

**ACGME Program Requirements for  
Graduate Medical Education  
in Hematology**

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49 Hematology is the internal medicine subspecialty that focuses on the care of  
50 patients with disorders of the blood, bone marrow, and the lymphatic,  
51 immunologic, hemostatic, and vascular systems.

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53 **Int.C. Length of Educational Program**

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55 The educational program in hematology must be 24 months in length. <sup>(Core)\*</sup>

56  
57 **I. Oversight**

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59 **I.A. Sponsoring Institution**

60  
61 *The Sponsoring Institution is the organization or entity that assumes the*  
62 *ultimate financial and academic responsibility for a program of graduate*  
63 *medical education consistent with the ACGME Institutional Requirements.*

64  
65 *When the Sponsoring Institution is not a rotation site for the program, the*  
66 *most commonly utilized site of clinical activity for the program is the*  
67 *primary clinical site.*

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69  
70 **Background and Intent: Participating sites will reflect the health care needs of the**  
71 **community and the educational needs of the fellows. A wide variety of organizations**  
72 **may provide a robust educational experience and, thus, Sponsoring Institutions and**  
73 **participating sites may encompass inpatient and outpatient settings including, but not**  
74 **limited to a university, a medical school, a teaching hospital, a nursing home, a**  
75 **school of public health, a health department, a public health agency, an organized**  
76 **health care delivery system, a medical examiner’s office, an educational consortium, a**  
77 **teaching health center, a physician group practice, federally qualified health center, or**  
78 **an educational foundation.**

79  
80 **I.A.1. The program must be sponsored by one ACGME-accredited**  
81 **Sponsoring Institution. <sup>(Core)</sup>**

82  
83 **I.B. Participating Sites**

84  
85 *A participating site is an organization providing educational experiences or*  
86 *educational assignments/rotations for fellows.*

87  
88 **I.B.1. The program, with approval of its Sponsoring Institution, must**  
89 **designate a primary clinical site. <sup>(Core)</sup>**

90  
91 **I.B.1.a) A hematology fellowship must function as an integral part of an**  
92 **ACGME-accredited residency program in internal medicine. <sup>(Core)</sup>**

93  
94 **I.B.1.b) The Sponsoring Institution must establish the hematology**  
95 **fellowship within a department of internal medicine or an**  
96 **administrative unit with the primary mission to advance internal**  
97 **medicine subspecialty education and patient care. <sup>(Detail)†</sup>**

98  
99 **I.B.1.c) The Sponsoring Institution must ensure that there is a reporting**

relationship with the program director of the internal medicine residency program to ensure compliance with ACGME accreditation requirements. <sup>(Core)</sup>

**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. <sup>(Core)</sup>**

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

**I.B.2.a).(1) be renewed at least every 10 years; and, <sup>(Core)</sup>**

**I.B.2.a).(2) be approved by the designated institutional official (DIO). <sup>(Core)</sup>**

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

**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. <sup>(Core)</sup>**

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

**I.B.4. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all fellows, of one month full time equivalent (FTE) or more through the ACGME's Accreditation Data System (ADS). <sup>(Core)</sup>**

120 **I.C. The program, in partnership with its Sponsoring Institution, must engage in**  
121 **practices that focus on mission-driven, ongoing, systematic recruitment**  
122 **and retention of a diverse and inclusive workforce of residents (if present),**  
123 **fellows, faculty members, senior administrative staff members, and other**  
124 **relevant members of its academic community.** <sup>(Core)</sup>  
125

**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).**

126  
127 **I.D. Resources**  
128

129 **I.D.1. The program, in partnership with its Sponsoring Institution, must**  
130 **ensure the availability of adequate resources for fellow education.**  
131 <sup>(Core)</sup>  
132

133 I.D.1.a) Space and Equipment

134  
135 There must be space and equipment for the program, including  
136 meeting rooms, examination rooms, computers, visual and other  
137 educational aids, and work/study space. <sup>(Core)</sup>  
138

139 I.D.1.b) Facilities

140  
141 I.D.1.b).(1) Inpatient and outpatient systems must be in place to  
142 prevent fellows from performing routine clerical functions,  
143 such as scheduling tests and appointments, and retrieving  
144 records and letters. <sup>(Detail)</sup>  
145

146 I.D.1.b).(2) The sponsoring institution must provide the broad range of  
147 facilities and clinical support services required to provide  
148 comprehensive care of adult patients. <sup>(Core)</sup>  
149

150 I.D.1.b).(3) Fellows must have access to a lounge facility during  
151 assigned duty hours. <sup>(Detail)</sup>  
152

153 I.D.1.b).(4) When fellows are in the hospital, assigned night duty, or  
154 called in from home, they must be provided with a secure  
155 space for their belongings. <sup>(Detail)</sup>  
156

157 I.D.1.b).(5) Radiation oncology facilities must be available. <sup>(Detail)</sup>  
158

159 I.D.1.c) Laboratory and Imaging Services

160  
161 The following must be present at the primary clinical site or at  
162 participating sites:  
163

164 I.D.1.c).(1) a hematology laboratory; <sup>(Core)</sup>

- 165
- 166 I.D.1.c).(2) access to specialized coagulation laboratory; <sup>(Core)</sup>
- 167
- 168 I.D.1.c).(3) nuclear medicine imaging; <sup>(Core)</sup>
- 169
- 170 I.D.1.c).(4) cross-sectional imaging, including coaxial tomography (CT)
- 171 and magnetic resonance imaging (MRI); and, <sup>(Core)</sup>
- 172
- 173 I.D.1.c).(5) positron emission tomography (PET) scan imaging. <sup>(Core)</sup>
- 174
- 175 I.D.1.d) Other Support Services
- 176
- 177 I.D.1.d).(1) There must be advanced pathology services, including:
- 178
- 179 I.D.1.d).(1).(a) immunopathology; <sup>(Core)</sup>
- 180
- 181 I.D.1.d).(1).(b) blood banking; and, <sup>(Core)</sup>
- 182
- 183 I.D.1.d).(1).(c) transfusion and apheresis services. <sup>(Core)</sup>
- 184
- 185 I.D.1.d).(2) There must be a medical oncology clinical program with
- 186 which hematology fellows may interact. <sup>(Detail)</sup>
- 187
- 188 I.D.1.e) Medical Records
- 189
- 190 Access to an electronic health record should be provided. In the
- 191 absence of an existing electronic health record, institutions must
- 192 demonstrate institutional commitment to its development, and
- 193 progress towards its implementation. <sup>(Core)</sup>
- 194
- 195 **I.D.2. The program, in partnership with its Sponsoring Institution, must**
- 196 **ensure healthy and safe learning and working environments that**
- 197 **promote fellow well-being and provide for:** <sup>(Core)</sup>
- 198
- 199 **I.D.2.a) access to food while on duty;** <sup>(Core)</sup>
- 200
- 201 **I.D.2.b) safe, quiet, clean, and private sleep/rest facilities available**
- 202 **and accessible for fellows with proximity appropriate for safe**
- 203 **patient care;** <sup>(Core)</sup>
- 204

**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.**

205

206 I.D.2.c) clean and private facilities for lactation that have refrigeration  
207 capabilities, with proximity appropriate for safe patient care;  
208 (Core)  
209

**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).**

210  
211 I.D.2.d) security and safety measures appropriate to the participating  
212 site; and, (Core)  
213

214 I.D.2.e) accommodations for fellows with disabilities consistent with  
215 the Sponsoring Institution's policy. (Core)  
216

217 I.D.3. Fellows must have ready access to subspecialty-specific and other  
218 appropriate reference material in print or electronic format. This  
219 must include access to electronic medical literature databases with  
220 full text capabilities. (Core)  
221

222 I.D.4. The program's educational and clinical resources must be adequate  
223 to support the number of fellows appointed to the program. (Core)  
224

225 I.D.4.a) Patient Population

227 I.D.4.a).(1) The patient population must have a variety of hematologic  
228 disorders. (Core)  
229

230 I.D.4.a).(2) There must be patients of each gender, with a broad age  
231 range, including geriatric patients. (Core)  
232

233 I.D.4.a).(3) A sufficient number of patients must be available to enable  
234 each fellow to achieve the required educational outcomes.  
235 (Core)  
236

237 I.E. *A fellowship program usually occurs in the context of many learners and  
238 other care providers and limited clinical resources. It should be structured  
239 to optimize education for all learners present.*  
240

241 I.E.1. Fellows should contribute to the education of residents in core  
242 programs, if present. (Core)  
243

**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.

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**II. Personnel**

**II.A. Program Director**

**II.A.1. There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core)**

**II.A.1.a) The Sponsoring Institution's Graduate Medical Education Committee (GMEC) must approve a change in program director. (Core)**

**II.A.1.b) Final approval of the program director resides with the Review Committee. (Core)**

**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 have overall responsibility for the program. The program director's nomination is reviewed and approved by the GMEC. Final approval of the program director resides with the applicable ACGME Review Committee.**

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**II.A.2. The program director and, as applicable, the program's leadership team, must be provided with support adequate for administration of the program based upon its size and configuration. (Core)**

**II.A.2.a) ~~At a minimum, the program director must be provided with the salary support required to devote 20-50 percent FTE of non-clinical time to the administration of the program. (Core)~~**

At a minimum, the program director must be provided with the dedicated time and support specified below for administration of the program: (Core)

<u>Number of Approved Fellow Positions</u>	<u>Minimum Support Required (FTE)</u>
<u>&lt;7</u>	<u>.2</u>
<u>7-9</u>	<u>.25</u>
<u>10-12</u>	<u>.3</u>
<u>13-15</u>	<u>.35</u>
<u>16-18</u>	<u>.4</u>

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**II.A.2.b) Programs must appoint at least one of the subspecialty-certified core faculty members to be associate program director(s). The associate program directors(s) must be provided with support equal to a dedicated minimum time for administration of the program as follows: (Core)**

280

<u>Number of Approved Fellow Positions</u>	<u>Minimum Support Required (FTE)</u>
<u>&lt;7</u>	<u>0</u>
<u>7-9</u>	<u>.13</u>
<u>10-12</u>	<u>.14</u>
<u>13-15</u>	<u>.15</u>
<u>16-18</u>	<u>.16</u>

