ACGME Program Requirements for Graduate Medical Education in Surgical Critical Care

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in Surgical Critical Care

One-year Common Program Requirements are in BOLD

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

Introduction

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

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

Int.B. Definition and Scope of the Subspecialty

Int.B.1. Surgical critical care is a subspecialty of surgery that manages complex surgical and medical problems in critically-ill surgical patients. Graduate educational programs in surgical critical care provide the educational, clinical, and administrative resources to allow fellows to develop advanced proficiency in the management of critically-ill surgical patients, to develop the qualifications necessary to supervise surgical critical care units, and to conduct scholarly activities in surgical critical care. The educational programs enhance and are an integral part of an Accreditation Council for Graduate Medical Education (ACGME)-accredited core program in surgery.

Int.B.2. The goal of a surgical critical care fellowship program is to prepare the fellow to function as a qualified practitioner at the advanced level of
performance expected of a Board-certified subspecialist. The education of surgeons in the practice of surgical critical care encompasses didactic instruction in the basic and clinical sciences of surgical diseases and conditions, as well as education in procedural skills and techniques used in the intensive care settings. This educational process leads to the acquisition of an appropriate fund of knowledge and technical skills, the ability to integrate the acquired knowledge into the clinical situation, and the development of judgment.

Int.C. The educational program in surgical critical care must be 12 months in length. *(Core)*

I. Institutions

I.A. Sponsoring Institution

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

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

I.A.1. The sponsoring institution must provide the program director with a minimum of 10% protected time or direct salary support or indirect salary support, such as release from clinical activities. *(Core)*

I.A.2. Sponsorship of the program must be in compliance with the policy detailed in section 15.00 of the ACGME Manual of Policies and Procedures. *(Core)*

I.A.3. The sponsoring institution must also sponsor an ACGME-accredited residency program in pediatric surgery, surgery, thoracic surgery, or vascular surgery. *(Core)*

I.A.3.a) There must be interaction between the core residency program in pediatric surgery, surgery, thoracic surgery, or vascular surgery and the fellowship program which results in coordination of educational, clinical, and investigative activities. *(Detail)*

I.A.4. Any institution that sponsors more than one critical care program must coordinate interdisciplinary requirements to ensure that fellows meet the specific criteria of their primary specialties. *(Detail)*

I.A.5. It is strongly suggested that the sponsoring institution also sponsor ACGME-accredited residency programs in those specialties that relate particularly to surgery, such as anesthesiology, diagnostic radiology, internal medicine, and pathology. *(Detail)*

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

The PLA should:

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

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

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

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

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

I.B.2.a) Clinical assignments to participating sites must be approved prior to fellows' rotating to the sites, and must not be more than three months in length.  

II. Program Personnel and Resources

II.A. Program Director

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

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

II.A.1.b) The length of the program director’s appointment must be at least two years.  

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

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

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

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

II.A.2.c).(1) This must include unrestricted credentials at the primary clinical site. (Core)

II.A.2.c).(2) The program director should possess licensure to practice medicine in the state where the primary clinical site is located. (Core)

II.A.2.d) faculty appointment in good standing at the primary clinical site. (Detail)

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

The program director must:

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

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

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

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

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

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

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

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

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

II.A.3.c).(7) requests for appeal of an adverse action; and, (Detail)
II.A.3.c).(8) appeal presentations to a Board of Appeal or the ACGME. (Detail)

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

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

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

II.A.3.e) maintain a collegial relationship with faculty members to enhance the educational opportunities for all fellows; and, (Detail)

II.A.3.f) direct or co-direct one or more of the critical care units in which the clinical aspects of the educational program take place, and personally supervise and teach surgery and surgical critical care fellows in that unit. (Core)

II.B. Faculty

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

II.B.1.a) In addition to the program director, at least one surgeon certified in surgical critical care must be appointed to the faculty for every critical care fellow enrolled in the program. (Core)

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

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

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

II.B.5. Non-surgical physician faculty members must be certified in critical care in their specialty area or possess alternative qualifications judged to be acceptable by the Review Committee. (Core)

II.B.6. Faculty members must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. (Core)

