ACGME Program Requirements for Graduate Medical Education in Pediatric Nephrology (Subspecialty of Pediatrics)

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Program Requirements for Graduate Medical Education
in Pediatric Nephrology

Common Program Requirements are in BOLD

~~In addition to complying with the requirements in this document, each program must comply with the Program Requirements for the respective subspecialty, which may exceed the minimum requirements set forth here. (Core)~~

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

48 ***expertise achieved, fellows develop mentored relationships built on an***
49 ***infrastructure that promotes collaborative research.***
50
51 **Int.B. Definition of Subspecialty**
52
53 ~~Scope of Training~~
54
55 Pediatric nephrology programs ~~must~~ provide fellows with the capability and
56 experience to understand, diagnose, and manage renal diseases, ~~and to~~
57 ~~understand the physiology of~~ fluids and electrolytes, and acid-base disorders
58 ~~regulation~~. (Core)* [Moved from Section VII Int.A.1.]
59
60 **Int.C. Length of Educational Program**
61
62 ~~Duration of Educational Experience~~
63
64 ~~Unless specified otherwise in the subspecialty-specific Program Requirements,~~
65 The educational program must be 36 months in length. (Core) [Moved from Int.B]
66
67 **I. Oversight**
68
69 **I.A. Sponsoring Institution**
70
71 ***The Sponsoring Institution is the organization or entity that assumes the***
72 ***ultimate financial and academic responsibility for a program of graduate***
73 ***medical education consistent with the ACGME Institutional Requirements.***
74
75 ***When the Sponsoring Institution is not a rotation site for the program, the***
76 ***most commonly utilized site of clinical activity for the program is the***
77 ***primary clinical site.***
78

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.

79
80 **I.A.1. The program must be sponsored by one ACGME-accredited**
81 **Sponsoring Institution. (Core)***
82
83 I.A.1.a) ~~The presence of a subspecialty program must not adversely affect~~
84 ~~the education of pediatric residents. (Core)~~ [Moved from I.A.1.a)]
85
86 **I.B. Participating Sites**
87
88 ***A participating site is an organization providing educational experiences or***
89 ***educational assignments/rotations for fellows.***

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I.B.1. The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)

I.B.1.a) An accredited pediatric nephrology ~~subspecialty~~ program must ~~exist in conjunction with and~~ be an integral part of a core pediatric residency program, and ~~must~~ should be sponsored by the same ACGME-accredited Sponsoring Institution. (Core) [Moved from I.A.1.]

I.B.1.a).(1) The pediatric nephrology ~~subspecialty~~ program should be geographically proximate to the core pediatric residency program. (Detail) [Moved from I.A.1.b)]

I.B.2. There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)

I.B.2.a) The PLA must:

I.B.2.a).(1) be renewed at least every 10 years; and, (Core)

I.B.2.a).(2) be approved by the designated institutional official (DIO). (Core)

I.B.3. The program must monitor the clinical learning and working environment at all participating sites. (Core)

I.B.3.a) At each participating site there must be one faculty member, designated by the program director, who is accountable for fellow education for that site, in collaboration with the program director. (Core)

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.

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**

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- **Specifying the duration and content of the educational experience**
- **Stating the policies and procedures that will govern fellow education during the assignment**

124
125 **I.B.4.** **The program director must submit any additions or deletions of**
126 **participating sites routinely providing an educational experience,**
127 **required for all fellows, of one month full time equivalent (FTE) or**
128 **more through the ACGME's Accreditation Data System (ADS). (Core)**
129
130 I.B.5. ~~Any site providing six months or more of required rotations should be~~
131 ~~approved by the Review Committee. (Detail)~~ [Moved from I.B.3.]
132
133 **I.C.** **The program, in partnership with its Sponsoring Institution, must engage in**
134 **practices that focus on mission-driven, ongoing, systematic recruitment**
135 **and retention of a diverse and inclusive workforce of residents (if present),**
136 **fellows, faculty members, senior administrative staff members, and other**
137 **relevant members of its academic community. (Core)**
138

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).

139
140 **I.D.** **Resources**
141
142 **I.D.1.** **The program, in partnership with its Sponsoring Institution, must**
143 **ensure the availability of adequate resources for fellow education.**
144 **(Core)**
145
146 I.D.1.a) ~~Adequate inpatient and outpatient facilities, as specified in the~~
147 ~~requirements for each subspecialty, must be available. (Core)~~
148 [Moved from II.D.1.]
149
150 ~~I.D.1.a).(1)~~ ~~These must be of sufficient size and be appropriately~~
151 ~~staffed and equipped to meet the educational needs of the~~
152 ~~program. (Core)~~ [Moved from II.D.1.a)]
153
154 I.D.1.b) There must be facilities for renal replacement therapy, ~~and~~ renal
155 biopsy, and renal transplantation. (Core) [Moved from VII.B.1.]
156
157 I.D.1.b).(1) ~~Space in an ambulatory setting for optimal evaluation and~~
158 ~~care of outpatients and an inpatient area with a full array of~~
159 ~~pediatric and related services staffed by pediatric residents~~
160 ~~and faculty. (Detail) [Moved from VII.B.1.a)]~~
161
162 I.D.1.c) Facilities and services, including a comprehensive laboratory,
163 pathology and imaging, must be available. (Core)
164

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I.D.1.d) The program must have access to laboratories in order to perform testing specific to pediatric nephrology. (Core)

I.D.1.e) An adequate number and variety of pediatric nephrology patients ranging in age from newborn through young adulthood, must be available to provide a broad experience for the fellows. (Core)

I.D.1.f) ~~Patients must range in age from newborn through young adulthood, as appropriate. (Core)~~ [Moved from II.D.3.]

I.D.1.g) ~~Adequate numbers of pediatric subspecialty patients must be available to provide a broad experience for the fellows. (Core)~~ [Moved from II.D.4.]

~~I.D.1.g).(1)~~ ~~The program must maintain an appropriate balance of the number and variety of patients, the number of faculty members, and the number of fellows in the program. (Core)~~ [Moved from II.D.4.a)]

~~I.D.1.g).(2)~~ A sufficient number of patients must be available in inpatient and outpatient settings to meet the educational needs of the program. (Core)

I.D.1.h) ~~Support services must include clinical laboratories, intensive care, nutrition, occupational and physical therapy, pathology, pharmacology, mental health, diagnostic imaging, respiratory therapy, and social services. (Core)~~ [Moved from II.D.2.]

I.D.1.i) ~~Laboratory and diagnostic services. (Core) [Moved from VII.B.2.]~~

~~I.D.1.i).(1)~~ ~~including: comprehensive diagnostic imaging, electron microscopy, immunology, immunopathology, histocompatibility, and diagnostic radionuclide imaging. (Detail) [Moved from VII.B.2.a)]~~

I.D.1.j) ~~A nutrition support service; social and psychological services and other relevant healthcare providers (e.g., nurse specialists, PAs). (Detail) [Moved from VII.B.3.]~~

I.D.1.k) ~~Adequate numbers of patients with a wide variety and complexity of renal disorders must be available to the training program to ensure that each fellow achieves competence in patient care. (Core) [Moved from VII.B.4.a)]~~

I.D.1.l) ~~The patient population should be of sufficient size to ensure adequate exposure of fellows to patients with acute renal injury and chronic dialysis, including patients who utilize home dialysis treatment modalities, to ensure adequate training in chronic dialysis and who require renal transplantation (living related donor and deceased donor) and patients who previously had renal~~

215 ~~transplantation and require long-term follow-up. (Core) [Moved from~~
216 ~~VII.B.4.b)]~~
217
218 **I.D.2.** **The program, in partnership with its Sponsoring Institution, must**
219 **ensure healthy and safe learning and working environments that**
220 **promote fellow well-being and provide for: (Core)**
221
222 **I.D.2.a)** **access to food while on duty; (Core)**
223
224 **I.D.2.b)** **safe, quiet, clean, and private sleep/rest facilities available**
225 **and accessible for fellows with proximity appropriate for safe**
226 **patient care; (Core)**
227

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.

228
229 **I.D.2.c)** **clean and private facilities for lactation that have refrigeration**
230 **capabilities, with proximity appropriate for safe patient care;**
231 **(Core)**
232

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).

233
234 **I.D.2.d)** **security and safety measures appropriate to the participating**
235 **site; and, (Core)**
236
237 **I.D.2.e)** **accommodations for fellows with disabilities consistent with**
238 **the Sponsoring Institution’s policy. (Core)**
239
240 **I.D.3.** **Fellows must have ready access to subspecialty-specific and other**
241 **appropriate reference material in print or electronic format. This**
242 **must include access to electronic medical literature databases with**
243 **full text capabilities. (Core)**
244
245 **I.D.4.** **The program’s educational and clinical resources must be adequate**
246 **to support the number of fellows appointed to the program. (Core)**
247

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248 **I.E.** ***A fellowship program usually occurs in the context of many learners and***
249 ***other care providers and limited clinical resources. It should be structured***
250 ***to optimize education for all learners present.***
251
252 **I.E.1.** **Fellows should contribute to the education of residents in core**
253 **programs, if present.** **(Core)**
254

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.

255
256 **II. Personnel**
257
258 **II.A. Program Director**
259
260 **II.A.1.** **There must be one faculty member appointed as program director**
261 **with authority and accountability for the overall program, including**
262 **compliance with all applicable program requirements.** **(Core)**
263
264 **II.A.1.a)** **The Sponsoring Institution's Graduate Medical Education**
265 **Committee (GMEC) must approve a change in program**
266 **director.** **(Core)**
267
268 **II.A.1.b)** **Final approval of the program director resides with the**
269 **Review Committee.** **(Core)**
270

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.

271
272 **II.A.2.** **The program director must be provided with support adequate for**
273 **administration of the program based upon its size and configuration.**
274 **(Core)**
275
276 II.A.2.a) Program leadership, including the program director and associate
277 program director(s), must be provided with a minimum combined
278 total of 20-35 percent ~~full time equivalent~~ ~~(~~FTE~~)~~ protected time for
279 the administration of the program (not including scholarly activity),
280 depending on the size of the program, as follows: (Core) [Moved
281 from I.A.2.]
282

Program Size	% FTE Required

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0-3 fellows	20%
4-6 fellows	25%
7-9 fellows	30%
≥ 10 fellows	35%

283

Specialty Background and Intent: The minimum total of 20-35 percent protected time for the administration of the program is the combined time required for the program director, and associate program director(s); it does not include time devoted to the program by the fellowship coordinator or other support personnel. Individual members of program leadership are not required to have 20-35 percent protected time each. Time provided by research grant funding does not count toward the minimum required protected time for the administration of the program.

