



**Accreditation Council for
Graduate Medical Education**

**ACGME Program Requirements for
Graduate Medical Education
in Female Pelvic Medicine and Reconstructive Surgery
(Obstetrics and Gynecology or Urology)**

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ACGME Program Requirements for Residency Education in Female Pelvic Medicine and Reconstructive Surgery

Common Program Requirements 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.

Introduction

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

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

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

Int.C. The educational program in female pelvic medicine and reconstructive surgery must be 36 months in length. ^{(Core)*}

I. Institutions

I.A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this

responsibility extends to fellow assignments at all participating sites. ^(Core)

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

I.A.1. The sponsoring institution must also sponsor Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs in either obstetrics and gynecology or urology. ^(Core)

I.A.1.a) The program must function as an integral part of an ACGME-accredited residency program in either obstetrics and gynecology or urology. ^(Core)

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

I.B. Participating Sites

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

The PLA should:

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

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

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

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

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

II. Program Personnel and Resources

II.A. Program Director

II.A.1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring

institution's GMEC must approve a change in program director. ^(Core)

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

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

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

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

II.A.3.b) current certification in the subspecialty by the American Board of Obstetrics and Gynecology or the American Board of Urology, or subspecialty qualifications that are acceptable to the Review Committee; ^(Core)

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

II.A.3.d) completion of a female pelvic medicine and reconstructive surgery fellowship at least five years prior to appointment as the program director; and, ^(Core)

II.A.3.e) documented clinical and scholarly expertise in female pelvic medicine and reconstructive surgery. ^(Core)

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

The program director must:

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

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

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

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

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

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

- II.A.4.g)** prepare and submit all information required and requested by the ACGME; ^(Core)
- II.A.4.g).(1)** This includes but is not limited to the program application forms and annual program updates to the ADS, and ensure that the information submitted is accurate and complete. ^(Core)
- II.A.4.h)** ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution; ^(Detail)
- II.A.4.i)** provide verification of fellowship education for all fellows, including those who leave the program prior to completion; ^(Detail)
- II.A.4.j)** implement policies and procedures consistent with the institutional and program requirements for fellow duty hours and the working environment, including moonlighting, ^(Core)
- and, to that end, must:
- II.A.4.j).(1)** distribute these policies and procedures to the fellows and faculty; ^(Detail)
- II.A.4.j).(2)** monitor fellow duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements; ^(Core)
- II.A.4.j).(3)** adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and, ^(Detail)
- II.A.4.j).(4)** if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue. ^(Detail)
- II.A.4.k)** monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged; ^(Detail)
- II.A.4.l)** comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of fellows, disciplinary action, and supervision of fellows; ^(Detail)
- II.A.4.m)** be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures; ^(Detail)
- II.A.4.n)** obtain review and approval of the sponsoring institution's GMEC/DIO before submitting information or requests to the

ACGME, including: ^(Core)

- II.A.4.n).(1) **all applications for ACGME accreditation of new programs;** ^(Detail)
- II.A.4.n).(2) **changes in fellow complement;** ^(Detail)
- II.A.4.n).(3) **major changes in program structure or length of training;** ^(Detail)
- II.A.4.n).(4) **progress reports requested by the Review Committee;** ^(Detail)
- II.A.4.n).(5) **requests for increases or any change to fellow duty hours;** ^(Detail)
- II.A.4.n).(6) **voluntary withdrawals of ACGME-accredited programs;** ^(Detail)
- II.A.4.n).(7) **requests for appeal of an adverse action; and,** ^(Detail)
- II.A.4.n).(8) **appeal presentations to a Board of Appeal or the ACGME.** ^(Detail)
- II.A.4.o) **obtain DIO review and co-signature on all program application forms, as well as any correspondence or document submitted to the ACGME that addresses:** ^(Detail)
- II.A.4.o).(1) **program citations, and/or,** ^(Detail)
- II.A.4.o).(2) **request for changes in the program that would have significant impact, including financial, on the program or institution.** ^(Detail)
- II.A.4.p) **dedicate at least eight hours per week of his or her professional effort to the administrative and educational activities of the female pelvic medicine and reconstructive surgery program.** ^(Core)

