ACGME Program Requirements for Graduate Medical Education in Regional Anesthesiology and Acute Pain Medicine (subspecialty of Anesthesiology)

Editorial revision: effective July 1, 2019
Currently in Effect Program Requirements incorporated into the 2019 Common Program Requirements

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

Common Program Requirements (Fellowship) are in BOLD

Where applicable, text in italics describes the underlying philosophy of the requirements in that section. These philosophic statements are not program requirements and are therefore not citable.

Background and Intent: These fellowship requirements reflect the fact that these learners have already completed the first phase of graduate medical education. Thus, the Common Program Requirements (Fellowship) are intended to explain the differences.

Introduction

Int.A. ***Fellowship is advanced graduate medical education beyond a core residency program for physicians who desire to enter more specialized practice. Fellowship-trained physicians serve the public by providing subspecialty care, which may also include core medical care, acting as a community resource for expertise in their field, creating and integrating new knowledge into practice, and educating future generations of physicians. Graduate medical education values the strength that a diverse group of physicians brings to medical care.***

Fellows who have completed residency are able to practice independently in their core specialty. The prior medical experience and expertise of fellows distinguish them from physicians entering into residency training. The fellow's care of patients within the subspecialty is undertaken with appropriate faculty supervision and conditional independence. Faculty members serve as role models of excellence, compassion, professionalism, and scholarship. The fellow develops deep medical knowledge, patient care skills, and expertise applicable to their focused area of practice. Fellowship is an intensive program of subspecialty clinical and didactic education that focuses on the multidisciplinary care of patients. Fellowship education is often physically, emotionally, and intellectually demanding, and occurs in a variety of clinical learning environments committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.

In addition to clinical education, many fellowship programs advance fellows' skills as physician-scientists. While the ability to create new knowledge within medicine is not exclusive to fellowship-educated physicians, the fellowship experience expands a physician's abilities to pursue hypothesis-driven scientific inquiry that results in contributions to the medical literature and patient care. Beyond the clinical subspecialty expertise achieved, fellows develop mentored relationships built on an infrastructure that promotes collaborative research.

Int.B. **Definition of Subspecialty**

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Regional anesthesiology and acute pain medicine focuses on the peri-operative management of acute pain of the surgical and non-surgical patient using both interventional and non-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 acute pain, including indications and contraindications for interventional pain management techniques;

Int.B.2. intra-operative application of multimodal analgesia, including 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 hospitalized non-surgical patients.

Int.C. Length of Educational Program

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

I. Oversight

I.A. Sponsoring Institution

The Sponsoring Institution is the organization or entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education consistent with the ACGME Institutional Requirements.

When the Sponsoring Institution is not a rotation site for the program, the most commonly utilized site of clinical activity for the program is the primary clinical site.

Background and Intent: Participating sites will reflect the health care needs of the community and the educational needs of the fellows. A wide variety of organizations may provide a robust educational experience and, thus, Sponsoring Institutions and participating sites may encompass inpatient and outpatient settings including, but not limited to a university, a medical school, a teaching hospital, a nursing home, a school of public health, a health department, a public health agency, an organized health care delivery system, a medical examiner's office, an educational consortium, a teaching health center, a physician group practice, federally qualified health center, or an educational foundation.

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90 **I.A.1. The program must be sponsored by one ACGME-accredited**
91 **Sponsoring Institution.** (Core)
92
93 **I.B. Participating Sites**
94
95 ***A participating site is an organization providing educational experiences or***
96 ***educational assignments/rotations for fellows.***
97
98 **I.B.1. The program, with approval of its Sponsoring Institution, must**
99 **designate a primary clinical site.** (Core)
100
101 I.B.1.a) The Sponsoring Institution must sponsor an Accreditation Council
102 for Graduate Medical Education (ACGME)-accredited
103 anesthesiology residency. (Core) [Moved from I.A.1]
104
105 I.B.1.b) There must be only one regional anesthesiology and acute pain
106 medicine program associated with a single anesthesiology
107 residency program. (Core) [Moved from I.A.2]
108
109 **I.B.2. There must be a program letter of agreement (PLA) between the**
110 **program and each participating site that governs the relationship**
111 **between the program and the participating site providing a required**
112 **assignment.** (Core)
113
114 **I.B.2.a) The PLA must:**
115
116 **I.B.2.a).(1) be renewed at least every 10 years; and,** (Core)
117
118 **I.B.2.a).(2) be approved by the designated institutional official**
119 **(DIO).** (Core)
120
121 **I.B.3. The program must monitor the clinical learning and working**
122 **environment at all participating sites.** (Core)
123
124 **I.B.3.a) At each participating site there must be one faculty member,**
125 **designated by the program director, who is accountable for**
126 **fellow education for that site, in collaboration with the**
127 **program director.** (Core)
128

Background and Intent: While all fellowship programs must be sponsored by a single ACGME-accredited Sponsoring Institution, many programs will utilize other clinical settings to provide required or elective training experiences. At times it is appropriate to utilize community sites that are not owned by or affiliated with the Sponsoring Institution. Some of these sites may be remote for geographic, transportation, or communication issues. When utilizing such sites, the program must designate a faculty member responsible for ensuring the quality of the educational experience. In some circumstances, the person charged with this responsibility may not be physically present at the site, but remains responsible for fellow education occurring at the site. The requirements under I.B.3. are intended to ensure that this will be the case.

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Suggested elements to be considered in PLAs will be found in the ACGME Program Director's Guide to the Common Program Requirements. These include: • Identifying the faculty members who will assume educational and supervisory responsibility for fellows • Specifying the responsibilities for teaching, supervision, and formal evaluation of fellows • Specifying the duration and content of the educational experience • Stating the policies and procedures that will govern fellow education during the assignment

I.B.4. **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 ACGME's Accreditation Data System (ADS).** (Core)

I.C. **The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents (if present), fellows, faculty members, senior administrative staff members, and other relevant members of its academic community.** (Core)

Background and Intent: It is expected that the Sponsoring Institution has, and programs implement, policies and procedures related to recruitment and retention of minorities underrepresented in medicine and medical leadership in accordance with the Sponsoring Institution's mission and aims. The program's annual evaluation must include an assessment of the program's efforts to recruit and retain a diverse workforce, as noted in V.C.1.c).(5).(c).

I.D. **Resources**

I.D.1. **The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for fellow education.** (Core)

I.D.1.a) Equipment required for the performance of a wide variety of regional anesthesia/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) [Moved from II.D.1]

I.D.1.b) There must be facilities and space for the education of fellows, including meeting space, conference space, space for academic activities, and access to computers. (Core) [Moved from II.D.2]

I.D.2. **The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote fellow well-being and provide for:** (Core)

I.D.2.a) **access to food while on duty;** (Core)

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I.D.2.b) **safe, quiet, clean, and private sleep/rest facilities available and accessible for fellows with proximity appropriate for safe patient care;** (Core)

Background and Intent: Care of patients within a hospital or health system occurs continually through the day and night. Such care requires that fellows function at their peak abilities, which requires the work environment to provide them with the ability to meet their basic needs within proximity of their clinical responsibilities. Access to food and rest are examples of these basic needs, which must be met while fellows are working. Fellows should have access to refrigeration where food may be stored. Food should be available when fellows are required to be in the hospital overnight. Rest facilities are necessary, even when overnight call is not required, to accommodate the fatigued fellow.

I.D.2.c) **clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care;** (Core)

Background and Intent: Sites must provide private and clean locations where fellows may lactate and store the milk within a refrigerator. These locations should be in close proximity to clinical responsibilities. It would be helpful to have additional support within these locations that may assist the fellow with the continued care of patients, such as a computer and a phone. While space is important, the time required for lactation is also critical for the well-being of the fellow and the fellow's family, as outlined in VI.C.1.d).(1).

I.D.2.d) **security and safety measures appropriate to the participating site; and,** (Core)

I.D.2.e) **accommodations for fellows with disabilities consistent with the Sponsoring Institution's policy.** (Core)

I.D.3. **Fellows must have ready access to subspecialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities.** (Core)

I.D.4. **The program's educational and clinical resources must be adequate to support the number of fellows appointed to the program.** (Core)

I.D.4.a) 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)† [Moved from II.D.3]

I.E. ***A fellowship program usually occurs in the context of many learners and other care providers and limited clinical resources. It should be structured to optimize education for all learners present.***

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198 **I.E.1.** **Fellows should contribute to the education of residents in core**
199 **programs, if present.** (Core)
200
201 I.E.2. The presence of other learners or staff members must not interfere with
202 the appointed fellows' education. (Core) [Moved from III.B.2]
203

Background and Intent: The clinical learning environment has become increasingly complex and often includes care providers, students, and post-graduate residents and fellows from multiple disciplines. The presence of these practitioners and their learners enriches the learning environment. Programs have a responsibility to monitor the learning environment to ensure that fellows' education is not compromised by the presence of other providers and learners, and that fellows' education does not compromise core residents' education.

204
205 **II. Personnel**
206
207 **II.A. Program Director**
208
209 **II.A.1.** **There must be one faculty member appointed as program director**
210 **with authority and accountability for the overall program, including**
211 **compliance with all applicable program requirements.** (Core)
212
213 **II.A.1.a)** **The Sponsoring Institution's Graduate Medical Education**
214 **Committee (GMEC) must approve a change in program**
215 **director.** (Core)
216
217 **II.A.1.b)** **Final approval of the program director resides with the**
218 **Review Committee.** (Core)
219

Background and Intent: While the ACGME recognizes the value of input from numerous individuals in the management of a fellowship, a single individual must be designated as program director and made responsible for the program. This individual will have dedicated time for the leadership of the fellowship, and it is this individual's responsibility to communicate with the fellows, faculty members, DIO, GMEC, and the ACGME. The program director's nomination is reviewed and approved by the GMEC. Final approval of program directors resides with the Review Committee.

220
221 **II.A.2.** **The program director must be provided with support adequate for**
222 **administration of the program based upon its size and configuration.**
223 (Core)
224
225 **[The Review Committee must further specify]**
226
227 [The Review Committee's specification will be included in the upcoming
228 focused revision to the Regional Anesthesiology and Acute Pain Medicine
229 Program Requirements]
230
231 **II.A.3.** **Qualifications of the program director:**
232
233 **II.A.3.a)** **must include subspecialty expertise and qualifications**
234 **acceptable to the Review Committee; and,** (Core)

235
236 **II.A.3.b)** **must include current certification in the subspecialty for**
237 **which they are the program director by the American Board**
238 **of** Anesthesiology ~~**or by the American Osteopathic Board of**~~
239 ~~**_____,**~~ **or subspecialty qualifications that are acceptable to**
240 **the Review Committee.** (Core)
241
242 [Note that while the Common Program Requirements deem
243 certification by a certifying board of the American Osteopathic
244 Association (AOA) acceptable, there is no AOA board that offers
245 certification in this subspecialty]
246
247 **II.A.4.** **Program Director Responsibilities**
248
249 **The program director must have responsibility, authority, and**
250 **accountability for: administration and operations; teaching and**
251 **scholarly activity; fellow recruitment and selection, evaluation, and**
252 **promotion of fellows, and disciplinary action; supervision of fellows;**
253 **and fellow education in the context of patient care.** (Core)
254
255 **II.A.4.a)** **The program director must:**
256
257 **II.A.4.a).(1)** **be a role model of professionalism;** (Core)
258

Background and Intent: The program director, as the leader of the program, must serve as a role model to fellows in addition to fulfilling the technical aspects of the role. As fellows are expected to demonstrate compassion, integrity, and respect for others, they must be able to look to the program director as an exemplar. It is of utmost importance, therefore, that the program director model outstanding professionalism, high quality patient care, educational excellence, and a scholarly approach to work. The program director creates an environment where respectful discussion is welcome, with the goal of continued improvement of the educational experience.

259
260 **II.A.4.a).(2)** **design and conduct the program in a fashion**
261 **consistent with the needs of the community, the**
262 **mission(s) of the Sponsoring Institution, and the**
263 **mission(s) of the program;** (Core)
264

Background and Intent: The mission of institutions participating in graduate medical education is to improve the health of the public. Each community has health needs that vary based upon location and demographics. Programs must understand the social determinants of health of the populations they serve and incorporate them in the design and implementation of the program curriculum, with the ultimate goal of addressing these needs and health disparities.

265
266 **II.A.4.a).(3)** **administer and maintain a learning environment**
267 **conducive to educating the fellows in each of the**
268 **ACGME Competency domains;** (Core)
269

Background and Intent: The program director may establish a leadership team to assist in the accomplishment of program goals. Fellowship programs can be highly complex. In a complex organization the leader typically has the ability to delegate authority to others, yet remains accountable. The leadership team may include physician and non-physician personnel with varying levels of education, training, and experience.

270
271 **II.A.4.a).(4)** **develop and oversee a process to evaluate candidates**
272 **prior to approval as program faculty members for**
273 **participation in the fellowship program education and**
274 **at least annually thereafter, as outlined in V.B.; (Core)**
275
276 **II.A.4.a).(5)** **have the authority to approve program faculty**
277 **members for participation in the fellowship program**
278 **education at all sites; (Core)**
279
280 **II.A.4.a).(6)** **have the authority to remove program faculty**
281 **members from participation in the fellowship program**
282 **education at all sites; (Core)**
283
284 **II.A.4.a).(7)** **have the authority to remove fellows from supervising**
285 **interactions and/or learning environments that do not**
286 **meet the standards of the program; (Core)**
287

Background and Intent: The program director has the responsibility to ensure that all who educate fellows effectively role model the Core Competencies. Working with a fellow is a privilege that is earned through effective teaching and professional role modeling. This privilege may be removed by the program director when the standards of the clinical learning environment are not met.

There may be faculty in a department who are not part of the educational program, and the program director controls who is teaching the residents.

288
289 **II.A.4.a).(8)** **submit accurate and complete information required**
290 **and requested by the DIO, GMEC, and ACGME; (Core)**
291
292 **II.A.4.a).(9)** **provide applicants who are offered an interview with**
293 **information related to the applicant's eligibility for the**
294 **relevant subspecialty board examination(s); (Core)**
295
296 **II.A.4.a).(10)** **provide a learning and working environment in which**
297 **fellows have the opportunity to raise concerns and**
298 **provide feedback in a confidential manner as**
299 **appropriate, without fear of intimidation or retaliation;**
300 **(Core)**
301
302 **II.A.4.a).(11)** **ensure the program's compliance with the Sponsoring**
303 **Institution's policies and procedures related to**
304 **grievances and due process; (Core)**
305

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306 **II.A.4.a).(12)** **ensure the program's compliance with the Sponsoring**
307 **Institution's policies and procedures for due process**
308 **when action is taken to suspend or dismiss, not to**
309 **promote, or not to renew the appointment of a fellow;**
310 **(Core)**
311

Background and Intent: A program does not operate independently of its Sponsoring Institution. It is expected that the program director will be aware of the Sponsoring Institution's policies and procedures, and will ensure they are followed by the program's leadership, faculty members, support personnel, and fellows.