**Background and Intent: To achieve successful graduate medical education, individuals serving as education and administrative leaders of fellowship programs, as well as those significantly engaged in the education, supervision, evaluation, and mentoring of fellows, must have sufficient dedicated professional time to perform the vital activities required to sustain an accredited program.**

**The ultimate outcome of graduate medical education is excellence in fellow education and patient care.**

**The program director and, as applicable, the program leadership team, devote a portion of their professional effort to the oversight and management of the fellowship program, as defined in II.A.4.-II.A.4.a).(16). Both provision of support for the time required for the leadership effort and flexibility regarding how this support is provided are important. Programs, in partnership with their Sponsoring Institutions, may provide support for this time in a variety of ways. Examples of support may include, but are not limited to, salary support, supplemental compensation, educational value units, or relief of time from other professional duties.**

**Program directors and, as applicable, members of the program leadership team, who are new to the role may need to devote additional time to program oversight and management initially as they learn and become proficient in administering the program. It is suggested that during this initial period the support described above be increased as needed.**

281

Subspecialty-Specific Background and Intent: For instance, a program with an approved complement of 12 fellows is required to have at least 30 percent FTE support for the Program Director and at least 14 percent FTE support for the associate program director(s). Because an associate program director is also a core faculty member, the minimum dedicated time requirements for associate program directors are inclusive of core faculty activities. An additional 10 percent FTE for the core faculty position is not required. For example, if one core faculty member is named the associate program director for a 12-fellow program, the required minimum support for that position is 14 percent FTE. Further, the Review Committee allows the minimum required FTE support to be shared among multiple associate program directors, as delegated by and at the discretion of the program director.

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**II.A.3. Qualifications of the program director:**

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**II.A.3.a) must include subspecialty expertise and qualifications acceptable to the Review Committee; and, <sup>(Core)</sup>**

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287

**II.A.3.a).(1) The program director must have administrative experience and at least three years of participation as an active faculty**

288

289 member in an ACGME-accredited internal medicine  
290 residency or hematology fellowship. (Core)

291  
292 **II.A.3.b) must include current certification in the subspecialty for**  
293 **which they are the program director by the American Board**  
294 **of Internal Medicine (ABIM) or by the American Osteopathic**  
295 **Board of Internal Medicine (AOBIM), or subspecialty**  
296 **qualifications that are acceptable to the Review Committee.**  
297 (Core)

298  
299 **II.A.3.b).(1) The Review Committee only accepts current ABIM or**  
300 **AOBIM certification in hematology. (Core)**

301  
302 **II.A.4. Program Director Responsibilities**

303  
304 **The program director must have responsibility, authority, and**  
305 **accountability for: administration and operations; teaching and**  
306 **scholarly activity; fellow recruitment and selection, evaluation, and**  
307 **promotion of fellows, and disciplinary action; supervision of fellows;**  
308 **and fellow education in the context of patient care. (Core)**

309  
310 **II.A.4.a) The program director must:**

311  
312 **II.A.4.a).(1) be a role model of professionalism; (Core)**  
313

**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.**

314  
315 **II.A.4.a).(2) design and conduct the program in a fashion**  
316 **consistent with the needs of the community, the**  
317 **mission(s) of the Sponsoring Institution, and the**  
318 **mission(s) of the program; (Core)**  
319

**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.**

320  
321 **II.A.4.a).(3) administer and maintain a learning environment**  
322 **conducive to educating the fellows in each of the**  
323 **ACGME Competency domains; (Core)**  
324

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

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- 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.; <sup>(Core)</sup>
  - II.A.4.a).(5)** have the authority to approve program faculty members for participation in the fellowship program education at all sites; <sup>(Core)</sup>
  - II.A.4.a).(6)** have the authority to remove program faculty members from participation in the fellowship program education at all sites; <sup>(Core)</sup>
  - 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; <sup>(Core)</sup>

**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.**

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- II.A.4.a).(8)** submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; <sup>(Core)</sup>
  - 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); <sup>(Core)</sup>
  - 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; <sup>(Core)</sup>
  - II.A.4.a).(11)** ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process; <sup>(Core)</sup>

361 II.A.4.a).(12) ensure the program's compliance with the Sponsoring  
362 Institution's policies and procedures for due process  
363 when action is taken to suspend or dismiss, not to  
364 promote, or not to renew the appointment of a fellow;  
365 (Core)  
366

**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.**

367 II.A.4.a).(13) ensure the program's compliance with the Sponsoring  
368 Institution's policies and procedures on employment  
369 and non-discrimination; (Core)  
370  
371

372 II.A.4.a).(13).(a) Fellows must not be required to sign a non-  
373 competition guarantee or restrictive covenant.  
374 (Core)  
375

376 II.A.4.a).(14) document verification of program completion for all  
377 graduating fellows within 30 days; (Core)  
378

379 II.A.4.a).(15) provide verification of an individual fellow's  
380 completion upon the fellow's request, within 30 days;  
381 and, (Core)  
382

**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.**

383 II.A.4.a).(16) obtain review and approval of the Sponsoring  
384 Institution's DIO before submitting information or  
385 requests to the ACGME, as required in the Institutional  
386 Requirements and outlined in the ACGME Program  
387 Director's Guide to the Common Program  
388 Requirements. (Core)  
389  
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## 391 II.B. Faculty

392  
393 *Faculty members are a foundational element of graduate medical education*  
394 *– faculty members teach fellows how to care for patients. Faculty members*  
395 *provide an important bridge allowing fellows to grow and become practice*  
396 *ready, ensuring that patients receive the highest quality of care. They are*  
397 *role models for future generations of physicians by demonstrating*  
398 *compassion, commitment to excellence in teaching and patient care,*  
399 *professionalism, and a dedication to lifelong learning. Faculty members*  
400 *experience the pride and joy of fostering the growth and development of*  
401 *future colleagues. The care they provide is enhanced by the opportunity to*

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

405  
406 *Faculty members ensure that patients receive the level of care expected*  
407 *from a specialist in the field. They recognize and respond to the needs of*  
408 *the patients, fellows, community, and institution. Faculty members provide*  
409 *appropriate levels of supervision to promote patient safety. Faculty*  
410 *members create an effective learning environment by acting in a*  
411 *professional manner and attending to the well-being of the fellows and*  
412 *themselves.*  
413

**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.**

414  
415 **II.B.1.** For each participating site, there must be a sufficient number of  
416 **faculty members with competence to instruct and supervise all**  
417 **fellows at that location.** <sup>(Core)</sup>

418  
419 **II.B.2.** Faculty members must:

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421 **II.B.2.a)** be role models of professionalism; <sup>(Core)</sup>

422  
423 **II.B.2.b)** demonstrate commitment to the delivery of safe, quality,  
424 **cost-effective, patient-centered care;** <sup>(Core)</sup>  
425

**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.**

426  
427 **II.B.2.c)** demonstrate a strong interest in the education of fellows; <sup>(Core)</sup>

428  
429 **II.B.2.d)** devote sufficient time to the educational program to fulfill  
430 **their supervisory and teaching responsibilities;** <sup>(Core)</sup>

431  
432 **II.B.2.e)** administer and maintain an educational environment  
433 **conducive to educating fellows;** <sup>(Core)</sup>

434  
435 **II.B.2.f)** regularly participate in organized clinical discussions,  
436 **rounds, journal clubs, and conferences; and,** <sup>(Core)</sup>

437  
438 **II.B.2.g)** pursue faculty development designed to enhance their skills  
439 **at least annually.** <sup>(Core)</sup>  
440

**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.

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

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

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

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

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

**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.**

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**II.B.3.d) Any other specialty physician faculty members must have current certification in their specialty by the appropriate American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board, or possess qualifications judged acceptable to the Review Committee.** (Core)

**II.B.3.d).(1) Faculty members who are ABIM- or AOBIM-certified in endocrinology, gastroenterology, infectious disease, medical oncology, and pulmonary disease should be available to participate in the education of fellows.** (Core)

**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, mentoring fellows, and assessing fellows' progress toward achievement of competence in and the independent practice of the specialty. Core faculty members should be selected for their broad knowledge of and involvement in the program, permitting them to effectively evaluate the program. Core faculty members may also be selected for their specific expertise and unique contribution to the program. Core faculty members are engaged in a broad range of activities, which may vary across programs and specialties. Core faculty members provide clinical teaching and supervision of fellows, and also participate in non-clinical activities related to fellow education and program administration. Examples of these non-clinical activities include, but are not limited to, interviewing and selecting fellow applicants, providing didactic instruction, mentoring fellows, simulation exercises, completing the annual ACGME Faculty Survey, and participating on the program's Clinical Competency Committee, Program Evaluation Committee, and other GME committees.**

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482 **II.B.4.a) Core faculty members must be designated by the program**  
483 **director.** <sup>(Core)</sup>  
484  
485 **II.B.4.b) Core faculty members must complete the annual ACGME**  
486 **Faculty Survey.** <sup>(Core)</sup>  
487  
488 II.B.4.c) In addition to the program director, there must be at least two core  
489 faculty members certified in hematology by the ABIM or the  
490 AOBIM. <sup>(Core)</sup>  
491

~~Specialty Background and Intent: The program must have a minimum number of ABIM- or AOBIM-certified hematology faculty members who devote significant time to teaching, supervising, and advising residents, and working closely with the program director. One way the hematology-certified faculty members can demonstrate they are devoting a significant portion of their effort to resident education is by dedicating an average of 10 hours per week to the program.~~

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493 II.B.4.d) For programs approved for more than four fellows, there must be  
494 at least one core faculty member certified in hematology by the  
495 ABIM or the AOBIM for every 1.5 fellows. <sup>(Core)</sup>  
496  
497 II.B.4.e) At a minimum, the required core faculty members, in aggregate  
498 and excluding members of the program leadership, must be  
499 provided with support equal to an average dedicated minimum of  
500 .1 FTE for educational and administrative responsibilities that do  
501 not involve direct patient care. <sup>(Core)</sup>  
502

Subspecialty-Specific Background and Intent: For instance, a program with an approved complement of 12 fellows is required to have a minimum of eight ABIM- or AOBIM-subspecialty-certified faculty members and an FTE of 10 percent each. Because an associate program director is also a core faculty member, the minimum dedicated time requirements for associate program directors are inclusive of core faculty activities. An additional 10 percent FTE for the core faculty position is not required. For example, if one core faculty member is

named the associate program director for a 12-fellow program, the required minimum support for that position is 14 percent FTE.