II.B. Faculty

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

The faculty must:

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

- II.B.1.b) administer and maintain an educational environment conducive to educating fellows in each of the ACGME competency areas.** ^(Core)
- II.B.2. The physician faculty must have current certification in the subspecialty by the American Board of Obstetrics and Gynecology or Urology, or possess qualifications judged acceptable to the Review Committee.** ^(Core)
- II.B.2.a) The Review Committee accepts only current ABMS specialty certification in either obstetrics and gynecology or urology. ^(Core)
- II.B.3. The physician faculty must possess current medical licensure and appropriate medical staff appointment.** ^(Core)
- II.B.4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.** ^(Core)
- II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.** ^(Core)
- II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. ^(Detail)
- II.B.5.b) Some members of the faculty should also demonstrate scholarship by one or more of the following:
- II.B.5.b).(1) peer-reviewed funding; ^(Detail)
- II.B.5.b).(2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks; ^(Detail)
- II.B.5.b).(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or, ^(Detail)
- II.B.5.b).(4) participation in national committees or educational organizations. ^(Detail)
- II.B.5.c) Faculty should encourage and support fellows in scholarly activities. ^(Core)
- II.B.6. In addition to the program director, there must be at least one other full-time program faculty member who is certified in female pelvic medicine and reconstructive surgery by either the American Board of Obstetrics and Gynecology or the American Board of Urology. ^(Core)
- II.B.7. For fellowship programs functioning as part of an ACGME-accredited obstetrics and gynecology residency, there should be one core faculty member who is a urologist certified by the American Board of Urology in female pelvic medicine and reconstructive surgery, or who possesses

other qualifications acceptable to the Review Committee. ^(Core)

II.B.8. For programs functioning as part of an ACGME-accredited urology residency, there should be one core faculty member who is an obstetrician-gynecologist certified by the American Board of Obstetrics and Gynecology in female pelvic medicine and reconstructive surgery, or who possesses other qualifications acceptable to the Review Committee. ^(Core)

II.B.9. Other faculty members must include qualified colorectal surgeons and gastroenterologists or other physicians who possess qualifications acceptable to the Review Committee. ^(Detail)

II.C. Other Program Personnel

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

II.D. Resources

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

II.D.1. The primary clinical site must include operating rooms, ambulatory clinic facilities, recovery rooms, intensive care units, blood banks, diagnostic laboratories, and imaging services. ^(Core)

II.D.1.a) Access to these resources must be available at all times for the management of complications. ^(Core)

II.D.2. The program must have clinical and laboratory research facilities that are equipped to allow fellows to engage in scholarly activities. ^(Core)

II.E. Medical Information Access

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

III. Fellow Appointments

III.A. Eligibility Criteria

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

III.A.1. Eligibility Requirements – Residency Programs

III.A.1.a) **All prerequisite post-graduate clinical education required for**

initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, or in Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada. Residency programs must receive verification of each applicant's level of competency in the required clinical field using ACGME or CanMEDS Milestones assessments from the prior training program. ^(Core)

- III.A.1.b) A physician who has completed a residency program that was not accredited by ACGME, RCPSC, or CFPC may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director at the ACGME-accredited program may be advanced to the PGY-2 level based on ACGME Milestones assessments at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry. ^(Core)
- III.A.1.c) A Review Committee may grant the exception to the eligibility requirements specified in Section III.A.2.b) for residency programs that require completion of a prerequisite residency program prior to admission. ^(Core)
- III.A.1.d) Review Committees will grant no other exceptions to these eligibility requirements for residency education. ^(Core)

III.A.2. Eligibility Requirements – Fellowship Programs

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

[See Program Requirements III.A.2.d) and III.A.2.e)]

- III.A.2.a) Fellowship programs must receive verification of each entering fellow's level of competency in the required field using ACGME or CanMEDS Milestones assessments from the core residency program. ^(Core)

