Accreditation Council for
Graduate Medical Education

ACGME Program Requirements for Regional Anesthesiology and Acute Pain Medicine

Program Requirements for Graduate Medical Education in Regional Anesthesiology and Acute Pain Medicine

Introduction

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

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

Int.B. Definition and Scope of the Specialty

Regional anesthesiology and acute pain medicine focuses on the management of acute pain, including the complete peri-operative pain management of surgical and non-surgical patients with or without interventional modes of analgesia. Fellowship training should result in the development of expertise in the practice and theory of regional anesthesiology and acute pain medicine.

Specifically, the scope of this specialty includes:

Int.B.1. pre-operative evaluation and management of pain, including indications and contraindications for interventional pain management techniques;

Int.B.2. intra-operative application of regional anesthesia (with or without general anesthesia);

Int.B.3. post-operative application of regional analgesia in inpatients and outpatients;

Int.B.4. peri-operative multimodal acute pain management of surgical patients; and,

Int.B.5. acute pain management of non-surgical patients.

Int.C. The educational program in regional anesthesiology and acute pain medicine must be 12 months in length. (Core)

I. Institutions

I.A. Sponsoring Institution

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

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

I.A.1. The Sponsoring Institution must sponsor an Accreditation Council for Graduate Medical Education (ACGME)-accredited anesthesiology residency. (Core)

I.A.2. There must be only one regional anesthesiology and acute pain medicine program associated with a single anesthesiology residency program. (Core)

I.B. Participating Sites

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

The PLA should:

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

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

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

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

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

II. Program Personnel and Resources

II.A. Program Director

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

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

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

II.A.2.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee; (Core)

II.A.2.b) current certification in the subspecialty by the American Board of Anesthesiology, or subspecialty qualifications that are acceptable to the Review Committee; and, (Core)

II.A.2.c) current medical licensure and appropriate medical staff appointment. (Core)

II.A.3. The program director must administer and maintain an educational environment conducive to educating the fellows in each of the ACGME competency areas. (Core)

The program director must:

II.A.3.a) prepare and submit all information required and requested by the ACGME; (Core)

II.A.3.b) be familiar with and oversee compliance with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures; (Detail)

II.A.3.c) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting information or requests to the ACGME, including: (Core)

II.A.3.c).(1) all applications for ACGME accreditation of new programs; (Detail)

II.A.3.c).(2) changes in fellow complement; (Detail)

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

II.A.3.c).(4) progress reports requested by the Review Committee;

(Detail)

II.A.3.c).(5) **requests for increases or any change to fellow duty hours; (Detail)**

II.A.3.c).(6) **voluntary withdrawals of ACGME-accredited programs; (Detail)**

II.A.3.c).(7) **requests for appeal of an adverse action; and, (Detail)**

II.A.3.c).(8) **appeal presentations to a Board of Appeal or the ACGME. (Detail)**

II.A.3.d) **obtain DIO review and co-signature on all program application forms, as well as any correspondence or document submitted to the ACGME that addresses: (Detail)**

II.A.3.d).(1) **program citations, and/or, (Detail)**

II.A.3.d).(2) **request for changes in the program that would have significant impact, including financial, on the program or institution. (Detail)**

II.B. Faculty

II.B.1. **There must be a sufficient number of faculty with documented qualifications to instruct and supervise all fellows. (Core)**

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

II.B.3. **The physician faculty must have current certification in the subspecialty by the American Board of Anesthesiology, or possess qualifications judged acceptable to the Review Committee. (Core)**

II.B.3.a) There must be at least two faculty members, including the program director, with expertise in regional anesthesiology and acute pain medicine. (Core)

II.B.3.b) At each participating site there must be a ratio of at least one FTE faculty member to two fellows. (Core)

II.B.4. **The physician faculty must possess current medical licensure and appropriate medical staff appointment. (Core)**

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

II.B.5.a) The members of the faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. (Core)

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

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

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

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

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

II.B.5.c) Faculty members must encourage and support fellows' scholarly activities. (Core)

II.C. Other Program Personnel

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

II.D. Resources

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

II.D.1. Equipment required for the performance of a wide variety of regional anesthesiology/analgesia techniques, including ultrasound and nerve stimulators, must be available. Appropriate monitoring and life support equipment must be immediately available when invasive procedures are performed by program personnel. (Core)

II.D.2. The patient population should include patients with a wide variety of clinical acute pain problems to allow fellows to develop broad clinical skills and knowledge required for a specialist in regional anesthesiology and acute pain medicine. (Detail)

II.E. Medical Information Access

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

III. Fellow Appointments

III.A. Eligibility Requirements – Fellowship Programs

All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, or in an RCPSC-accredited or CFPC-accredited residency program located in Canada. (Core)