312
313 **II.A.4.a).(13)** **ensure the program's compliance with the Sponsoring**
314 **Institution's policies and procedures on employment**
315 **and non-discrimination; (Core)**
316
317 **II.A.4.a).(13).(a)** **Fellows must not be required to sign a non-**
318 **competition guarantee or restrictive covenant.**
319 **(Core)**
320
321 **II.A.4.a).(14)** **document verification of program completion for all**
322 **graduating fellows within 30 days; (Core)**
323
324 **II.A.4.a).(15)** **provide verification of an individual fellow's**
325 **completion upon the fellow's request, within 30 days;**
326 **and, (Core)**
327

Background and Intent: Primary verification of graduate medical education is important to credentialing of physicians for further training and practice. Such verification must be accurate and timely. Sponsoring Institution and program policies for record retention are important to facilitate timely documentation of fellows who have previously completed the program. Fellows who leave the program prior to completion also require timely documentation of their summative evaluation.

328
329 **II.A.4.a).(16)** **obtain review and approval of the Sponsoring**
330 **Institution's DIO before submitting information or**
331 **requests to the ACGME, as required in the Institutional**
332 **Requirements and outlined in the ACGME Program**
333 **Director's Guide to the Common Program**
334 **Requirements. (Core)**
335
336 **II.B.** **Faculty**
337
338 ***Faculty members are a foundational element of graduate medical education***
339 ***– faculty members teach fellows how to care for patients. Faculty members***
340 ***provide an important bridge allowing fellows to grow and become practice***
341 ***ready, ensuring that patients receive the highest quality of care. They are***
342 ***role models for future generations of physicians by demonstrating***
343 ***compassion, commitment to excellence in teaching and patient care,***
344 ***professionalism, and a dedication to lifelong learning. Faculty members***
345 ***experience the pride and joy of fostering the growth and development of***
346 ***future colleagues. The care they provide is enhanced by the opportunity to***

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347 ***teach. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.***

351 ***Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, fellows, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the fellows and themselves.***

Background and Intent: "Faculty" refers to the entire teaching force responsible for educating fellows. The term "faculty," including "core faculty," does not imply or require an academic appointment or salary support.

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

364 **II.B.2.** **Faculty members must:**

366 **II.B.2.a)** **be role models of professionalism;** **(Core)**

368 **II.B.2.b)** **demonstrate commitment to the delivery of safe, quality, cost-effective, patient-centered care;** **(Core)**

Background and Intent: Patients have the right to expect quality, cost-effective care with patient safety at its core. The foundation for meeting this expectation is formed during residency and fellowship. Faculty members model these goals and continually strive for improvement in care and cost, embracing a commitment to the patient and the community they serve.

372 **II.B.2.c)** **demonstrate a strong interest in the education of fellows;** **(Core)**

374 **II.B.2.d)** **devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities;** **(Core)**

377 **II.B.2.e)** **administer and maintain an educational environment conducive to educating fellows;** **(Core)**

380 **II.B.2.f)** **regularly participate in organized clinical discussions, rounds, journal clubs, and conferences; and,** **(Core)**

383 **II.B.2.g)** **pursue faculty development designed to enhance their skills at least annually.** **(Core)**

Background and Intent: Faculty development is intended to describe structured programming developed for the purpose of enhancing transference of knowledge, skill, and behavior from the educator to the learner. Faculty development may occur in

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a variety of configurations (lecture, workshop, etc.) using internal and/or external resources. Programming is typically needs-based (individual or group) and may be specific to the institution or the program. Faculty development programming is to be reported for the fellowship program faculty in the aggregate.

II.B.2.h) Faculty members must encourage and support fellows' scholarly activities. (Core) [Moved from II.B.5.c)]

II.B.2.i) ~~The members of the faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. (Core)~~ [Moved from II.B.5.a)]

II.B.2.j) ~~Some members of the faculty should also demonstrate scholarship by one or more of the following: [Moved from II.B.5.b)]~~

~~II.B.2.j).(1) peer-reviewed funding; (Detail) [Moved from II.B.5.b).(1)]~~

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

~~II.B.2.j).(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or, (Detail) [Moved from II.B.5.b).(3)]~~

~~II.B.2.j).(4) participation in national committees or educational organizations. (Detail) [Moved from II.B.5.b).(4)]~~

II.B.3. Faculty Qualifications

II.B.3.a) Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)

II.B.3.b) Subspecialty physician faculty members must:

II.B.3.b).(1) have current certification in the subspecialty by the American Board of Anesthesiology **or the American Osteopathic Board of _____, or possess qualifications judged acceptable to the Review Committee. (Core)**

[Note that while the Common Program Requirements deem certification by a certifying board of the American Osteopathic Association (AOA) acceptable, there is no AOA board that offers certification in this subspecialty]

II.B.3.c) Any non-physician faculty members who participate in fellowship program education must be approved by the program director. (Core)

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Background and Intent: The provision of optimal and safe patient care requires a team approach. The education of fellows by non-physician educators enables the fellows to better manage patient care and provides valuable advancement of the fellows' knowledge. Furthermore, other individuals contribute to the education of the fellow in the basic science of the subspecialty or in research methodology. If the program director determines that the contribution of a non-physician individual is significant to the education of the fellow, the program director may designate the individual as a program faculty member or a program core faculty member.

432
433 **II.B.3.d)** **Any other specialty physician faculty members must have**
434 **current certification in their specialty by the appropriate**
435 **American Board of Medical Specialties (ABMS) member**
436 **board or American Osteopathic Association (AOA) certifying**
437 **board, or possess qualifications judged acceptable to the**
438 **Review Committee.** **(Core)**
439
440 **II.B.4.** **Core Faculty**
441
442 **Core faculty members must have a significant role in the education**
443 **and supervision of fellows and must devote a significant portion of**
444 **their entire effort to fellow education and/or administration, and**
445 **must, as a component of their activities, teach, evaluate, and provide**
446 **formative feedback to fellows.** **(Core)**
447

Background and Intent: Core faculty members are critical to the success of fellow education. They support the program leadership in developing, implementing, and assessing curriculum and in assessing fellows' progress toward achievement of competence in the subspecialty. Core faculty members should be selected for their broad knowledge of and involvement in the program, permitting them to effectively evaluate the program, including completion of the annual ACGME Faculty Survey.

448
449 **II.B.4.a)** **Core faculty members must be designated by the program**
450 **director.** **(Core)**
451
452 **II.B.4.b)** **Core faculty members must complete the annual ACGME**
453 **Faculty Survey.** **(Core)**
454
455 II.B.4.c) There must be at least four core faculty members, including the
456 program director, with expertise in regional anesthesiology and
457 acute pain medicine. (Core) [Moved from II.B.3.a.)]
458
459 II.B.4.d) At each participating site there must be a ratio of at least one ~~FTE~~
460 faculty member to one fellow. (Core) [Moved from II.B.3.b)]
461
462 **II.C.** **Program Coordinator**
463
464 **II.C.1.** **There must be a program coordinator.** **(Core)**
465
466 **II.C.2.** **The program coordinator must be provided with support adequate**
467 **for administration of the program based upon its size and**
468 **configuration.** **(Core)**

469

> **Background and Intent: Each program requires a lead administrative person, frequently referred to as a program coordinator, administrator, or as titled by the institution. This person will frequently manage the day-to-day operations of the program and serve as an important liaison with learners, faculty and other staff members, and the ACGME. Individuals serving in this role are recognized as program coordinators by the ACGME.**
>
> **The program coordinator is a member of the leadership team and is critical to the success of the program. As such, the program coordinator must possess skills in leadership and personnel management. Program coordinators are expected to develop unique knowledge of the ACGME and Program Requirements, policies, and procedures. Program coordinators assist the program director in accreditation efforts, educational programming, and support of fellows.**
>
> **Programs, in partnership with their Sponsoring Institutions, should encourage the professional development of their program coordinators and avail them of opportunities for both professional and personal growth. Programs with fewer fellows may not require a full-time coordinator; one coordinator may support more than one program.**

470
471 **II.D. Other Program Personnel**
472
473 **The program, in partnership with its Sponsoring Institution, must jointly**
474 **ensure the availability of necessary personnel for the effective**
475 **administration of the program.** (Core)
476

> **Background and Intent: Multiple personnel may be required to effectively administer a program. These may include staff members with clerical skills, project managers, education experts, and staff members to maintain electronic communication for the program. These personnel may support more than one program in more than one discipline.**

477
478 **III. Fellow Appointments**
479
480 **III.A. Eligibility Criteria**
481
482 **III.A.1. Eligibility Requirements – Fellowship Programs**
483
484 **All required clinical education for entry into ACGME-accredited**
485 **fellowship programs must be completed in an ACGME-accredited**
486 **residency program, an AOA-approved residency program, a**
487 **program with ACGME International (ACGME-I) Advanced Specialty**
488 **Accreditation, or a Royal College of Physicians and Surgeons of**
489 **Canada (RCPSC)-accredited or College of Family Physicians of**
490 **Canada (CFPC)-accredited residency program located in Canada.**
491 (Core)
492

> **Background and Intent: Eligibility for ABMS or AOA Board certification may not be satisfied by fellowship training. Applicants must be notified of this at the time of application, as required in II.A.4.a).(9).**

493

III.A.1.a) **Fellowship programs must receive verification of each entering fellow's level of competence in the required field, upon matriculation, using ACGME, ACGME-I, or CanMEDS Milestones evaluations from the core residency program.** **(Core)**

III.A.1.b) Prior to appointment in the program, fellows must have successfully completed an ~~ACGME-accredited residency in~~ anesthesiology residency program that satisfies the requirements in III.A.1. (Core) [Moved from III.A]

III.A.1.c) **Fellow Eligibility Exception**

The Review Committee for Anesthesiology **will allow the following exception to the fellowship eligibility requirements:**

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

III.A.1.c).(1).(a) **evaluation 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.1.c).(1).(b) **review and approval of the applicant's exceptional qualifications by the GMEC; and,** **(Core)**

III.A.1.c).(1).(c) **verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification.** **(Core)**

III.A.1.c).(2) **Applicants accepted through this exception must have an evaluation of their performance by the Clinical Competency Committee within 12 weeks of matriculation.** **(Core)**

Background and Intent: An exceptionally qualified international graduate applicant has (1) completed a residency program in the core specialty outside the continental United States that was not accredited by the ACGME, AOA, ACGME-I, RCPSC or CFPC, 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; and/or (c) demonstrated leadership during or after residency. Applicants being considered for

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these positions must be informed of the fact that their training may not lead to certification by ABMS member boards or AOA certifying boards.

In recognition of the diversity of medical education and training around the world, this early evaluation of clinical competence required for these applicants ensures they can provide quality and safe patient care. Any gaps in competence should be addressed as per policies for fellows already established by the program in partnership with the Sponsoring Institution.

536
537 **III.B.** **The program director must not appoint more fellows than approved by the**
538 **Review Committee.** (Core)
539
540 **III.B.1.** **All complement increases must be approved by the Review**
541 **Committee.** (Core)
542
543 **III.C.** **Fellow Transfers**
544
545 **The program must obtain verification of previous educational experiences**
546 **and a summative competency-based performance evaluation prior to**
547 **acceptance of a transferring fellow, and Milestones evaluations upon**
548 **matriculation.** (Core)
549
550 **IV. Educational Program**
551
552 ***The ACGME accreditation system is designed to encourage excellence and***
553 ***innovation in graduate medical education regardless of the organizational***
554 ***affiliation, size, or location of the program.***
555
556 ***The educational program must support the development of knowledgeable, skillful***
557 ***physicians who provide compassionate care.***
558
559 ***In addition, the program is expected to define its specific program aims consistent***
560 ***with the overall mission of its Sponsoring Institution, the needs of the community***
561 ***it serves and that its graduates will serve, and the distinctive capabilities of***
562 ***physicians it intends to graduate. While programs must demonstrate substantial***
563 ***compliance with the Common and subspecialty-specific Program Requirements, it***
564 ***is recognized that within this framework, programs may place different emphasis***
565 ***on research, leadership, public health, etc. It is expected that the program aims***
566 ***will reflect the nuanced program-specific goals for it and its graduates; for***
567 ***example, it is expected that a program aiming to prepare physician-scientists will***
568 ***have a different curriculum from one focusing on community health.***
569
570 **IV.A.** **The curriculum must contain the following educational components:** (Core)
571
572 **IV.A.1.** **a set of program aims consistent with the Sponsoring Institution's**
573 **mission, the needs of the community it serves, and the desired**
574 **distinctive capabilities of its graduates;** (Core)
575
576 **IV.A.1.a)** **The program's aims must be made available to program**
577 **applicants, fellows, and faculty members.** (Core)
578

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579 **IV.A.2.** **competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice in their subspecialty. These must be distributed, reviewed, and available to fellows and faculty members;** **(Core)**

IV.A.3. **delineation of fellow responsibilities for patient care, progressive responsibility for patient management, and graded supervision in their subspecialty;** **(Core)**

Background and Intent: These responsibilities may generally be described by PGY level and specifically by Milestones progress as determined by the Clinical Competency Committee. This approach encourages the transition to competency-based education. An advanced learner may be granted more responsibility independent of PGY level and a learner needing more time to accomplish a certain task may do so in a focused rather than global manner.

IV.A.4. **structured educational activities beyond direct patient care; and,** **(Core)**

Background and Intent: Patient care-related educational activities, such as morbidity and mortality conferences, tumor boards, surgical planning conferences, case discussions, etc., allow fellows to gain medical knowledge directly applicable to the patients they serve. Programs should define those educational activities in which fellows are expected to participate and for which time is protected. Further specification can be found in IV.C.

IV.A.5. **advancement of fellows' knowledge of ethical principles foundational to medical professionalism.** **(Core)**

IV.B. **ACGME Competencies**

Background and Intent: The Competencies provide a conceptual framework describing the required domains for a trusted physician to enter autonomous practice. These Competencies are core to the practice of all physicians, although the specifics are further defined by each subspecialty. The developmental trajectories in each of the Competencies are articulated through the Milestones for each subspecialty. The focus in fellowship is on subspecialty-specific patient care and medical knowledge, as well as refining the other competencies acquired in residency.

IV.B.1. **The program must integrate the following ACGME Competencies into the curriculum:** **(Core)**

IV.B.1.a) **Professionalism**

Fellows must demonstrate a commitment to professionalism and an adherence to ethical principles. **(Core)**

IV.B.1.b) **Patient Care and Procedural Skills**

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Background and Intent: Quality patient care is safe, effective, timely, efficient, patient-centered, equitable, and designed to improve population health, while reducing per capita costs. (See the Institute of Medicine [IOM]'s *Crossing the Quality Chasm: A New Health System for the 21st Century*, 2001 and Berwick D, Nolan T, Whittington J. *The Triple Aim: care, cost, and quality. Health Affairs.* 2008; 27(3):759-769.). In addition, there should be a focus on improving the clinician's well-being as a means to improve patient care and reduce burnout among residents, fellows, and practicing physicians.

These organizing principles inform the Common Program Requirements across all Competency domains. Specific content is determined by the Review Committees with input from the appropriate professional societies, certifying boards, and the community.