II.B.7. Faculty members must establish and maintain an environment of inquiry and scholarship with an active research component. (Core)
II.B.7.a) The program director and some members of the faculty should also demonstrate scholarship by one or more of the following: (Core)

II.B.7.a).(1) peer-reviewed funding; (Detail)

II.B.7.a).(2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks; (Detail)

II.B.7.a).(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or, (Detail)

II.B.7.a).(4) participation in national committees or educational organizations. (Detail)

II.C. Other Program Personnel

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

II.C.1. Staff members must include specially-trained nurses and technicians skilled in critical care instrumentation, respiratory function, and laboratory medicine. (Core)

II.D. Resources

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

II.D.1. Resources should include a simulation and skills laboratory. (Detail)

II.D.2. Resources must include:

II.D.2.a) a critical care unit located in a designated area within the institution, constructed and designed specifically for the care of critically-ill patients; (Core)

II.D.2.b) a common office space for fellows that includes a sufficient number of computers and adequate workspace at the primary clinical site; (Core)

II.D.2.c) online radiographic and laboratory systems at the primary clinical site and participating sites; (Core)

II.D.2.d) software resources for production of presentations, manuscripts, and portfolios; (Detail)

II.D.2.e) an average daily census of at least 10 patients in each intensive
care unit to which a fellow is assigned; and, (Detail)

II.D.2.f) an average daily census for each critical care unit to which fellows are assigned that ensures a fellow-to-patient ratio of 1:10. (Core)

II.D.3. The education must take place in care settings for critically-ill adult and/or pediatric surgical patients. (Core)

II.E. Medical Information Access

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

II.E.1. Fellows must have Internet access to full-text journals and electronic medical reference resources for education and patient care at all participating sites. (Detail)

III. Fellow Appointments

III.A. Eligibility Requirements – Fellowship Programs

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

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

III.A.2. Fellow Eligibility Exception

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

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

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

III.A.2.b) Review and approval of the applicant’s exceptional qualifications by the GMEC or a subcommittee of the GMEC; and (Core)
III.A.2.c) Satisfactory completion of the United States Medical Licensing Examination (USMLE) Steps 1, 2, and, if the applicant is eligible, 3, and; (Core)

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

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

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

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

III.A.2.f) The Review Committee for Surgery does not allow exceptions to the Eligibility Requirements for Fellowship Programs in Section III.A. (Core)

III.A.3. Prior to appointment in the program, fellows must have completed at least three clinical years in an ACGME-accredited graduate medical education program in one of the following specialties: anesthesiology, emergency medicine, neurological surgery, obstetrics and gynecology, orthopaedic surgery, otolaryngology, plastic surgery, surgery, thoracic surgery, vascular surgery, or urology, or have completed a general surgery residency accredited by the RCPSC. (Core)

III.A.3.a) Fellows who have completed an emergency medicine residency
must also complete one preparatory year as an advanced preliminary resident in surgery at the institution where they will enroll in the surgical critical care fellowship. The content of this year should be defined jointly by the program directors of the surgery program and the surgical critical care program. It must include clinical experience in the foundations of surgery and the management of complex surgical conditions. At a minimum, this preparatory year of education must include supervised clinical experience in: (Core)

III.A.3.a).(1) pre-operative evaluation, including respiratory, cardiovascular, and nutritional evaluation; (Core)
III.A.3.a).(2) pre-operative and post-operative care of surgical patients, including outpatient follow-up care; (Core)
III.A.3.a).(3) advanced care of injured patients; (Core)
III.A.3.a).(4) care of patients requiring abdominal, breast, head and neck, endocrine, transplant, cardiac, thoracic, vascular, and neurosurgical operations; (Core)
III.A.3.a).(5) management of complex wounds; and, (Core)
III.A.3.a).(6) minor operative procedures related to critical care, such as venous access, tube thoracostomy, and tracheostomy. (Core)

III.B. Number of Fellows

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

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

III.C. The presence of other learners, including residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners, in the program must not interfere with the appointed fellows’ education. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines. (Core)

IV. Educational Program

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

IV.A.1. Skills and competencies the fellow will be able to demonstrate at the conclusion of the program. The program must distribute these skills and competencies to fellows and faculty at least annually, in either written or electronic form. (Core)
IV.A.2. ACGME Competencies