Prior to appointment in the program, fellows must have successfully completed an ACGME-accredited residency in anesthesiology. (Core)

III.A.1. **Fellowship programs must receive verification of each entering fellow's level of competency in the required field using ACGME or CanMEDS Milestones assessments from the core residency program.** (Core)

III.A.2. **Fellow Eligibility Exception**

A Review Committee may grant the following exception to the fellowship eligibility requirements:

An ACGME-accredited fellowship program may accept an exceptionally qualified applicant, who does not satisfy the eligibility requirements listed in Sections III.A. and III.A.1., but who does meet all of the following additional qualifications and conditions:** (Core)

III.A.2.a) **Assessment by the program director and fellowship selection committee of the applicant's suitability to enter the program, based on prior training and review of the summative evaluations of training in the core specialty; and** (Core)

III.A.2.b) **Review and approval of the applicant's exceptional qualifications by the GMEC or a subcommittee of the GMEC; and** (Core)

III.A.2.c) **Satisfactory completion of the United States Medical Licensing Examination (USMLE) Steps 1, 2, and, if the applicant is eligible, 3, and;** (Core)

III.A.2.d) **For an international graduate, verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification; and,** (Core)

III.A.2.e) **Applicants accepted by this exception must complete fellowship Milestones evaluation (for the purposes of establishment of baseline performance by the Clinical Competency Committee), conducted by the receiving fellowship program within six weeks of matriculation. This evaluation may be waived for an applicant who has completed an ACGME International-accredited residency based on the applicant's Milestones evaluation conducted at the conclusion of the residency program.** (Core)

III.A.2.e).(1) **If the trainee does not meet the expected level of Milestones competency following entry into the fellowship program, the trainee must undergo a period of remediation, overseen by the Clinical Competency Committee and monitored by the GMEC or a subcommittee of the GMEC. This period of remediation must not count toward time in fellowship training. (Core)**

**** An exceptionally qualified applicant has (1) completed a non-ACGME-accredited residency program in the core specialty, and (2) demonstrated clinical excellence, in comparison to peers, throughout training. Additional evidence of exceptional qualifications is required, which may include one of the following: (a) participation in additional clinical or research training in the specialty or subspecialty; (b) demonstrated scholarship in the specialty or subspecialty; (c) demonstrated leadership during or after residency training; (d) completion of an ACGME-International-accredited residency program.**

III.A.3. **The Review Committee for** Anesthesiology **does allow exceptions to the Eligibility Requirements for Fellowship Programs in Section III.A. (Core)**

III.B. Number of Fellows

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

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

III.B.2. The presence of other learners or staff members must not interfere with the appointed fellows' education. (Core)

IV. Educational Program

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

IV.A.1. **Skills and competencies the fellow will be able to demonstrate at the conclusion of the program. The program must distribute these skills and competencies to fellows and faculty at least annually, in either written or electronic form. (Core)**

IV.A.2. **ACGME Competencies**

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

IV.A.2.a) **Patient Care and Procedural Skills**

IV.A.2.a).(1) **Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Fellows:** (Outcome)

IV.A.2.a).(1).(a) must demonstrate competence by following standards for patient care and established guidelines and procedures for patient safety, error reduction, and improved patient outcomes; (Outcome)

IV.A.2.a).(1).(b) must demonstrate the following competencies in regional anesthesiology: (outcome)

IV.A.2.a).(1).(b).(i) performance of pre-operative patient evaluation and optimization of clinical status; (Outcome)

IV.A.2.a).(1).(b).(ii) performance of a detailed neurologic history and physical examination with particular attention to pre-existing neurologic deficits and their impact on the anesthetic plan; (Outcome)

IV.A.2.a).(1).(b).(iii) rational selection of regional anesthesiology and/or post-operative analgesic techniques for specific clinical situations; (Outcome)

IV.A.2.a).(1).(b).(iii).(a) This must include regional techniques, multimodal analgesia, and opioid and non-opioid pharmacological management. (Core)

IV.A.2.a).(1).(b).(iv) selection of regional versus general anesthesia for various procedures and patients in regard to patient recovery, patient outcome, operating room efficiency, and cost of care; (Outcome)

IV.A.2.a).(1).(b).(v) management of inadequate operative regional anesthetic and post-operative analgesic techniques, including the use of supplemental blockade, alternate approaches, and pharmacological intervention; and, (Outcome)

IV.A.2.a).(1).(b).(vi) skills and knowledge necessary to perform and to effectively teach a wide range of advanced practice block techniques, achieving a high success and low complication rate. (Outcome)

IV.A.2.a).(1).(c) must demonstrate the following competencies in acute pain medicine:(Outcome)