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**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) At a minimum, the program coordinator must be provided with the dedicated time and support specified below for administration of the program. Additional administrative support must be provided based on the program size as follows: (Core)**

<u>Number of Approved Fellow Positions</u>	<u>Minimum FTE Required for Coordinator Support</u>	<u>Additional Aggregate FTE Required for Administration of the Program</u>
<u>1-3</u>	<u>.3</u>	<u>0</u>
<u>4-6</u>	<u>.3</u>	<u>.2</u>
<u>7-9</u>	<u>.3</u>	<u>.38</u>
<u>10-12</u>	<u>.3</u>	<u>.44</u>
<u>13-15</u>	<u>.3</u>	<u>.50</u>
<u>16-18</u>	<u>.3</u>	<u>.56</u>

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**Background and Intent: The requirement does not address the source of funding required to provide the specified salary support.**

**Each program requires a lead administrative person, frequently referred to as a program coordinator, administrator, or as otherwise titled by the institution. This person will frequently manage the day-to-day operations of the program and serve as an important liaison and facilitator between the learners, faculty and other staff members, and the ACGME. Individuals serving in this role are recognized as program coordinators by the ACGME.**

**The program coordinator is a key 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 appropriate to the complexity of the program. Program coordinators are expected to develop in-depth knowledge of the ACGME and Program Requirements, including policies and procedures. Program coordinators assist the program director in meeting accreditation requirements, 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.**

518

Subspecialty-Specific Background and Intent: For instance, a program with an approved complement of 12 fellows is required to have at least 74 percent FTE administrative support: 30 percent FTE for the program coordinator; and an additional 44 percent FTE aggregate support. This additional support may be for the program coordinator only or divided among the program coordinator and one or more other administrative personnel. The Review Committee has not specified how the FTE should be distributed to allow programs, in partnership with their Sponsoring Institution, to allocate the FTE as they see fit.

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**II.D. Other Program Personnel**

**The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective administration of the program. <sup>(Core)</sup>**

**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.**

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- II.D.1. There must be services available from other health care professionals, including dietitians, language interpreters, nurses, occupational therapists, physical therapists, and social workers. <sup>(Detail)</sup>
- II.D.2. The fellowship must have access to surgeons in general surgery and surgical specialties, including surgeons with special interest in oncology. <sup>(Detail)</sup>
- II.D.3. The fellowship must have access to other clinical specialists, including those in dermatology, obstetrics and gynecology, neurological surgery, neurology, orthopaedic surgery, otolaryngology, and urology. <sup>(Detail)</sup>
- II.D.4. There must be appropriate and timely consultation from other specialties. <sup>(Detail)</sup>
- II.D.5. Expertise in the following disciplines should be available to the program to provide multidisciplinary patient care and fellow education:
  - II.D.5.a) genetic counseling; <sup>(Detail)</sup>
  - II.D.5.b) hospice and palliative care; <sup>(Detail)</sup>
  - II.D.5.c) oncologic nursing; <sup>(Detail)</sup>
  - II.D.5.d) pain management; <sup>(Detail)</sup>
  - II.D.5.e) psychiatry; and, <sup>(Detail)</sup>
  - II.D.5.f) rehabilitation medicine. <sup>(Detail)</sup>

557 **III. Fellow Appointments**

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559 **III.A. Eligibility Criteria**

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561 **III.A.1. Eligibility Requirements – Fellowship Programs**

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563 **All required clinical education for entry into ACGME-accredited**  
564 **fellowship programs must be completed in an ACGME-accredited**  
565 **residency program, an AOA-approved residency program, a**  
566 **program with ACGME International (ACGME-I) Advanced Specialty**  
567 **Accreditation, or a Royal College of Physicians and Surgeons of**  
568 **Canada (RCPSC)-accredited or College of Family Physicians of**  
569 **Canada (CFPC)-accredited residency program located in Canada.**  
570 **(Core)**

570

571

**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).**

572

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

577

578 **III.A.1.b) Prior to appointment in the fellowship, fellows should have**  
579 **completed an internal medicine program that satisfies the**  
580 **requirements in III.A.1. (Core)**

581

582 **III.A.1.b).(1) Fellows who did not complete an internal medicine**  
583 **program that satisfies the requirements in III.A.1. must**  
584 **have completed at least three years of internal medicine**  
585 **education prior to starting the fellowship as well as met all**  
586 **of the criteria in the “Fellow Eligibility Exception” section**  
587 **below. (Core)**

588

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

590

591 **The Review Committee for Internal Medicine will allow the**  
592 **following exception to the fellowship eligibility requirements:**

593

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

600

601 **III.A.1.c).(1).(a) evaluation by the program director and**  
602 **fellowship selection committee of the**  
603 **applicant’s suitability to enter the program,**  
604 **based on prior training and review of the**

- 605 summative evaluations of training in the core  
 606 specialty; and, <sup>(Core)</sup>  
 607  
 608 **III.A.1.c).(1).(b)** review and approval of the applicant’s  
 609 exceptional qualifications by the GMEC; and,  
 610 <sup>(Core)</sup>  
 611  
 612 **III.A.1.c).(1).(c)** verification of Educational Commission for  
 613 Foreign Medical Graduates (ECFMG)  
 614 certification. <sup>(Core)</sup>  
 615  
 616 **III.A.1.c).(2)** Applicants accepted through this exception must have  
 617 an evaluation of their performance by the Clinical  
 618 Competency Committee within 12 weeks of  
 619 matriculation. <sup>(Core)</sup>  
 620

**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.

- 621  
 622 **III.B.** The program director must not appoint more fellows than approved by the  
 623 Review Committee. <sup>(Core)</sup>  
 624  
 625 **III.B.1.** All complement increases must be approved by the Review  
 626 Committee. <sup>(Core)</sup>  
 627  
 628 **III.B.2.** The number of available fellow positions in the program must be at least  
 629 one per year. <sup>(Detail)</sup>  
 630  
 631 **III.C.** **Fellow Transfers**  
 632  
 633 The program must obtain verification of previous educational experiences  
 634 and a summative competency-based performance evaluation prior to  
 635 acceptance of a transferring fellow, and Milestones evaluations upon  
 636 matriculation. <sup>(Core)</sup>  
 637  
 638 **IV. Educational Program**  
 639

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

643  
644 ***The educational program must support the development of knowledgeable, skillful***  
645 ***physicians who provide compassionate care.***

646  
647 ***In addition, the program is expected to define its specific program aims consistent***  
648 ***with the overall mission of its Sponsoring Institution, the needs of the community***  
649 ***it serves and that its graduates will serve, and the distinctive capabilities of***  
650 ***physicians it intends to graduate. While programs must demonstrate substantial***  
651 ***compliance with the Common and subspecialty-specific Program Requirements, it***  
652 ***is recognized that within this framework, programs may place different emphasis***  
653 ***on research, leadership, public health, etc. It is expected that the program aims***  
654 ***will reflect the nuanced program-specific goals for it and its graduates; for***  
655 ***example, it is expected that a program aiming to prepare physician-scientists will***  
656 ***have a different curriculum from one focusing on community health.***

657  
658 **IV.A. The curriculum must contain the following educational components:** (Core)

659  
660 **IV.A.1. a set of program aims consistent with the Sponsoring Institution’s**  
661 **mission, the needs of the community it serves, and the desired**  
662 **distinctive capabilities of its graduates;** (Core)

663  
664 **IV.A.1.a) The program’s aims must be made available to program**  
665 **applicants, fellows, and faculty members.** (Core)

666  
667 **IV.A.2. competency-based goals and objectives for each educational**  
668 **experience designed to promote progress on a trajectory to**  
669 **autonomous practice in their subspecialty. These must be**  
670 **distributed, reviewed, and available to fellows and faculty members;**  
671 (Core)

672  
673 **IV.A.3. delineation of fellow responsibilities for patient care, progressive**  
674 **responsibility for patient management, and graded supervision in**  
675 **their subspecialty;** (Core)

676  
**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.**

677  
678 **IV.A.4. structured educational activities beyond direct patient care; and,**  
679 (Core)

680  
**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.

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

**IV.B. ACGME Competencies**

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

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

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

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

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

**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.

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**IV.B.1.b).(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. (Core)

**IV.B.1.b).(1).(a)** Fellows must demonstrate competence in the practice of health promotion, disease prevention, diagnosis, care, and treatment of patients of each gender, from adolescence to old age, during health and all stages of illness. (Core)

**IV.B.1.b).(1).(b)** Fellows must demonstrate competence as a

711		consultant. (Core)
712		
713	IV.B.1.b).(1).(c)	Fellows must demonstrate competence in the:
714		
715	IV.B.1.b).(1).(c).(i)	care and management of geriatric patients
716		with hematologic disorders; (Core)
717		
718	IV.B.1.b).(1).(c).(ii)	care of patients with human
719		immunodeficiency virus-related
720		malignancies; (Core)
721		
722	IV.B.1.b).(1).(c).(iii)	evaluation and management of diagnosis,
723		pathology, staging, and management of
724		neoplastic disorders of the:
725		
726	IV.B.1.b).(1).(c).(iii).(a)	lymphoid organs; and, (Core)
727		
728	IV.B.1.b).(1).(c).(iii).(b)	hematopoietic system. (Core)
729		
730	IV.B.1.b).(1).(c).(iv)	management of the neutropenic and the
731		immunocompromised patient; (Core)
732		
733	IV.B.1.b).(1).(c).(v)	management of pain, anxiety, and
734		depression in patients with hematologic
735		disorders; (Core)
736		
737	IV.B.1.b).(1).(c).(vi)	multidisciplinary management of
738		hematologic malignancies; (Core)
739		
740	IV.B.1.b).(1).(c).(vii)	palliative care, including hospice and home
741		care; (Core)
742		
743	IV.B.1.b).(1).(c).(viii)	rehabilitation and psychosocial care of
744		patients with hematologic disorders; and,
745		(Core)
746		
747	IV.B.1.b).(1).(c).(ix)	role and use of hematologic, infectious
748		disease, and nutrition support. (Core)
749		
750	<b>IV.B.1.b).(2)</b>	<b>Fellows must be able to perform all medical,</b>
751		<b>diagnostic, and surgical procedures considered</b>
752		<b>essential for the area of practice. (Core)</b>
753		
754	IV.B.1.b).(2).(a)	Fellows must demonstrate competence in the:
755		
756	IV.B.1.b).(2).(a).(i)	assessment of hematologic disorders by
757		CT, MRI, PET scanning, and nuclear
758		imaging techniques; (Core)
759		
760	IV.B.1.b).(2).(a).(ii)	correlation of clinical information with
761		cytology, histology, and immunodiagnostic