610

611 **IV.B.1.b).(1)** **Fellows must be able to provide patient care that is**
612 **compassionate, appropriate, and effective for the**
613 **treatment of health problems and the promotion of**
614 **health.** (Core)
615
616 IV.B.1.b).(1).(a) Fellows must demonstrate competence by following
617 standards for patient care and established
618 guidelines and procedures for patient safety, error
619 reduction, and improved patient outcomes;
620 ~~(Outcome)~~(Core) [Moved from IV.A.2.a).(1).(a)]
621
622 IV.B.1.b).(1).(b) Fellows must demonstrate the following
623 competencies in regional anesthesiology and acute
624 pain medicine: ~~(Outcome)~~(Core) [Moved from
625 IV.A.2.a).(1).(b)]
626
627 IV.B.1.b).(1).(b).(i) performance of pre-operative patient
628 evaluation and optimization of clinical
629 status; ~~(Outcome)~~(Core) [Moved from
630 IV.A.2.a).(1).(b).(i)]
631
632 IV.B.1.b).(1).(b).(ii) performance of a detailed neurologic history
633 and physical examination with particular
634 attention to pre-existing neurologic deficits
635 and their impact on the anesthetic plan;
636 ~~(Outcome)~~(Core) [Moved from IV.A.2.a).(1).(b).(ii)]
637
638 IV.B.1.b).(1).(b).(iii) rational selection of regional anesthesia
639 and/or post-operative analgesic techniques
640 for specific clinical situations; ~~(Outcome)~~(Core)
641 [Moved from IV.A.2.a).(1).(b).(iii)]
642
643 IV.B.1.b).(1).(b).(iii).(a) This must include regional
644 techniques, multimodal analgesia,
645 integrative medicine, and opioid and
646 non-opioid pharmacological
647 management. (Core) [Moved from
648 IV.A.2.a).(1).(b).(iii).(a)]
649

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IV.B.1.b).(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~~)(<u>Core</u>) [Moved from IV.A.2.a).(1).(b).(iv)]

IV.B.1.b).(1).(b).(v) management of inadequate operative regional anesthesia and post-operative analgesic techniques, including the use of supplemental blockade, alternate approaches, and pharmacological intervention; (~~Outcome~~)(<u>Core</u>) [Moved from IV.A.2.a).(1).(b).(v)]

IV.B.1.b).(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; and, (~~Outcome~~)(<u>Core</u>) [Moved from IV.A.2.a).(1).(b).(vi)]

IV.B.1.b).(1).(b).(vii) management of an acute pain medicine service. (~~Outcome~~)(<u>Core</u>) [Moved from IV.A.2.a).(1).(b).(vii)]

IV.B.1.b).(1).(b).(vii).(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) [Moved from IV.A.2.a).(1).(b).(vii).(a)]

IV.B.1.b).(1).(c) <u>Fellows</u> must demonstrate the following competencies in acute pain medicine:((~~Outcome~~)(<u>Core</u>)[Moved from IV.A.2.a).(1).(c)]

IV.B.1.b).(1).(c).(i) understanding how the acute pain medicine service addresses: [Moved from IV.A.2.a).(1).(c).(i)]

IV.B.1.b).(1).(c).(i).(a) surgical regional anesthesia techniques (as placed by the operating room (OR) anesthesiologist); (~~Outcome~~)(<u>Core</u>) [Moved from IV.A.2.a).(1).(c).(i).(a)]

IV.B.1.b).(1).(c).(i).(b) the peri-operative use of analgesic techniques by the acute pain medicine service; (Outcome) [Moved

701 from IV.A.2.a).(1).(c).(i).(b)]
702
703 IV.B.1.b).(1).(c).(i).(c) the peri-operative management of
704 acute pain medicine intervention;
705 (~~Outcome~~)(Core) [Moved from
706 IV.A.2.a).(1).(c).(i).(c)]
707
708 IV.B.1.b).(1).(c).(i).(d) the provision of acute pain medicine
709 services directed toward the patient
710 with chronic pain who is also
711 experiencing acute pain; and,
712 (~~Outcome~~)(Core) [Moved from
713 IV.A.2.a).(1).(c).(i).(d)]
714
715 IV.B.1.b).(1).(c).(i).(e) the provision of acute pain
716 management to select non-surgical
717 patients, such as those with
718 conditions known to cause acute
719 pain. (~~Outcome~~)(Core) [Moved from
720 IV.A.2.a).(1).(c).(i).(e)]
721
722 **IV.B.1.b).(2) Fellows must be able to perform all medical,**
723 **diagnostic, and surgical procedures considered**
724 **essential for the area of practice. (Core)**
725
726 IV.B.1.b).(2).(a) Fellows must demonstrate competence in providing
727 anesthesia and peri-operative pain management for
728 patients undergoing orthopaedic surgery;
729 (~~Outcome~~)(Core) [Moved from IV.A.2.a).(2).(a)]
730
731 IV.B.1.b).(2).(b) Fellows must demonstrate competence in providing
732 anesthesia and peri-operative pain management for
733 patients undergoing non-orthopaedic surgery that is
734 amenable to regional anesthesia, including
735 neuraxial and peripheral nerve block; and,
736 (~~Outcome~~)(Core) [Moved from IV.A.2.a).(2).(b)]
737
738 IV.B.1.b).(2).(c) Fellows must demonstrate competence in bedside
739 point of care ultrasound for use in placement and
740 management of neuraxial and peripheral blocks.
741 (~~Outcome~~)(Core) [Moved from IV.A.2.a).(2).(c)]
742
743 **IV.B.1.c) Medical Knowledge**
744
745 **Fellows must demonstrate knowledge of established and**
746 **evolving biomedical, clinical, epidemiological and social-**
747 **behavioral sciences, as well as the application of this**
748 **knowledge to patient care. (Core)**
749
750 IV.B.1.c).(1) Fellows must demonstrate knowledge of anatomy and
751 clinical pharmacology, including: (~~Outcome~~)(Core) [Moved from

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IV.A.2.b).(1)]

IV.B.1.c).(1).(a) central neuraxial and peripheral nerve anatomy, to include: (~~Outcome~~)(Core) [Moved from IV.A.2.b).(1).(a)]

IV.B.1.c).(1).(a).(i) anatomy of neural pathways; (~~Outcome~~)(Core) [Moved from IV.A.2.b).(1).(a).(i)]

IV.B.1.c).(1).(a).(ii) differences between motor and sensory nerves; and, (~~Outcome~~)(Core) [Moved from IV.A.2.b).(1).(a).(ii)]

IV.B.1.c).(1).(a).(iii) microanatomy of the nerve cell. (~~Outcome~~)(Core) [Moved from IV.A.2.b).(1).(a).(iii)]

IV.B.1.c).(1).(b) local anesthetic pharmacology, to include the: (Outcome) [Moved from IV.A.2.b).(1).(b)]

IV.B.1.c).(1).(b).(i) mechanism of action, physicochemical properties, pharmacokinetics and pharmacodynamics, and appropriate dosing for single injection or continuous infusion; (~~Outcome~~)(Core) [Moved from IV.A.2.b).(1).(b).(i)]

IV.B.1.c).(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~~)(Core) [Moved from IV.A.2.b).(1).(b).(ii)]

IV.B.1.c).(1).(b).(iii) dosing, advantages, and disadvantages of local anesthetic adjuvants; and, (~~Outcome~~)(Core) [Moved from IV.A.2.b).(1).(b).(iii)]

IV.B.1.c).(1).(b).(iv) signs, symptoms, and treatment of local anesthetic systemic toxicity and neurotoxicity of local anesthetics. (~~Outcome~~)(Core) [Moved from IV.A.2.b).(1).(b).(iv)]

IV.B.1.c).(1).(c) neuraxial opioids, to include: (~~Outcome~~)(Core) [Moved from IV.A.2.b).(1).(c)]

IV.B.1.c).(1).(c).(i) indications/contraindications, mechanism of action, physicochemical properties, effective dosing, and duration of action; (~~Outcome~~)(Core) [Moved from IV.A.2.b).(1).(c).(i)]

IV.B.1.c).(1).(c).(ii) complications and adverse effects, including related monitoring, prevention, and therapy; and, (~~Outcome~~)(Core) [Moved from

803 IV.A.2.b).(1).(c).(ii)]

805 IV.B.1.c).(1).(c).(iii) differentiation of intrathecal versus epidural administration relative to dose, effect, and adverse effects. ~~(Outcome)~~(Core) [Moved from IV.A.2.b).(1).(c).(iii)]

810 IV.B.1.c).(1).(d) systemic opioids, to include: ~~(Outcome)~~(Core) [Moved from IV.A.2.b).(1).(d)]

813 IV.B.1.c).(1).(d).(i) pharmacokinetics of opioid analgesics, including bioavailability, absorption, distribution, metabolism, and excretion; ~~(Outcome)~~(Core) [Moved from IV.A.2.b).(1).(d).(i)]

818 IV.B.1.c).(1).(d).(ii) mechanism of action; ~~(Outcome)~~(Core) [Moved from IV.A.2.b).(1).(d).(ii)]

821 IV.B.1.c).(1).(d).(iii) chemical structure; ~~(Outcome)~~(Core) [Moved from IV.A.2.b).(1).(d).(iii)]

824 IV.B.1.c).(1).(d).(iv) mechanisms, uses, and contraindications for opioid agonists, opioid antagonists, mixed agents ~~(Outcome)~~(Core) [Moved from IV.A.2.b).(1).(d).(iv)]

829 IV.B.1.c).(1).(d).(v) use of patient controlled-analgesic systems; ~~(Outcome)~~(Core) [Moved from IV.A.2.b).(1).(d).(v)]

832 IV.B.1.c).(1).(d).(vi) post-procedure analgesic management in the patient with chronic pain and/or opioid-induced hyperalgesia; and, ~~(Outcome)~~(Core) [Moved from IV.A.2.b).(1).(d).(vi)]

837 IV.B.1.c).(1).(d).(vii) management of acute or chronic pain in the opioid tolerant patient. ~~(Outcome)~~(Core) [Moved from IV.A.2.b).(1).(d).(vii)]

841 IV.B.1.c).(1).(e) non-opioid analgesia, to include: ~~(Outcome)~~(Core) [Moved from IV.A.2.b).(1).(e)]

844 IV.B.1.c).(1).(e).(i) multimodal analgesia and its impact on recovery after surgery; and, ~~(Outcome)~~(Core) [Moved from IV.A.2.b).(1).(e).(i)]

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

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854 (~~Outcome~~)(Core) [Moved from IV.A.2.b).(1).(e).(ii)]
855
856 IV.B.1.c).(2) Fellows must demonstrate knowledge of regional
857 anesthesia techniques, including: [Moved from
858 IV.A.2.b).(2)]
859
860 IV.B.1.c).(2).(a) nerve localization techniques, to include:
861 (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(a)]
862
863 IV.B.1.c).(2).(a).(i) principles, operation, advantages, and
864 limitations of the peripheral nerve stimulator
865 to localize and anesthetize peripheral
866 nerves; (~~Outcome~~)(Core) [Moved from
867 IV.A.2.b).(2).(a).(i)]
868
869 IV.B.1.c).(2).(a).(ii) principles of paresthesia-seeking,
870 perivascular, or transvascular approaches
871 to nerve localization; and, (~~Outcome~~)(Core)
872 [Moved from IV.A.2.b).(2).(a).(ii)]
873
874 IV.B.1.c).(2).(a).(iii) principles, operation, advantages, safety
875 and limitations of ultrasound to localize and
876 anesthetize peripheral nerves. (~~Outcome~~)(Core)
877 [Moved from IV.A.2.b).(2).(a).(iii)]
878
879 IV.B.1.c).(2).(b) spinal anesthesia, to include: (~~Outcome~~)(Core) [Moved
880 from IV.A.2.b).(2).(b)]
881
882 IV.B.1.c).(2).(b).(i) anatomy of the neuraxis; (~~Outcome~~)(Core) [Moved
883 from IV.A.2.b).(2).(b).(i)]
884
885 IV.B.1.c).(2).(b).(ii) indications, contraindications, adverse
886 effects, complications, and management of
887 spinal anesthesia; (~~Outcome~~)(Core) [Moved from
888 IV.A.2.b).(2).(b).(ii)]
889
890 IV.B.1.c).(2).(b).(iii) cardiovascular and pulmonary physiologic
891 effects of spinal anesthesia; (~~Outcome~~)(Core)
892 [Moved from IV.A.2.b).(2).(b).(iii)]
893
894 IV.B.1.c).(2).(b).(iv) common mechanisms for failed spinal
895 anesthesia; (~~Outcome~~)(Core) [Moved from
896 IV.A.2.b).(2).(b).(iv)]
897
898 IV.B.1.c).(2).(b).(v) various local anesthetics for intrathecal use,
899 including agents, dosage, surgical and total
900 duration of action, and adjuvants;
901 (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(b).(v)]
902
903 IV.B.1.c).(2).(b).(vi) factors affecting intensity, extent, and
904 duration of block, including patient position,

dose, volume, and baricity of injectate; (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(b).(vi)]

IV.B.1.c).(2).(b).(vii) dural puncture headache, including symptoms, etiology, risk factors, and treatment; and, (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(b).(vii)]

IV.B.1.c).(2).(b).(viii) advantages and disadvantages of continuous spinal anesthesia. (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(b).(viii)]

IV.B.1.c).(2).(c) epidural anesthesia (lumbar and thoracic), to include: (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(c)]

IV.B.1.c).(2).(c).(i) indications, contraindications, adverse effects, complications, and management of epidural anesthesia and analgesia; (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(c).(i)]

IV.B.1.c).(2).(c).(ii) local anesthetics for epidural use, including agents, dosage, adjuvants, and duration of action; (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(c).(ii)]

IV.B.1.c).(2).(c).(iii) spinal and epidural anesthesia differences in reliability, latency, duration, and segmental limitations; (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(c).(iii)]

IV.B.1.c).(2).(c).(iv) value and techniques of test dosing to minimize complications of epidural anesthesia and analgesia; (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(c).(iv)]

IV.B.1.c).(2).(c).(v) interpretation of the volume-segment relationship and the effect of patient age, including extremes of age, pregnancy, position, and site of injection on resultant block; (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(c).(v)]

IV.B.1.c).(2).(c).(vi) combined spinal-epidural anesthesia, including advantages/disadvantages, dose requirements, complications, indications, and contraindications; (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(c).(vi)]

IV.B.1.c).(2).(c).(vii) outcome benefits of thoracic epidural analgesia for thoracic and abdominal

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surgery and thoracic trauma; and, (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(c).(vii)]

IV.B.1.c).(2).(c).(viii) differentiation between thoracic epidural anesthesia/analgesia and lumbar epidural anesthesia/analgesia, including advantages/disadvantages, dose requirements, complications, indications, and contraindications. (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(c).(viii)]

IV.B.1.c).(2).(d) upper extremity nerve block, to include: (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(d)]

IV.B.1.c).(2).(d).(i) anatomy and sonoanatomy of the brachial plexus in relation to sensory and motor innervation; (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(d).(i)]

IV.B.1.c).(2).(d).(ii) local anesthetics for brachial plexus block, including agents, dose, duration of action, and adjuvants; (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(d).(ii)]

IV.B.1.c).(2).(d).(iii) value and techniques of intravascular test dosing to minimize local anesthetic systemic toxicity associated with peripheral nerve block; (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(d).(iii)]

IV.B.1.c).(2).(d).(iv) differentiation between the various brachial plexus (or terminal nerve) block sites, including indications, contraindications, advantages, disadvantages, complications, and management specific to each; (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(d).(iv)]

IV.B.1.c).(2).(d).(v) indications and technique for cervical plexus, suprascapular, or intercostobrachial block as unique blocks or supplements to brachial plexus block; and, (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(d).(v)]

IV.B.1.c).(2).(d).(vi) technical and non-technical aspects unique to brachial plexus perineural catheter placement and management. (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(d).(vi)]

IV.B.1.c).(2).(e) lower extremity nerve block, to include: (~~Outcome~~)(Core)

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[Moved from IV.A.2.b).(2).(e)]

IV.B.1.c).(2).(e).(i) anatomy and sonoanatomy of the lower extremity, including sciatic, femoral, lateral femoral cutaneous, and obturator nerves, as well as the adductor canal and lumbar plexus (psoas), and options for saphenous nerve blockade; (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(e).(i)]