III.A.2.b) Fellow Eligibility Exception

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

An ACGME-accredited fellowship program may accept an exceptionally qualified applicant**, who does not satisfy the eligibility requirements listed in Sections III.A.2. and III.A.2.a),

but who does meet all of the following additional qualifications and conditions: ^(Core)

- III.A.2.b).(1) **Assessment by the program director and fellowship selection committee of the applicant's suitability to enter the program, based on prior training and review of the summative evaluations of training in the core specialty; and** ^(Core)
- III.A.2.b).(2) **Review and approval of the applicant's exceptional qualifications by the GMEC or a subcommittee of the GMEC; and** ^(Core)
- III.A.2.b).(3) **Satisfactory completion of the United States Medical Licensing Examination (USMLE) Steps 1, 2, and, if the applicant is eligible, 3, and;** ^(Core)
- III.A.2.b).(4) **For an international graduate, verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification; and,** ^(Core)
- III.A.2.b).(5) **Applicants accepted by this exception must complete fellowship Milestones evaluation (for the purposes of establishment of baseline performance by the Clinical Competency Committee), conducted by the receiving fellowship program within six weeks of matriculation. This evaluation may be waived for an applicant who has completed an ACGME International-accredited residency based on the applicant's Milestones evaluation conducted at the conclusion of the residency program.** ^(Core)
- III.A.2.b).(5).(a) **If the trainee does not meet the expected level of Milestones competency following entry into the fellowship program, the trainee must undergo a period of remediation, overseen by the Clinical Competency Committee and monitored by the GMEC or a subcommittee of the GMEC. This period of remediation must not count toward time in fellowship training.** ^(Core)

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

residency training; (d) completion of an ACGME-International-accredited residency program.

III.A.2.c) The Review Committees for Obstetrics and Gynecology and Urology do not allow exceptions to the Eligibility Requirements for Fellowship Programs in Section III.A.2. ^(Core)

III.A.2.d) To be eligible for appointment at the F1 level, a fellow must have satisfactorily completed an obstetrics and gynecology or urology residency accredited by the ACGME or an obstetrics and gynecology or urology program located in Canada and accredited by the RCPSC. ^(Core)

III.A.2.e) To be eligible for appointment at the F2 level, a fellow must have satisfactorily completed a urology residency accredited by the ACGME or a urology residency located in Canada and accredited by the RCPSC. ^(Core)

III.A.2.f) Prior to entering the program, each fellow must be informed of the requirements for completing the program, including the criteria to qualify for the subspecialty board examination. ^(Core)

III.B. Number of Fellows

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

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

III.B.2. There should be at least two fellows in the program at all times. ^(Detail)

III.C. Fellow Transfers

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

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

III.D. Appointment of Fellows and Other Learners

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

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

IV. Educational Program

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

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

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

IV.A.2.a) At the beginning of the program, each fellow must have an individual educational plan that includes a monthly block rotation diagram displaying the clinical, didactic, and research activities by rotation. ^(Detail)

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

IV.A.3.a) There must be regularly scheduled journal clubs, seminars, didactics, and morbidity and mortality conferences. ^(Core)

Topics must include:

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

IV.A.3.a).(2) behavioral, pharmacological, functional, and surgical treatment of urinary incontinence, anal incontinence, and pelvic floor dysfunction, including micturition and defecation disorders, and pelvic organ prolapse; ^(Detail)

IV.A.3.a).(3) diagnosis and evaluation of pelvic floor dysfunction, including urinary incontinence, voiding dysfunction, pelvic organ prolapse, defecation disorders, and sexual dysfunction; ^(Detail)

IV.A.3.a).(4) diagnosis and management of genitourinary and rectovaginal fistulae, urethral diverticula, injuries to the genitourinary tract, congenital anomalies, and infectious and non-infectious irritative conditions of the lower urinary tract and pelvic floor; ^(Detail)

IV.A.3.a).(5) management of genitourinary complications of vaginal delivery, spinal cord injuries, and medical, psychiatric, and geriatric conditions related to pelvic floor disorders; ^(Detail)

IV.A.3.a).(6) pathophysiology of pelvic floor dysfunction including urinary incontinence, anal incontinence, voiding dysfunction, pelvic organ prolapse, defecation disorders and sexual dysfunction; and, ^(Detail)