762		imaging techniques; <sup>(Core)</sup>
763		
764	IV.B.1.b).(2).(a).(iii)	indications and application of imaging techniques in patients with neoplastic and blood disorders; <sup>(Core)</sup>
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768	IV.B.1.b).(2).(a).(iv)	performance of bone marrow biopsies and aspirations; <sup>(Core)</sup>
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771	IV.B.1.b).(2).(a).(v)	assessment and interpretation of complete blood count; <sup>(Core)</sup>
772		
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774	IV.B.1.b).(2).(a).(vi)	interpretation of peripheral blood smears; <sup>(Core)</sup>
775		
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777	IV.B.1.b).(2).(a).(vii)	tests of hemostasis and thrombosis for both congenital and acquired disorders and regulation of antithrombotic therapy; <sup>(Core)</sup>
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781	IV.B.1.b).(2).(a).(viii)	treatment and diagnosis of paraneoplastic disorders; <sup>(Core)</sup>
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784	IV.B.1.b).(2).(a).(ix)	treatment of patients with acquired and congenital disorders of hemostasis and thrombosis, including the biochemistry and pharmacology of coagulation factor replacement therapy and use of antithrombotic therapy; <sup>(Core)</sup>
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791	IV.B.1.b).(2).(a).(x)	use of systemic therapies through all therapeutic routes; <sup>(Core)</sup>
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794	IV.B.1.b).(2).(a).(xi)	use of chemotherapeutic drugs, biologic products, and growth factors, as well as their mechanisms of action, pharmacokinetics, clinical indications, and limitations, including their effects, toxicity, and interactions; and, <sup>(Core)</sup>
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801	IV.B.1.b).(2).(a).(xii)	use of multiagent chemotherapeutic protocols and combined modality therapy of hematologic malignancies. <sup>(Core)</sup>
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805	<b>IV.B.1.c)</b>	<b>Medical Knowledge</b>
806		
807		<b>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. <sup>(Core)</sup></b>
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812	IV.B.1.c).(1)	Fellows must demonstrate knowledge of the scientific

813		method of problem solving and evidence-based decision
814		making. <sup>(Core)</sup>
815		
816	IV.B.1.c).(2)	Fellows must demonstrate knowledge of indications,
817		contraindications, limitations, complications, techniques,
818		and interpretation of results of those diagnostic and
819		therapeutic procedures integral to the discipline, including
820		the appropriate indications for and use of screening
821		tests/procedures. <sup>(Core)</sup>
822		
823	IV.B.1.c).(3)	Fellows must demonstrate knowledge of pathogenesis,
824		diagnosis, and treatment of disease, including: <sup>(Core)</sup>
825		
826	IV.B.1.c).(3).(a)	basic molecular and pathophysiologic mechanisms,
827		diagnosis, and therapy of diseases of the blood,
828		including anemias, diseases of white blood cells
829		and stem cells, and disorders of hemostasis and
830		thrombosis; and, <sup>(Core)</sup>
831		
832	IV.B.1.c).(3).(b)	etiology, epidemiology, natural history, diagnosis,
833		pathology, staging, and management of neoplastic
834		diseases of the blood, blood-forming organs, and
835		lymphatic tissues. <sup>(Core)</sup>
836		
837	IV.B.1.c).(4)	Fellows must demonstrate knowledge of genetics and
838		developmental biology, including:
839		
840	IV.B.1.c).(4).(a)	molecular genetics; <sup>(Core)</sup>
841		
842	IV.B.1.c).(4).(b)	prenatal diagnosis; <sup>(Core)</sup>
843		
844	IV.B.1.c).(4).(c)	the nature of oncogenes and their products; and,
845		<sup>(Core)</sup>
846		
847	IV.B.1.c).(4).(d)	cytogenetics. <sup>(Core)</sup>
848		
849	IV.B.1.c).(5)	Fellows must demonstrate knowledge of physiology and
850		pathophysiology, including:
851		
852	IV.B.1.c).(5).(a)	cell and molecular biology; <sup>(Core)</sup>
853		
854	IV.B.1.c).(5).(b)	hematopoiesis; <sup>(Core)</sup>
855		
856	IV.B.1.c).(5).(c)	principles of oncogenesis; <sup>(Core)</sup>
857		
858	IV.B.1.c).(5).(d)	tumor immunology; <sup>(Core)</sup>
859		
860	IV.B.1.c).(5).(e)	molecular mechanisms of hematopoietic and
861		lymphopoietic malignancies; <sup>(Core)</sup>
862		
863	IV.B.1.c).(5).(f)	basic and clinical pharmacology, pharmacokinetics,

864		and toxicity; and, (Core)
865		
866	IV.B.1.c).(5).(g)	pathophysiology and patterns of tumor metastases. (Core)
867		
868		
869	IV.B.1.c).(6)	Fellows must demonstrate knowledge of:
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871	IV.B.1.c).(6).(a)	clinical epidemiology and biostatistics, to include clinical study and experimental protocol design, data collection, and analysis; (Core)
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875	IV.B.1.c).(6).(b)	basic principles of laboratory and clinical testing, quality control, quality assurance, and proficiency standards; (Core)
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879	IV.B.1.c).(6).(c)	immune markers, immunophenotyping, flow cytometry, cytochemical studies, and cytogenetic and DNA analysis of neoplastic disorders; (Core)
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883	IV.B.1.c).(6).(d)	malignant and hematologic complications of organ transplantation; (Core)
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885		
886	IV.B.1.c).(6).(e)	gene therapy; (Core)
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888	IV.B.1.c).(6).(f)	effects of systemic disorders and drugs on the blood, blood-forming organs, and lymphatic tissues; (Core)
889		
890		
891		
892	IV.B.1.c).(6).(g)	transfusion medicine, including the evaluation of antibodies, blood compatibility, and the indications for and complications of blood component therapy and methods of apheresis procedures; (Core)
893		
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896		
897	IV.B.1.c).(6).(h)	acquired and congenital disorders of red cells, white cells, platelets and stem cells; (Core)
898		
899		
900	IV.B.1.c).(6).(i)	hematopoietic and lymphopoietic malignancies, including disorders of plasma cells; (Core)
901		
902		
903	IV.B.1.c).(6).(j)	functional characteristics, indications, risks, and process of using indwelling venous access devices; (Core)
904		
905		
906		
907	IV.B.1.c).(6).(k)	preparation of blood smears, bone marrow aspirates, and touch preparations; and, (Core)
908		
909		
910	IV.B.1.c).(6).(l)	the indications, risks, and process of performing therapeutic phlebotomy. (Core)
911		
912		
913	IV.B.1.c).(7)	Fellows must demonstrate knowledge of principles of, indications for, and limitations of radiation therapy in the
914		

915 treatment of cancer. <sup>(Core)</sup>  
 916  
 917 IV.B.1.c).(8) Fellows must demonstrate knowledge of principles of,  
 918 indications for, and complications of autologous and  
 919 allogeneic bone marrow or peripheral blood stem cell  
 920 transplantation. <sup>(Core)</sup>  
 921  
 922 IV.B.1.c).(9) Fellows must demonstrate knowledge of principles of,  
 923 indications for, and complications of peripheral stem cell  
 924 harvests. <sup>(Core)</sup>  
 925  
 926 IV.B.1.c).(10) Fellows must demonstrate knowledge of the management  
 927 of post-transplant complications. <sup>(Core)</sup>  
 928  
 929 IV.B.1.c).(11) Fellows must demonstrate knowledge of the mechanisms  
 930 of action, pharmacokinetics, clinical indications for, and  
 931 limitations of chemotherapeutic drugs, biologic products,  
 932 and growth factors, including their effects, toxicity, and  
 933 interactions. <sup>(Core)</sup>  
 934

935 **IV.B.1.d)**

**Practice-based Learning and Improvement**

936  
 937 **Fellows must demonstrate the ability to investigate and**  
 938 **evaluate their care of patients, to appraise and assimilate**  
 939 **scientific evidence, and to continuously improve patient care**  
 940 **based on constant self-evaluation and lifelong learning.** <sup>(Core)</sup>  
 941

**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.**

942  
 943 **IV.B.1.e)** **Interpersonal and Communication Skills**  
 944  
 945 **Fellows must demonstrate interpersonal and communication**  
 946 **skills that result in the effective exchange of information and**  
 947 **collaboration with patients, their families, and health**  
 948 **professionals.** <sup>(Core)</sup>  
 949

950 **IV.B.1.f)**

**Systems-based Practice**

951  
 952 **Fellows must demonstrate an awareness of and**  
 953 **responsiveness to the larger context and system of health**  
 954 **care, including the social determinants of health, as well as**  
 955 **the ability to call effectively on other resources to provide**  
 956 **optimal health care.** <sup>(Core)</sup>  
 957