IV.B.1.c).(2).(e).(ii) local anesthetics for lower extremity block, including agents, dose, duration of action, and adjuvants; (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(e).(ii)]

IV.B.1.c).(2).(e).(iii) value and techniques of intravascular test dosing to minimize local anesthetic systemic toxicity associated with peripheral nerve block; (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(e).(iii)]

IV.B.1.c).(2).(e).(iv) differentiation between the various approaches to lower-extremity blockade, including indications/contraindications, side effects, complications, and management specific to each; and, (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(e).(iv)]

IV.B.1.c).(2).(e).(v) technical and non-technical aspects unique to lower extremity perineural catheter placement and management. (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(e).(v)]

IV.B.1.c).(2).(f) truncal block, to include: (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(f)]

IV.B.1.c).(2).(f).(i) anatomy for intercostal, paravertebral, ilioinguinal-hypogastric, rectus sheath, and transversus abdominis plane blocks; (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(f).(i)]

IV.B.1.c).(2).(f).(ii) local anesthetics for truncal blockade: agents, dose, and duration of action; (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(f).(ii)]

IV.B.1.c).(2).(f).(iii) indications, contraindications, side effects, complications, safety, and management of truncal blockade; and, (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(f).(iii)]

IV.B.1.c).(2).(f).(iv) technical and non-technical aspects unique

to continuous truncal catheter placement and management. (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(f).(iv)]

IV.B.1.c).(2).(g) intravenous regional anesthesia, to include: (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(g)]

IV.B.1.c).(2).(g).(i) mechanism of action, indications, contraindications, advantages and disadvantages, adverse effects, complications, and management of intravenous regional anesthesia (IVRA); and, (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(g).(i)]

IV.B.1.c).(2).(g).(ii) agents used for IVRA, including local anesthetic choice, dosage, and use of adjuvants. (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(g).(ii)]

IV.B.1.c).(2).(h) complications of regional anesthesia and acute pain medicine, to include diagnosis and management of: (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(h)]

IV.B.1.c).(2).(h).(i) hemorrhagic complications, including complications due to anticoagulant and thrombolytic medications with specific reference to published guidelines; (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(h).(i)]

IV.B.1.c).(2).(h).(ii) infectious complications; (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(h).(ii)]

IV.B.1.c).(2).(h).(iii) neurological complications; (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(h).(iii)]

IV.B.1.c).(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~~)(Core) [Moved from IV.A.2.b).(2).(h).(iii).(a)]

IV.B.1.c).(2).(h).(iv) complications due to medicines, to include local anesthetic systemic toxicity and opioid-induced respiratory depression; and, (~~Outcome~~)(Core) [Moved from IV.A.2.b).(2).(h).(iv)]

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IV.B.1.c).(2).(h).(v) other complications, to include pneumothorax. ~~(Outcome)~~(Core) [Moved from IV.A.2.b).(2).(h).(v)]

IV.B.1.c).(3) Fellows must demonstrate knowledge of the complex biopsychosocial nature of pain. ~~(Outcome)~~(Core) [Moved from IV.A.2.b).(3)]

IV.B.1.d) Practice-based Learning and Improvement

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

> **Background and Intent: Practice-based learning and improvement is one of the defining characteristics of being a physician. It is the ability to investigate and evaluate the care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning.**
>
> **The intention of this Competency is to help a fellow refine the habits of mind required to continuously pursue quality improvement, well past the completion of fellowship.**

IV.B.1.e) 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. (Core)

IV.B.1.f) Systems-based Practice

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

IV.C. Curriculum Organization and Fellow Experiences

IV.C.1. The curriculum must be structured to optimize fellow educational experiences, the length of these experiences, and supervisory continuity. (Core)

[The Review Committee must further specify]

[The Review Committee’s specification will be included in the upcoming focused revision to the Regional Anesthesiology and Acute Pain Medicine Program Requirements]

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1152

1153 **IV.C.2.** **The program must provide instruction and experience in pain**
1154 **management if applicable for the subspecialty, including recognition**
1155 **of the signs of addiction.** **(Core)**
1156

1157 IV.C.3. The curriculum must include at least 10 months of clinical anesthesia
1158 experience, to include: (Core) [Moved from IV.A.3.a)]
1159

1160 IV.C.3.a) regional anesthesia experience of at least five months, including:
1161 (Core) [Moved from IV.A.3.a).(1)]
1162

1163 IV.C.3.a).(1) a minimum of 20 spinal (intrathecal) procedures either
1164 performed primarily or directly supervised by the fellow, to
1165 include demonstration and documentation of proficiency in
1166 using alternative approaches, difficult and high-risk
1167 procedures, and rescue blocks where others have failed;
1168 (Core) [Moved from IV.A.3.a).(1).(a)]
1169

1170 IV.C.3.a).(2) a minimum of 20 epidural procedures either performed
1171 primarily or directly supervised by the fellow, to include
1172 demonstration of proficiency in thoracic epidural and with
1173 demonstration and documentation of proficiency in using
1174 alternative approaches, difficult and high-risk procedures,
1175 and rescue blocks where others have failed; (Core) [Moved
1176 from IV.A.3.a).(1).(b)]
1177

1178 IV.C.3.a).(3) a minimum of 100 upper extremity nerve block procedures,
1179 to include demonstration of proficiency above and below
1180 the clavicle; of these; (Core) [Moved from IV.A.3.a).(1).(c)]
1181

1182 IV.C.3.a).(3).(a) a minimum of 20 must be above the clavicle; and,
1183 (Core) [Moved from IV.A.3.a).(1).(c).(i)]
1184

1185 IV.C.3.a).(3).(b) a minimum of 20 must be below the clavicle (Core)
1186 [Moved from IV.A.3.a).(1).(c).(ii)]
1187

1188 IV.C.3.a).(4) a minimum of 100 lower extremity nerve block procedures,
1189 to include demonstration of proficiency above and below
1190 the proximal thigh; of these; (Core) [Moved from
1191 IV.A.3.a).(1).(d)]
1192

1193 IV.C.3.a).(4).(a) a minimum of 20 must be at or above the proximal
1194 thigh; and, (Core) [Moved from IV.A.3.a).(1).(d).(i)]
1195

1196 IV.C.3.a).(4).(b) a minimum of 20 must be at or below the mid-thigh.
1197 (Core) [Moved from IV.A.3.a).(1).(d).(ii)]
1198

1199 IV.C.3.a).(5) a minimum of 70 truncal block procedures, to include
1200 demonstration of proficiency in the thorax and abdomen; of
1201 these; (Core) [Moved from IV.A.3.a).(1).(e)]
1202

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1203 IV.C.3.a).(5).(a) a minimum of 20 must be abdominal blocks; and,
1204 (Core) [Moved from IV.A.3.a).(1).(e).(i)]
1205
1206 IV.C.3.a).(5).(b) a minimum of 20 must be thoracic blocks; (Core)
1207 [Moved from IV.A.3.a).(1).(e).(ii)]
1208
1209 IV.C.3.a).(6) a minimum of 50 continuous peripheral nerve block
1210 catheter placement procedures, to include upper and lower
1211 extremity and truncal sites. (Core) [Moved from
1212 IV.A.3.a).(1).(f)]
1213
1214 IV.C.3.b) acute pain experience of at least three months, including: (Core)
1215 [Moved from IV.A.3.a).(2)]
1216
1217 IV.C.3.b).(1) supervised assessment and management of inpatients
1218 with acute pain; (Detail) [Moved from IV.A.3.a).(2).(a).]
1219
1220 IV.C.3.b).(2) management of epidural infusions, inpatient continuous
1221 peripheral nerve infusions, ambulatory continuous
1222 peripheral nerve infusions, and patient controlled
1223 analgesia; (Detail) [Moved from IV.A.3.a).(2).(b)]
1224
1225 IV.C.3.b).(3) supervised assessment with specialized acute pain
1226 considerations, to include concurrent anticoagulant
1227 administration, chronic opioid use, neuromuscular
1228 disorders, advanced age, and psychiatric disease; and,
1229 (Detail) [Moved from IV.A.3.a).(2).(c)]
1230
1231 IV.C.3.b).(4) a minimum of 50 unique documented new patients for
1232 each fellow. (Core) [Moved from IV.A.3.a).(2).(d)]
1233
1234 IV.C.3.c) chronic pain experience of at least two weeks, including
1235 documented involvement with a minimum of 20 new patients
1236 assessed in this setting; (Core) [Moved from IV.A.3.a).(3)]
1237
1238 IV.C.3.c).(1) This experience must include supervised participation with
1239 pain medicine specialists responsible for the assessment
1240 and management of patients with chronic pain, to include
1241 cancer pain.(Core) [Moved from IV.A.3.a).(3).(a)]
1242
1243 IV.C.3.c).(2) Patients should be seen through either consultation or
1244 while on a designated inpatient pain medicine service.
1245 (Detail) [Moved from IV.A.3.a).(3).(b)]
1246
1247 IV.C.3.d) pediatric experience; and, (Core) [Moved from IV.A.3.a).(4)]
1248
1249 IV.C.3.d).(1) There should be experience with the age-appropriate
1250 assessment and treatment of acute pain in children, to
1251 include participation in acute pain management and
1252 regional anesthesia for pediatric surgical patients,
1253 including children under 18 years. (Detail) [Moved from

IV.A.3.a).(4).(a)]

IV.C.3.e) trauma experience. (Core) [Moved from IV.A.3.a).(5)]

IV.C.3.e).(1) There should be experience with the assessment and treatment of acute pain in the setting of trauma or in the setting of patients who experience emergent non-elective surgery. (Detail) [Moved from IV.A.3.a).(5).(a)]

IV.C.4. There must be regularly scheduled didactic sessions. (Core) [Moved from IV.A.3.b)]

IV.C.4.a) 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) [Moved from IV.A.3.b).(1)]

IV.C.4.a).(1) Subspecialty conferences, including review of all current complications and deaths, seminars, and clinical and basic science instruction, should be regularly conducted. (Detail) [Moved from IV.A.3.b).(1).(a)]

IV.C.4.a).(2) Fellows and faculty members must regularly attend program lectures, conferences, seminars, and workshops. (Core) [Moved from IV.A.3.b).(1).(b)]

IV.C.4.a).(3) Fellows should actively participate in the planning and production of these meetings. (Detail) [Moved from IV.A.3.b).(1).(c)]

IV.C.4.a).(3).(a) Faculty members should be the leaders in the majority of the sessions. (Detail) [Moved from IV.A.3.b).(1).(c).(i)]

IV.C.4.a).(4) Multidisciplinary conferences should include the participation of faculty members from other specialties outside the fellowship. (Detail) [Moved from IV.A.3.b).(1).(d)]

IV.C.4.a).(4).(a) Fellows should attend a minimum of 10 local, regional, or national multidisciplinary conferences that are relevant to regional anesthesia and acute pain medicine, especially in orthopaedic surgery and pain medicine. (Detail) [Moved from IV.A.3.b).(1).(d).(i)]

IV.C.5. The curriculum must be designed in order for fellows ~~are expected~~ to develop skills and habits to ~~be able to~~ ~~meet the following goals~~: [Moved from IV.A.2.c)]

IV.C.5.a) identify strengths, deficiencies, and limits in knowledge and expertise; (Outcome)‡ [Moved from IV.A.2.c).(3)]

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1305
1306 IV.C.5.b) set learning and practice improvement goals; (Outcome) [Moved from
1307 IV.A.2.c).(4)]
1308
1309 IV.C.5.c) identify and perform appropriate learning activities, including
1310 didactic lectures and hands-on demonstrations that promulgate
1311 safety; (Outcome) [Moved from IV.A.2.c).(5)]
1312
1313 IV.C.5.d) incorporate formative evaluation feedback into daily practice;
1314 (Outcome) [Moved from IV.A.2.c).(6)]
1315
1316 IV.C.5.e) evaluate and apply evidence from scientific studies, expert
1317 guidelines, and practice pathways to patients' medical conditions;
1318 (Outcome) [Moved from IV.A.2.c).(7)]
1319
1320 IV.C.5.f) apply information technology to obtain and record patient
1321 information, access institutional and national policies and
1322 guidelines, and participate in self education; (Outcome) [Moved from
1323 IV.A.2.c).(8)]
1324
1325 IV.C.5.g) analyze their own practice with respect to patient outcomes
1326 (especially success and complications from regional blockade)
1327 and compare to available literature; (Outcome) [Moved from
1328 IV.A.2.c).(9)]
1329
1330 IV.C.5.h) participate in the education of patients, families, students, fellows,
1331 and other health care professionals; and, (Outcome) [Moved from
1332 IV.A.2.c).(10)]
1333
1334 **IV.C.5.i)** advocate for acute pain management and create best practices for
1335 pain management regarding major surgical procedures. (Outcome)
1336 [Moved from IV.A.2.c).(11)]
1337
1338 ~~Fellows are expected to demonstrate the ability to: [Moved from IV.A.2.d)]~~
1339
1340 IV.C.5.j) summarize information to the patient and family with respect to the
1341 options, alternatives, risks, and benefits of regional anesthesia
1342 and/or acute analgesic techniques in a manner that is clear,
1343 understandable, and ethical; (Outcome) [Moved from IV.A.2.d).(1)]
1344
1345 IV.C.5.k) develop effective listening skills and answer questions
1346 appropriately in the process of obtaining informed consent; and,
1347 (Outcome) [Moved from IV.A.2.d).(2)]
1348
1349 IV.C.5.l) operate effectively in a team environment, communicating and
1350 cooperating with surgeons, other physicians, nurses, pharmacists,
1351 physical therapists, and other members of the peri-operative team,
1352 including: (Outcome) [Moved from IV.A.2.d).(3)]
1353
1354 IV.C.5.l).(1) recognizing the roles of all team members; (Outcome) [Moved
1355 from IV.A.2.d).(3).(a)]

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1356
1357 IV.C.5.l).(2) communicating clearly in a professional manner that
1358 facilitates the achievement of care goals; (Outcome) [Moved
1359 from IV.A.2.d).(3).(b)]
1360
1361 IV.C.5.l).(3) helping other members of the team to enhance the sharing
1362 of important information; and, (Outcome) [Moved from
1363 IV.A.2.d).(3).(c)]
1364
1365 IV.C.5.l).(4) formulating care plans that utilize multidisciplinary team
1366 skills, such as a plan for facilitated recovery. (Outcome) [Moved
1367 from IV.A.2.d).(3).(d)]
1368
1369 ~~Fellows are expected to demonstrate: [Moved from IV.A.2.e)]~~
1370
1371 IV.C.5.m) demonstrate integrity, honesty, and accountability in conducting
1372 the practice of medicine; (Outcome) [Moved from IV.A.2.e).(1)]
1373
1374 IV.C.5.n) demonstrate a commitment to lifelong learning and excellence in
1375 practice; (Outcome) [Moved from IV.A.2.e).(2)]
1376
1377 IV.C.5.o) demonstrate consistent subjugation of self-interest to the good of
1378 the patient and the health care needs of society; and, (Outcome)
1379 [Moved from IV.A.2.e).(3)]
1380
1381 IV.C.5.p) demonstrate commitment to ethical principles in providing care,
1382 obtaining informed consent, and maintaining patient
1383 confidentiality. (Outcome) [Moved from IV.A.2.e).(4)]
1384
1385 ~~Fellows are expected to: [Moved from IV.A.2.f)]~~
1386
1387 IV.C.5.q) effectively choose regional anesthesia techniques and
1388 approaches to promote peri-operative efficiency and improve
1389 patient outcomes; (Outcome) [Moved from IV.A.2.f).(1)]
1390
1391 IV.C.5.r) understand the interaction of the regional anesthesia and acute
1392 pain medicine service with other elements of the health care
1393 system, including primary surgical and medical teams, and other
1394 consultant, nursing, pharmacy, and physical therapy services;
1395 (Outcome) [Moved from IV.A.2.f).(2)]
1396
1397 IV.C.5.s) demonstrate awareness of health care costs and resource
1398 allocation, and the impact of their choices on those costs and
1399 resources, as well as strategies to accommodate hospital
1400 formulary, drug shortages, and cost control; (Outcome) [Moved from
1401 IV.A.2.f).(3)]
1402
1403 IV.C.5.s).(1) advocate for patients and their families within the health
1404 care system, and assist them in understanding and
1405 negotiating complexities in the system; (Outcome) [Moved from
1406 IV.A.2.f).(4)]

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1407
1408 IV.C.5.s).(2) 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) [Moved from IV.A.2.f).(5)]

IV.C.5.s).(3) when indicated, safely and effectively perform a comprehensive range of advanced regional anesthesia procedures for appropriate indications, in a safe, consistent, and reliable manner, understanding the individual risks and benefits of each; (Outcome) [Moved from IV.A.2.f).(6)]

IV.C.5.s).(4) 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) [Moved from IV.A.2.f).(7)]

IV.C.5.s).(5) 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) [Moved from IV.A.2.f).(8)]

IV.C.5.s).(6) 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) [Moved from IV.A.2.f).(9)]

IV.D. Scholarship

Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through fellow participation in scholarly activities as defined in the subspecialty-specific Program Requirements. Scholarly activities may include discovery, integration, application, and teaching.