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

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

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

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

IV.A.2.a).(2).(a) must have supervised training that will enable them to demonstrate competence in the following critical care skills: (Outcome)

IV.A.2.a).(2).(a).(i) circulatory: performance of invasive and noninvasive monitoring techniques, and the use of vasoactive agents and management of hypotension and shock; application of trans-esophageal and transthoracic cardiac ultrasound and transvenous pacemakers, dysrhythmia diagnosis and treatment, and the management of cardiac assist devices; (Outcome)

IV.A.2.a).(2).(a).(ii) endocrine: performance of the diagnosis and management of acute endocrine disorders, including those of the pancreas, thyroid, adrenals, and pituitary; (Outcome)

IV.A.2.a).(2).(a).(iii) gastrointestinal: performance of utilization of gastrointestinal intubation and endoscopic techniques in the management of the critically-ill patient; and management of stomas, fistulas, and percutaneous catheter devices; (Outcome)

IV.A.2.a).(2).(a).(iv) hematologic: performance of assessment of coagulation status, and appropriate use of component therapy; (Outcome)

IV.A.2.a).(2).(a).(v) infectious disease: performance of classification of infections and application of isolation techniques, pharmacokinetics,
drug interactions, and management of antibiotic therapy during organ failure; nosocomial infections; and management of sepsis and septic shock; (Outcome)

IV.A.2.a).(2).(a).(vi) monitoring/bioengineering: performance of the use and calibration of transducers and other medical devices; (Outcome)

IV.A.2.a).(2).(a).(vii) neurological: performance of management of intracranial pressure and acute neurologic emergencies, including application of the use of intracranial pressure monitoring techniques and electroencephalography to evaluate cerebral function; (Outcome)

IV.A.2.a).(2).(a).(viii) nutritional: performance of the use of parenteral and enteral nutrition, and monitoring and assessing metabolism and nutrition; (Outcome)

IV.A.2.a).(2).(a).(ix) renal: performance of the evaluation of renal function; use of renal replacement therapies; management of hemodialysis, and management of electrolyte disorders and acid-base disturbances; and application of knowledge of the indications for and complications of hemodialysis; and, (Outcome)

IV.A.2.a).(2).(a).(x) respiratory: performance of airway management, including techniques of intubation, endoscopy, and tracheostomy, as well as ventilator management. (Outcome)

IV.A.2.a).(2).(b) must demonstrate competence in the application of the following critical care skills: (Outcome)

IV.A.2.a).(2).(b).(i) circulatory: transvenous pacemakers; dysrhythmia diagnosis and treatment, and the management of cardiac assist devices; and use of vasoactive agents and the management of hypotension and shock; (Outcome)

IV.A.2.a).(2).(b).(ii) neurological: the use of intracranial pressure monitoring techniques and electroencephalography to evaluate cerebral function; (Outcome)

IV.A.2.a).(2).(b).(iii) renal: knowledge of the indications for and
complications of hemodialysis, and management of electrolyte disorders and acid-base disturbances; and, (Outcome)

IV.A.2.a).(2).(b).(iv) miscellaneous: performance of the use of special beds for specific injuries, and employment of skeletal traction and fixation devices. (Outcome)

IV.A.2.a).(2).(c) must demonstrate competence in the evaluation and management of patients with end-of-life issues, and in palliative care. (Outcome)

IV.A.2.b) Medical Knowledge

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

IV.A.2.b).(1) must demonstrate advanced knowledge of the following aspects of critical care, particularly as they relate to the management of patients with hemodynamic instability, multiple system organ failure, and complex coexisting medical problems: (Outcome)

IV.A.2.b).(1).(a) biostatistics and experimental design; (Outcome)

IV.A.2.b).(1).(b) cardiopulmonary resuscitation; (Outcome)

IV.A.2.b).(1).(c) critical obstetric and gynecologic disorders; (Outcome)

IV.A.2.b).(1).(d) critical pediatric surgical conditions; (Outcome)

IV.A.2.b).(1).(e) ethical and legal aspects of surgical critical care; (Outcome)

IV.A.2.b).(1).(f) hematologic and coagulation disorders; (Outcome)

IV.A.2.b).(1).(g) inhalation and immersion injuries; (Outcome)