IV.A.2.a).(1).(c).(i) understanding how the acute pain medicine service addresses:

IV.A.2.a).(1).(c).(i).(a) surgical regional anesthetic techniques (as placed by the operating room (OR) anesthesiologist); (Outcome)

IV.A.2.a).(1).(c).(i).(b) the peri-operative use of analgesic techniques by the acute pain medicine service; (Outcome)

IV.A.2.a).(1).(c).(i).(c) the peri-operative management of acute pain medicine intervention; (Outcome)

IV.A.2.a).(1).(c).(i).(d) the provision of acute pain medicine services directed toward the patient with chronic pain who is also experiencing acute pain; and, (Outcome)

IV.A.2.a).(1).(c).(i).(e) the provision of acute pain management to select non-surgical patients, such as those with sickle cell disease or other conditions known to cause acute pain. (Outcome)

IV.A.2.a).(1).(c).(ii) management of an acute pain medicine service. (Outcome)

IV.A.2.a).(1).(c).(ii).(a) Patient management should include multimodal analgesic techniques, such as neuraxial and peripheral nerve catheters, local anesthetic and opioid infusions, and non-opioid analgesic adjuvants. (Detail)

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

IV.A.2.a).(2).(a) must demonstrate competence in providing anesthesia and peri-operative pain management for patients undergoing orthopedic surgery; (Outcome)

IV.A.2.a).(2).(b) must demonstrate competence in providing

anesthesia and peri-operative pain management for patients undergoing non-orthopaedic surgery that is amenable to regional anesthesiology, including neuraxial and peripheral nerve block; and, (Outcome)

IV.A.2.a).(2).(c) must demonstrate competence in bedside point of care ultrasound for use in placement and management of neuraxial and peripheral blocks. (Outcome)

IV.A.2.b) Medical Knowledge

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

IV.A.2.b).(1) must demonstrate knowledge of anatomy and clinical pharmacology, including: (Outcome)

IV.A.2.b).(1).(a) central neuraxial and peripheral nerve anatomy, including: (Outcome)

IV.A.2.b).(1).(a).(i) anatomy of neural pathways; (Outcome)

IV.A.2.b).(1).(a).(ii) differences between motor and sensory nerves; and, (Outcome)

IV.A.2.b).(1).(a).(iii) microanatomy of the nerve cell. (Outcome)

IV.A.2.b).(1).(b) local anesthetic pharmacology, including the: (Outcome)

IV.A.2.b).(1).(b).(i) mechanism of action, physicochemical properties, pharmacokinetics and pharmacodynamics, and appropriate dosing for single injection or continuous infusion; (Outcome)

IV.A.2.b).(1).(b).(ii) selection and dose of local anesthetics as indicated for specific surgical conditions and in different age groups from infants to adults; (Outcome)

IV.A.2.b).(1).(b).(iii) dosing, advantages, and disadvantages of local anesthetic adjuvants; and, (Outcome)

IV.A.2.b).(1).(b).(iv) signs, symptoms, and treatment of local anesthetic systemic toxicity or neurotoxicity of local anesthetics. (Outcome)

IV.A.2.b).(1).(c) neuraxial opioids, including: (Outcome)

IV.A.2.b).(1).(c).(i) indications/contraindications, mechanism of action, physicochemical properties, effective dosing, and duration of action; (Outcome)

IV.A.2.b).(1).(c).(ii) complications and adverse effects, including related monitoring, prevention, and therapy; and, (Outcome)

IV.A.2.b).(1).(c).(iii) differentiation of intrathecal versus epidural administration relative to dose, effect, and adverse effects. (Outcome)

IV.A.2.b).(1).(d) systemic opioids, including: (Outcome)

IV.A.2.b).(1).(d).(i) pharmacokinetics of opioid analgesics, to include bioavailability, absorption, distribution, metabolism, and excretion; (Outcome)

IV.A.2.b).(1).(d).(ii) mechanism of action; (Outcome)

IV.A.2.b).(1).(d).(iii) chemical structure; (Outcome)

IV.A.2.b).(1).(d).(iv) mechanisms, uses, and contraindications for opioid agonists, opioid antagonists, mixed agents and (Outcome)

IV.A.2.b).(1).(d).(v) use of patient controlled analgesic systems; (Outcome)

IV.A.2.b).(1).(d).(vi) post-procedure analgesic management in the patient with chronic pain and/or opioid-induced hyperalgesia; and, (Outcome)

IV.A.2.b).(1).(d).(vii) management of acute or chronic pain in the opioid tolerant patient. (Outcome)

IV.A.2.b).(1).(e) non-opioid analgesics, including: (Outcome)