The ACGME recognizes the diversity of fellowships and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other

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programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.

IV.D.1. Program Responsibilities

IV.D.1.a) The program must demonstrate evidence of scholarly activities, consistent with its mission(s) and aims. (Core)

IV.D.1.b) The program in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate fellow and faculty involvement in scholarly activities. (Core)

IV.D.1.b).(1) The faculty must establish and maintain an environment of inquiry and scholarship with an active research component. (Core) [Moved from II.B.5]

IV.D.2. Faculty Scholarly Activity

IV.D.2.a) Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core)

- **Research in basic science, education, translational science, patient care, or population health**
- **Peer-reviewed grants**
- **Quality improvement and/or patient safety initiatives**
- **Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports**
- **Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials**
- **Contribution to professional committees, educational organizations, or editorial boards**
- **Innovations in education**

IV.D.2.b) The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:

Background and Intent: For the purposes of education, metrics of scholarly activity represent one of the surrogates for the program's effectiveness in the creation of an environment of inquiry that advances the fellows' scholarly approach to patient care. The Review Committee will evaluate the dissemination of scholarship for the program as a whole, not for individual faculty members, for a five-year interval, for both core and non-core faculty members, with the goal of assessing the effectiveness of the creation of such an environment. The ACGME recognizes that there may be differences in scholarship requirements between different specialties and between residencies and fellowships in the same specialty.

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1497 **IV.D.2.b).(1)** **faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor;** **(Outcome)**
1498
1499
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1502
1503
1504
1505
1506 **IV.D.2.b).(2)** **peer-reviewed publication.** **(Outcome)**
1507
1508 **IV.D.3.** **Fellow Scholarly Activity**
1509
1510 IV.D.3.a) All fellows must complete a scholarly project. (Core) [Moved from IV.B.1]
1511
1512
1513 IV.D.3.a).(1) The results of such projects must be disseminated through a variety of means, including publication or presentation at local, regional, national, or international meetings. (Core) [Moved from IV.B.1.a)]
1514
1515
1516
1517
1518 IV.D.3.a).(2) To accomplish these objectives, the members of the regional anesthesiology and acute pain medicine faculty must mentor fellows in the preparation of research proposals, research methodology, and authorship guidelines. (Core) [Moved from IV.B.1.b)]
1519
1520
1521
1522
1523
1524 IV.D.3.a).(2).(a) Fellows should give research presentations at national or regional meetings. (Detail) [Moved from IV.B.1.b).(1)]
1525
1526
1527
1528 IV.D.3.b) Fellows must: [Moved from IV.B.1.c)]
1529
1530 IV.D.3.b).(1) engage in teaching activities as a major activity of the fellowship. (Core) [Moved from IV.B.1.c).(1)]
1531
1532
1533 IV.D.3.b).(2) create and present a lecture during departmental or divisional grand rounds, or at a local, regional, or national meeting, covering a topic, research, or case relevant to regional anesthesia or acute pain medicine; (Core) [Moved from IV.B.1.c).(2)]
1534
1535
1536
1537
1538
1539 IV.D.3.b).(3) prepare and present resident education lectures and journal reviews for regional anesthesia and/or acute pain medicine subspecialty conferences; (Core) [Moved from IV.B.1.c).(3)]
1540
1541
1542
1543
1544 IV.D.3.b).(4) participate and direct cadaver anatomy laboratories for regional anesthesia if available; (Core) [Moved from IV.B.1.c).(4)]
1545
1546
1547

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1548 IV.D.3.b).(5) develop teaching techniques by instructing residents
1549 and/or medical students at the bedside with the
1550 supervision of faculty member(s); and, (Core) [Moved from
1551 IV.B.1.c).(5)]
1552
1553 IV.D.3.b).(6) review and enhance web-based teaching resources, such
1554 as resident teaching materials, curriculum documents, and
1555 self-study and testing materials. (Core) [Moved from
1556 IV.B.1.c).(6)]
1557
1558 **V. Evaluation**
1559
1560 **V.A. Fellow Evaluation**
1561
1562 **V.A.1. Feedback and Evaluation**
1563

Background and Intent: Feedback is ongoing information provided regarding aspects of one's performance, knowledge, or understanding. The faculty empower fellows to provide much of that feedback themselves in a spirit of continuous learning and self-reflection. Feedback from faculty members in the context of routine clinical care should be frequent, and need not always be formally documented.

Formative and summative evaluation have distinct definitions. Formative evaluation is *monitoring fellow learning* and providing ongoing feedback that can be used by fellows to improve their learning in the context of provision of patient care or other educational opportunities. More specifically, formative evaluations help:

- **fellows identify their strengths and weaknesses and target areas that need work**
- **program directors and faculty members recognize where fellows are struggling and address problems immediately**

Summative evaluation is *evaluating a fellow's learning* by comparing the fellows against the goals and objectives of the rotation and program, respectively. Summative evaluation is utilized to make decisions about promotion to the next level of training, or program completion.

End-of-rotation and end-of-year evaluations have both summative and formative components. Information from a summative evaluation can be used formatively when fellows or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the fellowship program.

Feedback, formative evaluation, and summative evaluation compare intentions with accomplishments, enabling the transformation of a new specialist to one with growing subspecialty expertise.

1564
1565 **V.A.1.a) Faculty members must directly observe, evaluate, and**
1566 **frequently provide feedback on fellow performance during**
1567 **each rotation or similar educational assignment. (Core)**
1568
1569 V.A.1.a).(1) These assessments should include evaluations of
1570 interpersonal communication and relationship skills, fund of
1571 knowledge, manual skills, decision-making skills, and

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1572 critical analysis of clinical situations. (Detail) [Moved from V.A.2.b).(1).(a)]
1573
1574

Background and Intent: Faculty members should provide feedback frequently throughout the course of each rotation. Fellows require feedback from faculty members to reinforce well-performed duties and tasks, as well as to correct deficiencies. This feedback will allow for the development of the learner as they strive to achieve the Milestones. More frequent feedback is strongly encouraged for fellows who have deficiencies that may result in a poor final rotation evaluation.

1575
1576 **V.A.1.b) Evaluation must be documented at the completion of the**
1577 **assignment. (Core)**
1578
1579 **V.A.1.b).(1) For block rotations of greater than three months in**
1580 **duration, evaluation must be documented at least**
1581 **every three months. (Core)**
1582
1583 **V.A.1.b).(2) Longitudinal experiences such as continuity clinic in**
1584 **the context of other clinical responsibilities must be**
1585 **evaluated at least every three months and at**
1586 **completion. (Core)**
1587
1588 **V.A.1.c) The program must provide an objective performance**
1589 **evaluation based on the Competencies and the subspecialty-**
1590 **specific Milestones, and must: (Core)**
1591
1592 **V.A.1.c).(1) use multiple evaluators (e.g., faculty members, peers,**
1593 **patients, self, and other professional staff members);**
1594 **and, (Core)**
1595
1596 **V.A.1.c).(2) provide that information to the Clinical Competency**
1597 **Committee for its synthesis of progressive fellow**
1598 **performance and improvement toward unsupervised**
1599 **practice. (Core)**
1600

Background and Intent: The trajectory to autonomous practice in a subspecialty is documented by the subspecialty-specific Milestones evaluation during fellowship. These Milestones detail the progress of a fellow in attaining skill in each competency domain. It is expected that the most growth in fellowship education occurs in patient care and medical knowledge, while the other four domains of competency must be ensured in the context of the subspecialty. They are developed by a subspecialty group and allow evaluation based on observable behaviors. The Milestones are considered formative and should be used to identify learning needs. This may lead to focused or general curricular revision in any given program or to individualized learning plans for any specific fellow.

1601
1602 **V.A.1.d) The program director or their designee, with input from the**
1603 **Clinical Competency Committee, must:**
1604
1605 **V.A.1.d).(1) meet with and review with each fellow their**
1606 **documented semi-annual evaluation of performance,**

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1607 **including progress along the subspecialty-specific**
1608 **Milestones.** (Core)
1609
1610 **V.A.1.d).(2)** **assist fellows in developing individualized learning**
1611 **plans to capitalize on their strengths and identify areas**
1612 **for growth; and,** (Core)
1613
1614 **V.A.1.d).(3)** **develop plans for fellows failing to progress, following**
1615 **institutional policies and procedures.** (Core)
1616

Background and Intent: Learning is an active process that requires effort from the teacher and the learner. Faculty members evaluate a fellow's performance at least at the end of each rotation. The program director or their designee will review those evaluations, including their progress on the Milestones, at a minimum of every six months. Fellows should be encouraged to reflect upon the evaluation, using the information to reinforce well-performed tasks or knowledge or to modify deficiencies in knowledge or practice. Working together with the faculty members, fellows should develop an individualized learning plan.

Fellows who are experiencing difficulties with achieving progress along the Milestones may require intervention to address specific deficiencies. Such intervention, documented in an individual remediation plan developed by the program director or a faculty mentor and the fellow, will take a variety of forms based on the specific learning needs of the fellow. However, the ACGME recognizes that there are situations which require more significant intervention that may alter the time course of fellow progression. To ensure due process, it is essential that the program director follow institutional policies and procedures.

1617
1618 **V.A.1.e)** **At least annually, there must be a summative evaluation of**
1619 **each fellow that includes their readiness to progress to the**
1620 **next year of the program, if applicable.** (Core)
1621
1622 **V.A.1.f)** **The evaluations of a fellow's performance must be accessible**
1623 **for review by the fellow.** (Core)
1624
1625 **V.A.2.** **Final Evaluation**
1626
1627 **V.A.2.a)** **The program director must provide a final evaluation for each**
1628 **fellow upon completion of the program.** (Core)
1629
1630 **V.A.2.a).(1)** **The subspecialty-specific Milestones, and when**
1631 **applicable the subspecialty-specific Case Logs, must**
1632 **be used as tools to ensure fellows are able to engage**
1633 **in autonomous practice upon completion of the**
1634 **program.** (Core)
1635
1636 **V.A.2.a).(2)** **The final evaluation must:**
1637
1638 **V.A.2.a).(2).(a)** **become part of the fellow's permanent record**
1639 **maintained by the institution, and must be**

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1640 **accessible for review by the fellow in**
1641 **accordance with institutional policy;** **(Core)**
1642
1643 **V.A.2.a).(2).(b)** **verify that the fellow has demonstrated the**
1644 **knowledge, skills, and behaviors necessary to**
1645 **enter autonomous practice;** **(Core)**
1646
1647 **V.A.2.a).(2).(c)** **consider recommendations from the Clinical**
1648 **Competency Committee; and,** **(Core)**
1649
1650 **V.A.2.a).(2).(d)** **be shared with the fellow upon completion of**
1651 **the program.** **(Core)**
1652
1653 **V.A.3.** **A Clinical Competency Committee must be appointed by the**
1654 **program director.** **(Core)**
1655
1656 **V.A.3.a)** **At a minimum the Clinical Competency Committee must**
1657 **include three members, at least one of whom is a core faculty**
1658 **member. Members must be faculty members from the same**
1659 **program or other programs, or other health professionals**
1660 **who have extensive contact and experience with the**
1661 **program's fellows.** **(Core)**
1662
1663 **V.A.3.b)** **The Clinical Competency Committee must:**
1664
1665 **V.A.3.b).(1)** **review all fellow evaluations at least semi-annually;**
1666 **(Core)**
1667
1668 **V.A.3.b).(2)** **determine each fellow's progress on achievement of**
1669 **the subspecialty-specific Milestones; and,** **(Core)**
1670
1671 **V.A.3.b).(3)** **meet prior to the fellows' semi-annual evaluations and**
1672 **advise the program director regarding each fellow's**
1673 **progress.** **(Core)**
1674
1675 **V.B.** **Faculty Evaluation**
1676
1677 **V.B.1.** **The program must have a process to evaluate each faculty**
1678 **member's performance as it relates to the educational program at**
1679 **least annually.** **(Core)**
1680

Background and Intent: The program director is responsible for the education program and for whom delivers it. While the term faculty may be applied to physicians within a given institution for other reasons, it is applied to fellowship program faculty members only through approval by a program director. The development of the faculty improves the education, clinical, and research aspects of a program. Faculty members have a strong commitment to the fellow and desire to provide optimal education and work opportunities. Faculty members must be provided feedback on their contribution to the mission of the program. All faculty members who interact with fellows desire feedback on their education, clinical care, and research. If a faculty member does not interact with fellows, feedback is not required. With regard to the diverse operating

environments and configurations, the fellowship program director may need to work with others to determine the effectiveness of the program's faculty performance with regard to their role in the educational program. All teaching faculty members should have their educational efforts evaluated by the fellows in a confidential and anonymous manner. Other aspects for the feedback may include research or clinical productivity, review of patient outcomes, or peer review of scholarly activity. The process should reflect the local environment and identify the necessary information. The feedback from the various sources should be summarized and provided to the faculty on an annual basis by a member of the leadership team of the program.

1681
1682 **V.B.1.a)** **This evaluation must include a review of the faculty member's**
1683 **clinical teaching abilities, engagement with the educational**
1684 **program, participation in faculty development related to their**
1685 **skills as an educator, clinical performance, professionalism,**
1686 **and scholarly activities.** (Core)
1687
1688 **V.B.1.b)** **This evaluation must include written, confidential evaluations**
1689 **by the fellows.** (Core)
1690
1691 **V.B.2.** **Faculty members must receive feedback on their evaluations at least**
1692 **annually.** (Core)
1693
1694 **V.B.3.** **Results of the faculty educational evaluations should be**
1695 **incorporated into program-wide faculty development plans.** (Core)
1696

Background and Intent: The quality of the faculty's teaching and clinical care is a determinant of the quality of the program and the quality of the fellows' future clinical care. Therefore, the program has the responsibility to evaluate and improve the program faculty members' teaching, scholarship, professionalism, and quality care. This section mandates annual review of the program's faculty members for this purpose, and can be used as input into the Annual Program Evaluation.