IV.A.3.a).(7) research design, grant writing, research methodology, scientific writing, and presentation skills. ^(Detail)

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

IV.A.5. ACGME Competencies

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

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

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

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

IV.A.5.a).(2).(a) must demonstrate competence in:

IV.A.5.a).(2).(a).(i) assessing the effects of treatment, and recognizing and managing the complications of therapy; ^(Outcome)

IV.A.5.a).(2).(a).(ii) diagnosing and managing patients with urinary incontinence, pelvic organ prolapse, genitourinary and rectovaginal fistulae, anal incontinence, urethral diverticula, injuries to the genitourinary tract, congenital anomalies, and infectious and non-infectious irritative conditions of the lower urinary tract and pelvic floor; ^(Outcome)

IV.A.5.a).(2).(a).(iii) evaluating the lower urinary and genital tract for abnormalities including neoplasms, and interpreting cytology and biopsy results; ^(Outcome)

IV.A.5.a).(2).(a).(iv) performing advanced laparoscopic, abdominal, and vaginal surgery for

| | |
|--------------------------|---|
| | uterovaginal prolapse and post-hysterectomy vaginal vault prolapse including reconstructive and obliterative procedures. (Outcome) |
| IV.A.5.a).(2).(a).(v) | performing cystoscopy and cystoscopic manipulations, including stent placement retrograde pyelograms and ureteral stent placement; (Outcome) |
| IV.A.5.a).(2).(a).(vi) | performing urodynamic testing; (Outcome) |
| IV.A.5.a).(2).(a).(vii) | performing surgery for urinary incontinence including native tissue and synthetic slings and periurethral bulking agents; and, (Outcome) |
| IV.A.5.a).(2).(a).(viii) | performing surgery for complicated obstetric lacerations and treatment of related benign conditions occurring in the female pelvis. (Outcome) |
| IV.A.5.a).(2).(b) | completing the F1 year must demonstrate competence in: |
| IV.A.5.a).(2).(b).(i) | evaluating and managing hematuria; (Outcome) |
| IV.A.5.a).(2).(b).(ii) | evaluating and managing painful bladder, including interstitial cystitis; (Outcome) |
| IV.A.5.a).(2).(b).(iii) | evaluating and managing neurogenic voiding dysfunction; (Outcome) |
| IV.A.5.a).(2).(b).(iv) | evaluating and treating urinary tract infections; and, (Outcome) |
| IV.A.5.a).(2).(b).(v) | performing a female pelvic exam, including quantification of pelvic organ prolapse. (Outcome) |
| IV.A.5.a).(2).(c) | completing the F2 year must demonstrate competence in the behavioral, pharmacological, functional, non-surgical, and surgical treatment of: (Outcome) |
| IV.A.5.a).(2).(c).(i) | micturition and defecation disorders; (Outcome) |
| IV.A.5.a).(2).(c).(ii) | pelvic organ prolapse; and, (Outcome) |
| IV.A.5.a).(2).(c).(iii) | urinary incontinence. (Outcome) |
| IV.A.5.a).(2).(d) | completing the F3 year must demonstrate |

competence in:

- IV.A.5.a).(2).(d).(i) diagnosing and managing genitourinary and rectovaginal fistulae, urethral diverticula, injuries to the genitourinary tract, and congenital anomalies; and, ^(Outcome)
- IV.A.5.a).(2).(d).(ii) managing genitourinary complications following vaginal delivery, spinal cord injuries, and similar health events. ^(Outcome)

IV.A.5.b)