IV.A.2.b).(1).(e).(i) multimodal analgesia and its impact on recovery after surgery; and, (Outcome)

IV.A.2.b).(1).(e).(ii) pharmacology of acetaminophen, NSAIDs, COX-2 inhibitors, N-methyl-D-aspartic acid antagonists, α-2 agonists, and γ-aminobutyric acid-pentanoic agents and anticonvulsant drugs with respect to optimizing post-operative analgesia. (Outcome)

IV.A.2.b).(2) must demonstrate knowledge of regional anesthesia techniques, including:

IV.A.2.b).(2).(a) nerve localization techniques, including: (Outcome)

IV.A.2.b).(2).(a).(i) principles, operation, advantages, and limitations of the peripheral nerve stimulator to localize and anesthetize peripheral nerves; (Outcome)

IV.A.2.b).(2).(a).(ii) principles of paresthesia-seeking, perivascular, or transvascular approaches to nerve localization; and, (Outcome)

IV.A.2.b).(2).(a).(iii) principles, operation, advantages, safety and limitations of ultrasound to localize and anesthetize peripheral nerves. (Outcome)

IV.A.2.b).(2).(b) spinal anesthesia, including: (Outcome)

IV.A.2.b).(2).(b).(i) anatomy of the neuraxis; (Outcome)

IV.A.2.b).(2).(b).(ii) indications, contraindications, adverse effects, complications, and management of spinal anesthesia; (Outcome)

IV.A.2.b).(2).(b).(iii) cardiovascular and pulmonary physiologic effects of spinal anesthesia; (Outcome)

IV.A.2.b).(2).(b).(iv) common mechanisms for failed spinal anesthetics; (Outcome)

IV.A.2.b).(2).(b).(v) various local anesthetics for intrathecal use, to include agents, dosage, surgical and total duration of action, and adjuvants; (Outcome)

IV.A.2.b).(2).(b).(vi) factors affecting intensity, extent, and duration of block, to include patient position, dose, volume, and baricity of injectate; (Outcome)

IV.A.2.b).(2).(b).(vii) dural puncture headache, to include symptoms, etiology, risk factors, and treatment; and, (Outcome)

IV.A.2.b).(2).(b).(viii) advantages and disadvantages of continuous spinal anesthesia. (Outcome)

IV.A.2.b).(2).(c) epidural anesthesia (lumbar and thoracic), including: (Outcome)

IV.A.2.b).(2).(c).(i) indications, contraindications, adverse effects, complications, and management of epidural anesthesia and analgesia; (Outcome)

IV.A.2.b).(2).(c).(ii) local anesthetics for epidural use, to include agents, dosage, adjuvants, and duration of action; (Outcome)

IV.A.2.b).(2).(c).(iii) spinal and epidural anesthesia differences in reliability, latency, duration, and segmental limitations; (Outcome)

IV.A.2.b).(2).(c).(iv) value and techniques of test dosing to minimize complications of epidural anesthesia and analgesia; (Outcome)

IV.A.2.b).(2).(c).(v) interpretation of the volume-segment relationship and the effect of patient age, to include extremes of age, pregnancy, position, and site of injection on resultant block; (Outcome)

IV.A.2.b).(2).(c).(vi) combined spinal-epidural anesthesia, to include advantages/disadvantages, dose requirements, complications, indications, and contraindications; (Outcome)

IV.A.2.b).(2).(c).(vii) outcome benefits of thoracic epidural analgesia for thoracic and abdominal surgery and thoracic trauma; (Outcome)

IV.A.2.b).(2).(c).(viii) differentiation between thoracic epidural anesthesia/analgesia and lumbar epidural anesthesia/analgesia, to include advantages/disadvantages, dose requirements, complications, indications, and contraindications; and, (Outcome)

IV.A.2.b).(2).(c).(ix) impact of antithrombotic and thrombolytic medications on neuraxial and peripheral anesthesia/analgesia with specific reference to published guidelines. (Outcome)

IV.A.2.b).(2).(d) upper extremity nerve block, including: (Outcome)

IV.A.2.b).(2).(d).(i) anatomy and sonoanatomy of the brachial plexus in relation to sensory and motor innervation; (Outcome)