284
285 **II.A.3. Qualifications of the program director:**
286
287 **II.A.3.a) must include subspecialty expertise and qualifications**
288 **acceptable to the Review Committee; ~~and,~~ (Core)**
289
290 **II.A.3.b) must include current certification in the subspecialty for**
291 **which they are the program director by the American Board**
292 **of** Pediatrics **~~or by the American Osteopathic Board of _____,~~**
293 **or subspecialty qualifications that are acceptable to the**
294 **Review Committee; and, (Core)**
295
296 II.A.3.b).(1) ~~Qualifications other than subspecialty certification by the~~
297 ~~American Board of Pediatrics (ABP) will be considered~~
298 ~~only in exceptional circumstances. (Detail) [Moved from~~
299 ~~II.A.3.b).(1)]~~
300
301 [Note that while the Common Program Requirements
302 deem certification by a certifying board of the American
303 Osteopathic Association (AOA) acceptable, there is no
304 AOA board that offers certification in this subspecialty]
305

Specialty Background and Intent: Qualifications other than pediatric nephrology certification by the American Board of Pediatrics (ABP) will be considered only in exceptional circumstances. For a program director without pediatric nephrology certification from the ABP, the Review Committee will consider the following criteria in determining whether alternate qualifications are acceptable:

- completion of a pediatric nephrology fellowship program
- scholarship within the field of pediatric nephrology; specifically, evidence of on-going scholarship documented by contributions to the peer-reviewed literature in pediatric nephrology, and pediatric nephrology presentations at national meetings
- leadership and/or participation on committees in national pediatric subspecialty organizations
- current clinical activity in pediatric nephrology

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Years of practice are not an equivalent to specialty board certification, and the Review Committee does not accept the phrase "board eligible."

306
307 II.A.3.c) must include a record of ongoing involvement in scholarly
308 activities~~, including peer-review publications and mentoring (i.e.,~~
309 ~~guiding fellows in the acquisition of competence in the clinical,~~
310 ~~teaching, research, and advocacy skills pertinent to the discipline)~~.
311 (Core) [Moved from II.A.3.d)]
312
313 **II.A.4. Program Director Responsibilities**
314
315 **The program director must have responsibility, authority, and**
316 **accountability for: administration and operations; teaching and**
317 **scholarly activity; fellow recruitment and selection, evaluation, and**
318 **promotion of fellows, and disciplinary action; supervision of fellows;**
319 **and fellow education in the context of patient care.** (Core)
320
321 **II.A.4.a) The program director must:**
322
323 **II.A.4.a).(1) be a role model of professionalism;** (Core)
324

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.

325
326 **II.A.4.a).(2) design and conduct the program in a fashion**
327 **consistent with the needs of the community, the**
328 **mission(s) of the Sponsoring Institution, and the**
329 **mission(s) of the program;** (Core)
330

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.

331
332 **II.A.4.a).(3) administer and maintain a learning environment**
333 **conducive to educating the fellows in each of the**
334 **ACGME Competency domains;** (Core)
335

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

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others, yet remains accountable. The leadership team may include physician and non-physician personnel with varying levels of education, training, and experience.

336
337 **II.A.4.a).(4)** **develop and oversee a process to evaluate candidates prior to approval as program faculty members for participation in the fellowship program education and at least annually thereafter, as outlined in V.B.; (Core)**
338
339
340
341
342 **II.A.4.a).(5)** **have the authority to approve program faculty members for participation in the fellowship program education at all sites; (Core)**
343
344
345
346 **II.A.4.a).(6)** **have the authority to remove program faculty members from participation in the fellowship program education at all sites; (Core)**
347
348
349
350 **II.A.4.a).(7)** **have the authority to remove fellows from supervising interactions and/or learning environments that do not meet the standards of the program; (Core)**
351
352
353

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.

354
355 **II.A.4.a).(8)** **submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; (Core)**
356
357
358 **II.A.4.a).(9)** **provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant subspecialty board examination(s); (Core)**
359
360
361
362 **II.A.4.a).(10)** **provide a learning and working environment in which fellows have the opportunity to raise concerns and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; (Core)**
363
364
365
366
367
368 **II.A.4.a).(11)** **ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process; (Core)**
369
370
371
372 **II.A.4.a).(12)** **ensure the program's compliance with the Sponsoring Institution's policies and procedures for due process when action is taken to suspend or dismiss, not to promote, or not to renew the appointment of a fellow; (Core)**
373
374
375
376

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377

> **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.**

378
379 **II.A.4.a).(13)** **ensure the program's compliance with the Sponsoring**
380 **Institution's policies and procedures on employment**
381 **and non-discrimination; (Core)**
382
383 **II.A.4.a).(13).(a)** **Fellows must not be required to sign a non-**
384 **competition guarantee or restrictive covenant.**
385 **(Core)**
386
387 **II.A.4.a).(14)** **document verification of program completion for all**
388 **graduating fellows within 30 days; (Core)**
389
390 **II.A.4.a).(15)** **provide verification of an individual fellow's**
391 **completion upon the fellow's request, within 30 days;**
392 **and, (Core)**
393

> **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.**

394
395 **II.A.4.a).(16)** **obtain review and approval of the Sponsoring**
396 **Institution's DIO before submitting information or**
397 **requests to the ACGME, as required in the Institutional**
398 **Requirements and outlined in the ACGME Program**
399 **Director's Guide to the Common Program**
400 **Requirements. (Core)**
401
402 ~~II.A.4.a).(17)~~ ~~ensure that the fellows are mentored in their development~~
403 ~~of clinical, educational, and administrative skills; (Core)~~
404 [Moved from II.A.4.p)]
405
406 ~~II.A.4.a).(18)~~ ~~ensure that each fellow's experience in such procedures~~
407 ~~be documented and that such documentation is available~~
408 ~~for review; (Core)~~ [Moved from II.A.4.q)]
409
410 ~~II.A.4.a).(19)~~ ~~coordinate, with the core and subspecialty program~~
411 ~~directors, the incorporation of the competencies into~~
412 ~~fellowship education in order to foster consistent~~
413 ~~expectations with regard to fellows' achievement of them,~~
414 ~~and for faculty members with regard to evaluation~~
415 ~~processes; and, (Core)~~ [Moved from II.A.4.r)]
416

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417 ~~II.A.4.a).(20) maintain documentation of meetings that describe ongoing~~
418 ~~interaction among pediatric subspecialty and core program~~
419 ~~directors. (Core)~~ [Moved from II.A.4.s)]
420
421 ~~II.A.4.a).(21) These meetings should take place at least semi-annually.~~
422 ~~(Detail)~~ [Moved from II.A.4.s).(1)]
423
424 ~~II.A.4.a).(22) These meetings should address a departmental approach~~
425 ~~to common educational issues and concerns (e.g., core~~
426 ~~curriculum, competencies, evaluation). (Detail)~~ [Moved from
427 II.A.4.s).(2)]
428
429 **II.B. Faculty**
430
431 ***Faculty members are a foundational element of graduate medical education***
432 ***– faculty members teach fellows how to care for patients. Faculty members***
433 ***provide an important bridge allowing fellows to grow and become practice***
434 ***ready, ensuring that patients receive the highest quality of care. They are***
435 ***role models for future generations of physicians by demonstrating***
436 ***compassion, commitment to excellence in teaching and patient care,***
437 ***professionalism, and a dedication to lifelong learning. Faculty members***
438 ***experience the pride and joy of fostering the growth and development of***
439 ***future colleagues. The care they provide is enhanced by the opportunity to***
440 ***teach. By employing a scholarly approach to patient care, faculty members,***
441 ***through the graduate medical education system, improve the health of the***
442 ***individual and the population.***
443
444 ***Faculty members ensure that patients receive the level of care expected***
445 ***from a specialist in the field. They recognize and respond to the needs of***
446 ***the patients, fellows, community, and institution. Faculty members provide***
447 ***appropriate levels of supervision to promote patient safety. Faculty***
448 ***members create an effective learning environment by acting in a***
449 ***professional manner and attending to the well-being of the fellows and***
450 ***themselves.***
451

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.

452
453 **II.B.1. For each participating site, there must be a sufficient number of**
454 **faculty members with competence to instruct and supervise all**
455 **fellows at that location. (Core)**
456
457 **II.B.2. Faculty members must:**
458
459 **II.B.2.a) be role models of professionalism; (Core)**
460
461 **II.B.2.b) demonstrate commitment to the delivery of safe, quality,**
462 **cost-effective, patient-centered care; (Core)**
463

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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.

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

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

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

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

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 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) ~~This must include the~~ mentor~~ing of~~ fellows ~~as they apply~~ in the application of scientific principles, epidemiology, biostatistics, and evidence-based medicine to the clinical care of patients. (Core) [Moved from II.B.5.d)]

II.B.2.i) ~~To provide an appropriate academic environment for the fellows, the fellowship faculty must have a program of ongoing scholarship. (Core)~~ [Moved from II.B.5.f)]

~~II.B.2.i).(1)~~ ~~This must be characterized by peer-reviewed funding and/or publications. (Core)~~ [Moved from II.B.5.f).(1)]

~~II.B.2.i).(2)~~ ~~The members of the teaching faculty must play a substantial role in conceiving and writing the funding application(s), conducting the project, collecting and analyzing data, and publishing results. (Core)~~

II.B.3. **Faculty Qualifications**

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

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503 **II.B.3.b)** **Subspecialty physician faculty members must:**
504
505 **II.B.3.b).(1)** **have current certification in the subspecialty by the**
506 **American Board of** Pediatrics ~~**or the American**~~
507 ~~**Osteopathic Board of _____**~~**, or possess qualifications**
508 **judged acceptable to the Review Committee.** **(Core)**
509
510 [Note that while the Common Program Requirements
511 deem certification by a certifying board of the American
512 Osteopathic Association (AOA) acceptable, there is no
513 AOA board that offers certification in this subspecialty]
514
515 II.B.3.b).(2) ~~Acceptable qualifications for the required key subspecialty~~
516 ~~faculty include: (Core)~~ [Moved from II.B.2.a)]
517
518 II.B.3.b).(2).(a) ~~certification, if eligible, by the appropriate member~~
519 ~~board of the American Board of Medical Specialties~~
520 ~~(ABMS); or, (Core)~~ [Moved from II.B.2.a).(1)]
521
522 II.B.3.b).(2).(b) ~~if ineligible for certification, documented~~
523 ~~subspecialty training and peer-reviewed~~
524 ~~publications in the field, with evidence of active~~
525 ~~participation in applicable local and national~~
526 ~~professional societies. (Detail)~~ [Moved from
527 II.B.2.a).(2)]
528

Specialty Background and Intent: For a faculty member without pediatric nephrology certification from the ABP, the Review Committee will consider the following criteria in determining whether alternate qualifications are acceptable:

- completion of a pediatric nephrology fellowship program
- scholarship within the field of pediatric nephrology; specifically, evidence of on-going scholarship documented by contributions to the peer-reviewed literature in pediatric nephrology, and pediatric nephrology presentations at national meetings
- leadership and/or participation on committees in national pediatric subspecialty organizations
- current clinical activity in pediatric nephrology

If a faculty member is a recent graduate of a pediatric nephrology program, the Review Committee expects that individual to take and pass the next eligible ABP pediatric nephrology certifying examination. If the faculty member is unable to take the next administration of the certifying examination, an explanation should be provided.

Years of practice are not an equivalent to specialty board certification, and the Review Committee does not accept the phrase "board eligible."