958	<b>IV.C.</b>	<b>Curriculum Organization and Fellow Experiences</b>
959		
960	<b>IV.C.1.</b>	<b>The curriculum must be structured to optimize fellow educational experiences, the length of these experiences, and supervisory continuity.</b> <small>(Core)</small>
961		
962		
963		
964	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. <small>(Core)</small>
965		
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971	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 towards the shared goals of patient safety and quality improvement. <small>(Core)</small>
972		
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976	<b>IV.C.2.</b>	<b>The program must provide instruction and experience in pain management if applicable for the subspecialty, including recognition of the signs of addiction.</b> <small>(Core)</small>
977		
978		
979		
980	IV.C.3.	A minimum of 12 months must be devoted to clinical experience. <small>(Core)</small>
981		
982	IV.C.3.a)	The program must provide at least one month of clinical experience in autologous and allogeneic bone marrow transplantation. <small>(Core)</small>
983		
984		
985		
986	IV.C.4.	Fellows must participate in training using simulation. <small>(Detail)</small>
987		
988	IV.C.5.	Inpatient assignments should be of sufficient duration to permit continuing care of a majority of the patients throughout their hospitalization. <small>(Detail)</small>
989		
990		
991	IV.C.6.	Fellows must participate in multidisciplinary case management or tumor board conferences and in protocol studies. <small>(Core)</small>
992		
993		
994	IV.C.7.	Fellows must assume continuing responsibility for acutely- and chronically-ill patients in order to observe and manage both inpatients and outpatients with a wide variety of blood and neoplastic disorders, and the benefits and adverse effects of therapy. <small>(Detail)</small>
995		
996		
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998		
999	IV.C.8.	Fellows should participate in the care of patients undergoing:
1000		
1001	IV.C.8.a)	apheresis procedures; and, <small>(Core)</small>
1002		
1003	IV.C.8.b)	bone marrow or peripheral stem cell harvest for transplantation. <small>(Core)</small>
1004		
1005		
1006	IV.C.9.	Fellows must be educated about and should have experience with:
1007		
1008	IV.C.9.a)	performance and interpretation of partial thromboplastin time,

1009		prothrombin time, platelet aggregation, and bleeding time, as well
1010		as other standard and specialized coagulation assays; and, <sup>(Core)</sup>
1011		
1012	IV.C.9.b)	tests of hemostasis. <sup>(Core)</sup>
1013		
1014	IV.C.10.	Experience with Continuity Ambulatory Patients
1015		
1016	IV.C.10.a)	Fellows must have continuity ambulatory clinic experience that
1017		exposes them to the breadth and depth of the subspecialty. <sup>(Core)</sup>
1018		
1019	IV.C.10.b)	This experience should average one half-day each week. <sup>(Detail)</sup>
1020		
1021	IV.C.10.c)	This experience must include an appropriate distribution of
1022		patients of each gender and a diversity of ages. <sup>(Core)</sup>
1023		
1024		This should be accomplished through either:
1025		
1026	IV.C.10.c).(1)	a continuity clinic which provides fellows the opportunity to
1027		learn the course of disease; or, <sup>(Detail)</sup>
1028		
1029	IV.C.10.c).(2)	selected blocks of at least six months which address
1030		specific areas of hematologic disorders. <sup>(Detail)</sup>
1031		
1032	IV.C.10.d)	Each fellow should, on average, be responsible for four to eight
1033		patients during each half-day session. <sup>(Detail)</sup>
1034		
1035	IV.C.10.e)	The continuity patient care experience should not be interrupted
1036		by more than one month, excluding a fellow's vacation. <sup>(Detail)</sup>
1037		
1038	IV.C.10.f)	Fellows should be informed of the status of their continuity
1039		patients when such patients are hospitalized, as clinically
1040		appropriate. <sup>(Detail)</sup>
1041		
1042	IV.C.11.	Procedures and Technical Skills
1043		
1044	IV.C.11.a)	Direct supervision of procedures performed by each fellow must
1045		occur until proficiency has been acquired and documented by the
1046		program director. <sup>(Core)</sup>
1047		
1048	IV.C.11.b)	Faculty members must teach and supervise the fellows in the
1049		performance and interpretation of procedures, which must be
1050		documented in each fellow's record, including indications,
1051		outcomes, diagnoses, and supervisor(s). <sup>(Core)</sup>
1052		
1053	IV.C.11.c)	Additional training and experiences should be made available for
1054		those fellows who request the need to perform specified
1055		procedures in their post-training careers (e.g., training to achieve
1056		competence in the interpretation of bone marrow biopsies or
1057		aspirates, lumbar punctures for diagnosis or administration of
1058		intrathecal chemotherapy, administering therapeutics through
1059		Ommaya reservoirs). <sup>(Detail)</sup>

1060		
1061	IV.C.12.	Fellows must have experience in the role of a hematology consultant in both the inpatient and outpatient settings. <sup>(Core)</sup>
1062		
1063		
1064	IV.C.13.	The core curriculum must include a didactic program based upon the core knowledge content in the subspecialty area. <sup>(Core)</sup>
1065		
1066		
1067	IV.C.13.a)	The program must afford each fellow an opportunity to review topics covered in conferences that he or she was unable to attend. <sup>(Detail)</sup>
1068		
1069		
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1071	IV.C.13.b)	Fellows must participate in clinical case conferences, journal clubs, research conferences, and morbidity and mortality or quality improvement conferences. <sup>(Detail)</sup>
1072		
1073		
1074		
1075	IV.C.13.c)	All core conferences must have at least one faculty member present, and must be scheduled as to ensure peer-peer and peer-faculty interaction. <sup>(Detail)</sup>
1076		
1077		
1078		
1079	IV.C.14.	Patient-based teaching must include direct interaction between fellows and faculty members, bedside teaching, discussion of pathophysiology, and the use of current evidence in diagnostic and therapeutic decisions. <sup>(Core)</sup>
1080		
1081		
1082		
1083		
1084		The teaching must be:
1085		
1086	IV.C.14.a)	formally conducted on all inpatient, outpatient, and consultative services; and, <sup>(Detail)</sup>
1087		
1088		
1089	IV.C.14.b)	conducted with a frequency and duration that ensures a meaningful and continuous teaching relationship between the assigned supervising faculty member(s) and fellows. <sup>(Detail)</sup>
1090		
1091		
1092		
1093	IV.C.15.	Fellows must receive instruction in practice management relevant to hematology. <sup>(Detail)</sup>
1094		
1095		
1096	<b>IV.D.</b>	<b>Scholarship</b>
1097		
1098		<b><i>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.</i></b>
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1107		<b><i>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.</i></b>
1108		
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1110		

1111 *For example, some programs may concentrate their scholarly activity on*  
1112 *quality improvement, population health, and/or teaching, while other*  
1113 *programs might choose to utilize more classic forms of biomedical*  
1114 *research as the focus for scholarship.*

1115  
1116 **IV.D.1. Program Responsibilities**

1117  
1118 **IV.D.1.a) The program must demonstrate evidence of scholarly**  
1119 **activities, consistent with its mission(s) and aims. (Core)**

1120  
1121 **IV.D.1.b) The program in partnership with its Sponsoring Institution,**  
1122 **must allocate adequate resources to facilitate fellow and**  
1123 **faculty involvement in scholarly activities. (Core)**

1124  
1125 **IV.D.2. Faculty Scholarly Activity**

1126  
1127 **IV.D.2.a) Among their scholarly activity, programs must demonstrate**  
1128 **accomplishments in at least three of the following domains:**  
1129 **(Core)**

- 1130  
1131
- 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
- 1132  
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1142 **IV.D.2.b) The program must demonstrate dissemination of scholarly**  
1143 **activity within and external to the program by the following**  
1144 **methods:**

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

1148  
1149 **IV.D.2.b).(1) faculty participation in grand rounds, posters,**  
1150 **workshops, quality improvement presentations,**  
1151 **podium presentations, grant leadership, non-peer-**

1152 reviewed print/electronic resources, articles or  
1153 publications, book chapters, textbooks, webinars,  
1154 service on professional committees, or serving as a  
1155 journal reviewer, journal editorial board member, or  
1156 editor. (Outcome)†  
1157

1158 IV.D.2.b).(1).(a)

At least 50 percent of the core faculty members  
certified in hematology by the ABIM or AOBIM must  
annually engage in a variety of scholarly activities,  
as listed in Program Requirement IV.D.2.b).(1).  
(Core)

1163  
1164 **IV.D.3. Fellow Scholarly Activity**

1165  
1166 IV.D.3.a)

While in the program, at least 50 percent of a program's fellows  
must have engaged in more than one of the following scholarly  
activities: participation in grand rounds, posters, workshops,  
quality improvement presentations, podium presentations, grant  
leadership, non-peer-reviewed print/electronic resources, articles  
or publications, book chapters, textbooks, webinars, service on  
professional committees, or serving as a journal reviewer, journal  
editorial board member, or editor. (Outcome)

1174  
1175 **V. Evaluation**

1176  
1177 **V.A. Fellow Evaluation**

1178  
1179 **V.A.1. Feedback and Evaluation**  
1180

**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.**

1181  
1182 **V.A.1.a) Faculty members must directly observe, evaluate, and**  
1183 **frequently provide feedback on fellow performance during**  
1184 **each rotation or similar educational assignment. (Core)**  
1185

**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.**

1186  
1187 **V.A.1.a).(1) The faculty must discuss this evaluation with each fellow at**  
1188 **the completion of each assignment. (Core)**  
1189

1190 **V.A.1.a).(2) Assessment of procedural competence should include a**  
1191 **formal evaluation process and not be based solely on a**  
1192 **minimum number of procedures performed. (Detail)**  
1193

1194 **V.A.1.b) Evaluation must be documented at the completion of the**  
1195 **assignment. (Core)**  
1196

1197 **V.A.1.b).(1) For block rotations of greater than three months in**  
1198 **duration, evaluation must be documented at least**  
1199 **every three months. (Core)**  
1200

1201 **V.A.1.b).(2) Longitudinal experiences such as continuity clinic in**  
1202 **the context of other clinical responsibilities must be**  
1203 **evaluated at least every three months and at**  
1204 **completion. (Core)**  
1205

1206 **V.A.1.c) The program must provide an objective performance**  
1207 **evaluation based on the Competencies and the subspecialty-**  
1208 **specific Milestones, and must: (Core)**  
1209

1210 **V.A.1.c).(1) use multiple evaluators (e.g., faculty members, peers,**  
1211 **patients, self, and other professional staff members);**  
1212 **and, (Core)**  
1213