IV.A.2.b).(2).(d).(ii) local anesthetics for brachial plexus block, to include agents, dose, duration of action,

		and adjuvants; (Outcome)
IV.A.2.b).(2).(d).(iii)		value and techniques of intravascular test dosing to minimize local anesthetic systemic toxicity associated with peripheral nerve block; (Outcome)
IV.A.2.b).(2).(d).(iv)		differentiation between the various brachial plexus (or terminal nerve) block sites, to include indications, contraindications, advantages, disadvantages, complications, and management specific to each; (Outcome)
IV.A.2.b).(2).(d).(v)		indications and technique for cervical plexus, suprascapular, or intercostobrachial block as unique blocks or supplements to brachial plexus block; and, (Outcome)
IV.A.2.b).(2).(d).(vi)		technical and non-technical aspects unique to brachial plexus perineural catheter placement and management. (Outcome)
IV.A.2.b).(2).(e)	lower extremity nerve block, including: (Outcome)	
IV.A.2.b).(2).(e).(i)		anatomy and sonoanatomy of the lower extremity, to include sciatic, femoral, lateral femoral cutaneous, and obturator nerves, as well as the adductor canal and options for saphenous nerve blockade; (Outcome)
IV.A.2.b).(2).(e).(ii)		local anesthetics for lower extremity block, to include agents, dose, duration of action, and adjuvants; (Outcome)
IV.A.2.b).(2).(e).(iii)		value and techniques of intravascular test dosing to minimize local anesthetic systemic toxicity associated with peripheral nerve block; (Outcome)
IV.A.2.b).(2).(e).(iv)		differentiation between the various approaches to lower-extremity blockade, to include indications/contraindications, side effects, complications, and management specific to each; and, (Outcome)
IV.A.2.b).(2).(e).(v)		technical and non-technical aspects unique to lower extremity perineural catheter placement and management. (Outcome)
IV.A.2.b).(2).(f)	truncal block, including: (Outcome)	

IV.A.2.b).(2).(f).(i) anatomy for intercostal, paravertebral, ilioinguinal-hypogastric, rectus sheath and transversus abdominis plane blocks; (Outcome)

IV.A.2.b).(2).(f).(ii) local anesthetics for truncal blockade: agents, dose, and duration of action; (Outcome)

IV.A.2.b).(2).(f).(iii) indications, contraindications, side effects, complications, safety, and management of truncal blockade; and, (Outcome)

IV.A.2.b).(2).(f).(iv) technical and non-technical aspects unique to continuous truncal catheter placement and management. (Outcome)

IV.A.2.b).(2).(g) intravenous regional anesthesia, including: (Outcome)

IV.A.2.b).(2).(g).(i) mechanism of action, indications, contraindications, advantages and disadvantages, adverse effects, complications, and management of intravenous regional anesthesia (IVRA); and, (Outcome)

IV.A.2.b).(2).(g).(ii) agents used for IVRA, to include local anesthetic choice, dosage, and use of adjuvants. (Outcome)

IV.A.2.b).(2).(h) complications of regional anesthesiology and acute pain medicine, including diagnosis and management of: (Outcome)

IV.A.2.b).(2).(h).(i) hemorrhagic complications; (Outcome)

IV.A.2.b).(2).(h).(ii) infectious complications; (Outcome)

IV.A.2.b).(2).(h).(iii) neurological complications; (Outcome)

IV.A.2.b).(2).(h).(iii).(a) This knowledge must include the interpretation of tests recommended following plexus/nerve injury, including electromyography, nerve conduction studies, somatosensory evoked potentials, and motor evoked potentials. (Outcome)

IV.A.2.b).(2).(h).(iv) complications due to medicines, including local anesthetic systemic toxicity and opioid-induced respiratory depression; and, (Outcome)

IV.A.2.b).(2).(h).(v) other complications, including

pneumothorax. (Outcome)

IV.A.2.c) Practice-based Learning and Improvement

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

IV.A.2.c).(1) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; (Outcome)

IV.A.2.c).(2) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems; **(Outcome)**

IV.A.2.c).(3) identify strengths, deficiencies, and limits in knowledge and expertise; (Outcome)

IV.A.2.c).(4) set learning and practice improvement goals; (Outcome)

IV.A.2.c).(5) identify and perform appropriate learning activities, including didactic lectures and hands-on demonstrations that promulgate safety; (Outcome)

IV.A.2.c).(6) incorporate formative evaluation feedback into daily practice; (Outcome)

IV.A.2.c).(7) evaluate and apply evidence from scientific studies, expert guidelines, and practice pathways to patients' medical conditions; (Outcome)

IV.A.2.c).(8) apply information technology to obtain and record patient information, access institutional and national policies and guidelines, and participate in self education; (Outcome)

IV.A.2.c).(9) analyze their own practice with respect to patient outcomes (especially success and complications from regional blockade) and compare to available literature; (Outcome)

IV.A.2.c).(10) participate in the education of patients, families, students, fellows, and other health care professionals; and, (Outcome)

IV.A.2.c).(11) advocate for acute pain management and create best practices for pain management regarding major surgical procedures. (Outcome)

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

Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health

professionals. (Outcome)