Medical Knowledge

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

- IV.A.5.b).(1) completing the F1 year must demonstrate competence in their knowledge of:
 - IV.A.5.b).(1).(a) the epidemiology of urinary incontinence, pelvic organ prolapse, and defecation disorders, including birth, aging, and neurologic disease; ^(Outcome)
 - IV.A.5.b).(1).(b) the impact of urinary incontinence, pelvic organ prolapse, and defecation disorders on quality of life; ^(Outcome)
 - IV.A.5.b).(1).(c) the use and interpretation of disease-specific and global health questionnaires to evaluate the impact of pelvic floor disorders on quality of life; ^(Outcome)
 - IV.A.5.b).(1).(d) the scientific method of problem solving and evidence-based decision making; and, ^(Outcome)
 - IV.A.5.b).(1).(e) indications, contraindications, limitations, complications, techniques, and interpretation of results of those diagnostic and therapeutic procedures integral to the discipline, to include: ^(Outcome)
 - IV.A.5.b).(1).(e).(i) the indications for and use of screening tests and procedures including urinalysis, urine cytology, and pad test; and, ^(Outcome)
 - IV.A.5.b).(1).(e).(ii) use and interpretation of a voiding diary. ^(Outcome)
- IV.A.5.b).(2) completing the F2 year must demonstrate competence in their knowledge of:

- IV.A.5.b).(2).(a) the anatomy, physiology, and pathophysiology of the pelvic floor, including the lower urinary tract, and colorectal-anal and vaginal functioning; (Outcome)
- IV.A.5.b).(2).(b) clinically pertinent areas of pathology, infectious disease, geriatric medicine, physical therapy, pain management, sexual dysfunction, and psychosocial aspects of pelvic floor disorders; and, (Outcome)
- IV.A.5.b).(2).(c) indications, contraindications, limitations, complications, techniques, and interpretation of results of screening, diagnostic, and therapeutic procedures for the treatment and evaluation of pelvic floor disorders, to include: (Outcome)
- IV.A.5.b).(2).(c).(i) pelvic imaging studies for the diagnostic evaluation of urinary and anal incontinence, pelvic floor dysfunction, and prolapse; and, (Outcome)
- IV.A.5.b).(2).(c).(ii) urodynamic assessment. (Outcome)
- IV.A.5.b).(3) completing the F3 year must demonstrate competence in their knowledge of:
- IV.A.5.b).(3).(a) assessment and treatment of lower urinary tract dysfunction secondary to neurologic diseases; (Outcome)
- IV.A.5.b).(3).(b) indications, contraindications, limitations, complications, techniques, and interpretation of results of screening, diagnostic, and therapeutic procedures including surgery for: (Outcome)
- IV.A.5.b).(3).(b).(i) pelvic organ prolapse; (Outcome)
- IV.A.5.b).(3).(b).(ii) urinary incontinence; (Outcome)
- IV.A.5.b).(3).(b).(iii) rectovaginal fistula related to obstetric trauma; and, (Outcome)
- IV.A.5.b).(3).(b).(iv) vesicovaginal and urethrovaginal fistula. (Outcome)
- IV.A.5.b).(3).(c) quantitative techniques, including biostatistics, epidemiology, research design, and research methods. (Outcome)

IV.A.5.c)

Practice-based Learning and Improvement

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

(Outcome)

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

- IV.A.5.c).(1) identify strengths, deficiencies, and limits in one's knowledge and expertise;** (Outcome)
- IV.A.5.c).(2) set learning and improvement goals;** (Outcome)
- IV.A.5.c).(3) identify and perform appropriate learning activities;** (Outcome)
- IV.A.5.c).(4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;** (Outcome)
- IV.A.5.c).(5) incorporate formative evaluation feedback into daily practice;** (Outcome)
- IV.A.5.c).(6) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;** (Outcome)
- IV.A.5.c).(7) use information technology to optimize learning; and,** (Outcome)
- IV.A.5.c).(8) participate in the education of patients, families, students, fellows and other health professionals.** (Outcome)

IV.A.5.d) Interpersonal and Communication Skills

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

Fellows are expected to:

- IV.A.5.d).(1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;** (Outcome)
- IV.A.5.d).(2) communicate effectively with physicians, other health professionals, and health related agencies;** (Outcome)

- IV.A.5.d).(3) **work effectively as a member or leader of a health care team or other professional group;** ^(Outcome)
- IV.A.5.d).(4) **act in a consultative role to other physicians and health professionals; and,** ^(Outcome)
- IV.A.5.d).(5) **maintain comprehensive, timely, and legible medical records, if applicable.** ^(Outcome)