1214 **V.A.1.c).(2) provide that information to the Clinical Competency**  
1215 **Committee for its synthesis of progressive fellow**  
1216 **performance and improvement toward unsupervised**  
1217 **practice. (Core)**  
1218

**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.

- 1219  
1220 V.A.1.d) The program director or their designee, with input from the  
1221 Clinical Competency Committee, must:  
1222  
1223 V.A.1.d).(1) meet with and review with each fellow their  
1224 documented semi-annual evaluation of performance,  
1225 including progress along the subspecialty-specific  
1226 Milestones. <sup>(Core)</sup>  
1227  
1228 V.A.1.d).(2) assist fellows in developing individualized learning  
1229 plans to capitalize on their strengths and identify areas  
1230 for growth; and, <sup>(Core)</sup>  
1231  
1232 V.A.1.d).(3) develop plans for fellows failing to progress, following  
1233 institutional policies and procedures. <sup>(Core)</sup>  
1234

**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.

- 1235  
1236 V.A.1.e) At least annually, there must be a summative evaluation of  
1237 each fellow that includes their readiness to progress to the  
1238 next year of the program, if applicable. <sup>(Core)</sup>  
1239  
1240 V.A.1.f) The evaluations of a fellow's performance must be accessible  
1241 for review by the fellow. <sup>(Core)</sup>  
1242

1243	<b>V.A.2.</b>	<b>Final Evaluation</b>
1244		
1245	<b>V.A.2.a)</b>	<b>The program director must provide a final evaluation for each fellow upon completion of the program. <sup>(Core)</sup></b>
1246		
1247		
1248	<b>V.A.2.a).(1)</b>	<b>The subspecialty-specific Milestones, and when applicable the subspecialty-specific Case Logs, must be used as tools to ensure fellows are able to engage in autonomous practice upon completion of the program. <sup>(Core)</sup></b>
1249		
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1254	<b>V.A.2.a).(2)</b>	<b>The final evaluation must:</b>
1255		
1256	<b>V.A.2.a).(2).(a)</b>	<b>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; <sup>(Core)</sup></b>
1257		
1258		
1259		
1260		
1261	<b>V.A.2.a).(2).(b)</b>	<b>verify that the fellow has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice; <sup>(Core)</sup></b>
1262		
1263		
1264		
1265	<b>V.A.2.a).(2).(c)</b>	<b>consider recommendations from the Clinical Competency Committee; and, <sup>(Core)</sup></b>
1266		
1267		
1268	<b>V.A.2.a).(2).(d)</b>	<b>be shared with the fellow upon completion of the program. <sup>(Core)</sup></b>
1269		
1270		
1271	<b>V.A.3.</b>	<b>A Clinical Competency Committee must be appointed by the program director. <sup>(Core)</sup></b>
1272		
1273		
1274	<b>V.A.3.a)</b>	<b>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. <sup>(Core)</sup></b>
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1281	<b>V.A.3.b)</b>	<b>The Clinical Competency Committee must:</b>
1282		
1283	<b>V.A.3.b).(1)</b>	<b>review all fellow evaluations at least semi-annually; <sup>(Core)</sup></b>
1284		
1285		
1286	<b>V.A.3.b).(2)</b>	<b>determine each fellow’s progress on achievement of the subspecialty-specific Milestones; and, <sup>(Core)</sup></b>
1287		
1288		
1289	<b>V.A.3.b).(3)</b>	<b>meet prior to the fellows’ semi-annual evaluations and advise the program director regarding each fellow’s progress. <sup>(Core)</sup></b>
1290		
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1293	<b>V.B.</b>	<b>Faculty Evaluation</b>

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- 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)**

**Background and Intent: The program director is responsible for the education program and for whom delivers it. While the term faculty may be applied to physicians within a given institution for other reasons, it is applied to fellowship program faculty members only through approval by a program director. The development of the faculty improves the education, clinical, and research aspects of a program. Faculty members have a strong commitment to the fellow and desire to provide optimal education and work opportunities. Faculty members must be provided feedback on their contribution to the mission of the program. All faculty members who interact with fellows desire feedback on their education, clinical care, and research. If a faculty member does not interact with fellows, feedback is not required. With regard to the diverse operating environments and configurations, the fellowship program director may need to work with others to determine the effectiveness of the program's faculty performance with regard to their role in the educational program. All teaching faculty members should have their educational efforts evaluated by the fellows in a confidential and anonymous manner. Other aspects for the feedback may include research or clinical productivity, review of patient outcomes, or peer review of scholarly activity. The process should reflect the local environment and identify the necessary information. The feedback from the various sources should be summarized and provided to the faculty on an annual basis by a member of the leadership team of the program.**

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- 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)**
- V.B.1.b) This evaluation must include written, confidential evaluations by the fellows. (Core)**
- V.B.2. Faculty members must receive feedback on their evaluations at least annually. (Core)**
- V.B.3. Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)**

**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.**

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- V.C. Program Evaluation and Improvement**
- V.C.1. The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program**

- 1320 **Evaluation as part of the program's continuous improvement**  
 1321 **process.** <sup>(Core)</sup>  
 1322  
 1323 **V.C.1.a)** **The Program Evaluation Committee must be composed of at**  
 1324 **least two program faculty members, at least one of whom is a**  
 1325 **core faculty member, and at least one fellow.** <sup>(Core)</sup>  
 1326  
 1327 **V.C.1.b)** **Program Evaluation Committee responsibilities must include:**  
 1328  
 1329 **V.C.1.b).(1)** **acting as an advisor to the program director, through**  
 1330 **program oversight;** <sup>(Core)</sup>  
 1331  
 1332 **V.C.1.b).(2)** **review of the program's self-determined goals and**  
 1333 **progress toward meeting them;** <sup>(Core)</sup>  
 1334  
 1335 **V.C.1.b).(3)** **guiding ongoing program improvement, including**  
 1336 **development of new goals, based upon outcomes;**  
 1337 **and,** <sup>(Core)</sup>  
 1338  
 1339 **V.C.1.b).(4)** **review of the current operating environment to identify**  
 1340 **strengths, challenges, opportunities, and threats as**  
 1341 **related to the program's mission and aims.** <sup>(Core)</sup>  
 1342

**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.**

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 1344 **V.C.1.c)** **The Program Evaluation Committee should consider the**  
 1345 **following elements in its assessment of the program:**  
 1346  
 1347 **V.C.1.c).(1)** **curriculum;** <sup>(Core)</sup>  
 1348  
 1349 **V.C.1.c).(2)** **outcomes from prior Annual Program Evaluation(s);**  
 1350 <sup>(Core)</sup>  
 1351  
 1352 **V.C.1.c).(3)** **ACGME letters of notification, including citations,**  
 1353 **Areas for Improvement, and comments;** <sup>(Core)</sup>  
 1354  
 1355 **V.C.1.c).(4)** **quality and safety of patient care;** <sup>(Core)</sup>  
 1356  
 1357 **V.C.1.c).(5)** **aggregate fellow and faculty:**  
 1358  
 1359 **V.C.1.c).(5).(a)** **well-being;** <sup>(Core)</sup>  
 1360  
 1361 **V.C.1.c).(5).(b)** **recruitment and retention;** <sup>(Core)</sup>  
 1362  
 1363 **V.C.1.c).(5).(c)** **workforce diversity;** <sup>(Core)</sup>  
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1365	<b>V.C.1.c).(5).(d)</b>	<b>engagement in quality improvement and patient safety;</b> <sup>(Core)</sup>
1366		
1367		
1368	<b>V.C.1.c).(5).(e)</b>	<b>scholarly activity;</b> <sup>(Core)</sup>
1369		
1370	<b>V.C.1.c).(5).(f)</b>	<b>ACGME Resident/Fellow and Faculty Surveys (where applicable); and,</b> <sup>(Core)</sup>
1371		
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1373	<b>V.C.1.c).(5).(g)</b>	<b>written evaluations of the program.</b> <sup>(Core)</sup>
1374		
1375	<b>V.C.1.c).(6)</b>	<b>aggregate fellow:</b>
1376		
1377	<b>V.C.1.c).(6).(a)</b>	<b>achievement of the Milestones;</b> <sup>(Core)</sup>
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1379	<b>V.C.1.c).(6).(b)</b>	<b>in-training examinations (where applicable);</b> <sup>(Core)</sup>
1380		
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1382	<b>V.C.1.c).(6).(c)</b>	<b>board pass and certification rates; and,</b> <sup>(Core)</sup>
1383		
1384	<b>V.C.1.c).(6).(d)</b>	<b>graduate performance.</b> <sup>(Core)</sup>
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1386	<b>V.C.1.c).(7)</b>	<b>aggregate faculty:</b>
1387		
1388	<b>V.C.1.c).(7).(a)</b>	<b>evaluation; and,</b> <sup>(Core)</sup>
1389		
1390	<b>V.C.1.c).(7).(b)</b>	<b>professional development</b> <sup>(Core)</sup>
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1392	<b>V.C.1.d)</b>	<b>The Program Evaluation Committee must evaluate the program’s mission and aims, strengths, areas for improvement, and threats.</b> <sup>(Core)</sup>
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1396	<b>V.C.1.e)</b>	<b>The annual review, including the action plan, must:</b>
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1398	<b>V.C.1.e).(1)</b>	<b>be distributed to and discussed with the members of the teaching faculty and the fellows; and,</b> <sup>(Core)</sup>
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1401	<b>V.C.1.e).(2)</b>	<b>be submitted to the DIO.</b> <sup>(Core)</sup>
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1403	<b>V.C.2.</b>	<b>The program must participate in a Self-Study prior to its 10-Year Accreditation Site Visit.</b> <sup>(Core)</sup>
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1406	<b>V.C.2.a)</b>	<b>A summary of the Self-Study must be submitted to the DIO.</b> <sup>(Core)</sup>
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**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.

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- V.C.3.** *One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.*
- The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.*
- V.C.3.a)** For subspecialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program’s aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that subspecialty. *(Outcome)*
- 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.