Provision of documentation of alternate qualifications is the responsibility of the program director.

529

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530 **II.B.3.c)** **Any non-physician faculty members who participate in**
531 **fellowship program education must be approved by the**
532 **program director.** (Core)
533

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.

534
535 **II.B.3.d)** **Any other specialty physician faculty members must have**
536 **current certification in their specialty by the appropriate**
537 **American Board of Medical Specialties (ABMS) member**
538 **board or American Osteopathic Association (AOA) certifying**
539 **board, or possess qualifications judged acceptable to the**
540 **Review Committee.** (Core)
541
542 II.B.3.d).(1) In addition to the pediatric nephrology faculty members,
543 ABP- or AOBP-certified faculty members and consultants
544 in the following subspecialties must be available:
545
546 II.B.3.d).(1).(a) adolescent medicine; (Core)
547
548 II.B.3.d).(1).(b) developmental-behavioral pediatrics; (Core)
549
550 II.B.3.d).(1).(c) neonatal-perinatal medicine; (Core)
551
552 II.B.3.d).(1).(d) pediatric cardiology; (Core)
553
554 II.B.3.d).(1).(e) pediatric critical care medicine; (Core)
555
556 II.B.3.d).(1).(f) pediatric emergency medicine; (Core)
557
558 II.B.3.d).(1).(g) pediatric endocrinology; (Core)
559
560 II.B.3.d).(1).(h) pediatric gastroenterology; (Core)
561
562 II.B.3.d).(1).(i) pediatric hematology-oncology; (Core)
563
564 II.B.3.d).(1).(j) pediatric infectious diseases; (Core)
565
566 II.B.3.d).(1).(k) pediatric pulmonology; and, (Core)
567
568 II.B.3.d).(1).(l) pediatric rheumatology. (Core)
569
570 II.B.3.d).(2) The faculty should also include the following specialists
571 with substantial experience with pediatric problems:~~The~~

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572 ~~following faculty from other disciplines must be available:~~
573 [Moved from VII.A.2.]
574
575 II.B.3.d).(2).(a) anesthesiologist(s); (Detail) [Moved from II.B.2.b).(1)]
576
577 II.B.3.d).(2).(b) child and adolescent psychiatrist(s); (Detail) [Moved
578 from II.B.2.b).(1)]
579
580 II.B.3.d).(2).(c) child neurologist(s); (Detail) [Moved from II.B.2.b).(1)]
581
582 II.B.3.d).(2).(d) medical geneticist(s); (Detail) [Moved from
583 II.B.2.b).(1)]
584
585 II.B.3.d).(2).(e) pathologist(s); (Detail) [Moved from VII.A.2. and
586 II.B.2.b).(1)]
587
588 II.B.3.d).(2).(f) pediatric surgeon(s); (Detail) [Moved from VII.A.2.and
589 II.B.2.b).(1)]
590
591 II.B.3.d).(2).(g) pediatric urologist(s); (Detail) [Moved from VII.A.2.]
592
593 II.B.3.d).(2).(h) radiologist(s); and, (Detail) [Moved from VII.A.2.]
594
595 II.B.3.d).(2).(i) transplant surgeon(s). (~~Detail)~~Core) ~~organ~~
596 ~~transplantation. (Detail)~~ [Moved from VII.A.2.]
597
598 II.B.3.d).(2).(j) ~~psychiatry/psychology,and; (Detail)~~ [Moved from
599 VII.A.2.]
600

Subspecialty Background and Intent: The Review Committee recognizes that some programs may not have access to board certified pediatric subspecialists in some disciplines and will allow adult subspecialists with pediatric expertise. However, it is expected that faculty members have pediatric subspecialty certification, in those subspecialties where pediatric subspecialty board certification is available, whenever possible. Adult subspecialists should not be appointed as faculty members or consultants if pediatric subspecialists are available.

601
602 II.B.3.d).(3) Consultants should be available for transition care of
603 young adults. (Detail)
604
605 II.B.3.d).(4) ~~Teaching and consultant faculty members in the full range~~
606 ~~of pediatric subspecialties and in other related disciplines~~
607 ~~must be available as specified in the subspecialty-specific~~
608 ~~requirements. (Core)~~ [Moved from II.B.2.b)]
609
610 II.B.3.d).(5) ~~The faculty should include an anesthesiologist(s),~~
611 ~~pathologist(s), and radiologist(s) who have substantial~~
612 ~~experience with pediatric problems and who interact with~~
613 ~~the fellows, as well as a medical geneticist(s), child~~
614 ~~neurologist(s), child and adolescent psychiatrist(s),~~
615 ~~pediatric surgeon(s), and surgical subspecialists, as~~

~~appropriate to the subspecialty. (Detail)~~ [This requirement has been broken out and modified as listed above]

II.B.4. Core Faculty

Core faculty members must have a significant role in the education and supervision of fellows and must devote a significant portion of their entire effort to fellow education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to fellows. (Core)

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.

II.B.4.a) Core faculty members must be designated by the program director. (Core)

II.B.4.b) Core faculty members must complete the annual ACGME Faculty Survey. (Core)

II.B.4.b).(1) To ensure the quality of the educational and scholarly activity of the program, and to provide adequate supervision of fellows, there must be at least two ~~pediatric nephrologists~~ core faculty members, inclusive of the program director, who are certified in pediatric nephrology by the ABP, or who have other qualifications~~-~~acceptable to the Review Committee. (Core) [Moved from VII.A.1.]

II.C. Program Coordinator

II.C.1. There must be a program coordinator. (Core)

II.C.2. The program coordinator must be provided with support adequate for administration of the program based upon its size and configuration. (Core)

II.C.2.a) ~~The Sponsoring Institution must provide support for a program coordinator(s) and other support personnel required for operation of the program. (Core)~~ [Moved from I.A.3.]

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.

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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.

654
655 **II.D. Other Program Personnel**
656
657 **The program, in partnership with its Sponsoring Institution, must jointly**
658 **ensure the availability of necessary personnel for the effective**
659 **administration of the program.** **(Core)**
660

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.

661
662 II.D.1. In order to enhance fellows' understanding of the multidisciplinary nature
663 of pediatric nephrology, the following personnel with pediatric focus and
664 experience should be available:
665
666 II.D.1.a) child life therapist(s); (Detail) [Moved from II.C.1.]
667
668 II.D.1.b) dialysis support staff; (Detail)(Core)
669
670 II.D.1.c) nutritionistsdietician(s); (Detail) [Moved from II.C.1.]
671
672 II.D.1.d) mental health professional(s); (Detail)
673
674 II.D.1.e) subspecialty nurse(s); (Detail)
675
676 II.D.1.f) pharmacist(s); (Detail) [Moved from II.C.1.]
677
678 II.D.1.g) physical and occupational therapist(s); (Detail) [Moved from II.C.1.]
679
680 II.D.1.h) respiratory therapist(s); (Detail)
681
682 II.D.1.i) school and special education contacts; (Detail)
683
684 II.D.1.j) social worker(s); and, (Detail) [Moved from II.C.1.]
685
686 II.D.1.k) speech and language therapist(s). (Detail) [Moved from II.C.1.]
687
688 II.D.1.l) respiratory therapists, (Detail)[Moved from II.C.1.]

689
690 II.D.2. ~~Professional personnel should include nutritionists, social workers, respiratory therapists, pharmacists, subspecialty nurses, physical and occupational therapists, child life therapists, and speech therapists with pediatric focus and experience, as appropriate to the subspecialty. (Detail)~~ [This requirement has been broken out as listed above]
695
696 **III. Fellow Appointments**
697
698 **III.A. Eligibility Criteria**
699
700 **III.A.1. Eligibility Requirements – Fellowship Programs**
701
702 **All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, an AOA-approved residency program, a program with ACGME International (ACGME-I) Advanced Specialty Accreditation, or a Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency program located in Canada. (Core)**
710

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).

711
712 **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)**
716
717 III.A.1.b) Prerequisite ~~training~~ education for entry into a pediatric nephrology ~~subspecialty~~ program must include the satisfactory completion of ~~either an ACGME-accredited~~ a pediatrics or combined internal medicine-pediatrics residency ~~or~~ program that satisfies the requirements listed in III.A.1.~~, or an RCPSC-accredited internal medicine or pediatrics residency program located in Canada.~~ (Core) [Moved from III.A.2.]
724
725 **III.A.1.c) Fellow Eligibility Exception**
726
727 **The Review Committee for** Pediatrics **will allow the following exception to the fellowship eligibility requirements:**
729
730 **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)**
736

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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 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.**

III.A.1.d) ~~Applicants who do not meet the eligibility criteria in Program Requirement III.A.2. must be advised in writing by the program director to consult the ABP or other appropriate board regarding their eligibility for subspecialty certification. (Core)~~ [Moved from III.A.2.d)]

III.B. **The program director must not appoint more fellows than approved by the Review Committee. (Core)**

III.B.1. **All complement increases must be approved by the Review Committee. (Core)**

III.C. **Fellow Transfers**

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The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring fellow, and Milestones evaluations upon matriculation. **(Core)**

IV. Educational Program

The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.

The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.

In addition, the program is expected to define its specific program aims consistent with the overall mission of its Sponsoring Institution, the needs of the community it serves and that its graduates will serve, and the distinctive capabilities of physicians it intends to graduate. While programs must demonstrate substantial compliance with the Common and subspecialty-specific Program Requirements, it is recognized that within this framework, programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-specific goals for it and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from one focusing on community health.

IV.A. **The curriculum must contain the following educational components:** **(Core)**

IV.A.1. **a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates;** **(Core)**

IV.A.1.a) **The program's aims must be made available to program applicants, fellows, and faculty members.** **(Core)**

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.2.a) ~~Each educational unit or major professional activity must have a curriculum associated with it. (Core)~~ [Moved from IV.A.2.a)]

IV.A.2.b) ~~The competency-based goals and objectives, educational strategies, and assessment methods must align with intended outcomes of those activities. (Core)~~ [Moved from IV.A.2.b)]

IV.A.2.c) ~~The curriculum should incorporate the competencies into the context of the major professional activities for which fellows should be entrusted. (Detail)~~ [Moved from IV.A.2.c)]

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823 **IV.A.3.** **delineation of fellow responsibilities for patient care, progressive**
824 **responsibility for patient management, and graded supervision in**
825 **their subspecialty; (Core)**
826

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.

827
828 **IV.A.4.** **structured educational activities beyond direct patient care; and,**
829 **(Core)**
830

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.

831
832 **IV.A.5.** **advancement of fellows' knowledge of ethical principles**
833 **foundational to medical professionalism. (Core)**
834
835 **IV.B.** **ACGME Competencies**
836

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.