IV.A.2.b).(1).(h) metabolic, nutritional, and endocrine effects of critical illness; (Outcome)

IV.A.2.b).(1).(i) monitoring and medical instrumentation; (Outcome)

IV.A.2.b).(1).(j) pharmacokinetics and dynamics of drug metabolism and excretion in critical illness; (Outcome)

IV.A.2.b).(1).(k) physiology, pathophysiology, diagnosis, and therapy of disorders of the cardiovascular,
respiratory, gastrointestinal, genitourinary, neurological, endocrine, musculoskeletal, and immune systems, as well as of infectious diseases; (Outcome)

IV.A.2.b).(1).(l) principles and techniques of administration and management; and, (Outcome)

IV.A.2.b).(1).(m) trauma, thermal, electrical, and radiation injuries. (Outcome)

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

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

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

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

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

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

IV.A.2.d).(1) Fellows must demonstrate effective skills in teaching the specialty of surgical critical care. (Outcome)

IV.A.2.e) Professionalism

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

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

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

IV.A.2.f).(1) Fellows must be able to administer a surgical critical care unit and appoint, educate, and supervise specialized personnel; establish policy and procedures for the unit; and coordinate the activities of the unit with other
administrative units within the hospital. (Outcome)

IV.A.3. Curriculum Organization and Fellow Experiences

IV.A.3.a) All 12 months must be devoted to advanced educational and clinical activities related to the care of critically-ill patients and to the administration of critical care units. (Core)

IV.A.3.a).(1) At least eight months must be in a surgical intensive care unit. (Core)

IV.A.3.a).(1).(a) At least five of the eight months should be in a unit in which a surgeon is director or co-director. (Detail)

IV.A.3.a).(1).(b) The surgical intensive care unit must be largely dedicated to the care of one or more of the following surgical patients: adult surgical, burn, cardiothoracic, neurosurgical, pediatric surgical, transplant, and trauma. (Detail)

IV.A.3.a).(2) No more than two months should be in non-surgical intensive care units, such as medical, cardiac, or pediatric units. (Core)

IV.A.3.a).(3) No more than two months should be in elective rotations in areas relevant to critical care, such as trauma or acute care surgery. (Core)

IV.A.3.a).(3).(a) Elective clinical rotations done outside of the critical care unit should involve the care of patients with acute surgical diseases such as those related to injury or emergent surgical conditions. (Detail)

IV.A.3.b) The core curriculum must include a regularly-scheduled didactic program based on the core knowledge content and areas defined as a fellow’s outcomes in the specialty. (Core)

IV.A.3.c) Participation in direct operative care of critically-ill patients in the operating room during critical care rotations should not be so great as to interfere with the primary educational purpose of the critical care rotation. (Core)

IV.A.3.d) Fellows must keep two written records of their experience: a summary record documenting the numbers and types of critical care patients; and an operative log of numbers and types of operative experiences, including bedside procedures. (Core)

IV.A.3.e) A chief resident in surgery and a fellow in surgical critical care must not have primary responsibility for the same patient. (Core)

V. Evaluation
V.A. Fellow Evaluation

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

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

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

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

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

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

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

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

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

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

V.A.2. Formative Evaluation

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

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

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

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

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

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

V.A.2.d) Semiannual assessment must include a review of case volume, breadth, and complexity, and must ensure that fellows are maintaining the required written records. (Core)

V.A.3. Summative Evaluation

V.A.3.a) The specialty-specific Milestones must be used as one of the tools to ensure fellows are able to practice core professional activities without supervision upon completion of the program. (Core)

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

This evaluation must:

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

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

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

V.B. Faculty Evaluation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

V.C.4. 65% of a program’s graduates from the preceding five years taking the American Board of Surgery certifying examination for surgical critical care
VI. The Learning and Working Environment

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

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

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

VI.A.1. Patient Safety and Quality Improvement

*All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Graduate medical education must prepare fellows to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by fellows who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.*

*Fellows must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating fellows will apply these skills to critique their future unsupervised practice and effect quality improvement measures.*

*It is necessary for fellows and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.*

VI.A.1.a) Patient Safety

VI.A.1.a).(1) Culture of Safety
A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.

