currently responsible for each patient's care.
593
594 VI.C. Alertness Management/Fatigue Mitigation
595
596 VI.C.1. The program must:
597
598 VI.C.1.a) educate all faculty members and fellows to recognize the
599 signs of fatigue and sleep deprivation;
600
601 VI.C.1.b) educate all faculty members and fellows in alertness
602 management and fatigue mitigation processes; and,
603
604 VI.C.1.c) adopt fatigue mitigation processes to manage the potential
605 negative effects of fatigue on patient care and learning, such
606 as naps or back-up call schedules.
607
608 VI.C.2. Each program must have a process to ensure continuity of patient
609 care in the event that a fellow may be unable to perform his/her
610 patient care duties.
611
612 VI.C.3. The sponsoring institution must provide adequate sleep facilities

613 and/or safe transportation options for fellows who may be too
614 fatigued to safely return home.
615
616 **VI.D. Supervision of Fellows**
617
618 **VI.D.1. In the clinical learning environment, each patient must have an**
619 **identifiable, appropriately-credentialed and privileged attending**
620 **physician (or licensed independent practitioner as approved by each**
621 **Review Committee) who is ultimately responsible for that patient’s**
622 **care.**
623
624 **VI.D.1.a) This information should be available to fellows, faculty**
625 **members, and patients.**
626
627 **VI.D.1.b) Fellows and faculty members should inform patients of their**
628 **respective roles in each patient’s care.**
629
630 **VI.D.2. The program must demonstrate that the appropriate level of**
631 **supervision is in place for all fellows who care for patients.**
632
633 **Supervision may be exercised through a variety of methods. Some**
634 **activities require the physical presence of the supervising faculty**
635 **member. For many aspects of patient care, the supervising**
636 **physician may be a more advanced fellow. Other portions of care**
637 **provided by the fellow can be adequately supervised by the**
638 **immediate availability of the supervising faculty member or fellow**
639 **physician, either in the institution, or by means of telephonic and/or**
640 **electronic modalities. In some circumstances, supervision may**
641 **include post-hoc review of fellow-delivered care with feedback as to**
642 **the appropriateness of that care.**
643
644 **VI.D.3. Levels of Supervision**
645
646 **To ensure oversight of fellow supervision and graded authority and**
647 **responsibility, the program must use the following classification of**
648 **supervision:**
649
650 **VI.D.3.a) Direct Supervision – the supervising physician is physically**
651 **present with the fellow and patient.**
652
653 **VI.D.3.b) Indirect Supervision:**
654
655 **VI.D.3.b).(1) with direct supervision immediately available – the**
656 **supervising physician is physically within the hospital**
657 **or other site of patient care, and is immediately**
658 **available to provide Direct Supervision.**
659
660 **VI.D.3.b).(2) with direct supervision available – the supervising**
661 **physician is not physically present within the hospital**
662 **or other site of patient care, but is immediately**
663 **available by means of telephonic and/or electronic**

664		modalities, and is available to provide Direct
665		Supervision.
666		
667	VI.D.3.c)	Oversight – the supervising physician is available to provide
668		review of procedures/encounters with feedback provided
669		after care is delivered.
670		
671	VI.D.4.	The privilege of progressive authority and responsibility, conditional
672		independence, and a supervisory role in patient care delegated to
673		each fellow must be assigned by the program director and faculty
674		members.
675		
676	VI.D.4.a)	The program director must evaluate each fellow’s abilities
677		based on specific criteria. When available, evaluation should
678		be guided by specific national standards-based criteria.
679		
680	VI.D.4.b)	Faculty members functioning as supervising physicians
681		should delegate portions of care to fellows, based on the
682		needs of the patient and the skills of the fellows.
683		
684	VI.D.4.c)	Fellows should serve in a supervisory role of residents or
685		junior fellows in recognition of their progress toward
686		independence, based on the needs of each patient and the
687		skills of the individual fellow.
688		
689	VI.D.5.	Programs must set guidelines for circumstances and events in
690		which fellows must communicate with appropriate supervising
691		faculty members, such as the transfer of a patient to an intensive
692		care unit, or end-of-life decisions.
693		
694	VI.D.5.a)	Each fellow must know the limits of his/her scope of
695		authority, and the circumstances under which he/she is
696		permitted to act with conditional independence.
697		
698	VI.D.6.	Faculty supervision assignments should be of sufficient duration to
699		assess the knowledge and skills of each fellow and delegate to
700		him/her the appropriate level of patient care authority and
701		responsibility.
702		
703	VI.E.	Clinical Responsibilities
704		
705		The clinical responsibilities for each fellow must be based on PGY-level,
706		patient safety, fellow education, severity and complexity of patient
707		illness/condition and available support services.
708		
709		<i>[Optimal clinical workload will be further specified by each Review Committee.]</i>
710		
711	VI.F.	Teamwork
712		
713		Fellows must care for patients in an environment that maximizes effective
714		communication. This must include the opportunity to work as a member of