837
838 **IV.B.1.** **The program must integrate the following ACGME Competencies**
839 **into the curriculum: (Core)**
840
841 **IV.B.1.a)** **Professionalism**
842
843 **Fellows must demonstrate a commitment to professionalism**
844 **and an adherence to ethical principles. (Core)**
845
846 IV.B.1.a).(1) ~~trustworthiness that makes colleagues feel secure when~~
847 ~~the fellow is responsible for the care of patients; (Outcome)~~
848 [Moved from IV.A.5.e).(6)]
849
850 IV.B.1.a).(2) ~~leadership skills that enhance team function, the learning~~
851 ~~environment, and/or the health care delivery~~
852 ~~system/environment to improve patient care with the~~

853 ultimate intent of improving care of patients; and, (Outcome)
854 [Moved from IV.A.5.e).(7)]
855
856 IV.B.1.a).(3) the capacity to recognize that ambiguity is part of clinical
857 medicine and to respond by utilizing appropriate resources
858 in dealing with uncertainty. (Outcome) [Moved from
859 IV.A.5.e).(8)]
860
861 **IV.B.1.b) Patient Care and Procedural Skills**
862

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.

863
864 **IV.B.1.b).(1) Fellows must be able to provide patient care that is**
865 **compassionate, appropriate, and effective for the**
866 **treatment of health problems and the promotion of**
867 **health. (Core)**
868
869 IV.B.1.b).(1).(a) Fellows must develop competence in the necessary
870 clinical skills used needed in pediatric nephrology
871 the subspecialty and; (Outcome) (Core) [Moved from
872 IV.A.5.a).(1).(a)]
873
874 IV.B.1.b).(1).(b) Fellows must demonstrate the ability to provide
875 consultation, including the ability to perform a
876 history and physical examination, make informed
877 diagnostic and therapeutic decisions that result in
878 optimal clinical judgement, and develop and carry
879 out management plans, counsel patients and
880 families, and use information technology to
881 optimize patient care; (Outcome) (Core) [Moved from
882 IV.A.5.a).(1).(a)]
883
884 IV.B.1.b).(1).(c) Fellows must demonstrate the ability to provide
885 transfer of care that ensures seamless
886 transitions, (Outcome Core) [Moved from IV.A.5.a).(1).(b)]
887
888 IV.B.1.b).(1).(d) In order to promote emotional resilience in children,
889 adolescents and their families; fellows must:
890
891 IV.B.1.b).(1).(d).(i) provide care that is sensitive to the
892 developmental stage of the patient with

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893 common behavioral and mental health
894 issues, and the cultural context of the
895 patient and family; and, (Core)
896
897 IV.B.1.b).(1).(d).(ii) demonstrate the ability to refer and/or co-
898 manage patients with common behavioral
899 and mental health issues along with
900 appropriate specialists when indicated. (Core)
901
902 IV.B.1.b).(1).(e) Fellows must demonstrate competence in providing
903 or coordinating care with a medical home for
904 patients with complex and chronic diseases; (Core)
905
906 IV.B.1.b).(1).(f) Fellows must demonstrate competence in
907 performing competently use and interpreting the
908 results of interpret laboratory tests, and imaging,
909 and other diagnostic procedures for use in patient
910 care. (Outcome)(Core) [Moved from IV.A.5.a).(2).(a)]
911
912 IV.B.1.b).(1).(g) Fellows There should also be training in the
913 evaluation must demonstrate the ability to evaluate
914 the of psychosocial aspects of life-threatening and
915 chronic diseases as they affect the patient and the
916 family, and to in counseling both acutely ill and
917 chronically-ill patients and their families. (Core)
918 [Moved from Section VII Int.A.2.]
919
920 IV.B.1.b).(1).(h) Fellows The fellows must demonstrate
921 competence in the prevention, evaluation, and
922 management of the following: (Outcome) (Core) [Moved
923 from VIII.A.1.]
924
925 IV.B.1.b).(1).(h).(i) acute electrolyte and kidney disorders,
926 including hypertension and disorders of the
927 urinary tract; (Outcome) (Core) [Moved from
928 VIII.A.1.b)]
929
930 IV.B.1.b).(1).(h).(ii) chronic electrolyte and kidney disease
931 disorders, including hypertension and
932 disorders of the urinary tract; and, (Outcome)
933 (Core) [Moved from VIII.A.1.d)]
934
935 IV.B.1.b).(1).(h).(iii) end-stage renal disease and kidney
936 transplant. (Outcome) (Core) [Moved from
937 VIII.A.1.d)]
938
939 IV.B.1.b).(1).(h).(iv) perinatal and neonatal conditions including
940 congenital anomalies of the kidneys and
941 genitourinary tract (Outcome) [Moved from
942 VIII.A.1.a)]
943

944 IV.B.1.b).(1).(h).(v) ~~acute kidney injury (Outcome) [Moved from VIII.A.1.c)]~~
945
946
947 IV.B.1.b).(1).(h).(vi) ~~urinary tract infections, voiding dysfunction, nephrolithiasis, and urologic disorders (Outcome) [Moved from VIII.A.1.e)]~~
948
949
950
951 IV.B.1.b).(1).(h).(vii) ~~renal transplantation (Outcome) [Moved from VIII.A.1.f)]~~
952
953
954 IV.B.1.b).(1).(h).(viii) ~~fluid and electrolyte and acid base disorders (Outcome) [Moved from VIII.A.1.g)]~~
955
956
957 IV.B.1.b).(1).(h).(ix) ~~acute and chronic glomerular diseases (Outcome) [Moved from VIII.A.1.h)]~~
958
959
960 IV.B.1.b).(1).(h).(x) ~~inherited renal disorders including genetic syndromes, tubular disorders, and cystic diseases (Outcome) [Moved from VIII.A.1.i)]~~
961
962
963
964 IV.B.1.b).(1).(i) Fellows must demonstrate leadership skills to enhance team function, the learning environment, and/or the health care delivery system/environment with the ultimate intent of improving care of patients. (Core)
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970 IV.B.1.b).(1).(j) ~~In addition, fellows must have experience in the following: (Detail) [Moved from VIII.A.2.]~~
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972
973 IV.B.1.b).(1).(j).(i) ~~evaluation and selection of transplant candidates (Detail) [Moved from VIII.A.2.a)]~~
974
975
976 IV.B.1.b).(1).(j).(ii) ~~preoperative evaluation and preparation of transplant recipients (Detail) [Moved from VIII.A.2.b)]~~
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979
980 IV.B.1.b).(1).(j).(iii) ~~recognition and medical management of surgical and non-surgical complications of transplantation (Detail) [Moved from VIII.A.2.c)]~~
981
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983
984 IV.B.1.b).(1).(k) ~~Fellows should demonstrate competence in: (Outcome) [Moved from VIII.A.3.]~~
985
986
987 IV.B.1.b).(1).(k).(i) ~~acute and chronic dialysis and extracorporeal therapies including: (Outcome) [Moved from VIII.A.3.a)]~~
988
989
990
991 IV.B.1.b).(1).(k).(i).(a) ~~evaluation and selection of patients for continuous renal replacement therapies (Outcome) [Moved from VIII.A.3.a).(1)]~~
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995
996 IV.B.1.b).(1).(k).(i).(b) ~~initiation of hemodialysis, peritoneal dialysis, and CRRT (Outcome) [Moved from VIII.A.3.a).(2)]~~
997
998
999
1000 IV.B.1.b).(1).(k).(i).(c) ~~long-term follow-up of patients undergoing chronic dialysis (Outcome) [Moved from VIII.A.3.a).(3)]~~
1001
1002
1003
1004 IV.B.1.b).(1).(k).(i).(d) ~~understanding of the principles and management of access for acute and chronic dialysis (Outcome) [Moved from VIII.A.3.a).(4)]~~
1005
1006
1007
1008
1009 IV.B.1.b).(1).(k).(i).(e) ~~understanding the special nutritional requirements of acute and chronic dialysis patients (Outcome) [Moved from VIII.A.3.a).(5)]~~
1010
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1014 IV.B.1.b).(1).(k).(ii) ~~performance of percutaneous biopsy of native and transplanted kidneys (Outcome) [Moved from VIII.A.3.b)]~~
1015
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1017
1018 IV.B.1.b).(1).(k).(iii) ~~interpretation of urinalysis (Outcome) [Moved from VIII.A.3.c)]~~
1019
1020
1021 IV.B.1.b).(1).(k).(iv) ~~performance of peritoneal dialysis and acute and chronic dialysis and CRRT (Outcome) [Moved from VIII.A.3.d)]~~
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1024
1025 IV.B.1.b).(1).(l) ~~Fellows should demonstrate competence in clinical applications of: (Outcome) [Moved from VIII.A.4.]~~
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1028 IV.B.1.b).(1).(l).(i) ~~interpretation and evaluation of renal pathology specimens (Outcome) [Moved from VIII.A.4.a)]~~
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1032 IV.B.1.b).(1).(l).(ii) ~~interpretation of renal imaging procedures (Outcome) [Moved from VIII.A.4.b)]~~
1033
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1035 **IV.B.1.b).(2)** **Fellows must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)**
1036
1037
1038
1039 IV.B.1.b).(2).(a) Fellows must ~~acquire~~ demonstrate the necessary procedural skills and develop an understanding of ~~their~~ the indications, risks, and limitations~~.~~ of kidney-related procedures, including native and transplant kidney biopsy, acute and chronic peritoneal dialysis, acute and chronic hemodialysis,
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1045 and continuous renal replacement therapy. ~~(Outcome)~~
1046 (Core) [Moved from IV.A.5.a).(2).(a).(i)]
1047
1048 **IV.B.1.c) Medical Knowledge**
1049
1050 **Fellows must demonstrate knowledge of established and**
1051 **evolving biomedical, clinical, epidemiological and social-**
1052 **behavioral sciences, as well as the application of this**
1053 **knowledge to patient care. (Core)**
1054
1055 IV.B.1.c).(1) Fellows must ~~have a working understanding~~ demonstrate
1056 knowledge of biostatistics, clinical and laboratory research
1057 methodology, study design, preparation of applications for
1058 funding and/or approval of clinical research protocols,
1059 critical literature review, principles of evidence-based
1060 medicine, ethical principles involving clinical research, and
1061 ~~the achievement of proficiency in~~ teaching methods.
1062 ~~(Outcome)~~ (Core) [Moved from IV.A.5.b).(1)]
1063
1064 **IV.B.1.d) Practice-based Learning and Improvement**
1065
1066 **Fellows must demonstrate the ability to investigate and**
1067 **evaluate their care of patients, to appraise and assimilate**
1068 **scientific evidence, and to continuously improve patient care**
1069 **based on constant self-evaluation and lifelong learning. (Core)**
1070

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.