1697
1698 **V.C.** **Program Evaluation and Improvement**
1699
1700 **V.C.1.** **The program director must appoint the Program Evaluation**
1701 **Committee to conduct and document the Annual Program**
1702 **Evaluation as part of the program's continuous improvement**
1703 **process.** (Core)
1704
1705 **V.C.1.a)** **The Program Evaluation Committee must be composed of at**
1706 **least two program faculty members, at least one of whom is a**
1707 **core faculty member, and at least one fellow.** (Core)
1708
1709 **V.C.1.b)** **Program Evaluation Committee responsibilities must include:**
1710
1711 **V.C.1.b).(1)** **acting as an advisor to the program director, through**
1712 **program oversight;** (Core)
1713
1714 **V.C.1.b).(2)** **review of the program's self-determined goals and**
1715 **progress toward meeting them;** (Core)
1716

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1717 **V.C.1.b).(3)** **guiding ongoing program improvement, including development of new goals, based upon outcomes; and,** **(Core)**
1718
1719
1720
1721 **V.C.1.b).(4)** **review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims.** **(Core)**
1722
1723
1724

Background and Intent: In order to achieve its mission and train quality physicians, a program must evaluate its performance and plan for improvement in the Annual Program Evaluation. Performance of fellows and faculty members is a reflection of program quality, and can use metrics that reflect the goals that a program has set for itself. The Program Evaluation Committee utilizes outcome parameters and other data to assess the program's progress toward achievement of its goals and aims.

1725
1726 **V.C.1.c)** **The Program Evaluation Committee should consider the following elements in its assessment of the program:**
1727
1728
1729 **V.C.1.c).(1)** **curriculum;** **(Core)**
1730
1731 **V.C.1.c).(2)** **outcomes from prior Annual Program Evaluation(s);** **(Core)**
1732
1733
1734 **V.C.1.c).(3)** **ACGME letters of notification, including citations, Areas for Improvement, and comments;** **(Core)**
1735
1736
1737 **V.C.1.c).(4)** **quality and safety of patient care;** **(Core)**
1738
1739 **V.C.1.c).(5)** **aggregate fellow and faculty:**
1740
1741 **V.C.1.c).(5).(a)** **well-being;** **(Core)**
1742
1743 **V.C.1.c).(5).(b)** **recruitment and retention;** **(Core)**
1744
1745 **V.C.1.c).(5).(c)** **workforce diversity;** **(Core)**
1746
1747 **V.C.1.c).(5).(d)** **engagement in quality improvement and patient safety;** **(Core)**
1748
1749
1750 **V.C.1.c).(5).(e)** **scholarly activity;** **(Core)**
1751
1752 **V.C.1.c).(5).(f)** **ACGME Resident/Fellow and Faculty Surveys (where applicable); and,** **(Core)**
1753
1754
1755 **V.C.1.c).(5).(g)** **written evaluations of the program.** **(Core)**
1756
1757 **V.C.1.c).(6)** **aggregate fellow:**
1758
1759 **V.C.1.c).(6).(a)** **achievement of the Milestones;** **(Core)**
1760

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1761 **V.C.1.c).(6).(b)** **in-training examinations (where applicable);**
1762 **(Core)**
1763
1764 **V.C.1.c).(6).(c)** **board pass and certification rates; and, (Core)**
1765
1766 **V.C.1.c).(6).(d)** **graduate performance. (Core)**
1767
1768 **V.C.1.c).(7)** **aggregate faculty:**
1769
1770 **V.C.1.c).(7).(a)** **evaluation; and, (Core)**
1771
1772 **V.C.1.c).(7).(b)** **professional development (Core)**
1773
1774 **V.C.1.d)** **The Program Evaluation Committee must evaluate the**
1775 **program's mission and aims, strengths, areas for**
1776 **improvement, and threats. (Core)**
1777
1778 **V.C.1.e)** **The annual review, including the action plan, must:**
1779
1780 **V.C.1.e).(1)** **be distributed to and discussed with the members of**
1781 **the teaching faculty and the fellows; and, (Core)**
1782
1783 **V.C.1.e).(2)** **be submitted to the DIO. (Core)**
1784
1785 **V.C.2.** **The program must participate in a Self-Study prior to its 10-Year**
1786 **Accreditation Site Visit. (Core)**
1787
1788 **V.C.2.a)** **A summary of the Self-Study must be submitted to the DIO.**
1789 **(Core)**
1790

Background and Intent: Outcomes of the documented Annual Program Evaluation can be integrated into the 10-year Self-Study process. The Self-Study is an objective, comprehensive evaluation of the fellowship program, with the aim of improving it. Underlying the Self-Study is this longitudinal evaluation of the program and its learning environment, facilitated through sequential Annual Program Evaluations that focus on the required components, with an emphasis on program strengths and self-identified areas for improvement. Details regarding the timing and expectations for the Self-Study and the 10-Year Accreditation Site Visit are provided in the *ACGME Manual of Policies and Procedures*. Additionally, a description of the Self-Study process, as well as information on how to prepare for the 10-Year Accreditation Site Visit, is available on the ACGME website.

1791
1792 **V.C.3.** ***One goal of ACGME-accredited education is to educate physicians***
1793 ***who seek and achieve board certification. One measure of the***
1794 ***effectiveness of the educational program is the ultimate pass rate.***
1795
1796 ***The program director should encourage all eligible program***
1797 ***graduates to take the certifying examination offered by the***
1798 ***applicable American Board of Medical Specialties (ABMS) member***
1799 ***board or American Osteopathic Association (AOA) certifying board.***
1800

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1801 **V.C.3.a)** **For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty.** **(Outcome)**

1808 **V.C.3.b)** **For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty.** **(Outcome)**

1815 **V.C.3.c)** **For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty.** **(Outcome)**

1822 **V.C.3.d)** **For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty.** **(Outcome)**

1829 **V.C.3.e)** **For each of the exams referenced in V.C.3.a)-d), any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that subspecialty.** **(Outcome)**

1834

Background and Intent: Setting a single standard for pass rate that works across subspecialties is not supportable based on the heterogeneity of the psychometrics of different examinations. By using a percentile rank, the performance of the lower five percent (fifth percentile) of programs can be identified and set on a path to curricular and test preparation reform.

There are subspecialties where there is a very high board pass rate that could leave successful programs in the bottom five percent (fifth percentile) despite admirable performance. These high-performing programs should not be cited, and V.C.3.e) is designed to address this.

1835

1836 **V.C.3.f)** **Programs must report, in ADS, board certification status annually for the cohort of board-eligible fellows that graduated seven years earlier.** **(Core)**

1839

Background and Intent: It is essential that fellowship programs demonstrate knowledge and skill transfer to their fellows. One measure of that is the qualifying or

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initial certification exam pass rate. Another important parameter of the success of the program is the ultimate board certification rate of its graduates. Graduates are eligible for up to seven years from fellowship graduation for initial certification. The ACGME will calculate a rolling three-year average of the ultimate board certification rate at seven years post-graduation, and the Review Committees will monitor it.

The Review Committees will track the rolling seven-year certification rate as an indicator of program quality. Programs are encouraged to monitor their graduates' performance on board certification examinations.

In the future, the ACGME may establish parameters related to ultimate board certification rates.

1840
1841 **VI. The Learning and Working Environment**
1842
1843 ***Fellowship education must occur in the context of a learning and working***
1844 ***environment that emphasizes the following principles:***
1845
1846 - ***Excellence in the safety and quality of care rendered to patients by fellows***
1847 ***today***
1848
1849 - ***Excellence in the safety and quality of care rendered to patients by today's***
1850 ***fellows in their future practice***
1851
1852 - ***Excellence in professionalism through faculty modeling of:***
1853
1854 - ***the effacement of self-interest in a humanistic environment that supports***
1855 ***the professional development of physicians***
1856
1857 - ***the joy of curiosity, problem-solving, intellectual rigor, and discovery***
1858
1859 - ***Commitment to the well-being of the students, residents, fellows, faculty***
1860 ***members, and all members of the health care team***
1861

Background and Intent: The revised requirements are intended to provide greater flexibility within an established framework, allowing programs and fellows more discretion to structure clinical education in a way that best supports the above principles of professional development. With this increased flexibility comes the responsibility for programs and fellows to adhere to the 80-hour maximum weekly limit (unless a rotation-specific exception is granted by a Review Committee), and to utilize flexibility in a manner that optimizes patient safety, fellow education, and fellow well-being. The requirements are intended to support the development of a sense of professionalism by encouraging fellows to make decisions based on patient needs and their own well-being, without fear of jeopardizing their program's accreditation status. In addition, the proposed requirements eliminate the burdensome documentation requirement for fellows to justify clinical and educational work hour variations.

Clinical and educational work hours represent only one part of the larger issue of conditions of the learning and working environment, and Section VI has now been expanded to include greater attention to patient safety and fellow and faculty member

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well-being. The requirements are intended to support programs and fellows as they strive for excellence, while also ensuring ethical, humanistic training. Ensuring that flexibility is used in an appropriate manner is a shared responsibility of the program and fellows. With this flexibility comes a responsibility for fellows and faculty members to recognize the need to hand off care of a patient to another provider when a fellow is too fatigued to provide safe, high quality care and for programs to ensure that fellows remain within the 80-hour maximum weekly limit.

1862
1863 **VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability**
1864
1865 **VI.A.1. Patient Safety and Quality Improvement**
1866
1867–1875 ***All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Graduate medical education must prepare fellows to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by fellows who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.***
1876
1877–1881 ***Fellows must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating fellows will apply these skills to critique their future unsupervised practice and effect quality improvement measures.***
1882
1883–1885 ***It is necessary for fellows and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.***
1886
1887 **VI.A.1.a) Patient Safety**
1888
1889 **VI.A.1.a).(1) Culture of Safety**
1890
1891–1896 ***A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.***
1897
1898–1901 **VI.A.1.a).(1).(a) The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety.** (Core)
1902
1903–1905 **VI.A.1.a).(1).(b) The program must have a structure that promotes safe, interprofessional, team-based care.** (Core)

1906
1907 **VI.A.1.a).(2)** **Education on Patient Safety**
1908
1909 **Programs must provide formal educational activities**
1910 **that promote patient safety-related goals, tools, and**
1911 **techniques.** **(Core)**
1912

Background and Intent: Optimal patient safety occurs in the setting of a coordinated interprofessional learning and working environment.

1913
1914 **VI.A.1.a).(3)** **Patient Safety Events**
1915
1916 ***Reporting, investigation, and follow-up of adverse***
1917 ***events, near misses, and unsafe conditions are pivotal***
1918 ***mechanisms for improving patient safety, and are***
1919 ***essential for the success of any patient safety***
1920 ***program. Feedback and experiential learning are***
1921 ***essential to developing true competence in the ability***
1922 ***to identify causes and institute sustainable systems-***
1923 ***based changes to ameliorate patient safety***
1924 ***vulnerabilities.***
1925
1926 **VI.A.1.a).(3).(a)** **Residents, fellows, faculty members, and other**
1927 **clinical staff members must:**
1928
1929 **VI.A.1.a).(3).(a).(i)** **know their responsibilities in reporting**
1930 **patient safety events at the clinical site;**
1931 **(Core)**
1932
1933 **VI.A.1.a).(3).(a).(ii)** **know how to report patient safety**
1934 **events, including near misses, at the**
1935 **clinical site; and,** **(Core)**
1936
1937 **VI.A.1.a).(3).(a).(iii)** **be provided with summary information**
1938 **of their institution's patient safety**
1939 **reports.** **(Core)**
1940
1941 **VI.A.1.a).(3).(b)** **Fellows must participate as team members in**
1942 **real and/or simulated interprofessional clinical**
1943 **patient safety activities, such as root cause**
1944 **analyses or other activities that include**
1945 **analysis, as well as formulation and**
1946 **implementation of actions.** **(Core)**
1947
1948 **VI.A.1.a).(4)** **Fellow Education and Experience in Disclosure of**
1949 **Adverse Events**
1950
1951 ***Patient-centered care requires patients, and when***
1952 ***appropriate families, to be apprised of clinical***
1953 ***situations that affect them, including adverse events.***

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This is an important skill for faculty physicians to model, and for fellows to develop and apply.

VI.A.1.a).(4).(a) **All fellows must receive training in how to disclose adverse events to patients and families.** **(Core)**

VI.A.1.a).(4).(b) **Fellows should have the opportunity to participate in the disclosure of patient safety events, real or simulated.** **(Detail)**

VI.A.1.b) **Quality Improvement**

VI.A.1.b).(1) **Education in Quality Improvement**

A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.

VI.A.1.b).(1).(a) **Fellows must receive training and experience in quality improvement processes, including an understanding of health care disparities.** **(Core)**

VI.A.1.b).(2) **Quality Metrics**

Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.

VI.A.1.b).(2).(a) **Fellows and faculty members must receive data on quality metrics and benchmarks related to their patient populations.** **(Core)**

VI.A.1.b).(3) **Engagement in Quality Improvement Activities**

Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.

VI.A.1.b).(3).(a) **Fellows must have the opportunity to participate in interprofessional quality improvement activities.** **(Core)**

VI.A.1.b).(3).(a).(i) **This should include activities aimed at reducing health care disparities.** **(Detail)**

VI.A.2. **Supervision and Accountability**

VI.A.2.a) ***Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the***

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2005 *responsibility and accountability for their efforts in the*
2006 *provision of care. Effective programs, in partnership with*
2007 *their Sponsoring Institutions, define, widely communicate,*
2008 *and monitor a structured chain of responsibility and*
2009 *accountability as it relates to the supervision of all patient*
2010 *care.*
2011
2012 *Supervision in the setting of graduate medical education*
2013 *provides safe and effective care to patients; ensures each*
2014 *fellow's development of the skills, knowledge, and attitudes*
2015 *required to enter the unsupervised practice of medicine; and*
2016 *establishes a foundation for continued professional growth.*
2017
2018 **VI.A.2.a).(1)** **Each patient must have an identifiable and**
2019 **appropriately-credentialed and privileged attending**
2020 **physician (or licensed independent practitioner as**
2021 **specified by the applicable Review Committee) who is**
2022 **responsible and accountable for the patient's care.**
2023 **(Core)**
2024
2025 **VI.A.2.a).(1).(a)** **This information must be available to fellows,**
2026 **faculty members, other members of the health**
2027 **care team, and patients. (Core)**
2028
2029 **VI.A.2.a).(1).(b)** **Fellows and faculty members must inform each**
2030 **patient of their respective roles in that patient's**
2031 **care when providing direct patient care. (Core)**
2032
2033 **VI.A.2.b)** ***Supervision may be exercised through a variety of methods.***
2034 ***For many aspects of patient care, the supervising physician***
2035 ***may be a more advanced fellow. Other portions of care***
2036 ***provided by the fellow can be adequately supervised by the***
2037 ***immediate availability of the supervising faculty member or***
2038 ***fellow, either on site or by means of telephonic and/or***
2039 ***electronic modalities. Some activities require the physical***
2040 ***presence of the supervising faculty member. In some***
2041 ***circumstances, supervision may include post-hoc review of***
2042 ***fellow-delivered care with feedback.***
2043
2044 **VI.A.2.b).(1)** **The program must demonstrate that the appropriate**
2045 **level of supervision in place for all fellows is based on**
2046 **each fellow's level of training and ability, as well as**
2047 **patient complexity and acuity. Supervision may be**
2048 **exercised through a variety of methods, as appropriate**
2049 **to the situation. (Core)**
2050
2051 **VI.A.2.c)** **Levels of Supervision**
2052
2053 **To promote oversight of fellow supervision while providing**
2054 **for graded authority and responsibility, the program must use**
2055 **the following classification of supervision: (Core)**

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2056
2057 **VI.A.2.c).(1)** **Direct Supervision – the supervising physician is physically present with the fellow and patient.** **(Core)**
2058
2059
2060 **VI.A.2.c).(2)** **Indirect Supervision:**
2061
2062 **VI.A.2.c).(2).(a)** **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)**
2063
2064
2065
2066
2067
2068 **VI.A.2.c).(2).(b)** **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)**
2069
2070
2071
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2075 **VI.A.2.c).(3)** **Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.** **(Core)**
2076
2077
2078
2079 **VI.A.2.d)** **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)**
2080
2081
2082
2083
2084 **VI.A.2.d).(1)** **The program director must evaluate each fellow's abilities based on specific criteria, guided by the Milestones.** **(Core)**
2085
2086
2087
2088 **VI.A.2.d).(2)** **Faculty members functioning as supervising physicians must delegate portions of care to fellows based on the needs of the patient and the skills of each fellow.** **(Core)**
2089
2090
2091
2092
2093 **VI.A.2.d).(3)** **Fellows should serve in a supervisory role to junior fellows and residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.** **(Detail)**
2094
2095
2096
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2098
2099 **VI.A.2.e)** **Programs must set guidelines for circumstances and events in which fellows must communicate with the supervising faculty member(s).** **(Core)**
2100
2101
2102
2103 **VI.A.2.e).(1)** **Each fellow must know the limits of their scope of authority, and the circumstances under which the fellow is permitted to act with conditional independence.** **(Outcome)**
2104
2105
2106

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2107

Background and Intent: The ACGME Glossary of Terms defines conditional independence as: Graded, progressive responsibility for patient care with defined oversight.