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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. <sup>(Core)</sup>

**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.

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## 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*

**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.

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**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**

1509 ***A culture of safety requires continuous identification***  
1510 ***of vulnerabilities and a willingness to transparently***  
1511 ***deal with them. An effective organization has formal***  
1512 ***mechanisms to assess the knowledge, skills, and***  
1513 ***attitudes of its personnel toward safety in order to***  
1514 ***identify areas for improvement.***

1516 **VI.A.1.a).(1).(a)** **The program, its faculty, residents, and fellows**  
1517 **must actively participate in patient safety**  
1518 **systems and contribute to a culture of safety.**  
1519 **(Core)**

1521 **VI.A.1.a).(1).(b)** **The program must have a structure that**  
1522 **promotes safe, interprofessional, team-based**  
1523 **care. (Core)**

1525 **VI.A.1.a).(2)** **Education on Patient Safety**

1526  
1527 **Programs must provide formal educational activities**  
1528 **that promote patient safety-related goals, tools, and**  
1529 **techniques. (Core)**

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

1531  
1532 **VI.A.1.a).(3)** **Patient Safety Events**

1533  
1534 ***Reporting, investigation, and follow-up of adverse***  
1535 ***events, near misses, and unsafe conditions are pivotal***  
1536 ***mechanisms for improving patient safety, and are***  
1537 ***essential for the success of any patient safety***  
1538 ***program. Feedback and experiential learning are***  
1539 ***essential to developing true competence in the ability***  
1540 ***to identify causes and institute sustainable systems-***  
1541 ***based changes to ameliorate patient safety***  
1542 ***vulnerabilities.***

1544 **VI.A.1.a).(3).(a)** **Residents, fellows, faculty members, and other**  
1545 **clinical staff members must:**

1547 **VI.A.1.a).(3).(a).(i)** **know their responsibilities in reporting**  
1548 **patient safety events at the clinical site;**  
1549 **(Core)**

1551 **VI.A.1.a).(3).(a).(ii)** **know how to report patient safety**  
1552 **events, including near misses, at the**  
1553 **clinical site; and, (Core)**

1555 **VI.A.1.a).(3).(a).(iii)** **be provided with summary information**  
1556 **of their institution's patient safety**  
1557 **reports. (Core)**

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1559	<b>VI.A.1.a).(3).(b)</b>	<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. <sup>(Core)</sup></b>
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1566	<b>VI.A.1.a).(4)</b>	<b>Fellow Education and Experience in Disclosure of Adverse Events</b>
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1569		<i><b>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.</b></i>
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1575	<b>VI.A.1.a).(4).(a)</b>	<b>All fellows must receive training in how to disclose adverse events to patients and families. <sup>(Core)</sup></b>
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1579	<b>VI.A.1.a).(4).(b)</b>	<b>Fellows should have the opportunity to participate in the disclosure of patient safety events, real or simulated. <sup>(Detail)</sup></b>
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1583	<b>VI.A.1.b)</b>	<b>Quality Improvement</b>
1584		
1585	<b>VI.A.1.b).(1)</b>	<b>Education in Quality Improvement</b>
1586		
1587		<i><b>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.</b></i>
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1592	<b>VI.A.1.b).(1).(a)</b>	<b>Fellows must receive training and experience in quality improvement processes, including an understanding of health care disparities. <sup>(Core)</sup></b>
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1596	<b>VI.A.1.b).(2)</b>	<b>Quality Metrics</b>
1597		
1598		<i><b>Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.</b></i>
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1602	<b>VI.A.1.b).(2).(a)</b>	<b>Fellows and faculty members must receive data on quality metrics and benchmarks related to their patient populations. <sup>(Core)</sup></b>
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1606	<b>VI.A.1.b).(3)</b>	<b>Engagement in Quality Improvement Activities</b>
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1608 *Experiential learning is essential to developing the*  
1609 *ability to identify and institute sustainable systems-*  
1610 *based changes to improve patient care.*

1611  
1612 VI.A.1.b).(3).(a)

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

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1616 VI.A.1.b).(3).(a).(i)

This should include activities aimed at reducing health care disparities. <sup>(Detail)</sup>

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1619 VI.A.2.

## Supervision and Accountability

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1621 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.*

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1636 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. <sup>(Core)</sup>

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1643 VI.A.2.a).(1).(a)

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

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1647 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. <sup>(Core)</sup>

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1651 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 appropriate availability of the supervising faculty member or fellow, either on site or by means of telecommunication technology. Some activities require the physical presence of the supervising faculty member. In some circumstances,*

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*supervision may include post-hoc review of fellow-delivered care with feedback.*

**Background and Intent: Appropriate supervision is essential for patient safety and high-quality teaching. Supervision is also contextual. There is tremendous diversity of fellow patient interactions, education and training locations, and fellow skills and abilities even at the same level of the educational program. The degree of supervision is expected to evolve progressively as a fellow gains more experience, even with the same patient condition or procedure. All fellows have a level of supervision commensurate with their level of autonomy in practice; this level of supervision may be enhanced based on factors such as patient safety, complexity, acuity, urgency, risk of serious adverse events, or other pertinent variables.**

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- 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. <sup>(Core)</sup>
- VI.A.2.b).(2)** The program must define when physical presence of a supervising physician is required. <sup>(Core)</sup>
- VI.A.2.c)** Levels of Supervision
- To promote appropriate fellow supervision while providing for graded authority and responsibility, the program must use the following classification of supervision: <sup>(Core)</sup>
- VI.A.2.c).(1)** Direct Supervision:
- VI.A.2.c).(1).(a)** the supervising physician is physically present with the fellow during the key portions of the patient interaction; or, <sup>(Core)</sup>
- VI.A.2.c).(1).(b)** the supervising physician and/or patient is not physically present with the fellow and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology. <sup>(Core)</sup>
- VI.A.2.c).(2)** Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the fellow for guidance and is available to provide appropriate direct supervision. <sup>(Core)</sup>
- VI.A.2.c).(3)** Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. <sup>(Core)</sup>

- 1701 VI.A.2.d) The privilege of progressive authority and responsibility,
- 1702 conditional independence, and a supervisory role in patient
- 1703 care delegated to each fellow must be assigned by the
- 1704 program director and faculty members. <sup>(Core)</sup>
- 1705
- 1706 VI.A.2.d).(1) The program director must evaluate each fellow's
- 1707 abilities based on specific criteria, guided by the
- 1708 Milestones. <sup>(Core)</sup>
- 1709
- 1710 VI.A.2.d).(2) Faculty members functioning as supervising
- 1711 physicians must delegate portions of care to fellows
- 1712 based on the needs of the patient and the skills of
- 1713 each fellow. <sup>(Core)</sup>
- 1714
- 1715 VI.A.2.d).(3) Fellows should serve in a supervisory role to junior
- 1716 fellows and residents in recognition of their progress
- 1717 toward independence, based on the needs of each
- 1718 patient and the skills of the individual resident or
- 1719 fellow. <sup>(Detail)</sup>
- 1720
- 1721 VI.A.2.e) Programs must set guidelines for circumstances and events
- 1722 in which fellows must communicate with the supervising
- 1723 faculty member(s). <sup>(Core)</sup>
- 1724
- 1725 VI.A.2.e).(1) Each fellow must know the limits of their scope of
- 1726 authority, and the circumstances under which the
- 1727 fellow is permitted to act with conditional
- 1728 independence. <sup>(Outcome)</sup>
- 1729

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

- 1730
- 1731 VI.A.2.f) Faculty supervision assignments must be of sufficient
- 1732 duration to assess the knowledge and skills of each fellow
- 1733 and to delegate to the fellow the appropriate level of patient
- 1734 care authority and responsibility. <sup>(Core)</sup>
- 1735
- 1736 VI.B. Professionalism
- 1737
- 1738 VI.B.1. Programs, in partnership with their Sponsoring Institutions, must
- 1739 educate fellows and faculty members concerning the professional
- 1740 responsibilities of physicians, including their obligation to be
- 1741 appropriately rested and fit to provide the care required by their
- 1742 patients. <sup>(Core)</sup>
- 1743
- 1744 VI.B.2. The learning objectives of the program must:
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- 1746 VI.B.2.a) be accomplished through an appropriate blend of supervised
- 1747 patient care responsibilities, clinical teaching, and didactic
- 1748 educational events; <sup>(Core)</sup>

1749  
1750 VI.B.2.b) be accomplished without excessive reliance on fellows to  
1751 fulfill non-physician obligations; and, <sup>(Core)</sup>  
1752

**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.**

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1754 VI.B.2.c) ensure manageable patient care responsibilities. <sup>(Core)</sup>  
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**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.**

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1757 VI.B.3. The program director, in partnership with the Sponsoring Institution,  
1758 must provide a culture of professionalism that supports patient  
1759 safety and personal responsibility. <sup>(Core)</sup>

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1761 VI.B.4. Fellows and faculty members must demonstrate an understanding  
1762 of their personal role in the:

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1764 VI.B.4.a) provision of patient- and family-centered care; <sup>(Outcome)</sup>  
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1766 VI.B.4.b) safety and welfare of patients entrusted to their care,  
1767 including the ability to report unsafe conditions and adverse  
1768 events; <sup>(Outcome)</sup>  
1769

**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.**

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1771 VI.B.4.c) assurance of their fitness for work, including: <sup>(Outcome)</sup>  
1772

**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.**

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1774	VI.B.4.c).(1)	management of their time before, during, and after clinical assignments; and, (Outcome)
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1776		
1777	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)
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1781	VI.B.4.d)	commitment to lifelong learning; (Outcome)
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1783	VI.B.4.e)	monitoring of their patient care performance improvement indicators; and, (Outcome)
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1786	VI.B.4.f)	accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data. (Outcome)
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1789	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)
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1795	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)
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1801	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)
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1806	VI.C.	Well-Being
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1808		<i>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.</i>
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1817		<i>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</i>
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*clinical learning environment models constructive behaviors, and prepares fellows with the skills and attitudes needed to thrive throughout their careers.*

**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: [www.acgme.org/physicianwellbeing](http://www.acgme.org/physicianwellbeing).

The ACGME also created a repository for well-being materials, assessments, presentations, and more on the [Well-Being Tools and Resources page](#) in Learn at ACGME for programs seeking to develop or strengthen their own well-being initiatives. There are many activities that programs can implement now to assess and support physician well-being. These include the distribution and analysis of culture of safety surveys, ensuring the availability of counseling services, and paying attention to the safety of the entire health care team.