1071
1072 IV.B.1.d).(1) ~~self-evaluate performance and incorporate assessments~~
1073 ~~provided by faculty members, peers, and patients. (Outcome)~~
1074 [Moved from IV.A.5.c).(9)]
1075
1076 IV.B.1.d).(1).(a) ~~This should be a component of each fellow's~~
1077 ~~individual learning plan. (Detail)~~ [Moved from
1078 IV.A.5.c).(9).(a)]
1079
1080 **IV.B.1.e) Interpersonal and Communication Skills**
1081
1082 **Fellows must demonstrate interpersonal and communication**
1083 **skills that result in the effective exchange of information and**
1084 **collaboration with patients, their families, and health**
1085 **professionals. (Core)**
1086

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1087 IV.B.1.e).(1) ~~teach proficiently based on knowledge of the principles of adult learning, including participating effectively in curriculum development, delivery of information, provision of feedback to learners, and assessment of educational outcomes. (Outcome)~~ [Moved from IV.A.5.d).(6)]

1093 IV.B.1.e).(1).(a) ~~Graduates should be effective in teaching both individuals and groups of learners in clinical settings, classrooms, lectures, and seminars, as well as by electronic and print modalities. (Outcome)~~ [Moved from IV.A.5.d).(6).(a)]

1099 **IV.B.1.f)** **Systems-based Practice**

1101 **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)**

1107 IV.B.1.f).(1) ~~participate in the administrative aspects of the subspecialty, including: (Outcome)~~ [Moved from IV.A.5.f).(7)]

1110 IV.B.1.f).(1).(a) ~~knowledge of regional and national access to care, resources, workforce, and financing appropriate to the subspecialty through guided reading and discussion; and, (Outcome)~~ [Moved from IV.A.5.f).(7).(a)]

1116 IV.B.1.f).(1).(b) ~~organization and management of a subspecialty service within one's own delivery system by engaging fellows as active participants in discussions (e.g., through scheduled division activities/meetings) that involve: (Outcome)~~ [Moved from IV.A.5.f).(7).(b)]

1123 IV.B.1.f).(1).(b).(i) ~~staffing a service or unit, including managing personnel and making and adhering to a schedule; (Outcome)~~ [Moved from IV.A.5.f).(7).(b).(i)]

1128 IV.B.1.f).(1).(b).(ii) ~~drafting policies and procedures, leading interdisciplinary meetings and conferences, and providing in-service teaching sessions; (Outcome)~~ [Moved from IV.A.5.f).(7).(b).(ii)]

1133 IV.B.1.f).(1).(b).(iii) ~~proposals for hospital and community resources, including clinical, laboratory, and research space, equipment, and technology necessary for the program to provide state-of-the-art care while advancing knowledge~~

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1138 in the field; (Outcome) [Moved from IV.A.5.f).(7).(b).(iii)]
1139
1140
1141 IV.B.1.f).(1).(b).(iv) business planning and practice management, including billing and coding, personnel management policies, and professional liability; (Outcome) [Moved from IV.A.5.f).(7).(b).(iv)]
1142
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1147 IV.B.1.f).(1).(b).(v) division or program development, organization, and maintenance; and, (Outcome) [Moved from IV.A.5.f).(7).(b).(v)]
1148
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1151 IV.B.1.f).(1).(b).(vi) collaboration within (e.g., with pathology, radiology, or surgery) and beyond (e.g., participation in national specialty societies, cooperative care groups, or multi-center research) the institution as appropriate to the subspecialty. (Outcome) [Moved from IV.A.5.f).(7).(b).(vi)]
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1159 **IV.C. Curriculum Organization and Fellow Experiences**

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1161 **IV.C.1. The curriculum must be structured to optimize fellow educational experiences, the length of these experiences, and supervisory continuity. (Core)**
1162
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1164

1165 IV.C.1.a) Assignment of rotations must be structured to minimize the frequency of rotational transitions, and rotations must be of sufficient length to provide a quality educational experience, defined by continuity of patient care, ongoing supervision, longitudinal relationships with faculty members, and meaningful assessment and feedback. (Core)
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1172 IV.C.1.b) Clinical experiences should be structured to facilitate learning in a manner that allows fellows to function as part of an effective interprofessional team that works together longitudinally with shared goals of patient safety and quality improvement. (Core)
1173
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1177 **IV.C.2. The program must provide instruction and experience in pain management if applicable for the subspecialty, including recognition of the signs of addiction. (Core)**
1178
1179
1180

1181 IV.C.3. Fellows must have a minimum of 12 months of clinical experience. (Core)
1182

1183 IV.C.4. Fellows must participate in the management of have the opportunity to care for patients with renal and other related disorders in the intensive care unit setting. (Detail) [Moved from VII.B.4.c)]
1184
1185
1186

1187 IV.C.5. Fellows must have responsibility throughout their educational program for providing longitudinal outpatient care for a panel of outpatients throughout
1188

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~~their training~~ that is supervised by one or more members of the pediatric nephrology faculty. (Core) [Moved from VII.B.4.d)]

IV.C.6. Fellow education must include experience in serving as a ~~and provide appropriate~~ role model~~ing~~ and providing supervision to residents and/or medical students; ~~and (Outcome)~~ (Core) [Moved from IV.A.5.a).(1).(d)]

IV.C.7. Fellows must have a formally structured educational program in the clinical and basic sciences related to pediatric nephrology ~~the subspecialty~~. (Core) [Moved from IV.A.6.a)]

IV.C.7.a) The program must utilize didactic and clinical ~~practical~~ experience for fellow education. (Core) [Moved from IV.A.6.a).(1)]

IV.C.7.b) Pediatric nephrology ~~Subspecialty~~ conferences must occur regularly, and must involve active fellow participation ~~by the fellows~~ in planning and implementation. (Core) [Moved from IV.A.6.a).(2)]

IV.C.7.c) Fellow education must include instruction in: [Moved from IV.A.6.a).(3)]

IV.C.7.c).(1) basic and fundamental disciplines, as appropriate to pediatric nephrology ~~the subspecialty~~, such as anatomy, physiology, biochemistry, embryology, pathology, microbiology, pharmacology, immunology, genetics, and nutrition/metabolism~~.~~; (Core) [Moved from IV.A.6.a).(3)]

IV.C.7.c).(2) ~~Fellow education must include instruction in~~ pathophysiology of disease, reviews of recent advances in clinical medicine and biomedical research, conferences dealing with complications and death ~~and~~ as well as the scientific, ethical, and legal implications of confidentiality and informed consent~~.~~; (Core) [Moved from IV.A.6.a).(4)]

IV.C.7.c).(3) bioethics; ~~must be addressed in the formal curriculum~~. (Core) [Moved from IV.A.6.a).(5)]

IV.C.7.c).(3).(a) This should include attention to physician-patient, physician-family, physician-physician/allied health professional, and physician-society relationships. (Detail) [Moved from IV.A.6.a).(5).(a)]

IV.C.7.c).(4) ~~Fellow education must include instruction in~~ the economics of health care and current health care management issues, such as cost-effective patient care, practice management, preventive care, population health, quality improvement, resource allocation, and clinical outcomes. (Core) [Moved from IV.A.6.a).(6)]

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IV.C.7.d) Fellow education should include the system-based aspects of the economics, regulations, and practice management issues involved with dialysis and renal transplantation. (Detail)

IV.C.7.e) The program must offer instruction, through courses, workshops, seminars, and laboratory experience, to educate ~~provide appropriate background for~~ fellows in laboratory diagnostic techniques, radiologic imaging, ~~as well as~~ renal development and physiology, pathophysiology, immunopathology, cell and molecular biology, and genetics. ~~(Detail)~~ (Core) [Moved from VIII.B.]

IV.C.8. ~~A structured curriculum must be provided to allow fellows to participate and be assessed in the following activities~~: [Moved from IV.A.6.b)]

IV.C.8.a) ~~provide for and obtain consultation from other health care providers caring for children; (Core)~~ [Moved from IV.A.6.b).(1)]

IV.C.8.b) ~~contribute to the fiscally sound and ethical management of a practice (e.g., through billing, scheduling, coding, and record-keeping practices); (Core)~~ [Moved from IV.A.6.b).(2)]

IV.C.8.c) ~~apply public health principles and improvement methodology to improve care for populations, communities, and systems; (Core)~~ [Moved from IV.A.6.b).(3)]

IV.C.8.d) ~~lead an interprofessional health care team; (Core)~~ [Moved from IV.A.6.b).(4)]

IV.C.8.e) ~~facilitate hand-overs to another health care provider; and, (Core)~~ [Moved from IV.A.6.b).(5)]

IV.C.8.f) ~~lead within the subspecialty profession. (Core)~~ [Moved from IV.A.6.b).(6)]

IV.C.9. ~~The program must provide fellows with instruction and opportunities to interact effectively with patients, patients' families, professional associates, and others in carrying out their responsibilities as physicians in the subspecialty. (Core)~~ [Moved from IV.A.6.c)]

IV.C.9.a) ~~Fellows must learn to create and sustain a therapeutic relationship with patients, and to work effectively as members or leaders of patient care teams or other groups in which they participate as a researcher, educator, health advocate, or manager. (Core)~~ [Moved from IV.A.6.c).(1)]

IV.C.10. ~~The fellowship program and residency program must complement and enhance one another. (Core)~~ [Moved from IV.A.6.d)]

IV.D. Scholarship

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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 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.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:**

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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.

1339
1340 **IV.D.2.b).(1)** **faculty participation in grand rounds, posters,**
1341 **workshops, quality improvement presentations,**
1342 **podium presentations, grant leadership, non-peer-**
1343 **reviewed print/electronic resources, articles or**
1344 **publications, book chapters, textbooks, webinars,**
1345 **service on professional committees, or serving as a**
1346 **journal reviewer, journal editorial board member, or**
1347 **editor; (Outcome)‡**
1348
1349 IV.D.2.b).(1).(a) Scholarly activityies must should be in a field
1350 related to the subspecialty, such as basic science,
1351 clinical care, health services, health policy, quality
1352 improvement, or education, as it relates to pediatric
1353 nephrology. (Detail)(Core) [Moved here from II.B.5.e)]
1354
1355 **IV.D.2.b).(2)** **peer-reviewed publication. (Outcome)**
1356
1357 **IV.D.3.** **Fellow Scholarly Activity**
1358
1359 IV.D.3.a) Where appropriate, the core curriculum in scholarly activity should
1360 be a collaborative effort involving all of the pediatric subspecialty
1361 programs in at the institution. (Detail) [Moved from IV.B.1.a)]
1362
1363 IV.D.3.b) Each fellow must design and conduct a scholarly project in his or
1364 her subspecialty under the guidance of the fellowship program
1365 director and a designated mentor. (Core) [Moved from IV.B.2.a)]
1366
1367 IV.D.3.c) The program must provide a scholarship oversight committee for
1368 each fellow to oversee and evaluate his or her their progress as
1369 related to the scholarly activity project. (Core) [Moved from IV.B.2.b)]
1370
1371 IV.D.3.c).(1) Where applicable, the process of establishing fellow
1372 scholarship oversight committees should be a collaborative
1373 effort involving other pediatric subspecialty programs or
1374 other experts at the institution. (Detail) [Moved from
1375 IV.B.2.b).(1)]
1376
1377 IV.D.3.d) The scholarly experience must begin in the first year and continue
1378 for the entire period of training throughout the duration of the
1379 educational program. (Core) [Moved from IV.B.2.c)]
1380

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1381 IV.D.3.d).(1) Fellows must have a minimum of 12 months dedicated to
1382 research and scholarly activity, including ~~There must be~~
1383 ~~adequate time for each fellow to allow for~~ the development
1384 of requisite skills, project completion, and presentation of
1385 results to the scholarship oversight committee. (Core)
1386 [Moved from IV.B.2.c).(1)]
1387
1388 **V. Evaluation**
1389
1390 **V.A. Fellow Evaluation**
1391
1392 **V.A.1. Feedback and Evaluation**
1393

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.