2108
2109 **VI.A.2.f)** **Faculty supervision assignments must be of sufficient**
2110 **duration to assess the knowledge and skills of each fellow**
2111 **and to delegate to the fellow the appropriate level of patient**
2112 **care authority and responsibility.** (Core)
2113
2114 **VI.B. Professionalism**
2115
2116 **VI.B.1.** **Programs, in partnership with their Sponsoring Institutions, must**
2117 **educate fellows and faculty members concerning the professional**
2118 **responsibilities of physicians, including their obligation to be**
2119 **appropriately rested and fit to provide the care required by their**
2120 **patients.** (Core)
2121
2122 **VI.B.2.** **The learning objectives of the program must:**
2123
2124 **VI.B.2.a)** **be accomplished through an appropriate blend of supervised**
2125 **patient care responsibilities, clinical teaching, and didactic**
2126 **educational events;** (Core)
2127
2128 **VI.B.2.b)** **be accomplished without excessive reliance on fellows to**
2129 **fulfill non-physician obligations; and,** (Core)
2130

Background and Intent: Routine reliance on fellows to fulfill non-physician obligations increases work compression for fellows and does not provide an optimal educational experience. Non-physician obligations are those duties which in most institutions are performed by nursing and allied health professionals, transport services, or clerical staff. Examples of such obligations include transport of patients from the wards or units for procedures elsewhere in the hospital; routine blood drawing for laboratory tests; routine monitoring of patients when off the ward; and clerical duties, such as scheduling. While it is understood that fellows may be expected to do any of these things on occasion when the need arises, these activities should not be performed by fellows routinely and must be kept to a minimum to optimize fellow education.

2131
2132 **VI.B.2.c)** **ensure manageable patient care responsibilities.** (Core)
2133

Background and Intent: The Common Program Requirements do not define “manageable patient care responsibilities” as this is variable by specialty and PGY level. Review Committees will provide further detail regarding patient care responsibilities in the applicable specialty-specific Program Requirements and accompanying FAQs. However, all programs, regardless of specialty, should carefully assess how the assignment of patient care responsibilities can affect work compression.

2134

2135 **VI.B.3.** **The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility.** (Core)

2139 **VI.B.4.** **Fellows and faculty members must demonstrate an understanding of their personal role in the:**

2142 **VI.B.4.a)** **provision of patient- and family-centered care;** (Outcome)

2144 **VI.B.4.b)** **safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events;** (Outcome)

Background and Intent: This requirement emphasizes that responsibility for reporting unsafe conditions and adverse events is shared by all members of the team and is not solely the responsibility of the fellow.

2149 **VI.B.4.c)** **assurance of their fitness for work, including:** (Outcome)

Background and Intent: This requirement emphasizes the professional responsibility of faculty members and fellows to arrive for work adequately rested and ready to care for patients. It is also the responsibility of faculty members, fellows, and other members of the care team to be observant, to intervene, and/or to escalate their concern about fellow and faculty member fitness for work, depending on the situation, and in accordance with institutional policies.

2152 **VI.B.4.c).(1)** **management of their time before, during, and after clinical assignments; and,** (Outcome)

2155 **VI.B.4.c).(2)** **recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team.** (Outcome)

2159 **VI.B.4.d)** **commitment to lifelong learning;** (Outcome)

2161 **VI.B.4.e)** **monitoring of their patient care performance improvement indicators; and,** (Outcome)

2164 **VI.B.4.f)** **accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data.** (Outcome)

2167 **VI.B.5.** **All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition 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)

2173 **VI.B.6.** **Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is free from discrimination, sexual and other forms of**

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2176 **harassment, mistreatment, abuse, or coercion of students, fellows,**
2177 **faculty, and staff.** **(Core)**
2178
2179 **VI.B.7.** **Programs, in partnership with their Sponsoring Institutions, should**
2180 **have a process for education of fellows and faculty regarding**
2181 **unprofessional behavior and a confidential process for reporting,**
2182 **investigating, and addressing such concerns.** **(Core)**
2183
2184 **VI.C.** **Well-Being**
2185
2186 ***Psychological, emotional, and physical well-being are critical in the***
2187 ***development of the competent, caring, and resilient physician and require***
2188 ***proactive attention to life inside and outside of medicine. Well-being***
2189 ***requires that physicians retain the joy in medicine while managing their***
2190 ***own real life stresses. Self-care and responsibility to support other***
2191 ***members of the health care team are important components of***
2192 ***professionalism; they are also skills that must be modeled, learned, and***
2193 ***nurtured in the context of other aspects of fellowship training.***
2194
2195 ***Fellows and faculty members are at risk for burnout and depression.***
2196 ***Programs, in partnership with their Sponsoring Institutions, have the same***
2197 ***responsibility to address well-being as other aspects of resident***
2198 ***competence. Physicians and all members of the health care team share***
2199 ***responsibility for the well-being of each other. For example, a culture which***
2200 ***encourages covering for colleagues after an illness without the expectation***
2201 ***of reciprocity reflects the ideal of professionalism. A positive culture in a***
2202 ***clinical learning environment models constructive behaviors, and prepares***
2203 ***fellows with the skills and attitudes needed to thrive throughout their***
2204 ***careers.***
2205

Background and Intent: The ACGME is committed to addressing physician well-being for individuals and as it relates to the learning and working environment. The creation of a learning and working environment with a culture of respect and accountability for physician well-being is crucial to physicians' ability to deliver the safest, best possible care to patients. The ACGME is leveraging its resources in four key areas to support the ongoing focus on physician well-being: education, influence, research, and collaboration. Information regarding the ACGME's ongoing efforts in this area is available on the ACGME website. **As these efforts evolve, information will be shared with programs seeking to develop and/or strengthen their own well-being initiatives. In addition, there are many activities that programs can utilize now to assess and support physician well-being. These include culture of safety surveys, ensuring the availability of counseling services, and attention to the safety of the entire health care team.**

2206
2207 **VI.C.1.** **The responsibility of the program, in partnership with the**
2208 **Sponsoring Institution, to address well-being must include:**
2209
2210 **VI.C.1.a)** **efforts to enhance the meaning that each fellow finds in the**
2211 **experience of being a physician, including protecting time**
2212 **with patients, minimizing non-physician obligations,**

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2213 **providing administrative support, promoting progressive**
2214 **autonomy and flexibility, and enhancing professional**
2215 **relationships;** (Core)
2216
2217 **VI.C.1.b)** **attention to scheduling, work intensity, and work**
2218 **compression that impacts fellow well-being;** (Core)
2219
2220 **VI.C.1.c)** **evaluating workplace safety data and addressing the safety of**
2221 **fellows and faculty members;** (Core)
2222

Background and Intent: This requirement emphasizes the responsibility shared by the Sponsoring Institution and its programs to gather information and utilize systems that monitor and enhance fellow and faculty member safety, including physical safety. Issues to be addressed include, but are not limited to, monitoring of workplace injuries, physical or emotional violence, vehicle collisions, and emotional well-being after adverse events.

2223
2224 **VI.C.1.d)** **policies and programs that encourage optimal fellow and**
2225 **faculty member well-being; and,** (Core)
2226

Background and Intent: Well-being includes having time away from work to engage with family and friends, as well as to attend to personal needs and to one's own health, including adequate rest, healthy diet, and regular exercise.

2227
2228 **VI.C.1.d).(1)** **Fellows must be given the opportunity to attend**
2229 **medical, mental health, and dental care appointments,**
2230 **including those scheduled during their working hours.**
2231 (Core)
2232

Background and Intent: The intent of this requirement is to ensure that fellows have the opportunity to access medical and dental care, including mental health care, at times that are appropriate to their individual circumstances. Fellows must be provided with time away from the program as needed to access care, including appointments scheduled during their working hours.

2233
2234 **VI.C.1.e)** **attention to fellow and faculty member burnout, depression,**
2235 **and substance abuse. The program, in partnership with its**
2236 **Sponsoring Institution, must educate faculty members and**
2237 **fellows in identification of the symptoms of burnout,**
2238 **depression, and substance abuse, including means to assist**
2239 **those who experience these conditions. Fellows and faculty**
2240 **members must also be educated to recognize those**
2241 **symptoms in themselves and how to seek appropriate care.**
2242 **The program, in partnership with its Sponsoring Institution,**
2243 **must:** (Core)
2244

Background and Intent: Programs and Sponsoring Institutions are encouraged to review materials in order to create systems for identification of burnout, depression, and substance abuse. Materials and more information are available on the Physician Well-

being section of the ACGME website (http://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being).

2245
2246 **VI.C.1.e).(1)** **encourage fellows and faculty members to alert the**
2247 **program director or other designated personnel or**
2248 **programs when they are concerned that another**
2249 **fellow, resident, or faculty member may be displaying**
2250 **signs of burnout, depression, substance abuse,**
2251 **suicidal ideation, or potential for violence;** (Core)
2252

Background and Intent: Individuals experiencing burnout, depression, substance abuse, and/or suicidal ideation are often reluctant to reach out for help due to the stigma associated with these conditions, and are concerned that seeking help may have a negative impact on their career. Recognizing that physicians are at increased risk in these areas, it is essential that fellows and faculty members are able to report their concerns when another fellow or faculty member displays signs of any of these conditions, so that the program director or other designated personnel, such as the department chair, may assess the situation and intervene as necessary to facilitate access to appropriate care. Fellows and faculty members must know which personnel, in addition to the program director, have been designated with this responsibility; those personnel and the program director should be familiar with the institution's impaired physician policy and any employee health, employee assistance, and/or wellness programs within the institution. In cases of physician impairment, the program director or designated personnel should follow the policies of their institution for reporting.

2253
2254 **VI.C.1.e).(2)** **provide access to appropriate tools for self-screening;**
2255 **and,** (Core)
2256
2257 **VI.C.1.e).(3)** **provide access to confidential, affordable mental**
2258 **health assessment, counseling, and treatment,**
2259 **including access to urgent and emergent care 24**
2260 **hours a day, seven days a week.** (Core)
2261

Background and Intent: The intent of this requirement is to ensure that fellows have immediate access at all times to a mental health professional (psychiatrist, psychologist, Licensed Clinical Social Worker, Primary Mental Health Nurse Practitioner, or Licensed Professional Counselor) for urgent or emergent mental health issues. In-person, telemedicine, or telephonic means may be utilized to satisfy this requirement. Care in the Emergency Department may be necessary in some cases, but not as the primary or sole means to meet the requirement.

The reference to affordable counseling is intended to require that financial cost not be a barrier to obtaining care.

2262
2263 **VI.C.2.** **There are circumstances in which fellows may be unable to attend**
2264 **work, including but not limited to fatigue, illness, family**
2265 **emergencies, and parental leave. Each program must allow an**
2266 **appropriate length of absence for fellows unable to perform their**
2267 **patient care responsibilities.** (Core)
2268

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2269 **VI.C.2.a)** **The program must have policies and procedures in place to**
2270 **ensure coverage of patient care.** **(Core)**
2271
2272 **VI.C.2.b)** **These policies must be implemented without fear of negative**
2273 **consequences for the fellow who is or was unable to provide**
2274 **the clinical work.** **(Core)**
2275

Background and Intent: Fellows may need to extend their length of training depending on length of absence and specialty board eligibility requirements. Teammates should assist colleagues in need and equitably reintegrate them upon return.

2276
2277 **VI.D. Fatigue Mitigation**
2278
2279 **VI.D.1. Programs must:**
2280
2281 **VI.D.1.a)** **educate all faculty members and fellows to recognize the**
2282 **signs of fatigue and sleep deprivation;** **(Core)**
2283
2284 **VI.D.1.b)** **educate all faculty members and fellows in alertness**
2285 **management and fatigue mitigation processes; and,** **(Core)**
2286
2287 **VI.D.1.c)** **encourage fellows to use fatigue mitigation processes to**
2288 **manage the potential negative effects of fatigue on patient**
2289 **care and learning.** **(Detail)**
2290

Background and Intent: Providing medical care to patients is physically and mentally demanding. Night shifts, even for those who have had enough rest, cause fatigue. Experiencing fatigue in a supervised environment during training prepares fellows for managing fatigue in practice. It is expected that programs adopt fatigue mitigation processes and ensure that there are no negative consequences and/or stigma for using fatigue mitigation strategies.

This requirement emphasizes the importance of adequate rest before and after clinical responsibilities. Strategies that may be used include, but are not limited to, strategic napping; the judicious use of caffeine; availability of other caregivers; time management to maximize sleep off-duty; learning to recognize the signs of fatigue, and self-monitoring performance and/or asking others to monitor performance; remaining active to promote alertness; maintaining a healthy diet; using relaxation techniques to fall asleep; maintaining a consistent sleep routine; exercising regularly; increasing sleep time before and after call; and ensuring sufficient sleep recovery periods.