IV.A.5.e) Professionalism

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

Fellows are expected to demonstrate:

- IV.A.5.e).(1) **compassion, integrity, and respect for others;** ^(Outcome)
- IV.A.5.e).(2) **responsiveness to patient needs that supersedes self-interest;** ^(Outcome)
- IV.A.5.e).(3) **respect for patient privacy and autonomy;** ^(Outcome)
- IV.A.5.e).(4) **accountability to patients, society and the profession; and,** ^(Outcome)
- IV.A.5.e).(5) **sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.** ^(Outcome)

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

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

Fellows are expected to:

- IV.A.5.f).(1) **work effectively in various health care delivery settings and systems relevant to their clinical specialty;** ^(Outcome)
- IV.A.5.f).(2) **coordinate patient care within the health care system relevant to their clinical specialty;** ^(Outcome)
- IV.A.5.f).(3) **incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-**

based care as appropriate; ^(Outcome)

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

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

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

IV.A.6. Curriculum Organization and Fellow Experiences

IV.A.6.a) Fellows must have both inpatient and outpatient experiences. ^(Core)

IV.A.6.a).(1) Fellows should have supervised responsibility for the total care of the patient, including initial evaluation, establishment of diagnosis, selection of appropriate therapy, and management of complications. ^(Core)

IV.A.6.a).(2) Fellows must participate in continuity of patient care through pre-operative and post-operative clinics and inpatient contact. ^(Core)

IV.A.6.a).(3) Fellows must record all surgical procedures in which they have a significant role in the ACGME Case Log System. ^(Core)

IV.A.6.a).(4) The total time devoted to these experiences should not exceed 24 months. ^(Detail)

IV.A.6.b) The 12 months of the program not devoted to inpatient and outpatient experiences should be devoted to research and/or other elective experiences. ^(Detail)

IV.A.6.c) A fellow must not spend more than 10 percent of his or her time, when averaged over a four-week period, performing duties outside of female pelvic medicine and reconstructive surgery. ^(Detail)

IV.A.6.d) Fellows should participate in the diagnosis and management of clinically pertinent areas of pathology, infectious disease, geriatric medicine, physical therapy, pain management, pre- and post-operative care, sexual dysfunction, and psychosocial aspects of pelvic floor disorders. ^(Detail)

IV.B. Fellows' Scholarly Activities

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

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

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

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

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

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

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

V. Evaluation

V.A. Fellow Evaluation

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

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

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

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

V.A.1.a).(1).(b) **Chief residents who have completed core residency programs in their specialty and are eligible for specialty board certification may be members of the Clinical Competency Committee.** ^(Core)

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

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

V.A.3.a).(1) Each fellow must give an oral presentation of his or her scholarly project (thesis), which must be formally assessed by the faculty, including a written evaluation. ^(Outcome)

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

This evaluation must:

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

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

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

V.B. Faculty Evaluation

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

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

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

V.C. Program Evaluation and Improvement

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

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

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

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

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

improve the program. (Detail)

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

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

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

VI. The Learning and Working Environment

Fellowship education must occur in the context of a learning and working environment that emphasizes the following principles:

- *Excellence in the safety and quality of care rendered to patients by fellows today*
- *Excellence in the safety and quality of care rendered to patients by today's fellows in their future practice*
- *Excellence in professionalism through faculty modeling of:*
 - *the effacement of self-interest in a humanistic environment that supports the professional development of physicians*
 - *the joy of curiosity, problem-solving, intellectual rigor, and discovery*
- *Commitment to the well-being of the students, residents/fellows, faculty members, and all members of the health care team*

VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability

VI.A.1. Patient Safety and Quality Improvement

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.

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.

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.

VI.A.1.a) Patient Safety

VI.A.1.a).(1) Culture of Safety

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.

**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)**

VI.A.1.a).(1).(b) The program must have a structure that promotes safe, interprofessional, team-based care. (Core)

VI.A.1.a).(2) Education on Patient Safety

Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)

VI.A.1.a).(3) Patient Safety Events

Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.