1394
1395 **V.A.1.a) Faculty members must directly observe, evaluate, and**
1396 **frequently provide feedback on fellow performance during**
1397 **each rotation or similar educational assignment. (Core)**
1398

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.

1399
1400 **V.A.1.b)** **Evaluation must be documented at the completion of the**
1401 **assignment.** (Core)
1402
1403 **V.A.1.b).(1)** **For block rotations of greater than three months in**
1404 **duration, evaluation must be documented at least**
1405 **every three months.** (Core)
1406
1407 **V.A.1.b).(2)** **Longitudinal experiences such as continuity clinic in**
1408 **the context of other clinical responsibilities must be**
1409 **evaluated at least every three months and at**
1410 **completion.** (Core)
1411
1412 **V.A.1.c)** **The program must provide an objective performance**
1413 **evaluation based on the Competencies and the subspecialty-**
1414 **specific Milestones, and must:** (Core)
1415
1416 **V.A.1.c).(1)** **use multiple evaluators (e.g., faculty members, peers,**
1417 **patients, self, and other professional staff members);**
1418 **and,** (Core)
1419
1420 **V.A.1.c).(2)** **provide that information to the Clinical Competency**
1421 **Committee for its synthesis of progressive fellow**
1422 **performance and improvement toward unsupervised**
1423 **practice.** (Core)
1424

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.

1425
1426 **V.A.1.d)** **The program director or their designee, with input from the**
1427 **Clinical Competency Committee, must:**
1428
1429 **V.A.1.d).(1)** **meet with and review with each fellow their**
1430 **documented semi-annual evaluation of performance,**
1431 **including progress along the subspecialty-specific**
1432 **Milestones.** (Core)
1433
1434 **V.A.1.d).(2)** **assist fellows in developing individualized learning**
1435 **plans to capitalize on their strengths and identify areas**
1436 **for growth; and,** (Core)
1437

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1438 **V.A.1.d).(3)** **develop plans for fellows failing to progress, following**
1439 **institutional policies and procedures.** (Core)
1440

> **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.**

1441
1442 **V.A.1.e)** **At least annually, there must be a summative evaluation of**
1443 **each fellow that includes their readiness to progress to the**
1444 **next year of the program, if applicable.** (Core)
1445
1446 **V.A.1.f)** **The evaluations of a fellow's performance must be accessible**
1447 **for review by the fellow.** (Core)
1448
1449 **V.A.2.** **Final Evaluation**
1450
1451 **V.A.2.a)** **The program director must provide a final evaluation for each**
1452 **fellow upon completion of the program.** (Core)
1453
1454 **V.A.2.a).(1)** **The subspecialty-specific Milestones, and when**
1455 **applicable the subspecialty-specific Case Logs, must**
1456 **be used as tools to ensure fellows are able to engage**
1457 **in autonomous practice upon completion of the**
1458 **program.** (Core)
1459
1460 **V.A.2.a).(2)** **The final evaluation must:**
1461
1462 **V.A.2.a).(2).(a)** **become part of the fellow's permanent record**
1463 **maintained by the institution, and must be**
1464 **accessible for review by the fellow in**
1465 **accordance with institutional policy;** (Core)
1466
1467 **V.A.2.a).(2).(b)** **verify that the fellow has demonstrated the**
1468 **knowledge, skills, and behaviors necessary to**
1469 **enter autonomous practice;** (Core)
1470

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1471 **V.A.2.a).(2).(c)** **consider recommendations from the Clinical Competency Committee; and, (Core)**
1472
1473
1474 **V.A.2.a).(2).(d)** **be shared with the fellow upon completion of the program. (Core)**
1475
1476
1477 **V.A.3.** **A Clinical Competency Committee must be appointed by the program director. (Core)**
1478
1479
1480 **V.A.3.a)** **At a minimum the Clinical Competency Committee must include three members, at least one of whom is a core faculty member. Members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's fellows. (Core)**
1481
1482
1483
1484
1485
1486
1487 **V.A.3.b)** **The Clinical Competency Committee must:**
1488
1489 **V.A.3.b).(1)** **review all fellow evaluations at least semi-annually; (Core)**
1490
1491
1492 **V.A.3.b).(2)** **determine each fellow's progress on achievement of the subspecialty-specific Milestones; and, (Core)**
1493
1494
1495 **V.A.3.b).(3)** **meet prior to the fellows' semi-annual evaluations and advise the program director regarding each fellow's progress. (Core)**
1496
1497
1498
1499 **V.B.** **Faculty Evaluation**
1500
1501 **V.B.1.** **The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)**
1502
1503
1504

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.

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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.

1505
1506 **V.B.1.a) This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities. (Core)**
1511
1512 **V.B.1.b) This evaluation must include written, confidential evaluations by the fellows. (Core)**
1514
1515 **V.B.2. Faculty members must receive feedback on their evaluations at least annually. (Core)**
1517
1518 V.B.2.a) ~~Faculty members must receive feedback from these evaluations. (Core)~~ [Moved from V.B.4.]
1520
1521 **V.B.3. Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)**
1523

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.

1524
1525 **V.C. Program Evaluation and Improvement**
1526
1527 **V.C.1. The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)**
1531
1532 **V.C.1.a) The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one fellow. (Core)**
1535
1536 **V.C.1.b) Program Evaluation Committee responsibilities must include:**
1537
1538 **V.C.1.b).(1) acting as an advisor to the program director, through program oversight; (Core)**
1540
1541 **V.C.1.b).(2) review of the program's self-determined goals and progress toward meeting them; (Core)**
1543
1544 **V.C.1.b).(3) guiding ongoing program improvement, including development of new goals, based upon outcomes; and, (Core)**
1547

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1548 **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)**
1549
1550
1551

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.

1552
1553 **V.C.1.c)** **The Program Evaluation Committee should consider the following elements in its assessment of the program:**
1554
1555
1556 **V.C.1.c).(1)** **curriculum;** **(Core)**
1557
1558 **V.C.1.c).(2)** **outcomes from prior Annual Program Evaluation(s);** **(Core)**
1559
1560
1561 **V.C.1.c).(3)** **ACGME letters of notification, including citations, Areas for Improvement, and comments;** **(Core)**
1562
1563
1564 **V.C.1.c).(4)** **quality and safety of patient care;** **(Core)**
1565
1566 **V.C.1.c).(5)** **aggregate fellow and faculty:**
1567
1568 **V.C.1.c).(5).(a)** **well-being;** **(Core)**
1569
1570 **V.C.1.c).(5).(b)** **recruitment and retention;** **(Core)**
1571
1572 **V.C.1.c).(5).(c)** **workforce diversity;** **(Core)**
1573
1574 **V.C.1.c).(5).(d)** **engagement in quality improvement and patient safety;** **(Core)**
1575
1576
1577 **V.C.1.c).(5).(e)** **scholarly activity;** **(Core)**
1578
1579 **V.C.1.c).(5).(f)** **ACGME Resident/Fellow and Faculty Surveys (where applicable); and,** **(Core)**
1580
1581
1582 **V.C.1.c).(5).(g)** **written evaluations of the program.** **(Core)**
1583
1584 **V.C.1.c).(6)** **aggregate fellow:**
1585
1586 **V.C.1.c).(6).(a)** **achievement of the Milestones;** **(Core)**
1587
1588 **V.C.1.c).(6).(b)** **in-training examinations (where applicable);** **(Core)**
1589
1590
1591 **V.C.1.c).(6).(c)** **board pass and certification rates; and,** **(Core)**
1592

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1593 **V.C.1.c).(6).(d)** **graduate performance.** (Core)
1594
1595 **V.C.1.c).(7)** **aggregate faculty:**
1596
1597 **V.C.1.c).(7).(a)** **evaluation; and,** (Core)
1598
1599 **V.C.1.c).(7).(b)** **professional development** (Core)
1600
1601 **V.C.1.d)** **The Program Evaluation Committee must evaluate the**
1602 **program's mission and aims, strengths, areas for**
1603 **improvement, and threats.** (Core)
1604
1605 **V.C.1.e)** **The annual review, including the action plan, must:**
1606
1607 **V.C.1.e).(1)** **be distributed to and discussed with the members of**
1608 **the teaching faculty and the fellows; and,** (Core)
1609
1610 **V.C.1.e).(2)** **be submitted to the DIO.** (Core)
1611
1612 **V.C.2.** **The program must participate in a Self-Study prior to its 10-Year**
1613 **Accreditation Site Visit.** (Core)
1614
1615 **V.C.2.a)** **A summary of the Self-Study must be submitted to the DIO.**
1616 (Core)
1617

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.

1618
1619 **V.C.3.** ***One goal of ACGME-accredited education is to educate physicians***
1620 ***who seek and achieve board certification. One measure of the***
1621 ***effectiveness of the educational program is the ultimate pass rate.***
1622
1623 ***The program director should encourage all eligible program***
1624 ***graduates to take the certifying examination offered by the***
1625 ***applicable American Board of Medical Specialties (ABMS) member***
1626 ***board or American Osteopathic Association (AOA) certifying board.***
1627
1628 **V.C.3.a)** **For subspecialties in which the ABMS member board and/or**
1629 **AOA certifying board offer(s) an annual written exam, in the**
1630 **preceding three years, the program's aggregate pass rate of**
1631 **those taking the examination for the first time must be higher**

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than the bottom fifth percentile of programs in that subspecialty. (Outcome)

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)

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)

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)

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)

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.

V.C.3.e).(1) ~~At least 75 percent of the program's graduates from the preceding six years who take the certifying examination for the first time must pass. (Outcome)~~ [Moved from V.C.4.]

V.C.3.e).(2) ~~The same evaluation mechanisms used in the related core pediatrics residency program should be adapted for and implemented in all of the pediatric subspecialty programs that function with it. (Detail)~~ [Moved from V.C.5.]

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1672 **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)**
1673
1674
1675

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 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.

1676
1677 **VI. The Learning and Working Environment**
1678
1679 ***Fellowship education must occur in the context of a learning and working***
1680 ***environment that emphasizes the following principles:***
1681

- 1682 ***Excellence in the safety and quality of care rendered to patients by fellows*** 1683 ***today***
1684
- 1685 ***Excellence in the safety and quality of care rendered to patients by today's*** 1686 ***fellows in their future practice***
1687
- 1688 ***Excellence in professionalism through faculty modeling of:***
1689
    - 1690 ***the effacement of self-interest in a humanistic environment that supports*** 1691 ***the professional development of physicians***
1692
    - 1693 ***the joy of curiosity, problem-solving, intellectual rigor, and discovery***
1694
- 1695 ***Commitment to the well-being of the students, residents, fellows, faculty*** 1696 ***members, and all members of the health care team***
1697

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 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.