2291
2292 **VI.D.2.** **Each program must ensure continuity of patient care, consistent**
2293 **with the program's policies and procedures referenced in VI.C.2–**
2294 **VI.C.2.b), in the event that a fellow may be unable to perform their**
2295 **patient care responsibilities due to excessive fatigue.** **(Core)**
2296
2297 **VI.D.3.** **The program, in partnership with its Sponsoring Institution, must**
2298 **ensure adequate sleep facilities and safe transportation options for**
2299 **fellows who may be too fatigued to safely return home.** **(Core)**
2300

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2301 **VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care**
2302
2303 **VI.E.1. Clinical Responsibilities**
2304
2305 **The clinical responsibilities for each fellow must be based on PGY**
2306 **level, patient safety, fellow ability, severity and complexity of patient**
2307 **illness/condition, and available support services.** (Core)
2308
2309 VI.E.1.a) The clinical workload should allow fellows to complete the
2310 required case numbers and develop the required competencies in
2311 patient care with a focus on learning over meeting service
2312 obligations. (Detail)
2313

Background and Intent: The changing clinical care environment of medicine has meant that work compression due to high complexity has increased stress on fellows. Faculty members and program directors need to make sure fellows function in an environment that has safe patient care and a sense of fellow well-being. Some Review Committees have addressed this by setting limits on patient admissions, and it is an essential responsibility of the program director to monitor fellow workload. Workload should be distributed among the fellow team and interdisciplinary teams to minimize work compression.

2314
2315 **VI.E.2. Teamwork**
2316
2317 **Fellows must care for patients in an environment that maximizes**
2318 **communication. This must include the opportunity to work as a**
2319 **member of effective interprofessional teams that are appropriate to**
2320 **the delivery of care in the subspecialty and larger health system.**
2321 (Core)
2322
2323 VI.E.2.a) Fellows should demonstrate leadership in the coordination of
2324 patient care, with teams that may include surgeons,
2325 anesthesiology colleagues, other medical trainees, specialized
2326 advanced practice nurses, physician assistants, and medical
2327 subspecialists, such as neurologists, intensivists, and chronic pain
2328 specialists. (Detail)
2329
2330 VI.E.2.b) Fellows should understand the effective deployment of
2331 interprofessional teams that may include non-physician health
2332 care professionals, such as advanced practice nurses, physician
2333 assistants, pharmacists, physical therapists, specialized nurses,
2334 and technicians, in order to provide high-quality, cost-effective
2335 patient care. (Detail)
2336
2337 **VI.E.3. Transitions of Care**
2338
2339 **VI.E.3.a) Programs must design clinical assignments to optimize**
2340 **transitions in patient care, including their safety, frequency,**
2341 **and structure.** (Core)
2342

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2343 **VI.E.3.b)** **Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.** **(Core)**
2344
2345
2346
2347
2348 **VI.E.3.c)** **Programs must ensure that fellows are competent in communicating with team members in the hand-over process.** **(Outcome)**
2349
2350
2351
2352 **VI.E.3.d)** **Programs and clinical sites must maintain and communicate schedules of attending physicians and fellows currently responsible for care.** **(Core)**
2353
2354
2355
2356 **VI.E.3.e)** **Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2-VI.C.2.b), in the event that a fellow may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency.** **(Core)**
2357
2358
2359
2360
2361
2362 **VI.F. Clinical Experience and Education**
2363
2364 ***Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide fellows with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.***
2365
2366
2367
2368

Background and Intent: In the new requirements, the terms "clinical experience and education," "clinical and educational work," and "clinical and educational work hours" replace the terms "duty hours," "duty periods," and "duty." These changes have been made in response to concerns that the previous use of the term "duty" in reference to number of hours worked may have led some to conclude that fellows' duty to "clock out" on time superseded their duty to their patients.

2369
2370 **VI.F.1. Maximum Hours of Clinical and Educational Work per Week**
2371
2372 **Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting.** **(Core)**
2373
2374
2375
2376

Background and Intent: Programs and fellows have a shared responsibility to ensure that the 80-hour maximum weekly limit is not exceeded. While the requirement has been written with the intent of allowing fellows to remain beyond their scheduled work periods to care for a patient or participate in an educational activity, these additional hours must be accounted for in the allocated 80 hours when averaged over four weeks.

Scheduling
While the ACGME acknowledges that, on rare occasions, a fellow may work in excess of 80 hours in a given week, all programs and fellows utilizing this flexibility will be required to adhere to the 80-hour maximum weekly limit when averaged over a four-

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week period. Programs that regularly schedule fellows to work 80 hours per week and still permit fellows to remain beyond their scheduled work period are likely to exceed the 80-hour maximum, which would not be in substantial compliance with the requirement. These programs should adjust schedules so that fellows are scheduled to work fewer than 80 hours per week, which would allow fellows to remain beyond their scheduled work period when needed without violating the 80-hour requirement. Programs may wish to consider using night float and/or making adjustments to the frequency of in-house call to ensure compliance with the 80-hour maximum weekly limit.

Oversight
With increased flexibility introduced into the Requirements, programs permitting this flexibility will need to account for the potential for fellows to remain beyond their assigned work periods when developing schedules, to avoid exceeding the 80-hour maximum weekly limit, averaged over four weeks. The ACGME Review Committees will strictly monitor and enforce compliance with the 80-hour requirement. Where violations of the 80-hour requirement are identified, programs will be subject to citation and at risk for an adverse accreditation action.

Work from Home
While the requirement specifies that clinical work done from home must be counted toward the 80-hour maximum weekly limit, the expectation remains that scheduling be structured so that fellows are able to complete most work on site during scheduled clinical work hours without requiring them to take work home. The new requirements acknowledge the changing landscape of medicine, including electronic health records, and the resulting increase in the amount of work fellows choose to do from home. The requirement provides flexibility for fellows to do this while ensuring that the time spent by fellows completing clinical work from home is accomplished within the 80-hour weekly maximum. Types of work from home that must be counted include using an electronic health record and taking calls from home. Reading done in preparation for the following day's cases, studying, and research done from home do not count toward the 80 hours. Fellow decisions to leave the hospital before their clinical work has been completed and to finish that work later from home should be made in consultation with the fellow's supervisor. In such circumstances, fellows should be mindful of their professional responsibility to complete work in a timely manner and to maintain patient confidentiality.

During the public comment period many individuals raised questions and concerns related to this change. Some questioned whether minute by minute tracking would be required; in other words, if a fellow spends three minutes on a phone call and then a few hours later spends two minutes on another call, will the fellow need to report that time. Others raised concerns related to the ability of programs and institutions to verify the accuracy of the information reported by fellows. The new requirements are not an attempt to micromanage this process. Fellows are to track the time they spend on clinical work from home and to report that time to the program. Decisions regarding whether to report infrequent phone calls of very short duration will be left to the individual fellow. Programs will need to factor in time fellows are spending on clinical work at home when schedules are developed to ensure that fellows are not working in excess of 80 hours per week, averaged over four weeks. There is no requirement that programs assume responsibility for documenting this time. Rather, the program's responsibility is ensuring that fellows report their time from home and that schedules

are structured to ensure that fellows are not working in excess of 80 hours per week, averaged over four weeks.

2377
2378 **VI.F.2. Mandatory Time Free of Clinical Work and Education**
2379
2380 **VI.F.2.a)** **The program must design an effective program structure that**
2381 **is configured to provide fellows with educational**
2382 **opportunities, as well as reasonable opportunities for rest**
2383 **and personal well-being.** (Core)
2384
2385 **VI.F.2.b)** **Fellows should have eight hours off between scheduled**
2386 **clinical work and education periods.** (Detail)
2387
2388 **VI.F.2.b).(1)** **There may be circumstances when fellows choose to**
2389 **stay to care for their patients or return to the hospital**
2390 **with fewer than eight hours free of clinical experience**
2391 **and education. This must occur within the context of**
2392 **the 80-hour and the one-day-off-in-seven**
2393 **requirements.** (Detail)
2394

Background and Intent: While it is expected that fellow schedules will be structured to ensure that fellows are provided with a minimum of eight hours off between scheduled work periods, it is recognized that fellows may choose to remain beyond their scheduled time, or return to the clinical site during this time-off period, to care for a patient. The requirement preserves the flexibility for fellows to make those choices. It is also noted that the 80-hour weekly limit (averaged over four weeks) is a deterrent for scheduling fewer than eight hours off between clinical and education work periods, as it would be difficult for a program to design a schedule that provides fewer than eight hours off without violating the 80-hour rule.

2395
2396 **VI.F.2.c)** **Fellows must have at least 14 hours free of clinical work and**
2397 **education after 24 hours of in-house call.** (Core)
2398

Background and Intent: Fellows have a responsibility to return to work rested, and thus are expected to use this time away from work to get adequate rest. In support of this goal, fellows are encouraged to prioritize sleep over other discretionary activities.

2399
2400 **VI.F.2.d)** **Fellows must be scheduled for a minimum of one day in**
2401 **seven free of clinical work and required education (when**
2402 **averaged over four weeks). At-home call cannot be assigned**
2403 **on these free days.** (Core)
2404

Background and Intent: The requirement provides flexibility for programs to distribute days off in a manner that meets program and fellow needs. It is strongly recommended that fellows' preference regarding how their days off are distributed be considered as schedules are developed. It is desirable that days off be distributed throughout the month, but some fellows may prefer to group their days off to have a "golden weekend, " meaning a consecutive Saturday and Sunday free from work. The requirement for one free day in seven should not be interpreted as precluding a golden weekend. Where feasible, schedules may be designed to provide fellows with a weekend, or two

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consecutive days, free of work. The applicable Review Committee will evaluate the number of consecutive days of work and determine whether they meet educational objectives. Programs are encouraged to distribute days off in a fashion that optimizes fellow well-being, and educational and personal goals. It is noted that a day off is defined in the ACGME Glossary of Terms as "one (1) continuous 24-hour period free from all administrative, clinical, and educational activities."

2405
2406 **VI.F.3. Maximum Clinical Work and Education Period Length**
2407
2408 **VI.F.3.a) Clinical and educational work periods for fellows must not**
2409 **exceed 24 hours of continuous scheduled clinical**
2410 **assignments.** (Core)
2411
2412 **VI.F.3.a).(1) Up to four hours of additional time may be used for**
2413 **activities related to patient safety, such as providing**
2414 **effective transitions of care, and/or fellow education.**
2415 (Core)
2416
2417 **VI.F.3.a).(1).(a) Additional patient care responsibilities must not**
2418 **be assigned to a fellow during this time.** (Core)
2419

Background and Intent: The additional time referenced in VI.F.3.a).(1) should not be used for the care of new patients. It is essential that the fellow continue to function as a member of the team in an environment where other members of the team can assess fellow fatigue, and that supervision for post-call fellows is provided. This 24 hours and up to an additional four hours must occur within the context of 80-hour weekly limit, averaged over four weeks.

2420
2421 **VI.F.4. Clinical and Educational Work Hour Exceptions**
2422
2423 **VI.F.4.a) In rare circumstances, after handing off all other**
2424 **responsibilities, a fellow, on their own initiative, may elect to**
2425 **remain or return to the clinical site in the following**
2426 **circumstances:**
2427
2428 **VI.F.4.a).(1) to continue to provide care to a single severely ill or**
2429 **unstable patient;** (Detail)
2430
2431 **VI.F.4.a).(2) humanistic attention to the needs of a patient or**
2432 **family; or,** (Detail)
2433
2434 **VI.F.4.a).(3) to attend unique educational events.** (Detail)
2435
2436 **VI.F.4.b) These additional hours of care or education will be counted**
2437 **toward the 80-hour weekly limit.** (Detail)
2438

Background and Intent: This requirement is intended to provide fellows with some control over their schedules by providing the flexibility to voluntarily remain beyond the scheduled responsibilities under the circumstances described above. It is important to note that a fellow may remain to attend a conference, or return for a conference later in

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the day, only if the decision is made voluntarily. Fellows must not be required to stay. Programs allowing fellows to remain or return beyond the scheduled work and clinical education period must ensure that the decision to remain is initiated by the fellow and that fellows are not coerced. This additional time must be counted toward the 80-hour maximum weekly limit.

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2440 **VI.F.4.c)** **A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.**
2441
2442
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2444
2445 The Review Committee for Anesthesiology will not consider requests for exceptions to the 80-hour limit to the residents' work week.
2446
2447
2448
2449 **VI.F.4.c).(1)** **In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the *ACGME Manual of Policies and Procedures.*** (Core)
2450
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2453
2454 **VI.F.4.c).(2)** **Prior to submitting the request to the Review Committee, the program director must obtain approval from the Sponsoring Institution's GMEC and DIO.** (Core)
2455
2456
2457

Background and Intent: The provision for exceptions for up to 88 hours per week has been modified to specify that exceptions may be granted for specific rotations if the program can justify the increase based on criteria specified by the Review Committee. As in the past, Review Committees may opt not to permit exceptions. The underlying philosophy for this requirement is that while it is expected that all fellows should be able to train within an 80-hour work week, it is recognized that some programs may include rotations with alternate structures based on the nature of the specialty. DIO/GMEC approval is required before the request will be considered by the Review Committee.

2458
2459 **VI.F.5.** **Moonlighting**
2460
2461 **VI.F.5.a)** **Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program, and must not interfere with the fellow's fitness for work nor compromise patient safety.** (Core)
2462
2463
2464
2465
2466 **VI.F.5.b)** **Time spent by fellows in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit.** (Core)
2467
2468
2469

Background and Intent: For additional clarification of the expectations related to moonlighting, please refer to the Common Program Requirement FAQs (available at http://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements).

2470
2471 **VI.F.6.** **In-House Night Float**

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2472
2473 **Night float must occur within the context of the 80-hour and one-**
2474 **day-off-in-seven requirements.** (Core)
2475

Background and Intent: The requirement for no more than six consecutive nights of night float was removed to provide programs with increased flexibility in scheduling.

2476
2477 **VI.F.7. Maximum In-House On-Call Frequency**
2478
2479 **Fellows must be scheduled for in-house call no more frequently than**
2480 **every third night (when averaged over a four-week period).** (Core)
2481
2482 **VI.F.8. At-Home Call**
2483
2484 **VI.F.8.a) Time spent on patient care activities by fellows on at-home**
2485 **call must count toward the 80-hour maximum weekly limit.**
2486 **The frequency of at-home call is not subject to the every-**
2487 **third-night limitation, but must satisfy the requirement for one**
2488 **day in seven free of clinical work and education, when**
2489 **averaged over four weeks.** (Core)
2490
2491 **VI.F.8.a).(1) At-home call must not be so frequent or taxing as to**
2492 **preclude rest or reasonable personal time for each**
2493 **fellow.** (Core)
2494
2495 **VI.F.8.b) Fellows are permitted to return to the hospital while on at-**
2496 **home call to provide direct care for new or established**
2497 **patients. These hours of inpatient patient care must be**
2498 **included in the 80-hour maximum weekly limit.** (Detail)
2499

Background and Intent: This requirement has been modified to specify that clinical work done from home when a fellow is taking at-home call must count toward the 80-hour maximum weekly limit. This change acknowledges the often significant amount of time fellows devote to clinical activities when taking at-home call, and ensures that taking at-home call does not result in fellows routinely working more than 80 hours per week. At-home call activities that must be counted include responding to phone calls and other forms of communication, as well as documentation, such as entering notes in an electronic health record. Activities such as reading about the next day's case, studying, or research activities do not count toward the 80-hour weekly limit.

In their evaluation of fellowship programs, Review Committees will look at the overall impact of at-home call on fellow rest and personal time.

2500
2501 ***
2502
2503 ***Core Requirements:** Statements that define structure, resource, or process elements
2504 essential to every graduate medical educational program.
2505
2506 †**Detail Requirements:** Statements that describe a specific structure, resource, or process, for
2507 achieving compliance with a Core Requirement. Programs and sponsoring institutions in

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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 Recognition

For programs with or applying for Osteopathic Recognition, the Osteopathic Recognition Requirements also apply (www.acgme.org/OsteopathicRecognition).

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