Fellows are expected to demonstrate the ability to:

IV.A.2.d).(1) summarize information to the patient and family with respect to the options, alternatives, risks, and benefits of regional anesthesia and/or acute analgesic techniques in a manner that is clear, understandable, and ethical; (Outcome)

IV.A.2.d).(2) develop effective listening skills and answer questions appropriately in the process of obtaining informed consent; and, (Outcome)

IV.A.2.d).(3) operate effectively in a team environment, communicating and cooperating with surgeons, other physicians, nurses, pharmacists, physical therapists, and other members of the peri-operative team, including: (Outcome)

IV.A.2.d).(3).(a) recognizing the roles of all team members; (Outcome)

IV.A.2.d).(3).(b) communicating clearly in a professional manner that facilitates the achievement of care goals; (Outcome)

IV.A.2.d).(3).(c) helping other members of the team to enhance the sharing of important information; and, (Outcome)

IV.A.2.d).(3).(d) formulating care plans that utilize multidisciplinary team skills, such as a plan for facilitated recovery. (Outcome)

IV.A.2.e) Professionalism

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

Fellows are expected to demonstrate:

IV.A.2.e).(1) integrity, honesty, and accountability in conducting the practice of medicine; (Outcome)

IV.A.2.e).(2) a commitment to life-long learning and excellence in practice; (Outcome)

IV.A.2.e).(3) consistent subjugation of self-interest to the good of the patient and the health care needs of society; and, (Outcome)

IV.A.2.e).(4) commitment to ethical principles in providing care, obtaining informed consent, and maintaining patient confidentiality. (Outcome)

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

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

Fellows are expected to:

IV.A.2.f).(1) effectively choose regional anesthesiology techniques and approaches to promote peri-operative efficiency and improve patient outcomes; (Outcome)

IV.A.2.f).(2) understand the interaction of the regional anesthesia and acute pain medicine service with other elements of the health care system, including primary surgical and medical teams, and other consultant, nursing, pharmacy, and physical therapy services; (Outcome)

IV.A.2.f).(3) demonstrate awareness of health care costs and resource allocation, and the impact of their choices on those costs and resources; (Outcome)

IV.A.2.f).(4) advocate for patients and their families within the health care system, and assist them in understanding and negotiating complexities in the system; (Outcome)

IV.A.2.f).(5) provide direct acute pain management and medical consultation for the full spectrum of injuries, medical etiologies, and surgical and other invasive procedures that produce acute pain in the hospital setting; (Outcome)

IV.A.2.f).(6) when indicated, safely and effectively perform a comprehensive range of advanced regional anesthesiology procedures for appropriate indications, in a safe, consistent, and reliable manner, understanding the individual risks and benefits of each; (Outcome)

IV.A.2.f).(7) act as a consultant to other anesthesiologists, surgeons, physicians, nurses, pharmacists, physical therapists and other medical professionals, operating room managers, hospital administrators, and other allied health providers; (Outcome)

IV.A.2.f).(8) provide leadership in the organization and management of an acute pain medicine service within the hospital setting, comprising a variety of specialists to provide a comprehensive, multimodal acute pain management treatment plan; and, (Outcome)

IV.A.2.f).(9) develop the knowledge and skills required to establish a new regional anesthesiology and acute pain medicine program in his/her future practice, and to adopt emerging knowledge and techniques for the acute pain management of patients whom he/she encounters. (Outcome)

IV.A.3. Curriculum Organization and Fellow Experience

IV.A.3.a) The curriculum must include at least 10 months of clinical anesthesiology experience, to include: (Core)

IV.A.3.a).(1) regional anesthesiology experience of at least six months, including: (Core)

IV.A.3.a).(1).(a) a minimum of 20 spinal (intrathecal) procedures either performed primarily or directly supervised by the fellow, to include demonstration and documentation of proficiency in using alternative approaches (e.g., paramedian, epidural-assisted, non-pencil point needle, and image-guided), difficult and high-risk procedures, and rescue blocks where others have failed; (Core)

IV.A.3.a).(1).(b) a minimum of 20 epidural procedures either performed primarily or directly supervised by the fellow, to include demonstration of proficiency in thoracic epidural and with demonstration and documentation of proficiency in using alternative approaches (e.g., paramedian, spinal-needle assisted, and image-guided), difficult and high-risk procedures, and rescue blocks where others have failed; (Core)

IV.A.3.a).(1).(c) a minimum of 100 upper extremity nerve block procedures, to include demonstration of proficiency in interscalene block, supraclavicular block, infraclavicular block, and axillary block; (Core)