1698
1699 **VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability**
1700
1701 **VI.A.1. Patient Safety and Quality Improvement**
1702
1703–1711 ***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.***
1712
1713–1717 ***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.***
1718
1719–1721 ***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.***
1722
1723 **VI.A.1.a) Patient Safety**
1724
1725 **VI.A.1.a).(1) Culture of Safety**
1726
1727–1732 ***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.***
1733
1734–1735 **VI.A.1.a).(1).(a) The program, its faculty, residents, and fellows must actively participate in patient safety**

1736 **systems and contribute to a culture of safety.**
1737 **(Core)**
1738
1739 **VI.A.1.a).(1).(b)** **The program must have a structure that**
1740 **promotes safe, interprofessional, team-based**
1741 **care. (Core)**
1742
1743 **VI.A.1.a).(2)** **Education on Patient Safety**
1744
1745 **Programs must provide formal educational activities**
1746 **that promote patient safety-related goals, tools, and**
1747 **techniques. (Core)**
1748

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

1749
1750 **VI.A.1.a).(3)** **Patient Safety Events**
1751
1752 ***Reporting, investigation, and follow-up of adverse***
1753 ***events, near misses, and unsafe conditions are pivotal***
1754 ***mechanisms for improving patient safety, and are***
1755 ***essential for the success of any patient safety***
1756 ***program. Feedback and experiential learning are***
1757 ***essential to developing true competence in the ability***
1758 ***to identify causes and institute sustainable systems-***
1759 ***based changes to ameliorate patient safety***
1760 ***vulnerabilities.***
1761
1762 **VI.A.1.a).(3).(a)** **Residents, fellows, faculty members, and other**
1763 **clinical staff members must:**
1764
1765 **VI.A.1.a).(3).(a).(i)** **know their responsibilities in reporting**
1766 **patient safety events at the clinical site;**
1767 **(Core)**
1768
1769 **VI.A.1.a).(3).(a).(ii)** **know how to report patient safety**
1770 **events, including near misses, at the**
1771 **clinical site; and, (Core)**
1772
1773 **VI.A.1.a).(3).(a).(iii)** **be provided with summary information**
1774 **of their institution's patient safety**
1775 **reports. (Core)**
1776
1777 **VI.A.1.a).(3).(b)** **Fellows must participate as team members in**
1778 **real and/or simulated interprofessional clinical**
1779 **patient safety activities, such as root cause**
1780 **analyses or other activities that include**
1781 **analysis, as well as formulation and**
1782 **implementation of actions. (Core)**
1783

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1784 **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)

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1834 **VI.A.1.b).(3).(a).(i)** **This should include activities aimed at**
1835 **reducing health care disparities.** (Detail)
1836
1837 **VI.A.2.** **Supervision and Accountability**
1838
1839 **VI.A.2.a)** ***Although the attending physician is ultimately responsible for***
1840 ***the care of the patient, every physician shares in the***
1841 ***responsibility and accountability for their efforts in the***
1842 ***provision of care. Effective programs, in partnership with***
1843 ***their Sponsoring Institutions, define, widely communicate,***
1844 ***and monitor a structured chain of responsibility and***
1845 ***accountability as it relates to the supervision of all patient***
1846 ***care.***
1847
1848 ***Supervision in the setting of graduate medical education***
1849 ***provides safe and effective care to patients; ensures each***
1850 ***fellow's development of the skills, knowledge, and attitudes***
1851 ***required to enter the unsupervised practice of medicine; and***
1852 ***establishes a foundation for continued professional growth.***
1853
1854 **VI.A.2.a).(1)** **Each patient must have an identifiable and**
1855 **appropriately-credentialed and privileged attending**
1856 **physician (or licensed independent practitioner as**
1857 **specified by the applicable Review Committee) who is**
1858 **responsible and accountable for the patient's care.**
1859 (Core)
1860

Specialty Background and Intent: Licensed independent professionals may include, but are not limited to: nurse practitioners, physician assistants, psychologists, physical and occupational therapists, speech and language therapists, dieticians, counselors, and audiologists, as appropriate.

1861
1862 **VI.A.2.a).(1).(a)** **This information must be available to fellows,**
1863 **faculty members, other members of the health**
1864 **care team, and patients.** (Core)
1865
1866 **VI.A.2.a).(1).(b)** **Fellows and faculty members must inform each**
1867 **patient of their respective roles in that patient's**
1868 **care when providing direct patient care.** (Core)
1869
1870 **VI.A.2.b)** ***Supervision may be exercised through a variety of methods.***
1871 ***For many aspects of patient care, the supervising physician***
1872 ***may be a more advanced fellow. Other portions of care***
1873 ***provided by the fellow can be adequately supervised by the***
1874 ***immediate availability of the supervising faculty member or***
1875 ***fellow, either on site or by means of telephonic and/or***
1876 ***electronic modalities. Some activities require the physical***
1877 ***presence of the supervising faculty member. In some***
1878 ***circumstances, supervision may include post-hoc review of***
1879 ***fellow-delivered care with feedback.***
1880

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1881 **VI.A.2.b).(1)** **The program must demonstrate that the appropriate level of supervision in place for all fellows is based on each fellow's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation.** **(Core)**

1888 **VI.A.2.c)** **Levels of Supervision**

1890 **To promote oversight of fellow supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:** **(Core)**

1894 **VI.A.2.c).(1)** **Direct Supervision – the supervising physician is physically present with the fellow and patient.** **(Core)**

1897 **VI.A.2.c).(2)** **Indirect Supervision:**

1899 **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)**

1905 **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)**

1912 **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)**

1916 **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)**

1921 **VI.A.2.d).(1)** **The program director must evaluate each fellow's abilities based on specific criteria, guided by the Milestones.** **(Core)**

1925 **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)**

1930 **VI.A.2.d).(3)** **Fellows should serve in a supervisory role to junior fellows and residents in recognition of their progress**

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1932 **toward independence, based on the needs of each**
1933 **patient and the skills of the individual resident or**
1934 **fellow.** (Detail)
1935
1936 **VI.A.2.e)** **Programs must set guidelines for circumstances and events**
1937 **in which fellows must communicate with the supervising**
1938 **faculty member(s).** (Core)
1939
1940 **VI.A.2.e).(1)** **Each fellow must know the limits of their scope of**
1941 **authority, and the circumstances under which the**
1942 **fellow is permitted to act with conditional**
1943 **independence.** (Outcome)
1944

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

1945
1946 **VI.A.2.f)** **Faculty supervision assignments must be of sufficient**
1947 **duration to assess the knowledge and skills of each fellow**
1948 **and to delegate to the fellow the appropriate level of patient**
1949 **care authority and responsibility.** (Core)
1950
1951 **VI.B.** **Professionalism**
1952
1953 **VI.B.1.** **Programs, in partnership with their Sponsoring Institutions, must**
1954 **educate fellows and faculty members concerning the professional**
1955 **responsibilities of physicians, including their obligation to be**
1956 **appropriately rested and fit to provide the care required by their**
1957 **patients.** (Core)
1958
1959 **VI.B.2.** **The learning objectives of the program must:**
1960
1961 **VI.B.2.a)** **be accomplished through an appropriate blend of supervised**
1962 **patient care responsibilities, clinical teaching, and didactic**
1963 **educational events;** (Core)
1964
1965 **VI.B.2.b)** **be accomplished without excessive reliance on fellows to**
1966 **fulfill non-physician obligations; and,** (Core)
1967

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.

1968

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1969 **VI.B.2.c)** **ensure manageable patient care responsibilities.** **(Core)**
1970

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.

1971
1972 **VI.B.3.** **The program director, in partnership with the Sponsoring Institution,**
1973 **must provide a culture of professionalism that supports patient**
1974 **safety and personal responsibility.** **(Core)**
1975
1976 **VI.B.4.** **Fellows and faculty members must demonstrate an understanding**
1977 **of their personal role in the:**
1978
1979 **VI.B.4.a)** **provision of patient- and family-centered care;** **(Outcome)**
1980
1981 **VI.B.4.b)** **safety and welfare of patients entrusted to their care,**
1982 **including the ability to report unsafe conditions and adverse**
1983 **events;** **(Outcome)**
1984

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.

1985
1986 **VI.B.4.c)** **assurance of their fitness for work, including:** **(Outcome)**
1987

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.

1988
1989 **VI.B.4.c).(1)** **management of their time before, during, and after**
1990 **clinical assignments; and,** **(Outcome)**
1991
1992 **VI.B.4.c).(2)** **recognition of impairment, including from illness,**
1993 **fatigue, and substance use, in themselves, their peers,**
1994 **and other members of the health care team.** **(Outcome)**
1995
1996 **VI.B.4.d)** **commitment to lifelong learning;** **(Outcome)**
1997
1998 **VI.B.4.e)** **monitoring of their patient care performance improvement**
1999 **indicators; and,** **(Outcome)**
2000
2001 **VI.B.4.f)** **accurate reporting of clinical and educational work hours,**
2002 **patient outcomes, and clinical experience data.** **(Outcome)**

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2003
2004 **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)**
2009
2010 **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 harassment, mistreatment, abuse, or coercion of students, fellows, faculty, and staff.** **(Core)**
2015
2016 **VI.B.7.** **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)**
2020
2021 **VI.C.** **Well-Being**
2022
2023 ***Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of fellowship training.***
2031
2032 ***Fellows and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. For example, a culture which encourages covering for colleagues after an illness without the expectation of reciprocity reflects the ideal of professionalism. A positive culture in a clinical learning environment models constructive behaviors, and prepares fellows with the skills and attitudes needed to thrive throughout their careers.***
2042

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

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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.

2043
2044 **VI.C.1.** **The responsibility of the program, in partnership with the**
2045 **Sponsoring Institution, to address well-being must include:**
2046
2047 **VI.C.1.a)** **efforts to enhance the meaning that each fellow finds in the**
2048 **experience of being a physician, including protecting time**
2049 **with patients, minimizing non-physician obligations,**
2050 **providing administrative support, promoting progressive**
2051 **autonomy and flexibility, and enhancing professional**
2052 **relationships;** **(Core)**
2053
2054 **VI.C.1.b)** **attention to scheduling, work intensity, and work**
2055 **compression that impacts fellow well-being;** **(Core)**
2056
2057 **VI.C.1.c)** **evaluating workplace safety data and addressing the safety of**
2058 **fellows and faculty members;** **(Core)**
2059

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.

2060
2061 **VI.C.1.d)** **policies and programs that encourage optimal fellow and**
2062 **faculty member well-being; and,** **(Core)**
2063

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.

2064
2065 **VI.C.1.d).(1)** **Fellows must be given the opportunity to attend**
2066 **medical, mental health, and dental care appointments,**
2067 **including those scheduled during their working hours.**
2068 **(Core)**
2069

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.

2070
2071 **VI.C.1.e)** **attention to fellow and faculty member burnout, depression,**
2072 **and substance abuse. The program, in partnership with its**
2073 **Sponsoring Institution, must educate faculty members and**
2074 **fellows in identification of the symptoms of burnout,**
2075 **depression, and substance abuse, including means to assist**

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2076 **those who experience these conditions. Fellows and faculty**
2077 **members must also be educated to recognize those**
2078 **symptoms in themselves and how to seek appropriate care.**
2079 **The program, in partnership with its Sponsoring Institution,**
2080 **must: (Core)**
2081

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).