VI.A.1.a).(3).(a) Residents, fellows, faculty members, and other clinical staff members must:

**VI.A.1.a).(3).(a).(i) know their responsibilities in reporting patient safety events at the clinical site;
(Core)**

- VI.A.1.a).(3).(a).(ii) know how to report patient safety events, including near misses, at the clinical site; and, ^(Core)
- VI.A.1.a).(3).(a).(iii) be provided with summary information of their institution's patient safety reports. ^(Core)
- VI.A.1.a).(3).(b) **Fellows must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions.** ^(Core)
- VI.A.1.a).(4) **Fellow Education and Experience in Disclosure of Adverse Events**
- Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. 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 responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.*

Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each fellow's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

VI.A.2.a).(1) Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care. ^(Core)

VI.A.2.a).(1).(a) This information must be available to fellows, faculty members, other members of the health care team, and patients. ^(Core)

VI.A.2.a).(1).(b) Fellows and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. ^(Core)

VI.A.2.b) *Supervision may be exercised through a variety of methods.*

- VI.A.2.d).(1)** The program director must evaluate each fellow's abilities based on specific criteria, guided by the Milestones. ^(Core)
- 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)
- VI.A.2.d).(3)** Fellows should serve in a supervisory role to residents or junior fellows in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. ^(Detail)
- VI.A.2.e)** Programs must set guidelines for circumstances and events in which fellows must communicate with the supervising faculty member(s). ^(Core)
- 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)
- VI.A.2.f)** Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each fellow and to delegate to the fellow the appropriate level of patient care authority and responsibility. ^(Core)
- VI.B. Professionalism**
- VI.B.1.** Programs, in partnership with their Sponsoring Institutions, must educate fellows and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients. ^(Core)
- VI.B.2.** The learning objectives of the program must:
- VI.B.2.a)** be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; ^(Core)
- VI.B.2.b)** be accomplished without excessive reliance on fellows to fulfill non-physician obligations; and, ^(Core)
- VI.B.2.c)** ensure manageable patient care responsibilities. ^(Core)
- 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)

- VI.B.4. Fellows and faculty members must demonstrate an understanding of their personal role in the:**
- VI.B.4.a) provision of patient- and family-centered care; (Outcome)**
 - VI.B.4.b) safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; (Outcome)**
 - VI.B.4.c) assurance of their fitness for work, including: (Outcome)**
 - VI.B.4.c).(1) management of their time before, during, and after clinical assignments; and, (Outcome)**
 - 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)**
 - VI.B.4.d) commitment to lifelong learning; (Outcome)**
 - VI.B.4.e) monitoring of their patient care performance improvement indicators; and, (Outcome)**
 - VI.B.4.f) accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data. (Outcome)**
- 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)**
- VI.B.6. Programs must provide a professional, respectful, and civil environment that is free from mistreatment, abuse, or coercion of students, residents/fellows, faculty, and staff. Programs, in partnership with their Sponsoring Institutions, should have a process for education of fellows and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)**

VI.C. Well-Being

In the current health care environment, fellows and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician. Self-care is an important component of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of fellowship training. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as they do to evaluate other aspects of fellow competence.

- VI.C.1. This responsibility must include:**
- VI.C.1.a) efforts to enhance the meaning that each fellow finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; (Core)**
 - VI.C.1.b) attention to scheduling, work intensity, and work compression that impacts fellow well-being; (Core)**
 - VI.C.1.c) evaluating workplace safety data and addressing the safety of fellows and faculty members; (Core)**
 - VI.C.1.d) policies and programs that encourage optimal fellow and faculty member well-being; and, (Core)**
 - VI.C.1.d).(1) Fellows must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core)**
 - VI.C.1.e) attention to fellow and faculty member burnout, depression, and substance abuse. The program, in partnership with its Sponsoring Institution, must educate faculty members and fellows in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Fellows and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must: (Core)**
 - VI.C.1.e).(1) encourage fellows and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence; (Core)**
 - VI.C.1.e).(2) provide access to appropriate tools for self-screening; and, (Core)**
 - VI.C.1.e).(3) provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)**
 - VI.C.2. There are circumstances in which fellows may be unable to attend**

work, including but not limited to fatigue, illness, and family emergencies. Each program must have policies and procedures in place that ensure coverage of patient care in the event that a fellow may be unable to perform their patient care responsibilities. These policies must be implemented without fear of negative consequences for the fellow who is unable to provide the clinical work. ^(Core)