715 **effective interprofessional teams that are appropriate to the delivery of care**
716 **in the specialty.**
717
718 *[Each Review Committee will define the elements that must be present in each*
719 *specialty.]*
720
721 **VI.G. Fellow Duty Hours**
722
723 **VI.G.1. Maximum Hours of Work per Week**
724
725 **Duty hours must be limited to 80 hours per week, averaged over a**
726 **four-week period, inclusive of all in-house call activities and all**
727 **moonlighting.**
728
729 **VI.G.1.a) Duty Hour Exceptions**
730
731 **A Review Committee may grant exceptions for up to 10% or a**
732 **maximum of 88 hours to individual programs based on a**
733 **sound educational rationale.**
734
735 **VI.G.1.a).(1) In preparing a request for an exception the program**
736 **director must follow the duty hour exception policy**
737 **from the ACGME Manual on Policies and Procedures.**
738
739 **VI.G.1.a).(2) Prior to submitting the request to the Review**
740 **Committee, the program director must obtain approval**
741 **of the institution’s GMEC and DIO.**
742
743 **VI.G.2. Moonlighting**
744
745 **VI.G.2.a) Moonlighting must not interfere with the ability of the fellow**
746 **to achieve the goals and objectives of the educational**
747 **program.**
748
749 **VI.G.2.b) Time spent by fellows in Internal and External Moonlighting**
750 **(as defined in the ACGME Glossary of Terms) must be**
751 **counted towards the 80-hour Maximum Weekly Hour Limit.**
752
753 **VI.G.3. Mandatory Time Free of Duty**
754
755 **Fellows must be scheduled for a minimum of one day free of duty**
756 **every week (when averaged over four weeks). At-home call cannot**
757 **be assigned on these free days.**
758
759 **VI.G.4. Maximum Duty Period Length**
760
761 **Duty periods of fellows may be scheduled to a maximum of 24 hours**
762 **of continuous duty in the hospital. Programs must encourage**
763 **fellows to use alertness management strategies in the context of**
764 **patient care responsibilities. Strategic napping, especially after 16**

765 hours of continuous duty and between the hours of 10:00 p.m. and
766 8:00 a.m., is strongly suggested.
767

768 **VI.G.4.a)** It is essential for patient safety and fellow education that
769 effective transitions in care occur. Fellows may be allowed to
770 remain on-site in order to accomplish these tasks; however,
771 this period of time must be no longer than an additional four
772 hours.
773

774 **VI.G.4.b)** Fellows must not be assigned additional clinical
775 responsibilities after 24 hours of continuous in-house duty.
776

777 **VI.G.4.c)** In unusual circumstances, fellows, on their own initiative,
778 may remain beyond their scheduled period of duty to
779 continue to provide care to a single patient. Justifications for
780 such extensions of duty are limited to reasons of required
781 continuity for a severely ill or unstable patient, academic
782 importance of the events transpiring, or humanistic attention
783 to the needs of a patient or family.
784

785 **VI.G.4.c).(1)** Under those circumstances, the fellow must:
786

787 **VI.G.4.c).(1).(a)** appropriately hand over the care of all other
788 patients to the team responsible for their
789 continuing care; and,
790

791 **VI.G.4.c).(1).(b)** document the reasons for remaining to care for
792 the patient in question and submit that
793 documentation in every circumstance to the
794 program director.
795

796 **VI.G.4.c).(2)** The program director must review each submission of
797 additional service, and track both individual fellow and
798 program-wide episodes of additional duty.
799

800 **VI.G.5.** **Minimum Time Off between Scheduled Duty Periods**
801

802 **VI.G.5.a)** Fellows in the final years of education *[as defined by the*
803 *Review Committee]* must be prepared to enter the
804 unsupervised practice of medicine and care for patients over
805 irregular or extended periods.
806

807 **VI.G.5.a).(1)** This preparation must occur within the context of the
808 80-hour, maximum duty period length, and one-day-
809 off-in-seven standards. While it is desirable that
810 fellows in their final years of education have eight
811 hours free of duty between scheduled duty periods,
812 there may be circumstances *[as defined by the Review*
813 *Committee]* when these fellows must stay on duty to
814 care for their patients or return to the hospital with
815 fewer than eight hours free of duty.

816
817 **VI.G.5.a).(1).(a)** **Circumstances of return-to-hospital activities**
818 **with fewer than eight hours away from the**
819 **hospital by fellows in their final years of**
820 **education must be monitored by the program**
821 **director.**
822
823 **VI.G.6.** **Maximum Frequency of In-House Night Float**
824
825 **Fellows must not be scheduled for more than six consecutive nights**
826 **of night float.**
827
828 *[The maximum number of consecutive weeks of night float, and maximum*
829 *number of months of night float per year may be further specified by the*
830 *Review Committee.]*
831
832 **VI.G.7.** **Maximum In-House On-Call Frequency**
833
834 **Fellows must be scheduled for in-house call no more frequently than**
835 **every-third-night (when averaged over a four-week period).**
836
837 **VI.G.8.** **At-Home Call**
838
839 **VI.G.8.a)** **Time spent in the hospital by fellows on at-home call must**
840 **count towards the 80-hour maximum weekly hour limit. The**
841 **frequency of at-home call is not subject to the every-third-**
842 **night limitation, but must satisfy the requirement for one-day-**
843 **in-seven free of duty, when averaged over four weeks.**
844
845 **VI.G.8.a).(1)** **At-home call must not be so frequent or taxing as to**
846 **preclude rest or reasonable personal time for each**
847 **fellow.**
848
849 **VI.G.8.b)** **Fellows are permitted to return to the hospital while on at-**
850 **home call to care for new or established patients. Each**
851 **episode of this type of care, while it must be included in the**
852 **80-hour weekly maximum, will not initiate a new “off-duty**
853 **period”.**
854
855 *******