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- VI.C.1.** The responsibility of the program, in partnership with the Sponsoring Institution, to address well-being must include:
- VI.C.1.a)** efforts to enhance the meaning that each fellow finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; <sup>(Core)</sup>
- VI.C.1.b)** attention to scheduling, work intensity, and work compression that impacts fellow well-being; <sup>(Core)</sup>
- VI.C.1.c)** evaluating workplace safety data and addressing the safety of fellows and faculty members; <sup>(Core)</sup>

**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.

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

**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.

1849  
1850 VI.C.1.d).(1) Fellows must be given the opportunity to attend  
1851 medical, mental health, and dental care appointments,  
1852 including those scheduled during their working hours.  
1853 (Core)  
1854

**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.

1855  
1856 VI.C.1.e) attention to fellow and faculty member burnout, depression,  
1857 and substance use disorder. The program, in partnership with  
1858 its Sponsoring Institution, must educate faculty members and  
1859 fellows in identification of the symptoms of burnout,  
1860 depression, and substance use disorder, including means to  
1861 assist those who experience these conditions. Fellows and  
1862 faculty members must also be educated to recognize those  
1863 symptoms in themselves and how to seek appropriate care.  
1864 The program, in partnership with its Sponsoring Institution,  
1865 must: (Core)  
1866

**Background and Intent:** Programs and Sponsoring Institutions are encouraged to review materials in order to create systems for identification of burnout, depression, and substance use disorder. Materials and more information are available in Learn at ACGME (<https://dl.acgme.org/pages/well-being-tools-resources>).

1867  
1868 VI.C.1.e).(1) encourage fellows and faculty members to alert the  
1869 program director or other designated personnel or  
1870 programs when they are concerned that another  
1871 fellow, resident, or faculty member may be displaying  
1872 signs of burnout, depression, a substance use  
1873 disorder, suicidal ideation, or potential for violence;  
1874 (Core)  
1875

**Background and Intent:** Individuals experiencing burnout, depression, substance use disorder, 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.

- 1876  
1877 **VI.C.1.e).(2)** provide access to appropriate tools for self-screening;  
1878 and, <sup>(Core)</sup>  
1879  
1880 **VI.C.1.e).(3)** provide access to confidential, affordable mental  
1881 health assessment, counseling, and treatment,  
1882 including access to urgent and emergent care 24  
1883 hours a day, seven days a week. <sup>(Core)</sup>  
1884

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

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

- 1885  
1886 **VI.C.2.** There are circumstances in which fellows may be unable to attend  
1887 work, including but not limited to fatigue, illness, family  
1888 emergencies, and parental leave. Each program must allow an  
1889 appropriate length of absence for fellows unable to perform their  
1890 patient care responsibilities. <sup>(Core)</sup>  
1891  
1892 **VI.C.2.a)** The program must have policies and procedures in place to  
1893 ensure coverage of patient care. <sup>(Core)</sup>  
1894  
1895 **VI.C.2.b)** These policies must be implemented without fear of negative  
1896 consequences for the fellow who is or was unable to provide  
1897 the clinical work. <sup>(Core)</sup>  
1898

**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.

- 1899  
1900 **VI.D. Fatigue Mitigation**  
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1902 **VI.D.1. Programs must:**  
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1904 **VI.D.1.a)** educate all faculty members and fellows to recognize the  
1905 signs of fatigue and sleep deprivation; <sup>(Core)</sup>  
1906  
1907 **VI.D.1.b)** educate all faculty members and fellows in alertness  
1908 management and fatigue mitigation processes; and, <sup>(Core)</sup>  
1909  
1910 **VI.D.1.c)** encourage fellows to use fatigue mitigation processes to  
1911 manage the potential negative effects of fatigue on patient  
1912 care and learning. <sup>(Detail)</sup>

1913

**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.**

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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.**

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- 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 subspecialty and larger health system. (Core)**

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1941	<b>VI.E.3.</b>	<b>Transitions of Care</b>
1942		
1943	<b>VI.E.3.a)</b>	<b>Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. <sup>(Core)</sup></b>
1944		
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1947	<b>VI.E.3.b)</b>	<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. <sup>(Core)</sup></b>
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1952	<b>VI.E.3.c)</b>	<b>Programs must ensure that fellows are competent in communicating with team members in the hand-over process. <sup>(Outcome)</sup></b>
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1956	<b>VI.E.3.d)</b>	<b>Programs and clinical sites must maintain and communicate schedules of attending physicians and fellows currently responsible for care. <sup>(Core)</sup></b>
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1960	<b>VI.E.3.e)</b>	<b>Each program must ensure continuity of patient care, consistent with the program’s policies and procedures referenced in VI.C.2-VI.C.2.b), in the event that a fellow may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency. <sup>(Core)</sup></b>
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1966	<b>VI.F.</b>	<b>Clinical Experience and Education</b>
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1968		<i>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.</i>
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**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.

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1974	<b>VI.F.1.</b>	<b>Maximum Hours of Clinical and Educational Work per Week</b>
1975		
1976		<b>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. <sup>(Core)</sup></b>
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**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 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.

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- 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. <sup>(Core)</sup>**
- VI.F.2.b) Fellows should have eight hours off between scheduled clinical work and education periods. <sup>(Detail)</sup>**
- 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. <sup>(Detail)</sup>**

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

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

**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.**

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- 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. <sup>(Core)</sup>**

**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."

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2010	<b>VI.F.3.</b>	<b>Maximum Clinical Work and Education Period Length</b>
2011		
2012	<b>VI.F.3.a)</b>	<b>Clinical and educational work periods for fellows must not exceed 24 hours of continuous scheduled clinical assignments. <sup>(Core)</sup></b>
2013		
2014		
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2016	<b>VI.F.3.a).(1)</b>	<b>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. <sup>(Core)</sup></b>
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2021	<b>VI.F.3.a).(1).(a)</b>	<b>Additional patient care responsibilities must not be assigned to a fellow during this time. <sup>(Core)</sup></b>
2022		
2023		

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

2024		
2025	<b>VI.F.4.</b>	<b>Clinical and Educational Work Hour Exceptions</b>
2026		
2027	<b>VI.F.4.a)</b>	<b>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:</b>
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2032	<b>VI.F.4.a).(1)</b>	<b>to continue to provide care to a single severely ill or unstable patient; <sup>(Detail)</sup></b>
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2035	<b>VI.F.4.a).(2)</b>	<b>humanistic attention to the needs of a patient or family; or, <sup>(Detail)</sup></b>
2036		
2037		
2038	<b>VI.F.4.a).(3)</b>	<b>to attend unique educational events. <sup>(Detail)</sup></b>
2039		

2040 VI.F.4.b) These additional hours of care or education will be counted  
2041 toward the 80-hour weekly limit. <sup>(Detail)</sup>  
2042

**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.

2043  
2044 VI.F.4.c) A Review Committee may grant rotation-specific exceptions  
2045 for up to 10 percent or a maximum of 88 clinical and  
2046 educational work hours to individual programs based on a  
2047 sound educational rationale.  
2048  
2049 The Review Committee for Internal Medicine will not consider  
2050 requests for exceptions to the 80-hour limit to the fellows' work  
2051 week.  
2052

2053 VI.F.5. Moonlighting

2054 VI.F.5.a) Moonlighting must not interfere with the ability of the fellow  
2055 to achieve the goals and objectives of the educational  
2056 program, and must not interfere with the fellow's fitness for  
2057 work nor compromise patient safety. <sup>(Core)</sup>  
2058  
2059

2060 VI.F.5.b) Time spent by fellows in internal and external moonlighting  
2061 (as defined in the ACGME Glossary of Terms) must be  
2062 counted toward the 80-hour maximum weekly limit. <sup>(Core)</sup>  
2063

**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>).

2064 VI.F.6. In-House Night Float  
2065  
2066 Night float must occur within the context of the 80-hour and one-  
2067 day-off-in-seven requirements. <sup>(Core)</sup>  
2068  
2069

**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.

2070 VI.F.7. Maximum In-House On-Call Frequency  
2071  
2072 Fellows must be scheduled for in-house call no more frequently than  
2073 every third night (when averaged over a four-week period). <sup>(Core)</sup>  
2074  
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2076 VI.F.7.a) Internal Medicine fellowships must not average in-house call over  
2077 a four-week period. <sup>(Core)</sup>

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2079 **VI.F.8. At-Home Call**

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2081 **VI.F.8.a)** Time spent on patient care activities by fellows on at-home  
2082 call must count toward the 80-hour maximum weekly limit.  
2083 The frequency of at-home call is not subject to the every-  
2084 third-night limitation, but must satisfy the requirement for one  
2085 day in seven free of clinical work and education, when  
2086 averaged over four weeks. <sup>(Core)</sup>

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2088 **VI.F.8.a).(1)** At-home call must not be so frequent or taxing as to  
2089 preclude rest or reasonable personal time for each  
2090 fellow. <sup>(Core)</sup>

2091  
2092 **VI.F.8.b)** Fellows are permitted to return to the hospital while on at-  
2093 home call to provide direct care for new or established  
2094 patients. These hours of inpatient patient care must be  
2095 included in the 80-hour maximum weekly limit. <sup>(Detail)</sup>

2096

**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.**

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2100 **\*Core Requirements:** Statements that define structure, resource, or process elements  
2101 essential to every graduate medical educational program.

2102

2103 **†Detail Requirements:** Statements that describe a specific structure, resource, or process, for  
2104 achieving compliance with a Core Requirement. Programs and sponsoring institutions in  
2105 substantial compliance with the Outcome Requirements may utilize alternative or innovative  
2106 approaches to meet Core Requirements.

2107

2108 **‡Outcome Requirements:** Statements that specify expected measurable or observable  
2109 attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their  
2110 graduate medical education.

2111

2112 **Osteopathic Recognition**

2113 For programs with or applying for Osteopathic Recognition, the Osteopathic Recognition  
2114 Requirements also apply ([www.acgme.org/OsteopathicRecognition](http://www.acgme.org/OsteopathicRecognition)).