VI.A.1.a).(1).(a) The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)

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

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

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

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

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

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

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

VI.A.1.a).(3).(a).(ii) know how to report patient safety events, including near misses, at the clinical site; and, (Core)

VI.A.1.a).(3).(a).(iii) be provided with summary information of their institution’s patient safety reports. (Core)
VI.A.1.a).(3).(b) Fellows must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. *(Core)*

VI.A.1.a).(4) Fellow Education and Experience in Disclosure of Adverse Events

*Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for fellows to develop and apply.*

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

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

VI.A.1.b) Quality Improvement

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

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

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

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

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

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

VI.A.1.b).(3) Engagement in Quality Improvement Activities
Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.

VI.A.1.b).(3).(a)

Fellows must have the opportunity to participate in interprofessional quality improvement activities. (Core)

VI.A.1.b).(3).(a).(i)

This should include activities aimed at reducing health care disparities. (Detail)

VI.A.2. Supervision and Accountability

VI.A.2.a) Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.

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

VI.A.2.a).(1)

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

VI.A.2.a).(1).(a)

This information must be available to fellows, faculty members, other members of the health care team, and patients. (Core)

VI.A.2.a).(1).(b)

Fellows and faculty members must inform each patient of their respective roles in that patient’s care when providing direct patient care. (Core)

VI.A.2.b) Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced fellow. Other portions of care provided by the fellow can be adequately supervised by the immediate availability of the supervising faculty member or fellow physician, either on site or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. In
some circumstances, supervision may include post-hoc review of fellow-delivered care with feedback.

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)*

VI.A.2.c) Levels of Supervision

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

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

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

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)*

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)*

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)*

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)*

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

VI.A.2.d).(2) Faculty members functioning as supervising physicians must delegate portions of care to fellows based on the needs of the patient and the skills of each fellow. *(Core)*
VI.A.2.d)(3) Fellows should serve in a supervisory role to residents or junior fellows in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)

VI.A.2.e) Programs must set guidelines for circumstances and events in which fellows must communicate with the supervising faculty member(s). (Core)

VI.A.2.e)(1) Each fellow must know the limits of their scope of authority, and the circumstances under which the fellow is permitted to act with conditional independence. (Outcome)

VI.A.2.f) Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each fellow and to delegate to the fellow the appropriate level of patient care authority and responsibility. (Core)

VI.B. Professionalism

VI.B.1. Programs, in partnership with their Sponsoring Institutions, must educate fellows and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients. (Core)

VI.B.2. The learning objectives of the program must:

VI.B.2.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; (Core)

VI.B.2.b) be accomplished without excessive reliance on fellows to fulfill non-physician obligations; and, (Core)

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

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

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

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

VI.B.4.b) safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse
VI.B.4.c) assurance of their fitness for work, including: (Outcome)

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

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

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

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

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

VI.B.5. All fellows and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient’s care to another qualified and rested provider. (Outcome)

VI.B.6. Programs must provide a professional, respectful, and civil environment that is free from mistreatment, abuse, or coercion of students, residents/fellows, faculty, and staff. Programs, in partnership with their Sponsoring Institutions, should have a process for education of fellows and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)

VI.C. Well-Being

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

VI.C.1. This responsibility must include:

VI.C.1.a) efforts to enhance the meaning that each fellow finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional
VI.C.1.b) attention to scheduling, work intensity, and work compression that impacts fellow well-being; (Core)

VI.C.1.c) evaluating workplace safety data and addressing the safety of fellows and faculty members; (Core)

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

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

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

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

VI.C.1.e).(2) provide access to appropriate tools for self-screening; and, (Core)

VI.C.1.e).(3) provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)

VI.C.2. There are circumstances in which fellows may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. Each program must have policies and procedures in place that ensure coverage of patient care in the event that a fellow may be unable to perform their patient care responsibilities. These policies must be implemented without fear of negative consequences for the fellow who is unable to provide the clinical work. (Core)
VI.D. Fatigue Mitigation

VI.D.1. Programs must:

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

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

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

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

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

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

VI.E.1. Clinical Responsibilities

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

VI.E.1.a) The workload associated with optimal clinical care of surgical patients is a continuum from the moment of admission to the point of discharge. (Detail)