2082
2083 **VI.C.1.e).(1)** **encourage fellows and faculty members to alert the**
2084 **program director or other designated personnel or**
2085 **programs when they are concerned that another**
2086 **fellow, resident, or faculty member may be displaying**
2087 **signs of burnout, depression, substance abuse,**
2088 **suicidal ideation, or potential for violence; (Core)**
2089

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.

2090
2091 **VI.C.1.e).(2)** **provide access to appropriate tools for self-screening;**
2092 **and, (Core)**
2093
2094 **VI.C.1.e).(3)** **provide access to confidential, affordable mental**
2095 **health assessment, counseling, and treatment,**
2096 **including access to urgent and emergent care 24**
2097 **hours a day, seven days a week. (Core)**
2098

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.

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

2099
2100 **VI.C.2.** **There are circumstances in which fellows may be unable to attend**
2101 **work, including but not limited to fatigue, illness, family**
2102 **emergencies, and parental leave. Each program must allow an**
2103 **appropriate length of absence for fellows unable to perform their**
2104 **patient care responsibilities.** **(Core)**
2105
2106 **VI.C.2.a)** **The program must have policies and procedures in place to**
2107 **ensure coverage of patient care.** **(Core)**
2108
2109 **VI.C.2.b)** **These policies must be implemented without fear of negative**
2110 **consequences for the fellow who is or was unable to provide**
2111 **the clinical work.** **(Core)**
2112

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.

2113
2114 **VI.D.** **Fatigue Mitigation**
2115
2116 **VI.D.1.** **Programs must:**
2117
2118 **VI.D.1.a)** **educate all faculty members and fellows to recognize the**
2119 **signs of fatigue and sleep deprivation;** **(Core)**
2120
2121 **VI.D.1.b)** **educate all faculty members and fellows in alertness**
2122 **management and fatigue mitigation processes; and,** **(Core)**
2123
2124 **VI.D.1.c)** **encourage fellows to use fatigue mitigation processes to**
2125 **manage the potential negative effects of fatigue on patient**
2126 **care and learning.** **(Detail)**
2127

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.

2128

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VI.D.2. **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. (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)

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.

VI.E.1.a) The program director must have the authority and responsibility to set and adjust the ~~appropriate~~ clinical responsibilities and ensure that fellows have appropriate clinical responsibilities and an appropriate patient load ~~(i.e., patient caps) for each fellow based on the PGY-level, patient safety, fellow education, severity and complexity of patient illness/condition, and available support services~~. (Core)

Specialty Background and Intent: Insufficient patient experiences do not meet educational needs; an excessive patient load suggests an inappropriate reliance on fellows for service obligations, which may jeopardize the educational experience.

VI.E.1.a).(1) This must include progressive clinical, technical, and consultative experiences that will enable ~~the~~ each fellow~~s~~ to develop expertise as a pediatric nephrology consultant ~~in the subspecialty~~. (Core)

VI.E.1.a).(2) Lines of responsibility for the ~~pediatric residents and the~~ fellows must be clearly defined. (Core)

VI.E.1.a).(3) ~~The program director must ensure that fellows maintain an appropriate patient load. Insufficient patient experiences do not meet educational needs; an excessive patient load suggests an inappropriate reliance on fellows for service~~

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2168 ~~obligations, which may jeopardize the educational~~
2169 ~~experience. (Core)~~
2170
2171 **VI.E.2. Teamwork**
2172
2173 **Fellows must care for patients in an environment that maximizes**
2174 **communication. This must include the opportunity to work as a**
2175 **member of effective interprofessional teams that are appropriate to**
2176 **the delivery of care in the subspecialty and larger health system.**
2177 **(Core)**
2178
2179 VI.E.2.a) ~~Interprofessional team members should participate in the~~
2180 ~~education of fellows. (Detail)~~
2181

Specialty Background and Intent: Nurses, physician assistants, advanced practice providers, pharmacists, social workers, child-life specialists, physical and occupational therapists, speech and language therapists, audiologists, respiratory therapists, psychologists, and dieticians are examples of professional personnel who may be part of the interprofessional teams.

2182
2183 **VI.E.3. Transitions of Care**
2184
2185 **VI.E.3.a) Programs must design clinical assignments to optimize**
2186 **transitions in patient care, including their safety, frequency,**
2187 **and structure. (Core)**
2188
2189 **VI.E.3.b) Programs, in partnership with their Sponsoring Institutions,**
2190 **must ensure and monitor effective, structured hand-over**
2191 **processes to facilitate both continuity of care and patient**
2192 **safety. (Core)**
2193
2194 **VI.E.3.c) Programs must ensure that fellows are competent in**
2195 **communicating with team members in the hand-over process.**
2196 **(Outcome)**
2197
2198 **VI.E.3.d) Programs and clinical sites must maintain and communicate**
2199 **schedules of attending physicians and fellows currently**
2200 **responsible for care. (Core)**
2201
2202 **VI.E.3.e) Each program must ensure continuity of patient care,**
2203 **consistent with the program's policies and procedures**
2204 **referenced in VI.C.2-VI.C.2.b), in the event that a fellow may**
2205 **be unable to perform their patient care responsibilities due to**
2206 **excessive fatigue or illness, or family emergency. (Core)**
2207
2208 **VI.F. Clinical Experience and Education**
2209
2210 ***Programs, in partnership with their Sponsoring Institutions, must design***
2211 ***an effective program structure that is configured to provide fellows with***
2212 ***educational and clinical experience opportunities, as well as reasonable***
2213 ***opportunities for rest and personal activities.***

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2214

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.

2215
2216 **VI.F.1. Maximum Hours of Clinical and Educational Work per Week**
2217
2218 **Clinical and educational work hours must be limited to no more than**
2219 **80 hours per week, averaged over a four-week period, inclusive of all**
2220 **in-house clinical and educational activities, clinical work done from**
2221 **home, and all moonlighting.** (Core)
2222

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-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

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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.

2223
2224 **VI.F.2. Mandatory Time Free of Clinical Work and Education**
2225
2226 **VI.F.2.a) The program must design an effective program structure that**
2227 **is configured to provide fellows with educational**
2228 **opportunities, as well as reasonable opportunities for rest**
2229 **and personal well-being.** (Core)
2230
2231 **VI.F.2.b) Fellows should have eight hours off between scheduled**
2232 **clinical work and education periods.** (Detail)
2233
2234 **VI.F.2.b).(1) There may be circumstances when fellows choose to**
2235 **stay to care for their patients or return to the hospital**
2236 **with fewer than eight hours free of clinical experience**
2237 **and education. This must occur within the context of**
2238 **the 80-hour and the one-day-off-in-seven**
2239 **requirements.** (Detail)
2240

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

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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.

2241
2242 **VI.F.2.c)** **Fellows must have at least 14 hours free of clinical work and**
2243 **education after 24 hours of in-house call.** (Core)
2244

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.

2245
2246 **VI.F.2.d)** **Fellows must be scheduled for a minimum of one day in**
2247 **seven free of clinical work and required education (when**
2248 **averaged over four weeks). At-home call cannot be assigned**
2249 **on these free days.** (Core)
2250

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 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."

2251
2252 **VI.F.3.** **Maximum Clinical Work and Education Period Length**
2253
2254 **VI.F.3.a)** **Clinical and educational work periods for fellows must not**
2255 **exceed 24 hours of continuous scheduled clinical**
2256 **assignments.** (Core)
2257
2258 **VI.F.3.a).(1)** **Up to four hours of additional time may be used for**
2259 **activities related to patient safety, such as providing**
2260 **effective transitions of care, and/or fellow education.**
2261 (Core)
2262
2263 **VI.F.3.a).(1).(a)** **Additional patient care responsibilities must not**
2264 **be assigned to a fellow during this time.** (Core)
2265

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

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up to an additional four hours must occur within the context of 80-hour weekly limit, averaged over four weeks.

2266
2267 **VI.F.4. Clinical and Educational Work Hour Exceptions**
2268
2269 **VI.F.4.a)** **In rare circumstances, after handing off all other**
2270 **responsibilities, a fellow, on their own initiative, may elect to**
2271 **remain or return to the clinical site in the following**
2272 **circumstances:**
2273
2274 **VI.F.4.a).(1)** **to continue to provide care to a single severely ill or**
2275 **unstable patient; (Detail)**
2276
2277 **VI.F.4.a).(2)** **humanistic attention to the needs of a patient or**
2278 **family; or, (Detail)**
2279
2280 **VI.F.4.a).(3)** **to attend unique educational events. (Detail)**
2281
2282 **VI.F.4.b)** **These additional hours of care or education will be counted**
2283 **toward the 80-hour weekly limit. (Detail)**
2284

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 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.

2285
2286 **VI.F.4.c)** **A Review Committee may grant rotation-specific exceptions**
2287 **for up to 10 percent or a maximum of 88 clinical and**
2288 **educational work hours to individual programs based on a**
2289 **sound educational rationale.**
2290
2291 The Review Committee for Pediatrics will not consider requests
2292 for exceptions to the 80-hour limit to the fellows' work week.
2293
2294 **VI.F.4.c).(1)** **In preparing a request for an exception, the program**
2295 **director must follow the clinical and educational work**
2296 **hour exception policy from the *ACGME Manual of***
2297 ***Policies and Procedures.* (Core)**
2298
2299 **VI.F.4.c).(2)** **Prior to submitting the request to the Review**
2300 **Committee, the program director must obtain approval**
2301 **from the Sponsoring Institution's GMEC and DIO. (Core)**
2302

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.

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)**

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).

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.6.a) ~~Fellows should not have more than four total weeks of night float per year, and night float should not be scheduled in consecutive weeks. (Detail)~~

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.

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)**

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2340 **VI.F.8.a).(1)** **At-home call must not be so frequent or taxing as to**
2341 **preclude rest or reasonable personal time for each**
2342 **fellow.** (Core)
2343
2344 **VI.F.8.b)** **Fellows are permitted to return to the hospital while on at-**
2345 **home call to provide direct care for new or established**
2346 **patients. These hours of inpatient patient care must be**
2347 **included in the 80-hour maximum weekly limit.** (Detail)
2348

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.

2349
2350 ***
2351
2352 ***Core Requirements:** Statements that define structure, resource, or process elements essential to every
2353 graduate medical educational program.
2354
2355 †**Detail Requirements:** Statements that describe a specific structure, resource, or process, for achieving
2356 compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance
2357 with the Outcome Requirements may utilize alternative or innovative approaches to meet Core
2358 Requirements.
2359
2360 ‡**Outcome Requirements:** Statements that specify expected measurable or observable attributes
2361 (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical
2362 education.
2363
2364 **Osteopathic Recognition**
2365 For programs with or applying for Osteopathic Recognition, the Osteopathic Recognition Requirements
2366 also apply (www.acgme.org/OsteopathicRecognition).

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