VI.D. Fatigue Mitigation

VI.D.1. Programs must:

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

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

VI.D.1.c) encourage fellows to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. ^(Detail)

VI.D.2. Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2, in the event that a fellow may be unable to perform their patient care responsibilities due to excessive fatigue. ^(Core)

VI.D.3. The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for fellows who may be too fatigued to safely return home. ^(Core)

VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care

VI.E.1. Clinical Responsibilities

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

VI.E.2. Teamwork

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

VI.E.2.a) The interprofessional team may include: physicians from other specialties such as colorectal surgery and gastroenterology, credentialed registered nurses (RNs), certified nurses, certified nurse specialists (CNSs), certified, dietitians, mental health providers, nurse practitioners (NPs), other advanced practice

nurses, other advanced practice providers, pharmacists, physical and occupational therapists, physician assistants (PAs) and social workers should be integrated into both the didactic and clinical experience of the fellow as clinically relevant. ^(Detail)

VI.E.3. Transitions of Care

- VI.E.3.a) Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. ^(Core)**
- 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)**
- VI.E.3.c) Programs must ensure that fellows are competent in communicating with team members in the hand-over process. ^(Outcome)**
- VI.E.3.d) Programs and clinical sites must maintain and communicate schedules of attending physicians and fellows currently responsible for care. ^(Core)**
- 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, 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)**

VI.F. Clinical Experience and Education

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.

VI.F.1. Maximum Hours of Clinical and Educational Work per Week

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)

VI.F.2. Mandatory Time Free of Clinical Work and Education

- VI.F.2.a) The program must design an effective program structure that is configured to provide fellows with educational opportunities, as well as reasonable opportunities for rest and personal well-being. ^(Core)**

- VI.F.2.b)** Fellows should have eight hours off between scheduled clinical work and education periods. ^(Detail)
- VI.F.2.b).(1)** There may be circumstances when fellows choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements. ^(Detail)
- VI.F.2.c)** Fellows must have at least 14 hours free of clinical work and education after 24 hours of in-house call. ^(Core)
- VI.F.2.d)** Fellows must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. ^(Core)
- VI.F.3.** **Maximum Clinical Work and Education Period Length**
- VI.F.3.a)** Clinical and educational work periods for fellows must not exceed 24 hours of continuous scheduled clinical assignments. ^(Core)
- VI.F.3.a).(1)** Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or fellow education. ^(Core)
- VI.F.3.a).(1).(a)** Additional patient care responsibilities must not be assigned to a fellow during this time. ^(Core)
- VI.F.4.** **Clinical and Educational Work Hour Exceptions**
- VI.F.4.a)** In rare circumstances, after handing off all other responsibilities, a fellow, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:
- VI.F.4.a).(1)** to continue to provide care to a single severely ill or unstable patient; ^(Detail)
- VI.F.4.a).(2)** humanistic attention to the needs of a patient or family; or, ^(Detail)
- VI.F.4.a).(3)** to attend unique educational events. ^(Detail)
- VI.F.4.b)** These additional hours of care or education will be counted toward the 80-hour weekly limit. ^(Detail)
- 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.

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

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)

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)

VI.F.5. Moonlighting

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)

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)

VI.F.6. In-House Night Float

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

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

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

VI.F.8. At-Home Call

VI.F.8.a) Time spent on patient care activities by fellows on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. (Core)

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

VI.F.8.b) Fellows are permitted to return to the hospital while on at-

home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit. (Detail)

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

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

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

Osteopathic Recognition

For programs seeking Osteopathic Recognition for the entire program, or for a track within the program, the Osteopathic Recognition Requirements are also applicable.

http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/Osteopathic_Recognition_Requirements.pdf