IV.A.3.a).(1).(d) a minimum of 100 lower extremity nerve block procedures, to include demonstration of proficiency in proximal sciatic block (e.g. gluteal and subgluteal), popliteal sciatic block, femoral block, adductor canal block, and ankle block; (Core)

IV.A.3.a).(1).(e) a minimum of 70 truncal block procedures, to include demonstration of proficiency in transversus abdominis plane block, rectus sheath block, intercostal nerve block, and paravertebral block; and, (Core)

IV.A.3.a).(1).(e).(i) Of these, a minimum of 20 must be paravertebral block.(Core)

IV.A.3.a).(1).(f) a minimum of 50 continuous peripheral nerve block catheter placement procedures, to include upper and lower extremity and truncal sites. (Core)

IV.A.3.a).(2) acute pain experience of at least two months, including: (Core)

IV.A.3.a).(2).(a) supervised assessment and management of inpatients with acute pain; (Detail)

IV.A.3.a).(2).(b) management of epidural infusions, inpatient continuous peripheral nerve infusions, ambulatory continuous peripheral nerve infusions, and patient controlled analgesia; (Detail)

IV.A.3.a).(2).(c) supervised assessment with specialized acute pain considerations, to include concurrent anticoagulant administration, chronic opioid use, neuromuscular disorders, advanced age, and psychiatric disease; and, (Detail)

IV.A.3.a).(2).(d) a minimum of 20 documented new patients for each fellow. (Core)

IV.A.3.a).(3) chronic pain experience of at least two weeks, including documented involvement with a minimum of 20 new patients assessed in this setting; (Core)

IV.A.3.a).(3).(a) This experience must include supervised participation with pain medicine specialists responsible for the assessment and management of patients with chronic pain, including cancer pain.(Core)

IV.A.3.a).(3).(b) Patients should be seen through either consultation or while on a designated inpatient pain medicine service. (Detail)

IV.A.3.a).(4) pediatric experience; and, (Core)

IV.A.3.a).(4).(a) There should be experience with the age-appropriate assessment and treatment of acute pain in children including participation in acute pain management and regional anesthesia for pediatric surgical patients including infants, children, and adolescents (under 18 years). (Detail)

IV.A.3.a).(5) trauma experience (Core).

IV.A.3.a).(6) There should be experience with the assessment and treatment of acute pain in the setting of trauma. (Detail)

IV.A.3.b) There must be regularly scheduled didactic sessions. (Core)

IV.A.3.b).(1) The didactic curriculum should include lectures, peer-review case conferences, and/or morbidity and mortality conferences, as well as interdepartmental conferences or departmental grand rounds. (Detail)

IV.A.3.b).(1).(a) Subspecialty conferences, including review of all current complications and deaths, seminars, and clinical and basic science instruction, should be regularly conducted. (Detail)

IV.A.3.b).(1).(b) Fellows and faculty members must regularly attend program lectures, conferences, seminars, and workshops. (Core)

IV.A.3.b).(1).(c) Fellows should actively participate in the planning and production of these meetings. (Detail)

IV.A.3.b).(1).(c).(i) Faculty members should be the leaders in the majority of the sessions. (Detail)

IV.A.3.b).(1).(d) Multidisciplinary conferences must include participation from faculty members from regional anesthesiology, pain medicine, orthopaedic surgery, general surgery, obstetrics and gynecology, and pediatrics. (Core)

IV.A.3.b).(1).(d).(i) Fellows should attend a minimum of 10 multidisciplinary conferences that are relevant to regional anesthesiology and acute pain medicine, especially in orthopaedic surgery and pain medicine. (Detail)

IV.B. Fellows' Scholarly Activities

IV.B.1. Academic Activities

IV.B.1.a) Fellows must participate in research as a major activity of the fellowship. (Core)

IV.B.1.b) To accomplish these objectives, the regional anesthesiology and acute pain medicine faculty must mentor the fellow in the preparation of research proposals, research methodology, and authorship guidelines. (Core)

IV.B.1.b).(1) Fellows should give research presentations at national or regional meetings. (Detail)

Fellows must:

IV.B.1.b).(2) engage in teaching activities as a major activity of the fellowship. (Core)

IV.B.1.b).(3) create and present a lecture during departmental or divisional grand rounds, or at a local/regional/national meeting, covering a topic, research, or a case relevant to regional anesthesia or acute pain medicine; (Core)

IV.B.1.b).(4) prepare and present resident education lectures and journal reviews for regional anesthesia and/or acute pain medicine subspecialty conferences; (Core)

IV.B.1.b).(5) participate and direct cadaver anatomy laboratories for regional anesthesia if available; (Core)

IV.B.1.b).(6) develop teaching techniques by instructing residents and/or medical students at the bedside with the supervision of faculty member(s); and, (Core)

IV.B.1.b).(7) review and enhance web-based teaching resources, such as resident teaching materials, curriculum documents, and self-study and testing materials. (Core)

V. Evaluation

V.A. Fellow Evaluation

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

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

V.A.1.a).(1) The program director may appoint additional members of the Clinical Competency Committee.