VI.E.1.b) During the residency education process, surgical teams should be made up of attending surgeons, residents at various PG levels, medical students (when appropriate), and other health care providers. (Detail)

VI.E.1.c) The work of the caregiver team should be assigned to team members based on each member’s level of education, experience, and competence. (Detail)

VI.E.1.d) As fellows progress through levels of increasing competence and responsibility, it is expected that work assignments will keep pace with their advancement. (Detail)

VI.E.2. Teamwork

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

VI.E.2.a) Effective surgical practices entail the involvement of members with a mix of complementary skills and attributes (physicians, nurses, and other staff). Success requires both an unwavering mutual respect for those skills and contributions, and a shared commitment to the process of patient care. (Detail)

VI.E.2.b) Fellows must collaborate with fellow surgical residents, and especially with faculty, other physicians outside of their specialty, and non-traditional health care providers, to best formulate treatment plans for an increasingly diverse patient population. (Detail)

VI.E.2.c) Fellows must assume personal responsibility to complete all tasks to which they are assigned (or which they voluntarily assume) in a timely fashion. These tasks must be completed in the hours assigned, or, if that is not possible, fellows must learn and utilize the established methods for handing off remaining tasks to another member of the fellow team so that patient care is not compromised. (Detail)

VI.E.2.d) Lines of authority should be defined by programs, and all fellows must have a working knowledge of these expected reporting relationships to maximize quality care and patient safety. (Detail)

VI.E.3. Transitions of Care

VI.E.3.a) Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)

VI.E.3.b) Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. (Core)

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

VI.E.3.d) Programs and clinical sites must maintain and communicate schedules of attending physicians and fellows currently responsible for care. (Core)

VI.E.3.e) Each program must ensure continuity of patient care, consistent with the program’s policies and procedures referenced in VI.C.2, in the event that a fellow may be unable to perform their patient care responsibilities due to excessive
fatigue or illness, or family emergency. (Core)

VI.F. Clinical Experience and Education

Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide fellows with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.

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

Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)

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

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

VI.F.2.b) Fellows should have eight hours off between scheduled clinical work and education periods. (Detail)

VI.F.2.b).(1) There may be circumstances when fellows choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements. (Detail)

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

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

VI.F.3. Maximum Clinical Work and Education Period Length

VI.F.3.a) Clinical and educational work periods for fellows must not exceed 24 hours of continuous scheduled clinical assignments. (Core)

VI.F.3.a).(1) Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or fellow education. (Core)
VI.F.3.a).(1).(a) Additional patient care responsibilities must not be assigned to a fellow during this time. (Core)

VI.F.4. Clinical and Educational Work Hour Exceptions

VI.F.4.a) In rare circumstances, after handing off all other responsibilities, a fellow, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:

VI.F.4.a).(1) to continue to provide care to a single severely ill or unstable patient; (Detail)

VI.F.4.a).(2) humanistic attention to the needs of a patient or family; or, (Detail)

VI.F.4.a).(3) to attend unique educational events. (Detail)

VI.F.4.b) These additional hours of care or education will be counted toward the 80-hour weekly limit. (Detail)

VI.F.4.c) A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.

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

VI.F.4.c).(1) In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the ACGME Manual of Policies and Procedures. (Core)

VI.F.4.c).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval from the Sponsoring Institution's GMEC and DIO. (Core)

VI.F.5. Moonlighting

VI.F.5.a) Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program, and must not interfere with the fellow’s fitness for work nor compromise patient safety. (Core)

VI.F.5.b) Time spent by fellows in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core)
VI.F.6. **In-House Night Float**

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

VI.F.6.a) Any rotation that requires fellows to work nights in succession is considered a night float rotation, and the total time on nights is counted toward the maximum allowable time for each fellow. (Core)

VI.F.6.b) Night float rotations must not exceed two months in succession, or three months in succession for rotations with night shifts alternating with day shifts. (Core)

VI.F.6.c) There can be no more than four months of night float per year. (Core)

VI.F.6.d) There must be at least two months between each night float rotation. (Core)

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

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

VI.F.8. **At-Home Call**

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

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

VI.F.8.b) Fellows are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit. (Detail)

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

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

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

**Osteopathic Recognition**

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

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