V.A.1.a).(1).(a) These additional members must be physician faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's fellows in patient care and other health care settings. (Core)

V.A.1.a).(1).(b) Chief residents who have completed core residency programs in their specialty and are eligible for specialty board certification may be

members of the Clinical Competency Committee. (Core)

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

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

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

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

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

V.A.2. **Formative Evaluation**

V.A.2.a) **The faculty must evaluate fellow performance in a timely manner.** (Core)

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

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

V.A.2.b).(1).(a) These should include evaluations of interpersonal communication and relationship skills, fund of knowledge, manual skills, decision-making skills, and critical analysis of clinical situations. (Detail)

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

V.A.2.b).(3) **provide each fellow with documented semiannual evaluation of performance with feedback.** (Core)

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

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

V.A.3.a) **The specialty-specific Milestones must be used as one of the tools to ensure fellows are able to practice core professional**

activities without supervision upon completion of the program. (Core)

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

This evaluation must:

V.A.3.b).(1) **become part of the fellow's permanent record maintained by the institution, and must be accessible for review by the fellow in accordance with institutional policy;** (Detail)

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

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

V.B. Faculty Evaluation

V.B.1. **At least annually, the program must evaluate faculty performance as it relates to the educational program.** (Core)

V.B.2. **These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.** (Detail)

V.C. Program Evaluation and Improvement

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

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

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

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

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

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

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

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

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

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

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

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

V.C.2.b) faculty development; and, (Core)

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

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

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

VI. Fellow Duty Hours in the Learning and Working Environment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

VI.B. Transitions of Care

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

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

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

VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending

physicians and fellows currently responsible for each patient's care. (Detail)

VI.C. Alertness Management/Fatigue Mitigation

VI.C.1. The program must:

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

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

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

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

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

VI.D. Supervision of Fellows

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

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

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

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

Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced fellow. Other portions of care provided by the fellow can be adequately supervised by the immediate availability of the supervising faculty member or fellow physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of fellow-delivered care with feedback as to

the appropriateness of that care. (Detail)

VI.D.3. Levels of Supervision

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

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

VI.D.3.b) Indirect Supervision:

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

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

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

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

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

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

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

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

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

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

VI.E. Clinical Responsibilities

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

VI.E.1. An optimal clinical workload allows fellows to complete the required case numbers and develop the required competencies in patient care with a focus on learning over meeting service obligations. (Detail)

VI.F. Teamwork

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

VI.F.1. Fellows should demonstrate leadership in the coordination of patient care, with teams that may include surgeons, anesthesiology colleagues, other medical trainees, specialized advanced practice nurses, physician assistants, and medical subspecialists such as neurologists, intensivists, and chronic pain specialists. (Detail)

VI.F.2. Fellows should understand the effective deployment of interprofessional teams that may include non-physician health care professionals, such as advanced practice nurses, physician assistants, pharmacists, physical therapists, specialized nurses, and technicians in order to provide high-quality, cost-effective patient care. (Detail)

VI.G. Fellow Duty Hours

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

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

VI.G.1.a) Duty Hour Exceptions

A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a

sound educational rationale. (Detail)

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

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

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

VI.G.2. **Moonlighting**

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

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

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

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

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

Duty periods of fellows may be scheduled to a maximum of 24 hours of continuous duty in the hospital. (Core)

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

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

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

(Core)

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

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

VI.G.4.d).(1).(a) **appropriately hand over the care of all other patients to the team responsible for their continuing care; and,** (Detail)

VI.G.4.d).(1).(b) **document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.** (Detail)

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

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

VI.G.5.a) **Fellows must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.** (Outcome)

Anesthesiology subspecialty fellows are considered to be in the final year(s) of education.

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

VI.G.5.a).(1).(a) **Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by fellows must be monitored by the program director.** (Detail)

VI.G.5.a).(1).(b) The Review Committee defines such circumstances as: required continuity of care for a severely ill or unstable patient, or a complex patient

with whom the fellow has been involved; events of exceptional educational value; or humanistic attention to the needs of a patient or family. (Detail)

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

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

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

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

VI.G.8. At-Home Call

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

VI.G.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each fellow. (Core)

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

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

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

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

Osteopathic Principles Recognition

For programs seeking Osteopathic Principles Recognition for the entire program, or for a track within the program, the Osteopathic Recognition Requirements are also applicable. (http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/Osteopathic_Recognition_Requirements.pdf)